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NAME EN BESKRYWINGS

Mag ons nog pleit vir die behoud van name van persone en plekke in die geneeskundige terminologie, of moet ons poog om beskrywende terme waar moontlik te gebruik? Elkeen mag sy voorkeur gee na eie smaak, maar ons voel tog dat die gebruik van persoonsname toelaatbaar is omdat hulle in baie gevalle korter en geriefliker is as die omskrywende benaming, en ook, en veral omrede van hul historiese waarde.

Die gebruik van ‚Bornholm se siekte' en ‚Coxsackie se virus-infeksie' voer ons gedagtes na veraf lande en herinner ons aan die broederskap van die geneeskunde!

Dikwels word ten onregte 'n naam aan 'n siektebeeld gekoppel—soms selfs om onverstaanbare redes. Ook is dit dikwels nie die eerste beskrywer wat so vereer word nie, bv. von Recklinghausen se neurofibromatose (1882) is reeds in 1793 deur Tilesius beskryf,[1] terwyl Caleb Parry, van Bath, Hirschsprung se siekte herken het nog voor Hirschsprung gebore is, en Graves se siekte beskryf het lank voor Graves dit gedoen het.[2]

Shapiro[3] bespreek die dubbelnaam in die geskiedenis in 'n onlangse artikel. Voor die negentiende eeu was die reuse in die mediese geskiedenis alleenwerkers, bv. Hippokrates, Vesalius, Sydenham, Laennec en Heberden. Hierna het medewerkers begin verskyn met die gevolg dat die geneeskundige terminologie vandag wemel van samestellings soos Weil-Felix, Libman-Sacks, ens.

Daar is die groep wat egter toevallig met 'n dubbeldoorvan geseën is (ons dink bv. aan die Afrikaanse vanne soos de Waal Rossouw, van Wyk Louw). Hieronder val mense soos Riva Rocci, Brown Séquard, Price Jones, Smith Petersen, Parkes Weber en Szent Györgyi, wie se name dus sonder 'n koppelteken gespel moet word. H. Bence Jones het Bence Jones-proteïen beskryf.

Dikwels gebeur dit dat 'n dubbelnaam enkel word, bv. 75 jaar gelede was die Horner-sindroom as die Bernard-Horner-sindroom bekend, aangesien Claude Bernard die letsel eksperimenteel by diere opgewek het, terwyl Horner dit later by mense beskryf het. Dit geld ook vir die Wassermann-reaksie en die Widal-toets wat vroeër respektiewelik Bordet-Wassermann en Gruber-Widal geheet het.

'n Onafhanklike ontdekking is ook 'n oorsaak vir so 'n samestelling, bv. Stokes was Adams se opvolger as professor van Interne Geneeskunde te Dublin, maar afgesien van hierdie verwantskap het hul 19 jaar na mekaar die sindroom van Stokes-Adams beskryf. Stokes het ook die vorige beskrywing van Cheyne erken toe hy Cheyne-Stokes-asemhaling beskryf het. Onder dié groep val ook nog die Charcot-Marie-Tooth beskrywings en die Reed-Sternberg-selle.

Obstruksie van die lewerare, deur Budd in 1857 beskryf, word in 1899 deur Chiari herontdek en heet toe die Budd-Chiari-sindroom. Die periode van herontdekking is soms kort (Waterhouse 1911 en Friderichsen 1918), terwyl Baumgarten 75 jaar na Cruveilhier die veneuse geruis oor die lewer waargeneem het. Op hierdie wyse word werkers met dieselfde belangstelling oor jare heen verenig en vereer. Dit kan egter belaglik word as 'n mens dink aan terme soos Laurence-Moon-Biedl wat na analogie hiervan die Laurence - Moon - Biedl - Bardet - Solis - Cohen - Weis - sindroom genoem kon word!

Die musikale klank van name rangskik hul soms, eerder as die prioriteit van ontdekking, bv. Pel-Ebstein moes eintlik kronologies andersom gewees het.

Die senior outeur het soms nooit eers geskryf oor die toestand nie, bv. Arrillaga het aan die sindroom wat hy beskryf het die naam van sy leermeester Ayerza geheg. Dit was dus lank bekend as die Ayerza-Arrillaga-sindroom, toe Ayerza s'n, hoewel dit wil voorkom asof ‚cor pulmonale' die hele kombinasie gaan uitwis!

Hoewel operasies gewoonlik net chirurgiese name bevat, is die Blalock-Taussig-operasie, 'n chirurg-internis samestelling, en histories sou Taussig-Blalock miskien meer korrek wees omdat Taussig vir Blalock oorreed het om die subklaviese arterie aan die homolaterale pulmonale arterie te anastomeer.

Austin Flint, Graham Steel en Argyll Robertson is net die volle name van drs. A. Flint, G. Steel en A. Robertson respektiewelik.

