CHOICE OF DRUGS AND DOSAGE

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MY OWN experience as to choice of drug and dosage is extremely limited. What I wish to state are at most only preliminary impressions and are expected to prompt much debate. I am sure that most, if not all of you, have in this problem of therapy called for help from the endocrinologists. In my instance, my colleague, Dr. R. W. Schneider, of our department of endocrinology and metabolism, has given complete cooperation and supervised the drug therapy. He has for some time been particularly interested in steroid chemistry.

At first I should like to mention that there are two things that are beginning to crystallize in my mind as a result of today's meeting. I should like to emphasize a few of the statements already mentioned. First, there is or has been a mortality rate of between one fourth and one third of all the cases of chronic beryllium poisoning around the country. I believe that everyone agrees with this. As Dr. Wilson mentioned this morning, between 25 and 30 per cent of their 73 patients in the Salem area have died. Dr. De Nardi and I have found the same approximate mortality rate in a smaller group in the Cleveland area. Approximately one half of the remaining living patients are either already pulmonary cripples or are showing a definite progressive tendency toward becoming such. The other half of the remaining patients seem either to have reached a stationary point or to show definite clinical, as well as possibly spontaneous roentgenological, improvement. We then may say that our patients have been divided into thirds, namely, one third that have died, another third whose disease has been progressing in an unrelenting manner and finally a third in whom the poisoning has stopped progressing without having caused complete disability or has even shown some clinical regression. From what I have heard of today's presentation, I am impressed that most, if not all of us, have been treating the second group of patients, particularly those that would be best classified as showing pulmonary insufficiency, with ACTH or cortisone. I believe that we are all impressed that there has been a minimal or moderate improvement in all cases. I am sure that most of you who are treating patients with ACTH or cortisone have approached the problem of chronic berylliosis with an open mind and with the feeling that such is probably not the definitive therapy but that at least it may be temporarily salvaging patients from present death. In other words, we are trying at least to check momentarily the otherwise relentless progression toward death of the middle third group of patients. The other fact that has been impressed on me from this meeting has been the considerable variation in the protocol of treatment.

Before specifically discussing the choice of drug and dosage, I believe one must review a few of the known basic concepts of these drugs, their action and control.

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