These symptoms had been present for three years. She had had a normal pregnancy in 1938.

On examination there was no evidence of recurrence of tumour. The residual urine was found to be 475 c.c. Examination of the urine revealed numerous white blood cells and scattered red cells. Culture of the urine revealed *Bact. coli.* The P.S.P. test showed a two hour excretion of 35% of the dye. The upper urinary tract visualized by intravenous urography (Fig. 3a) revealed a moderate bilateral hydronephrosis and hydroureter. Cystoscopic examination of the bladder revealed a generalized vesical neck contracture with heavy trabeculation of the bladder wall. The cystometrogram showed good detrusor tone.

A transurethral resection of the vesical neck was performed on June 16, 1947, with removal of two grams of tissue. The postoperative course was uneventful. A Foley catheter was retained for four days. Following its removal she voided with no difficulty and the urinary frequency was greatly reduced. The residual urine was 20 c.c. The pathological examination revealed an exudative, purulent and ulcerative inflammation. She was discharged from hospital on July 5.

This case is interesting in that one would probably first consider neurogenic vesical dysfunction as the causative factor. During the early postoperative period the detrusor function was undoubtedly disturbed from temporary damage to the sacral nerves. It is our impression that the bladder neck became contracted as a result of a chronic inflammatory reaction associated with the period of prolonged catheter drainage.

SUMMARY

The importance of lesions of the urethra and bladder neck in the causation of urological symptoms in women is considered. It is pointed out that pathological lesions may be present in spite of normal urinary findings.

The etiology of vesical neck obstruction in women is considered. It is the authors' impression that chronic infection is probably the factor of greatest importance.

The symptoms, findings and results in cases treated by transurethral resection are reviewed. The excellent results of this form of therapy have led us to abandon in most cases the older, palliative methods of treatment, such as dilatation of the urethra and vesical neck.

It is also implied that caution should be used in making a diagnosis of neurogenic vesical dysfunction, in spite of a suggestive history. An obstructive lesion may be the basis for the dysfunction.

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MANAGEMENT OF THE LATE WITHDRAWAL SYMPTOMS OF ALCOHOL*

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ADDICTION TO ALCOHOL may be defined satisfactorily in the same way that one defines addiction to any other drug. It is a state in which a person has lost the power of self-control with reference to the drug and abuses it to the extent that he or society is harmed.[1] Addiction to alcohol results in the death of 39 out of every 100 addicts. There is a complete loss to society of a further 11, six of these die in a psychotic state and the remaining five are dependent on others for their subsistence.[2] The problem presented becomes even greater when one considers the ability of the usual problem drinker to make himself seem a nuisance and uncooperative.[3]

Most people who begin to drink too much and too frequently realize it early and their methods of personal control are successful. Others, who do not gain this awareness in time probably because of a somatic factor which allows alcohol to produce euphoria without too distressing side-reactions, go on to addiction.[4] Some of these people are sick and drink for the alleviation of their symptoms, but in others the emotional factors would seem to be strong social tendencies which cannot be considered abnormal in any customary sense of the word. The majority of addicts to alcohol are ordinary people who develop addiction as a side effect of their social life.[5] These addicts to alcohol differ from addicts to other drugs, as they might be expected to differ, since our society which disapproves

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vigorously of all the other types is benevolently disposed towards the use of alcohol except in its abject or ridiculous aspects.[6]

A syndrome of late withdrawal symptoms has been discussed in a previous paper. These late symptoms occur regularly in problem drinkers who have developed intolerance which cannot be accounted for by fatigue or emotional disturbance. It occurs occasionally in those who have been regularly experiencing "blackouts" or alcoholic fugues without intolerance. This syndrome begins from within a few days after the withdrawal of alcohol up to about two months afterwards. The symptoms are irritability, depression, insomnia, restlessness, a sense of loneliness and lack of concentration. The symptoms occur in a wide variety of intensity, from mild irritable and depressed conditions to dangerous depressions and confused states which have a schizoid colouring. The depressions are occasionally strongly paranoidal. Once the syndrome begins it reaches its maximum intensity within a few days to a month. These symptoms seem to be directly related to the withdrawal of alcohol, and the administration of tetraethylthiuram disulphide does not complicate the picture. The effect of this drug appears to be, not the production, but the alleviation of symptoms in those patients on whom the drug acted as a soporific. Whether the drug is being used or not there is a spontaneous decrease in intensity of symptoms at about six months, and again at about 12. Traces seem to remain for years but they present little difficulty after a year and no real problem after 18 months to two years.

