"Well," he said, "there ain't no constitution that could stand it."

That is the reason—there isn't any constitution that could stand all those things.

I have used *Lac caninum* in alternating throat trouble with success.

DR. GRIMMER: Just a few words in answer to Dr. Morgan. As he knows and we all know, of course, no one person has all these provings. This is the sum total of the symptoms gathered by the provers, but when you meet even a part of the symptoms in a patient, *Lac caninum* may be called to your attention and may prove valuable in many cases. It isn't generally given in cases of gonorrhœa or syphilis, but it is, as we see by the study and by the confirmations of Dr. Clarke and others, highly valuable in both these conditions, and we shouldn't forget it.

—*The Homœopathic Recorder, June, 1947.*

RHEUMATISM AND RHEUMATIC ARTHRITIS

By DR. W. KARO

MR. CHAIRMAN, LADIES AND GENTLEMEN,—The aim of my lecture is to draw your attention to one of the most common and crippling diseases of our time, namely, to Rheumatism.

There are seven cases of rheumatism to every one of cancer, and ten cases to every one of tuberculosis.

The frequency of rheumatism and its seriousness for human welfare may be illustrated by a few figures.

Dr. Kemsley's statistics of the year 1927 show that of 1,000 insured people unfit for work over a period of more than three months, over 14 per cent. were rheumatic cases. Moreover, 16 per cent. of all rheumatic patients are gradually developing diseases of the heart.

The annual death rate of heart diseases in England and Wales is 95,000, of which 40 per cent. are due to rheumatic fever.

Further statistics of Davidson and Duthrie prove that at least 300,000 new cases of rheumatic diseases in Scotland require medical treatment every year. Of these patients 75 per cent. are suffering from rheumatic fibrositis, i.e. rheumatism of the muscles, nerves or tendons.

Impressed by such figures, showing the gravity of the problem, which rheumatic diseases present, Dr. Davidson quite rightly calls rheumatism *"Public Health Enemy No. 1."*.

It was for these reasons that the governments of nearly all civilized countries have set up special committees to investigate the causes and nature of rheumatism in order to find the best way of dealing with the problem.

The committee for England is dividing rheumatic diseases into the following nine groups:—

(1) Rheumatic fever or acute rheumatism.
(2) Subacute rheumatism.
(3) Muscular rheumatism.
(4) Lumbago.
(5) Sciatica.
(6) Rheumatic arthritis.
(7) Osteo-arthritis.
(8) Gout.
(9) Various chronic joint changes.

In the limited space of my lecture I am dealing with arthritis only, and even here I have to restrict myself to a few of the more important points.

It may be easier for you to understand the clinical symptoms when I start off by describing a normal joint. The following sentences are partly quoted from Dr. Phelps' excellent book, *Arthritis* (Medical Publications, Ltd., London, W.7).

The bones are connected by joints, but at the same time are separated from each other by elastic cushions, the so-called articular cartilages, which form the gliding surfaces of the joint. During movement the surfaces rub against each other and the cartilage gives a little, returning only to its normal surface when pressure is released.

The joint cavity is completely enveloped by a tough capsule; their edges are fused to the covering of the bones and thus enclose the articular surfaces.

The capsule is lined on its inner surface by a membrane of flat cells, the so-called synovial membrane.

The joint cavity itself is filled with a light yellow viscid fluid containing numerous drops of oil.

The *rubbing surfaces of the cartilage* are gradually worn off by their activity, and are continually replaced by new living cartilage. The worn-out cartilage undergoes fatty degeneration, and is changed into additional lubricating fluid.

When a joint becomes inflamed, the various tissues of the joint undergo changes. The nature of these changes and the tissues primarily involved *vary* in the different types of arthritis.

We must differentiate between two entirely distinct types, namely, between the rheumatic arthritis and the osteo-arthritis.

Rheumatic arthritis is an inflammatory process which primarily starts in the synovial membrane. It is clinically a constitutional disease, characterized by progressive and symmetrical changes in the joints. It is a disease which on the whole, is more frequent among anæmic, undernourished, asthenic people.

Acute attacks of rheumatic arthritis start suddenly with swelling, redness, heat and pain in the affected joints. Sometimes the pain is so severe that the patient is afraid to move.

He shrinks from being touched and even dreads the shaking of his bed or the slamming of a door. When

several joints are affected, the patient lies with his hips slightly flexed and turned outwards, the knees and elbows bent, and the fingers spread and extended. The rheumatic affliction often moves from one joint to another. For instance, there may be a decline in the affected hip, but the attack may be transferred or spread to the knees or elbows or to some other joint.

