STAFF CONFERENCE

Thursday - May 1, 1930

CASE I.

LOBAR PNEUMONIA.

The case is that of a man, 55 years old, admitted to the University Hospital 4-9-30 and died 4-15-30 (6 days). Chief complaint - pain in side, cough and fever. Patient had a chill and pain side April 6, 1930. Had a cold for some time previous to this which was persistent and did not go away. Doctor called day patient was taken ill, who said he had a bad cold. On Monday, patient seemed to feel better. On Tuesday, his fever went down to 99. On Wednesday, April 9th, patient became worse, and doctor made a diagnosis of pneumonia. Has not felt well since the spring of 1930. Had low blood pressure, rheumatism in shoulder, and insomnia. Pneumonia at 12 and again at 20, the latter affecting both lungs. About four years ago, had epileptic seizures. Has these attacks at intervals 5 to 6 months apart. Fracture of ribs about 11 years ago and again 6 years ago. Father dead influenza and pneumonia. Mother dead same. Wife living and well. Three children living. Occupation cabinet maker.

Physical Examination: Thin, asthenic type. Eyes and ears negative. Running nose. Injected throat. Enlarged glands neck. Stiffness of neck. Some pain on flexion. Kernig negative. Hyperresonance over entire right lung with suggestion of tympany. Excursion diminished on right. Dullness not present except on right posterior side under scapula. Bronchovesicular to bronchial breathing over right anterior chest. Bronchial breating over apex. Tubular to bronchial breathing on posterior surface. Tubular over upper lobe. Increased vocal frumitus over area showing change in breath sounds. Numerous rales over both lungs, more coarse in left. Over-affected regions, rales are crepitant. Heart normal. Pulse 112. Respiration 24. Abdomen - tenderness along costal margin. Abdominal wall slightly tense, probably due to tympanites. Reflexes negative.

Urine albumen positive once. Hemoglobin 87, wbc. 26,450, P. 95, L. 4, E. 1. B.U.N. 22.87. NaCl 443. CO_2 46. Wbc. 31.250, 21.350, 34.000, 31.700, 19.900. 3-13-30, chest plates bedside, lboar pneumonia right upper lobe, bilateral diaphragmatic pleurisy. Four days later, lobar pneumonia right upper lobe increased, possible beginning lobar consolidation, right middle lobe, congestion right lower lobe, probable encapsulated empyema right lower. Blood pressure - systolic 104 to 120, diastolic 45 to 70.

Progress notes: Medication - digitalen, digitalis, aspirin, phenacetin, intravenous glucose, morphine sulphate, caseara, oxygen, proctoclysis, homocaffeine, hypodermoclysis, intravenous saline, caffeine sodium benzoate. 4-12-30, Cyanotic tinge of ears, nose, and lips. Dullness over right chest more marked. Tubular breathing more pronounced over anterior surface than before. Condition serious. 4-14-30, Findings indicate invasion of middle lobe with passive congestion of the base. 4-15-30, Respirations very difficult. Exitus 12:20 P. M. Temperature septic type 98.6 to 104.6. Pulse 90 to 120. Respiration 24 to 36. Fluid intake 2700, 3100, 2350, 2850, 2500. Output 625, 925, 825, 900, 600.

Diagnosis: Lobar pneumonia, right.

2. Acute bronchopneumonia, left.
3. Empyema, right.
4. Cloudy swelling, heart, liver, and kidneys.
5. Acute splenitis
6. Pleural adhesions
7. Puncture wounds
8. Emaciation

II.

