Letters to the Editor

WHY NOT CALL CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) SIMPLY OBSTRUCTIVE BRONCHITIS AND EMPHYSEMA (OCBE)?

Sir, The term chronic obstructive pulmonary disease (COPD) has been in use for about four decades. It easily describes irreversible airway obstruction due to a varying combination of chronic bronchitis and emphysema side stepping without the hardship of defining the respective pathogenic roles of the two. Its abbreviated form is quite convenient to write quickly as the diagnosis in clinical notes. Just as in the UK, in Nepal it is a very common diagnosis that is frequently encountered in emergency rooms and the medical wards, especially during the winter. But the ease of its use is also likely to lead to misuse, and it is inappropriate to use regularly in middle-aged and elderly breathless patients, especially those with chronic asthma.

I became acutely aware of this when I observed many postgraduate students using the term COPD rather too liberally and some, in fact, applying it to every chronically breathless patient. During a seminar involving 52 interns, medical officers, residents and registrars, I asked them to write what they understood by COPD. Twenty-seven per cent indicated that COPD was airway obstruction due to chronic bronchitis and / or emphysema and 32% indicated it was due to the above, together with chronic asthma. The remainder vaguely described COPD as a chronic respiratory disease associated with cough and breathlessness and as any disease in older patients associated with cough and breathlessness. This may have many important therapeutic implications. One clinician's COPD does not appear to be the same as that of another.

Some residents indicated that the inclusion of asthma in the term COPD is mentioned in common international textbooks of medicine, and I had to agree! The two common compact textbooks followed by undergraduates, and even postgraduates, are *Davidson's Principles and Practice of Medicine* and Kumar and Clark's *Cinical Medicine*. The former states: 'Chronic obstructive pulmonary disease is the internationally preferred term encompassing chronic bronchitis, emphysema and some cases of chronic asthma'[1] Similarly the latter states: 'COPD has become the most popular term to describe patients with chronic bronchitis and emphysema. The distinction between COPD and asthma is blurred because most patients with COPD have some reversible airflow obstruction.'[2]

Published data of inclusion of chronic asthma patients in the COPD group, with consequent denial of inhaled corticosteroids, are scarce. Data on COPD patients treated with inhaled corticosteroids are more abundant and over 40% of patients with COPD are reported to be treated with inhaled corticosteroids.[3] Since only a small minority do actually respond to trials of corticosteroids, many such patients are probably being treated without benefit.[4] Such use of inhaled corticosteroids might have been encouraged by the observation of a beneficial effect in some patients with chronic asthma who inadvertently have been included in the diagnosis of COPD.

Undoubtedly specialists and better medical centres may not fall into the trap of a disassociation between diagnosis and treatment of COPD, but general practitioners and other not so well established medical centres may. In developing countries, repeated spirometry to check for corticosteroids responsiveness may not be possible in the majority of patients with presumed COPD.

Agreement of a precise definition of COPD may be needed.[5] The term COPD has gracefully linked obstructive airways disease due to chronic bronchitis and emphysema, as was intended when the term was introduced but if chronic asthma is also added, that could be dangerous. Why not then simply call COPD obstructive chronic bronchitis and emphysema (OBCE)? This would facilitate easier communication among clinicians, epidemiologists and experts, and avoid any potential dissociation between diagnosis and treatment of chronic breathless patients.

MD Bhattarai

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PROUST, MEMORY AND THE ENGRAM

Sir, Having read your article on Proust, Memory and the Engram (*Proc R Coll Edinb* 2000; 30:172-5) I was struck by the description of 'involuntary memory'.

My outstanding experience of this arose the first season I grew tomato plants in 1976 when I was 34 years old. When I came to shake the stems to assist the pollination I was immediately transported to my grandfather's greenhouse where at the age of eight I experienced the identical characteristic odour for the first time. The recall was immediate, vivid and emotional. For a few seconds I had recaptured that moment some 24 years earlier.

The intensity of the moment remains with me although it is not now as sharp.

