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SOME EMERGENCIES OF GENERAL PRACTICE

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It would seem that for most of us life comes in phases. For our generation there was the period before the First World War, then the phase of the war, followed by the period between the wars, and then the phase of the Second World War. These are common to all, but there are also phases peculiar to each of us. I am now looking back over the period when I was actively engaged in the work of the Hospital and the teaching carried on there. Thinking of my early days and the difficulties then confronting me I wondered if in any way I could help those starting out on the same road. As a result, I am tempted to offer you this paper on some of the emergencies confronting the beginner in homœopathic general practice.

I think emergencies are one of one's greatest difficulties when beginning to practise Homœopathy. In an acute emergency one has to do something immediately; we cannot spend time hunting for a drug.

All these emergency cases fall roughly into two main groups—the patient who is dying, and the patient who is in great pain. You sometimes get the two combined. There is a third problem—is the case medical or surgical?—and that is always at the back of one's mind. Here it is your general medical skill that comes in; in the other two types it is a question of homœopathic knowledge. So it is the dangerous case and the case of acute pain that I want to consider here.

In the first instance you will find that the matching of acute pain is much the more difficult; the cases of acute danger are much easier to tackle. The dangerous cases usually resolve themselves into a question of cardiac failure in one form or another. I think from the homœopathic standpoint one can tackle these cases of incipient cardiac failure very satisfactorily.

The simplest way to group the dangerous cases from a drug point of view is to look on them under three headings: 1, the cases with acute cardiac failure; 2, the case in which there is a gradual cardiac failure with a tendency to dilatation; and 3, the case of acute cardiac attack of the anginous type.

ACUTE CARDIAC FAILURE

For the acute cardiac failures I think you will find that most of your cases require one of four drugs: *Arsenic, Antimony tart., Carbo veg.*, and *Oxalic acid.* There are various points about these individual drugs which help you in your selection, and you will find

that very soon you begin to select your drug almost as quickly as you spot your pathological condition, and by the time you have overhauled your patient you know what to give.

In the *Arsenic* case you have the typical *Arsenic* mental distress, with extreme fear, extreme anxiety, mental and physical restlessness, and with a constant thirst, a desire for small sips of ice-cold water.

So far as the actual local symptoms are concerned the main complaint is of a feeling of extreme cardiac pressure, a sensation of great weight on, or constriction of, the chest, as if the patient cannot get enough breath in, and a fear that he is just going to die.

The patients as a rule are cold, they feel cold, but they may complain of some burning pain in the chest.

In appearance they always look extremely anxious and are grey, their lips rather pale, may be a little cyanotic, and they give you the impression of being very dangerously ill. They very often have a peculiar pinched, wrinkled, grey appearance.

As a rule in these cases you will get the history that the attack has developed quite suddenly, and the response to *Arsenic* should be equally quick. If you do not get a response to *Arsenic* within a quarter of an hour the patient is not an *Arsenic* one. The first response that you ought to get is a diminution of the patient's mental anxiety and extreme fear, the restlessness begins to subside, and he begins to feel a little warmer.

In these cases my experience has been that you

are wise to administer the highest potency of *Arsenic* you have with you, and as I now carry all remedies up to the *cm.* I always give *cms.* of *Arsenic.* But whatever potency you have with you, use the highest, because this is the kind of case that will die very rapidly and you gain more by giving whatever potency you have than by wasting time going home to get a higher one. The *Arsenic* seems to act very much like a temporary cardiac stimulant, and I find that in the majority of these cases you have to repeat the dose, certainly to begin with, about every 15 minutes.

The next thing is that very often one sees a case of that sort which responds perfectly well, the patient is better, everyone feels he is getting over it, and then in three, or four, or six hours the symptoms begin to come back, the patient no longer responds to *Arsenic,* collapses and dies. That was my experience at one time. Then it began to dawn on me that had I given another drug during the reactive period I could have carried these cases on. I found that when this was done the patients did not get the secondary collapse and were thus saved. To achieve this result you have to give your secondary drug within four to six hours of the primary collapse while the patient is still responding to the *Arsenic,* otherwise you are in great danger of having a secondary collapse which you cannot combat. So remember that this is one of the very few instances in which one appears to ride right across the dictum that so long as the patient is improving one carries on with the same drug. In these acute cases if you have set up a reaction at all

you have got to take advantage of it, otherwise the patient will sink again.

