

ents of this group are still much debated. Meanwhile, the various doctrines in dispute should not be allowed to influence our views upon treatment, and certainly have no claim to the predominance which they have so often successfully asserted.

In health the urine contains no sugar, or only a minute trace, so that all carbohydrates ingested are in some way converted or destroyed, provided their quantity is not excessive—that is to say, this capacity for utilising carbohydrate food is not unlimited, and is subject to variations in different individuals and in the same person at different times. A dose of grape sugar, varying from 150 to 200 grammes, is invariably followed by transient glycosuria, and we are familiar with the occasional occurrence of the same phenomenon in healthy persons after some error of diet, such as taking too much sweet champagne. Such cases are on the borderland of diabetes, and von Noorden has suggested that persons who become easily glycosuric from slightly exceeding their usual allowance of carbohydrate food are liable to become diabetic. This is a point upon which further evidence is required, but it is impossible to deny their close relation to those milder cases of diabetes which yield readily to a moderate reduction of carbohydrate food.

But carbohydrate food is not the only source of sugar. In severe diabetes, glycosuria continues, although much reduced in amount, when the patient is placed on a flesh diet, and this is explained by the discovery that a carbohydrate molecule is formed in the process of converting albumen into urea in the proportion of 45 parts per cent. This fact, duly appreciated, must convince everyone of the futility of persisting in withholding carbohydrates in the hope of removing the glycosuria; or at least it cuts away the physiological ground for this practice, and compels us to look for its justification, if it can be justified, in clinical experience. This is the point at which I wish to arrive. If it is conceded that the disputed data of physiologists do not afford a sound basis for our treatment of diabetes, but that we must look to clinical results before we say that a means is good or bad, then the old routine method is doomed.

Instead of ordering a stereotyped diet in every case, we shall try experimentally in each individual how much carbohydrate, or rather what combination of proteid, fat, and carbohydrate gives the best result. This is the method which I wish to advocate here to-day, and perhaps you will allow me to say that the views I now entertain have been adopted solely upon the basis of clinical experience. The first definite step towards the acquisition of clinical experience in the dietetic treatment of diabetes was made by Rollo when he put his