The personality change which accompanies a broken femur is seldom the cause of concern, and is usually not given serious consideration. It is left to "nature" with good results. The late withdrawal symptoms of alcohol may be considered as very similar. Most of these patients not only drink because they are sick but also are sick because they drink. The long term treatment is frequently as dramatic as the treatment of the acute phases; it is relatively simple and much more satisfying since the prognosis is good. The majority automatically adjust to their environment if sobriety can be maintained[7] and they salvage, at least adequately, the pre-alcoholic personality.[8] These late symptoms manifest themselves through the personality of the patient, but in a manner which indicates that they have their foundation in the physical changes resulting from continued excessive drinking. Their occurrence in the problem drinker can be predicted if he continues to abstain after the occurrence of alcoholic fugues plus repeated and inexplicable tolerance. The time relation of the onset, attainment of maximum intensity, decrease, and disappearance of symptoms to the withdrawal of alcohol is fairly regular. They respond to relatively simple therapy. The prognosis is good and it depends, not on the therapy or the therapist, but on the patient's continuing to abstain from alcohol,[7] for from one to one and a half years.

Supervision by the physician can be of great assistance to the patient and the patient's friends, in this painful period. Most relapses seem to start during exacerbations of these late symptoms. Most patients who have the symptoms in milder degree have little need for the physician, but even in these cases the preparation of the patient and his wife or close friends for the difficult times which may be expected ahead, helps to give them the persistency and courage to tolerate and endure. The danger that the patient may become dependent on drugs prescribed to relieve the symptoms is slight. It can be balanced against the danger to the man's employment, to his marital happiness, and to himself from acts arising from depression, and the danger of relapse. The proper time at which the physician should intervene is a matter of clinical judgment but the response of a severe depression or an apparently severe confusional state to simple therapy is gratifying and prompt.

Treatment of the late withdrawal symptoms should start with prevention, but here the physician faces a curious paradox. Society as a whole, and usually the physician as a representative of that society, approves of the use of alcohol in moderation and even to "excess" on occasion. In spite of such difficulties, which are more apparent than real, he can render more than a little service by lending his prestige and authority to all those groups which are attempting to educate the public to moderation in the use of alcohol.

When called upon to treat the acute stages the physician is on firmer ground although it seems a little late. Now he can assist in making the patient aware of the existence of alcoholism as a problem, and later of the fact that the patient's own methods of solving this problem do not work. The awareness of these facts seems necessary in each case.[9] The patient will resent

orders, but will frequently be strongly influenced by a friendly opinion from a respected individual. At this time the physician can give those who are apt to develop late withdrawal symptoms some concept of the long drawn-out struggle which occurs before a satisfactory alcohol-free existence can be achieved. The addict to alcohol is accustomed to deceiving and expects to be deceived. It is essential for the physician to give him as honest an appraisal of what he faces as possible. Instead of becoming discouraged, the patient gains courage as he finds that the physician has been free from subterfuge. Sympathetic assistance and free discussion during the acute stage help to prepare a proportion of patients to face the long term programme.

Although the late withdrawal symptoms do not occur at once, they should be discussed with the patient who is liable to them when he initiates a programme of long term abstinence. For a few days or for a month or two the patient is proud of himself for being "on the wagon," he feels wonderful, there is money in his pocket, and then the vicious syndrome of late withdrawal symptoms starts. If he has been forewarned he can be reassured more readily by the physician, who can now give understanding and encouragement or occasionally just listen when that is necessary.[10] The late symptoms are much exaggerated by difficulties arising in the personal and occupational life of the patient, because in both these spheres the addict to alcohol has invariably developed difficulties. To help meet these the physician must be expected to accept his traditional role of guide, philosopher and friend.

