

## Introduction

Before discussing the question of prescribing for acute pneumonias I would like to make certain that you all understand the rudiments of what one is attempting to do when tackling cases from the homoeopathic point of view. The point is this. In homoeopathic prescribing your endeavor is to find a drug which will cover not only the actual pathological picture but also the reaction of the individual patient to that disease. Suppose you consider an acute illness, you want a drug which will cover the symptoms that are produced by the infective organism, that is to say, the ordinary symptoms on which you found your diagnosis. The patient is infected, say, with pneumococcus, and has the symptoms of pneumonia, so you want a drug which will cover the pneumonic symptom complex. Well, so far there is no difference from what is done in ordinary medicine.

But, in addition to that, in homoeopathic prescribing you endeavor to find out in what way any one patient A infected with a pneumococcus will react differently from a patient B infected with the same strain of pneumococcus. Your first endeavor is to find the group of drugs which produces the symptom complex of a pneumococcal infection; your second is to choose from that group the individual drug which covers not only the pneumococcal symptoms but also the manner in which the patient A reacts to his pneumococcal infection. The drug which covers the combined picture is the one you want for patient A, but it would not be successful for patient B who's reacting differently to the same infection. So your whole endeavor is to establish the differences between one patient with a pneumococcal infection and another. First of all you find the common ground, on which you make your diagnosis; then you look for the contrasting points in your different cases in order to make your individual prescription.

The whole of your success in homoeopathic prescribing depends on your power of recognizing which symptoms are common to every case of infection by a specific organism and which are dependent on the individual reaction of the patient who is infected. It is your ability to recognize differences in identical diseases which determines your success, and that is why the experienced clinician is a far more successful homoeopathic prescriber than the inexperienced; he knows what a pneumonia should do, how it should behave, what are its constant symptoms, and he comes to a case and says, "Hello, this man is a little different". It is on that difference that he finds his prescription, and it is because he recognizes that difference that he is successful. So do not imagine that the practice of Homoeopathy is going to make your clinical medicine of less use for you; on the contrary, it is going to take advantage of every atom of knowledge and experience that you have, and the greater your clinical experience the more successful you are going to be. We are always hearing that we homoeopaths are symptom hunters, that we prescribe on symptoms alone. We do nothing of the kind. The only successful homoeopathic prescribers I have known have been most observant clinicians. Instead of tending to neglect one's clinical work one pays more and more attention to it and it steadily improves, and it is on that that successful homoeopathic prescribing depends.

From what I have said, you will see the significance of the statement that you must cover the totality of your symptoms, in other words, the symptoms of the disease and all the other symptoms as well. In practice you select the drugs which you know have an affinity to the symptoms of

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the disease you are treating possibly a dozen or so drugs and you can then neglect these diagnostic symptoms, as you know these drugs all have them, and concentrate on finding symptoms which from a diagnostic point of view are not normally considered at all.

Suppose you take a case of pneumonia; it does not interest you that the patient has a temperature, a rapid pulse, rapid respiration, rusty sputum, because all the drugs you consider for the treatment of a pneumonia have these symptoms and you do not need to bother about them at all. But it does matter to you whether the individual patient has a generally evenly coated tongue, whether he has a dry mouth or a moist one, whether he is thirsty or thirstless, whether he is more comfortable lying on the affected side or on the opposite one, whether he is drugged and toxic or delirious and excited, whether he is more at peace with somebody by his bed or prefers to be left alone. All that sort of thing you very definitely want to know; it is on that sort of thing you prescribe; but you only take it into account after you have decided that the drugs you are considering have the constant features on which you have made your diagnosis. It is not a question of neglecting your clinical side; it is a question of knowing which drugs have the clinical picture, and adding to that the points on which you are going to prescribe.

Then there is another difficulty which, from the purely practical standpoint, I want to make very clear, and that is this vexed question of what strength of drug, i.e. potency, you are going to use and what repetition you are going to give.

Where you are dealing with acute disease your choice of potency is very much simplified. It is very much more difficult where you are dealing with chronic disease.

You will find from experience that where you are dealing with acute disease there are two attitudes of mind you can adopt. One is "play for safety", and this was advocated by some of the senior men when I first came here. They maintained that in acute disease if you restricted your prescription to low potencies you avoided the complications of the disease, you made your patients more comfortable, and you reduced your mortality rate.

But by this method you do not reduce your duration of disease.

Suppose you were dealing with the average case of pneumonia in which you expected your crisis from the seventh to the tenth day.

By prescribing low potencies you would relieve the patient's distress, you would diminish the severity of the attack, you would avoid complications such as a developing pleural effusion and possibly empyema; the patient would run a normal course, with a slightly lowered temperature; he would have a perfectly good, well sustained pulse; there would be no signs of a flagging heart; the crisis would be very much more of a lysis than a crisis, but it would not occur before the normal period of seven to ten days.

The patient would never cause a moment's anxiety, he would just steadily get better.

That you can do. I have seen it done repeatedly, and it is a course of action which was strongly advocated in this hospital. They said the mortality rate under that line of treatment was enormously better than the mortality under the orthodox treatment, whether it was the expectant treatment or the active treatment of pneumonia; and I think that is true, your mortality rate will be better.

The second method of treating these acute conditions is by the administration of higher potencies something above a thirty. You will find that by the administration of these higher potencies you

abort the disease. It does not run its normal course; the duration of the illness is very much shortened and you have an anticipated crisis.

Instead of getting the crisis from the seventh to tenth day you get it from twelve to forty eight hours after starting treatment, irrespective of the day of disease.

The relative advantages of the two methods of treatment are obvious.

If you can cut short the duration of an acute illness of that sort you are still further diminishing your complications, you are still further diminishing the stress your patient has to endure, and you are less liable to get any signs of weakness developing. But you have precipitated a crisis, and a crisis is always attended by a certain amount of stress, possibly a certain amount of risk although this is not so likely when the crisis occurs early in the disease as when it occurs after seven to ten days of continuous fever. The temperature crashes over a few hours, but you do not get a collapse because you have a perfectly healthy patient to start with instead of one whose vitality is impaired by long toxæmia.

Another point of contrast in the two systems is this. By using the lower potencies your matching of the drug symptoms with the symptoms of the patient does not require to be quite so accurate as it does when you are using the higher potencies. Where you are using the higher potencies you must get a very accurate correspondence between the symptoms of your patient and the symptoms of your drug.

If you are using the lower potencies you can produce a modifying effect without necessarily covering the whole case, so your work is less difficult. It is easier to prescribe the lower potencies and get a general similarity, whereas if you are prescribing the higher potencies you have to get a much more accurate matching. I am quite sure that anyone who has tried the two systems, and has had a bad case and seen the crisis in twelve hours, never rests satisfied with merely making the patient safe and comfortable over ten days; once you have experienced the power of the one you will never go back to the other. One is more difficult, but it is much better; the other is easier, and is better than treating cases on orthodox lines. One requires more detailed drug knowledge than the other, but I think it is worth while acquiring that knowledge in order to obtain the better results.

Then as far as repetition is concerned. Where you are using low potencies you have to keep up your drug administration right throughout the course of the disease. You will probably find that you have to give more than one drug; your first drug modifies the picture and you then get indications for a second prescription, and possibly a third, before the crisis takes place.

Where you are using the higher potencies, it is advisable to continue the administration of the selected drug until the temperature has reached normal and has remained normal for at least six hours.

Otherwise you will find the patient tends to get a further rise of temperature and will require a second course of medicine, possibly the same but possibly different, say, twenty four hours later, whereas if you have kept up your administration for six hours after the temperature has become normal you do not, as a rule, get any relapse at all.

As regards the frequency of administration of the drug, in the average case, where you are using a low potency it is quite sufficient to give the drug about once in four hours; and, as far as I can see, there is no particular advantage in giving it more frequently. As far as the high potencies are concerned, I think it is wiser to give the drug every two hours, the reason being that you want a

number of stimuli in a comparatively short period of time in order to obtain the crisis within twelve to twenty four hours. So in ordinary practice if giving a low potency, one repeats four-hourly and is perfectly happy to go back in twenty four hours, not expecting to have to change the drug or the potency, and expecting to find the patient more comfortable, without much change in temperature. In another twenty four hours the temperature should be coming down, the patient obviously doing well, and all anxiety disappearing; possibly by then a fresh prescription will be required, but there will be nothing dramatic, and no reason to hurry.

Where you are using a high potency, you start off giving the drug every two hours, and you go back in six, twelve, or twenty four hours. In six hours you ought to find the temperature coming down; in twelve hours it will probably be down to normal, and in twenty four it certainly ought to be.

That is the difference of the two systems, but they are both effective.

Many people advocate that at the start it is wiser to use low potencies until you acquire confidence in your drug selection, and then as you gain greater knowledge heighten the potency and shorten the interval, so that eventually you are treating all your cases with medium or high potency. Possibly it is a wise way to do. Personally, I think it is better to go out for the best right from the start, do the extra work required in order to get more accurate matching, and aim for an early crisis in every case.

It is sometimes said that certain drugs are effective in high potency and certain drugs only effective in low. I do not think this is so.

The reason certain medicines have been found effective more commonly in low potency turns on the point of general similarity. Most of the drugs which are used exclusively in low potencies have not been fully proved; we have no knowledge of their finer differentiating points, we only have a knowledge of their cruder effects. So when you use one of these drugs in a higher potency you cannot accurately match the finer differentiating symptoms of the case. The higher you go, the more accurate the prescribing must be; in low potency a general similarity is enough to give an effect. Suppose you get a marked effect from a low potency, and later go high you will certainly get an effect. In that case it is worth while noting the finer points of the case and seeing if they crop up in the next case in which you think of giving that drug.

In the average case of pneumonia that you meet with there are three stages in the disease. There is first of all the stage of congestion, or invasion, in other words, the incipient stage in which you are in doubt whether you are going to tackle a pneumonia at all. Then there is the stage of frank consolidation, in which the patient is running a good temperature, and has obvious physical signs in the chest.

And later there is the stage of resolution, in which the condition is beginning to clear up. If we consider these three stages from the ordinary clinical standpoint the picture the patient presents is quite different in each stage, and for that reason your drug selection in each stage will be different, so from the homoeopathic prescribing point of view one tends to group pneumonias under the various stages. Firstly, one takes the group of drugs which would apply to the incipient pneumonia. Secondly, one takes the group of drugs which would apply to the frankly developed pneumonia in a strong healthy person. Thirdly, one considers the pneumonias which is either of a more septic type or a straight pneumonia in a bad soil, such as an alcoholic, or again a creeping type of pneumonia or a frank bronchopneumonia.

Fourthly, one takes the group of drugs which would apply to the resolution stage of pneumonia, or the unresolved pneumonia which is not clearing up properly. So from the prescribing point of view you link up your drugs according to the clinical picture.

## **Incipient stage (group I)**

In the incipient pneumonia stage there are four drugs which are commonly indicated, and I think the simplest way is to take these up in order. There are Aconite, Belladonna, Ferrum phos. and Ipecac.

### **Aconitum napellus**

In the Aconite pneumonias you will always get a history of a very sudden onset. Usually the story is that the patient has been out and exposed to cold, and the same evening he comes down with a temperature it is a very acute, rapidly developing condition. You are much more likely to meet with it in the strong, healthy, robust patient. As a rule you will find a high temperature, very marked excitement, restlessness, and pretty acute anxiety. The patient has a full, bounding pulse, a very flushed face, and a hot, dry skin. Usually he complains of a very dry mouth which feels hot and tingling and is accompanied by intense thirst. The desire is almost always for cold drinks.

Well, that is the picture as you see it. And, of course, on that you cannot make your diagnosis; you cannot decide whether the patient has an ordinary chill which will subside in no time, or whether it is going on to a definite Subdivided condition.

Then to take up the points that lead one to prescribe Aconite.

With this intense excitement, restlessness and anxiety, in your Aconite patient you find you have contracted pupils. That is the first point you have to fix on from the prescribing point of view.

The next point is that, in spite of the extremely hot, flushed face and hot skin, your Aconite patients complain of coldness of the extremities.

Another point which is an Aconite indication is that the patients very quickly develop a constant, dry, short cough, which they say is due to the dryness of their throat. Very early they begin to have pains, pretty acute stabbing ones, usually in the left side of the chest.

If you see your Aconite patient after the first twelve hours you can usually make out early signs at the left apex that is where you get your first definite clinical indication that the patient is starting a consolidation. And here a distinguishing point comes in; the Aconite patient with definite early involvement of the left side of the chest is aggravated by lying on the affected side, he is more uncomfortable turned over on the left. The most comfortable position is well propped up, lying on the back.

Very early, if the patient is developing pneumonia, he begins to bring up small quantities of sputum which is streaked with bright blood, and with the effort of coughing he feels as if his chest were being cut.

If you see the patient within the first twenty four hours, or possibly within the first thirty six hours, you will find these Aconite indications, but if it has gone on beyond thirty six hours at the outside you will not get your response from Aconite. Nor will you get Aconite indications. If it has gone beyond the Aconite stage there will be definite patches of consolidation in the affected

lung and you will get no response to Aconite, you will have to go on to one of the drugs for the later stages of pneumonia.

