STAFF CONFERENCE

Thursday, February 20, 1930

CASE I.

White - female - married - 26. Gravida none; para none. First admitted 8-9-28. Expired 2-15-30.

Present illness started February, 1928. Bleeding for two months. Flow about like ordinary menses. Felt pain in left lower abdomen, weakness, and weight loss from 168 to 130 pounds (38 lbs.) Went to another hospital April 27, 1928 with ulcerated lesion of cervix. Diagnosis - chronic cervicitis. Leukorrhea for 2 or 3 months preceding onset of flow. Married at 21. Menstrual history negative. Family history negative for malignancy. Patient had syphilis 4 years ago, followed by 1 year treatment. Wassermann negative for the past 3 years. Was told she had leakage of the heart many years ago. Occasional attacks of tachycardia and palpitation. Pleurisy right chest about 1 year ago. Epigastric distress after meals. Belches foul material. Helped by cold water, not by alkali or food. Fatty foods cause belching, no pain. Appendectomy and tonsillectomy 1916.

Physical examination: Head and neck negative. Thorax negative. Blood pressure 108/60. Heart negative. Abdomen flat, no tenderness, scar over McBurney's point. Reflexes negative. Pelvic examination - external genitalia normal; cervix shows a large, sharply marginated and undermined ulcerated area, clean character with finely granular base; no purulent discharge. Impression - ulcer of cervix, either syphilis, tuberculosis, fungus infection, or malignancy.

Biopsy shows squamous carcinoma.

Laboratory: Urine - albumen trace, many wbc. Hemoglobin 78, reds 3.9, wbc. 11.2 Wassermann negative. Hemoglobin dropped to 55. X-ray chronic bronchitis

Given 2400 milligram hours of radium, 50 S. E. D. to cervix in 2 treatments in 3 days. Went home and felt well for 3 weeks when pain returned. Creamy discharge from vagina. No bleeding. Now taking morphine for pain. Stayed in hospital 257 days on second admission. Given 2400 milligram hours of radium, followed by 50% S. E. D. to cervix in 2 treatments in 3 days, followed by 150 S. E. D. to skin, anterior and posterior pelvis, in 7 treatments in 22 days. Later, 2400 milligram hours, followed by 50 and 150% S. E. D. Again 118% S. E. D. to anterior and posterior lower abdominal wall and pelvis in 6 treatments in 24 days. Bowel and bladder normal. Abdomen very tender over both lower quadrants. Cervix clean and healing well. Was thought to have a pyometria. Cervix thick, canal cannot be entered. Marked infiltration about cervix. Started to bleed from vagina. Lost about 300 cc. of blood. Patient was packed, but began to bleed again and lost 200 cc. more. Given 300 cc. of medical transfusion and about 600 cc. of normal saline. Felt better following this treatment. Again a severe hemorrhage of 1000 cc. in a very short time of about 10 minutes. Uterus packed immediately. Was given 500 cc. of surgical transfusion. Running markedly septic course. Radiation treatment stopped. Was sent home taking morphine sulphate by mouth, apparently about the same. Stayed home 2 months and returned for 158 days. Still complains of pain. Condition unchanged. Patient cheerful but seems tired, appetite fair. Sleeps fairly well. Had another attack of vaginal bleeding for 2 or 3 days, but it was not excessive. Large hemorrhage occurred just before exitus.

Blood urea nitrogen last done 12-11-29, 16.8. Last hemoglobin - on entrance 61%.

AUTOPSY: Group 1. Squamous carcinoma of cervix.

Group 2. Extension to parametrium? right hydronephrosis, marked; left hydronephrosis, moderate; anemia.

CASE II.

White - male - 22 - student. Health Service 4 days.

Chief complaint: Malaise, abdominal pain.