Nog baie sulke voorbeelde word genoem in die artikel van Shapiro.[3] Indien nie om die interessantheid daarvan nie, het die eienaam tog waarskynlik sy plek omdat in hierdie samestellings veel van die geskiedenis van die geneeskunde verewig is. Die gebruik van eiename dui byvoorbeeld op grootmoedigheid (waar Pick sy prioriteit prysgee vir die ontslape Niemann in Niemann-Pick se siekte), en op kleinlikheid (waar lang redenasies oor prioriteit en benaming selfs vandag nog in die moderne briewerubrieke van tydskrifte verskyn oor ontslape helde). Ons sien die miskenning van iets groots en sy herontdekking jare later, ook die patos en tragiek van die lewe as ons dink aan Thomsen se siekte. Al het Leyden dit twee jaar vantevore beskryf, en vele daarna, het Julius Thomsen vyf goeie redes waarom myotonia congenita na hom sal heet: Die familie wat hy in 1876 beskryf het, was hyself en sy vier seuns.[1]

1. Brain, Russell (1955): *Diseases of the Nervous System*, 5e uitgawe. Londen: Oxford University Press.
2. Apley, J. (1959): Lancet, **1**, 641.
3. Shapiro, E. (1958): Arch. Intern. Med., **3**, 662.

THE HEALTH OF THE CAPE COLOURED

The Annual Report of the Medical Officer of Health for the City of Cape Town contains detailed information extending over nearly 50 years on the vital statistics of the different ethnic groups that constitute the population of this municipality. Dr. E. D. Cooper has recently published his report for 1957, with provisional statistics for 1958. This excellent

report affords material for statistical studies throwing light on the health conditions in the different racial constituents of a population which has grown* from 163,440 in the year 1916-17 to 517,501† in the calendar year 1957. The 1916-17 population consisted of 53% Europeans and 47% non-Europeans; and the proportion of non-Europeans has since grown until for 1957 it is estimated that the population consists of about 40% Europeans and 60% non-Europeans (of which about 85% are Coloured and the remainder Natives and Indians).

A striking feature of these Cape Town reports has always been the racial disparity in birth rates and death rates. Thus, over 40 years ago (1913-16) the non-European death rate and infant mortality rate were more than twice as great as the European, and there were still greater disparities in the mortality from certain particular conditions such as diarrhoeal, respiratory, tubercular and other infectious diseases. Today the general death rate of the non-European group has become more nearly equal to that of the European—partly owing to differences in age constitution and the higher European mortality from diseases of the heart and arteries and from cancer—but disparities no less great than 40 years ago are still apparent in infant mortality and in diarrhoeal, respiratory, tubercular and other infectious diseases. The reason why this is so notwithstanding the decline in the non-European mortality rates (see below) is that a still greater decline has taken place in the corresponding rates for Europeans.

The other striking feature brought out by the Cape Town report is the great improvement that has taken place in the health of the non-Europeans as reflected by the recorded deaths during the past 40 years. From 1913-16 to 1952-56 the non-European general death rate fell by 55%, the infant mortality rate by 53% and the death rate from tuberculosis by 64%. From 1921-25 to 1951-55 the non-European death rate from bronchitis and pneumonia, and that from measles and whooping cough, both fell by 87%. Since 1955 the non-European mortality under all these headings has continued to decline. In diarrhoeal diseases the improvement had not been so great; the number of infantile deaths from diarrhoea in 1951-55 was only 21% less than that in 1921-25.

The non-European population for which these rates have been extracted includes Natives and Indians, but as the Coloured constitute 85% of the non-Europeans the non-European rates may be taken as broadly reflecting the health conditions of the Coloured people. That this gives a fair approximation is shown by a comparison of available figures for the Coloured and for non-European as a whole.

It is seldom realized that the improvement in the health of the Coloured people as reflected in the Cape Town statistics is such that today their general death rate, their infant mortality rate, and their death rates from bronchitis and pneumonia, measles and whooping cough, are all actually lower than the corresponding rates of the Europeans of Cape Town some 40 years ago—and far lower than corresponding rates for the whole population of England and Wales in the mid-nineteenth century.

What is the explanation of this recent and continuing improvement in the health of the Coloured people of Cape Town? Amongst the chief factors should be placed (1) sanitation and health administration, (2) medical and nursing care of the sick, and (3) social and economic conditions. As regards the first of these, the Coloured share with the Europeans the benefits of modern urban sanitation and administration. As for care in sickness, through the medical and allied professions and the public hospitals, clinics and district nursing, they have at their service most of the great advances in medical science that have been made in recent years. It is hard to appraise the relative importance of the different factors, but from universal experience it is safe to attribute a potent influence on health to social and economic conditions operating through such agencies as nutrition, housing, culture and education, and occupational conditions.

While much has already been accomplished by and for the Cape Coloured, a comparison of their conditions and their health statistics with those of the Europeans in association with whom they live demonstrates how much more remains to be achieved and to what greater heights the Cape Coloured may rise.

* The municipal area was extended by the addition of the Wynberg area (population 25,140) in 1927-28 and Windermere (population 14,235) in 1943-44.

† This figure excludes the population of Langa Native Township (23,123).