That is the typical Aconite onset. And here I think it might be worth while discussing dosage and repetition in these incipient pneumonias, because the same applies to all four drugs.

In these acute conditions, if you want to abort the attack altogether it is no use prescribing under a 30. If you give 3x of Aconite you will modify the temperature, you will modify the distress, you will modify the anxiety, and you will modify the pain. But you will not arrest the progress of the Subdivision and when you go back and see the patient next day you will be able to make out definite physical signs in the chest. If you give potencies above the 30, when you go back next day you will find that the temperature has fallen and all the symptoms are subsiding. The whole thing just fades out and you will think you have probably made a mistake in your diagnosis and it was merely a common or garden chill and was never going to be a pneumonia at all.

If you have simply an Aconite chill, which has not yet developed a raging temperature, Aconite low will do away with the effects.

But a 6, for instance, will only do it if you get in very early.

Once your raging temperature has developed you must give a high potency if you want to abort pneumonia. If you have simply an irritation from exposure to cold Aconite wipes it out; say the patient has a temperature of 99, a dose of Aconite in any potency will stop it. But if the patient is heading for a pneumonia Aconite 6 will not do it. I have seen it tried.

If you are using potencies above a 30, I think you are wise to repeat your medicine at not longer intervals than one hour for the first four hours, and after that keep up your administration at two-hourly intervals over a period of twelve hours in all. If you do that, and your prescribing is accurate, you will see case after case in which you have obvious physical signs starting, which from your experience you know would be a commencing pneumonia, but which in twenty four hours is perfectly well you simply abort the whole thing. This applies to all four drugs for incipient pneumonias.

The administration must be kept up until the temperature is right down, otherwise it is very liable to swing again.

The 30 also works but it works more slowly; you will abort these cases with it, but not in twelve hours, you will have to keep up the administration longer. At the end of twelve hours you will not be satisfied that the patient is well; he will be obviously on the way to recovery, but you will have to keep up the administration for at least another twelve hours.

### **Ferrum phosphoricum**

The next most common of these early drugs is Ferrum phos. The Ferrum phos. picture also is fairly definite. As a rule, the pneumonia takes a little longer to develop than in Aconite.

For instance, if you get an exposure one afternoon you are unlikely to find the Ferrum phos. picture developing before the following morning. And you may get Ferrum phos. running on to about the third day of Subdivision, until you have definite, obvious consolidation.

The first distinguishing feature between the Ferrum phos. patient and the Aconite is the appearance. Instead of the very brightly flushed face and hot, dry skin of the Aconite, in Ferrum phos. you usually find either a localized flush over the malar regions, or else a very variable state of redness, that is to say, if the patient is coughing, is disturbed, or has to talk, he very rapidly

flushes up a bright red flush, but when he rests that flush tends to ebb away and leave just the malar flush on a rather palish background.

Also in Ferrum phos. you often find a very suggestive pallor round the mouth.

The next thing about Ferrum phos. is that you do not find the same degree of excitement and terror as there is in Aconite.

The patients are more tired, they are very indisposed to talk, they are very sensitive to any disturbance round about them, any noise, any loud speaking seems to distress them, and they want to be left quiet. They are very much more at peace if they are quiet and if no one interferes with them which is exactly the reverse of the Aconite state in which the patients are terrified, want someone to be about all the time, are sure they are going to die, and are afraid to be left alone.

As regards temperature and pulse rate, it is very difficult to distinguish between Aconite and Ferrum phos. Both run a high temperature, and both have a rapid, bounding pulse.

Where thirst is concerned there is very little to it also. They are both very thirsty, and both want quantities of cold water. But occasionally you come across Ferrum phos. patients who complain of rather a sweetish taste, and instead of wanting cold water they prefer something rather sour to counteract this sweet taste.

The tongue in Aconite and Ferrum phos. is different. In Aconite it is usually dry, and not particularly coated. In Ferrum phos. it gives the impression of being somewhat swollen. At the commencement it is usually red, although it may have a faint white coating; by the third day it will have developed a definite coat.

But in the earlier stages it is a rather darkish red, swollen looking tongue.

The Ferrum phos. patient has a pretty incessant, tormenting cough, but, instead of being induced by a sensation of dryness in the throat as in Aconite, it is excited by a sense of irritation lower down behind the sternum. Very frequently you get a history that if the patient has a violent bout of coughing it is very liable to bring on an attack of epistaxis.

There is another constant point about the Ferrum phos. patients, and that is that in their febrile attacks they are definitely chilly.

They are sensitive to cold, and their cough is liable to be excited by a draught of cold air.

Another point that distinguishes Ferrum phos. from Aconite is that the right side of the chest is much more likely to be involved than the left. You very often find pleuritic signs on the right side quite early in the Subdivision, it is not at all unusual for a definite pleuritic rub to develop within forty eight hours of the onset, and with that pleuritic rub you are liable to get the development of very sharp pleuritic pains, which, of course, are aggravated by motion. Apart from their pleurisies your Ferrum phos. patients are often restless, but once they have developed a pleurisy any movement hurts them.

A further point which sometimes helps you is that the time of aggravation in Ferrum phos. tends to be in the early morning, usually between 4 o'clock and 6 o'clock, whereas the Aconite time of aggravation is late in the evening, sometimes up to midnight.

The character of the sputum is a help, though not so much in distinguishing between Ferrum phos. and the other acute drugs as between Ferrum phos. and Phosphorus with which it may easily be confused. In the Ferrum phos. cases you are liable to get a bright red streaked sputum, rather than the rusty sputum of the later pneumonia drugs, in other words Ferrum phos. is indicated in the early stage of consolidation. The Phosphorus sputum on the other hand is beginning

to turn rusty, it is a darker red and there is more blood in contrast to the streaky sputum in Ferum phos.

### **Belladonna**

Here again you have a very clear cut, definite picture. The onset of the Belladonna attack is just about as acute as that of Aconite. You often find a Belladonna case developing the same evening as the patient has been subjected to exposure. The attack is always very severe. It is attended by a violent temperature, running up to 105 or over, with intense excitement of the heart, and a pulse which feels as if it would almost burst through the vessels. The patient is always extremely excited, and I have seen these Belladonna cases, particularly in children, in which the patients have been practically delirious within twelve hours of the onset of the Subdivision, with the temperature running up to 106. They always have a bright red face, and very often you will find a generalized blush over the whole skin and the surface burning hot to touch.

If the patients go on to the delirious state or possibly even short of that you always find intense excitement in Belladonna.

It is not the extreme anxiety and fear of impending death which you get in Aconite. It is a question of excitement; and in the adult the Belladonna case is the type which comes into hospital and Sister reports : "I will have to get a special for this patient, I cannot keep him in bed, he is restless, excited and crying out, and almost impossible to control".

The next thing which distinguishes these patients is the state of the pupils, which in Belladonna are always widely dilated. You can tack on to that the Belladonna photophobia, which is intense; these patients are invariably sensitive to light. If you are nursing a Belladonna pneumonia you are tempted to keep a light in the room as the patient appears to be terrified of all sorts of things, but, if you do, for goodness sake do not let it shine on your patient.

They seem to see strange things in shadowy corners, and one feels one must keep the light on to let them see what is there, but it is absolutely essential that it should not shine on them. This is a very useful distinguishing point, because some of the other drugs have a similar condition in delirium, but they hate to be in the dark and want the room lighted as otherwise they imagine all sorts of thing sin dark corners.

Belladonna patients always prefer to have the room darkened because of their photophobia which outweighs all else.

Then as regards the thirst, Belladonna patients always have a dry mouth. It is always laid down in the textbooks that Belladonna is intensely thirsty, but I have seen quite a number of Belladonna pneumonias in which there was very little thirst at all; the patients complained of the mouth being very dry, hot, and burning, and yet they were not particularly thirsty. So do not be put off Belladonna because the patient is not as thirsty as one would expect from these statements in the textbooks.

In the pneumonias you do not get the typical strawberry tongue that is described in Belladonna; you are much more likely to find a congested, dry, dark red tongue.

I think a right sided pneumonia is more common in Belladonna, but I have seen cases with the main involvement on the left side. The thing that is constant about them is that any movement of any kind is liable to bring on an attack of coughing. In the early stages, the Belladonna cough is a very dry, painful, tearing cough, and the sputum is usually very scanty indeed.

These patients always have a very intense, congestive throbbing headache, which is worse if they are lying with the head at all low, and is frightfully sensitive to any movement.

Another symptom of Belladonna which is sometimes helpful is that the patients are very liable to develop an acute hyperaesthesia of the chest wall over the affected area. The chest wall becomes astonishingly sensitive to touch, and is horribly painful on coughing. And, because of this hyperaesthesia of the chest wall the patients are unable to lie on the affected side.

### **Ipecacuanha**

The fourth of these drugs for the acute stage of pneumonia is Ipecac. and it applies much more to children than it does to adults. I do not know if you were taught, as we were, that 80 per cent. of children's ailments start with an attack of vomiting, no matter what the child is going to develop. I think it is very nearly true, with the result that many of these children with a commencing pneumonia, or possible even more commonly with a commencing bronchopneumonia, show very definite indications for Ipecac..

In my experience the onset of the Ipecac. pneumonia is a little slower than it is in the other three drugs. One usually does not find clear cut indications for it under about twenty four hours. The story you are given is that the child has been seedy the previous day, off its food, possibly feeling rather sickish, or it may actually have vomited. And I think Ipecac. is more commonly indicated in the milder weather than in the intensely cold weather In a pneumonic attack the typical Ipecac. child usually tends to be flushed. It is rather a dusky flush, and the child has a hot, sweaty face. The temperature in Ipecac. is usually not so high as in the other drugs it is roundabout 103 and the pulse is not quite so bounding.

Always in these Ipecac. children the thing that strikes you is the amount of mucus in the chest; there is mostly a diffuse, generalized rattle. And invariably the patients have very suffocative paroxysms of coughing. The point that makes you think of Ipecac. is that these suffocative attacks of coughing very often go on to definite retching and the child brings up a quantity of stringy, difficult, bloodstained sputum. One has to distinguish these attacks from those found in some of the later drugs. In some of the Resolution pneumonias you find similar suffocative coughs, which again go on practically to vomiting, but in them the patients bring up quantities of dark, offensive blood, whereas the blood in the Ipecac. sputum is always the bright red of a commencing pneumonia.

After these paroxysms of coughing you often find the Ipecac. patients very exhausted, and then their flush disappears and you get the typical pallid, whitish, pale lipped Ipecac. patient. You get the impression, after these attacks, that the patients are very tired, very wearied, and during that stage they are awfully difficult to please. They feel rotten, they feel sick, they do not want to be fussed, and they may ask for something, but they do not really want it and will refuse it if they get it, they are just miserable.

In their pneumonic attacks these Ipecac. patients always have a good deal of nasal irritation, with pretty violent attacks of sneezing. I have never seen an Ipecac. pneumonia yet which did not have these sneezing attacks.

The appearance of the mouth is somewhat suggestive. It is usually rather sticky, and I have seen two different types of tongue in these cases.

In a straight going lobar pneumonia I think more commonly the Ipecac.

tongue is clean. But in a bronchopneumonia, where there is probably a good deal of nausea apart from that caused by the actual attacks of coughing, I have seen an Ipecac. tongue which was pretty heavily coated. As a rule these Ipecac. patients are completely thirstless.

Another thing that is constant about Ipecac. patients is that they are always very sensitive to a stuffy atmosphere; it brings on their cough, and it increases their distress, so you find that they always like to have a current of air about them.

Well, that covers your incipient pneumonias, and you ought to be able to abort any of these cases in twelve to twenty four hours. If you do not see the case early enough for that you will probably have to consider one of your other drugs. You may be lucky and get a Ferrum phos. which has persisted, or you may possibly get an Ipecac. which has persisted, but you are unlikely to get an Aconite after the first twenty four hours, or a Belladonna after the first thirty six hours.

## **Frankly developed pneumonia (group II)**

For the average case of frankly developed pneumonia, when you are quite satisfied that you can make your diagnosis on the physical signs, that is to say, the case you see after the first twenty four hours, commonly you have to consider one of four drugs : Bryonia, Phosphorus, Veratrum viride, or Chelidonium. These, I think are much the commonest drugs for the simple, uncomplicated, straight going lobar pneumonias. It is a little difficult to say whether Bryonia or Phosphorus is more common, and it varies a good deal with the season of the year. In the milder weather probably you come across more Bryonia, and in the colder weather more Phosphorus, so over the years you will probably see as many Bryonia pneumonias as Phosphorus ones. As regards the other drugs, there will be a year, or an epidemic, in which you will see quite a number of Veratrum viride pneumonias, and then there may probably be two or three years in which you see comparatively few it seems to run in definite strains of pneumonic infection. The Chelidonium pneumonias are a little less common, and I think they also tend to come more in the milder weather than in the sharp, cold weather.

### **Bryonia alba**

In the Bryonia pneumonias there is usually a history of a fairly gradual onset. The kind of story you get is that the patient has been out of sorts for a day or two, complaining of indefinite feelings of malaise, and then that one morning he woke feeling thoroughly ill, very often with an attack of sneezing and a feeling of blocking in the head.