As already mentioned, rheumatic arthritis strikes simultaneously the corresponding joints on the right and left sides.

The bilateral symmetrical distribution of rheumatic lesions is the characteristic feature, which distinguishes it from other cases of acute arthritis. Here I must mention the many cases of so-called specific infectious arthritis, such as tubercular, syphilitic or gonorrhœal arthritis. I would add the cases of arthritis associated with other infectious diseases, such as typhoid fever, pneumonia, blood poisoning, also acute cases of arthritis secondary to nervous diseases, such as locomotor ataxy, etc.

All these, and many other cases, although they may represent the same clinical symptoms, have nothing to do with rheumatism. They are never symmetrical.

Whilst rheumatic arthritis starts always in the synovial membrane, osteo-arthritis begins in the cartilages.

Osteo-arthritis, in contradistinction to rheumatic arthritis, is a rather chronic degenerative process, more frequent among well-nourished, obese people during or after middle age. It is characterized by progressive deterioration and erosion of the cartilaginous surfaces of joints and alterations in the bones.

Both types of arthritis are progressive, and with the advance of the disease the surrounding tissues also become involved.

Excessive amount of fluid may or may not be present in the joint.

When the amount of fluid is excessive, the joints capsule and ligaments with the overlying muscles become

stretched and weakened. Muscle atrophy, i.e. wasting, is therefore a common symptom of all kinds of arthritis.

In the advanced and terminal stage of arthritis there are characteristic deformities: —

Inflammation of the joint nearly always causes pain, the nature and degree of which depends on the *amount of inflammatory activity* present.

In the majority of cases the pain is coupled with *contraction* of the neighbouring muscles, a condition called "*muscle-spasm*". It expresses itself in a characteristic manner.

The flexor muscles, which bend a joint, are normally stronger than the opposing extensors, which straighten a joint out. The *spastic* flexors thus overpower the weaker extensors and consequently the joint assumed a position of flexion (is bent), which, if maintained, leads to *a shortening* of the flexor muscles, medically called *flexor deformity*.

In chronic arthritis, where there is *no active inflammation*, pain is only felt on movement of the joint. In these cases pain and spasms appear as *stiffness* of the joint. Stiffness, uncomfortable mobility and pains become progressive. They are especially marked in arthritis of the larger joints, such as knees, or hip, or spine. When the knees are affected, there is difficulty in arising from a sitting position and in climbing stairs. Stiffness and pains are in many cases coupled with increased perspiration.

Furthermore, all these rheumatic or arthritic patients are very sensitive to wind and weather changes; their subjective symptoms are, on the whole, better by dry heat and worse at night.

The diagnosis of an attack of arthritis may be difficult in some cases, due to the fact that the pains are often felt at the periphery rather than at the actual place of the disease. For instance, in a case of arthritis of the hip, the pain is felt at the knee. In cases of arthritis of the spine and of the neck, the pain radiates along the spinal nerves to the arms and fingers. These so-called *radiculitis pains*

may lead to the most serious misconceptions. Take the case of spondylitis of the dorsal part of the spine; in such a case the patient suffers from pains in the chest. These pains are identical with pains due to heart diseases, or, when they are felt in the right side, they might be mistaken for the symptoms arising from gall-bladder disease.

Needless to underline the paramount importance of a correct diagnosis, which can only be arrived at by a thorough examination, appropriate tests and by taking into account the whole history of the patient. It is the only way to plan and carry out a successful treatment.

Before deciding on any scheme of treatment, we should remember that the patient as a whole, and not the label of any disease should be treated. That means every arthritic or rheumatic patient represents a new problem, and his treatment should be individualized accordingly. We should always try to secure the co-operation of the patient. A characteristic feature of the more advanced forms of arthritis is their chronic nature and we should explain to the patient that striking results cannot always be expected, that relapses are inevitable and that the patient should have confidence in his physician's ability to deal with the ever-changing symptoms.

First of all we should estimate the degree of activity of the disease. This is essential, although it may sometimes be a rather complicated task, which cannot be discussed in the limited time at my disposal.

The next step is to search thoroughly for the causing factors. Many factors are believed to play a part in the development of the different forms of arthritis.

The exact ætiology of arthritis, however, remains still unestablished. This applies especially to the question of focal infection. This is a problem which requires our careful consideration. The commonest septic spots are the tonsils, the teeth, the nasal sinuses and the mucous membranes of the intestinal tract. Less frequently are the septic spots in the prostate, the womb, or the gall-bladder.

