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Furthermore, it has been reemphasized that there are some considerable differences in its manifestations in different localities. It appears that the agglutination test is still the most practical diagnostic criterion. Blood culture would be a more useful procedure if more cases were provisionally diagnosed at an early stage, but this is still the exception rather than the rule. We agree with Stitt that the agglutination test should be used "once there is a suspicion of undulant fever", but we think that such suspicions ought to be more easily and more frequently aroused. It is well for us to keep in mind that almost any case of ill-defined illness that persists over a period of several weeks or more may possibly be undulant fever.

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678 SOUTH FERRIS AVENUE.

## RECLAMATION OF THE ALCOHOLIC

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The allergic nature of true alcoholism has been postulated in a previous paper (1). We there endeavored to show that alcohol does not become a problem to every person who uses it, and that the use of alcohol in itself does not produce a chronic alcoholic. Of those who are able to drink with impunity, however, a certain number will sooner or later develop this anaphylactic condition, in which the tissue cells are sensitized to alcohol. We believe that the alarming increase in such cases may be directly attributed to the failure of the medical profession to recognize the true alcoholic pathology and to treat the condition as a somatic dysfunction rather than as a combined physical condition and a psychological maladjustment. But before instituting treatment, it is essential to determine whether a case is acute or chronic; that is, allergic.

To present all the minutiae of the treatment of allergic alcoholism in the space of one article is, of course, impossible. It is necessary, though, first to divide these alcoholics roughly into two groups; namely, first, those who have reached an acute crisis and, therefore, require hospitalization either to avoid the crisis and prevent delirium tremens, or to bring the patient safely through such a crisis; and, second, those whose condition is such that, with proper treatment, no danger of a crisis exists. Practically all cases would be in the second category if the patient's condition was recognized and the proper treatment started promptly. However, through failure of the patient to reach the physician in time, or through failure of the physician to provide treatment, many do reach the crisis stage.

It is, therefore, necessary to recognize three phases of treatment. The first phase applies only to those in the first category, referred to above, which ordinarily should have been avoided. The last two phases apply to both categories since they are necessary regardless of whether or not the patient had to go through the first phase. We might define these three phases as follows: 1, Management of the acute crisis; 2, physical normalization and cell revitalization so that craving is eliminated, and 3, mental and normal stabilization, which naturally involves some "normal psychology".

### Management of the Acute Crisis

Regardless of the fact that such a stage is usually avoidable, it is not avoided in many instances, and, hence, its existence must be recognized, not only so that it may be properly treated, but also so that it may be avoided in a larger percentage of cases. If the physician has kept abreast of current developments in the handling of this problem, such a crisis exists only because it was there before the patient came to the physician. This being true, prompt and thorough measures must be taken before any body cell normalization is undertaken. In other words, with a crisis, a negative treatment is first required. We firmly believe that most such acute cases should be hospitalized, but, in selected cases, and where hospitalization is impossible, home treatment may be undertaken.

As the most serious complication of acute alcoholism is acute delirium, the first consideration of the attending physician must be to determine whether or not this is imminent. The imminence of delirium tremens can usually be recognized within a few hours; its onset is recognized by:

1. A persistent rapid action of the heart (pulse rate to 140).
2. A rise in temperature to 100° F. plus.
3. Persistent insomnia not yielding to sedatives.
4. Increase in the tremors, which may include the muscles of the face, and progress to an ataxic gait.
5. Profuse perspiration (present in over half of our cases).
6. The general picture of progressive alcoholism, although the patient is receiving practically no alcohol.

In the presence of the foregoing symptoms, the alcohol must not be abruptly discontinued. From our experience in thousands of cases, we believe the average patient properly treated without deprivation of alcohol will seldom develop delirium tremens. The patient must be adjusted to a controlling dose which is physiological for him—say one ounce every four hours, with an occasional ounce between, if symptoms increase.

To relieve the pressure in the brain and spinal cord (unless spinal puncture is contemplated), dehydration

must be begun at once. Unless contraindicated, we begin with a large dose of physic, preferably a cathartic to be followed by a saline purgative. The chief contraindication is enlargement of the liver. If abdominal distention is present, catharsis must be discarded and high colonic irrigations of warm saline should be substituted. On the next day, if the abdomen is no longer distended, the cathartic can be administered advantageously. In patients who are obstreperous and uncooperative, these warm saline irrigations have a somewhat sedative action. The dehydration is continued for from three to four days, depending on the strength of the patient.