During the morning he felt shivery, he may have had an actual rigor, and by the afternoon he had a good going temperature. The probability is that these people have been running a slight temperature for the previous twelve to twenty four hours, though they have not consulted you for it; they have certainly been off colour.

When you see a Bryonia pneumonia the impression you get is of a definitely congested, heavy looking, sleepy looking patient.

The face is somewhat dusky in colour. The patient feels hot, and usually has a hot, damp sweat. It is not a profuse perspiration but the skin is hot and damp. Twelve to twenty four hours later you very often get a dusky appearance of the extremities. About the same time you find the lips are beginning to turn dusky in colour, and they very soon tend to become dry and to crack. They have a somewhat swollen appearance.

The patient very often complains of a rather intense frontal headache which settles down over the eyes. Often it is much more a feeling of weight than of actual pain, but it becomes painful on any movement or exertion, such as talking or sitting up. Another thing you can link on to this aggravation of the headache from sitting up is that these Bryonia patients very often feel generally extremely ill on sitting up, they become giddy and somewhat faint.

In these Bryonia pneumonias you always find a heavy thick, white coating on a dry tongue; the mouth feels dry, and the patient is very thirsty. Very often there is a bitter taste in the mouth, and the main desire is for large quantities of cold water. In this connection there is one point that is worth remembering about the nursing of these patients, and that is that if you let them drink as much cold water as they want it is bad for them and very often makes them feel sick. So when dealing with a Bryonia patient it is wise to regulate the quantity of water they take, especially at any one time, and not to allow them to have all they would like.

The next thing to consider is the mental reaction of Bryonia patients.

Bryonia patients, as I said before, look heavy and dull, and they very definitely dislike being disturbed at all. They resent having to do anything, for instance, having to move, or having to turn over to be examined. They dislike having to talk, and talking upsets them and makes them worse. They are very short tempered and they are difficult to satisfy. They often ask for something and refuse it when it is brought to them, they are thoroughly cross grained. They easily become annoyed, and if they are annoyed it always aggravates their physical condition.

I have often seen a Bryonia pneumonia who was doing quite well until he had visitors in who annoyed him and promptly he had a rise of a degree or a degree and a half of temperature in a couple of hours, with increase of physical distress, increase of cough, and very often marked increase of pain. So, again from the nursing point of view, you are very wise to prohibit visitors to your Bryonia patients. This is sometimes a little difficult to do, because the Bryonia patients rather tend to harp on their business affairs, they think about them, they talk about them, they often worry about them, and very often they ask to be allowed to see somebody from the office. If you do allow it, they are most likely to be annoyed at what the people in the office are doing, and this annoyance is very bad for them. So, from the practical point of view, never allow any possibility of such a thing happening in the case of a Bryonia patient.

As far as the actual physical condition is concerned, in Bryonia you are much more likely to kind the right lung involved than the left. If the Subdivision is more extensive, you find the right lung involved to a greater degree than the left. But do not rule out Bryonia altogether because you have a left sided pneumonia; I have seen several pneumonias now which were confined to the left side but in which Bryonia was indicated and worked very well indeed. So do not say, "well, this is a left sided pneumonia, it cannot be a Bryonia "it can. Much more commonly you find the right side involved, but the fact that it is left sided does not rule Bryonia out.

In these Bryonia cases you are very liable to get a pleurpneumonia, rather than a straight pneumonia, with very sharp, intense, pleuritic pain. And there are one or two points about that pain which are sometimes helpful. First of all, it is very much aggravated by any movement on the patient's part. Secondly, it is usually mainly on the right side. Thirdly, the patient likes to lie on the side that is affected; if it is a right sided pneumonia you find him turning over on to the right side as that is the most easy position, and if it is a left sided pneumonia you find him turning over on to the left side.

When the patient coughs which he does a great deal he has intense pain in the chest, and it is then that you see the Bryonia picture of the patient sitting up in bed trying to hold the chest with his hands to keep it quiet while he is coughing. And, again from the clinical point de view, you do give your Bryonia patients great help by strapping up the affected side of the chest; either adhesive plaster or a tight binder gives great relief. You know the modern custom is to put anti-phlogistine on the pneumonia patient; well, it does help the Bryonia case, but it is the splinting of the chest that helps, more than the antiphlogistine itself.

The breathing of the Bryonia patient is always very sort. He takes short, panting breaths, keeping the breathing as shallow as possible because any movement of the chest wall hurts. So you see the patient sitting firmly propped up, breathing short, panting breaths.

Usually in these Bryonia pneumonias there is a certain amount of irritation in the throat, and the patients mostly have a rather hoarse voice.

There are one or two other points if the pneumonia has gone on a little further and run into the fourth, fifth, or sixth day. These patients then become more toxic, more drugged looking, rather heavier, and they are liable to develop a low type of muttering, wandering delirium; it is never a very violent one. In their delirium they are very often uncertain as to where they are, for instance, if they are at home they do not recognize it and they say they want to go home. They are also very apt to develop that old Bryonia symptom of worrying about their business; they think they are still at work, they have a deuce of a lot to do, and they keep on talking about it and imagining they are still back at the office.

Then occasionally but not so commonly you find one of these Bryonia patients becoming acutely anxious, and when this anxiety state develops you will quite often get him becoming restless.

That is a little apt to confuse you because you have it firmly imprinted in your mind that Bryonia is very much aggravated by any movement. But if you go into the question he will tell you that, although any movement increases his discomfort and his pain, he just cannot lie still even though moving hurts him. It is never the extreme restlessness that you get in some of the other drugs, and if it is associated with that nervous anxiety do not rule out Bryonia on the fact that the patient is restless.

Another Bryonia distinguishing point is that the patients are hot blooded. They feel hot, and they are uncomfortable in a hot atmosphere.

If the room is too warm it will aggravate their cough, and they very much prefer a cold room and a current of air.

Well, that is the commonest type of pneumonia, at least in this country.

Possibly, as I say, it is rather commoner in the spring than in the real cold, wintry weather, and you will find that Bryonia will cover the majority of the cases you see of that type.

### **Phosphorus**

The next commonest drug in pneumonia is Phosphorus.

As a rule the Phosphorus pneumonia develops rather more quickly than the Bryonia one. The kind of story I have come to associate with a Phosphorus pneumonia is that the patient had been feeling very tired for possibly twelve or twenty four hours, and then he probably went out into a cold atmosphere and on going out felt an acute sense of oppression or tightness in the chest.

Usually the same night he left hot and developed a dry cough. Possibly there was also a little

hoarseness, or even actual loss of voice, and the feeling of tightness and oppression in the chest very much increased. Next he developed a sort of catchy respiration, a slight embarrassment on inspiration, and the breathing became rather difficult.

In appearance you will find the Phosphorus pneumonias have a brighter red flush than the Bryonias they are not quite so dusky. Although they have a flush, when they are peaceful it tends to die down a bit, and you do not get the same degree of cyanosis of the lips. The skin surface is hot, and it is moist, but not so moist as in Bryonia. Though the patients are obviously tired they do not give you the same impression of sleepiness as the Bryonias do; they are more awake, they are more worried, and they are more anxious.

One seeing these patients you are immediately impressed by the fact that their respiration is seriously embarrassed. Their breathing is obviously difficult, and they say they cannot get enough air; Very early in the Subdivision there are signs of the accessory respiratory mechanism coming into play, the chest wall is heaving a bit, the nose is flapping, and the patient is obviously having difficulty. In these earlier stages the difficulty is out of proportion to the actual physical signs to be found in the chest.

Next you notice that the patient tends to be rather tremulous. The hands are a little shaky, the facial muscles are twitching, and there may also be irregular twitching of the alae nasi.

Always in these Phosphorus pneumonias there is a very trying, tormenting, irritating cough. And that cough is very often accompanied by a feeling of rawness, or burning in the chest.

In the earlier stages, I think, the Phosphorus tongue tends to be dry and reddish, and it gives you the appearance of being a little swollen.

But by the third or fourth day there is a certain amount of light, dry, white or whitish yellow coating; These Phosphorus patients are always intensely thirsty, and their desire in pneumonia, as always, is for cold drinks. Phosphorus patients, no matter what their ailments, always want cold drinks, but in pneumonia, with their very dry mouth, they very often ask for something juicy or sour rather than plain cold water.

There is another point that sometimes helps you in the diagnosis of your Phosphorus pneumonias, and that is the position which the patients find most comfortable. They want to be propped up, which is not surprising when you consider the feeling of oppression in the chest, but in addition to that you often see them with the chin tilted up and the head thrown well back, which they say very considerably helps their difficult breathing.

That is a useful point, because it distinguishes Phosphorus from some of the other drugs which take up a position leaning forward with the elbows on the knees. There are not many drugs which adopt the Phosphorus attitude, and it is always very suggestive when you see it.

Another point which ought to help you is that they are chilly patients; they feel the cold, and any draught of cold air is liable to excite an attack of coughing.

A further helpful point is that in their pneumonias, with their state of anxiety and distress, Phosphorus patients very much dislike being left alone. They become scared if they are alone, and they feel very much more peaceful and comforted if they have someone about, particularly if they are in actual contact with them. It is not enough merely to sit by the bed of a Phosphorus patient, he wants you to hold his hand, and the actual physical contact gives him a sense of great relief.

There is one point I missed in both these drugs, and that is the character of the sputum. In the Phosphorus patient in the earlier stages there is a very tormenting, dry cough, with very little sputum indeed.

By about the third day that sputum tends to increase, and there is a rather bright, red streak through the mucous sputum. By the fourth day that red streak is becoming darker, and very soon afterwards the typical rusty sputum appears.

In the Bryonia case the sputum is much darker in colour right from the beginning; even before it reaches the actual rusty stage of consolidation the blood in the sputum is darker than that of Phosphorus.

And the sputum in Bryonia is, I think, more sticky, more difficult to expel, and rather tends to hang about the mouth. The Phosphorus sputum is liable to be a little more watery, and although scanty it is easier to get up.

As regards the temperature and the pulse rate in Bryonia and Phosphorus than it does in Bryonia, and possibly the pulse is a little fuller, but they both run a temperature round about 103, and they both tend to have quite a full, strong pulse.

### **Veratrum viride**

The third of these frank pneumonia drugs is Veratrum viride, and here you have a very clear cut picture indeed.

The onset is very similar to that in a Phosphorus case. It develops at much the same rate, but is not attended by the same degree of oppression of the chest. In Veratrum viride there is a very much more rapid rise of temperature, and there is apt to be a much higher fever, probably running up to 105. There is a difference in the colour of the Veratrum viride patient and the Phosphorus patient. It is a little difficult to put into words, though if you could only see the two patients it would be quite easy to point out the difference. Although both are congested, and both have red faces, yet I think the Veratrum viride patient gives you the impression of being a little more livid than the Phosphorus one; I think that is the nearest one can get to it.

The Veratrum viride patient always complains of a feeling of intense pulsation, he feels as if his heart were simply pounding out through the chest wall. The pulse is full and bounding, and with that you very often get the impression that the Veratrum viride patient's face is rather bloated and swollen looking.

There is always marked excitement in these pneumonias. Very violent delirium may develop quite early, and the patients are liable to have all sorts of obsessions that they see faces and figures on the wall.

It is always something terrifying that they see, and with that state of intense excitement, in Veratrum viride you will always find widely dilated pupils.

You will realize that this is almost word for word a repetition of the description of the picture you meet with in Belladonna, but it is impossible to confound the two. Belladonna has an intense flush and a burning dry skin; whereas Veratrum viride is lived and covered with beads of sweat. In spite of the high temperature, and without any fall in temperature, there is always profuse perspiration in the Veratrum viride patients.

I have seen them in pneumonia with a temperature of 105, the sweat standing out in beads all over, and in spite of that profuse sweat there was no drop in temperature at all.

These *Veratrum viride* patients are always intensely thirsty, and very often with their thirst there is a feeling of slight nausea. There is one point, a clinical one, that I want to give you about their thirst.

I have never come across it in any of the *Materia Medica*s, but clinically I have had it verified quite frequently and it is that the *Veratrum viride* patients often complain of everything they take tasting abominably sweet. For instance, I remember the first child I saw with a *Veratrum viride* pneumonia, and one of his bitterest complaints was that everything he took, plain water, fruit drinks, anything in fact, tasted abominably sweet.

We had an awful hunt to try and match it up with a drug, and finally it was on his general indications, not on his sweet taste, that he got his *Veratrum viride*, and he promptly cleared up. Since that time I have had the symptom verified at least half a dozen times. You do not always get it, but when you do it is a useful lead towards the possibility of *Veratrum viride*.

There is another point which is almost diagnostic of *Veratrum viride* when you meet it, and it concerns the tongue. You get two types of tongue in *Veratrum viride*. One has a thick, yellowish coating, and it is not uncommon. But the one that you look for, and hope for, is a tongue with a thick coating and a bright red streak down the centre.