Present Illness: Had a cold 1 week ago with moderate nasal obstruction and cough. Sore throat 2 days ago, felt well otherwise. C.C. Malaise, nausea and vomiting, generalized abdominal pain, and diarrhea. Throat no longer feels sore, no cough. Pain in abdomen is generalized. Bowels move 3 to 4 times a day. Acute onset. Stayed in room all day. Came to Health Service in evening with high temperature and rapid pulse. Backache last night. Abdominal pain, full, first noted in left side. No cramps, no localization. Took no food yesterday after breakfast because of nausea but felt hungry and ate some breakfast this morning. Similar attack last November, '29. No vomiting, but similar abdominal tenderness. Hurt to walk, slight drawing of muscles. Kept on working, but felt it for over a month in the left side.

Physical examination: Appears toxic. Throat is markedly inflamed but no exudate. Lungs negative. Abdomen is rigid all over, right rectus more tense than left. No rash on skin. Rectal negative. Impression: Generalized peritoneal irritation, very atypical for appendicitis. Possible scarlet fever. Acute respiratory infection. Early pneumonia.

Laboratory Examination: Urine - faint trace of albumen, many casts, numerous pus cells. Hemoglobin 81, wbc. 31., pmn's 70, lymphocytes 3, myelocytes 11, metamyelocytes 16.

Course: Exploration not advised because of character of findings. Next day abdomen more rigid, otherwise seems to be about the same. In the afternoon, distension. Patient very toxic, very tender in the left lumbar region. Throat very red and covered with membrane. Still considered generalized septicemia with localization in abdomen. Nausea, vomiting. Question of exploration considered. Day of exitus, patient going progressively downward. Patient very critical. Possible value of opening the abdomen at this time would be to discover a primary purpose. Operation considered justifiable with the patient in better condition to withstand it. Temperature 99 to 103, pulse 110 to 180. Respirations 28 to 40.

Autopsy: Group I. Adenocarcinoma of splenic flexure of colon.

Group II. 1. Perforation 2. Acute generalized fibrinopurulent peritonitis 3. Slight (purulent) right hydrothorax 4. Acute bronchopneumonia 5. Cloudy swelling. 6. Slight lymphadenitis of mesenteric nodes.

TUMOR DEATHS

Birth to age 35 - years 1925 to date.

Age	
1 -	Papilloma of larynx
	Sarcoma of ovary
2 -	Retrobulbar tumor of orbit
3 -	Retroperitoneal lymphosarcoma
4 -	Retroperitoneal lymphosarcoma
	Glioma of brain
	Glioma of eye
6 -	Glioma of brain
9 -	Glioma of brain (3 cases)
11 -	Mixed tumor of kidney and bladder
14 -	Sarcoma of bladder
	Glioma of cord
15 -	Glioma of brain (2 cases)
16 -	Ewings endothelioma (multiple)
	Glioma of cord
17 -	Hard fibroma (left nares)
18 -	Glioma of brain
20 -	Osteogenic sarcoma (femur)
22 -	Osteogenic sarcoma (ilium)
	Sarcoma of bone (multiple)
	Carcinoma of rectum
	Carcinoma of splenic flexure
24 -	Carcinoma of fundus of uterus
26 -	Glioma of brain
29 -	Osteogenic sarcoma (ilium)
	Mixed tumor of testicle (2)
	Carcinoma of cervix (2)
30 -	Osteogenic sarcoma (ilium)
	Sarcoma of esophagus
	Mixed tumor of testicle
	Glioma of brain
31 -	Tumor of mediastinum
32 -	Carcinoma of stomach
	Osteogenic sarcoma (clavicle)
	Carcinoma of cervix
33 -	Carcinoma of cervix

Age
34 - Carcinoma of ovary
Malignant melanoma (neck)

Age
35 - Malignant melanoma of eye
Carcinoma of cervix
Mixed tumor of nasopharynx

CLINIC COMMENTS:

Henry L. Ulrich, M. D., Chairman of Clinics, American College of Physicians, desires to express his great appreciation of the splendid cooperation received from the staff of the University Hospitals. From all sides he heard unstinted praise for the clinics and demonstrations put on during the sessions last week. He has also received a letter of thanks and appreciation from the officers and regents of the College, confirming these complimentary remarks. He adds, "I think we can say with justifiable satisfaction that this meeting has put across the idea to the profession of this country that there is a medical center of the Twin Cities". The following points were especially noticed by our visitors:

