EXPERIENCES OF HOMOEOPATHY IN DISEASES OF THE EYE

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I have been asked to write something of my experiences of Homoeopathy in diseases of the eye, and while I gladly accede to the request, let me say at once that I am no expert, for it is only within the last ten years or so that I have practised Homoeopathy at all seriously.

My experiences have lead me to the opinion that it is the only truly scientific and logical method of prescribing. It is scientific because the observer uses as the basis of his activities symptoms which are an accurate subjective delineation of a departure from the normal (whether interpreted correctly is another matter), matching them accurately with the remedy. This is in contrast with allopathic methods where no such sure guide is forthcoming, and where each individual prescribes what seems right to him, there being no general agreement owing to the lack of a basic law of cure, and therefore no truly constitutional treatment.

Pharmacology when studied on homoeopathic principles offers today the finest field for research in medicine, for treatment is undoubtedly its weakest link. It also offers the widest scope for those who have conrage enough to pursue their investigations independently, and for ever cease to perpetuate the errors of their forefathers. It seems a pity that so many millions can be spent on research which often yields such doubtful benefit on humanity, while a system of medicine which has already benefited so many is crying out for investigation and consideration.

I have found that one criticism levelled at the homoeopath is that he treats only by symptoms and tends to ignore pathology and examination by approved physical methods. If this is true it is to be deplored, for while pathology is only gross symptomatology, we cannot afford to ignore any form of information in an economy so complex as the human body.

The eye affords a unique background for observing the effects of drugs. Primary disease is rare, but secondary disease due to disturbances elsewhere is only too common; ulceration, the different forms of keratitis, cataract, glaucoma, retinal and choroidal disease, and the various toxic manifestations are invariably the outcome of constitutional disease—the eye is the offended organ, not the offender.

Hypericum: This was brought to my notice some years ago for the relief of pain following operations on the eye, and it has given me uniformly satisfactory results, replacing the usual anodynes (aspirin, phenacetin, etc.) I had hitherto used, and avoiding the depressing effects of strong drugs. I used the 200th potency for a time, but now prefer the 3x tincture, giving

one dose before and two after operation, at two hour intervals. It relieves the usual pain and soreness felt after the effect of the local anaesthetic has passed off. Its action would seem to be on the ends of divided nerves. When probing the lachrymal duct, patients have asked for it before beginning, as it relieves the pain and soreness afterwards. Although outside my province as an oculist, I have found it useful in dental extractions: in one case sent to me for refractive error, where a portion of the stump of a molar had been left in on account of the condition of the patient, the intense pain which had lasted for five days was relieved quite dramatically by a few doses of Hypericum 6. This remedy ought to form part of the equipment of every ophthalmic surgeon.

Another drug which effected one of the most marvellous instantaneous cures I have ever seen was Cimicifuga raeemosa. The patient had persistent orbital pain, with aching eyes, some headache, and a congested appearance of eyes and lids; also menopausal flushings and pain in the lower part of the back. Tht optic nerve showed a mild hyperaemia with the misty, ill-defined appearance whieh one has come to associate with pelvic disturbance and reflexes from the generative tract. The pain in the eyes and orbit was so intense that the woman was really ill and utterly worn out. Her glasses were correct, and her own doctor had tried almost everything to relieve the condition without avail. What led me to think of the drug I cannot quite say—I suppose it was one of those intuitions which come to most of us sooner or later—however she was given Cim. rac. 3, and the effect was temarkahle; it so impressed the patient she returned two days later to tell me "it was like Homocea, it touches the spot". To see the effect on the eye itself and on the fundus was a revelation. I was never more surprised in any case, and it served to show me what medicine can do, and in such infinitesimal amounts, and how sensitive the body really is.