If you have a pneumonia with a high temperature, full bounding pulse, generalized sweat, thirst, and that red streak down the centre of the tongue, you need not bother your head any further; that is *Veratrum viride*, and will clear up on it every time. I remember one year we had six *Veratrum viride* pneumonias in the hospital during the winter; they all had *Veratrum viride*, and every one of them had their crisis the same night. So if you have these legs to stand on you are perfectly safe to push in *Veratrum viride*, and you will get your results every time.

There is one other point that I have had verified. You know the *Bryonia* patients have an aggravation from having to sit up, it makes them giddy and they very often resent having to move.

In *Veratrum viride*, also, there is an aggravation from sitting up, but it is different; the patients do not become giddy, but they complain that their vision becomes dim. I have verified that clinically on several occasions. You can tack on to that another *Veratrum viride* symptom on which is not uncommon, I think, in the drugs with widely dilated pupils and that is that you always find a certain amount of photophobia in the *Veratrum viride* patients.

The sputum in *Veratrum viride* comes in about midway between the *Phosphorus* and the *Bryonia* ones; it is not quite so bright as the *Phosphorus* and not quite so dusky as the *Bryonia*. It is a little difficult to expel, it is a little sticky, and there is always a certain amount of chest pain while coughing and trying to bring it up, but there is not the acute, stabbing pain of *Bryonia*, or the raw burning of *Phosphorus*.

### **Chelidonium majus**

I think most of the pneumonias in which you give *Bryonia* without success are cases in which you have missed *Chelidonium*. The two are very alike in appearance, and they are very alike in the character of their pains. They are also very similar in onset. The *Chelidonium* patients are usually rather out of sorts, and you very commonly find that they have had a loss of appetite and general discomfort preceding the onset of their pneumonias.

In Chelidonium the appearance is somewhat dusky. It is rather similar to the Bryonia duskiness, but, instead of the bluish look that you find in Bryonia, there is a slightly yellowish tinge in Chelidonium.

On this yellowish base there is liable to be a rather localized, deeper, malar flush, and quite often that flush is one sided. Very commonly it is the right side which is more flushed than the left.

As far as mentality is concerned, these two drugs are very similar, or at least they appear to be so at first sight. The Chelidonium patients are lethargic, they do not want to be disturbed, they do not want to make any effort, they are as much aggravated by movement as the Bryonia patients, and they are definitely irritable. But their irritability, when you get down to it, is rather different. Bryonia patients are absorbed in their own worries, and say "for heaven's sake leave me alone", whereas Chelidonium patients are much more spiteful and snappy. For instance, you may be cross questioning them and going along quite nicely, and suddenly they spit out at you in the most surprising and uncivil way that is the typical Chelidonium reaction.

Then always in Chelidonium at least in every Chelidonium case I have seen the involvement is on the right side. Bryonia also has the involvement on the right side, and yet it is just here that you get distinguishing points. In the Bryonia case as a rule the pains in the chest are much more round towards the axilla, or round towards the back. In Chelidonium the pains tend to be more towards the front, and go right through to the scapular region. Instead of the sharp, stabbing pains being in the side, you get them more in the front of the chest and going right through to the back.

As regards the appearance of the tongue in the two drugs, the Bryonia one tends to be whitish, and the Chelidonium one tends to be yellow. As far as the sputum is concerned I think there is more profuse expectoration in Chelidonium, it is not so difficult to get up, and it is not quite so dusky as the Bryonia sputum.

Then you get your outstanding distinction. In Bryonia you have an intense thirst for cold drinks. In Chelidonium you have a desire for hot things. So there the two drugs at once part company. As a rule the position taken up by the two patients is different. The Bryonia patient tends to turn over on to the affected side.

The Chelidonium patient likes to sit up and lean forward. Both keep as still as they possibly can. By the way, there is one point I have missed in all the drugs, and that is their period of aggravation. In Bryonia it tends to be roundabout 9 o'clock in the evening. Chelidonium has two periods of aggravation, it has one about 4 o'clock in the afternoon, and another about 4 o'clock in the morning, so there is a double periodicity in the twenty four hours. As far as Phosphorus and Veratrum viride are concerned, there is no definite hour of maximum intensity, but both tend to become worse in the evening just before nightfall, when there is a period of increased excitement, increased nervousness, and increased apprehension.

Well, these are the main drugs for your ordinary, frankly developed pneumonias.

### **Dosage in Developed Pneumonias**

Where you are dealing with any of these typical lobar pneumonias I think the question of dosage is really quite simple.

There was a good deal of difference of opinion, and I think there is possibly some difference still, as to the optimum potency in these frank pneumonias, but having watched it here over the last twenty years I have no doubt myself as to what gives the best results.

When I came here first almost everyone in the hospital was using low potencies in these cases. Later some of the men started using medium potencies, usually a 30, and with great courage a 200. In America I had been taught to use much higher potencies, and of later years this practice has been more and more adopted here. Now we are using all potencies up to the very highest, and I am convinced that, where the prescribing is accurate, the best results are obtained by the use of the very highest potencies. I should say that in my own practice, in the average case, I would prescribe a 10m, though where the indications were very clear my preference would always be to go higher provided there were no contra indications. I give cm's in preference to 10m's if I am perfectly certain that I have the right drug.

Then as regards repetition. Watching the results again, the average case of pneumonia, when it is frankly developed, will require at least six doses of the medicine; it may require more. One finds that the average length of action of each dose is round about two hours; That is to say, one gives a dose, and in two hours time one will find the patient needs a repetition. So in practice what one does is to order six doses of whatever potency one chooses, in the average case probably a 10m, and have it repeated every two hours.

In the great majority of cases you find that is all the medicine that is required; in the frank, straight case, one prescription will be sufficient, you will get a crisis, and you will not have to repeat. In a minority of the cases you will find that you have to keep up your administration after the twelve hours, but if you do I think you will find that you do not have to repeat so frequently, you will probably have to give another three doses in all, at four hourly intervals.

## **Complicated pneumonias (mixed infection or alcoholic patient) (group III)**

We now come to the much more difficult problem of firstly, the complicated pneumonia complicated either by the fact that the patient has a mixed infection, or by the fact that he is a very unhealthy patient to start with and secondly, the creeping type of pneumonia or the frank bronchopneumonia. These are the types of case that are much more difficult to handle. It is more difficult to decide what your dosage should be, and what your repetition should be, and it is the type of case which seldom responds to one prescription. Mostly your first drug improves matters and the patient becomes very much better, the symptoms change, and you then have to give a second prescription to clear up the case.

When you are getting on to the later stages of a pneumonia it is a little difficult to choose your right potency. Suppose you are called in to a pneumonia that has been running five, six, or seven days, and the patient is obviously flagging; it requires a considerable amount of judgment to give the right potency, because you can over do it, you can give too high, to which they cannot respond, and so do them harm; on the other hand you can miss the chance of clearing up the whole thing by giving too low and not setting up enough response. It is certainly difficult to choose right potencies for these cases.

In a certain type of mixed infection mixed influenzal pneumococcal infection. I think there is a grave danger in giving too high a potency.

It is difficult to find a happy medium. In some of these bad cases if you give too high a potency you kill the patients, if too low they do not respond, and it varies in different patients even in the same epidemic. What they found in America was that in cases of that sort their best potency was a 1m, which seemed to be high but not dangerous, and eventually they always gave a 1m in these severe cases, with very good results.

Where you are dealing with the frankly alcoholic patient with a pneumococcal infection, I think you are quite safe with the higher potencies.

So, in practice, what I have come to is that in these unpleasant, mixed infections, I tend to give a 1m rather than a 10m, because it seems to produce less disturbance and yet produces a very definite reaction; and I repeat at about the same intervals as for an ordinary, straight pneumonia. But where I am dealing with a frankly alcoholic patient I tend to give higher potencies, probably a 10m, possibly a cm. And, incidentally, I find that in the majority of these alcoholic patients one is wise to give some alcoholic stimulus during the time of their acute crisis they do better when they have it, it steadies them, and they are less liable to become delirious.

Then as regards the drugs which you may require for these complicated pneumonias, it is a little difficult to differentiate between those required for a case of mixed infection and those for an alcoholic case, because although the cause may be different in the two cases the symptom picture one sees in the bed is very similar whether one is dealing with a bad mixed infection or with an alcoholic patient, so one has to group these drugs together. I think some of them possibly apply more commonly to the alcoholic type, but they may equally be required in the more septic type without an alcoholic history. To cover this type of case one has to consider about half a dozen drugs, which group themselves pretty well together; they are Baptisia, Mercury, Rhus, Pyrogen, Hepar, and Lachesis.

I find it very difficult to give you a key drug of this group.

At one time I used to consider that Mercury was the outstanding one for the alcoholic type of pneumonia; now I think one more commonly gets indications for Lachesis in this type; occasionally one gets indications for Baptisia. Again in the so called septic type, I used to look on Baptisia as the key drug, but nowadays I see as many Pyrogen and Lachesis cases in these septic pneumonias; they run very close together.

### **Baptisia tinctoria**

Taking the ordinary case of rather virulent pneumonia in which there are indications for Baptisia, there is usually a history of a fairly slow onset of the Subdivision. Occasionally in the course of a very virulent epidemic you will find Baptisia cases developing with astonishing rapidity, even in a few hours, but in the majority of cases, in an average winter, the onset is much slower.

The first outstanding characteristic of Baptisia pneumonias is the befogged mental confusion.

The patients are dull mentally, they find it difficult to think, they find it difficult to answer your questions, and you will probably have difficulty in taking the case as very often they do not remember the details of their illness.

Their speech is rather slow, and often you will find them becoming mildly delirious quite early in the course of the Subdivision. It is a gentle, wandering delirium, with again a good deal of confu-

sion as to where they are and what they feel like. Very often you will find them drowsy; you can wake them up, but if you do you will get an incomplete answer and they they will drowse off again.

Another Baptisia symptom is that in spite of their drowsy state these patients are restless. They have generalized aching pain, they complain of their bed being hard, it hurts them to lie, and you will find them moving about to get a more comfortable position. Sometimes that restlessness is associated with their inability to locate what is happening to them, they feel their arms or legs are uncomfortable and they move about to make sure where they are, or what is happening to them. Another point is that these Baptisia patients are always cyanosed.

They have rather a puffy, cyanotic appearance, their eyes look heavy, usually half closed, their lips are cyanosed, and there is a lot of sordes about the mouth. The mouth itself is always offensive, and very, very dry indeed. The tongue usually has a brown coat down the centre; it may be yellow to begin with, but it usually very rapidly becomes brown.

The tongue itself is very dry to touch. But, in spite of this intense dryness of the tongue, you do not get excessive thirst in the Baptisias.

They will take a sip of water, but that is all they want; for one thing they cannot be bothered, and for another the thirst is not excessive.

The skin surface of the Baptisia patient is always hot and damp, and the patients often complain of very unpleasant waves of heat all over. Always with their damp sweat they develop a very heavy, unpleasant odour.

The main complaint is a feeling of intense oppression in the chest, and with this sensation they are rather afraid to lie down because lying seems to increase it and makes them feel as if they are going to suffocate.

Very often they will tell you that the feeling of compression is not so much a sensation of the chest wall being tight as of the lungs inside being compressed, and this at once distinguishes it from the ordinary tightness of the chest which you find in so many of the other drugs.

Another characteristic about these patients is that they have a rather scanty sputum, which is very sticky and difficult to expel, in spite of the fact that there is often a good deal of rale in the chest. In appearance the patient is not unlike a very much more toxic Bryonia patient.

### **Pyrogenium**

The Pyrogen pneumonias are usually much more rapid in their onset than the Baptisias. Mentally the patients are quite different. You will always get a certain amount of loquacity in your Pyrogen patients.

They are rather impatient, they talk fast, they talk a good deal, and they are liable to be rather irritable.

In appearance the Pyrogen patients tend to have a brighter flush, they are not quite so cyanotic as the Baptisias. On any exertion, coughing, or anything of that sort, they tend to flush up much more, and they then become definitely dusky. After a paroxysm of coughing the colour tends to ebb, and they may become definitely pale.

The temperature tends to be definitely higher than in the average Baptisia case, running up to 104 or 105, and it is always accompanied by very considerable hot sweat.

The tongue in Pyrogen and Baptisia cases is sometimes very difficult to distinguish as you will get Pyrogen patients with one that is almost as dry as it is in Baptisia, and with the same kind of brown, dry coating. But occasionally you will come across a Pyrogen patient with a much redder tongue with less coating on it, and which is very dry and accompanied by a good deal of thirst. Both these patients suffer from waves of heat, but in Pyrogen they are always followed by waves of shivering they are alternate hot and cold waves. It is almost as if the patient suddenly blushed from his toes to his head, exactly the same thing as would be described as "hot flushes".

In both the Baptisias and the Pyrogen there is exactly the same complaint of general soreness, which is described in the same way; they say the bed is too hard and they move about to try to get an easy position, which makes them restless. They give exactly the same description of not knowing where their arms and legs are, and they both say they are moving about in order to bring their sensation back to normal. You cannot distinguish the one from the other in this respect.

There is one point you can tack on to these aching pains, and that is that in pyrogen cases you quite commonly hear the statement that the illness started as an aching in the legs which gradually spread up.

