The eighth Annual General Meeting of the British Association of Allergists took place at the Royal Society of Medicine, London, on February 4th, 1956. Dr. D. A. Long gave a paper on “Adrenal Cortex and Hypersensitivity in Different Species” (vide Proc. roy. Soc. Med. 49, 295, 1956). The clinical side was presented by Dr. D. A. Williams on “The Use of Cortisone and Corticotrophin Gel in the Treatment of Asthma”, and the President, Dr. R. S. Bruce Pearson spoke on “Treatment of Asthma with Corticotrophin and Cortisone”.

In the afternoon Mr. H. Shaw talked on “Hydrocortisone by Local Injection for Control of Nasal Polypi”. The final talk was by Dr. Howard Whittle on “Corticosteroids in Skin Disorders”. Dr. A. W. Frankland, Honorary Secretary, British Association of Allergists, Wright-Fleming Institute, St.Marys’ Hospital, London, W. 2.

The Use of Cortisone and Corticotrophin Gel in the Treatment of Asthma
By D. A. WILLIAMS

The results of 100 short courses of ACTH gel/Cortisone in 71 asthmatics, their subsequent histories and requirements were presented. Eight (11%) had complete subjective relief, 8% partial relief, 8% no relief and 2 died of status asthmaticus, both proven post-mortem. The short courses were for 7-14 days, the maximum daily close of Cortisone being 300 mgms. and of ACTH gel 160 units. Antibiotics were also used when indicated.

In the 10 failures, the possibility of the dosage being inadequate in some and of bronchial infection preventing improvement in others, was considered. Only five complications were classed as severe. One, a melaena in a man who had had no symptoms of his duodenal ulcer for 16 years; two had boils; one an allergic reaction to ACTH gel and one recurrent precordial pain after ACTH gel in a woman of 69 years known to have coronary atheroma.

The remission of symptoms lasted from a few days to 2 months, with an average of 24 days. The type of asthma and the effectiveness or otherwise of the fundamental treatment of the asthma affected the length of remission to a far greater degree than the type and dose of hormone used. Fifty per cent of these cases required further hormonal treatment and of these latter cases 37% later improved and were able to discontinue their hormonal treatment. The importance of continuing to search for and treat the basic causes of asthma in these patients was emphasized.

Six (8%) of these 71 patients, observed over a period of 3-4 years, died of asthma. No deaths from other causes occurred. These deaths were not attributed to hormonal therapy, but to failure to control their asthma. ACTH/Gortisone was being used in 37% of hospital admissions for asthma.

Treatment of Asthma with Corticotrophin and Cortisone
By R. S. BRUCE PEARSON

Fifty-one in-patients with status asthmaticus or severe chronic asthma, and twenty-seven out-patients with resistant asthma have been treated with ACTH or Cortisone. Some cases received
treatment with both these substances and thirteen of the patients are included in both in-patient and out-patient groups. The difficulty of making sure that good results were really attributable to Corticotrophin and Cortisone and not to associated treatment with antibiotics or to spontaneous recovery were discussed. Objective methods of assessment by means of respiratory tracings, the quantity of spasmolytic drugs used and the attack rate were used as much as possible.

Forty-two in-patients were treated with Corticotrophin; these included thirteen classified as allergic, fifteen as intrinsic and twelve with asthma secondary to bronchitis. Excellent or good results were achieved in 9, 11 and 8 members of the three groups. Comparison between the different methods of administering ACTH showed no appreciable difference in response but intravenous administration was certainly the most economical. Three deaths took place during treatment but in two of these, who died shortly after admission, the treatment had not had time to be effective. The third death was due to an unsuspected pneumonia.

Sixteen in-patients were treated with Cortisone; nine had also received Corticotrophin. Excellent results were obtained in four, good in eight, slight in two and no effect in four. One patient died in an attack of asthma after receiving fifty milligrams every six hours for thirty-six hours. He was not regarded as a severe case of asthma and his death was totally unexpected.

Nineteen out-patients were treated with Cortisone for periods of time varying from 3 months to three years. One patient required only 30 to 50 mgms. daily to keep him reasonably well, but all the remainder were given between 60 and 100 mgm. daily. Ten patients treated for six months, received placebo tablets for a similar period. Only seven of these 19 patients were classified as ‘good’ or ‘excellent’. There were two others who did well but responded in an equally satisfactory manner on placebo tablets and were consequently not regarded as Cortisone successes.

Eight ambulant patients were treated with ACTHARR gel and seven of these did well; all had previously responded well to ACTH as in-patients.

Analysis of the failures and those who benefitted only to a slight extent showed that poor results were associated with 1) death before treatment had become effective (2), 2) termination of treatment on account of side effects including one death from pneumonia developing under treatment (5), 3) the presence of emphysema, pulmonary fibrosis or bronchiectasis (9). In five cases excellent or good results were obtained on one or more other occasions, and in these, uncontrolled infection or inadequate dosage may have been responsible for the poor results. Among the out-patient group persistent wheezing when unassociated with evidence of emphysema, was usually accompanied by poor response especially when it had been established for a period of years. Three out-patients with relatively mild intermittent attacks also failed to respond to Cortisone in doses of approximately 100 mgm. daily, over a period of six months. No explanation could be offered to account for these failures. Although emotional factors were commonly present in those patients who did badly, they were encountered as often in those who responded well.