Wealth of material - One man said that it reminded him of the Osler Clinic of the old days. Another said that he expected to find about half as good work done as in his home city because it was twice as large. He went home with a different conception. Another made a trip out here to get our attitude toward malignancy. He was especially interested in the fact that the internists were very active in this field. Practically all went away with a very decided impression that we had a real roentgenologist on our staff. Many complimentary remarks were heard about "practicing dermatologic medicine". Two men were especially anxious to see our morgue. They went away with a distinct impression that it was worse than their own. One man did not come back because he said there were "two many young men" on the program. The president of the organization stated to the press that he had seen the finest clinics here that have ever been held in connection with any meeting. The president is from the south. A few believed that some of our material was too "high brow." No one heard any complaints about the length of the 30 minute clinics. All were decidedly impressed with the wealth of hematologic material presented.

Our new building came in for a great deal of praise, many visitors coming back again to show their friends about. It may be possible that a few went home without knowing about visualizing the left auricle, but this is doubtful. Two men from the east remarked that they were agreeably surprised at the rapid progress made by their associates in the middle west.

We should organize a society of the "Sons of Wild Jackasses". Many complimentary remarks were heard about the readable charts. Is everyone satisfied with clinical histories on lantern slides?

Dr. Shapiro's presentation of Congenital Heart Disease was most impressive. In spite of the relatively small crowd in attendance, many went to the clinics in the anatomy building. At times, as many as 100 people were present. A group of men, especially interested in the Health Service, had an opportunity to view it first hand through the courtesy of Dr. H. S. Diehl. It was most impressive to see patients presented in the various clinics several years after the first observations and diagnoses had been made. No complaints were heard about running the clinics on time although comments not so complimentary were heard about the arrangement elsewhere. Dr. Wells believes that he should not be represented as the "Will Rogers" of pathology but rather as the "Chic Sale". This may be our last opportunity for some time to put on such a demonstration, but if we have another opportunity, I am sure we have all gained valuable information on how it should be done from this event.

BEST SUGGESTION:

Avoid discussion of therapy to be carried out in the other fellow's department.

DISCUSSION SUBJECT:

Shall we edit a hospital bulletin?

SPECIAL ANNOUNCEMENT

The Medical Six O'Clock club of the Medical School will hold a special meeting in the Minnesota Union Thursday, February 27, 1930, at 6:30 P. M., to discuss the problems of the Medical School. This will be in the nature of an open forum and ten discussion subjects have been selected. Everyone is urgently requested to be present.

PLEASE:

The Training School Office requests that all men giving clinics call the floors when they are through with the patient so that the nurses may go down and bring them back without any undue delay.

CLASSIFICATION OF INTESTINAL OBSTRUCTION

A. MECHANICAL

I. NARROWING OF LUMEN

1. Strictures of bowel wall
   a. Congenital (Atresia, Imperforate anus)
   b. Acquired (Inflammatory, Traumatic, Vascular, Neoplastic)

   → SIMPLE

2. Obturation

   → SIMPLE

3. Compression from without (Especially pelvis and retroperitoneal duodenum)

   → SIMPLE

II. ADHESIVE BANDS (Congenital, Inflammatory, Traumatic, Neoplastic)

→ SIMPLE OR STRANGULATION

III. HERNIA

1. External) STRANGULATION (with only few exceptions)
2. Internal) STRANGULATION (usually)

IV. VOLVULUS) STRANGULATION

V. INTUSSUSCEPTION) STRANGULATION

B. NERVOUS

I. INHIBITION ILEUS (Paralytic) Adynamic

→ SIMPLE, OCCASIONALLY STRANGULATION

II. SPASTIC ILEUS (Dynamic)

→ SIMPLE

C. VASCULAR

I. THROMBOSIS & EMBOLISM OF MESENTERIC VESSELS

II. SEVERANCE OR INJURY OF MESENTERIC VESSELS (Operative or blunt trauma)

→ STRANGULATION