The drugs which as a rule I have found these *Arsenic* cases go on to in the reactive stage are *Phosphorus* or *Sulphur*, but that is by no means constant. You can quite see that grey, pinched, anxious *Arsenic* patient responding, getting a little warmer, less pinched and drawn, not so anxious or restless, with a little more colour, and becoming a typical *Phosphorus* type. Equally you can see them going to the other extreme, where they are too hot, with irregular waves of heat and cold, rather tending to push the blankets off, still with air hunger and going on to *Sulphur*.

These are the two commonest drugs you will need, but whatever the response is you ought to be able to follow up immediately you get the reaction well under way.

The *Antimony tart.* patients have very much the same sort of condition, but mentally they are quite different. In *Antimony tart.* there is a more definite tendency towards cyanosis than in *Arsenic*, you never see a patient needing *Antimony tart.* without very definite cyanotic signs in the finger nails, often extending over the whole of the hands, and the feet may be involved as well.

We do not get the same degree of mental anxiety in *Antimony tart.* as in *Arsenic*. The patients are more down and out, much more hopeless and depressed. They are never quite so restless nor so pale. Again, there is none of the thirst you meet with in *Arsenic*,

in fact anything to drink seems to increase the feeling of distress.

Another contrast is that the *Antimony tart.* patient is very much aggravated by heat, and especially by any stuffiness in the atmosphere. But there is one point to remember here as a contrast between *Antimony tart.* and *Carbo veg.*: the *Antimony tart.* patients do not like a stream of air circulating round them; they want the room fresh, but they like it still.

In most *Antimony tart.* patients there is a very early tendency to œdema of the lower extremities.

Another point which helps in your *Antimony tart.* diagnosis is that practically all these patients have a very thickly coated tongue—it is a thick white coat—and a rather sticky, uncomfortable mouth.

They have a feeling of fullness in the chest much more than the sensation of acute pressure found in *Arsenic.* And you are likely to find pretty generalized, diffuse râles in the lower parts of the chest on both sides.

In contrast to *Arsenic,* the collapse is similar to that after a pneumonic crisis, and if the patient responds to *Antimony tart.* it will carry him through. You do not have to be on your guard to find the follow-up drug as you have to be in an *Arsenic* case.

The *Carbo veg.* case gives the classical picture of the patient with all the symptoms of collapse. They have the cold sweaty skin, are mentally dull, rather foggy in their outlook with not a very clear idea of where they are or what is going to happen to them. There is intense air hunger, and, in spite of their cold,

clammy extremities, they want the air blowing on them; they cannot bear the bedclothes around the neck and they do definitely benefit from the exhibition of oxygen.

They are very much paler than the *Antimony tart.* patients, the lips tend to be pale rather than cyanotic, and there is none of the underlying blueness one associates with *Antimony tart.*

The next point is that they always have a feeling of great distension, not so much in the chest as in the upper abdomen, and the cardiac distress is always associated with a good deal of flatulence.

Like the *Antimony tart.* patients, any attempt to eat or drink tends to increase the distress, and they have none of the *Arsenic* thirst.

Another apparent contradiction you come across in *Carbo veg.* is that, in spite of the desire to be uncovered and the intolerance of the blankets around the upper part of the neck or chest, these patients complain of icy-cold extremities, as if the legs were just lumps of lead, and they cannot get them warm at all.

I think in *Carbo veg.* you have to be careful as to how long you are going to keep up your drug administration when you get the patient responding—sweating less, the surface becoming warmer, and the distress less acute. You are wise then to be thinking of a second drug, because some *Carbo veg.* patients do relapse although many of them make quite a straight recovery on that remedy. You do have to be careful. If you find the patient has responded up to a point

on *Carbo veg.* do not imagine that a higher potency of *Carbo veg.* is necessarily going to carry on the improvement. As a rule it does not, and it is much better to look round for a fresh drug to keep up the reaction. In the majority of these cases the drug that follows best has been *Sulphur*, although *Kali carb.* should always be considered.

The last of the drugs which I commonly think of for these collapsed conditions is *Oxalic acid.*

Oxalic acid has one or two very outstanding symptoms which are a great help in the selection of that drug.