Discussion of what alcohol has meant to a man does seem to help prepare him for the loss of these values. When problem drinkers look back on their alcoholic habits they are usually unable to give any very satisfying reason why they persistently drank to excess.[11] Listening to them, however, one seems to hear the same theme with minor variations. It is the experience which is common to most of us. We begin to drink because it has social approval. Some of those who later will drink to excess, drink to show off. A surprisingly large number of those who will later become addicts discover almost immediately that they have a greater tolerance for alcohol than most of their friends. They use this to gain attention and admiration with the same motives that inspire other young men of their age group to gain attention and admiration starring in hockey or basketball. In their social experiments these youngsters find that alcohol is a source of true euphoria.[12] Later, taking alcohol is found to be one way of meeting hunger, thirst, fatigue and pain, whether physical or mental. As time passes the problem drinker develops a set alcoholic behaviour. Alcohol is sought for the social contacts, the euphoria and the relief of all distresses. Then alcohol becomes in itself a source of guilt and distress as a result of the problem drinker's behaviour in his job, home, and social group. Now alcohol is sought for all the previous effects but also to bring relief from what it has caused. The addict to alcohol becomes unwilling to tolerate a sense of being alone, an absence of euphoria[13] or distress. Part of the preparation, aimed at reducing conflicts which will complicate the late withdrawal symptoms, is a consideration of the inevitability of at least occasional loneliness, occasional distress and rarely more than occasional euphoria.

A prospect of occasional distress must be faced by most of us but some steps may be taken which will make the lonely hours a rarity and which can reasonably be expected to contribute some euphoria. A social programme should be prepared and an avocation should be selected or revived. The most readily available social programmes are offered by church groups and the Alcoholics Anonymous organization. The avocation will be most valuable if it is something in which the hands are involved rather than reading. Almost any craft is valuable so long as there is no real antipathy to it. It should be something which has social approval. Once selected the patient should be prepared to practise it, read about it and obtain a satisfactory teacher. Such a craft is useful during the wakeful hours of the late withdrawal symptoms when companionship is either not available or not sought. Later it becomes a source of pride and a technique by which the patient can gain expressions of social approval to substitute for the expressions of social approval which he previously received from his drinking companions. It has seemed that the simplest approach is to start this programme during the free period following the immediate withdrawal symptoms. Depression or confusion may necessitate stopping an avocational programme if the avocation threatens to add a burden to one who has already had about all

that he can carry. Under these circumstances it may be started again during the second six months of abstinence.

The undertaking of a life free from alcohol involves the family of the problem drinker. The wife may be a factor in her husband's drinking.[14] On the other hand she is forced into a difficult role. The responsibilities of the home are gladly passed on to her during the time that her husband is taken up with drinking. With his abstinence they are taken casually from her again. In the lower income groups the husband has placed the family income in jeopardy and the wife has been well aware of the danger of leaving the care of the finances to him. With the husband's abstinence the wife is faced with seeing the family responsibilities taken on again by one who, whatever his other virtues, has proved himself incapable in financial matters.

Most wives of problem drinkers feel that if their husbands would just stop drinking their troubles would be over. The period of freedom from symptoms which usually follows the acute withdrawal period confirms this. If the wives of patients who are expected to develop the late withdrawal symptoms are prepared for the minimal symptoms of black moods during the months ahead, the arrival of such symptoms will not be such a painful shock. If the wife has the assurance that the symptoms will be much less in a matter of six months and practically over in a year, she faces these time limits cheerfully.

Religious support which in the past has given the greatest outside help to problem drinkers[2] is still an unrivalled source of assistance for those who are at all religiously inclined. The patient can be encouraged to seek assistance from his religious advisor or referred to a clergyman of his faith. Frequently in the pursuit of alcohol, religious duties have been dropped and advice to return to those duties is accepted readily and even gratefully.

