A short review, entitled “Data in the literature on prolonged therapy with A.C.T.H. and long acting A.C.T.H. preparations, with some remarks on their pharmacology” was given by F. A. Nelemans (Utrecht). He concluded that corticotrophine and cortisone should only in very special circumstances be given for more than a few weeks, and the utmost care is necessary. Since biological standardisation of the different long acting preparations on the market does not give comparable clinical results, the use of one type of preparation specific for each patient is advocated.

A. A. H. Karsenaar and A. Querido (Leiden) discussed the clinical basis and indications for prolonged administration of A.C.T.H. and the use of long acting A.C.T.H. preparations. Apart from the difficulties in evaluating the effect of A.C.T.H. therapy (among other things the euphoria of the patients during treatment makes objective evaluation difficult), the authors stressed the importance of determining the urinary excretion of 17-ketosteroids. They prefer this determination to blood eosinophil counts for several reasons. From the results the clinical discrepancy of different preparations having the same strength in international units is stressed. Several so-called long acting preparations have been tested; most of them were not satisfactory for clinical use. Two preparations of different origin, one a zinc compound, were very useful in clinical practice. As the 17-ketosteroids in the urine is only an indirect estimate of the glucocorticoid production it was an improvement to determine the 17-ketosteroids blood level. The small spread of the blood level in normal persons (6.3±1.2 micrograms per ml.) and the uniform rise after administration of A.C.T.H. indicated that the blood level can be considered as a measure of the production. With ordinary A.C.T.H. the blood level was normal again within 6 hours; with the long acting preparation the level reached its maximum in 6 hours and returned to normal only after 24 hours. The authors concluded that with laboratory help the maximum dose of A.C.T.H. can be determined but that the minimum effective dose can be found only by clinical trial.

J. Goslings and A. Cats (Leiden) spoke on their experience with prolonged A.C.T.H. therapy in chronic rheumatoid arthritis. They stressed the fact that rheumatoid arthritis fluctuates; without enough control-groups it is impossible to evaluate a therapy. Using three groups of 6 patients over a period of 6 weeks, the authors found that doses as small as 5 or 10 units of a long acting A.C.T.H. preparation every day or 10 to 20 units every other day can sometimes produce a favourable clinical change.

F. Schwarz and F. L. J. Jordan (Utrecht) discussed the results with internal diseases. One of their patients had a chronic granulopenia and splenomegaly (? chronic hypoplastic neutropenia as described by Spaet and Damescheck). A.C.T.H. gave a prompt and marked rise of the granulocytes. Cortisone was not able to maintain this. Repeating the A.C.T.H. therapy restored the granulocytes, as did cortrophine Z (a long acting A.C.T.H.) in the same dose. Two patients
with a true aplastic anaemia had only a temporary moderate reaction to A.C.T.H. Two patients with lupus erythematoses dis-seminatus had a very low serum complement during the active phase. A.C.T.H. and cortisone restored the complement to normal. A female patient with scleroderma and low complement had a less marked response. For Organon Ltd the influence on eosinophils of two long acting A.C.T.H. preparations was studied. In all cases an eosinophilia for about 48 hours has been found.

P. van Aken and J. J. Zoon (Utrecht) discussed the effect of long acting A.C.T.H. and cortisone on pemphigus. They described 11 patients treated with A.C.T.H. and/or cortisone (pemphigus vulgaris 8, pemphigus foliaceus 2, pemphigus vegetans 1). Starting with 40 mg. A.C.T.H. or 100 mg. cortisone per day, the dose was raised to effective level in a few days, according to the condition of the skin and mucous membranes, the general clinical picture, the laboratory findings and the blood eosinophils. After healing of the skin lesions the dose was gradually lowered to that which suppressed all or nearly all symptoms. If possible, the therapy is then stopped, but in many cases one is forced to give massive doses again for variable periods. Between 1922 and 1949, 30 out of 31 patients died from their pemphigus. Of the 11 patients treated with A.C.T.H. or cortisone from 1950 to 1953, 5 died (1 from pemphigus: dosage too low; 1 from stopping the treatment on his own initiative; 1 without a clear cause three months after stopping the treatment and healed pemphigus; 2 from heart failure present before treatment). The other 6 patients are free or practically free from pemphigus, their general condition being good or excellent. Summarizing, one may say that the results at least temporarily may be excellent and that for a number of patients the therapy has been life saving. We are not able to say that the therapy has prolonged the lives of all the patients; on the other hand suffering was relieved in all cases. In the period of reduction of dosage serious complications are sometimes seen, though these do not necessarily contra-indicate further therapy at a later date. A.C.T.H. gives more serious and more frequent undesired reactions than does cortisone. Cortisone is therefore the drug of choice for prolonged therapy. This does not mean that A.C.T.H. must not be used in cases where cortisone is ineffective.

J. Groen (Amsterdam) described his results with A.C.T.H. plus psychotherapy in bronchial asthma. He showed that very small doses of A.C.T.H. (5 units or less per day) favourably supplement psychotherapy.

H. J. Sluiter (Groningen) described his experiences with long acting A.C.T.H. preparations in bronchial asthma. Most of the patients, resistant to the usual therapies, improved on A.C.T.H., but the majority relapsed after therapy was discontinued. 14 patients were treated as out-patients after a preliminary in-patient period. The author used several long acting A.C.T.H. preparations – in one the A.C.T.H. was combined with zinc, in another with carboxymethylcellulose – but found no obvious differences between them. During the use of these long acting preparations, in addition to the clinical picture the following were determined: weight, blood pressure, albuminuria, reduction, urobilinuria, eosinophilia, 17-ketosteroids, sodium, potassium, vital capacity and 1 second value (both before and after epinephrine) , haematocryt and blood gases. The results were not very impressive. One of the main reasons may have been the bad condition of the patients at the beginning of treatment.

W. J. F. van der Bijl and P. J. van der Werff (Amsterdam) treated bronchial asthma with a long acting A.C.T.H. (Acton prolongatum) and with A.C.T.H. Both therapy groups consisted of 16 patients suffering from severe or chronic asthma in whom the usual anti-allergic therapy was
unsatisfactory. Acton prolongatum was administered every third, fourth, sixth or seventh day. The average treatment lasted for 31 days. The following conclusions were drawn:
The clinical effects of A.C.T.H. and Acton prolongatum are similar.
The improvement from Acton prolongatum starts later and the treatment is longer, but less Acton prolongatum (in units) than A.C.T.H. is needed.
The maximum eosinopenia is reached in 8 hours, and a return to normal takes 48 hours.
The results were similar to those of Bergstrand, Engström and Kraepelien. Severe asthma attacks should be treated with A.C.T.H. followed by Acton prolongatum. With Acton prolongatum the out-patient treatment of asthma is possible. Chronic asthmatic patients with eosinophilic bronchitis can be treated with Acton prolongatum. Patients treated with inhalation-allergens in high dilution and experiencing attacks of asthma can be desensitised under the protection of Acton prolongatum. F. A. Nelemans.