Sulphur: This is a remedy of which I have little experience except in boils, and in the related Hepar sulph. in suppurations, but within the last month I have learned what it can do in post-operative infection. The patient was 72, and had double subcapsular senile cataract, Rt. 6.00, Lt. 2.60. On November 25th I did an iridectomy on the left eye prior to removal of the lens three months later. The operation was done under the usual aseptic conditions, and I could blame nothing at the time of the operation for the subsequent occurrence. On the third day I noticed more reaction than is normal, suggestive of a mild iritis. (We never give atropine after operation in such cases—they do better without it.) On the fourth morning there was a definite posterior synechia at about 6 o'clock. Atropin, cocaine and adrenalin drops with aspirin internally were used, and the eye improved on the sixth and two following days. On the ninth there appeared to be a relapse, and on the tenth morning, to my horror, the wound was filled with a narrow streak of pus; this slowly increased at the outer limit of the wound and eventually filled the whole angle of the anterior chamber, leaving the pupillary area

relatively clear. Mercurius sol. and Arnica had no effect, and I was afraid to use Hepar sulph. for fear of increasing the quantity of pus. As I thought the case would go on to panophthalmitis and possibly orbital cellulitis, I gave one injection of Edwenil, in the hope of stimulating resistance and absorption. (In a case I had four years ago running a high temperature this material brought the temperature down, but had no effect on the course of the disease, and the eye was lost.) This sent the temperature up one degree, and the next day the anterior chamber was full of pus, and the pupillary area obliterated; my fingers itched to tap the anterior chamber, but the patient persuaded me to wait till the morning. (Incidentally it looks quite a simple thing to tap the anterior chamber, but it is surprisingly difficult to get any material out, and I have never been struck with the procedure at any time.) It was a wise move to desist as it subsequently turned out. The same evening Dr. Frank Bodman saw the case with me, and he suggested Sulphur 6 t.d.s., I think largely from the make-up of the patient. Candidly I thought the eye was doomed, for in an experience of over thirty-seven years, I have never seen a case recover which had gone to the same extent. Three days after we began the Sulphur the temperature dropped one and a half degrees and I was able to detect the position of the pupil. From then onwards the anterior chamber slowly began to clear and the pus absorb. This progress continued uninterruptedly, and ten days after the Sulphur was begun details of the iris could be seen, and there was only a small deposit of fibrotic material below the position of the original synechia. The eye continued to clear, the intense bulbar congestion and oedema, as well as that of the lids, gradually died down, and the patient was up and about before Christmas. I hope to do a successful extraction later. The previous history of the patient was good, but I only discovered during the illness that she has been addicted to boils and had had injections of vaccines and taken quantities of yeast; there was no albumen or sugar in the urine.

It would be interesting to compare the result with that of similar cases treated with the sulphonamide group of drugs, but if the latter cured I doubt if the general condition of the patient would be so good afterwards as it was in this Sulphur case, for nobody would have thought she had come through so serious an illness. Dr. Bodman agrees with me that the result is to be solely attributed to the Sulphur, and I record these details with the greatest pleasure as such recoveries must be very very few indeed.

Speaking generally, what is required in such cases is to mitigate the virulence of the infection and assist absorption. Anything that increases the quantity of pus (drugs or heat) is undesirable, and I do not think tapping the anterior chamber is of much use. Should such a case go on as they usually do to orbital cellulitis and possible meningitis, the eye itself must be treated as an abscess, incised and drained but on no account removed, for fear of interfering with the barrier nature has set up. I have found frequent lavage with a mild antiseptic, such as boracic acid, preferable to strong antiseptic

solutions; permanganate of potash did not suit the case here reported. I should add that atropin, cocaine and adrenalin drops were given throughout this patient's illness, and they evidently did not interfere at all with the action of the Sulphur.

Sulphur poisoning—One of the results of Sulphur poisoning is muscae volitantes. I have now a most intractable case following massive injections of colloidal sulphur for rheumatic fibrositis. This patient had twelve intravenous injections from August to October 1934. Her eye troubles began soon after the beginning of the course. The spots got thicker and thicker. After the third injection her eyes felt like burning coals and as if bursting out of her head; the temporal veins stood out like cords when she had rigors after the injections, and she always smelt sulphur at the back of the nose after each injection. About eighteen months after the eye symptoms began she had operations on the Continent for double glaucoma, iridectomies being done. Objectively I could find no evidence of glaucoma at any time, and my opinion that the operations were unnecessary was independently confirmed by a London oculist. The patient's nervous system was in a dreadful state, and she was to be pitied. I wanted to try the effect of high potency Sulphur, and ordered Sulphur 30, but unfortunately the patient found out what it was and refused to take it.

Incidentally, if anyone can give me a remedy for muscae volitantes I should be deeply grateful, as I have literally tried every remedy in the Pharmacopoeia without avail, as also drugs which depress retinal sensitivity.