Alcoholics Anonymous groups will give enthusiastic assistance to the patient during the difficult months of the late withdrawal symptoms. Unless a patient is a zealous atheist or burdened by strong religious conflicts he is making the recovery from addiction to alcohol unnecessarily difficult if he does not become an active member of this organization. Before receiving the assistance of this group the writer considered the outlook for the alcoholic addict poor. The prognosis for Bacon's secondary type of problem drinker (the fairly well-adjusted individual who progresses from social drinking to addiction[15]) seemed worse than for those who drank as a symptom of some underlying condition. Today the prognosis is excellent for any member of Bacon's secondary group who is once convinced that he must stop drinking. Legitimate criticism might be levelled at Alcoholics Anonymous but the mistakes are mistakes of the head and not of the heart. All problem drinkers who come to this clinic for help are advised to become active members as one of the steps towards recovery.

Alcoholics Anonymous provides a unique support during this period of the late withdrawal symptoms. Fellow members who have been through a similar set of symptoms and who have lived through similar experiences provide relief from the sense of loneliness. Group meetings and the friendly associations which each member finds among his fellow members fill the need for social contact which was a factor in the development of addiction to alcohol. In the Alcoholics Anonymous group there is social pressure towards *not* drinking, while in most social groups the pressure is towards drinking. Among the members of Alcoholics Anonymous the patient will find his decision to go "dry" reinforced by empathy. His sponsors and other members will share their experiences with him. He will see and hear other persons who are examples of the change he is trying to make. Before a group he will learn to say with humility and honesty, "I am an alcoholic," and he will tell of his attempts to abstain. As long as a man is following some course of action and only he knows about it, he can drop it when he chooses because only he is involved, but once he has gone on record before the group, who are all trying the same thing, they too become involved and he hesitates to let himself down in their eyes. A little later he will expose experiences and feelings, which seldom see the light, to someone else attempting the same rough road. In this way he will help the novitiate, reinforce his own resolve to continue abstaining, and, with the opportunity of reliving the deep emotional experiences, change in some small way his long-held attitudes towards drinking. Once the physician establishes reasonable rapport with this organization he can depend on them to contact him should the withdrawal symptoms become so great that the man's behaviour causes concern.

Suffering has no special virtue in recovery from alcoholic addiction, but there is some danger in substituting dependency on a drug for dependency on alcohol. This is probably minimal if the relief of symptoms aimed at is about the relief which would be considered satisfactory in other illnesses—that is, relief sufficient to make the condition bearable rather than complete relief. When a man's symptoms are endangering his job, his marital life or himself they should be relieved.

The youthful addict seems to be especially intolerant of these secondary symptoms, which probably accounts for the difficulty in treating him successfully.[16] Once this younger man has decided that he must stop drinking, rendering his symptoms bearable makes the prognosis as good as in the older man. Complete relief of symptoms is not aimed at and the patient is informed that the aim is only amelioration.

Depression, fatigue and lack of concentration are relieved by Benzedrine sulphate. Where the symptoms are of such intensity that they interfere with a patient's job they can usually be relieved adequately by 2.5 mgm. Benzedrine sulphate by mouth at breakfast and lunch time. Where the symptoms are of such severity that the patient is considering suicide, or is obviously confused or in a condition which seems impossible to care for outside a mental hospital, 5 mgm. of Benzedrine sulphate at breakfast and lunch will usually give enough relief for the patient to carry on effectively and with reasonable cheerfulness.