DIABETES MELLITUS:

The case is that of a 63 year old woman, admitted to the University Hospital 4-14-30 and died 4-23-30 (14 days). Chief complaint - ulcer of right foot. 11-28-29, was hit on both right and left feet by a screen door. Was also badly scratched on right knee. Within one week both the knee and left foot were perfectly healed, but right foot would not heal, and has grown progressively worse. About three years ago, patient went to eye specialist for chronic dacryocystitis. Was told that she had diabetes. Noticed that she was bothered with polydipsia, polyphagia, and polyuria, but thought nothing of it. One and one-half years ago, she had complained to a doctor about drinking so much water, weakness, and tired aching legs, but was told that she was in a run down condition. Treated three years ago in Abbott Hospital for diabetes. Following this, was on a strict diet and insulin. Last year, she has not followed the diet very well, ate whatever she wanted to. Since her trouble with her foot, she has gone back to her diet but has not had insulin. Past history - health up to three years ago good, sun stroke seventeen years ago, occasional colds, frequent severe headaches (frontal and occipital) since attack of sun stroke, slight impairment of hearing (right ear) following influenza, occasional palpitation of heart when excited, occasional dysmenorrhea. Father dead old age. Mother dead old age. Two sisters dead accident. Two sisters, one brother living and well. No history of diabetes in family. Occupation works on farm, would work away from home at present if she could get an easy job. Present home is with one of her daughters.

Physical examination: Elderly woman, recumbent, apparently suffering no pain, but appears tired, obese. Skin on arms scaly and dry. Slight mystagmus and strabismus. Impaired hearing right ear. Most of teeth gone. Those present in poor condition. Eczematous areas under both breasts. Chest negative. Heart occasional extrasystole. Blood pressure 110/60. Spleen and liver not palpable. Arms dry and scaly. Hands show evidence of hard work. Nail on right thumb black. Scar on right elbow. Reflexes sluggish. Right leg no deformity. Foot shows small ulcer. Left leg brownish pigmentation on anterior surface. Toe nails hypertrophied. Back negative. Oscillometric index-right ankle 1/2 to 3/4, below knee, 1-1/2, above knee 1; left ankle 1-1/2 to 2, below knee 3-1/2, above knee 3. Intravenous wheals all remained about 40 minutes and disappeared all about the same time 70 minutes plus. The elastic bandage test shows impairment. Dorsalis pedis pulse not felt on either side. Sloughing area right heel tender, Achilles' increasing in size, has a very foul odor. Applied Dakin's solution. Patient complained greatly of pain in ulcer and leg.

4-16-30, Seen in staff rounds, going down hill, becoming more toxic. Amputation advised. Special attention paid to treatment of diabetes and preparation of leg before operation. Operation 4-17-30: Oblique flap to upper third of tibia. Fibula cut off one inch shorter than tibia. No statement about condition of vessels. Sugar free after operation. Given fluids, tetanus, and gas gangrene antitoxin. 4-19-30: Rales and changes in breath sounds in left base posteriorly. Blood pressure 130/70. During last two days patient has shown some sugar in urine. Temperature 103.6, apparently has an infection. Emesis, abdominal distension, rapid pulse, flushed cheeks, heavy breathing. Stomach washed out, enema given. 4-2-30, Intensive diabetic care, treatment continued. Given fluids. Complains of pain in legs. 4-21-30, Stump gangrenous. Condition not so good. Taken to operating room, and reamputation done through thigh. 4-22-30, X-ray of chest shows beginning pneumonia, right lung, and some change in left. Oxygen tent. 4-23-30, Respirations rapid, pulse imperceptible. Exitus 8:25 A. M.

Laboratory: Urine - sugar positive and negative, acetone and diacetic acid positive and negative. Hemoglobin 96, 3bc. 6,250, P. 71, L. 25, E. 3, M. 1. B.U.N. 18.66. Blood sugar, .353, later .12. 4-19-30, Urea nitrogen 16.8, CO_2 56. 4-22-30, Blood sugar .13. X-ray examination, 3-15-30, shows chronic bronchitis; possible early bronchiectasis; right base, cardiac enlargement, slight, left ventricular type; low grade periostitis of right fibula; slight calcification of arteries of legs and feet; pes planus; slight atrophy of right foot; soft tissue ulcer posterior to right heel. Probably beginning pneumonia

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left base. Eye grounds negative. Electrocardiogram - extrasystoles, ventricular.