In alcoholic gastritis, vomiting is common following the administration of saline purgatives by mouth. This simply amounts to a saline lavage, and the saline should be repeated until it is retained. Acidosis is frequently present in these cases and should be recognized and treated by the usual methods.

Remembering that we are still dealing with the acute stage and considering only the negative treatment, we must recognize that sleep must be induced. This is a prime necessity in view of the insomnia which is universal with these cases. Morphine should be avoided if at all possible, as it increases brain congestion and frequently leads to a fatal issue. Before a sedative is administered, the physician must ascertain whether one has previously been given and action is delayed. The cumulative action of an additional dose is sometimes most serious. We have seen a number of instances in which a dose of morphine fired a whole train of sedatives that had been given previously with no effect, with promptly fatal results. If the patient contrives to get more alcohol than has been prescribed and large doses of sedatives must be administered, the depressant action of the alcohol, combined with the sedation, may culminate in a state of mental confusion leading to hallucinosis.

On about the fourth day the alcohol can be entirely withdrawn, as by this time the crisis has been avoided or safely passed through and, hence, the patient is in the second phase of the treatment (which should have been the first stage in most cases, as previously noted). The following is typical of a patient who had to go through the first phase:

**CASE I (Hospital No. 17).—**Mr. M., aged forty-one. His family history was Negative.

**Personal history:** The patient had been a moderate drinker for ten years, with no apparent interference with his work, which was exacting, or his family life, which was normal. The picture then changed over a period of a few months, so that alcohol became an immediate problem. He would abstain entirely for a week and then, on taking one drink, would again have to continue for a number of days, sometimes weeks. He could not understand this development in his case, believing it due to some lack of will power, and finally falling back on other alibis.

Physical examination was negative as regards organic disease. The heart was rapid (pulse rate 120); blood pressure 180-100. Generalized tremors were present. The facial expression was anxious and there was a general sense of apprehension. No food had been eaten for the preceding three days and insomnia was marked.

**Treatment:** Immediate detoxication was initiated by means of free catharsis and the cerebral pressure automatically relieved. He was allowed a moderate amount of alcohol, varied according to his condition. Sedatives were given in moderation, but not enough to cause a sudden "knock-out". Following three days of this treatment, alcohol and sedatives were discontinued, and the patient, still being nervous and finding difficulty in sleeping, we decided to try an especially prepared combination consisting of an orthocolloidal iodine complex and an orthocolloidal gold. In one week's time, there was a return to entire normalcy as regards the physical condition and the treatment was continued for a period of three weeks.

#### Physical Normalization and Cell Revitalization

In this phase are included all allergic patients who have either been kept clear of the acute crisis or who have been safely passed through that phase by hospitalization. Therefore, in this phase we are able to start to deal with alcoholism as a manifestation of an allergy. We have established to our satisfaction that this allergy is the result of the body cells becoming sensitized to alcohol. It naturally follows that the proper treatment is one which will desensitize the cells, restore them to normal, and add to their defensive mechanism by activating them and re-energizing them. Without such a corrective of the constitutional condition, neither the ordinary allergic patient who has not had a crisis, nor those who have passed through the crisis as a result of the negative treatment described above, can be benefited to any lasting extent.

Since this body cell condition is a colloidal phenomenon, the logical treatment in the restoration to normal, physiologically, is the administration of an appropriate colloidal preparation such as that referred to in the case previously described. This particularly appeals to us in that our experience demonstrates that it relieves the necessity for the use of sedatives which often produce disastrous results, retard recovery and lead to various habit formations, and, in addition, the danger of "let-down" is obviated, as illustrated with the following cases:

**CASE II (Hospital No. 413).—**A man of thirty-six just returning from China, where he had been drinking heavily for a period of five or six months, presented himself for treatment, with the usual history. Following the standard method of detoxication, a tremor, of the intention type, persisted, which we were unable to relieve with the usual means of sedatives or physiotherapy. We then used the special colloidal iodine complex and colloidal gold, and, in about a week, there was a marked diminution in the tremor. After two weeks of further treatment, the condition was scarcely noticeable and the craving for alcohol had not returned.