The first is that the patients always complain of a feeling of the most intense exhaustion, very often associated with a sensation of numbness. They frequently state that their legs and feet feel numb and paralysed, as if they had no legs at all.

The skin surface is just about as cold and clammy as it is in *Carbo veg.*, but there is a peculiar mottled cyanosis in *Oxalic acid* which you do not get in the other drugs. The finger tips and finger nails and toe nails will be definitely cyanotic, but in addition there is a peculiar mottled appearance of the hands and feet which is quite distinctive of *Oxalic acid.* There is a somewhat similar mottled, cyanotic appearance in the face, especially over the malar bones.

These patients, in contrast to the *Arsenic* type, want to keep absolutely still, and movement of any kind greatly increases their distress.

In addition to the general distress, most of these *Oxalic acid* patients complain of very definite sharp

pre-cordial pains. These pains are not like the typical anginous stab, but more of a sharp pricking sort of pain which usually comes through from the back and may run up the left side of the sternum towards the clavicle, or down the left side of the sternum into the epigastrium.

The most startling cases giving this picture that I have seen have been in the critical stage of an influenzal pneumonia where the patient was just fading out, having lost all strength, and the heart failing rapidly. I think all the patients of that type that I have seen have been left basal pneumonias. I remember seeing two or three patients who apparently were doing quite well on *Natrum sulph.* react beautifully to *Oxalic acid.* But one does get indications for its use in chronic cardiac cases as well.

GRADUAL CARDIAC FAILURE WITH TENDENCY TO DILATATION

In these cases the heart is just gradually giving out, beginning to dilate a little, becoming slightly irregular, while the patients are going down hill. If the condition is not so acute as to call for one of the four drugs we have been discussing there are another three or four which you may find very helpful. That is quite apart from your ordinary prescribing. You find that in many of these cases in which there is a tendency to cardiac failure: the heart picks up and the tendency to dilatation disappears on your ordinary prescribing, and you do not need to prescribe on the cardiac symptoms particularly, that is to say, the

patient responds to the drug for their general symptoms. For instance, quite frequently in pneumonia, a bad case, with the patient pretty worn out with indications for *Lycopodium* there is a tendency to a failing heart, with dilatation, but after the administration of *Lycopodium* the heart picks up, the pulse steadies, and the tendency to dilatation disappears. You find the same in all acute illnesses where the patient is responding to the particular drug indicated. But you also get cases in which the patient is doing quite well but there is a tendency to cardiac failure which is not responding to the apparently indicated remedy, then you have to consider the drugs for cardiac failure in addition.

For these cases the most common drugs are the *Snake Poisons*, especially *Lachesis* and *Naja*. And less commonly *Lycopus* and *Laurocerasus*.

It is very difficult to distinguish one Snake Poison from another in such conditions. In appearance they are all very similar, but much the most common remedies for these conditions are *Lachesis* and *Naja*.

The *Lachesis* picture I think is pretty typical of all, and there are just a few indications which make one choose *Naja* in preference to *Lachesis*.

In all these cases indicating the Snake Poisons you get a rather purplish, bloated appearance. They suffer from a feeling of tightness or constriction in the chest, more commonly in the upper part of the chest, and they are intolerant of any weight or pressure of the bedclothes, or any tight clothing round the upper part of the chest or neck. All are sensitive

to heat; they feel hot and they dislike a hot stuffy room. They have a marked aggravation after sleep; they get acute suffocative attacks when they fall asleep and they wake up in increased distress.

All these Snake Poison patients in their cardiac distresses have a marked aggravation from being turned over on to the left side. They have a very marked tremor, and their hands are shaky. And most of them as they tend to get worse become mentally fogged, confused, and very often become difficult and suspicious.

If there were nothing more than that, one would give *Lachesis*. But in a certain number of these cases you get rather acute stitching pains which go right through the chest from the pre-cordium to the region of the scapula, associated with very marked numbness, particularly in the left arm and hand. Where that numbness is pronounced one would give *Naja* in preference to *Lachesis*.

