In Memoriam

C. Miller Fisher
An Appreciation

J.P. Mohr, MD, MS; Louis R. Caplan, MD; J. Philip Kistler, MD

Regarded by many as the leading clinical neurologist of the 20th century, Charles Miller Fisher, MD, approaching his 99th birthday, decided against continuing his efforts to resist the disabling effects of age and quietly died April 14, 2012. Intellectually active to the end, he had just finished his eighth volume of memoirs.

His first publication, in 1945,1 reflects the eye for detail that characterized all his work: medical observations among those (himself included) rescued by the German raider whose brief exchange of gunfire sank his Canadian Navy ship the HMS Voltaire in 1941. The account also included details of medical treatment options during his time in a prison camp into late 1944.

His career bridged the period from the single to the numerous coinvestigator and then, toward the end, back to the single-author publications.2 Much of his work was done on his own but he was generous by including trainees and colleagues in publications. His bibliography contains >200 publications.3 Among those of special interest to readers of Stroke are the justly famous and seminal observations on carotid artery occlusive disease,4 especially in plaque pathology,5 anticoagulation for ischemic stroke,6 atrial fibrillation and embolic hemorrhagic infarction and system embolism,7 transient ischemic attack and transient monocular blindness,8 >15 lacunar syndromes9 and 4 par enchymatous hematoma syndromes,10 basal rupture of intracranial aneurysm,11 spontaneous carotid dissection,12 spasm with aneurysmal subarachnoid hemorrhage,13 reversible cerebral vasospasm,14 bilateral hemiparesis from basilar branch infarction syndrome,15 even ocular palsy in temporal arteritis.17

Many of the syndromes were described with alliterative and memorable titles: transient global amnesia, subclavian steal, ocular bobbing, wrong-way eyes, one-and-a-half syndrome, oval pupils, the landed trout syndrome, string sign; some of them proved too long to be accepted as titles (the best example being dysarthria-clumsy-hand syndrome, the common facial paresis deemed too many findings to be included in a title of an article), symptomatic occult hydrocephalus (now known as normal pressure hydrocephalus), and even such contentious—but correct—observation as protracted hiccup—a male malady.

Permanently alert to small details, he was regularly the despair of those in a hurry for the quick answer, a tireless (some said tedious) neuropa thologist, a thorough reviewer of the literature, and a clinician prepared to spend what time was necessary to understand the details of the case as many can attest who were caught up in his rounds or were office patients waiting their turn long after his secretary had left for the day. He occasionally failed to appear, appointments or scheduled presentation notwithstanding, if distracted en route to the hospital by a parade or at a game pursuing his pathological devotion to baseball. Late morning arrival was usual, but late nights leaving the rule, his faithful and supportive wife Doris driving in from home to retrieve him. Few clinicians seemingly aware they needed sleep, late night calls for advice were common.
She regularly acted as the gatekeeper, causing one clinician to remark that, “His own wife doesn’t know where he is. When I called this morning around 2:00 she said she’d check to see if he has come in.” If his lectures were not the stuff of legend (Harvard students dubbed him “shifting dullness”), those on hand when he interviewed and examined patients and his Socratic method of teaching reflected his mastery and deep commitment to pathophysiology and semiology.18

No stranger to controversy or intellectual challenges, indeed seeming to welcome them, his observations overturned many prior assumptions of the existence or inferred mechanisms of some diseases; cerebral Burger disease and infarction-at-a-distance, now recognized as distal field infarction in carotid disease16; the typical duration of transient ischemic attacks (<15 minutes, not 24 hours)20; a recognizable syndrome for cerebellar hemorrhage;21 lateral midbrain displacement (not tentorial herniation with downward compression) in mass effect coma;22 systolic more than diastolic arterial pressure as a risk for stroke;23 migraine equivalents not transient ischemic attacks24; subarachnoid hemorrhage volume as a factor in aneurysmal vasospasm;25 bleeding globes the main finding in “Charcot-Bouchard” aneurysms26; his reluctant acknowledgment of a combined sensorimotor stroke syndrome could arise from thalamic lacune; amnestic state from unilateral posterior cerebral infarction;28 new ipsilateral infarction worsening ipsilateral hemiparesis due to prior contralateral infarction; even an example of bilateral internuclear ophthalmoplegia from single basilar branch occlusion.30 These are just a small sample from Dr Fisher’s cerebrovascular material.

Generations of strokologists and patients have benefited from his work. They are happy he ignored the advice he was given as a fledgling neuropathologist: not to waste a career on his work. They are happy he ignored the advice he was given as a fledgling neuropathologist: not to waste a career on his work. They are happy he ignored the advice he was given as a fledgling neuropathologist: not to waste a career on his work. They are happy he ignored the advice he was given as a fledgling neuropathologist: not to waste a career on his work.

References

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*Stroke*. 2012;43:1739-1740; originally published online June 12, 2012; doi: 10.1161/STROKEAHA.112.661512

*Stroke* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0039-2499. Online ISSN: 1524-4628

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://stroke.ahajournals.org/content/43/7/1739

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