

*Beryllium Excretion.*—We had hoped that by quantitative determinations of the 24-hour urinary output of beryllium we could demonstrate some correlation between clinical improvement and excretion, either acceleration or retention. No such correlation was possible (table 3). Although there appeared to be some retention of beryllium during treatment in cases 1 and 2, there was no change in case 3, and the results were too inconstant to permit any conclusion in cases 4 and 5.

*Re-Treatment.*—Within two months after discontinuing ACTH treatment, N. B. (case 3) began losing weight, and symptoms of reduced respiratory capacity

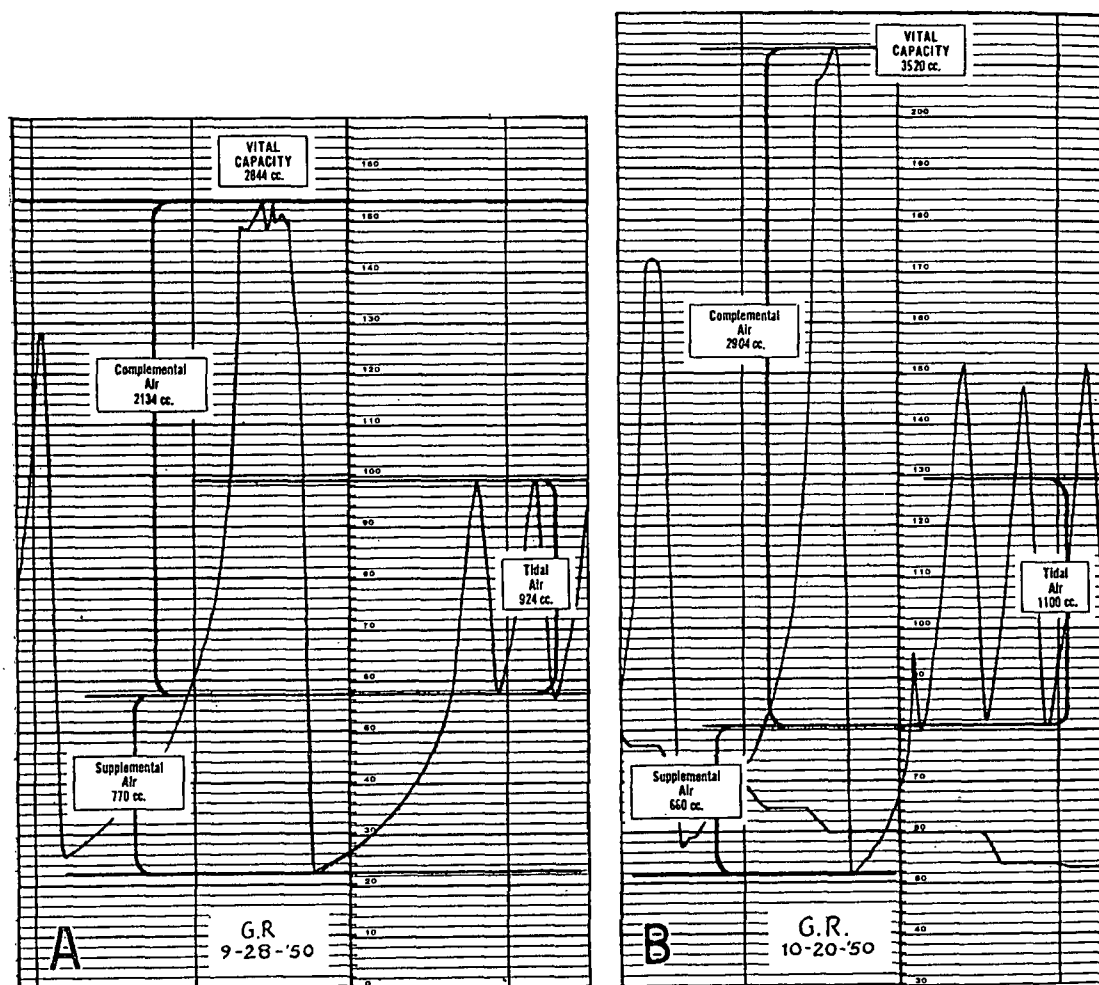


Fig. 9 (case 4).—Spirometric tracings of patient G. R.: *A*, made before therapy, showing a reduction in the vital capacity (65 per cent normal). The prolongation of the expiratory phase of respiration is indicative of an obstructive type of respiratory dysfunction. *B*, made on the seventeenth day of ACTH therapy, showing a significant increase in vital capacity and a less abnormal expiratory pattern.

reappeared. Whereas his maximal breathing capacity had been 184 just before he was discharged from the hospital, Oct. 9, 1950, it had fallen to 121 (fig. 6) on Dec. 16, 1950 with a corresponding reduction in his vital capacity (fig. 7). These determinations indicated that his condition had deteriorated to the pre-ACTH treatment level, and he was readmitted to the hospital on Dec. 28, 1950 for oral cortisone therapy. The usual treatment schedule of 300 mg. the first day, 200 mg. the second and 100 mg. the third and succeeding days was begun. There occurred