It is a quite frequent story.

In contrast to the chest symptoms in Baptisia, the Pyrogen case suffers much more from a sense of general oppression of the chest, with a good deal of aching soreness actually on the chest wall. And the respirations in the Pyrogen case are always very rapid and very shallow, which is frequently the case in Baptisia also.

The sputum in the Pyrogen case tends to be more profuse, it is somewhat pussy, and it is always offensive.

Then there is one other point which at once distinguishes the Pyrogen pneumonia from that of any other drug in the Materia Medica, and that is that there is always a discrepancy between the pulse and the temperature. That discrepancy may be a very rapid pulse with a comparatively low temperature; or equally commonly it may be a high temperature and a comparatively slow pulse. It may go either way, but it is the discrepancy between the pulse and the temperature that really matters.

### **Lachesis mutus**

Lachesis is very similar to Baptisia and Pyrogen. I think in the majority of cases you will find your Lachesis pneumonias cropping up later in the winter or in the early spring; You very often find them cropping up just at the end of a cold spell when the weather is beginning to get warmer. In these pneumonias you have to acquire an entirely fresh picture of Lachesis from the one you associate with Lachesis in the chronic patient. For instance, you know your chronic Lachesis patient simply talks your head off, but in the pneumonias where Lachesis is indicated you are much more likely to get the extremely toxic, fuddled, maudlin, drunken sort of patient. They are rather heavy looking, with a mottled, cyanotic appearance, a very puffy looking face, and puffy, swollen looking, cyanotic lips. Their speech is thick, they have difficulty in articulating, and they are liable to drop half their words. They stumble over what they are saying, and frequently they leave a sentence half finished.

Another point that is sometimes helpful in spotting your Lachesis patient is that their very cyanotic, swollen looking lips tend to become incredibly sensitive to touch.

Quite frequently these people go on to a frank delirium tremens, with all sorts of delusions. They hear voices, they imagine all sorts of things, they become suspicious, they think they are being poisoned, and they refuse to take their medicine.

As far as the appearance of the tongue is concerned, it is always a very dry, swollen, dark red tongue. And in spite of that dry tongue you will get a good deal of very sticky, stringy saliva in the mouth. These Lachesis patients have great difficulty in coughing, they have a horrible feeling of suffocation, they have great difficulty in breathing, and they are simply terrified to lie down. They hate to go to sleep because of this sense of suffocation, and if they do drowse off they are almost certain to wake up with a sense of suffocation and a most distressing attack of coughing. There are one or two definite Lachesis symptoms which are useful.

These patients mostly get a very violent, surging headache with their cough. It feels as if all the blood in their body is forced into their head. Their head is hot and bursting and yet at the same time they often complain that their legs, feet, and very often their hands, too, are feeling icy cold. Then with their chest involvement they always have a horrible feeling of fullness in the chest, which may be just behind the sternum, or it may be in either side. More commonly the main involvement is on the left side in Lachesis pneumonias.

There are two very typical Lachesis symptoms. One is that with their respiratory distress these patients always have a horrible choking sensation, a feeling of tightness round their throat, and they cannot bear to have the blankets up round their neck as they feel they would strangle if they did. The other is that although they get acute stabbing pains in the chest, very often on the left side of the chest, they cannot bear any pressure on the chest at all. This distinguishes Lachesis from so many of the other drugs with stabbing pains which are relieved by firm pressure on the chest.

As regards the sputum, in Lachesis it is usually scanty. The patient feels as if he had a lump in the chest and as if he could shift it a certain distance but when it got half way it stuck. You can hear the rattle in the chest, and yet the patient cannot expel anything.

Occasionally you come across an apparent contradiction in that sort of muddled, besotted patient. These Lachesis patients sometimes develop a hyperaesthesia over the affected area of the chest, which is exceedingly sensitive to touch. They may develop a hyperaesthesia to noise. They may become very sensitive to light. And they are often hyperaesthesia to smell; for instance, you notice that during the period when smoking is allowed in the wards the Lachesis patient is enormously distressed, quite out of all proportion to the actual odour.

### **Mercurius solubilis**

I think you are liable to meet with Mercury pneumonias about the same time of the year as Lachesis ones, that is in the later part of the winter. In their pneumonias at first sight it is awfully difficult to distinguish your Mercury mentality from the Lachesis mentality, but in appearance I think there is a certain amount of difference.

Like the Lachesis patient, the Mercury patient tends to have a very puffy face, but it is rather more livid in colour and gives you the impression of being more sickly looking, the patient looks

more ill somehow. I think the Mercury patient is a little more sweaty, and the skin looks a little more greasy.

As regards mentality, you get very much the same sort of D.T. 's developing in the Mercury patients as in the Lachesis, and they become just about as suspicious. Their speech is almost as difficult, it is rather hurried, and they tend to fall over their words; but it is much more a case of stammering than of failing to finish a sentence in the way Lachesis patients do. I think the Mercury patients are rather more irritable, and they are definitely more anxious and more restless.

The next thing which helps you is that in the Mercury patients there is very marked, generalized tremor, tremor of the hands, tremor of the tongue, tremor of the facial muscles.

Then in Mercury there is much more commonly a tendency to ulceration of the corners of the mouth, and a much more profuse, watery salivation; it is not so stringy as in Lachesis.

Quite often you will find definite aphthous patches in the mouth, on the insides of the cheek, or on the tongue, and these usually sting and burn on touch.

The appearance of the two tongues is dissimilar. In Mercury it is a rather swollen, flabby, pale, greasy looking tongue. But if the patient has developed definite D.T. 's you will find it becoming more coated and tending to be rather drier. The patients usually complain of an unpleasant, sweetish, offensive taste.

In these Mercury patients there is always a pretty profuse, generalized sweat. As a rule there is a swinging temperature, and you can link on to that the general Mercury instability to heat, they are either far too hot or far too cold. The Lachesis patients, of course, are always hot, they cannot stand heat. And incidentally your Lachesis patients are thirsty, they want cold drinks, and they very often get a horrible choking sensation if they attempt to take anything hot; it very much aggravates their distress and aggravates their embarrassment in breathing. The Mercury patients tend to be much more thirsty than the Lachesis ones, and they have an incessant desire for ice cold drinks.

The cough in Mercury tends to be rather different. It is usually a dry, racking cough. And here you will very frequently get a typical Mercury indication, which is that the cough tends to come in double paroxysms. The patient has a violent paroxysm, then a pause, then another paroxysm, and then a period of peace.

Another distinction is that as a rule you get your main involvement on the right side in Mercury, rather than on the left side as in Lachesis.

Very often it is the right lower lobe which is affected, and there are sharp stabbing pains going right through to the back.

As far as the sensation in the chest is concerned, it is not unlike the Lachesis feeling that the chest is full, and with their paroxysms of coughing the patients often tell you they feel as if their chest would simply burst.

Finally, the sputum in Mercury is, I think, rather more profuse than in Lachesis; it is rather more liquid, it is usually pretty dark in colour, and it is always offensive.

In discussing these complicated pneumonias you will notice I have taken all the rather hot, congested, muttering types together. There are two other drugs which I ought to mention for the same conditions, and the distinguishing point about them is that they are both definitely chilly, in other words, the patients are sensitive to cold, which immediately differentiates them from the four drugs we have already taken. These two are Hepar sulph. and Rhus tox.

## **Hepar Sulph**

Where you are dealing with a Hepar pneumonia you always have a septic type to contend with, and you get the impression that the patient is very ill. As a rule Hepar patients are palish in appearance, although they may have a somewhat hectic flush.

The skin surface is usually moist, with a rather sour smelling sweat.

The first thing that will strike you about these patients is their extreme sensitiveness to cold. Your Hepar patients are very chilly, they want their blankets right up to their necks, they want their room as hot as they can have it, they hate to have any draught in the neighbourhood at all.

Mentally, they are very difficult. They have a horrible, discontented, dissatisfied, critical outlook.

They have a marvellous faculty of remembering any unpleasant occurrence that they have had.

They will probably tell you they have seen another doctor the day before and he did not do them any good; or else they will tell you that the nurse did not carry out your instructions.

They always have a complaint of some kind.

These Hepar patients are definitely oversensitive. They are disturbed by their surroundings, they are disturbed by any noise in their neighbourhood, and they very often react unpleasantly to particular people, for instance you will find they take a dislike to one particular nurse in the ward, and nothing she can do is any good.

Their speech is always hasty, the words simply tumble out of them in a gush, and it is usually a complaint of some kind that they have to talk about.

They tend to develop a definite labial herpetic eruption, or a crack at the corner of the mouth.

The upper lip tends to be rather swollen, thickened, and very often reddened. Quite often in these Hepar pneumonias there is a deep split in the centre of the lower lip.

The tongue is always very sensitive. Very often they complain of a hot, burning tongue, or of a burning tip to the tongue, and you often find aphthous patches scattered about the mouth, either on the sides of the tongue, or on the lips, and they are always horribly sensitive. These patients usually complain of a rather bitter taste.

One point which always strikes me as a contradiction in the Hepar patients, is that, in spite of their very sensitive mouth, they like rather highly tasting drinks and food, something with a bit of a bite about it.

These patients have two main physical complaints. One is a sense of extreme weakness in the chest. The other and this is much more common is acute stabbing pains in the chest. These pains are accompanied by a definite aggravation from lying on the affected side. You will find as we go along that the position taken up by the patient in pneumonia is constantly cropping up as a differentiating point; one could almost split the drugs into two groups, those in which the patient is ameliorated by lying on the affected side and those in which the patient is aggravated by it.

As regards the cough, in Hepar it is always a very choking, strangling, spasmodic cough. It comes in quite frequent paroxysms, and is accompanied by acute dyspnoea. In these paroxysms you will find the patient sitting up in bed with the head tilted well back, and in their pneumonias the cough is accompanied by a very profuse, usually purulent, blood stained sputum. A striking thing about the cough is that it is appallingly easily produced by any cold, for instance, you merely have to wave anything in the neighbourhood of a typical Hepar patient to produce one of these spasms, and if the patient even puts a hand out of the blankets a paroxysm will be started if the hand gets chilled.

As a rule the temperature in these Hepar cases is a rather swinging, septic type of temperature. It is accompanied by very profuse sweating, and yet in spite of the sweating there is not a definite drop in temperature and the patient feels if anything more uncomfortable for it.

Any slight effort on the patient's part will produce one of these violent sweats.

These Hepar cases always feel very much worse after they have been asleep. You expect your pneumonias to wake up feeling better if they have a decent sleep, but the Hepar always feel much worse. Their sleep is unrestful and they have very distressing dreams, very often they are dreams of fire.

There are two periods at which you get marked aggravation in Hepar.

One is round about 6 or 7 o'clock in the evening, when the patients very often have a rise of temperature. The other is about 2 o'clock in the morning. At this time the patients very often have an acute paroxysm of coughing. They are liable to become very exhausted by this and may settle down afterwards and fall asleep, and if so you will get your post sleep aggravation later in the morning.

### **Rhus toxicodendron**

The other chilly drug for this mixed type of infection is Rhus tox.

I think in the majority of cases the Rhus tox. pneumonias develop somewhat slowly, and you will very often get a history that the onset of the pneumonia was caused by the patient's being out and getting soaked damp in particular is the exciting cause of Rhus pneumonias, and especially cold damp.

In appearance these Rhus patients are always somewhat cyanotic, they are rather dusky in colour, and they have a moist skin, very often they have a profuse sweat. The lips are very cyanotic, and extensive herpetic eruptions are developed quite early in the Subdivision. I think in Rhus the herpes tends to appear first of all on the lower lip, but mostly by the time you see the patients they have pretty generalized, extensive herpetic eruptions about the mouth.

In their pneumonic attacks these Rhus patients are horribly distressed, they feel ill, they are anxious, and they are dreadfully restless, they cannot get peace at all. They are very depressed, and have a general feeling of discouragement. They will very often tell you that they feel so horribly uncomfortable that they think they would be better if you could only let them out of bed, they say that if they could only move about a little more it would help them.

In their anxiety, particularly if they are becoming a bit muddled, they are very liable to get an obsession that they may be poisoned. Quite frequently in these cases you will find the patients becoming mildly delirious. It is a low, restless, muttering delirium, and it is always accompanied by extreme physical restlessness as well.

In addition to general restlessness, in these Rhus cases you will usually get a complaint of pretty generalized aching pains, and the patients say these aching pains are easier if they keep on the move.

The tongue in Rhus is fairly suggestive. In the earlier stages, certainly in the stages before the patients become delirious, you get a typical Rhus tongue, which is a white coated tongue with a red margin, or a red triangular tip. But by the time the muttering delirious state has developed the tongue will have tended to become brown, and intensely dry. The patients often complain of a

horrible metallic sort of taste; they may call it coppery, or something of that sort, but in any case it is a very unpleasant, metallic taste. There is always very marked, constant thirst.

The patients complain of the mouth and throat feeling appallingly dry, almost as if burnt, and they have incessant thirst, with a preference for cold drinks.