Arnica and Ledum: I have found Arnica useful for preventing septic infection, given before operation, for bruising in any tissue, for extravasations and for absorbing styes. Ledum belongs to the same group, and is preferable in some cases of this nature. The following is a recent experience: I was called one day at noon to a throat, nose and ear hospital in which I was advisory ophthalmic surgeon to see a patient who had been operated on that morning for a deflected septum (submucous resection) and who towards the end of the operation developed an alarming proptosis of the right eye. When I saw her, vision was nil, pupil semi-dilated and the optic nerve quite white, temperature 99. The patient was a married woman, thin and scraggy, and manifestly in poor health. She assured me her sight was good when she entered the operation room. I made a diagnosis of massive exudation into the orbit, strangulating the nerve and pushing forward the globe; orbital cellulitis could be ruled out.

My first thought was to give Arnica, but I had read somewhere that Ledum was to be preferred in some cases, and I ordered Ledum 6 every hour. I saw the patient four hours later, when there was a distinct improvement: the proptosis was less marked and the patient thought she saw my hand move across in front of the eye. I increased the potency to 30 and ordered it every three hours. The next morning the proptosis was very much less, vision was 6/36, the pupil reacted well, and by that afternoon (that is,

28 hours after the occurrence) the eye was normal again with vision 6/6.

The staff, both surgical and nursing were so impressed with the result that they wished me to explain the case and treatment. Normally I suppose the patient would have been treated with aspirin and hot compresses which was actually suggested, with leeching or blistering over the mastoid, and in my early days I should probably have done an external orbitotomy to relieve the strangulated nerve. I have never seen a case exactly like this one, though some years ago I removed a clot from the apex of the orbit, the result of a fractured base and damage to a vessel by a spicule of bone.

I feel sure the less operative interference we do the better, and this ledum case is an excellent instance of how it can be avoided. It is a valuable remedy, but space forbids me to write on its more generalized use, but I have seen it give excellent results.

Ruta is a drug I have found useful in accommodation asthenopia, eyestrain from uncorrected error in refraction—what used to be called panorama headaches. It is astonishing what a strain moving objects and the focusing of such make on the accommodation and convergence of the eye. The lateral movements of the eye in the attempt to keep them in focus upset the accommodation, and the far point is never at rest for a moment. Even with the aid of glasses such a strain may be produced, as when driving a car over long distances or for hours at a time. A patient recently was worn out with a very severe headache at the end of a 200 miles' run, in an attempt to cover over 400 miles in two days. Two doses of Ruta 6 were given on the morning of the second day's run. The patient experienced no further trouble whatever and completed the journey in comfort. The fact that medicine will help a case such as this is no justification for not attending to the cause, as in all probability if persisted in it would lose its effect. It is useful also in spasm of the accommodation and a refraction can be done in many cases without having to resort to a mydriatic which would normally be required. In the phorias my experience is that this remedy is of little use.

Cineraria maritima and other drugs for cataract—I have used the juice of this plant for many years with a view to retarding the development of opacities in the lens. Spectroscopically I found it contained large quantities of potassium, and it probably owes its usefulness to this element in an organic form. As cataract advances, the potassium content of the lens gets less and its place is taken by unionized calcium, but this excess by no means indicates that the lens is obtaining enough; it is the ionic calcium available that matters. I have had more successes with calcium and vitamins than with any other form of treatment. Naphthalin will not produce cataract if there is enough calcium available for the needs of the lens.

The cause of cataract should be sought for if possible. Pyorrhoea and septic tonsils in my experience are the greatest offenders. I have seen well-marked opacities clear up entirely after removal of offending teeth. There is no specific in any pharmacopoeia for cataract, as its development depends

on the constitutional condition of the patient and the immediate cause. One of the greatest difficulties we are up against is the hereditary influence. I think we are breeding a race whose crystalline lenses are breaking down earlier than those of our forefathers.

Nosode prepared from cataractous lens material—I have used this for some years, having had it made and given it to provers. In the provings gastro-intestinal troubles such as vague indigestion, colicky pains, and especially nausea were the most prominent, also weakness about the knees and legs. As confirming this latter symptom in the proving, a patient taking the nosode for incipient cataract has so improved in her walking powers that it astonished her husband, as it so clearly occurred after taking the medicine for her eyes.