If the pain—stitching in character—is more marked one tends to give *Naja*, but if the feeling of constriction is predominant then *Lachesis* is the remedy. But the general symptoms are identical. I think possibly *Naja* is a little less red, less bloated looking, a little paler than *Lachesis*, but that is not very striking.

Apart from the Snake Poisons there are to other drugs which you will find very useful in these conditions. The first of these is *Lycopus*.

You get indications for *Lycopus* in a case in which the heart is just starting to fail; it is beginning to

dilate a little, and the pulse is tending to become a little irregular.

The patients are pale rather than cyanotic, and are always restless.

The outstanding symptom of the *Lycopus* case is that the patients complain of a horrible tumultuous sensation in the cardiac region. They very often tell you it feels as if their heart had suddenly run away and was just going mad. This is accompanied by a feeling of intense throbbing extending up into the neck and right into the head.

The other *Lycopus* symptom which helps is that accompanying this tumult in the chest there is a very marked tendency to cough. It feels as if the heart just runs away, it sets up an acute irritation, and they cough.

Another *Lycopus* distinguishing symptom is that the distress is vastly increased by turning over on the right side—a contrast with the Snake Poisons which are worse turning over on the left side.

Lastly, these *Lycopus* patients have an intense dislike of any food, and particularly of the smell of food.

The last of these drugs I want to touch on is *Laurocerasus*.

The *Laurocerasus* picture is very definite, and I think the easiest way to remember it is to picture for yourself the appearance presented by a congenital heart in a patient 16 to 18 years of age. You know the peculiar bluish-red appearance of the congenital heart, somewhat clubbed fingers, which again are

rather congested, and the bluish appearance—almost like ripe grapes—of the lips. That is the underlying colour you get in *Laurocerasus*.

These patients always suffer from extreme dyspnœa, very nearly Cheyne-Stokes in character. They take a sudden gasp for breath, followed by two or three long breaths, then the breathing gets gradually shallower, next a pause, then two or three gasps, and so it goes on.

Another feature is that the respiratory dyspnœa gets very much worse when the patient sits up; they are better in a semi-prone position.

A point which is an apparent contradiction is that with this extreme cyanosis you get a very early tendency to the development of hypostatic pneumonia at the bases, and when it has developed the cough is very much more troublesome unless they are reasonably propped up. When lying down the cough is worse, yet if they sit up the feeling of constriction is increased, so they have to get a position midway between.

These patients are always chilly. They want to be kept warm, and they feel cold to touch. And of course, as you would expect in a condition of that sort, any movement or exertion aggravates them acutely.

ANGINOUS ATTACKS

Let us look now at the cases with definite anginous attacks. For these cases you must give the patient relief very speedily. It is a little difficult to pick out of the Materia Medica the most commonly

indicated drug for it, but I think one can limit the choice to about one of half a dozen :—*Aconite, Cactus, Arsenic, Iodine, Spongia, Spigelia* and *Lilium tig.*

The outstanding characteristic of the majority of these cases in their first attack is an absolutely overwhelming fear. The patient is certain he is going to die, and that very speedily, and he is terrified. He is quite unable to keep still, and yet any movement seems to aggravate his distress. Here a dose of *Aconite* in high potency will give relief almost instantaneously. I have seen a case of that sort and put a dose of *Aconite* on the tongue and almost before the remedy could be swallowed that patient was feeling better. I usually carried 10*m* as my highest potency in general practice and I gave *Aconite* 10*m*.

That man had a similar attack at a later date, and the anxiety, the distress, and the fear were nothing like so marked because he had come through one attack before, and *Aconite* had no effect at all. That has been my experience. Where you are dealing with the first attack and the patient is quite certain he is going to die, *Aconite* does relieve him right away, but is does not act in a second or later attack. So if you get a man with his first attack, give a dose of *Aconite* and you will probably find in no time he is feeling more comfortable. But if he has had a previous attack *Aconite* will not be helpful.

For the patient who is having a subsequent attack much the most likely drug to help is *Cactus*. *Cactus* has a good deal of anxiety and fear, but it is quite different from that of *Aconite*. It is not a fear that

the immediate attack will be fatal, it is more a conviction that he has an absolutely incurable condition which will eventually kill him.

