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CLIFFORD MITCHELL

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ORIGINAL ARTICLES.

DIABETIC DETERIORATION.

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Instead of presenting a paper on the treatment of dropsy, about which I have nothing particularly new to report, other than will be found in my forthcoming book on Renal Therapeutics, I beg leave to send in to the Minnesota Society a few thoughts on a subject which is probably new to many of you, and certainly to myself. The practice of medicine is full of surprises. Dynasties of theorists fall, and thrones of authorities crumble. The naming, the classifying, and the describing of diseases, must be jealously watched for fear that in our endeavor to pigeon-hole our diagnosis we forget the patient himself altogether.

Of what disease is albuminuria a symptom? Any medical student will answer "Bright's disease." Of what disease is sugar in the urine a symptom? Diabetes mellitus, of course. Broadly speaking, these answers are correct, and no doubt would be marked perfect on an examination paper. But after a good many surprises in my study of renal diseases, I have finally come to the conclusion that albuminuria is sometimes an early symptom of diabetes mellitus, or at any rate a phenomenon often preceding the

advent of glycosuria, while sugar is certainly sometimes found in the urine of those cases which, sometime subsequently, die of nephritis.

The important point is just this: Modern medical education, with its classifying tendency, holds our nose down to the grindstone of the apparent lesion so closely, that we may overlook altogether the diathesis of the patient. For example, there comes into my office some day, a man who has been rejected by a life insurance company, because of albuminuria. I examine his urine and, sure enough, I find albuminuria and cylindruria, low specific gravity, deficient solids, and the general make up of the urine of chronic interstitial nephritis. But in other respects he is doing quite well, as the slang phrase is, and is singularly free from the cardiac and vascular changes which characterize contracting kidney. In fact he has no symptoms whatever of chronic nephritis of any kind, barring the urine. Now he wants his insurance policy, and what is to be done with him? Naturally enough in the light of our best knowledge, we cut down his supply of meat, encourage him in the use of milk, and vegetables, and give him, merc. cor. in small doses, three or four times daily. What happens? In about a month we find a little sugar in his urine which gradually increases until it is four per cent or more. We throw overboard our theory of chronic interstitial nephritis, put him on strict diabetic diet, and not only does the sugar decrease, but the albumin (previously found), decreases as well.

This sort of thing is upsetting to our pigeon-hole view of albuminuria, the significance thereof, and the dietetics thereof. After a few cases in my experience like the one above described, a very uneasy feeling comes over me when a patient presents himself with symptomless albuminuria which he wishes to get rid of.

But I have purposely omitted certain details for the reason that I have not myself paid sufficient attention to them in the past, and wish to emphasize them now. In the first place most of these albuminuric-glycosurics-in-disguise, are fat, and I have learned to suspect every fat man of having

diabetes mellitus concealed about him somewhere; and second, most of them aver that meat suits their digestion better than carbohydrates. Here we have three points about the particular cases in question: fat persons with an intolerance for carbohydrates with albuminuria and a slight cylindruria. Does it mean Bright's disease in any form? Most likely not, if there are no other evidences of that malady; more likely diabetes mellitus; most probably diabetes mellitus in a prodromal stage, if you can find history of that disease in the patient's family.

After seeing several cases of this kind develop into full fledged diabetics with almost total disappearance of the albuminuria and cylindruria, it was with no small satisfaction that I picked up a monograph by Dr. Heinrich Stern of New York, in which the following ideas are advanced: diabetes mellitus is probably only indicative of a single stage in the process of a certain type of molecular or somatic deterioration. It is not likely that it developes independently and spontaneously. There are three stages of the deterioration:

1st. The prodromic or preglycosuric stage. 2nd. The period of glycosuria or diabetes mellitus proper. 3rd. The post-glycosuric stage or period of ethyl-diacetic acid poisoning.

The importance of recognizing the prodromia or preglycosuric stage can readily be seen. The first point is to establish the family history of diabetes which is not hereditary in itself, but the diabetic diathesis is. Given then a person in whose family diabetes mellitus has existed or exists, how are we to recognize the prodromal stage of the disorder in the individual in question? By combining Stern's observations with my own, the following rules may be laid down:

1st. The individual is fat. 2nd. He has disturbances of digestion and intolerence of carbohydrates. 3rd. There are sickening pains, not of a colicy nature, yet in the epigastric region, increasing after eating, and worse on pressure. So much we both agree upon. In addition I find

two conditions that Stern does not speak of, as follows:

4th. Slight albuminuria and cylindruria. 5th. A tendency to void a little sugar in the urine at certain hours in the day, increased by eating or drinking articles rich in glucose.

Stern speaks of a number of symptoms as diminution of sexual desire, great nervous irritability, hypochrondriasis, cutaneous disorders and so on. Now when the second stage of the deterioration, or true diabetes mellitus itself appears, the patient loses flesh, has excessive appetite, and thirst. The urine increases in volume, and the albumin disappears to a trace.

The albumin, which in the beginning is but slight, becomes so small in the large volume of urine, that it may escape observation altogether, and we are in the habit of paying little attention to it anyway, because we are taught that diabetic urine most always contains a trace of albumin, so we accept it contentedly and think nothing of it.

