Rougnon's letter to Lorry on the death of Captain Charles *A landmark in the history of angina pectoris*

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Rougnon's letter to Lorry is probably the rarest of medical books, as only two copies are known to exist compared with three of Servetus. In spite of its rarity it has been more widely quoted and discussed than any other work on angina pectoris with the exception of Heberden's account of a disorder of the breast, read at the College of Physicians on 21 July 1768, but not published in the *Transactions* until 1772. Rougnon's letter, dated 18 March, was published as a small volume of 55 pages at Besançon by J. F. Charmet in 1768, so that it antedated Heberden's paper by four months and its publication by four years, and so French physicians have acclaimed it as the first description of angina pectoris.

Nicolas Francois Rougnon du Magny (1727-1799) was Professor of Medicine at the University of Besançon, the capital town of Franche-Comté, from 1759 to 1793, when the university was closed after the revolution. Rougnon, a catholic and a monarchist, was deprived of his hospital appointments and put under surveillance, his wife and two daughters being imprisoned.

Anne Charles Lorry, Docteur-Régent of the Faculty of Medicine of Paris, a fashionable court physician described as '*le médecin des salons*', had been a fellow student of Rougnon's in Paris.

Captain Charles, the son of a former professor of the university was a retired cavalry officer and evidently a well-known figure in Besançon society. Thanks to Rougnon's letter, he now ranks alongside Seneca, John Hunter, and Arnold of Rugby as one of the notable patients in the history of angina pectoris.

Many eminent authorities on diseases of

the heart in the last century have discussed the case of Captain Charles at length, but knowledge has advanced since their day, so let us re-examine the case and hold an imaginary clinico-pathological conference in which they take part.

History

Captain Charles, aged 50, had retired from the army in full vigour and health some years previously, but, leading a more sedentary life, he had put on weight. He suffered from obstinate attacks of intermittent fever with slight jaundice which responded to diet and mineral waters. For some years he had complained of difficulty in breathing which gradually increased until he could not walk 100 yards at all quickly without provoking a sense of suffocation which was relieved by halting for a few moments. His friends noticed that his breath had a bad odour. Six weeks before his death he had informed Rougnon that during the attacks of dyspnoea he experienced '*une gêne singulière sur toute la partie antérieure de la poitrine en forme de plastron*', and was unable to take a deep breath. The word *gêne* is difficult to translate precisely but we may conclude that he felt as if the front of his chest was constricted by a breast-plate. On 23 February 1768, after lunching with the élite of his friends he was late in setting out for another gathering held at a house about 700 yards away. Hurrying there, he was seized by an oppression and leant against the doorway, rejecting the help of a servant who came to his aid, after which he hurried up two flights of stairs and took his seat at the meeting much oppressed. He appeared to his friends to be dying, was carried out, and found to be dead.

Necropsy The body was opened by a surgeon the following evening in the presence of Rougnon, Athalin, the Rector of the University, and other physicians and surgeons whose curiosity had been aroused. The brain was healthy. It was difficult to open the chest on account of an extraordinary

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FIG. 1 Portrait of Rougnon by C. N. Oudot, from Coutenot's biography of Rougnon (1895).

L E T T R E

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M. ROUGNON,

*Professeur en Médecine en l'Université
de Besançon, & Membre de l'Académie
des Sciences, Belles-Lettres
& Arts de cette Ville;*

A

M. LORRY,

Docteur - Régent de la Faculté de
Médecine de Paris, touchant les
causes de la mort de feu Monsieur
CHARLES, ancien Capitaine de
Cavalerie, arrivée à Besançon, le
23 Février 1768.

A BESANÇON;

De l'Imprimerie de J. F. CHARMET;

M. DCC. LXVIII.

FIG. 2 Facsimile title-page of Rougnon's Letter, from photostat kindly supplied by Mr. L. M. Payne, Librarian, Royal College of Physicians.

hardness of the costal cartilages which were ossified. The ribs lacked their normal obliquity and took an almost horizontal course. The left side of the pericardium and diaphragm was covered by a mass of fat. The heart was larger than normal by a third, due to dilatation of the thin-walled right ventricle. All the valves and the left ventricle were normal, the right atrium and vena cava were dilated, and the coronary veins were grossly distended and varicose. There is no mention of the coronary arteries. The stomach contained much gas but little food, and the intestinal vessels were palpable as if inflamed. The liver was enlarged.