The cough is always a very troublesome one. It is a constant, tormenting cough, and the patients will usually tell you that they have a feeling of intense irritation in the middle of the chest, somewhere behind the sternum.

The respirations are always very shallow, short, hurried, and difficult.

These Rhus patients are just about as sensitive to cold as are the Hepar patients, and the attack of coughing will be brought on by any cold draught, or any exposure to cold. In both cases when examining your patients you have to be very careful not to uncover them too much or you will precipitate one of these violent paroxysms of coughing.

There is always a certain amount of laryngeal involvement in these Rhus cases, and it may be very troublesome indeed. Short of this, there is always at least a degree of hoarseness.

The sputum in the Rhus case is usually fairly profuse, rather liquid, dark in colour, and definitely bloodstained. The temperature tends to be of the swinging type, but it does not have the same degree of swing as you find in Hepar. As a rule there is rather a full pulse, which is fast and not well sustained.

There are two other points which sometimes help you in your Rhus diagnosis.

One is that after a paroxysm of coughing, when the patient has apparently got very hot, he immediately gets a horribly chilly sensation, sweats profusely, feels horribly cold, and wants to be covered up. And the other point, which you can link on to that, is that, although they are intensely thirsty, if they drink too much cold water they are apt to feel very chilly, and it is very likely to precipitate another paroxysm of coughing.

As a rule in these Rhus cases the times of maximum aggravation occur during the night rather than during the day. The patients become more restless, more worried, and more inclined to get out of bed, during the night.

## **Complicated pneumonias (bronchopneumonia) (group III)**

There is another class of drugs which I always look on as useful in either the creeping type of pneumonia, or in definite bronchopneumonia in the adult. You know the type of unpleasant case that starts as a frank lobar pneumonia, and probably twenty four hours later a patch appears somewhere in the uninvolved lung, and the next day there is another patch somewhere else, possibly without much clearing up of the old area; That is the type of case in which these drugs are indicated, and I think you can cover it pretty well with four. On particular indications you may require any of the drugs I have already described, but I think you are more likely to need, Pulsatilla, Natrum sulph., Senega, or Lobelia for these cases. They all have certain points of similarity, of course, but they all have their own individualizing symptoms. I think possibly Natrum sulph. is more typical of these than any of the others, so I will start with it.

### **Natrium sulphuricum**

As a rule in the Natrum sulph. pneumonias, or bronchopneumonias, you get a history of a fairly gradual onset. You find physical signs in one area, probably quite a small area, and the condition is steadily spreading. The patients are usually definitely cyanotic, and not infrequently in Natrum sulph. there is a sort of yellowish tinge, there may even be a definite jaundice. It is a quite frequently indicated drug in postoperative pneumonias pneumonia following an acute appendix, pneumonia following a gall bladder operation, etc.

The outstanding characteristic of the Natrum sulph. patient, apart from the type of pneumonia, is the mentality. Natrum sulph. patients are always extremely depressed. It is not a weepy depression at all, but they feel horribly gloomy and flat, they do not want to be disturbed, they do not want to be interfered with, they are quite liable to turn their back on you, they do not want to be questioned, and they do not want to have to think. They are quite liable to say "For heaven's sake leave me alone". Very often they display a certain amount of irritability if they have to talk to you, and they are strangely sensitive to noise and often acutely irritated by it. They are always sensitive to heat, they cannot bear a stuffy room at all, and they always have a hot, sticky skin surface.

The tongue in Natrum sulph. is very suggestive. It has a pretty general greyish green coating. At times you may find a yellowish tongue with a definitely brown base, or a whitish tongue with a yellow base.

But that greyish green tongue is the one characteristic of Natrum sulph.

The patients always complain of a good deal of acute pain in the chest, and it is a pretty acute stabbing pain accompanied by a feeling of general soreness in the chest wall. That stabbing pain is very much aggravated by coughing, and while coughing you will find these Natrum sulph. patients sitting up supporting the side of the chest to keep it as quiet as possible.

There is always a degree of physical restlessness in Natrum sulph.

patients, they feel jolly uncomfortable, they are forced to change their position, but their movement does not give them any sense of relief at all.

Then all the Natrum sulph. pneumonias I have seen have complained very bitterly of an intensely troublesome occipital headache.

There is usually a rather bitter taste in the mouth, but the thirst is not extreme.

Another symptom which is sometimes very distressing is a feeling of intense heat in the legs, from about the knees downwards.

You know the ordinary Natrum sulph. time of aggravation is taken to be about 5 o'clock in the morning, well, in their pneumonias that is not the time of maximum aggravation, it is much earlier, it is between 3 and 4 o'clock in the morning. You are liable to get a very bad spell in these Natrum sulph. pneumonias about 3 or 4 o'clock in the morning, definitely earlier than the 5 o'clock aggravation that you expect in Natrum sulph..

As regards the sputum, quite frequently in these Natrum sulph. cases it is definitely greenish, and it may even be definitely bile stained.

One winter we had quite a number of cases with frankly bile stained sputum in their pneumonias. And with that greenish, or yellowish, sputum there is a good deal of rusty material intermingled. There is a fair quantity of sputum, and as a rule it comes up without undue difficulty.

In spite of the fact that you have this creeping type of pneumonia, you will always get the maximum involvement on the left side, usually, I think, the left lower lobe.

### **Pulsatilla pratensis**

I think the next most common of these drugs is Pulsatilla. In the average Pulsatilla pneumonia, or bronchopneumonia, I think you usually get a history of the patient's having had a frank cold, a catarrhal condition, which has spread down into the chest. It is in the slowly advancing, progressive pneumonia that you most commonly get your indications for Pulsatilla.

In appearance the Pulsatilla pneumonia patients are always definitely dusky; it is a red colour, but it is a dusky red; The patients give you the impression of being rather bloated and puffy looking; They also give you the impression of not having a great deal of bite about them, they are of the rather mild, gentle, yielding type, and they do not stand up against their infection well, the Subdivision seems to be gradually spreading and snowing them under. They become definitely anxious about themselves, worried, afraid that they are not going to get better, and they very definitely hate being left alone. They want somebody about, and they want attention.

In their pneumonias Pulsatilla patients get very marked dyspnoea; it is very extreme. It is accompanied by a feeling of intense tightness in the chest, or a feeling of horrible fullness in the chest, with a very acute air hunger; they want to have the doors and windows open, and they love a draught of air about.

This dyspnoea tends to get worse as the evening progresses; They have a pretty violent, gagging, choking cough, and in their paroxysms of coughing they are liable to become acutely cyanosed. Quite frequently you will get the statement by these Pulsatilla patients that after one of these violent choking coughs it feels as if something were torn loose in the chest and the whole chest left raw.

After one of these paroxysms there is always a complaint of extreme soreness in the chest wall, which feels as if all the muscles were strained.

These Pulsatilla patients in their pneumonias complain of a very dry mouth and throat, and the tongue usually has a thick, sticky, whitish coat. But in spite of this dryness of their mouth and throat the patients are not thirsty. They may like a little sourish drink to relieve the dryness, but there is no real thirst in the Pulsatilla pneumonias.

As regards position, these patients are rather more uncomfortable lying on the side which is mainly involved. Their most comfortable position is lying on the back, propped up a bit, and particularly with the arms raised out from the sides; you may even find them pushing their arms up above the head.

All these Pulsatilla patients are, of course, sensitive to heat, and, as you would expect, they often complain of a feeling of generalized hotness. But occasionally you will come across a Pulsatilla patient who says that intermingled with this generalized heat they have patchy areas of chilliness. The sputum in Pulsatilla is always a difficult one. It is very tenacious indeed, and the patient almost chokes in the effort to expel it. It is usually yellowish in colour, and, of course, definitely bloodstained.

### **Senega**

The third of these drugs is Senega. In many ways it is not unlike the other two drugs we have taken. There is much the same kind of pathological state, but I think there is rather more bronchi-

tis surrounding the patch of consolidation than there is in the two previous drugs. In other words, there are more raies coarse raies which are pretty generalized in the chest, and amongst them you will pick up definite patches of consolidation.

You usually meet your Senega case after the patient has been ill for some days. And most of those I have seen have given me the impression that had one seen them earlier they would probably have been Bryonia missed Bryonia might quite well run on to a Senega.

In appearance the Senega patients are very flushed. It is not a very bright flush but it is pretty general, and the patients give you the impression of being puffy and rather bloated looking. They have a hot sweaty skin, and they always have very intense respiratory embarrassment. Their main complaint is always a feeling of intense oppression in the chest, very often they say it feels as if they had a ton weight sitting on the chest, and they just cannot breathe.

The impression these patients give you is that they are intensely tired; they are weary, and phlegmatic, and just tired out. Yet underneath that tiredness there is definite anxiety. I remember seeing one patient exceedingly ill with an influenzal pneumonia who had a small daughter ill at the same time, with the same condition, and it was astonishing how little interest the mother took in the illness of her daughter. She never even asked how the child was.

She was very definitely anxious about her own state and as to whether she was going to get better because she had so many responsibilities about the house, and yet the fact that her child was seriously ill at the moment made no impression at all. It is a weird mixture of a mental state, and it is pretty typical of Senega.

The Senega cough is awfully troublesome. It is a practically constant, violent cough, and it produces a strange sort of hyperaesthesia of the walls of the chest. Very often in these cases with a generalized bronchitis, when you are percussing the chest you will get on to an area of hyperaesthesia, and you will always find it is over a consolidated area.

With this generalized aching in the chest wall which accompanies the violent coughing there is always a certain amount of restlessness; the patients say they are rather more comfortable and the aching pain is rather easier if they move about a bit.

With the paroxysms of coughing they become frightfully hot, very red in the face, and covered with a hot sweat. And with this profuse sweating there is apt to be a good deal of sudaminous rash.

These Senega patients say they feel too hot and that they like air, but in spite of that they start coughing at once if you open the windows. Though the patients feel far too hot, and they are sweating and want to push off their blankets, yet an actual current of air will start them coughing. Mostly in their pneumonias there is a certain amount of hoarseness, and I have seen several Senega pneumonias now in which there was complete loss of voice.

As a rule the condition is more extensive on the right side, but it tends to spread from the right side over to the left. Every Senega case I have seen has had peculiarly loud, harsh, breathing with their respiratory distress. There is liable to be a certain amount of cyanosis of the extremities. The patients frequently have a very high temperature, and they are liable to develop signs of a failing heart early in the Subdivision; the right side of the heart begins to dilate, and a definite generalized oedema of the lungs is very likely to develop.

The most striking cases of Senega pneumonia which I have seen have been in middle aged women, about 45 or so, always rather heavy, overweight, and rather short necked, just the bron-

chial type. You will get indications for Senega in senile patients suffering from coughs, but that is in cases of chronic bronchitis, which presents quite a different picture.

### **Lobelia inflata**

You will find that Lobelia is not very often indicated, but it does cover a very definite picture, and it has one or two very striking symptoms which, I think, are not covered by any other drug.

The impression you get of Lobelia patients is that they are pretty ill.

They look rather pale, and they have a rather sweaty skin surface. They always complain of a feeling of horrible oppression and of a very marked sense of fullness in the chest, which they say they cannot shift at all.

They have a very spasmodic, dry cough, which seems to do them no good and which is always attended by nausea. They want to keep as still as they possibly can, and any movement, any exertion, very much increases their sense of respiratory embarrassment, and also the nausea.

The nausea which accompanies the coughing is, like most nausea cases, associated with a good deal of salivation. But there is one definite characteristic about the Lobelia nausea and that is that it is very greatly relieved by eating or drinking.

Accompanying the nausea the patients have a very distressing feeling of emptiness in the epigastrium.

Another characteristic Lobelia symptom is that the patients are very liable to develop intensely irritating urticarial patches, accompanied by a generalized tingling of the skin surface. Alternatively, they sometimes develop a localized oedema of the chest wall. I remember seeing one patient with a Lobelia pneumonia whose chest wall on one side was a great, solid, oedematous mass.

And as a rule you find that that localized oedema is over the affected area.

Another thing you find quite frequently in the Lobelia patients is that after a violent paroxysm of coughing they are liable to develop localized patches of ecchymosis.

In these cases there is always a rather fast pulse, which is soft and thready. And, as I mentioned before, there is a very marked aversion to movement of any kind; it increases their respiratory distress, and it also increases their nausea. You will always find a certain amount of air hunger; the patients are more comfortable if there is fresh, circulating air, although they do not like a definite draught.

Mentally, the Lobelia patients tend to be rather depressed; they want to be left quiet, they do not want to be disturbed.

There is one other Lobelia symptom which sometimes crops up, and that is that in these pneumonic attacks the patients quite frequently complain of very violent sacral pains. They have a good deal of respiratory distress, and one's tendency is to prop them up a bit, but if one does one often finds they complain bitterly of this sacral pain and extreme sacral tenderness.

You will see that here you have a very definite symptom picture which is difficult to cover without Lobelia, so although it is comparatively rarely indicated you do want to know it.

## Late pneumonia (group IV)

We now come to the consideration of drugs for the later stages of pneumonia, either a pneumonia you have not seen in the earlier stages, or one that is not resolving well, not clearing up satisfactorily, and in which you want to clear the chest up finally.

