THE TECHNIQUE OF THE INSULIN SHOCK AND METRAZOL TREATMENTS

BY L. LARAMOUR BRYAN, M. D.

INSULIN SHOCK TREATMENT

Selection of Cases:

New cases, or those of relatively short duration, are preferable for insulin hypoglycemic shock treatment. A patient with a well-preserved personality, fair educational advantages and whose mental disorder is of short duration, undoubtedly offers the best prognosis. However, if this treatment is ultimately to be of value in a broader sense one must treat cases of longer duration. Patients who have been ill for four or five years occasionally show a good response. Individuals with a basically subnormal intelligence seem to have an extremely poor prognosis and thus far the writer has not seen any of these show an appreciable improvement.

Patients should be in good physical health. A careful physical examination should be done. An X-ray or fluoroscopic examination of the chest is advisable and if cardiac lesions exist electrocardiographic readings should be obtained. Veins should be good or at least accessible, as it may be necessary to give intravenous glucose at any time as a life-saving measure.

Undernourished patients can usually be treated safely for as a rule their physical condition improves under treatment. The appetite being keener they usually gain in weight.

Orientation of Patients:

A psychological approach is advisable in preparing patients for insulin hypoglycemic shock treatment. It has proven to be of definite value. If patients are in good contact and accessible one should discuss the treatment with them briefly as in this way one may, to a certain degree, avoid psychic trauma. It is not advisable to place patients in a treatment room without enlightening them as to what the treatment is for or what is expected of them. We are frequently asked by relatives whether or not we think it advisable for them to inform the patient about the treatment. In almost every instance we advise the relatives to do so. In this way pa-
tients are more likely to have confidence in their relatives and it simplifies matters for the physician in establishing rapport. If one can have the patient enter the treatment room willingly and in a cooperative mood subsequent treatment will in all probability be more satisfactory.

**Diet:**

A small breakfast low in carbohydrates is given prior to treatment as we have found that when no breakfast is given many patients become disgruntled. A high carbohydrate diet is given for dinner and supper in order to keep a favorable carbohydrate balance and thus prevent a latent shock.

**Medication:**

Sakel prefers to give tincture of digitalis minims 15 t. i. d., or its equivalent for three days and then minims 15 daily for the remainder of treatment. We feel that this is of doubtful value and now we do not use it routinely. Magnesium sulphate is of value in patients who become constipated after the administration of insulin. It should not be used routinely, however, as under treatment some cases develop diarrhea.

**Treatment Room and Personnel:**

The treatment room should be made as attractive as possible so that it lends an air of cheerfulness to the patient. It is important that the personnel should have a kindly, sympathetic attitude toward the patient as this may give him confidence and a sense of security. Our treatment room will accommodate 30, 15 males and 15 females. It should be equipped with running water so that one can wash the hands and use reasonably good technique in tubefeeding and in giving intravenous glucose.

**Preparatory Phase:**

Sakel recommends 15 or 20 units of insulin as an initial dose. Subsequent doses can in most cases be increased by 20 units per dose. In this way the shock dose will be reached in the average case in from three to ten days. By increasing the dose rapidly one eliminates a certain amount of psychic trauma and the patient complains less about the unpleasantness of the treatment.