Irritability or restlessness to such a degree that the job or the home is seriously threatened can be relieved by mephenesin in 0.5 gm. doses at breakfast and lunch and 1.0 gm. doses at dinner and bedtime. In this dosage the maximum action does not seem to take place at once but only after the patient has been taking medication for three or four days. The effective dose of mephenesin seems to vary considerably with some patients. If the patient is still irritable or his mood labile after a dosage of mephenesin has been reached which allows him to sit down and feel relaxed, sodium bromide added in doses of 0.2 to 0.3 gm. three or four times a day can be expected to give appreciable relief after it has been taken for three or four days. If the Benzedrine sulphate should produce feelings of jumpiness to such an extent that these cause concern, sodium bromide is again the most useful of drugs given in this dosage three or four times daily, although little effect is seen for three or four days. Isoamylbarbitone in 0.03 gm. doses two or three times daily is the only other drug which has resulted in patients spontaneously reporting that the medication is making things run smoothly.

A thirst for alcohol may be encountered during this late period. It is rare before thirty and becomes progressively more common after that. If the thirst for alcohol is more than the patient can tolerate, he should be admitted to hospital; the administration of 10 to 30 units of insulin half an hour before lunch and supper will then give relief. After a few days the insulin may be terminated and a continued relief from the thirst will be experienced. The thirst may recur in a few weeks, or it may never recur, or if it does it may be more easily endured. Insulin is given under constant supervision with glucose ready for drinking, for gavage or for intravenous use. The patient is not given the glucose till he is perspiring and flushing or with subjective symptoms of drowsiness and vertigo. He is not allowed to become alarmed, and for the first few times treatment is terminated at any expression of alarm. After the first couple of days he tolerates it with no difficulty.

If insomnia progresses to sleeplessness the patient can be given much relief by explaining the need for rest even if he is not sleeping, and at the same time giving him three nights' sleep with adequate sedatives such as pentobarbital sodium 0.13 to 0.2 grams. This may be repeated so that he gets three nights' sleep out of every six or seven. This can be given for long periods with no increase of dosage, and usually two or three weeks on this routine restores a normal sleep rhythm. The patient must be cautioned against splitting his dosage, because he tends to think that a little sleep is better every night than a sound sleep for three nights out of six or seven.

Symptoms of gastritis occasionally make their appearance together with the late withdrawal symptoms; these are readily relieved with Banthine 50 mgm. three or four times daily for a few weeks.

SUMMARY

1. The problem drinker can expect a difficult time during the first year of abstinence if he has been having alcoholic fugues and then de-

velops intolerance which has no obvious explanation.

2. The wife and family of the problem drinker can expect a similarly difficult time. Both the patient and his wife should be forewarned.