Medication: Codeine sulphate, cinchophan, luminal, saline packs to foot, light basket, allonal, pyramidon, sodium salicylates, cascara, insulin, morphine sulphate, chloral hydrate, phenol packs, lanolin, boric acid packs, alcohol and boric acid, rubber dam and hot water bottle applications, Dakin's packs, vaseline strips, novocain injections, mineral oil, triple bromides, aspirin, hypodermoclysis, tetanus and gas gangrene antitoxin, digalin, hyperventilation, gastric lavage, rectal tube, intravenous glucose, oxygen tent, caffeine sodium benzoate, adrenalin.

Temperature - preoperative 98 to 100, postoperative 99 to 105. Pulse - preoperative 70 to 90, postoperative 80 to 130. Respirations 16 to 28.

DIAGNOSES:

1. Diabetes mellitus (clinical)
2. Generalized arteriosclerosis
3. Ulcer of right heel (clinical)
4. Absence of right lower extremity (two-thirds)
5. Operation wounds
6. Pulmonary atelectasis
7. Chronic cholecystitis and lithiasis
8. Slight fatty metamorphosis of liver
9. Slight passive congestion of liver
10. Arteriolosclerosis of kidneys
11. Uterine myomata
12. Small renal cyst
13. Slight hemothorax

CASE III.

OSTEOGENIC SARCOMA:

The case is that of a man, 49 years old, admitted to the University Hospital 12-17-29, died 4-1-30 (105 days). First admitted 1-14-29. History states that in the spring of 1923, he accidentally struck himself on the left knee with a hammer. The blow knocked him down, and he was dizzy for a few minutes but quickly recovered. The knee did not bother him all summer. In October, 1923, he developed a sharp, continual pain along the shaft of the left tibia. It lasted about one week. His knee has always been weak. Patient apparently recovered from this attack and had no trouble until May, 1924, when he had an attack of pain similar to the first, which lasted three weeks. The next attack, October 24, 1924, when he had another attack of pain which lasted up to first admission, 1-14-29.

Physical examination: Lower third of left thigh and left knee are markedly swollen. Local heat, swelling, local tenderness, but no redness. Movement of knee joint limited. Both left and right inguinal nodes enlarged and indurated. 1-29-26, Left leg amputated at upper third of thigh, and later patient transfused with 500 cc. of whole blood. Stereoscopic plates of chest showed no lesion. Ten days following amputation, the amputation of the thigh was continued, and a disarticulation of the left hip was performed. Left hospital and readmitted 8-5-29. Complaint - pain in right chest, pain right costal margin, pain in right hip joint. All developed in May, 1929. Pain full, loss of weight 10 or 12 lbs. since May; no weakness noticed. An attack of biliary colic spring 1929. One year ago, 1928, patient fell and hurt his right chest. If he lies on his left side, he gets the sharp pain in his right chest. No pain on deep respiration. Pain in right hip present all the time. Previous health good. Family history - no malignancy. Wife and eleven children living and well. Occupation mechanic on railroad.

In August, 1929, x-ray examination of pelvis showed probable osteoclastic metastasis to sacrum. Chest x-ray showed encapsulated effusion of left base with effusion of pleurae. Gall-bladder examination showed normal functioning gall-bladder. Plates of chest were again made which showed probable metastasis to the lung and to the pleurae. He was given 150% skin erythema dose to right ischium in four treatments, a 100% to the left in three treatments and 103% to

the chest in six treatments. He was sent home for further observation.

Readmitted the third time, stating that he felt quite comfortable for a while except for pain in the right costal margin. These pains continued to become worse until December 6, 1929, when he was unable to get out of bed. Patient also complained of dry cough. Physical examination essentially the same as on previous admission. X-ray of pelvis and spine showed osteoclastic metastasis to sacrum and probable osteoclastic metastasis to ilium and pleural effusion. Plates of ribs and spine showed multiple metastasis to spine and ribs. Was given deep x-ray therapy to ribs and spine. Novocain injections, from 7 to 10, in the costal spaces. This relieved the pain in the chest wall, but the patient still had deep visceral pain. On January 13, 1930, paravertebral injections of absolute alcohol on the right 5th to 10th segments were given with some relief of pain. Attempt made to tap the chest, but this proved unsuccessful. Coley's mixture was injected in left gluteal region in the left buttocks every third day until 2-24-30. From March 13, 1930 the patient's condition gradually grew worse. His liver became enlarged, his appetite very poor, and he finally died 4-1-30.

