CASE REPORTS

Postal diagnosis: breaking the bad news in the 17th century

John Forrester

On 19 August 1693 a young Italian doctor wrote, unasked, to a senior colleague to tell him that he was suffering from a lethal disorder, although the younger doctor had probably never seen the elder one during the illness. The letter survives and gives full details of the reasoning underlying the diagnosis; the published version included the postmortem findings.

The younger doctor

Alexander Knips Macoppe (fig 1) was a native of Padua, although the name hardly suggests his Italian origin; his ancestors were German. He was about 29 when he wrote the letter and had recently acquired a medical doctorate at Leiden on the topic of aortic polyp. For his thesis he had carefully studied the history of cardiac as well as aortic polyp. The term was first used during a necropsy by Tulp at Amsterdam in the 1630s, but so called polyp had been reported not only in the heart but also in various blood vessels since then, and vigorous controversy soon began and long continued over the distinction between postmortem clot and various other findings that represented genuine disease.

The patient

Charles Patin (fig 2), when he received the letter, was principal professor of surgery at the university of

Fig 2—Charles Patin (1633-93). Courtesy of the Library of the Royal College of Physicians of Edinburgh

Fig 1—Alexander Knips Macoppe (1662-1744). Courtesy of the Wellcome Institute Library, London

Padua. He was 60 years old and worn out, so it was said, by care and literary work. His earlier career had been precocious, versatile, and stormy. His mother (he wrote years later) had given him 20 months of breast feeding as a good start, and he could read at 3 years old and write at 4, because she taught him. At 6 he could speak Latin to educated people and French to the household. At 14 he became a Master of Arts, but turned to medicine only after a false start in law. He was enthusiastically supported by his father, a notable Parisian physician.

But Charles's glittering prospects in Paris vanished in 1668, when he was 33—he was caught in possession of books forbidden by the rigid censorship of Louis XIV and had to flee France to avoid a life sentence in the galleys that plied the Mediterranean. Roaming in exile from court to court in Germany and Italy, Charles impressed the local rulers by his medical skill and also by writing vivid accounts of his travels and the antiquities he found. He also became a specialist in ancient coins, writing several works about them. After 11 years he settled in Padua as a professor of medicine. Ultimately Louis XIV offered him a pardon, but Charles never returned to France.

Symptoms and diagnosis

In 1693 Charles looked pale, had an uneven and irregular pulse, and was short of breath even on slight

slopes. Though he had no chest pain, his heart pulsed and worried him. He salivated a lot; but that was probably due to the mercury his physicians had given, to let the errant humours out of him. A hot bath made him much worse; with bleeding, which was done repeatedly, he improved for a while, but not for long.

Charles's physicians had offered a wide range of diagnoses: excessive thickness of the blood, flatus lodged in the heart or elsewhere, asthma, tubercle or abscess in the lungs, arterial aneurysm, or dilation of the cardiac ventricles. Irreverently, young Alexander argued for the diagnosis he had studied for his doctorate: aortic polyp. He made his case in nearly 40 journal pages of close argument, going back as far in medical history as Galen's report on his fellow physician Antipater, who had a very irregular pulse and was regarded as having blockage of the great arteries in the lung—with death in six months. Alexander did not agree with Galen either; if Galen had done a postmortem examination he would have found some obstruction of the aorta, a better explanation of the pulse irregularity.

With intermittent symptoms, wrote Alexander, Charles's obstruction must be rapidly varying; it could hardly be due to some longlasting thickening of the blood, nor to impaired contraction of a heart which seemed to jump vigorously about. He led his colleague step by step to the conclusion that a polyp in the left side of the heart or in the aorta must be responsible—a spongy thing, capable of quick expansion and contraction. Was this a rash conclusion to reach, since Alexander had not even examined the patient? Not in the 17th century; when the techniques of physical examination were completely unexplored,¹ what counted for a physician was the description of symptoms and a grasp of theory. Hence consultation by correspondence was commonplace, and many volumes of such consultations survive. Mere surgeons might, of course, need to make a physical examination of their patients.

Prognosis

Alexander wrote grimly to Charles: "Only autopsy can show you graphically the specific characteristics of your polypous excrescence. . . . Don't be too alarmed unless you find yourself with constant unremitting palpitation, cold extremities, lividity of the whole body, cold sweat, intermittent cardiac syncope, and severe shortness of breath." Yet faint hope remained; the record showed a few cases of apparent long survival, and the treatment proposed was based theoretically on methods of dissolving and preventing clot.

