

MILITARY MEDICINE

To the Editor:

In the editorial in the March 2013 edition of *IMAJ*, Dr. Abramovitch discusses the implications of war on medical education [1]. Referring to three articles in that issue that report on the impact of war, displacement, and violence on population health, he states that “the authors [of these articles] seem unaware that the impact of war on medical education has a long history.” We would like to add that the military environment has not only had a long history of influence on medical education, but also currently exerts a strong, exciting and innovating influence on contemporary medical education in Israel today.

In the early 2000s, the Israel Defense Forces (IDF) Medical Corps sought to better prepare medical cadets for their military service. This same period also saw a decrease in the number of young men and women enrolling in the academic reserve program to train as military physicians and it became evident that a paradigm change was necessary to attract more students to a career in military medicine. The establishment of an academic program of excellence for military medical students was envisioned to train these students comprehensively and to prepare them for the unique challenges faced by the combat physician. The result was the Tzameret military track at the Hebrew University-Hadassah Medical School in a joint venture with the Ministry of Defense and the IDF Medical Corps. Students enrolled in the military track receive a full standard medical education identical to that provided to all medical students. In addition, however, students of the military track receive dedicated training in military medicine in a 6 year academically supervised curriculum, whose content is carefully timed to parallel the general medical school courses. Topics include combat casualty care, preparedness and response to chemical and biological agents, preventive medicine and force protection, aeromedicine and evacuation, naval and hyperbaric medicine, physiological stress

and tolerance to extreme conditions, military medical ethics, identification and management of post-traumatic stress disorder (PTSD) and adjustment disorders in the military, and military forensic medicine and disaster victim identification. Special consideration is given to the challenges of providing medical care to soldiers in the training environment. Students in the military track also attend a semester-long course, unique among all medical schools in Israel, in medical leadership and attend twice-weekly training sessions in physical fitness aimed to improve their performance in the military environment and to instill the values of a healthy lifestyle. The curriculum is supplemented by a series of field trips to military bases, medical units, and sites of importance in national and medical history.

The military track is currently in its fourth year and includes over 230 students from backgrounds as diverse as the Israeli population itself. We are currently developing the clinical curriculum for the fifth and sixth years of training which will emphasize ambulatory medicine in the military setting.

In his editorial, Abramovitch reminds us that medical educators have called for the integration of war-related topics into the regular medical curriculum, including human rights in wartime, impact of PTSD and other psychosocial consequences of war, medical innovation during wartime, and other topics. We strongly agree and point out that all of these, along with other topics in military medicine, are currently being taught to students in the Military Medicine Track. At full capacity, this program will include over 400 students, all of whom will, upon completing their initial military service, integrate into the civilian health care system in Israel. Although the curriculum in military medicine is currently intended exclusively for students of the military track, we foresee that it will not be long before many of the courses of the program will be offered to non-military track students as well.

Abramovitch also cites the 2008 study by Batley et al. [2] which was conducted,

ironically, in Lebanon after the 2006 Lebanon-Israel war. This study found that Lebanese medical students reported positive effects of their wartime experience, including feelings of increased resourcefulness, compassion, humanitarianism, and professional pride. These are values that we hope to instill not only reactively through wartime experiences, but also proactively through a well-designed, coordinated curriculum in military medicine.

M. Hartal MD MPH¹, S.D. Gertz MD PhD² and Y. Kreiss MD MHA MPA¹

¹Israel Defense Forces Medical Corps

²Military Track of Medicine and the Institute for Medical Research, Hebrew University-Hadassah Medical School, Jerusalem, Israel
[hartal4@gmail.com]

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QUESTIONABLE EPONYMS

To the Editor:

In a recent issue (Vol. 15, number 3, March 2013) there were two articles related to Wegener's granulomatosis, one by Kenis et al. (page 180) and the other by Green et al. (page 188). In 1936, Friedrich Wegener described cases of a small-vessel vasculitis. In 1954, the disorder became more widely known as Wegener's granulomatosis. In a publication by Woywodt and Matteson, entitled “Wegener's granulomatosis – probing the untold past of the man behind the eponym” [*Rheumatology* 45 (10): 1303-6. doi:10.1093/rheumatology/kel258], the authors concluded: “Evidence suggests that Dr. Wegener was, at least at some point of his career, a follower of the Nazi regime. The data indicate that Dr. Wegener was wanted by Polish authorities and that his files were forwarded to the United Nations War Crimes Commission. Finally, Dr Wegener worked in close proximity to the genocide machinery in Lodz.”