3. Invaluable aid can be rendered by a man's faith.

4. A patient who does not become an active member of Alcoholics Anonymous is making this period unnecessarily difficult.

5. Severe depression, confusion or paranoid reactions can be relieved by Benzedrine sulphate.

6. Jumpiness, irritability and restlessness respond to mephenesin.

7. Mood lability, and milder degrees of irritability and restlessness, are ameliorated by sodium bromide.

8. Insomnia can be successfully controlled by adequate sedation.

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RÉSUMÉ

L'état d'asservissement à l'alcool est celui dans lequel se trouve toute personne ayant perdu contrôle d'elle-même par rapport au médicament et étant devenue une menace pour la société et pour elle-même. Trente-neuf pour cent de ces malades en meurent; onze pour cent sont une perte totale pour la société, six de ceux-ci sombrant dans la psychose et les cinq autres étant complètement incapables de pourvoir à leur propre subsistance. La plupart des alcooliques sont des gens ordinaires qui s'adonnent à l'alcool comme un "à côté" de leur vie sociale. La différence entre eux et les morphinomanes par exemple réside en l'attitude de tolérance de notre société vis-à-vis de l'alcool et de sa désapprobation des autres drogues. Le syndrome tardif du retranchement a déjà été présenté dans un article précédent. Le traitement à longue durée est souvent aussi impressionnant que celui de la phase aiguë; il est relativement simple et beaucoup plus satisfaisant car le pronostic est bon. Le malade doit faire abstinence pendant un an ou un an et demi. Sa surveillance par le médecin peut être d'un grand secours, en préparant le malade et les siens à prévoir les difficultés avant qu'elles ne surgissent. Dans la phase aiguë, le médecin peut aider l'alcoolique en lui exposant les problèmes que pose sa maladie et l'incapacité de celui-ci à chercher à les résoudre. Le malade qui d'habitude se rebiffe au commandement sera souvent influencé par l'opinion amicale de quelqu'un qu'il respecte. L'alcoolique est habitué à tromper et s'attend à l'être. La plus grande franchise est donc essentielle dans l'exposé des difficultés futures. Si le malade est averti, il saura mieux supporter le syndrome tardif de réaction à la privation. Lorsque les alcooliques réformés se penchent sur leur passé, ils sont habituellement incapables de fournir aucune raison satisfaisante pour justifier leurs excès. L'individu commence à boire parce que la société le tolère ou même l'approuve. Certains d'entre eux le font pour se mettre en évidence. Plusieurs parmi eux se rendent compte qu'ils peuvent tolérer l'alcool mieux que leurs amis et se servent de cette capacité pour attirer l'attention et l'admiration comme d'autres le feraient en s'illustrant dans les sports. Après quelque temps, on se tourne vers l'alcool pour ses relations sociales, l'euphorie qu'il procure, ainsi que pour le soulagement de tous les maux. L'alcool devient alors une source de culpabilité par les problèmes qu'il crée au foyer, à l'ouvrage, et dans l'entourage social du buveur. L'alcoolique ne veut plus supporter la solitude, l'affliction, ou le manque d'euphorie. La préparation à la solution des problèmes que comporte le syndrome tardif du retranchement réside en l'inévitabilité de la solitude, au moins passagère, d'angoisse possible et de l'euphorie relativement rare, et de leur acceptation comme telles. Le programme social tel qu'offert par les groupes religieux ou par les alcooliques anonymes d'une part et un passe-temps préférablement basé sur une occupation manuelle d'autre part sont les meilleures garanties contre les heures sombres. Au cours de sa guérison, certains aspects de la vie familiale de l'alcoolique doivent être modifiés; c'est ainsi que la femme à qui échoit la gérance des économies doit abandonner cette obligation lorsque son mari devient en état de la reprendre. La souffrance en elle-même n'offre aucune vertu curative particulière dans le problème de l'alcoolisme, mais il faut se garder, en voulant la calmer, de provoquer une substitution de drogues chez un individu déjà incliné vers l'accoutumance. Le jeune alcoolique tolère moins bien les symptômes tardifs de retranchement que son collègue plus âgé. Néanmoins, s'il est déterminé à guérir, son pronostic demeure bon à condition que ses symptômes soient rendus supportables. Il n'est pas nécessaire de chercher à les masquer entièrement. Le sulfate de Benzédrine à raison de 2.5 mgm. par jour per os suffit habituellement à combattre la dépression, la lassitude et le manque de concentration intellectuelle. La méphénésine peut aider à surmonter l'irritabilité et l'agitation. Si le malade ressent un besoin intense d'alcool, comme le fait se produit assez souvent chez les gens de 30 ans et plus, il doit être hospitalisé et recevoir de 10 à 30 unités d'insuline une demi-heure avant le dîner et le souper, ce qui devrait faire disparaitre ce désir au bout de quelques jours. M.R.D.

TOO MANY COOKS

A barbiturate addict whose case is described in the *Lancet* (2: 58, 1954) must hold a record for multiple medical care. "Despite her evasiveness, it emerged that she was attending no less than eight other departments at various hospitals, as well as three outside practitioners, all of whom were from time to time called upon to prescribe barbiturates. A friend obtained more drugs from yet another doctor. It was estimated that she was taking between 20 and 30 grains of barbiturate (quinalbarbitone, pentobarbitone, amylobarbitone) a day.

She attended an ear, nose, and throat department for attacks of dizziness; a department of physical medicine for muscle pains and backache; a physician for insomnia; a psychiatrist for anxiety over attacks of sleepiness, and a neurologist for headache and double vision."