For that type of case there are about half a dozen drugs which you have to know fairly well Antimony tart., Carbo veg., kali carb., Arsenic, Lycopodium and Sulphur. When I have covered these drugs you ought to be quite prepared to go and tackle a pneumonia epidemic and expect to get a 100 per cent. recoveries, which is rather better than they are getting with their newest pneumonia preparations they are still getting 23 per cent. deaths.

I think the best way to take up these drugs is in the order in which I have given them to you.

### Antimonium tartaricum

In the adult you expect to find the symptom of Antimony tart. cropping up late in a pneumonia, you do not usually get them in the early stages, and by the time the patients have gone on to an Antimony tart. state they are seriously ill. The appearance of these patients is suggestive, they are pale, they have a pinched look, rather a bluish coloration of the skin, and they are covered with a cold sweat. The nose looks rather pointed, pinched in, and very often it has a somewhat sooty colour.

Owing to the extensive chest involvement you will find the alae nasi flapping and with the obvious effort to get as much air in as possible all the muscles down the side of the neck are standing out and the patient is struggling for breath. The lips in typical Antimony tart.

cases are rather livid, although if the patients are running towards a collapse, as they sometimes do in Antimony tart., the lips may tend to become paler, and in any case they are usually very dry.

The impression you get of these patients is one of extremes suffering; They are intensely distressed, and their main reaction is one of wanting to be left alone "For heaven's sake don't disturb me". They do not want to speak, they do not want to be spoken to, and very often they do not even want to be looked at. The patients themselves are very miserable, and you often find them lying panting for breath and moaning.

As a rule there is a very thick coating to the tongue; it is a horrible, pasty, white coating, and the tongue looks just as if it had been painted with white enamel. In a few cases you may find a somewhat brown coat, which is very dry, but that is exceptional. The outstanding point is that, in spite of the dryness of the lips and tongue, these Antimony tart. patients are completely thirstless. Another practical point to remember is that these Antimony tart. cases have a loathing of food of any kind, and in particular any attempt to feed them on milk will produce an acute nausea the Antimony tart. patients have an acute intolerance of milk.

As far as the actual chest condition is concerned, there is invariably an excessive secretion of mucus; standing by the bed you can hear the moist bubble in the chest. There is a very rattling cough, and yet, in spite of the rattle, there is very little sputum expelled. With the effort to expel that sputum the Antimony tart. patients usually suffer from pretty acute nausea, and they may actually vomit.

With their violent cough these patients suffer from a great sense of oppression in the chest, and very often there is great soreness of the chest wall. They cannot bear any weight on the chest at

all, they want to push the blankets off, they want to get them away from their neck, and any suggestion of weight, even a single blanket, will embarrass them.

These patients are very sensitive to any stuffy atmosphere. They have an acute air hunger, and a warm room makes them very much more uncomfortable.

And an important point is that they are particularly aggravated by any radiant heat.

With the extensive chest involvement, the hands and fingers, feet and lower extremities, are very liable to become bluish, cyanotic, also the patients become very tremulous and, in spite of their general heat and aggravation from warmth, they very often complain of a feeling of coldness from about the knees downwards.

As you would expect in a case of this kind; it is impossible for the patient to lie down flat; the only thing that gives him any comfort at all is to be propped up in bed, at the same time avoiding any suggestion of constriction of the chest.

I do not think there is any particular preference for either side of the chest in Antimony tart.; I have seen as many cases involving the left side as the right.

Another point is that in these Antimony tart. cases there is always a tendency to heart failure, the circulation is giving out, the pulse tends to become irregular, and the heart tends to dilate.

Well, that is the kind of case that we meet here from about the fifth day of Subdivision onwards.

We quite frequently see patients coming in in that state. But we do not expect a patient ever to get into that state once he is in the hospital.

### **Carbo vegetabilis**

In Antimony tart. we have just discussed one type of very serious case.

The next one, which is just about as serious, is Carbo veg., and at first sight it is a little difficult to distinguish between it and the Antimony tart. case. However, there are certain distinguishing points.

In appearance, as you first see these patients, there is very little to distinguish the two, the Carbo veg. looks just as ill, he has the same sort of pinched appearance, the same respiratory embarrassment, the same kind of flapping nose, and the same bluish colour. I think, in the majority of cases, the Carbo veg. patient is a little more blue, and the Antimony tart. patient a little more livid. As a rule in the Carbo veg. case there is less cyanosis of the extremities, which are more likely to be pale and covered with an icy, cold sweat.

Both these drugs are covered with a cold sweat, I think it is about equally marked in the two.

They both have an intense air hunger, but here you find your first distinguishing point.

Your Carbo veg. patients say that they have an intense air hunger, and yet they feel frightfully cold, whereas there is none of that feeling of frightful coldness in the Antimony tart. patients.

As a rule, instead of the rather dry, bluish lips of Antimony tart.

the lips of Carbo veg. tend to be purplish and somewhat swollen.

And instead of the white coating on the tongue which is so typical of Antimony tart. you are very much more liable to get a dirty, yellowish brown, very dry tongue. Again as a distinguishing point between the two, in Carbo veg. you will get marked thirst, whereas in Antimony tart. the patient is thirstless.

The typical Carbo veg. patient wants sips of cold water, and very often complains of a very unpleasant, foul taste in the mouth.

As far as the actual chest condition in Carbo veg. is concerned, you are more liable to get definite extensive areas of consolidation, and rather less generalized bubbling in the chest.

There is usually far more acute rawness in the chest in Carbo veg.

than in Antimony tart. And in the Carbo veg. patient you mostly find that the sputum is just about as difficult as it is in Antimony tart.; the patient will tell you it comes up so far and then they just cannot get it out. But instead of that effort to expectorate producing the vomiting that you meet with in Antimony tart. in Carboveg. it is very much more likely to produce an attack of extreme exhaustion, the patient lying back simply gasping for breath.

Incidentally, these Carbo veg. patients respond astonishingly well to the administration of oxygen.

Both Carbo veg. and Antimony tart. have that horrible sense of a load on the chest. It is a feeling of dreadful oppression, which the patients describe either as an absolute weight sitting on the chest, or as the chest being full almost to bursting.

Another distinguishing point is that in Carbo veg. there is always marked abdominal discomfort, a feeling of distension, fullness and flatulence, instead of the intense nausea of Antimony tart..

As far as the position taken up by the two patients is concerned there is very little to distinguish them. They both want to be propped up, and they both want to avoid any constriction of the chest or round the neck, but the Carbo veg. will allow you to put a single blanket up to keep them warm, whereas the Antimony tart. simply cannot tolerate it.

Another point about Carbo veg. patients is that they always tend to sleep into an aggravation; they doze off and then wake up simply gasping for breath.

In the Carbo veg. patient, as in the Antimony tart. patient, you have a definitely failing heart.

I think as a rule the temperature tends to be less high in the Carbo veg.

case than it does in the Antimony tart., and I think you are most likely to meet your Carbo veg. case just immediately before, or just immediately after, a pneumonic crisis.

As far as relief from your drug is concerned, you should get this almost immediately in an Antimony tart. case, and the Carbo veg. patient should be comfortable in about six hours. It is astonishing how quickly they respond. It is usually a question of acute heart failure, and either the patients respond at once or else you should give one of the other heart failure drugs. I should expect one of these Carbo veg. patients with critical collapse to be out of danger in twelve hours. But they are exactly the type one used to dash at with all sorts of diffusible stimulants and they mostly died, whereas now one expects them to recover.

If you want to cure these cases, however, do not give them stimulants.

I have seen cases of that sort in which there was obvious heart failure and the physician had pushed in Coramin and Carbo veg. did no good at all afterwards, it simply did not have any effect. Nowadays I would never employ any stimulant in a case of that sort; I am sure one gets better results without. The only exception I would make would be strong coffee in the case of Carbo veg., as these patients sometimes do respond astonishingly well to it. They have a desire for it, even a craving for it, and it often seems to do them good. But that is the only exception I would make.

As regards potency, in Carbo veg. one is dealing with an acute collapse, there is a dilating heart and a heart failure, and one must obtain an effect fairly quickly, so my personal preference is to go high and give frequently until I get a definite response. I would give cm's every ten or fifteen

minutes until I got a definite response. The kind of response one gets is that the patient begins to feel warmer. Instead of the icy coldness they begin to feel less cold, they look less cold, they are less cold to touch, and the sweat begins to disappear. I would then space the drug out and give it every half hour, until there were definite signs that the heart was taking up again, in other words, until the pulse was fuller, the distress getting less, and the cyanosis beginning to fade. As a rule you get the patient through the crisis in twelve hours.

But to do that you must give frequent repetition to begin with and you must keep up your action for some hours, given cm's all the time. I have tried low potencies in cases of this kind and the patients did not respond at all; I have then jumped up to a cm and the drug has had immediate effect.

So much is this so that up in the private wards, where one quite frequently sees these cases, the Sister does not want anything but cm's for them that is how experienced Sisters come to look on it, they always want the highest potency you will order as they say the other is a waste of time.

That is practical experience, it is not a desire for any particular potency.

Antimony tart. cases are not so acute, in them you are dealing with a waterlogged chest rather than a sudden cardiac failure. It is slower in onset, and you have more time to play with. In these cases 10m's hourly at first and later two hourly will be sufficient.

### **Kalium carbonicum**

I think Kali carb. tends to be indicated from about the fifth day of Subdivision onwards, although you may get indications for it earlier. It is a very serious case, but it is a case that you see before the really critical stage comes along. Very often it is a case which has responded to a certain extent to one of your previous drugs, but you are not satisfied with its progress, the patient is still running a temperature and, although more comfortable, is not clearing up. It is in that type of case that you find your Kali carb. indications.

The appearance is always that of a patient who has been pretty exhausted by their attack. He looks rather pale, flabby, and washed out, and has a sort of haggard, exhausted appearance. Very often in Kali carb.

there is a puffy look about the face. The patient always has an anxious, worried, rather frightened expression. And with that there is very often a good deal of tremor of the facial muscles, and twitching of the hands and fingers; he picks at the fingers, and picks at the bedclothes.

These patients dislike being left alone, they get more worried, more scared. They are definitely sensitive, they are very easily annoyed, very easily irritated, and they are particularly sensitive to any noise in their immediate neighbourhood.

The lips tend to be cyanotic, dry, and cracked. As regards the tongue, I think most commonly Kali carb., patients complain that it feels as if it had been scalded; it is dry and red and has this burnt feeling.

But you will quite frequently meet with a case in which the tongue has a dirty, greyish white coat. As a rule these Kali carb. patients are not markedly thirsty; their mouth is dry, and they may want a little sip of water, but they are not markedly thirsty.

The cough tends to be very dry, and suffocative in type. And with an attack of coughing you will find these patients breaking out into a profuse sweat. The sputum is always scanty, difficult to expel, and very often it only comes up into the back of the throat and is swallowed.

There are two very definite Kali carb. indications. The first is that these Kali carb. patients are frightfully sensitive to any draught of air, it produces a violent attack of coughing, a regular paroxysm, and it also produces a horrible sense of chilliness. The other characteristic point is the position taken up by Kali carb. patients in their respiratory distress. They always want to sit upright, and, unlike the other drugs we have considered, they lean forward and support themselves with their elbows on their knees, or they like a bed table across the bed and they lean forward on that.

Always in these Kali carb. pneumonic cases the patients have violent chest pains with their cough. The kind of pains they get are the stitches right through the chest, or acute stabbing pains in chest.

The pains are very much aggravated by any motion, and, of course, they are produced by any of these violent spasmodic coughs. I think as a rule the maximum involvement is on the left side of the chest rather than on the right, and, whichever side it is, it tends to involve the lower lobes rather than the upper.

You do not tend to get the same degree of cardiac failure in Kali carb. as you do in the two preceding drugs. You get a weak pulse without a great deal of tone in it, but you do not tend to get the acute dilation of the heart that you do in the others. You get a weak, running pulse, but not acute heart failure.

There is one other useful diagnostic point, and that is the time of maximum aggravation. It is in the early hours of the morning, between 2 and 4 o'clock. You may meet with it at any time during that interval, but you are most likely to get your worst period about 3 o'clock in the morning.

Quite frequently you will find your Kali carb. patients sitting up in the typical position, gasping for breath, about 3 o'clock in the morning, with a horrible feeling of oppression and tightness in the chest and acute stabbing pains.

There is one point which sometimes tends to make you confuse your Kali carb.'s, and that is that in their pneumonias these Kali carb.

patients do get a good deal of flatulence, a good deal of abdominal discomfort, and a good deal of abdominal distension.

When considering the question of potency you may have to be a little careful in dealing with old people in Kali carb. cases. Where you have indications for Kali carb. you are not dealing with an acute emergency, and in consequence you do not need your highest potencies. I would give 1 m's to older Kali carb.'s for choice. The average case responds well to 10m's repeated in the usual way.

### **Lycopodium clavatum**

Of the last three drugs I thought of looking at I think Lycopodium probably follows the Kali picture more closely than any of the other drugs; it is very similar in many ways.