I think it acts best in lower potencies, but I have tried it up to 12c. I am having one prepared from healthy bovine lens material, of which I find a 2 per cent solution the best means of absorbing cortical masses left behind in cataract extraction, and in traumatic cataract; such injections should be given before operation in any complicated or difficult case. It helps to prevent iritis phacoanaphylactica. I hope this potentized material may act equally well.*

Drosera: This remedy was responsible for a very remarkable result in a long-standing case of obsolescent tubercle of the choroid, with detachment of the retina. I give a résumé of the case:

1926. Illness began with wasting to about 7 stone. No organic disease found. Ditto in 1928.

1930. Saw oculist for blood-shot right eye. W.R. negative. Attended an eye hospital for 18 months. On Potassium iodide. Lost sight of right eye with detachment of retina.

1932. Saw surgeon for right psoas abscess. After operation, cataract appeared in sightless eye (result of the detachment).

1934. Left eye affected. Exam. for T.B. Chest still negative. Given Tuberculin injections, after which a small swelling near right hip became active.

1935. Saw me in Bath. There was a fold of detachment in left retina leading up to a tubercle of the choroid. Left V.A. 6/36. I put him on Tub. bov. for a month, with Adexolin and Haliborange. He remained fairly well for a year, though his sight was still barely 6/24. A month later (9-11-36) a sudden relapse. Vision for hand movements only. Impossible to see fundus and details at site of lesion. I gave Drosera 12, two doses at 6 hours' interval. The next morning the patient could see things on the mantelshelf, and by 5 o'clock the same day the vision had cleared still more. For two days he had photopsia but no photophobia. There followed an interval of two weeks

* For further information, references may be made to the writer's paper 'The Non-Surgical Treatment of Cataract' in *Glasgow Medical Journal*, September 1938, vol. CXXX, p. 109.

during which the vision was unchanged. I then repeated the Drosera 12, giving another dose a week later.

Steady improvement set in, so that within five weeks of this acute relapse the vision in the left eye had recovered from practically nil to 6/6. Ophthalmoscopically a patch of choroidal atrophy could be seen, with a narrow band of detachment leading up to it.

A month later: Vision 6/9. Drosera 18. The eye was very clear for ten days. Five months later, vision still 6/9. Drosera 18, five doses.

I am afraid this article is already too long, but the experiences of Homoeopathy recorded were all with remedies I have thoroughly tested and proved to be of value. Needless to say, a good deal more might have been said in support of the homoeopathic principle, but it was with no sense of writing a complete exposition of its application to ophthalmology that I have recorded these experiences. They are original clinical observations, and as such I hope may carry more weight than if they had been simply abstracted drug pictures.

In conclusion I should like to comment on the ophthalmic sections of the various repertories in common use. In my opinion, much is tabulated and described in terms which are inaccurate and often unknown to modern ophthalmology. While agreeing that special symptoms are probably best described and listed in the provers' own words, it is a fact that in these repertories such symptoms have definite pathological or objective conditions interspersed amongst them. The point I should like to stress is that such conditions should be correctly described. For instance, what is "Paralysis of the optic nerve"? Or what are we to judge from such a vague heading as "Eye-balls—Bad effects from operations", neither the type of operation nor structure operated on being indicated, and with no hint as to the nature of the damage done. Another strange condition is "Perceptive power lost". What does this mean? It might be due to many and varied causes, such as defective light perception or form sense, word-blindness or an error in refraction, and all these with many other possible conditions could not be covered by the one remedy given. It seems obvious that the heading is useless and an example of the type of entry likely to bring the Repertory into disrepute, whereas there should be no reason why any oculist should not be able to turn to such a repertory for help, while remaining on familiar ground, however little he might know of Homoeopathy. As matters stand at present it is a great pity that useful information should be tabulated in such an ambiguous and often erroneous way, so that any oculist reading it would be utterly bewildered and would probably turn the whole thing down as useless.

If such is the case with regard to eyes, on which one may claim to express an opinion, may not such remarks be equally true of other sections of such repertories? I suggest that the whole system needs a thorough revision, preferably by an international commission, and that the materia medica and repertories be critically examined, so that there is nothing redundant nor

irrelevant admitted, and that such revision be undertaken at least every seven years.

Finally, is it not unfortunate that a system of treatment so scientifically accurate and therefore simple should be presented in such a way, with its encumbrances and complications, as to damage its cause from the outset? This is surely one of the main reasons why it has not yet taken its rightful place in modern medicine.

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