



Letters to the Editor

Wegener's Disease and Clara Cells: Eponyms and Dignity in Respiratory Medicine[☆]**Enfermedad de Wegener y células Clara: la eponimia y la dignidad médicas en medicina del aparato respiratorio**

Dear Editor,

We would like to comment on a situation that, in recent years, has led to the adoption of a series of agreements between the most important respiratory medicine journals (*American Journal of Respiratory and Critical Care Medicine*, *Chest*, *European Respiratory Journal* and *Thorax*) and the *Forum of International Respiratory Societies* (FIRS).

It has been proposed to refrain from using in our professional practice, and especially in all medical publications, the names of professionals who actively collaborated in activities that are considered crimes against humanity. We cannot ever forget the programmed genocide of Jews and Romani gypsies, and the execution of homosexuals and the physically and mentally disabled, as well as an important number of Spanish citizens (about 5000) in Nazi death camps. Among the doctors who actively collaborated with Nazism was Dr. Friedrich Wegener, who described the disease that, until now, has borne his name.¹ Starting in 1932, Wegener became an active member of the German National-Socialist party,² as well as a high official in the *Sturmabteilung* (the paramilitary Storm Detachment or Assault Division),^{3,4} sadly famous for its ominous participation during the *Kristallnacht* (Night of Broken Glass). By 1939, he was working as a pathologist in Lotz, participating in the necropsies of prisoners who had been executed nearby. The Polish government declared Wegener a war criminal at the end of the war, and his case was transferred to the United Nations War Crimes Commission, but Wegener was never prosecuted before he died in 1990. When these facts surfaced decades later, the *American College of Chest Physicians* (ACCP) withdrew the *Clinical Award* that he had been awarded in 1989, while at the same time proposing to modify the term "Wegener's granulomatosis"⁵ to ANCA-associated vasculitides,³ granulomatosis with polyangiitis (GPA) or even respiratory granulomatosis.⁶

Similarly, Dr. Max Clara, who described the cells that bear his name, was also an active member of the Nazi party.⁷ Clara himself admitted in 1937 that his finding of non-ciliated secretory cells of the bronchiolar epithelium was based on samples obtained from prisoners executed by the Regime. According to the methodology reported in his articles, these samples were "preserved by vascular injection immediately after death".⁸ It has also been demonstrated that the Clara's scientific research during this time period was

directly linked with the abundance of "anatomical material" available at the time.^{9,10} Finally, it seems that both he as well as his collaborators directly participated in experimentation with prisoners who were later executed.^{10,11} In the aftermath of the war, Clara was arrested and imprisoned for a short time, after which he was no longer accepted in any German academic institutions but continued to practice in Turkey. In this case, it has been proposed that the term "Clara cells" should be changed to "club cells" or "bronchiolar exocrine cells".¹⁰ Also, the expression "Clara cell protein" should be substituted with "protein secreted by club cells".

The academic quality of the two aforementioned clinicians cannot be refuted. Nevertheless, their careers were founded on acts of questionable ethical behavior, the promotion and political backing of known criminals⁹ and their direct involvement in racist doctrine.¹² Therefore, it seems improper to acknowledge them with eponyms in the medical nomenclature, as this represents a high distinction for those of our profession. Our main objective in medicine is to help those who suffer from disease, and ethical behavior is a fundamental guideline. In this direction, the ACCP considers that "academic life cannot be separated from moral life," and the medical community should condemn such behavior. Patient associations have also made several requests for eponyms that they consider offensive to be substituted.⁹ Furthermore, the FIRS and the editors-in-chief of the aforementioned journals also consider terms without eponyms to be better because they also describe diseases and other biological phenomena more precisely.^{13,14}

In May 2012, in a joint meeting of the FIRS and the head editors of the aforementioned journals, it was decided that the terms (a) Wegener's disease, and (b) Clara cells (associated with Clara cell protein) would start to be replaced by their alternative denominations as of January 2013, while maintaining the term Clara in parentheses for one year afterwards. This same month, the different journals will publish this resolution in editorial pieces stating that as of January 2014 both expressions should disappear definitively. At the same time, the World Health Organization (WHO) will be urged to modify their diagnostic codes ICD10 and ICD11. We believe that *Archivos de Bronconeumología*, the journal of the Spanish Society of Pneumology and Thoracic Surgery (*SEPAR*), the Latin American Thoracic Society (*ALAT*) and the Ibero-American Association of Thoracic Surgery (*AIATC*), should join other prestigious respiratory medicine journals and proceed towards changing to the denomination of granulomatosis as well as bronchial exocrine cells in their publications. In addition, this would subscribe to the growing tendency towards abandoning eponyms in medicine.^{13,14}

