



LETTERS TO THE EDITOR

Hasday: Treatment of obesity in 10th century[☆]

Hasday: tratamiento de la obesidad en el siglo x

Sir,

This year marks the 1100th anniversary of the birth of the Jewish physician Hasday Ibn Shaprut (915–975), the author of the first antiobesity diet in the world. We would like therefore to pay him our most humble tribute.

When the king of Leon, Ordoño II, died, he was succeeded by his stepbrother Sancho I (935–966), known by both Christians and Moors by the nickname of “the Fat”. This was hardly surprising, given that the king’s weight eventually reached 21 arrobas (a Castilian weight unit), which is equivalent to a little over 240 kg.¹ According to chronicles of the time, the obesity of the sovereign was due to his gargantuan appetite, as he ate every day seven meals with 17 different dishes, most of them consisting of game. The monarch had some difficulty in governing his realm, because a good part of the nobility criticized him and made fun of his fatness. They argued that they could not accept being governed by someone who could not even get out of bed or walk without help. Count Fernán González went even further and questioned dynastic continuity, as obesity prevented the king from publicly showing that he had consummated his marriage.

In 957, Sancho I was summarily deposed by the troops of the count. The sovereign fled Leon and went to Navarre, to his grandmother, Queen Toda. Queen Toda decided to take matters into her own hands so that her grandson could recover his throne as soon as possible. Dramatic measures were needed, and the first thing Sancho had to do was to lose weight and present a more respectable appearance. But where could a medical center for the appropriate treatment be found in the 10th century? The answer was the Caliphate of Córdoba of Abd al-Rahman III, who immediately sent the king his personal physician, Hasday Ibn Shaprut, a Jew.² This physician was a man of short stature—he was a little over

one meter in height, according to chronicles—who was born in Jaen, then called Yaffan, which would go down in history as the main center of the Golden Age of Jewish culture in Spain. Hasday had achieved prominence as a physician in Al-Andalus, where he was considered the discoverer of a universal remedy he called Al-Faruk, a sort of antidote against all types of poison.

When Hasday met Sancho he must have been taken aback at the sight of such a singular human being. However, Hasday could do nothing there, as he did not have his remedies and potions at hand. Sancho would therefore have to travel to Cordova to undergo the slimming treatment; otherwise, he would be unable to give back to Sancho what he termed “the primitive cunning of his lightness”.^{2,3}

Soon after that visit, Sancho went with his grandmother, Queen Toda, to Cordova to be treated by Hasday. First of all, the physician shut Sancho up in a room, where he lay on a bed with his feet and hands tied. He only left his captivity to take long walks during which he was pulled with ropes by slaves, while leaning on an assistant. When the exercise was over, Sancho was obliged to take endless steam baths, which were an even greater torment for him.³ But all this physical exercise was as nothing compared to the dietary regime he was compelled to follow. To prevent food intake, Hasday ordered that Sancho’s mouth be sewn up, with only a small opening being left so that with the aid of a straw he could sip liquids (“Hebrew herbs”), which gave him continuous diarrhea. It appears that Sancho was only fed fluids throughout his stay at Cordova, receiving daily seven infusions combining salt water, orange-flower water, water boiled with vegetables, and fruit. These very probably contained theriac, a drug consisting of a variable number of ingredients, sometimes more than 70, including opium. We can easily imagine that Sancho must have felt himself at death’s door on such a diet, but surprisingly he survived the rigorous hygienic and dietary regimen to which the Jewish physician subjected him.

The treatment started to have an effect, and his body eventually acquired the flabbiness associated with rapid weight loss. Flabs of flesh appeared all over his body. To reduce them, Hasday ordered prolonged body massages to try and recover the firmness of the skin. As the treatment was beginning to seem that it would never come to an end, Queen Toda, who had become the queen regent on the death of her husband, decided to return alone to Navarre, leaving her grandson in the hands of the physicians.

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Diet and physical exercise finally had the desired effect. After 40 long days on this strict and noxious diet, Sancho's weight had been reduced to 120 kg and he was able to walk distances longer than 5 km without being pulled by ropes or any other assistance. In addition, he was able to ride a horse, lift his sword and, what perhaps cheered him most, lie with a woman.^{2,3} Sancho was now ready to recover his throne.

One day in 959, Sancho the Fat left Cordova and headed for his beloved Leon. With the help of the Caliph's army as well as that of the Kingdom of Navarre, towns surrendered to him as he passed on his way to the capital. Here he encountered no resistance at all and recovered his throne in 960.³

It is said that after his return to Leon, Sancho did not abuse his liking for game again and became a regular eater of fruit. This eventually proved his downfall. In 966, the reign of Sancho I came to an untimely end when he was given a poisoned apple by the rebel count Gonzalo Menéndez.

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Determination of glycosylated hemoglobin during hospitalization as an opportunity to assess and optimize glycemic control in our patients: An unresolved matter[☆]



La determinación de hemoglobina glucosilada durante la hospitalización como una oportunidad para valorar y optimizar el control glucémico en nuestros pacientes: una asignatura pendiente

Dear Editor,

Diabetes mellitus is a highly prevalent disease in the general population, and this is particularly relevant for patients who require hospital admission for any reason because of its impact on morbidity and mortality.^{1,2} Internal medicine departments assume a high proportion of admissions of elderly patients with diabetes and/or complex chronic diseases³ who have great difficulty in accessing the healthcare system because of their functional and cognitive limitations. The hospitalization of these patients is a good opportunity for optimizing blood glucose control, thus improving their health outcomes.

Both the consensus document on the treatment of hyperglycemia during the hospital stay published in 2009 by Pérez et al. and the 2015 ADA standards recommend the

measurement of glycosylated hemoglobin A1c (HbA1c) levels during or in the three months prior to hospitalization.^{4,5} In an interesting article recently published in this journal by Sáenz-Abad et al.,⁶ the authors concluded that hospital protocols should consider HbA1c as one of the determinants of blood glucose control during the hospital stay, together with prior treatment, blood glucose levels at baseline and in the first 24 h of admission, fasting, and the use of corticosteroids.

To analyze the adherence of our unit to international recommendations for measuring HbA1c levels during hospitalization, our group conducted a retrospective cohort study in a group of patients admitted for any reason to our internal medicine clinical management unit with a diagnosis of type 2 diabetes mellitus who were at least on metformin. The recruitment period was two and a half years (from November 2012 to April 2015), during which there were 330 episodes in 278 patients. The mean patient age was 76.7 ± 9.4 years, with a distribution by sex of 45.8% males and 54.2% females. HbA1c was only measured during hospital admission in 143 (43.3%) of the episodes analyzed. The mean HbA1c level was $7.13 \pm 1.48\%$ (range, 4.6–14.1), which agrees with the above mentioned study.⁵

To establish what should be considered as adherence to guidelines in terms of HbA1c measurement, nonfatal episodes were analyzed separately, because it was thought that healthcare professionals who cared for patients with a fatal vital prognosis during hospitalization did not consider it appropriate to determine the prior degree of blood glucose control in these patients as this would provide no clinical benefit and would therefore represent an unnecessary expense. Thus, the proportion of patients for whom HbA1c measurement was requested at admission and who were finally discharged was 49.1%. It may thus be concluded that HbA1c levels were not available during hospitalization in half the patients admitted. When patients in whom HbA1c had been tested in the three months prior to hospital admission were added, we found that HbA1c measurements performed during or in the three months prior to admission were not available for 87 (26.37% of all patients recruited) clinical

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