Summary: Spring, 1923, accidental injury to left knee. October, 1923, attack of pain. May, 1924, second attack. October, 1924, third attack. Tumor present 1-14-29. Amputation 1-29-26. Reamputation 10 days later. Readmission August 5, 1929 for metastasis in bones and viscera. Death 4-1-30.

DIAGNOSES:

1. Sarcoma of left femur (clinical)
2. Absence of left lower extremity
3. Metastases to right lung and pleural cavity
4. Eversion of disphragm
5. Emaciation
6. Metastases to vertebrae (clinical)

CASE IV.

RHEUMATIC ENDOCARDITIS:

The case is that of a 24 year old girl, admitted to the University Hospital 3-26-30 and died 4-23-30 (28 days). Chief complaints - (1) heart disease, (2) rheumatism. February, 1930, patient had her first attack, which she describes as a feeling of being all in. This came in after no particular exertion or cause, and two days later gradually became worse. Other symptoms - dyspnea, precordial pain, sharp stabbing in nature, radiating to left shoulder. A physician gave her digitalis by mouth and sodium salicylates. Following this, she felt fine on some days, and other days felt badly. Sent to hospital because of failure to improve on medication. Measles, chicken-pox, frequent attacks of tonsillitis. Tonsillectomy 1921. Attack of rheumatism 1927, late in spring, came on after walking home. Affected hip first, then migrated to other joints, being mono-articular or polyarticular. Joints were red and painful at this time. During the summer, 1927, the trouble subsided, and she has had no further attack until present illness. Attack of rheumatism came on in present illness after attack of heart disease. Tonsils removed shortly after attack of rheumatism. Was in hospital one month with heart trouble. Has been in bed continuously with present attack. Various joints have been swollen and red and then have subsided. Patient says she feels better than when present illness developed. Other complaints - no running ear, no abscessed teeth (had one pulled), adenopathy in neck during sore throats, no hemoptysis, notices palpitation occasionally, occasional edema of ankles, appetite poor.

Physical examination: No general statement. Head negative. Eyes react normally. Ears and nose normal. Teeth good, several fillings. Throat no injection or reddening. No note of condition of tonsillar fossae. No adenopathy of neck. Expansion of chest free and equal. Percussion normal. Palpation, no bulging. Tactile fremitus normal. No rales. Heart rapid. Murmur heard over entire precordium, transmitted to axilla. Presystolic and systolic in time, loud

and blowing in character. Visible pulsation, especially below level of third rib. P. M. I. is very prominent in fifth interspace to left of midclavicular line. Heart is apparently slightly enlarged by percussion. Blood pressure 100/60. Abdomen - no masses, scars, or ascites. Liver and spleen not palpable. Extremities - probable slight edema of legs, reflexes normal except left knee jerk was not obtained.

