

vised nurses and mothers so frequently ply themselves and their little ones. Insufficient clothing, and sudden exposure to cold and inclement weather, by which atonic congestions and inflammations are induced. Scrofulous nurses. Inattention on the part of the nurse to the kind and quality of her own diet, to habits of cleanliness and chastity; in brief, any error of circumstance or condition which tends to irritate her milk and disorder her general system, is a direct and palpable cause of exciting this form of disease in her child.

Symptoms and Diagnosis.—For convenience of description, the disease, as occurring in childhood, may be divided into three stages, as follows:

1. The premonitory symptoms of mesenteric disease are not peculiar. There is obvious indigestion; the bowels are loose; the appetite capricious; the child exhibits considerable languor; throws up its food; is fretful and restless day and night. The doctor says its food disagrees and is not at all appropriate. He recommends, perhaps, farina gruel; or, may be, arrow root; not unlikely malt; and, more than likely, mutton broth, without regard to age or condition. Each is faithfully tried in its turn, but the child grows rapidly worse.

2. The second stage supervenes. The child has fever; its little hands are hot and dry; there is much thirst and manifest hunger, indeed the appetite is rapacious; the bowels move hourly; the stools are lienteric, watery, of deep yellow color, commingled with green; there is much flatulence; the abdomen is bloated and tympanitic. He may have been ill but a few days, and already the disease has made fearful draughts on his strength and flesh. Foolish but well intentioned experiments may have been instituted to nourish the little sufferer, but evidently with no success.

3. The third stage, arbitrarily speaking, finds matters still growing worse. Emaciation and hunger, always characteristic indications of the disease, are now more than ever prominent and ruling symptoms. The skin, owing to the extreme wasting, literally hangs in wrinkles from the limbs; the stools are not less frequent, often fœtid, mixed with the

ingesta, watery; sometimes amber colored, sometimes white and chalky, at others still, green as grass. Hectic fever, olliquative sweats occur, with frequent rigors; restlessness continues; the pulse is frequent, thread-like and compressible; the features are pointed; eyes either dull or glassy. The voice at this low stage of the case is hardly human; its faint whines resembling more the feeble bleating of new born lambs. The bowels may remain swollen to the close, but not unfrequently they become sunken, and exhibit, in common with other parts, an extremely wasted appearance. Well may Sydenham have designated such cases "febris hectica infantum."

When lung complications exist, which is not unfrequent, it is at the later stages they assume the most serious aspect. In addition to the symptoms already noted will be cough; enlargement of the cervical and bronchial glands; ulceration of the throat and the characteristic signs revealed by percussion and auscultation. I have known infants of a few months old afflicted with the disease, cough and raise like old tubercular patients.

It will be observed that I have related above the symptoms, such as will be presented in a case of the disease allowed to run its course unchecked. All cases, happily, do not present this serious phase, because early and effective medical treatment arrests its progress. I always feel proud of my art and satisfied with myself when conscious of having thus arrested the malady and saved the little innocent from a premature and torturing death.

Prognosis.—In respect to the prognosis, much might be said; but would it not be better to read what respectable allopathic authorities say on this point?

Dr. Copeland writes: "When the disease is clearly manifested, the prognosis is unfavorable; and no hopes of recovery should be entertained when it is associated with tubercles in the lungs, or with chronic peritonitis. On the other hand, when the disease is not far advanced, and before hectic symptoms are established, or the emaciation becomes great, or the stools have assumed a chalky or lienteric appearance, hopes

of recovery may be entertained, although, even in these cases, a cautious prognosis should be given. The younger the child the greater is the danger. The causes and complications of the disease should also in some degree influence the prognosis. When these causes admit of removal; when unwholesome food and impure air produce the malady, and may be removed; and when intestinal irritation is the only complication, then, a more favorable opinion may be given than under other circumstances" (*Medical Dictionary*).

Dr. Good writes; "Yet it is only in recent and uncomplicated cases that we can fairly hope for success, let our medical plan be what it may. In the scirrhus, sarcomatous, steatomatous and, especially, the fungous modifications and, more especially still, where several of these are playing their parts simultaneously, the art of medicine may possibly retard, but can never entirely ward off, the fate that is approaching, with perhaps a slow, unperceived, and insidious, but at the same time, with a certain and irresistible stealth of footstep" (*Study of Medicine*; article, *Parabysma Mesentericum*).