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Hydrocortisone by Local Injection for Control of Nasal Polypi
By H. J. SHAW

After reviewing briefly the materials and methods used in the treatment of allergic rhinitis and nasal polyposis with corticosteroids during the last 7 years, the author concludes that their use is justified in selected cases.
A report of a trial of Hydrocortisone free alcohol (20 mgm./ml.) in a water miscible vehicle is presented. A group of 25 patients with bilateral nasal polyposis and allergic rhinitis were given local injections of the Hydrocortisone solution into the polypi of one side, those on the opposite side being injected with the vehicle alone as a control. Treatments were given once weekly for a minimum period of 4 weeks, injections thereafter depending upon the response. The majority of patients improved subjectively and objectively during treatment, although the degree of improvement was almost the same on the two sides. Relapse almost invariably took place on discontinuing treatment.

A further small group of 6 patients with uncomplicated allergic rhinitis were given submucosal injections of the Hydrocortisone solution. No improvement was obtained in this group.

It is suggested that further controlled investigations of corticosteroids in stronger solution or suspension be undertaken before a definite conclusion can be reached.

Corticosteroids in Skin Disorders
By C. HOWARD WHITTLE

The corticosteroids have a limited scope in the field of dermatology, and until Hydrocortisone became available their use was confined to a few severe, hitherto intractable, disorders such as pemphigus, disseminate lupus erythematosus, acute dermatomyositis, the acute phase of periarteritis nodosa and Stevens Johnson syndrome. Some of the purpuras, drug eruptions, exfoliative dermatitis and widespread eczema-tous reactions may respond more rapidly to corticosteroids than to other agents. These conditions are not all obviously allergic in nature though allergy may play a part.

Dermatologists are now agreed that ACTH and Cortisone should be reserved (1) for saving or prolonging life, as in pemphigus, where Cortisone is preferable to ACTH and is used as substitution therapy for adrenal deficiency; (2) for shortening the course of a self-limiting condition as in drug eruptions; and (3) for tiding the patient over a crisis or emergency in others. Prednisone and prednisolone, now on trial, will probably supplant Cortisone because they avoid the sodium and fluid retention effect of the latter.

Hydrocortisone in the form of an ointment has been proved by several controlled clinical trials to be valuable in initiating healing and maintaining a remission in such conditions as lichen simplex, otitis externa, infantile eczema and Besnier’s prurigo, nummular eczema, ano-genital pruritus and a few other disorders. The percentage of cases that respond varies from about 30% - 90%. Successful results reported in the controlled trials of Hydrocortisone ointment are as follows: infantile eczema and Besnier’s prurigo 360/509 (78%), ano-genital pruritus 80/130 (62%), nummular eczema 26/57 (46%), contact dermatitis 34/55 (62%), lichen simplex 24/46 (52%), otitis externa 24/28 (89%), other skin disorders 21/61 (34%). The best results are in otitis externa and infantile eczema. The figures were obtained from the list of references given.

A response may be initiated by concentrations as low as 1% and maintained by still lower concentrations, e. g. 0.5% or even 0.1%. Expense can be saved by restricting its use to lesions which fail to respond to other measures and also to small lesions which require only tiny amounts of the hormone. Fluorohydrocortisone has no advantages over Hydrocortisone and as it may be absorbed it is apt to produce unwanted side effects. Hydrocortisone is not absorbed as such, and its mode of action is still unknown. It may act, as small doses of X-rays on the skin do, by influencing enzyme action at some stage of protein synthesis in the cell cytoplasm.
References

News Items – Nachrichten – Nouvelles
3. Aerosol-Kongress
Aerosol-Kongreß in der Kongreßhalle im Arminiuspark, Bad Lippspringe, Westfalen, unter
Vorsitz des amtsführenden Präsidenten des wissenschaft-lchen Beirats, Prof. Dr. Schulemann,
Bonn. Generalsekretär des Kongresses ist Dipl. Phys. Dr. Nückel, Arminiuspark 3 a, Bad
Lippspringe (Tel.: 649). Der Kongreß wird als Hauptthemen 1. Medizinische Aerosolprobleme
und 2. Luft hygienische Aerosolprobleme behandeln. Außerdem werden verschiedene spezielle
Fragen durch einzelne Arbeitskreise behandelt. Im Kurmittelhaus von Bad Lippspringe werden
Demonstrationen zur Diagnostik und Therapie mit Aerosolen abgehalten. Im Foyer der
Kongreßhalle wird eine Ausstellung von Aerosolpräparaten und Verneblern für Medizin und
Pflanzenschutz stattfinden. Weitere Auskünfte erteilt der Generalsekretär Dr. Nückel auf
Anfrage.