**CASE III (Hospital No. 981).—**A young man of twenty-eight had suffered severe attacks of migraine since the age of 14. He had been said to be allergic to many forms of food and had eliminated most types of food as a consequence. He had for some time been using morphine and hyocine for relief of the attacks of pain. For the past few months, he had been living in a room from which all light had been eliminated, believing that was of further benefit to him. His weight was

eighty pounds. His mental attitude was one of despair and he had practically lost all interest in the general affairs of life. Following our detoxicating treatment, we decided, along with our usual procedure in such cases, to try the special colloidal iodine complex and colloidal gold preparation (previously referred to as being appropriate with alcoholics). The result was that in the next two weeks he had gained fourteen pounds, was able to endure his attacks of migraine, which were much milder in character, was eating a mixed diet, moving about daily, and is talking of resuming his studies.

However, these patients are still in the second phase of the entire condition, and elimination of the phenomenon of craving that follows the treatment does not constitute a cure. In some cases, desire never returns. In others, relapses occur, but it is noteworthy that the intervals between debauches are lengthened, and the sprees, when they do occur, are not so prolonged. As in the case of any other allergy, the body can not usually be exposed again to the sensitizing agent without danger. In these patients, therefore, there can be no compromise with alcohol. The final cure rests with themselves. What we can do is to give them a sound physical basis on which to build the intelligently controlled mental attitude which is essential to their complete restoration. This, however, will be discussed when we outline the third phase of treatment. We must utter a word of caution here, however, which is that measures designed to contribute to the physical rehabilitation of the patient are not indicated while delirium tremens is imminent, but only when the crisis has been brought under control or where no such crisis exists.

#### Psychotherapeutic Approach

Most of these allergics are above average in intelligence and become worthwhile members of society when freed from alcoholism. In some, constitutional psychopaths, manic-depressives, and those in whom alcohol has produced a degenerative condition of the brain cells, the prognosis is bad; with these, temporary improvement is obtained but relapse is the rule. By this, we do not mean that, where the prognosis is bad, the alcoholic should be cast aside into the psychopathic scrap heap without any attempt at reclamation. Frequently, a patient with a seemingly complete mental breakdown shows a remarkable transformation after his system has been detoxicated and re-normalized. In other words, it usually is impossible to predict whether there is anything left worth saving and on which to build, until he has been normalized by the treatment and medication described. When this has been done, then, for the first time, we can see what material we have to work with in trying to restore a normal attitude toward life.

In allergics with physical ailments or deformities the prognosis is good, especially if during hospitalization the other condition can be remedied. But the largest group comprises individuals as normal as the rest of us except that they have become allergic to alcohol. They must be given an intelligent conception of their anaphylactic condition.

Our approach is somewhat as follows: We endeavor to impress upon the patient that his condition is physical

and not mental as regards the drug; that the reasons he gives for drinking (social and financial problems, escape from a feeling of inferiority, etc.) are but alibis. He has a medical problem to face, that a law of nature is working inexorably in his case as in a diabetic. We define allergy and interpret its characteristics, until we are sure he has grasped the fundamental nature of his case. He can then appreciate that only by entirely avoiding the toxic factor, alcohol, can he avoid an "attack" of alcoholism.

If we can bring our detoxicated and cell normalized patient, who has lost his craving for alcohol, to this viewpoint, he will be in a position to make a decision to forego its use. Without quibbling over words, we wish to differentiate between a decision and a resolution, or declaration, of which the alcoholic has probably made many. A resolution is an expression of a momentary emotional desire to reform. Its influence lasts only until he has an impulse to take a drink. A decision, on the other hand, is the expression of a mental conviction, based on an intelligent conception of his condition. After a resolution is made the individual must fight constantly with himself; the old environmental forces are still arrayed against him, and he finally succumbs to his old means of escape. However, if he has made a decision, through understanding of facts appealing to his intelligence, he has changed his entire attitude. He can go back to his former environment, mix with his drinking friends (without concern, because his craving has been counteracted), and meet his worries and disappointments as a normal person; he is free from all the emotional restrictions that formerly activated him to drink. No will power is needed because he is not tempted.

We have seen this reasoning operate successfully in many cases, even as we have seen many failures following what we term resolutions or declarations.

#### Moral Psychology

We believe that this decision is in the nature of an inspiration. The patient knows he has reached a lasting conclusion, and experiences a sense of great relief. These individuals, introverts for the most part, whose interests center entirely in themselves, once they have made their decision, frequently ask how they can help others.

