What's in a name? A diagnosis by any other name would be as meet?

AJ Larner
Cognitive Function Clinic,
Walton Centre for Neurology and
Neurosurgery, Liverpool, L9 7LJ, UK.

Correspondence to:
E: a.larner@thewaltoncentre.nhs.uk

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It is through the agency of Juliet (who, according to the internal evidence of the play, is not yet fourteen years old) that Shakespeare asks:

> What's in a name? that which we call a rose
> By any other name would smell as sweet.

(*Romeo and Juliet*, Act II, scene II, lines 47-48).

A recent case highlighted the issue of diagnostic naming, prompting my attempted (lame?) revision of Shakespeare's lines.

A 46-year-old lady with longstanding psoriasis was referred to the neurology clinic by her dermatologist for opinion on recurrent episodes of unilateral facial swelling over the previous three years. These occurred around once a month and lasted for about 24 hours. There were no obvious triggers and episodes were self-limiting. There was no history of facial weakness (confirmed by photos of her face when symptomatic), sensory disturbance or tongue involvement. Previous MR brain imaging was normal. A diagnosis of monosymptomatic Melkersson-Rosenthal syndrome (MRS) was made and the patient reassured that no further neurological investigation was required.

Simultaneously the dermatologist had referred the patient to an allergist. The allergist made a diagnosis of chronic spontaneous angioedema, and checked complement and C1 inhibitor levels which proved normal. The patient was, understandably, confused by the different diagnostic labels.

MRS is defined by the triad of orofacial oedema, recurrent facial palsy and fissured tongue (lingua plicata). Most neurologists will recall MRS amongst the small print causes of recurrent facial nerve palsy but the classical triad is rarely observed, oligosymptomatic and monosymptomatic forms being more common.[1] Facial oedema is the most common initial finding and is an acknowledged mimic of hereditary or acquired angioedema. A possible association of MRS and psoriasis has been described.[2] Allergic diseases (atopic eczema, allergic rhinitis) have been observed concurrently with MRS.[3]

Eponyms may sometimes be memorable, particularly if the name(s) involved seem(s) exotic; MRS may fall into this category, despite its rarity (I believe I have only diagnosed it once before in 20 years as a Consultant). Eponyms may prompt those with an interest in history to investigate the originators, if indeed they were the first to describe the disorder. It is possible that neither Ernst Melkersson (1928)[4] nor Curt Rosenthal (1931)[5] were the first to report "their" condition.[6]

Naming may be conceptualised as a form of cross-modal non-contextual paired associate learning, a process which may be challenging for both learning and retention. How often do patients attending the cognitive clinic complain of difficulty remembering peoples' names? Eponyms may have a certain economy of expression, but risk implying uniformity where there may in fact be heterogeneity, for example at the clinical, investigational, pathological or genetic level ("Pick's disease" might be cited as a good example of this). Moreover, eponyms convey no information on pathogenesis or aetiology, whether defined or suspected, of the disease they denote. The case may therefore be made that this is a situation in which the more descriptive, if prosaic, nomenclature is to be preferred.

Other arguments in favour of abandoning eponyms have been made, for example in cases of misnaming, misattribution, and misuse, and for lacking accuracy.[7] The ethical imperative to expunge from eponymic recognition those involved in Nazi activities is well recognised.[7,8] However, others favour retention,[9] and it seems that de facto eponymous labelling will persist, with the potential to confuse patients.

If we agree with Cicero's claim, in his *Tusculan Disputations*, that the "imposition of names on things is the highest part of wisdom,"[10] then care is needed in this exercise since it is more than simply an arid exercise in semantics. Overall I am sympathetic to the position favoured by Woywodt and Matteson,[7] that medical eponyms should be abandoned in favour of a more descriptive nomenclature. A potential implication of this approach is that nomenclature should be provisional, and hence flexible in the face of new understandings of disease processes.

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