The necropsy was far from tranquil and the audience engaged in a lively discussion. Some saw only fat on the heart, others noted the dilated vena cava, and some saw nothing unusual, saying 'M. Charles est mort parce qu'il est mort'. In a lengthy dissertation, Rougnon concluded that ossification of the costal cartilages had interfered with inspiration and so prevented the free passage of blood through the lungs, causing stasis of the right heart which struggled against the obstacle in the lungs until the circulation through them ceased, and blood no longer reached the left ventricle. He finished by discussing the diagnosis and treatment of ossified costal cartilages. There was no mention of pain in the case history, but in his discussion after the necropsy, Rougnon spoke of '*une douleur gravative dans la région du cœur*' during the attacks of suffocation. Let us now consider the opinions of some of those who have studied the case.

Professor Gairdner of Glasgow (1891) obtained extracts from the text from Doctor Lereboullet of Paris, and found no trace of anything like a clinical description of angina pectoris in Rougnon's letter and Lereboullet took the same view.

Osler (1897) after citing Rougnon's letter in detail disagreed with Gairdner - 'the suddenness of the attacks, the pain in the region of the heart, the abrupt termination, and the mode of death - during exertion after a heavy meal - favour the view that the case was one of true angina.'

G. A. Gibson (1898) of Edinburgh, having obtained a typescript of Rougnon's letter from the original in U.S.A., analysed the case of Captain Charles in some detail, and concluded that the description entirely lacked the special features fully described by Heberden, Jenner, and Black.

Professor Jaccoud (1865) of Paris stated that Rougnon's letter contained the first didactic description of angina pectoris, though he made the error of not giving a name to the new disease, but this is no reason to say that the discovery did not belong to him.

Professor Huchard (1899) proposed the hyphenated eponym of Rougnon-Heberden

disease and this was adopted by Barié and other French authorities on heart disease.

Professor Peter (1883) of Paris stated that angina pectoris was first described in France by Rougnon who clearly isolated the disease from the ill-defined group of asthmas, but neglected to give it a name. In spite of Heberden's insistence on the absence of dyspnoea, Peter stated that the pain was often accompanied by suffocation and dyspnoea with râles in the chest.

Jean Crocq of Brussels in his book on angina pectoris (1893) pointed out that if publication of a case established priority, then this belongs to Morgagni or even to Seneca, and he preferred the title of *Maladie de Heberden*. Crocq was perhaps the first early author in French to attribute anginal pain exclusively to coronary disease and myocardial ischaemia.

Professor Hans Kohn (1927) of Berlin, the most zealous opponent of Rougnon's claim, concluded that Captain Charles did not suffer from angina but from emphysema causing gross dilatation of the heart and venous congestion. He quoted Claude Bernard that priority in science did not consist of facts but of conclusions drawn from them. Even if Captain Charles did have angina, Rougnon did not recognize it. He also indicated a serious cause of error which arose because the title of Rougnon's letter had been frequently misquoted as '*lettre sur une maladie nouvelle*', and certainly Osler was guilty of this. Rougnon never claimed to have described a new disease. Clifford Allbutt (1915) concluded that it was fair to say that though Heberden named angina pectoris and gave by far the better description of it, yet the first precise discernment and description of it was in a letter by Rougnon to Lorry published in 1768.

Sir Humphry Rolleston (1937) concluded that Captain Charles had progressive cardiac failure possibly secondary to hypertension.

To sum up our conference, of the ten authorities I have cited, five are in favour and five are opposed to the claim that Rougnon was the first to describe angina pectoris. Heberden certainly separated anginal pain from dyspnoea – 'in particular they have no shortness of breath from which it is entirely different', and this explains why Gairdner and others rejected the case. However, today, we might well accept Peter's opinion that severe coronary insufficiency, not to mention cardiac infarction, may be accompanied or followed by pulmonary oedema. This combination was first clearly described by Merk-

len as due to '*un coeur à la fois douloureux et faible*.' Gallavardin separated paradyspnoeic angina from true angina of effort, and the French conception of angina of decubitus as given by Vaquez implies that patients with acute pulmonary oedema and nocturnal dyspnoea also have anginal pain. Modern haemodynamic investigations and apex cardiograms certainly lend support to the view that severe anginal pain may be accompanied by some degree of left heart failure, and of course we recognize anginal pain as a symptom of primary pulmonary hypertension.

It is quite clear that Captain Charles had chronic lung disease with heart failure and he may well have had pulmonary hypertension. Readers will form their own opinion of the symptoms and whether they accept paradyspnoeic oppression in the chest as anginal as many French authorities have done. All will probably agree that Rougnon did not describe Heberden's angina of effort, indeed his account added little to the old idea of asthma dolorificum.

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¹ Only known copies of Rougnon's booklet are in the Town Library at Besançon and in the National Library of Medicine at Bethesda. The photostat copy in the Royal College of Physicians was presented to Sir John Parkinson by Professor Hans Kohn of Berlin.