CASE NO. 1

Widow aged 67 came under observation December 11, 1945. Blood pressure 200 over 90. Complained of severe backache and stiffness of both knee joints. X-ray of the lower spine and knees showed the presence of nodules characteristic of the degenerative form of arthritis. Her finger joints were enlarged with typical Heberden nodes.

Blood count was as follows: Hemoglobin, 70 per cent; Erythrocytes, 4,330,000; Leucocytes, 5,800. Wasserman and Kahn negative. Urinalysis revealed nothing abnormal.

She was placed on a diet list which included all vegetables and all fruits. Bread was limited to four slices of whole wheat bread daily. She was permitted to eat the white-of-egg desserts, but everything containing the yolk of eggs, all meats and all internal organs were excluded. In fact, she followed our typical low cholesterol diet. This treatment is based upon the fact that cholesterol deposits in the arteries and the joints were responsible for the high blood pressure and degenerative arthritis.

Although her basal metabolism test was within normal limits, her skin was rough and nails brittle. She was placed upon one grain of thyroid taken in the morning upon arising and given the Squibb's Brewers' Yeast Powder, two teaspoonfuls once daily, for the Vitamin B content.

Her back and knees improved rapidly and by February 26, 1946, her blood pressure was 150 over 70. Administration of thyroid was stopped. At that time her diet was increased to include the lean portion of beef, chicken, turkey, lamb and baked fish once daily, avoiding all gravies.

When she reported December 2, 1946, her blood pressure was 140 over 70 and she was free from all pain. Her weight was 129 pounds.

We see many cases of this combination of hypertension and degenerative arthritis that are completely relieved by this method of treatment. Both thyroid and iodine are cholesterol solvents and one or the other should be administered regardless of the basal rate.
CASE NO. 2

Female aged 64 had been under our care for minor digestive disturbances and bronchitis for the past five years. January 17, 1947, she came to the office with a temperature of 102.5 degrees complaining of pain in the upper part of the right chest. She had no cough, but had lost her appetite and the pain was disturbing her. Complete physical examination of the chest revealed absolutely no lesion whatsoever, no dulness on percussion, no rales heard. This finding was corroborated by two other members of the staff. It really appeared to be a case of intercostal neuralgia. However, because of her rise in temperature we had an x-ray of her chest which revealed a shadow indicating consolidation in the lower part of the upper right lobe.

She was sent home and a practical nurse was engaged who fed her every two hours. She was given a tablet Grain 7.5 sulfathiazole every three hours with a glassful of water. In two days' time the temperature had subsided entirely and she began to cough and expectorate blood and mucus characteristic of lobar pneumonia. A microscopic examination of the sputum revealed a pneumococcus, negative for tubercle bacilli. Her appetite improved. She was kept in bed for one week's time. She had taken 20 of the sulfathiazole tablets which were now discontinued and she was placed on liquid peptonoids and creosote, 2 drams every two hours. She returned to her work as saleswoman.

Reported again to the office on February 25, 1947. Her chest was again x-rayed and a slight thickening of plenooa corresponding to the lower surface of the pneumonic process was disclosed. She was free from cough or discomfort and regained her weight and strength.

This is truly a case of a typical lobar pneumonia, which could only be diagnosed by x-ray of the chest.

CASE NO. 3

Diabetes mellitus. Patient male aged 58, 5 foot 7 in height, weight 210 pounds. Had been under treatment elsewhere for diabetes for four years. He was given a diet of large fat content and was taking 40 units of insulin daily. His blood pressure was 210 over 110. He was obese, the liver enlarged, a hand's breadth below the rib margins. His skin was dry and he suffered from itching, headache and vertigo. The basal metabolism rate was minus 10, fasting blood sugar 180, NPN 36.

He was placed on a diet of low cholesterol content, consisting chiefly of fresh vegetables and fruit. Fresh brewers' yeast powder was administered to maintain the vitamin B complex. Two grains of desiccated thyroid was given in the morning upon arising. Thyroid is a cholesterol solvent. We frequently see subthyroid patients who have been taking large doses after meals. The acid content of the stomach quickly digests the thyroid and no results are produced; a much smaller dosage in the fasting stomach is effective.

The patient lost weight rapidly, his headache and vertigo disappeared, his skin cleared up and in two months' time his liver was normal in size, his blood pressure was reduced to 140 over 80. The insulin was gradually reduced. In six months' time his fasting blood sugar was 80. The urine was free from sugar and the insulin was discontinued. His diet was increased to one portion of lean meat once daily and a fairly normal carbohydrate content, the egg yolk, internal organs, butter, pork, cream and other fats of high cholesterol content were avoided.

We see many cases of this character who improve when the high fat diet is discontinued, and iodine or thyroid is administered.

The occult blood test in the feces. This test is of extreme value. We have made it a rule that no matter what the patient complains of a routine analysis of the feces should be done in every case. The gastric ulcer patient will soon show a negative test. If it remains positive for several weeks under strict ulcer cure regimen a diagnosis of malignancy is made and operation advised. Many patients have been saved by this method. We have collected now 78 cases with persistent occult blood in the feces in which x-ray examination of the entire gastro-intestinal tract has been negative, palpation negative, patient sustained no weight loss and no loss in appetite. The diagnosis finally established was malignancy and was confirmed by operative procedure. In 35 of the cases a lesion was located in the stomach, 32 in the colon, 9 in the small intestine and 2 in the oesophagus. All of these were early in character and all successfully removed by surgery without a single fatality.

One remarkable case not included in this list occurred in a female aged 36 who had slight digestive disturbances, no weight loss, but persistent occult blood reaction in the feces. Operation disclosed an inoperable carcinoma in the second portion of the duodenum which finally resulted in metastasis and death.

In all of these cases it is very important to exclude the presence of bleeding from other sources such as nasal sinuses, throat, gums, hemorrhoids, cervix, and rectal and sigmoid polyps. Even in a virgin we find that we can introduce a three-eighths-inch vaginoscope with the patient in the knee-chest posture and have a good view of the cervix. We find benign polyps in the rectum and sigmoid can be readily destroyed by the diathermy spark.

We employ a modification of the Guaiac test for occult blood, inasmuch as we found that the other tests were really too delicate in character. The test we employ follows:


Method: 1 cc. Guaiac solution; 8 cc. hydrogen peroxide. A swab or applicator is dipped into the feces and it is added to this mixture, stirred well and allowed to stand for two minutes.

The amount of blood varies with the intensity of the color: light green, 1 plus; green, 2 plus; light blue, 3 plus; royal blue, 4 plus.