AJ King

PROUST, MEMORY AND THE ENGRAM

Sir, Time - memory - time - memory, the double helix of Proustian prose, is no better transcribed than by the narrator in Volume 3 (page 150 Penguin 1983): 'later on ... I would endeavour to recall it; but in vain; my memory had not been warned in time; it had thought it unnecessary to keep a copy'. One of the less appetising discoveries of late middle age is that one's hippocampal photocopier keeps running out of paper.

TL Chambers

CORONARY COLLATERAL CIRCULATION

Sir, The coronary collateral circulation has immense potential for the prevention and treatment of coronary disease but unfortunately nowadays it is almost always diseased and occluded in patients. Haddy[1] used magnesium infusions to dilate arteries of dogs and found that vasodilatation increased *pari passu* with the concentration of magnesium in humans: a rapid intravenous injection of 8-12 mmols of magnesium appears to permanently dilate the coronary collateral circulation with a dramatic improvement of angina, acute myocardial infarction and congestive heart failure.[2]

For example, a man of 44 had a severe myocardial infarction with subsequent crippling angina and a complicating ventricular aneurysm. After six intravenous injections of 8 mmols of magnesium, he was free from angina and enjoyed life for a further 17 years; he was able to perform an exercise test in Guys Hospital for 12.5 minutes without exhibiting any ECG changes. A coronary arteriogram showed complete blockage of the left anterior descending artery but the distal portion was well filled by collateral flow from the right coronary artery.

Of 126 patients with angina treated with intravenous magnesium, 116 had complete or marked relief of anginal pain and many remained free from angina for 15 years or more.[2] Perlia[3] reported 77 out of 79 patients with angina were much improved after treatment with intravenous magnesium. Results in acute myocardial infarction and congestive heart failure[2] were excellent, and intravenous magnesium was also very effective in non-haemorrhagic cerebrovascular disease, claudication, gangrene, chronic leg ulceration and early renal disease.[2]

The prophylactic use of magnesium injections in early middle age could potentially improve life expectancy.

SE Browne

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LETTER FROM AGARTALA, INDIA.

Sir, India is now faced with a population explosion and with poverty, illiteracy, persistent superstitions and similar types of problems; the suffering of the larger part of the population of India is boundless. Every year a number of births equivalent to the entire population of Australia is being added to the already over populated country adding further to our misery. It is true that development in science, technology, agriculture, industry, health and various other fields is taking place, but the ever-expanding population is diluting all our efforts.

Health, food, clothing, shelter and freedom of speech are the basic needs of the human race. If we consider the question of health, one may wonder whether our citizens are receiving enough attention in connection with the promotion of health throughout the length and breadth of the country. The answer is obviously negative. There is a scarcity of pure drinking water even in the metropolis and larger towns: the comparable situation in rural India can well be imagined. As a result, water borne diseases like typhoid, dysentery, cholera and diarrhoea are our regular companions. No effective and enthusiastic measures are being taken to control the breeding mosquitoes; the resurgence of malaria as a direct consequence causes mortality and morbidity of millions of Indians. Stemming from poverty and ignorance, vast numbers of children lose their sight from deficiency of vitamin A-containing food. (Unoperated cataract is another cause of blindness in our elderly population.) To summarise, the majority of our people are in the midst of extreme misery due to poverty, malnutrition, illness, lack of education and unhygienic living conditions.

In the midst of this pitiable scenario, there is a mushrooming of multi-storied nursing homes, polyclinics and diagnostic centres in metropolitan cities and the larger towns. They are, of course, highly expensive, beyond the reach of the working man. It is curious to note that if somebody ends up there, he is likely to have a series of tests such as ultrasound, CT and MRI scans, intravenous eurography, stress ECGs, echocardiogram, angiography and many other similar types of investigations in addition to more routine and common tests. One may wonder, are these expensive sophisticated tests really necessary? Of course, some patients may need them but is it not a fact that many people are being over-investigated and money and effort are being unnecessarily drained. Lay people are being lured into these establishments by the availability of 'high-tech' sophisticated investigation facilities. But is this appropriate in a country such as India where basic health needs are being denied to the majority of our population?

From personal experience, it can be emphasised that most of the illnesses can be effectively managed by clinical impression, supported by simple blood, stool and urine tests; in some cases X-rays, ECGs, ultrasounds and selected biochemical tests are needed but nothing more than is usually necessary.

