

BOOKS, THE CHILDREN OF THE BRAIN

'The Lobotomist'

Walter Jackson Freeman, M.D. (1895-1972), is one of the most reviled physicians of the 20th century, but from the 1930s through the 1950s he was celebrated, showered with awards, and featured on the covers of magazines, all for his single-minded advocacy of frontal lobotomy as an almost universal cure for a wide variety of mental illnesses.

Now, in a new biography, "The Lobotomist: A Maverick Medical Genius and His Tragic Quest to Rid the World of Mental Illness" (Hoboken, N.J.: John Wiley & Sons, 2005), medical journalist Jack El-Hai attempts to explain Dr. Freeman's celebrity and, in small part, tries to rehabilitate Dr. Freeman's reputation by connecting his biological orientation to that of modern-day psychiatrists.

Mr. El-Hai is not successful. Instead of feeling better disposed to Dr. Freeman, I was astounded at the numerous examples of Dr. Freeman's jaw-dropping callousness, arrogance, and almost pathologic disdain for scientific rigor.

Mr. El-Hai starts Dr. Freeman's story in 1936. At the annual meeting of the Southern Medical Association that November, Dr. Freeman, chair of neurology at George Washington University in Washington, described his work with neurosurgeon James Winston Watts, M.D. Following the experience of psychiatrist Egas Moniz in Portugal, they had given frontal lobotomies to six patients.

The technique called for burring holes on both sides of the skull and cutting both frontal lobes in several places. Although one of the patients seemed to have suffered serious damage after they cut several blood vessels, Dr. Freeman's report was positive: "All of our patients have returned home, and some of them are no longer in need of nursing care."

The mood of the audience appeared to range somewhere between skeptical and horrified, until a towering psychiatric leader, Adolf Meyer, M.D., spoke for the defense and saved the day for Freeman and Watts. Not that psychiatrists as a group ever warmed up to the surgery; as Free-

man commented 10 years later, "If we waited for psychiatrists to send patients to us we'd still be on our first hundred cases instead of our fifth hundred."

Even though he had no formal training as a surgeon or psychiatrist, Dr. Freeman had many strong opinions about surgery and psychiatric patients. Dr. Watts allowed him to be an equal participant as a surgeon in the 10 years in which they operated together, even though there was never a dearth of objections to Dr. Freeman's involvement from witnesses and others. Dr. Freeman knew he had to acquire independence.

To this effect, in 1946 Dr. Freeman instituted two modifications: Instead of anesthesia, he would give the patient an electroshock, and he would devote himself to "transorbital lobotomy," which he described very

tellingly to one of his sons as "knocking [patients] out with a shock and while they are under the 'anesthetic' thrusting an ice pick up between the eyeball and the eyelid through the roof of the orbit[,] actually into the frontal lobe of the brain[,] and making the lateral cut by swinging the thing from side to side."

Dr. Freeman was probably correct in thinking that no local hospital would allow him to undertake the procedure unaided in its operating rooms. Never shy, he conducted the first 10 operations in the offices he shared with Dr. Watts. The patients were supposed to go home with their relatives or in a taxi after the surgery.

Dr. Freeman's career mushroomed after 1946, as he drove thousands of miles around the United States, armed with the electroshock machine and an ice pick, and operating with no apparent need of help, supervision, surgical precautions, or surgical privileges.

He was a superb self-promoter and had newspaper and magazine writers rhapsodizing about his ability to eliminate bad connections in the brain so that formerly hopeless patients would be better able to function. Indeed, the 1949 Nobel Prize in physiology or medicine was awarded to Egas Moniz for "his invention of a surgical treatment for mental illness."

At the top of his prestige and acclaim, Dr. Freeman came to think that he could double-handedly—he claimed to be ambidextrous and would operate on both sides of the brain at the same time—reduce the chronic population of state hospitals. He operated on as many as five patients an hour, and on one memorable day he performed 25 transorbital lobotomies.

Overall, he claimed that one-third of all of his lobotomy patients had greatly improved mental status, one-third showed no change, and one-third were left worse off.

A casual attitude about mental illness and the mentally ill may have contributed to his fame.

How casual? At Cherokee State Hospital in Iowa, 3 out of 25 patients he treated died. Freeman inadvertently caused one of those deaths when he stopped to photograph the position of the leukotome; the instrument sank deeply into the patient's mid-brain. In Virginia, he left in the middle of an operation to catch a plane and a physician who had just started his training had to complete the procedure. This newly minted lobotomist broke the metal tip of the pick in the patient's brain.