Dr. Watson writes: "This (tabes mesenterica) is not only a very common, but a very fatal disease among children and young persons. The glands of the mesentery enlarge and become charged with tubercular matter. * * Their enlargement is commonly connected with scrofulous disease and ulceration of the mucous follicles of the intestines; and the little patients die because the lacteals are no longer able to take up from the food a sufficient supply of nutriment (?) They die starved. But some few cases do recover from tabes mesenterica," (*Watson's Practice of Physic*). Dr. Dunglison also remarks, that the prognosis "is usually unfavorable," (*Medical Dictionary*).

Such briefly is the allopathic estimate of this truly terrible malady, and the confidence which they repose in their method of treating it. What graver comment could be made against a system of therapeutics than that it were important in the treatment of a disease, or class of diseases, not strictly self-limited, and which by nature tend irresistibly to death?

The propriety of rendering a cautious prognosis in so grave a disease as tabes of any kind, is not to be questioned. It is fairly questionable, however, that we are not to hope for success except in "recent and uncomplicated cases," "let our medical plan be what it may." Although it is freely admitted that many case will die despite our "medical plan," from causes and circumstances not within our control, yet when we are able to remove the direct exciting causes of the disease, in other words, to place the patient under favorable relations to life, such as appropriate food, proper clothing, fresh air and sunshine, we should not only hope, but confidently *expect*, to save our patient, whatever may be the specific predisposing causes which we have to contend against.

(*To be continued.*)

HOMŒOPATHIC TOCOLOGY.

BY B. FINCKE, M. D., BROOKLYN, N. Y.

(*Continued from page 258.*)

OBSERVATIONS.—In connection with this subject I beg to submit the following observations:

1. In the case number one, the sac, in which the child was enclosed was a firm and very slippery membrane, but readily separated when once a breach was made into it. It was a uniform transparent parchment-like structure without interlacing fibres and without vascular arrangement. It resembled isinglass very much, with the exception of a bluish-white shade which, however, interfered but little with its transparency. The sac was closely drawn round the fœtus which had just room enough to lay in it doubled up. The membrane was not folded on the abdominal side as it is usually represented in the text books, but smooth and uniform, and in no way different from the dorsal side. The umbilical cord was inserted into it, midway between the two extremities of the sac,

at right angles with the circumference. That part, coiled round the neck of the foetus, was quite blue; that part lying outside of the sac, was white as usual.

The foetal portion of the placenta was much torn and suffused with blood, but not the slightest trace of blood or injury could be detected upon the sac which enclosed the child.

2. Considering this state of things, there can not be the slightest doubt that the sac described was the amnion, and now the question arises, what relation, in this case, did the ovular membranes bear to each other?

In the common mode of normal childbirth (*Eutokia*) the three membranes of the ovum, the decidua reflexa, the chorion and the amnion, form one single sac, which is ruptured during labor. The foetus, then, passes through into the world. The placenta follows the same path, and is either expelled or extracted, with the membranes turned inside out. For the reason of the similitude of the process this discharge of the placenta has been appropriately styled "Afterbirth" (*Hysteron*).

In order to examine the relation of the membranes, we have to draw the sac of the afterbirth back from the placenta. We, then, find, going from without inwards, 1, the rough and bloody decidua reflexa, adhering closely to the chorion; 2, the chorion, and, 3, the amnion. The amnion then is the inner lining of the sac, glistening and slippery, covering at the same time the placenta and the umbilical cord in one continuous envelope. The amnion and chorion sometimes can be distinctly seen to consist of an exterior and an interior lamina, with a shining transparent jelly between. A blow-pipe may, with a little dexterity, be brought in and the membrane infiltrated, to prove the existence of the two laminae. The interior is quite glossy, smooth and slippery, and the exterior somewhat rough.

As we proceed in our examination, after drawing off the amnion from the chorion underneath, all along its connection with it, which in some instances we are able to do, we find the chorion likewise covering the foetal surface of the placenta and the cord. If we now consider the attachment of the

chorion to the placenta, we find that between its two coats, extending all over the placenta, it contains the terminations of the placental vessels which, from all sides, increasing in size, are directed toward the insertion of the navel-string, where they enter into the arrangement of the umbilical circulation. In this same direction the chorion increases in thickness until it forms the insertion of the cord, sometimes visible as a firm fibrous ring, and helps to build up the umbilical cord itself by giving it its internal sheath, the outer covering being furnished by the amnion.

On the placental side, the exterior coat of the chorion, as far as it contains the large collective placental vessels, meets the interior coat at the rim of the placenta and forms a firm fibrous margin of considerable thickness all around. Looking towards the placenta, then, the outer part of the exterior coat of the chorion, is continued into the fibrous structure which in combination with the outgrowth from the allantois and from the decidua vera constitutes the substance of the placenta itself.

Along the foetal circumference, the decidua reflexa, being the membrane lying to the outside, adheres, more or less, to the exterior coat of the chorion.