That is one point about the *Cactus* indications. Another is the type of the actual distress of which the patient complains. He feels as if he had a tight band round the chest which was gradually becoming tighter and tighter and that if this constriction did not let up soon the heart would be unable to function. It is that feeling of *increasing* tension which gives you the *Cactus* indication.

In addition you may get stabbing, radiating pains from the pre-cordium, but they are not so characteristic of *Cactus* as the intense constricting feeling, which is, of course, just exactly how the majority of your anginous patients describe it.

In these acute conditions I always give the drug in high potency because it acts much more quickly and one wants instant relief.

Then you will get an occasional patient having an anginous attack with very similar constricting feelings, not quite so intense but a definite feeling of constriction. The patient has been ailing for some time, is rather anxious and worried, very chilly, and accompanying this feeling of constriction there is an acute, distressing, burning sensation in the chest. These anginous patients respond very well to a dose of *Arsenic*. I have never seen *Arsenic* do anything in an anginous attack except in the rather broken down, ill-looking patient, who is a bit pale, rather withered looking, very definitely anxious, fearful, with

that sense of constriction accompanied by the burning discomfort in the chest. And *Arsenic* does relieve these cases quickly.

There is another type of case which is very similar to that, with very much the same sensation, but the feeling of constriction, the feeling of tension, is described as being actually in the heart itself rather than involving the whole of the side of the chest.

The patients are just about as anxious as the *Arsenicum* patients—in fact all these anginous patients are anxious—but instead of the intense chilliness of the *Arsenic* they are uncomfortable in heat and in a stuffy atmosphere. They are just about as restless, but instead of the pale, drawn appearance which you get in *Arsenic*, they tend to be rather flushed, and as a rule they are dark-haired, dark-complexioned people. They are rather underweight, in spite of the fact that they have always been pretty good livers and very often have an appetite above the average although they have not been putting on weight. These cases respond exceedingly well to *Iodine*.

Then there is yet another type of case in which instead of the complaint being of constriction it is of a progressive sensation of swelling in the heart region. It feels as if the heart gets bigger and bigger until it would finally burst, and this sensation of fullness spreads up into the neck.

This sensation of fullness and swelling is very much aggravated by lying down, when the patient feels as if he would nearly choke, and it is accompanied by very acute pain.

The patients themselves are chilly, and any draught of air increases their distress.

In addition to the feeling of distension, they usually complain of more or less marked numbness, particularly of the left arm and hand, though very frequently there is numbness of the hand only without any involvement of the arm, and not infrequently they complain of numbness of the lower extremities too.

As a rule the face and neck give you the impression of being somewhat congested; they do not have the pale, drawn, wrinkled *Arsenicum* appearance.

And these cases respond well to *Spongia*.

Another drug which you will find useful in a condition which is somewhat similar, though not an angina at all, but which you meet with in hysterical women. You will fail to find any cardiac lesion, but they will produce a symptom picture difficult to distinguish from a true anginous attack. They have the very marked stabbing, radiating pains, and often an intense hyperæsthesia of the chest wall. They are very depressed, frightened, and intensely irritable. They are sensitive to heat, and their distress is aggravated by any movement.

In addition to the stabbing pains they have the anginous sense of constriction, tightness, of the chest wall.

These cases are usually associated with some kind of pelvic lesion, or a history of having had some gynæcological illness.

I have seen quite a number of these cases now

in which an electro-cardiogram shows no lesion at all. And all the symptoms have cleared up entirely with *Lilium tig.*

So you see when you are confronted with one of these very distressing conditions where you have to make a quick decision, it is fairly easy to individualize and get something which will give almost instantaneous relief.

(To be Continued).

—*The British Homœopathic Journal, March, 1946.*

ARTERIAL HYPERTENSION

BY THE LATE DR. FRANCOIS CARTIER

Synonym: Full, hard pulse.

Terminology: English: High blood pressure, German: Grosse spanning.

Spanish: Hypertension. Italian: Hypertensione.

The inequality of the blood pressure does not constitute a special disease, but a pathological condition which is met in a great number of diseases, and which plays a more and more important role in modern therapeutics. It is important then, to keep an eye on it, and it is no exaggeration to say that it is wise to examine one's blood pressure from time to time for the enjoyment of a long life.

In a number of diseases the measurement of the pressure facilitates the choice of the remedy. At the very onset we will group some medicaments together,