At present, our country needs practice of preventive medicine in the form of a supply of pure drinking water, good housing, an ecologically friendly environment, nutritious diet, eradication of illiteracy and superstition, and, above all, population control. For population control we need enhancement of literacy rate among our womenfolk. Unless our mothers and sisters are enlightened, all our efforts directed to population control will turn out be useless.

The public health measures can only be effectively implemented through the state's bureaucratic machinery, and for this to occur political will in that direction is the need of the hour.

Larger nursing homes and diagnostic centres are catering to the need of only a small fraction of our society and it is not a solution to our health problem. We must turn our eyes to the rural India and practise preventive medicine more effectively.

SK Datta

AN EARLY POST MORTEM

Sir, About 50 years ago I studied pathology at Edinburgh University. At the centre of my study lay the post mortem examination where many clinical arguments were settled. I don't suppose the techniques then in use are very different today. However, I had not realised how far back in time they stretched, so imagine my surprise to discover a readily recognisable description of a post mortem carried out 250 years ago by two surgeons from Langholm.[1]

The Sederunt Book of the Justices of Dumfries describes the murder of Thomas Scott. The presentation was given by the procurator fiscal at Dumfries on the fifth day of December 1749. Apparently Lancelot Brown in Standing Stean at Woodhouselees had upon the twenty-ninth day of November assaulted a Strangerman, Thomas Scott, who had stayed in his father's home some days:

> After drinking at the said James Brown's fireside upon the night of the twenty ninth day of November last bypast he had died of a bleeding, which was alledged to have been occasioned by a Hurt or Bruise he had gott on the Wednesday night preceeding: And the said Lancelot Brown laid hold on the Stranger, brought him over the Fire and flung him upon the Settle; and that there was blood seen about the mouth of the Stranger or his nose, and that he continued blooding at the Nose until he died, which was the Night of the thirtyeth day of the said month. That it plainly appeared that the said Lancelot Brown was guilty of murdering the Stranger, at least that the Bruises the said Lancelot gave him occasioned such a Flux of Blood from his nose which was the cause of his death.

On the third of December James and John Mowats, Surgeons in Langholm, conducted a post mortem on the man:

> They did find upon opening the Chist that the Lungs did strongly adhere on the Right side to the Pleura, but little or no Corruption, and no Blood to be found in them, and but little in the largest Blood Vessels but could discover no Appearance of Violence or Vessels broke, or extravast blood in the Cavity of the Thorax, nor any Corrupt Smells, but when they came to the Stomach found blood to the quantity of a pound or more, and but a little corrupted, but how such a quantity of blood came there was impossible to find out, both from his having been dead three days and the Intestines tending much to putrefaction: but if he had been Subject to any preceeding Blooding which was reported, they did think that by the Scuffle and Struggling with heat of Passion might put the Blood into a more Violent Motion than ordinary, and by that enlarged whatever ruptured vessels might be and so poured in these contents as they found in the Stommach, but in every other case quite healthy and lusty.

Perhaps Scott simply died of the severe and prolonged nosebleed and swallowed a large quantity of this blood. Our forebears, without so many of the advantages we enjoy today, were surprisingly knowledgeable though their knowledge of the body's physiology was laughingly primitive. The distances they had to travel, usually on horse back, proved no obstacle to the execution of their duties. Langholm is about ten miles from Woodhouselees and Dumfries thirty miles from Langholm.

Sherlock Holmes would certainly have been interested in this case for Benjamin Bell (1749-1806), the first of the Edinburgh Scientific Surgeons and great grandfather to Joseph Bell on whose character Conan Doyle based his fictional detective, was brought up at Woodhouselees, a lonely farm deep in the folds of the Debatable Land and the scene of the murder. Young Benjamin would no doubt hear the tale of the murder often retold and it probably remained in the family folklore to be recited to Joseph three generations later.[2]

I like to feel that I have a remote connection with Joseph Bell for in Sydney in 1950 I met Dr Scott Skirving who had been in the same year as Conan Doyle and who had been taught by Joseph Bell. In his Memoirs Dr Scott Skirving recounts two tales with an earthly medical flavour about Joseph Bell.