Alexander's eagerness to bring bad news is comprehensible in a medical tradition where the views of antiquity still counted for much. The Hippocratic treatise on prognosis was a workmanlike guide for the doctor who wanted to achieve therapeutic success, but it said nothing about considering the patient's feelings.² Galen too described a complex intellectual exercise, excellent for the physician's reputation; but how best to communicate it to the patient was not his concern.³ In medieval times the Galenic tradition continued; the doctor who believed that the prognosis was hopeless could say so boldly, perhaps losing his fee, but building his reputation; however, he should incline to the bright side when possible.⁴ Whether a doctor should keep the patient in ignorance about a hopeless prognosis is more a 20th century concern.^{5,6}

Outcome

Charles got the letter—and it did him no good at all. From that moment, his dyspnoea grew much worse.

Fig 3—Charles Patin's lesion: (left) left ventricle of heart opened up, with the dilated aorta—AAA: edges of opened left ventricle, drawn apart; BBB: aorta opened to show dilatation; CC: mouth of each coronary artery; 222: three semilunar valves; aaa: columnae carnae, into which "rudimenta polyposa" were inserted; (upper right) the whole polyp, intact and with its outer coat removed—AA: apex of polyp; BB: base of polyp; aaa: short processes torn away from the aortic roots; eee: inner coat, to which the others seemed similar; 222: coats making up a series of fibrils; 333: filaments linking the fibrils; (lower right) inner structure of dissected and opened polyp—AAA: edges showing coats, one overlying another; BB: opened duct of the polyp; aaa: little columns or outgrowths blocking the duct all round. Courtesy of the Library of Edinburgh University

He was orthopnoeic, stuck in bed with increasing oedema, cursing every remedy and taking none, and he died on 10 October. Alexander was not discouraged by Charles's death. Such a distinguished patient merited a necropsy. The aorta was so dilated as to resemble a second heart, and inside it was a "polypous concretion," bigger than a goose's egg, with a tortuous internal duct. The left side of the heart contained clot and bits of "polyp"; the right side was empty. Alexander had been right, and all the other doctors blushed for shame. He added these findings to the text of his letter, along with a further account of the preceding literature and a detailed engraving of the polyp, the dilated aorta, and the adjoining left ventricle. The whole account was published promptly: on its own as a monograph, and then in an appropriate journal in the following year.⁷ Duplicate publication may now be an offence, but then it was a legitimate means of self aggrandisement.

Postmortem examination

To a pathologist today the lesion found at necropsy (fig 3) indicates a syphilitic aneurysm of the aorta, although it is striking that the valve ring is not noticeably dilated. We think of the aorta dilated by the arterial blood pressure; in the 17th century, people thought rather of the organising clot within the "polyp" as causing the dilatation. Alexander made no mention of syphilis, but his contemporaries had syphilis in mind as a possible cause of polyp of the heart (or aorta), and indeed of almost any lesion.⁸

Later life of the younger doctor

Alexander lived on to the age of 82 and was at work till the day before he died; there is no record of any postmortem examination. According to his devoted disciple Scanagatus, Alexander built up a great reputation for treating venereal disease with mercury and for spa therapy applied to various conditions.⁹ But he never took any medications himself.

Alexander's views mellowed as he grew older: as

Florence Nightingale remarked, "unlicked cubs grow up into good old Bears, tho' I don't know how."¹⁰ He later wrote advice to his juniors on prognosis: "Use ambiguous phrases"; "Smile with those who are going to be cured, but weep with the dying; such tears sell well"; "If the prognosis is bad, hide it from the patient, or merely hint at it."¹¹

I am indebted to Dr David Lamb of the department of pathology, University of Edinburgh, for the diagnosis, and to many librarians for patience in the face of recondite requests.

