ADRENOCORTICAL HORMONES IN PRACTICAL CONDITIONS

To the Editor:

In reply to your inquiry about the patients who were treated by us with ACTH (The Journal 19 (1951) 137-145), they all relapsed within short periods after the drug was discontinued. The iridocyclitis which was present in one of them, however, remained quiescent for about three months. After that the symptoms returned, but my colleagues at the leprosarium have been able to control them pretty well by instillations of a dilute solution of cortisone (i.e., the commercial solution of Cortone containing 25 mgm. per cc., diluted with 3 parts of saline). As for the Koff method of treatment which you mention, Dr. Nieves Berti and I have five cases that have responded extremely well to it, and the benefit appears to last more than a week after each injection, longer than was indicated by Koff. The method consists, as you know, of the subconjunctival injection of about 8.3 mg. of cortisone under the conjunctiva after local anesthesia (J. American Med. Assoc. 144 (1950) 1259).

There is no question in the minds of my ophthalmic friends that cortisone is revolutionizing the treatment of the acute “allergic” diseases of the eyes, and the difficulties which accompany Hansen’s disease—the acute difficulties, that is—appear to be no exception. There is a very good review of this subject, by R. W. Smith, and E. H. Steffensen, in the New England Journal of Medicine (245 (1951) Nos. 25 and 26, Dec. 20 and 27).

One more point: There have been numerous reports which indicate that in infections, and particularly in tuberculosis, although these hormones mask the symptoms, they enhance the virulence. A note of caution on this point which I wanted to add to our article reached the Publication Office too late to be included. I think one would have to be careful about administering these drugs to patients with leprosy over prolonged periods.

Instituto de Investigación

Científica

Marcel Roche

Caracas — Venezuela

ADRENOCORTICAL HORMONES AND THIOSEMICARBazonE

To the Editor:

As Dr. Roche will tell you, in reply to your question, the physicians at the Cabo Blanco leprosarium had to discontinue the work with ACTH because of the cost of the drug. Recently Dr. Roche has started a new series of observations, and we should learn more of what can be expected of that drug in
leprosy. I have heard that a few of the patients with iridocyclitis have themselves purchased cortisone, and that the results with it have been as good as in the case treated with ACTH which was reported.

A few words about thiosemicarbazone: It will soon be two years since we began to work with it. Every three months I have examined those patients, which now number 100 as the group was increased to that number during 1950. In general, what we said in our publication [The Journal 18 (1950) 451-455] can still be maintained. There has been no support for the fears of bad tolerance which had been felt, considering what may happen in tuberculosis. We hope in due time to report the value which this drug may have in the therapy of leprosy.

Caracas, Venezuela

MARTIN VEGAS

CORTISONE INJECTIONS FOR IRITIS

To THE EDITOR:

In reply to your request for further information about our experience with subconjunctival injections of cortisone in the treatment of iritis, to which you called attention in a recent editorial note [The Journal 19 (1951) 471-472], the following answers your specific questions:

(1) The cortisone deposit remains visible for from 7 to 21 days at the most, depending on how much is deposited.
(2) The deposit does not spread over a larger area than is occupied immediately after the injection.
(3) Pallor (decrease of hyperemia) develops in 24 to 72 hours.
(4) The spread of the pallor outward from the immediate injection area is a matter of hours.
(5) The local depository effect seems to us to persist for much longer than 48 to 72 hours, probably for as long as the deposit is visible. However, we give the second injection, when indicated, because we feel that the cortisone does not reach the anterior chamber in sufficient concentration to affect the iritis in some of the severe cases.

One of the last issues of the British Journal of Ophthalmology contained a symposium on about 600 cases treated with ACTH and cortisone in England. In this article Duke-Elder states that, in their experience, the subconjunctival method is the method of choice in dealing with inflammations of the anterior segment, particularly iritis.

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