One day a pimply furtive looking youth, with dilated pupils and damp clammy hands, came into the theatre.

'A masturbator' said Bell with conviction.

'No Sir' said the youth, 'I'm only a journeyman baker'.

Another young outpatient came before him and at once Bell said:

'A case of congenital syphilis. Look at the teeth they are Hutchison's.'

'No sir' said the man 'it was not Hutchison made them, but Mr McPherson in Lothian Road.'

J Wilson

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THE LOST ART OF VITRIOLIC RIPOSTE

Sir, There is some controversy regarding how the stethoscope should be used for listening to lung sounds. Some say bell. Some say diaphragm - I say it should be kept in the pocket whilst listening to a radiologist's interpretation of the chest X-ray. Whilst researching the history of the use of the stethoscope (*Lancet* 1826; 667) I noted the following exchange of views on the preceding page and wish to encourage the Editor of *Proceedings* to emulate such editorial embellishments:

> We have received the following letter from 'the only person of his name in the medical profession' - LUSH!
>
> Sir, - As I am the only person of my name in the medical profession, I must take it for granted that it is to me the 'report' has attributed the publication of some cases in

Dr. Macleod's Journal. To this I reply, that I have never written a line in it - that I have never even read a page of it - and that I have never reported hospital cases for any journal whatsoever. So much for the truth of the 'report' which I am anxious to contradict, from a wish not to appropriate myself the labours of others. The *rhetorical embellishments* of the paragraph in question require no comment.

CHARLES LUSH, MD
Licentiate of the Royal College of Physicians
Leadenhall-street, Aug. 12, 1826.

We can assure Dr Lush that his mawkish decumbency to one, at least, of the St. Thomas' surgeons, coupled with other acts or projects of his, was quite sufficient to originate the rumour in question, setting aside the studied accuracy of the style in which the cases were written. But he did not write them, it seems; and however humble his pretensions may be, is desirous of letting the world know it, not wishing 'to appropriate to himself the blunders of others,' having enough of his own. Lush says he has no connection with Dr Macleod's Journal, that he has never read a page of it, that he has never reported cases &c, and we suspect if he had told us what else he had *not* read, and what else he had *not* done, he would have used several quires of paper; at all events he may be assured that we *know* him, and that if we hear any more of his vagaries the public shall know him too.

PD Welsby

THE ROLE OF SEROLOGICAL TESTS IN REDEFINING COELIAC DISEASE.

Sir, This review poses some of the fundamental questions about gluten hypersensitivity in particular,[1] and disease manifestations in general, that some may have always wondered about but never dared to ask. For instance, why is it that for any given autoimmune reaction (including the one which initiates clinical manifestations of coeliac disease), one organ or system is selectively damaged in some patients and a different one in others? For the polymyalgia rheumatica (PMR) / cranial arteritis (CA) syndrome some answers already exist, including evidence that interferon-gamma (a T-cell-derived cytokine) plays a part in the progression from PMR to overt arteritis.[2] An analogous marker might exist to differentiate those coeliacs prone to jejunal damage in contrast to those who are susceptible to neurological damage.

What about the 'set point' for switching on the 'feed back' system for disease markers, be they serological ones, as in coeliac disease, or biochemical ones, as, for instance, in primary hyperparathyroidism? The common thread is that of a wide spectrum of reactivity, hence the co-existence of coeliac disease with absence of serological markers in some patients, and the activation of the entire immunological cascade in others.[1] Likewise, in primary hyperparathyroidism, some patients with histologically authenticated disease (including complications strongly justifying surgical treatment) have normal levels of parathyroid hormone,[3] while others (with comparable plasma calcium levels) are more typically characterised by the expected elevation in serum parathyroid hormone levels.[4] In this instance, a convenient analogy is the recognition of the existence of a calcium-sensing receptor for the regulation of parathyroid hormone secretion,[5] implying, by analogy, that there might also be a molecular basis for the variability in the synthesis of immunological markers following gluten challenge in susceptible individuals.

OMP Jolobe

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