3-3-30, Very dyspneic. Nausea and vomiting several times today. 7:00 P. M., felt a very peculiar sensation along sternal margin, as if bubbles of air were escaping. Pulse very rapid, 100 to 120. Respirations 36. Definite rub could be heard along sternal margin from second to fifth interspace. It sounded as if two pieces of leather were being rubbed together. Could also be heard over the precordial area and very well in the left anterior axillary line. Many fine crepitant rales, right base. Area of bronchial breathing. Rub posterior above level of sixth dorsal spine, extending out to angle of scapulae. A few course rales over left base. Increased spoken and whispered voice transmission. Dullness over this area. 3-4-30, Very uncomfortable. Abdominal distension, Expelled much gas. 8:00 P. M., feeling much better. Taking fluids by mouth. Respiration less rapid and labored. Area of dullness in bronchial breathing over left posterior chest with moist rales over right. 4-5-30, Physical findings the same, feels better, color good. Questionable pleural friction rub at right base posteriorly. No notes between 3-4-30 and 4-5-30. Cardiac dullness extends completely to axilla and there is flatness rather than dullness. Pericardium tapped in fourth interspace, left sternal border, but no fluid obtained. Deemed unwise to tap outside of apex because of evidence of pleuritis. Was thought the consolidation in left lower lobe was too extensive for lung compression by enlarged heart. 4-6-30, Friction rub not so definite. Slight accumulation of fluid at left base. Now impaired resonance over right lower lobe. Breathing bronchovesicular to distant tubular, suggesting consolidation here as well. 4-8-30, Thoracentesis, 500 cc. turbid fluid obtained from left side. Findings about the same except pulse is decreased and is of better quality. 4-10-30, Thoracentesis, right, 350 cc., left 500 cc. Fluid from right, cell count 2350 wbc., many rbc. Marked amount of albumen. Enema for distension. Patient is about the same. 4-11-30, Condition about the same. Feels fairly well. 4-12-30, Much better. Itching dermatitis of back. No dyspnea, not irrational, breathes easily. 4-13-30, Thoracentesis, right 350, left 150. Fluid thick. Experienced some relief following removal of same. 4-15-30, Complains of noise, inclined to be emotional. Dyspnea and some increase in pallor. 4-16-30, Blood culture shows short chain streptococci, positive at end of 18 days. 4-18-30, Thoracentesis, 1000 cc. from both sides, 350 from left and 600 from right. 4-22-30, Has suddenly turned worse, marked crocyanosis, extremities cold and clammy. Respirations rapid, gasping, and pulse thready, moribund. Exitus 4-23-30 at 8:25 S. M.

Laboratory: Occasional finding of sugar in urine, occasional trace of albumen. Sediment - occasional finding of rbc. Entrance - hemoglobin 65, rbc. 3.07, wbc. 10.550, P. 76, L. 23, B. 1. B.U.N. 14.93. Sugar .093. Pleural fluid, 4-2-30, large gram positive diplococci and many staphylococci. 4-3-30, Hemoglobin 54, wbc. 16.400. 4-7-30, Pleural culture - few long chains of streptococci and many B. coli. 4-16-30, Pleural culture contains many gram positive cocci in pairs and occasionally 3 or 4 probably streptococci and some staphylococci. 4-22-30, Hemoglobin 65, wbc. 19.950. X-ray, 3-27-30, single chest, bedside, cardiac enlargement, pulmonary congestion, probable pleural effusion, left base, probable beginning lobar pneumonia, right lower. 4-17-30, Diffusely dilated heart, bilateral pleural effusion. Eye grounds - normal fundi. 3-31-30. Blood pressure average systolic 100, average diastolic 60.

Therapy: Morphine sulphate, digitan, sodium salicylates, cinchophen, digitan ampoules, restricted fluids, S. S. enema, continuous ice cap to cardiac region, luminal, cascara, proctoclysis, forced fluids, high caloric diet, sodium bicarbonate, tap water enema, glucose proctoclysis, pituitrin, allonal, caffeine

Sodium benzoate, coddoine sulphate, calomine lotion, rectal tube, applications of heat, adronalin, artificial respiration.

Temperature: Septic type, 98 to 101. Pulse 90 to 130. Respirations 20 to 44.

DIAGNOSES:

1. Acute rheumatic endocarditis, mitral and aortic
2. Old aortic valve defect
3. Acute sero-fibrinous pericarditis
4. Recent adhesions of pericardium
5. Bilateral hemothorax
6. Passive congestion of liver and spleen
7. Fatty metamorphosis of liver
8. Pulmonary stelectasis
9. Adenoma of liver
10. Slight edema of ankles
11. Cloudy swelling of kidneys