In a list of medical eponyms with Nazi associations, Wegener appears among the

shameful Nazi doctors after whom diseases are named. In 2011, the American College of Rheumatology (ACR), the American Society of Nephrology (ASN) and the European League Against Rheumatism (EULAR) resolved to change the name of the disease to Granulomatosis with polyangiitis. *IMAJ* already related to this issue in an article “Eponyms and the Nazi era: time to remember and time for change” by R.D. Strous and M.C. Edelman [*IMAJ* 2007; 9 (3): 207-14].

I believe that the Journal of the Israel Medical Association should be especially careful in the appropriate use of medical terms and should not provide continued glory to Nazi doctors especially after the recent Holocaust memorial day and in view of the journal being aware of this issue.

J. Sosna MD

Chairman, Dept. of Radiology, Hadassah Hebrew University Medical Center, Jerusalem, and President, Israel Radiological Association (ISRA)

PARAPARESIS AND RHABDOMYOLYSIS

To the Editor:

The uncommon case reported in your journal [1] brought to mind our four patients who developed an unusual clinical phenomenon of compartment syndrome with development of a flaccid paraparesis

and rhabdomyolysis immediately after awakening from a prolonged sleep episode in an unusual posture (due to alcohol consumption and drug abuse), which might, in fact, be a ‘new syndrome’ [2].

Electrophysiological investigations were indicative of a sensory-motor axonal-demyelinative polyneuropathy. All patients were heavy smokers and two had subclinical hypothyroidism. Incomplete recovery was noted during the rehabilitation and follow-up period. Did our patients develop a syndrome that is a new entity, or was it simply a coincidence of prolonged unusual posture followed by an acute onset of rhabdomyolysis, paraparesis and polyneuropathy?

The patients suffered from depressed mood, smoked cigarettes, consumed alcohol and/or drugs, and fell asleep in bizarre postures, which was followed by a combination of rhabdomyolysis and compartment syndrome. Eventually they were diagnosed as having polyneuropathy and cauda equina syndrome. Another case was described by a Croatian colleague, Dr. Pavao Vlahek [3]. His patient was admitted with rhabdomyolysis and paraparesis after sleeping on the floor in an awkward position for 5 hours. He woke up with paraparesis. He was first admitted to an intensive care unit with high creatine phosphokinase (>30,000 units) and treated for acute renal failure for 2 weeks.

He was then sent to a specialized ward where he was started on a rehabilitation program. It was assumed that he had a spinal cord injury as a result of falling off the couch, but this was not supported by clinical or radiological evidence. The patient is a doctor who served in the Croatian liberation war during the 1990s. He was captured and spent a few months in a Serbian prison camp where he was subjected to torture. It was presumed that he woke up at night, started to walk, and fell because he already had lower limb weakness. It appears that all these patients experienced the rare combination of a common pre-morbid condition and prolonged sleep in an unusual posture. Clinicians should be aware of this new clinical picture.

Ohry MD

Section of Rehabilitation Medicine, Reuth Medical Center, Tel Aviv, Israel
[aohry@bezeqint.net]

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Capsule

Anti-IFN- α/β receptor antibody treatment ameliorates disease in lupus-predisposed mice

The demonstration in humans and mice that nucleic acid-sensing TLRs and type 1 interferons are essential disease mediators is a milestone in delineating the mechanisms of lupus pathogenesis. Baccala et al. show that *Ifnb* gene deletion does not modify disease progression in NZB mice, thereby strongly implicating IFN α subtypes as the principal pathogenic effectors. They further document that long-term treatment of male BXSB mice with an anti-IFN α/β receptor Ab of mouse origin reduced serologic, cellular and histologic disease manifestations and extended survival, suggesting that disease acceleration by the *Tlr7* gene duplication in this model is mediated by type 1 IFN signaling. The efficacy of this

treatment in BXSB mice was clearly evident when applied early in the disease process, but only partial reductions in some disease characteristics were observed when treatment was initiated at later stages. A transient therapeutic effect was also noted in the MRL-Fas(lpr) model, although overall mortality was unaffected. The combined findings suggest that IFN α/β receptor blockade, particularly when started at early disease stages, may be a useful treatment approach for human systemic lupus erythematosus and other autoimmune syndromes.

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Elias Toubi