CASE III (Hospital No. 993).—A man of thirty-eight, who had been drinking heavily for five years, had lost all his property and was practically disowned by his family, was brought to the hospital with a gastric hemorrhage. His general condition was typical of allergic alcoholism and apparently he was mentally beyond hope. Following thorough elimination and medical rehabilitation, he made a satisfactory physical return. He then took up moral psychology and, in two years' time, has entirely recovered his lost fortune and has been elected to a prominent public position. On meeting this patient recently, we experienced a strange sensation; while we recognized the features, a different man seemed to be speaking, as if a self-confident stranger had stepped into this man's body.

CASE IV (Hospital No. 1152).—A broker, who had earned as much as \$25,000 a year, and had come, through alcohol, to a position where he was being supported by his wife, presented himself for treatment.

carrying with him two books on philosophy from which he hoped to get a new inspiration. His desire to discontinue alcohol was intense, and he certainly made every effort within his own capabilities to do so. Following the course of treatment in which the alcohol and toxic products were eliminated and his craving counteracted, he took up moral psychology. At first, he found it difficult to rehabilitate himself financially, as his old friends had no confidence in his future conduct. Later he was given an opportunity, and is now a director in a large corporation. He gives part of his income

to help others in his former condition, and has gathered about him a group of over fifty men, all free from their former alcoholism through the application of this method of treatment and "normal psychology".

To such patients we recommend "moral psychology", and in those of our patients who have joined or initiated such groups the change has been spectacular.

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293 CENTRAL PARK WEST

## A RAPID METHOD OF ESTIMATING URINE SUGAR\*

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Sometime ago Sheftel (1) described a simple, rapid method of determining sugar in urine. Its principle depends upon the fact that the cuprous oxide formed by reduction takes on a yellow instead of red color, in the presence of a sufficient amount of creatinine and a hydrophilic colloid, such as acacia. There is apparently no change in chemical reaction, but the addition of creatinine, as explained by Maclean (2), and obviously acacia, too, holds the cuprous oxide precipitate in a fine suspension which imparts a yellow color, while without these two substances large particles of cuprous oxide are deposited which appear brick red. The yellow colored cuprous oxide forms different shades of color from green to yellow with an excess of the blue colored cupric ions, depending upon the amount of sugar present. A colored chart can then be built up, the colors corresponding to the various concentrations of glucose.

In cooperating with our laboratory, Dr. Sheftel made additional suggestions, and the method has been further simplified. The procedure now proves so convenient and easy that any person unacquainted with the method can obtain results of approximation, and a trained technician can secure figures correct to about 0.1 percent, a limit of error allowable in clinical chemistry (3). The time required actually to perform this test does not exceed five minutes.

Before examination of the urine, weighed amounts of the reagents for each single test, as shown below, are prepared:

Copper sulphate .....	43.00 mgm.
Sodium citrate .....	218.40 mgm.
Sodium carbonate .....	156.00 mgm.
Acacia .....	1.10 mgm.
Creatinine .....	0.35 mgm.

It should be noted that the oxidizing system is the same as that of the now famous Benedict's reagent (4). The quantities of the substances are arbitrary. They were determined by repeated trials for the best performance of the test. To prevent bumping and foaming, a pinch of talcum and a trace of a higher al-

cohol such as dodecanol are added. For convenience, we prepared tablets containing all the above ingredients in the same proportions as enumerated. A standard water color scale was also made to cover ranges from 0.0, 0.2, 0.4, 0.6, 0.8, 1.0, 1.2, 1.4, 1.6, 1.8 to 2.0 percent. The colors were determined by dissolving the theoretical amounts of glucose in sugar-free urine and by reacting with the afore-mentioned oxidizing system in identically the same manner as described in the next paragraph.

To make the test, one introduces 1.5 cc. of water into a pyrex tube (13 by 120 mm.), 0.25 cc. of urine, and a reagent tablet. The tube is held over a microburner, and the contents are allowed to boil for one and one-half to two minutes. After cooling for one-half to one minute, the tube is gently agitated and the color matched on the scale. If the color lies between two shades, the average of the two is taken. This gives directly the percentage of sugar in the specimen. The total amount of sugar excreted by a diabetic patient during a twenty-four hour period may be calculated as follows: Glucose in gm. = total number of liters x 10 x percent found.

