Editorial

A Further Note on the History of the Classification of Cardiovascular Diagnosis

WHEN I read Dr. Charles Kossmann’s excellent historical editorial “Nomenclature and Criteria for the Diagnosis of Cardiovascular Diseases” in the September issue of Circulation, it occurred to me that as an early worker in the field before 1920, I can supply information from my own experience, especially in Boston, which can amplify Dr. Kossmann’s historical account.

Before 1900 almost all discussions and writings about heart disease were concerned primarily and often solely with structural abnormalities such as valvular deformities, enlargement of the heart chambers, pericarditis, and congenital deformities. At the turn of the century James Mackenzie and Karl Wenckebach, both of whom I myself observed in action, the former in the second decade of the century and the latter in the third, introduced the category of disorders of cardiovascular function to be added to that of structural defects. In my fourth (senior) year in medical school (1910 to 1911) I walked the wards of the Massachusetts General Hospital with Dr. Joseph Pratt and visited the medical outpatient department with him while he studied cardiac cases and took tracings with the Mackenzie Ink Polygraph, which he had secured from Mackenzie’s own watchmaker in Burnley, England. Thus even at that early date there was his own special cardiac clinic at the Massachusetts General Hospital, but it was very small.

In 1914 a very important milestone was added to the progress of thebreaking of the trail to cardiology by Richard Cabot of the Harvard Medical School and the Massachusetts General Hospital, for which he has never been accorded adequate credit. Under the title “The Four Common Types of Heart Disease, An Analysis of Six Hundred Cases” Cabot read his paper before the Section on Practice of Medicine of the American Medical Association in Atlantic City, New Jersey, in June 1914. It was published in the Journal of the American Medical Association, October 24, 1914 (Vol. LXIII, page 1461). The first sentence of that notable paper read as follows:

“To classify cases of disease according to their pathogenic agent or process, and not solely by naming the region affected or the function disturbed, is the ideal of scientific progress in medicine.”

Since Richard Cabot was one of the visiting physicians on the West Medical Service at the M.G.H., in which I served for a year and a half as intern and three and a half years as resident, it was natural for me to apply this advice of his to the cardiac cases with which I was concerned when in the fall of 1914 I returned from my year with Thomas Lewis and James Mackenzie to begin my first year as West Medical Resident at the M.G.H. In fact, one of my earliest papers, which was presented at the Heart Symposium of the Mississippi Valley Medical Association in Lexington, Kentucky, on October 19, 1915, and published in the Lancet-Clinic on November 27, and in the Boston Medical and Surgical Journal on December 2, entitled “Observations Upon the Etiology and Treatment of Heart Disease,” was concerned with my own observations of the relationship of etiology, such as rheumatism, syphilis, “cardiorenal disease” (most of which was undoubtedly hypertensive), “cardiosclerosis” (some of which was doubtless coronary heart disease), and hyperthyroidism to various arrhythmias, alternation of the pulse, and congestive heart failure (myocardial insufficiency). It was a relatively simple personal study during the
year August 1, 1914 to August 1, 1915, of 300 patients in the wards and outpatient department of the M.G.H. based on the teachings which I had received during the previous year by Lewis, Mackenzie, and Cabot.

Then came the war in which I served late in 1916 under the British back of the Somme in Northern France, and later from 1917 to 1919 at Base Hospital No. 6 of the American Expeditionary Force in Southern France and with the Red Cross in Eastern Macedonia. Returning to Boston in October 1919 to resume a West Medical Residency at the M.G.H., I was dispatched in December to visit various outpatient departments in the hospitals of New York and Baltimore to acquire useful information for a reorganization of the medical outpatient clinic at the M.G.H., which was temporarily given to me as an assignment. It was during that trip to New York that one of my hospital visits took me to the Bellevue Outpatient Department where I met John Wyckoff for the first time. We were warm friends thereafter. I remember seeing and hailing the diagnostic folders in which the patients' records were kept, and which, in contrast to the current custom at the time throughout the U.S.A. were in complete accord with my own views and practice except that I put the etiologic diagnosis first as the most important, instead of last. In fact, in my historical first chapter added to the fourth edition (1951) of my book Heart Disease, I recorded Wyckoff’s name and date (of that visit in 1919) as a pioneer in the classification of cardiac diagnosis. My own personal case record cards and index sheets with the special diagnostic headings were privately printed in 1920. But several years elapsed before my system was adopted by my seniors on the medical services at the M.G.H.

Early in 1921, Dr. Merrill M. Myers of Des Moines, Iowa, who was studying with me that year, persuaded me that it would be useful for many other physicians throughout the country to know of the practicality of this simple nomenclature. Our paper was published in the Journal of the American Medical Association on October 29, 1921 (Vol. LXXVII, page 1414). In that paper we wrote “one of the most important reasons for insisting on the etiologic diagnosis, besides allowing much greater accuracy in prognosis, is to forward the prevention of heart disease, about which the medical world is beginning to take more action than in the past.” In our discussion on etiology we replaced the word “cardiorenal” by “hypertensive” and “cardiosclerosis” by “arteriosclerotic,” recognizing its increasing frequency even at that date, probably because we were beginning to recognize the coronary element in it. We added a note about the additional functional grouping of the New York Association of Cardiac Clinics to which Dr. Kossmann has referred. During that decade the New York cardiologists published several important papers, that by Alfred Cohn in 1922 on the Clinical Charts, that by the Committee on Cardiac Clinics (Dr. William P. St. Laurence, chairman) in 1923 on “Requirements for an Ideal Cardiac Clinic and a System of Nomenclature,” which included for the first time diagnostic criteria, and that in 1926 by the Committee on Research of the New American Heart Association on “A Nomenclature for Cardiac Diagnosis,” all leading up to the volume in 1928 called “Criteria for the Classification and Diagnosis of Heart Disease,” which has become the classic in the field and is now appearing in its sixth edition.

It is quite possible that other pioneers in cardiology in other clinics in other cities, and in other countries besides those of us at the Bellevue and Massachusetts General Hospitals, may have interesting and even more pioneer experiences to relate concerning the classification and criteria of cardiovascular diagnosis.

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