In the majority of cases you do not get indications for Lycopodium before the second half of the course of the average pneumonia, in other words, it is not usually indicated until after the fourth day. As a rule, you will get a history that at the beginning of their illness these patients were mentally fairly active, and that they are now becoming very tired, very weary, rather worried about their condition, and not a little frightened.

In appearance, they give you the impression of being anxious; they have rather a worried look, and a practically perpetual frown. They are rather sallow in colour, a sort of yellowish grey appearance, and they have obvious acute respiratory distress. The lips tend to be somewhat cyanosed, very often they are definitely cyanosed, and there may be a somewhat dusky appearance generally. If you see these patients latish in the Subdivision, about the fourth or fifth day, you will find them becoming definitely weak, and rather torpid and sluggish.

The mentality of the typical Lycopodium pneumonia patients is a little difficult to get hold of because although they are anxious, worried about themselves, wanting attention, wanting somebody about, yet they are peevish and irritable with those trying to help them. They are rather domineering, they are definitely exacting in their demands on their attendants, and yet that is coupled up with the desire to get as much attention as they possibly can. After they have been asleep they are very liable to wake up in a very cross tempered mood.

Associated with the respiratory distress, there is a somewhat pinched appearance of the nose which is not unlike the Antimonium tart. appearance, and there is a good deal of flapping of the nostrils.

But there is more general twitching of the facial muscles in Lycopodium, and the nose gives the impression of being dusky, rather than sooty as in Antimonium tart.

Another point about the Lycopodium patients is that they always tend to have a very noticeable yellow discoloration of the teeth. Very often they complain of a sour taste in the mouth, and the tongue tends to be coated white. In addition to this coat, there are often definitely sensitive spots along the margin of the tongue, and the patient often complains that it feels stiff and swollen. Lycopodium patients are rather variable as regards thirst. Sometimes you will get a Lycopodium patient who is definitely thirsty, but again you may get a patient who is not thirsty at all. If they are thirsty they prefer warm drinks to cold. And if they have much to drink it is very apt to produce a sensation of fullness and flatulence; it may actually produce a sense of nausea.

The respiration in the Lycopodium case is always very difficult, short, panting, laboured breathing. The patients usually complain of a feeling of tightness in the chest, or even of an actual sensation of constriction.

The cough is always a very difficult, paroxysmal; violent, spasmodic cough. Very often the patient complains of intense rawness in the chest after coughing.

The sputum is always scanty, tough, and very difficult to get up.

It is very often a yellowish grey, bloodstained sputum, and not infrequently the patients tell you that it tastes definitely salty.

As a rule the patients complain of feeling chilly. They are sensitive to cold, but they dislike a stuffy room. Usually there is very little sweating, the skin may be slightly moist but there is no definite sweat. In most of these cases you will find your maximum involvement on the right side of the chest rather than the left. And you will always get a complaint of a good deal of abdominal flatulence, particularly is this so after taking anything in the way of food; the patient feels absolutely bloated on any attempt to eat.

As a rule these Lycopodium patients are very uncomfortable if they are lying on the back, their breathing becomes more laboured, and they are more distressed. They are very much better sitting up.

Another small point is that you will very often see these patients sleeping with their eyes half open. Not infrequently they have a very restless kind of sleep, and they often dream of fatal accidents.

In the Lycopodium case there is one very constant period during which there is a general aggravation of the patient's distress, and that is between the hours of 4 and 8 o'clock in the evening. During this time you will get an increase of temperature, increased respiratory distress, and very often increased cough. Very often the temperature swings up about 4 o'clock, stays up until about 8 o'clock, and then begins to drop.

As regards the temperature in Lycopodium, commonly it is a medium high one, ranging round about 103. The pulse tends to be rather compressible, soft and rapid.

Lycopodium cases respond well to 10m's repeated 2 hourly.

### **Arsenicum album**

Arsenicum is one of the drugs which you will require only in the collapsed stage of a pneumonic crisis; you seldom get indications for it during the active stage of a pneumonia.

The picture presented by the Arsenicum patient is very typical. There is always intense mental and physical restlessness. In the earlier stages of the collapse you will see the patient constantly tossing about, never still for a moment, and as the collapse goes on he gets weaker and weaker until he is hardly able to move, and even then his eyes keep it up to the very last.

Right throughout the whole picture there is exactly the same sort of mental state extreme mental anxiety, extreme fear, the patient is certain he is going to die, he wants attention, wants somebody there, is afraid of being left alone, and wishes to goodness you would get on and do something for him.

The appearance of these patients is somewhat suggestive. As a rule they are pale, and rather livid looking, or they may be somewhat cyanotic, and the surface is covered with a cold, clammy, sweat. The lips are usually cyanotic; they may be rather full, but very often you will see them looking rather shrunken, shrivelled looking, and actually bluish.

The patients themselves are always intensely chilly. Very often there is almost a rigor; the patients keep shivering with cold, they want to be covered up, and they cannot bear any draught about.

They are always intensely thirsty, their mouths are parched and dry, and there is a constant desire for sips of water. The strange thing is that, in spite of their general chilliness, they want their water as cold as they can get it.

The characteristic thing about the tongue in the Arsenicum case is its dryness. It may be red, or it may be brown, but it is always dry, dry to the touch, and the patient often complains of the mouth feeling burning hot.

Then as regards the cough in these Arsenicum cases, you will very often find the patients hardly coughing at all, they do not seem to have sufficient strength to cough. Any cough that there is is very useless and brings up no sputum at all. If the patients are not quite so ill as that, they have a very violent, suffocative cough which makes them sit up in bed feeling as if they were going to strangle.

They always complain of intense compression in the chest; it feels horribly tight, as if they could not breathe at all. And after coughing, or even when they are lying still, they often complain of-

burning pain in the chest. After one of these paroxysms of coughing they very often have violent pain round their lower ribs, and very often pain in the epigastrium, too.

The sputum in Arsenicum is always scanty, because, as I mentioned before, the patients do not seem to have the strength to get it up.

Very often they cough it up into the back of the throat and just swallow it.

In these Arsenicum cases you are very apt to get a falling temperature; you may get an actual collapse temperature, with a running pulse and possibly a fibrillating heart. And the patients often complain of a horrible feeling of tremendous weakness in the chest.

The collapse in Arsenicum cases is very liable to take place in the early hours of the morning, it is usually sometime between 1 o'clock and 3 o'clock and is most likely between 1 o'clock and 2 o'clock.

Well, that is the picture as you see it. And here I want to put in a word of warning. If you have a case of that sort, with definite Arsenicum indications, and you prescribe Arsenicum and get a reaction taking place, unless you follow that Arsenicum up with another drug within the next twelve hours you will find your collapse recurring; then you will find that your patient does not respond to a repetition of your Arsenicum and that patient will die.

The kind of response you get to Arsenicum is that the intense mental anxiety begins to subside, the intense chilliness subsides, the patient begins to feel warmer and more at peace. The intense sweating stops, the temperature begins to rise a little, and the pulse begins to steady down. Well that is the stage at which you must follow up with your next drug.

You may require any drug in the Materia Medica to follow up that reactive stage, but the two which are very much the most commonly indicated are Phosphorus and Sulphur. If you get your patient becoming warmer, the anxiety going, the pulse improving, the temperature rising, and instead of the white, livid appearance the patient becoming rather flushed, and still remaining thirsty, then the probability is that he is going on to a Phosphorus reaction. If, on the other hand, the response is not quite so complete, the patient is becoming a little warmer and then having cold waves, the anxiety is not quite so great but he is feeling frightfully tired out, he is still a bit sweaty, possibly the legs and feet are a little cold and the upper part a little hot, or possibly the legs and feet are a little hot and the upper part cold, he is intermittently hot then cold and chilly, then the patient is going on to Sulphur. And, as I already said, you will find that in the majority of cases Phosphorus or Sulphur is the drug with which you have to follow up your Arsenical response, and you will find a *Im* your most useful potency repeated 2 hourly.

## **Sulphur**

The last of these drugs I want to touch on in detail is Sulphur.

There is practically no Subdivision from which humanity suffers in which you may not find Sulphur indicated, and there are various occasions in pneumonia in which you may want Sulphur. It may be indicated in any stage of the Subdivision from the second day onwards. You may want to prescribe Sulphur in one of these difficult cases which is not clearing, one in which you have had indications for a drug which has done a certain amount of good, then you have had indications for another drug which again has done some good, and finally you cannot get clear indications for anything and the patient is not yet well. An intercurrent dose of Sulphur will set up a response. You may get indications for Sulphur in a case in which the patient has done quite well up

to a point, the temperature has comedown, either by crisis or by lysis, and yet the physical signs are not improving to your satisfaction; a dose of Sulphur will very often clear up the whole thing, start your resolution, or clear up remaining patches in the lung. But these are not the cases I want to cover in the description of the straight Sulphur pneumonia.

I think the appearance of the patient is the first thing that makes you consider Sulphur in a pneumonia, and the second is the patient's complaint.

In appearance the Sulphur pneumonic patient always gives you the impression of being very dusky and dirty looking. All the orifices tend to be red, the lips are red, the nose gives the impression of being red, the ears are red, very often there is a mild blepharitis, the eyes look congested and red, and the patient gives you the impression of being dirty and untidy.

As far as the complaint of these patients is concerned, their main one is a feeling of intense weariness. They feel deadly ill, they are very low spirited, and they are definitely complaining. They always suffer from a feeling of intense oppression of the chest, which they say feels as if it had a ton weight sitting on it.

Then in these Sulphur cases there is a strange mixture in their temperature sensations. You tend to look on your Sulphur patients as burning hot, with burning hot feet which they want to sick out of bed.

Well, you do at times find that state in your Sulphur pneumonia patients, but much more commonly you find they have alternating waves of heat and cold. You will very often find they have hot patches and cold patches, for instance, a hot head, or hot hands and feet, associated with chilliness in the back. It is that irregular distribution of heat and cold which is typical of the Sulphur pneumonic patient.

Another thing that strikes you about the Sulphur pneumonias is that they are definitely going to the bad. They are very ill, and they are not reacting properly to their Subdivision.

In their pneumonias the Sulphur patients develop a very worrying cough.

It never seems to leave them at peace at all, and it simply wears them out; they get frightfully tired of it and they are apt to get irritable with it.

The sputum is very scanty, and the cough is always associated with pretty acute pains in the chest, which usually stick right through to the back.

I think as a rule in these Sulphur cases you are liable to have more extensive involvement of the left side of the chest, rather than the right.

You will very often see a case in which there are the typical pains one associates with Chelidonium pains in the front of the chest going right through to the scapula. But a differentiating point is that you are more likely to get them on the right of the chest in Chelidonium, whereas in Sulphur they are more frequently on the left side. Occasionally, however, you do come across a Sulphur case with the typical Chelidonium pain on the right side of the chest.

These Sulphur patients always complain of a horribly dry mouth, which is very often offensive. The tongue is usually thickly coated, rather dirty, and there is always intense thirst.

Then there are one or two typical Sulphur symptoms. One is that these patients are very liable to have their worst paroxysms of coughing after they have been asleep. Another is that very often after being asleep they wake with a horrible feeling of pulsation in the chest, accompanied by pretty acute anxiety and a feeling that they are going to die. There is one odd thing in these Sulphur pneumonias, and that is that in spite of the fact that they often wake up in this acute distress

they quite frequently tell you that while they are asleep they have singularly pleasant, peaceful dreams. It is about the only drug in the Materia Medica that I know which has that peaceful dream in a distressful condition like a pneumonia.

Another point about these patients is that, as they are very tired and very exhausted, they tend to slip down in the bed, and if they do get low it very much increase their respiratory distress. You will find that these Sulphur pneumonia patients all have a pretty acute air hunger; they want as much air about them as they can get, and they are very embarrassed if the room becomes at all close.

There are two periods in which you are liable to get trouble. The first is about 5 o'clock in the morning. At the time the patients are apt to wake up with the horrible feeling in their chests, and extreme exhaustion. They feel there is something deadly wrong and are sure that they are going to die. And quite frequently about that time in the morning they have an attack of diarrhoea; The other period in which your Sulphur pneumonia feels very bad is about 11 o'clock in the morning, between 11 and 12. At that time they get into the horrible Sulphur sinking, depressed, low, miserable state.

These Sulphur patients are always sweaty, and it is usually a hot, heavy smelling sweat. And, speaking of this, when you are nursing a Sulphur pneumonia do be careful not to allow the nurse to give the patient a blanket bath, because although he has that horrid, offensive sweat you will find if you do allow him to have a blanket bath he will get a rise of temperature the same evening for a certainty. Another thing worth remembering from the practical point of view is that Sulphur patients do not stand talking well. This is not quite so marked as it is in Bryonia (incidentally quite a number of your Bryonia cases will run on to Sulphur ), but the Sulphur patient is very definitely aggravated by having to talk. He feels completely exhausted and tired out by it, and it does him definite harm. So do not allow your Sulphur patients to have visitors.

In the acute stage Sulphur patients respond remarkably well to the very highest potencies; cm's repeated 2 hourly; but in the stage of exhaustion it is wiser to administer 1 m's instead at the same intervals.