If the color of the boiled solution proves to be brownish orange, or more yellow than that given by two percent, the sugar content obviously exceeds two percent. In that case, the urine must be diluted with sugar-free urine from a normal person—1:2, 1:5, or 1:10 depending upon the degree of glycosuria—and the test is repeated. The reading is multiplied by the number of times the urine is diluted, to give the percentage of the specimen.

If the solution after boiling is blue with a greenish hue but does not appear to approach midway between 0.0 and 0.2 percent, the urine is then considered to contain a trace of sugar.

In Table 1, the results obtained by the present method are compared with those by the Benedict method and the polariscopic method. In Table 2, the results from the examination of the urines of nine diabetics, by both the present and the Benedict methods, are placed side by side. There is an apparent agreement among the figures obtained by the present

\*From the Lilly Research Laboratories.

# Quarterly Cumulative Index Medicus



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VOL. 21  
JANUARY—JUNE  
1937

CHICAGO  
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- SILBERT, S.**, Thrombo-anglitis obliterans and Addison's disease in same patient, *J.A.M.A.* 108: 551-552, Feb. 13, '37
- SILD, A.**: See **CORNIL, L.** (Marseille), *jt. auth.*
- SILER, J. F.**, and others, Protective antibodies in blood serum of individuals after immunization with typhoid vaccine, *Am.J.Pub.Health* 27: 142-151, Feb. '37; also, *Mil. Surgeon* 80: 91-104, Feb. '37
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  - modifying silicic acid content of blood by administering silogran (ethylsilicicmoleate) by mouth and by inhalation, [M. Baldus] *Med.Welt* 11: 201-203, Feb. 13, '37
  - nature of silicon in living beings, [E. Kahane & G. Antoine] *Bull.Soc.chim.biol.* 18: 1769-1782, Dec. '36
  - presence of silicon particles in animal organs, [G. Antoine] *Bull.Soc.chim.biol.* 18: 1783-1788, Dec. '36
  - quartz in industrial dusts and deposits on human lung tissues; x-ray diffraction, chemical and spectrographic studies, [V. Hicks, O. McElroy & M. E. Wargal] *J.Indust.Hyg.& Toxicol.* 19: 177-186, April '37
  - silica and silicate solubilities, [A. C. Titus] *J.Indust. Hyg.& Toxicol.* 19: 138-145, March '37
  - in blood: See Blood, silicon compounds
  - therapy: See Peptic Ulcer, therapy
- SILICON IRON**: See Arsenic and Arsenic Compounds, toxicity; Phosphorus and Phosphorus Compounds, poisoning
- SILICOSIS**: See Pneumoconiosis
- SILK, C. I.**, Standardization of tuberculosis case finding procedure in schools, *Dis.of Chest* 3: 13, Feb. '37
- SILKWORTH, W. D.**, Alcoholism as manifestation of allergy, *M.Rec.* 145: 249-251, March 17, '37
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- SILLIG, CÉSAR**, See *Obituaries*
- SILOGAN (ethylsilicicmoleate)**: See *Silicon Compounds*
- SILVA, ALBERTO**, De que morreu Felipe I, das Espanhas? *Bahia med.* 7: 197-204, Sept. '36
- SILVA, ALVARO**: See **GARCIA MONTES, G.**, *jt. auth.*
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- SILVA NUNES**: See **CORDEIRO FERREIRA, jt. auth.**
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- See also Conjunctivitis, prevention; Measles, prevention; Stains and Staining; Venereal Diseases, prevention; Water, purification
  - method of retrieving silver from fixing baths, [H. Arens & J. Eggert] *Röntgenpraxis* 8: 753-763, Nov. '36
  - question of bactericidal value of Moiseev's silver preparation, [V. D. Bantov] *Novy khir.arkhiv* 37: 13-16, '36
  - arsphenamine: See Uterus, cervix
- SILVER—Continued**
- colloidal: See also Chorea, therapy; Cornea, ulcers; Intestines, diseases; Uterus, cervix
  - bactericidal and growth-inhibiting action of guastron studies on pathogenic bacteria, [H. Wachler] *Monat.schr.f.Ohrehn.* 71: 47-48, Jan. '37
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  - nitrate: See Burns, therapy; Stains and Staining; Teeth, caries
  - oligodynamic effects: See also Water, purification
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  - sodium silver thiosulfate: See Gonorrhea, therapy
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