The question about the relation of the ovular membranes, in the case of intra-amniotic childbirth, can now be answered to this effect: that there the difference is only in the circumstance that the amnion, instead of distending immediately from or within a few inches of its placental reflection upon the cord, is attached to the cord for a considerable length and then distends into the sac enclosing the foetus, entirely independent of the surrounding chorion and adhering decidua reflexa. One part of the cord, therefore, is located outside of the amnion in the open space between amnion and chorion, during gestation.

The higher insertion of the amnion into the cord for a few inches is of no unfrequent occurrence, and is seen sometimes to follow the spinal direction of the cord.

3. Labor, accordingly, may proceed in a two fold manner,

depending upon the attachment of the amnion into the navel-string; the one where the amnion is departing from the point where the cord leaves the placenta or within a few inches near it, the other where it is inserted high enough to admit of an intra-amniotic childbirth.

4. In the first instance, delivery would proceed as usually observed, by rupture of the amnion, though it would not be impossible that, even then, child, amnion and afterbirth, might be expelled simultaneously in its natural order. In that respect it would be interesting to know the specialities of childbirth of Indian squaws and other savages, who are reported to bring forth their offspring without seriously interrupting ordinary duties, or even causing much delay, when participating in long marches.

5. In the other instance, it appears that, in a case like number one, the most favorable chance for natural delivery is presented, inasmuch, as the firmness of the amnion enables the foetus to form a tough, slippery, elastic and elliptic body which is capable of adapting itself to the maternal passage without obstacles intervening, such as prolapse of the extremities. And, in such a case, prolapse of the funis would not be a very formidable sign, if ever it should occur.

6. The contractions of the womb can only tend to present either one or the other of its two smaller and rounded extremities to the one centre of the os tinsæ, and any false presentation is utterly impossible. The presentation, then, would be simplified, being either a vertical or a horizontal presentation. If the latter take place, it will immediately be acted upon and corrected by the womb itself. For the body represents only one larger and one smaller end of the ellipse. If the womb contract equally on all sides upon the body in horizontal position, it will necessarily find more resistance at the larger end than at the smaller one, and the result will be the conversion of the vicious horizontal into the correct vertical presentation. And thus capital or caudal turning would be natural and necessary consequence of the uterine contraction.

7. Montgomery reports very thick membranes, which at

first he took for hydrocephalus. He thinks the assumption of thick and rigid membranes is often erroneous, and that the phenomenon rather depends upon the weakness of the uterine contractions. The cases herein above reported, and all of them, show the firmness of the membranes, but by no means any inefficiency of uterine contractions, since they terminated favorably.

Therefore, and conformably to the preceding observations, it seems altogether advisable, in case of delay, to abstain from artificially rupturing the membranes, because it might deprive us of the very best mode of delivery.

On the contrary, the main indication seems to be, that the uterus in its contractive power should be supported by proper medication.

8. When, after the expulsion, the sack of the amnion remains closed, there seems to be no danger for the child, so long as the cord is pulsating vigorously. For the child must then be regarded as being *in utero* still. The membrane forms a hermetically closed envelope which excludes atmospheric respiration and consequently precludes the necessity of a direct supply of atmospheric air. And the circulation being unimpaired, the child is nourished as before by the foeto-maternal circulation.

9. Here arises a nice physiological question. Is not this, after the expulsion of the child, the natural indication: not to have the cord cut sooner than when it ceases to beat, and then to leave it untied on the maternal side? Possibly, if so, the separation of the placenta from the womb would be facilitated, because the pressure of the placental circulation on the foetal side is taken away by the oozing out of the placental blood through the placental extremity of the separated cord.

We do not know, whether in the reported cases of adherent placenta, the placenta was out or not, before the cord ceased to pulsate, and whether the cord on the external side was left untied. At all events correct observations in this respect are highly desirable.

10. The entire absence of liquor amnii, in case number

one, bears testimony to the complete and perfect development of the fœtus. *E converso*. Hydramnios takes place only in hydropic females, and a large amount of amniotic fluid is observed, together with poorly developed children, in weak females.

11. It is true that some of the other cases show a large amount of liquor amnii together with an entire membrane on delivery. In one case (3) the interior of the membrane looked like a honeycomb; in another (5) the liquor consisted of a yellow unctuous fluid. And there seems to be a certain incongruity between the firmness of the amnion as indicating vigor and the copiousness of liquor as indicating weakness on the part of the mother.