1 Reiser SJ. *Medicine and the reign of technology*. Cambridge: Cambridge University Press, 1978:6.

- 2 Hippocrates. Prognostic. In: Hippocrates. Vol 2. London: Heinemann, 1923:1-55. (Translator WHS Jones.)
- 3 Galen. On prognosis. In: Nutton V, ed. *Corpus Medicorum Graecorum*. Berlin: Akademie Verlag, 1979:V8,1.
- 4 O'Boyle C. *Medieval prognosis and astrology: a working edition of the Aggregationes de Crisi et Criticis Diebus, with introduction and English summary*. Cambridge: Wellcome Unit for the History of Medicine, 1991:15.
- 5 Hutchison R. Preface. In: *Prognosis*. Vol 1. London: The Lancet, 1935:7.
- 6 Gavey CJ. *The management of the hopeless case*. London: HK Lewis, 1952.
- 7 Knips Macoppe A. *De aortae polypo epistola medica praeclarissima*. . . . Nuremberg: 1694: 85-123.
- 8 Von Haller A, ed. *Disputationes ad morborum historiam et curationem facientes*. Vol 2. Lausanne: Bousquet, 1757:681.
- 9 Scanagatus N. *De Alexandro Knips Macoppe, primario in patavina academia medicinae practicae professore, ac de duobus remediis ab eo maxime illustratis, mercurio et aponensibus thermis commentariolum*. Padua: Typis Seminarii, 1745.
- 10 Woodham-Smith C. *Florence Nightingale*. London: Constable, 1950:171.
- 11 Knips Macoppe A. *Aphorismi medico-politici centum, edidit nunc primum et praefatus est Florianus Caldanius*. Venice: 1795.

A new breed of parasuicide patient

Gerry Doyle

Eddy presented to our services with a short history of deliberate self harm and has posed management problems ever since. He moved to this area as part of an assignment of tropical birds bought by a family run pet shop. Being a brightly coloured tropical parrot, he stood out in the cockatoo enclosure. Perhaps jealous of Eddy's attractive plumage, the other residents attacked Eddy, plucking him bare of all his feathers.

Eddy was transferred to the shop owner's home for convalescence. Grandma took pity on him, and the two were soon inseparable. He would sit on her shoulder while she attended to the household chores, a carefully placed towel providing the necessary protection. Eddy blossomed under this arrangement and soon regained his coating and composure. When staff shortages necessitated Grandma helping out in the shop it was considered best to maintain Eddy at home in the community where he was thought to be safe from his assailants. But on return from work Grandma was horrified to see that Eddy was bald from the neck down—he had plucked out his own feathers during the day.

Consequently, at initial interview Eddy presented in a somewhat oven ready state. It was difficult to establish any rapport as Eddy was easily distracted and unable to settle. He would explore his immediate environment while keeping one eye on the interviewer. His speech was spontaneous, animated, unnecessarily loud, repetitive, and inappropriate in content. He consistently failed to answer questions regarding mood and suicidal ideation.

How best to interpret and manage Eddy's behaviour has aroused much debate among the staff on our unit. We seem to be facing a familiar dilemma: how can we help and support while avoiding rewarding self injurious behaviour? One line of thinking is that Eddy's actions represent an attempt to return to a chick-like state. Comparisons have been made with sufferers from anorexia nervosa, who by starving themselves perpetuate a child-like state and invariably induce considerable guilt feelings in their parents.

Another view is that Eddy is suffering from a post-traumatic stress disorder. Certainly the original assault would be considered "exceptionally threatening . . . likely to cause pervasive distress in almost anyone."¹ But there is none of the emotional blunting or detachment from people that is typically seen in this disorder.

Similarly, an adjustment disorder has been suggested, and we are reminded of the *International Classification of Diseases's* description of this condition:

"The individual may feel liable to dramatic behaviour and outbursts of violence."¹

We all think that it is important to examine the relationship that Eddy has formed with Grandma, and explore what role this may have played in his presentation. It is worth remembering that as a pet shop parrot Eddy may not have received adequate mothering as an infant. This may be affecting his ability to form healthy adult relationships. We also wonder if Grandma is suffering from empty nest syndrome and so encourages dependent relationships.

Eddy in an oven ready state

Although we have had difficulty acquiring information on Eddy's premorbid personality, we think that his actions may be part of a broader picture of maladaptive behaviour. This leads us to consider whether Eddy suffers from a personality disorder of the dependent or the borderline type. These share the core characteristic of a fear of being abandoned. The borderline person typically experiences crisis when an intense relationship seems threatened. The dependent person feels helpless when alone "because of exaggerated fears of inability to care for oneself."¹

We all believe that Eddy's self injuring represents a form of learned behaviour, and we had hoped to enlist the help of a psychologist, but have been unable to do so. It seems that our psychologists already have long waiting lists of "traumatised birds" and "not so pretty boys."

1 World Health Organisation. *International statistical classification of diseases and related health problems. Tenth revision*. Geneva: World Health Organisation, 1994.