The question of treatment of these prodromal cases, is a highly important one, as an ounce of prevention in the present may be worth more than several pounds of sugar in the future.

The essentials of treatment in the preglycosuric stage are as follows:

1st. Diminish the food supply while insisting on regularity of meals.

2nd. Prohibit nothing except alcoholic drinks, beer, and malted beverages.

3rd. Advise milk and American cheese, particularly the latter.

4th. Give the patient a radical change of climate.

5th. If a change of climate can not be had, advise air-baths, i. e. gymnastics, or even sitting still in a more or less nude state, in a room the temperature of which is just high enough so that the patient avoids being chilled.

For remedies, Stern advises arsenic and gold, but I think there is much in these cases that suggests uranium nitrate as being the closest indicated remedy in many ways. We

know that it is recommended by our symptomatologists for cases originating, as they say, in "dyspepsia or digestive derangements," and the latter are a feature in the prodromal stage above described. Arsenic is indicated chiefly for emaciated diabetics, and I do not see that it fits the cases so well in the prodromal stages as later when the hunger, thirst, loss of strength, and flesh, so often point to it as the remedy. Of aurum, however, I think better than arsenic for the prodromal stage owing to the mental symptoms, which in some cases are characteristic. There is a good deal in symptomatology, as pathology in slowly finding out, and one of the things which makes the study of pathology a necessity, is that it explains to the inquiring mind why symptomatology often cures.

THE SIGNIFICANCE AND INTERPRETATION OF SYMPTOMS.

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BEAVER DAM, WIS.

To him who is a believer in the homœopathic law of similia, the word symptom means much more than to our neighborly friend who is pleased to call himself "Regular." To the mere symptomatologist, a member of our school who has a blind faith in symptoms and nothing else in medicine save the indicated remedy, a symptom is almost sacred. A symptom has been defined as a functional or vital phenomenon of disease. It is an incomplete index to some condition. A sort of marginal reference to other symptoms, which in their totality indicate the homœopathic remedy.

In the beginning of this paper I wish to disclaim all desire or intention of making any attack on homœopathy or questioning the value of the "totality of symptoms," as a means of finding the indicated remedy. I simply wish to call attention to the vital importance of thoroughly analyzing all symptoms before using them, either in the framing

of our diagnosis, or as a guide to the remedy. If we always had the time, and the disposition, and the ability to scrutinize with judicial eye, all subjective symptoms as they present, at the same time being impartial in our observation of the objective symptoms, I imagine there would be more correct symptomatic interpretations, and as a result more effective prescriptions. On the whole, symptoms are troublesome affairs—they often annoy, vex and perplex us as physicians. They torment, irritate and distress the patient. If however, the patients were free from symptoms, the doctors would develop a whole lot of their own—chiefly of a reflex character—traceable to empty pocketbooks.

Without doubt, pain is the most common and most frequently met of all symptoms. It is the *bete noir* of the average human being. Humanity in general, and men in particular, greatly prefer to be excused from this most annoying symptom. To the patient, the significance of a pain may be little except that "it hurts" but to the doctor, it is an ear mark of some particular condition or disease. If we see an individual who is complaining of a lancinating pain in the side, we may be assisted in our diagnosis by the patient's statement, that he has an attack of pleurisy, and wants something to relieve this "cussed pain". The pain in the opinion of the patient may be "cussed." That much may be taken for granted, but it may not be pleuritic. True, the pain is in a region suggestive of a pleuritic difficulty, and on superficial examination we might be tempted to accept the patient's diagnosis.

After a young doctor gets fooled once or twice and has been caught napping two or three times, he ought to get his eye teeth cut, so to speak, and take nothing for granted until he has carefully gone over the ground, and has reasons for the faith that is in him. It would be as sensible to say that a man had a cancer of the stomach, because he had vomited a few times, as to say that one has pleurisy because he has pain in his side. After hearing our patient's description of his pain, and noting his physiognomy, with its telltale story of distress, the thought of pleurisy comes

THE PREVENTIVE TREATMENT OF BRIGHT'S DISEASE.

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One is predisposed to Bright's disease perhaps in two ways. First, by heredity, and second, by occupation or circumstance. Gouty ancestry is a possible factor in predisposition to Bright's, as is also that of heart disease, syphilis, cancer, and consumption, together, of course, with Bright's disease itself. It is by no means true, however, that family history of these disorders is certain to mean Bright's disease in all descendants, but if of such heritage one should not fail to take ordinary precautions with view to earliest possible recognition of any existing kidney disease.

Occupations, in virtue of which one is liable to Bright's, are those in which alternate heating and chilling of the body occur, those in which the person is continually chilled by wetting, and those in which there is great mental strain and worry. Among my patients have been those from both the humblest and the highest walks of life, both the man who cleans out sewers and the millionaire whose financial responsibilities whiten his hair and disturb his rest.

One who is predisposed to Bright's by heredity or occupation will be further liable to its onset if he live in a climate subject