But, if weak and hydropic subjects produce hydropic amnions which soon give way to the pressure, it does not follow that, under certain circumstances, vigorous subjects do not present the two opposite states of firmness of the texture and copiousness of the contents of the amnion. For, then, the seeming incongruity is reconciled by that law of compensation which holds good in organic life as well as in the organic world.

12. If the moderate amount of amniotic fluid which generally does not exceed one to two pounds, is favorable for the development and expulsion of the fœtus; then any larger amount of it must be considered as unfavorable and the more so the more it exceeds the average.

13. Relating to the development of the fœtus, experience proves that weakly and hydropic subjects produce a great quantity of liquor amnii, and at the same time a poor fœtus. The connection between the two facts is obvious. The increased secretion of the liquor amnii indicates, invariably, an impoverished condition of the blood of the mother. This allows a more copious and watery transudation into the fœtal membranes, and lessens the plastic properties required for the development of the fœtus.

14. As to the expulsion of the fœtus. A large amount of liquor amnii, though it implies a thin and less resistant am-

nion, compensating the uterine contractions (since it does not require so much force to break it, as it would if having a greater resistance), yet, it appears to be unfavorable for the expulsion. For, if the amount is large, the fœtus is separated from the walls of the uterus by a greater quantity of intervening fluid, consequently liable to movements not immediately guarded and not regulated by the walls of the uterus. This may cause misplacements of the cord and malpresentations of the fœtus. And the same accidents may be occasioned by the circumstance, that on sudden breaking of the waters a draught ensues towards the os tinsæ, carrying the nearest part of the fœtus, such as the cord or extremities with it, independently of and contrary to uterine action.

15. With the views here entertained, an excess of amniotic fluid is to be considered as a result of an abnormal course of pregnancy, and as such it calls for early and persevering homœopathic treatment.

The presence of such excess is to be ascertained from the size of the abdomen being excessive in proportion to the size of the woman. In order to select the proper homœopathic remedy, this and concomitant symptoms and circumstances have to be examined.

16. It has been stated, very correctly, that pregnancy *per se* is not a pathological state, but a physiological development of the organism. As soon however as it deviates and ceases to be a mere physiological condition, which unfortunately is only too often the case in our present stage of civilization; then it is necessary to obviate and meet the difference on pathological and therapeutical grounds. Homœopathic treatment, judiciously applied, will always be conducive to the best of the organism, and it is a matter of actual experience that when the homœopathic treatment of a case of pregnancy and labor did not seem to prevent evil consequences at that time, it did exert its beneficial influences the next time.

Much will always be gained in any case of pregnancy by a prophylactic dose of Pulsatilla, repeated at intervals of a fortnight.

17. The entire want of liquor amnii, as reported in case number one, is of rare occurrence as Rokitansky states (*Lehrbuch der pathol. Anat.*, Wien, 1861, third edition, Vol. III, page 545), "The amniotic fluid sometimes is present in extraordinary large quantity (Hydramnios); more remarkable, however, are the rare cases, where its quantity is so little, that the fœtus appears to be enclosed tightly by the amnios."

In our case there was no fluid whatever.

(To be continued.)

REMARKS ON ALOES.*

BY CARROLL DUNHAM, M. D., NEW YORK.

Among the remedies of which provings have been published within the last five years, none has seem to me more deserving of attention than Aloes.

The symptoms which have seemed to me the most characteristic are those of the head and of the abdomen, stool and urine. They are those on which my use of Aloes in practice has been based. Chief among these are those of the stool.

From symptoms 512 to 860, we gather that Aloes produces a diarrhœa consisting of light colored semi-liquid fœces, preceded and accompanied by much gurgling and flatus in the abdomen; that the diarrhœa occurs especially in the morning, say from two, a.m., to ten, a.m.; that the desire for stool is sudden and extremely urgent, being felt in the hypogastrium and in the rectum, and being so urgent that the patient can scarcely retain the fœces long enough to effect the necessary strategic "change of base;" that, during this brief interval, he fears to evacuate wind by the anus or to make any physical exertion, or even to strain to pass water, lest he should have an involuntary evacuation of the bowels. This sensation of the uncertain tenure by which the fœces are held

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in the rectum is a very well marked characteristic of Aloes, as shown by the following symptoms:

"The evacuation takes place without any exertion on the part of the patient; it seems, as it were, to fall out of the rectum (765). At stool a constant feeling as if there were more fœces to be passed (769). Involuntary passage of fœces when emitting flatus (824). Disposition to stool when passing water (826). Fœces and urine seem inclined to pass and do pass simultaneously (827). When passing water feeling as if a thin stool were about to pass (828). When standing, sensation as if fœces would pass (833)."