Many would consider distasteful the way Dr. Freeman described his mishaps: "I'm afraid she is a gone goose as far as useful life hereafter is concerned," he said about one patient. Another had a hemiparesis after the procedure; Dr. Freeman went to the adjacent waiting room and requested \$1,000 from the husband to treat the complication.

By the mid-1950s, however, the lobotomy was about to become obsolete. The advent of chlorpromazine and other treatments, a more enlightened view of mental

disorders, a better diagnostic system, the progressive reduction of the census in state hospitals, and other factors doomed lobotomy to obsolescence in the midst of progressive rejection, if not total repudiation.

Dr. Freeman emerged at a time when somatic treatments, careful clinical evaluation, and general theories of psychotherapy were competing. If Mr. El-Hai believes that Dr. Freeman has been replaced by the "medication management" crowd, the only consolation is that the present epidemic may not be as bad and may end with the demise of managed care.

So, are we safe from a repeat? It must be

remembered that Dr. Freeman was not a charlatan who came from nowhere. His grandfather, William Keen, M.D., had been an acclaimed president of the American Medical Association, and his father and brother also were physicians.

Dr. Freeman went to Yale University and the University of Pennsylvania. He organized a well-run laboratory at St. Elizabeths Hospital in Washington

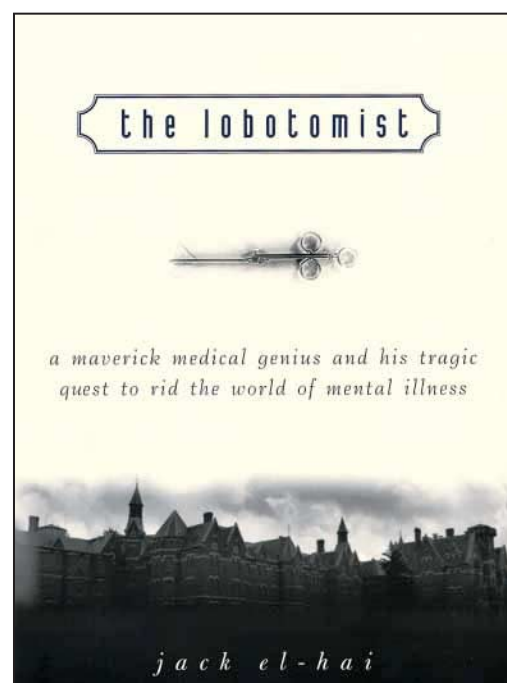
and was the first secretary of the American Board of Psychiatry and Neurology. His credentials clearly distinguished him from the average snake-oil salesman, even if his practice did not.

The moral of the story is that we must not rely on credentials alone. Solid clinical research, persistent demands for compelling evidence when a new procedure is proposed, and ongoing supervision of its application are the best defenses against any future travesty. ■

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BY RODRIGO A. MUÑOZ, M.D.



As an attempt to rehabilitate the reputation of Dr. Freeman, the book does not succeed.

Consider Low-Dose Topiramate for Newly Diagnosed Epilepsy

BY BRUCE JANCIN
Denver Bureau

BRECKENRIDGE, COLO. — Topiramate monotherapy at a target dosage of 100 mg/day—substantially less than conventional dosing—is at least as effective as standard therapeutic doses of carbamazepine or valproate for newly diagnosed epilepsy regardless of seizure type, Jacci Bainbridge, Pharm.D., said at a conference on epilepsy syndromes sponsored by the University of Texas at San Antonio.

Moreover, for this purpose topiramate (Topamax) at 100 mg/day has markedly fewer side effects and costs less than the much more widely used 200 mg/day dosing—and with no significant drop-off in efficacy, added Dr. Bainbridge of the University of Colorado, Denver.

She cited a study led by Michael D. Privitera, M.D., of the University of Cincinnati, who assigned 613 patients with newly diagnosed epilepsy to either carbamazepine (Tegretol) at 600 mg/day or valproate (Depakote) at 1,250 mg/day as

preferred therapy based upon clinical presentation. Within each study arm, participants were then randomized to double-blind treatment using the traditional antiepileptic drug or topiramate at 100 or 200 mg/day.

Outcome measures included time to first seizure, time to withdrawal from the study, and the proportion of patients seizure free during the last 6 months of the trial, Dr. Bainbridge said.

In both study arms there were no significant differences in these efficacy mea-

sures between the various treatments. However, patients on topiramate at 100 mg/day had the lowest rate of study discontinuation due to adverse events (Acta Neurol. Scand. 2003;107:165-75).

In a more recent secondary post hoc analysis of data from the Johnson & Johnson-sponsored trial, it was determined that there were no significant differences in efficacy for the various drugs in patients with partial-onset seizures at baseline compared with those who had generalized seizures. ■