What should be our attitude, are we justified to treat such cases by conservative methods or should we prefer surgical interference? This question may be very difficult in complicated cases, and I would rather prefer to communicate with an expert, before the patient is condemned to loose all his teeth, to have his tonsils removed or his sinuses operated on. I stress the point that indiscriminate eradication of diseased tonsils or wholesale extraction of teeth is unjustified and does not in the least prevent relapses of rheumatic diseases.

There are, certainly, cases in which an operation should be performed, as every chronic focal sepsis lowers the general resistance of the patient. This is especially true when a closed abscess around the root of a tooth or in a tonsillar cavity is present. Pyorrhœa, however, is no indication for extraction of all teeth. Many cases of pyorrhœa can be cured by conservative constitutional and local treatment. On the other hand a dead tooth or an abscess in or around the apex or root of a tooth calls for extraction.

We should, however, always remember that the eradication of any septic spot, although it often improves, at least for the time being, the patient's general health, is no real cure for rheumatism for the simple reason that the cause of rheumatism is a much deeper thing than a septic spot. Really, it is the condition that produces the spot, and it is this condition which requires our utmost attention.

The clinical fact that colon bacilli are present in almost every septic spot leads to the conclusion that the real cause of rheumatism, at least in these cases, is a more or less serious disorder of the bowels, especially of the colon, where the colon bacilli come from. Our primary therapeutic task in these conditions is therefore to restore the normal functioning of the bowels.

You may know of Dr. Hay's theory that arthritis is nothing but the symptom of a disproportion in the chemistry of the body, and that rheumatism never attacks a person

whose bowels are sufficiently emptied every day and really cleared of the usual fermenting and putrefying slacks.

Whether we accept Dr. Hay's theory or not, it is an undeniable fact that almost every rheumatic patient suffers from a more or less marked insufficiency of the bowels, commonly known as constipation. The Carmin test discloses the fact that even patients who have one or two stools daily, may suffer from a retarded elimination of the waste-products from the colon.

To restore the normal function of the colon we should start the treatment with a fast cure, adapted to the constitution of the patient.

The best known fast cures are the *Guelpa cure* and the Schroth, cure. Both are drastic, but highly efficient cures, which, however, should never be prescribed to anæmic, under-nourished patients who rather need a fattening diet. We better start these weak patients off with 1-2 days fasting on a *fruit* diet and with high colonic irrigations for 3 days running at the beginning, keeping this up once or twice a week until the activity of the colon has been fully restored.

These methods alone may be curative in not too advanced cases, especially if combined with all kinds of physical treatment, such as massage, gymnastics, electrical treatment, etc.

In the majority of chronic cases medicinal treatment is indispensable. It should be carefully planned, no matter which of the many methods of therapy is to be applied.

Each practitioner has his own method, and it cannot be the aim of my lecture to criticize or to advertise any of the manifold methods.

Personally, I rely on the homœopathic principles, which I explained to you in a special lecture. I cannot enlarge on this problem any further, as the time of my lecture is already exhausted.

Let me, in conclusion, only state that no one of us has a single specific drug for rheumatic arthritis, but we have

a specific *cure* for the individual rheumatic patient, if we are able to understand our particular patient's body and mind. We all know that when the patient's mind gives way to gloom and panic, the symptoms of the disease will progressively increase.

Let us not forget that in spite of the great progresses of medical knowledge there will always be hundreds and hundreds of hopelessly crippled human beings, who will need something other than drugs or ointments. They have to be comforted, they need our understanding. Whoever attends such unfortunate patients can only hope to succeed, if he can show a keen sense of cheerful sympathy with all sincerity.

—*Heal Thyself, April, 1947.*

ACUTE AND CHRONIC HEPATITIS

GARTH W. BOERICKE, M.D., PHILADELPHIA, PA.

Diffuse hepatitis or mild jaundice is produced in ninety-five per cent of the cases by either the hepato-cellular or destructive type of liver disease. We are of the opinion that there exists a subclinical form of hepatitis where jaundice is not a feature and where the symptoms are of a purely subjective nature. This we will discuss later in the paper. Somewhat similar to this syndrome is a condition of hepatitis which has followed an attack of jaundice but with the symptoms persisting long after the jaundice has disappeared. This syndrome has been discussed by others. In hepato-cellular jaundice there are several predisposing factors which are of importance. The first of these is malnutrition. It appears that marked depletion of the glycogen reserve increases the case with which the liver cells become damaged. It also has been shown that diet deficient in protein makes the liver more susceptible to this damage and vitamin B fractions if deficient also contribute to hepatic disease.