There is also a similar frequency or urgency of the desire to pass urine, with a similar uncertainty in the tenure of that excretion, as we perceive from the following symptoms:

"Frequent desire to urinate (990). Increased desire—quantity not increased (992). So urgent a desire he can hardly retain the urine (993). On rising he was obliged to *run quickly* to urinate (996)."

And the similarity of the affection of the urinary organs and the intestines is shown in symptom 1001:

"At stool urination; when urinating desire for stool."

In connection with these two series of symptoms, those of the pelvis deserve notice. Among them we find, "heaviness, pressure downwards (865, 861). Feeling as if a plug were wedged in between the symphysis pubis and the os coccygis (860)." This is equivalent to a weight upon the perineum. Viewing it in combination with the symptoms of stool and urine above referred to, we are justified in saying of Aloes, in regard to this portion of its sphere of action, that it strikes the patient equally "between *wind* and *water*."

It is understood, of course, that this is not the only action of Aloes upon the abdominal organs. It is believed, however, to be that variety of action which is most characteristic of the remedy and least likely to be confounded with the effect of any other drug. In the frequent desire for stool; in the frequent, pappy, not very abundant stool; in the pressure downwards in the back and pelvis; in the abundant formation of

flatus in the abdomen which rumbles and gurgles, producing pinching pain in the lower part of the abdomen just before the stool, the action of Aloes very closely resembles that of Nux vom., a remedy so useful in diarrhœa and dysentery. It is distinguished, however, by the peculiarities of the evacuation of stool. Nux vom. produces very frequent desire for stool, with inability to evacuate the fœces. Under Aloes, on the contrary, the difficulty is to retain the fœces as long as the patient desires to do so. Aloes seems to paralyze the sphincter ani to a certain extent. Nux vom. to excite in it a spasmodic action of exalted power. In this action on the sphincter. Aloes resembles *Hyoscyamus*.

Among the symptoms of the head I am inclined to regard as characteristic of Aloes, those which describe a heavy confused dullness in the front part of the head extending to the root of the nose with inability to think; a pain in the forehead which compels the patient to close the eyes or, if he wishes to look at any thing, to constrict the eyes, making the aperture of the lids very small. It must be admitted, however, that symptoms so similar to these are found under other remedies, that these symptoms *alone* could not be regarded as a sure indication for Aloes.

The following cases will show how I have prescribed Aloes, and will suggest some reflections upon the mode of selecting remedies in practice.

Within the last three years I have treated about thirty-five cases which so closely resemble each other in their characteristic elements, that the description of all may be given in that of the last of the series which came under my care a month ago.

A young man applied for relief from a diarrhœa which had persisted about two weeks in spite of various remedies which had been prescribed for it, and among which were Calcarea, Nux vom., Bryonia and the inevitable Arsenicum. He described his stools as being light yellow, pappy, somewhat frothy, and tolerably abundant. They were preceded by flatulent rumbling in the abdomen and by pinching pain in the hypogastrium. The necessity for a stool awakened him

from a sound sleep about three, a.m. From this hour to nine a.m., he had from four to six stools of the character above described. None at any other period of day or night. When the desire for stool was felt, the urgency became instantly so great that he was compelled to spring from the bed and hasten to the water-closet. Yet this urgency *was not of the nature of tenesmus* but rather a sensation of weakness in the sphincter, as though he could not prevent the fœces from falling out. During stool which passed freely, in a mass, the instant the restraint of the patient's volition was withdrawn from the sphincter ani, there was a slight burning in the rectum. After stool, cessation of pain, but a very slight general sensation of weakness and lassitude.

During this period, from three to nine, a.m., the patient was compelled to avoid all rapid or severe exertion of body, and especially straining to pass water. The penalty of such exertion or straining was sure to be an involuntary evacuation of fœces.

I prescribed one powder of Sac. lactis containing two globules of Aloes²⁰⁰, to be taken dry on the tongue at ten, a.m. (the hour at which he called on me.) From this time he had no diarrhœa. The next morning he slept until seven, a.m., and at nine had a natural stool as was his habit in health.

Case 2. During the winter season, a gentleman, about 70 years of age, applied for relief from a dull heavy frontal headache, which incapacitated him from mental labor. He could give me no more definite nor characteristic description of his ailment. It was felt as soon as he waked and lasted all day. From such a description as the above, it would be impossible to prescribe with any certainty of selecting the right remedy. I set myself therefore to investigate the patient's previous history in the hope of getting some help from the Anamnesis, to which Hahnemann and Bœnninghausen attach so much importance. I learned that this headache was no new affliction. It had for years annoyed this gentleman, rather more during the winter season, whereas during the summer he was comparatively free from it. No peculiarity of diet or regimen could explain this fact.