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Treatment With Subcutaneous Drainage in the Pneumomediastinum and Massive Subcutaneous Emphysema^{*}

Tratamiento con drenajes subcutáneos en el neumomediastino y enfisema subcutáneo masivo

Dear Editor,

Pneumomediastinum (PM) and subcutaneous emphysema (SE) are generally benign entities with a self-limiting course. There is a potential risk for complications due to massive accumulation of air that could compromise the life of the patient by interfering with respiratory mechanics and complicating venous return. In these cases, a less aggressive and effective therapeutic option is the use of subcutaneous drains. We present the case of a 75-year-old male with PM and massive SE that was resolved with this type of drains.

A 75-year-old male with GOLD grade IV COPD, who had undergone upper right lobectomy for pulmonary epidermoid carcinoma, came to our emergency room due to COPD exacerbation. The patient was admitted to hospital and evolved favorably during the first 72 h. On the fourth day of hospitalization, after the exertion of defecating, he presented dyspnea and left pleuritic chest pain. Upon examination, subcutaneous emphysema was found in the apical region of the left hemithorax. Chest radiography confirmed the presence of air in the subcutaneous tissue. The patient was treated with rest, oxygen therapy and analgesia, but the subcutaneous emphysema extended throughout the thorax, face, eyelids and abdomen. Thoracic CT showed the presence of PM and massive SE with no evidence of pneumothorax, pulmonary emphysema and post-surgical absence of the left upper pulmonary lobe (Fig. 1). After 48 h, the patient presented symptoms of thoracic discomfort, sweating and presyncope, and electrocardiogram demonstrated paroxysmal atrial fibrillation. In this situation, it was decided to insert a right subcutaneous drain (Fig. 2). The patient's symptoms improved almost immediately, and the drain was able to be withdrawn 5 days later. Over the following 6 months, the patient presented no relapse.

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PM and SE are usually caused by a iatrogenic or traumatic trigger, although on occasion they may be secondary to an abrupt increase in intra-alveolar pressure, which is a phenomenon known as the Macklin effect.¹ The incidence of PM is low although underdiagnosed because its symptoms are non-specific and the radiological signs are difficult to identify. Typical symptoms at onset include chest pain, dyspnea and subcutaneous emphysema, and occasionally cervical pain, odynophagia, dysphagia, dysphonia

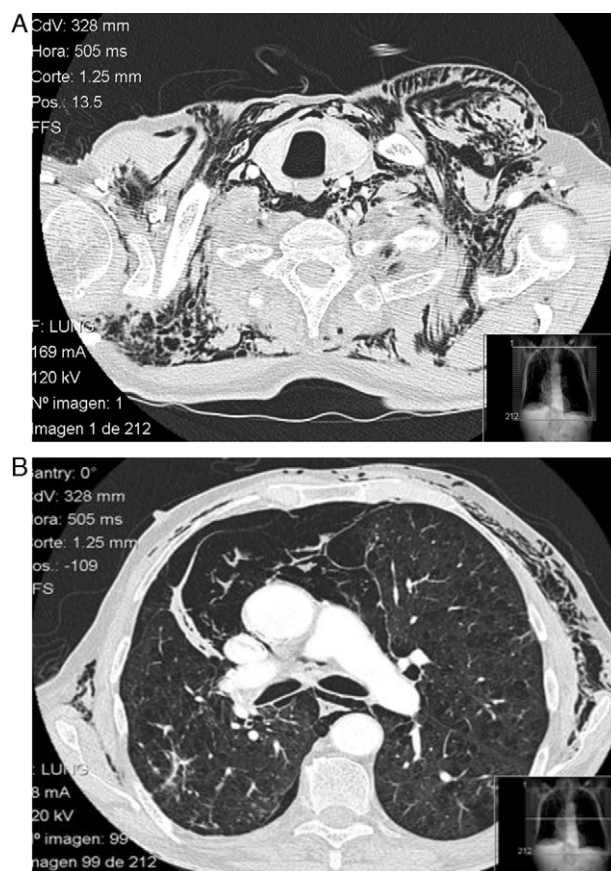


Fig. 1. (A and B) Thoracic CT image showing the presence of gas in the subcutaneous and mediastinal tissue.