STAFF CONFERENCE

Thursday - May 15, 1930

CASE I.

ADENOMATOUS GOITER WITH HYPERTHYROIDISM.

The case is that of a woman, 47 years old, admitted to the University Hospital 4-5-30 and died 4-10-30 (5 days). Chief complaints - nervousness, gastric distress, palpitation of heart, easy fatigue. In 1914, patient noticed she had a goiter. Except for enlargement had no symptoms. Treated externally by a physician and apparently the gland became smaller. In 1924, ten years later, patient began to experience trouble with her digestion (oranges, pickles, apples), being troubled with gas and mild pain over the lower epigastrium. Relief by eating, although no definite relation to food, and by alkali. About three years ago, patient's gland began to enlarge again, and at the same time the food distress became worse. Eight months ago, she became nervous and had palpitation upon working hard. Sweat considerably, tired easily. Weight loss 6 lbs. in 7 months, although appetite was good. Was taking Lugol's solution about one month. She became much less nervous and her heart seemed to be normal. Other complaints - weakness of eyes, posterior nasal discharge two years, dental caries (upper plate), dyspnea six months, varicosities of lower extremities, irregular menstruation three or four months. Family history negative. Occupation housewife. Married 27 years, 2 children living and well.

Physical examination: Fairly well nourished and developed female, sitting up in chair, apparently eager to be doing something. Skin warm and moist. No suggestive eye signs except slight lid lag. Dental caries, upper plate. Tonsils moderately enlarged. Enlargement of thyroid gland, particularly to the left, a large solid smooth growth. Few small nodules palpable about 7 to 8 times normal size. Pulsations felt, no thrill, chest negative. Heart - loud tones, no murmurs, regular, not enlarged. Blood pressure 160/80. Abdomen negative. Fine tremor of hands. Varicosities of left leg. Reflexes normal. Pelvic examination - relaxed floor, moderate mucoid discharge, moderate cystocele, second degree retroversion, lacerated cervix, chronic cervicitis, adnexa negative.

Laboratory: Urine negative. Hemoglobin 74, rbc. 4.43, wbc. 5.750, P. 66, L. 33, M. 1, group 4. B. M. R., 3-24-30, plus 44. Blood Wassermann negative. X-ray examination, 4-10-30, 6' chest plate - cardiac enlargement, left ventricular type, first stage; deviation of trachea to right; calcification of cervical glands, right.

Prepared for operation with Lugol's, minims. 10 t.i.d. High collar incision almost straight. 4-10-30, time 1 hr. 10 min. Gland enlarged 4 or 5 times normal size, contained large cysts. Right lobe contained 2 or 3 small adenomata, measuring about 1 cm. in diameter. One on the left side, about 5 cm. in diameter. Superior pole isolated, doubly clamped, and triply ligated. Capsule of thyroid clamped around it s margins, clamping the vessels, and the thyroid excised between clamps. All bleeding points clamped and ligated. Right lobe removed in similar manner, but due to its smallness was much more easily accessible. Prethyroid muscles resutured in midline. Platysma sutured and skin approximated with skin clips. Returned to room 12:10 P. M. semiconscious.

Preoperative preparation: Lugols, M. 40, 8:00 P. M.; luminal, grain 2; amytol, grain 6; morphine sulphate; atropine sulphate; retention enema, 1000 cc.; 60 M. Lugol's.

3:50 P. M., Patient suddenly became cyanotic. Dressings removed. Clips removed. Laryngotomy tube inserted. Respiration ceased. Artificial respiration. Exitus 4:15 P. M.

Diagnoses: (1) Adenomatous goiter with hyperthyroidism, (2) Partial absence of thyroid, (3) Thyroidectomy wound, (4) Tracheotomy, (5) Hemorrhage in superior mediastinum and thyroid fossa, (6) Edema of vocal cords, (7) Old operation scar, (8) Absence of appendix, (9) Adhesions of omentum to abdominal scar,

(10) Congestion of spleen, (11) Chronic cholecystitis and lithiasis, (12) Chronic cervicitis, (13) Cystic ovaries, (14) Myomata of uterus.

CASE II.

INTUSSUSCEPTION.

The case is that of a baby boy, 9 months old, admitted to the University Hospital April 2nd, 6:25 P. M., and died April 3rd, 5:00 A. M. Had been perfectly well up until 4-1-30, 9 P. M., when he was seized with sudden crying spell, doubled up, and appeared quite ill. At 11 P. M. passed a bloody stool. Had no normal bowel movement since, but has been passing blood by rectum. Vomited shortly afterwards and again about five hours ago. None since. Before admission, baby appeared quite ill, and at frequent intervals was seized with severe crying spells and extreme restlessness.

Physical examination: Well developed, well nourished, quite ill baby boy. Slight redness of throat. Numerous coarse rhonchi through chest. Note: baby had upper respiratory infection for several days prior to illness. Abdomen - no rigidity, mass definitely palpable in left lower quadrant. Rectal examination revealed mass at end of examining finger, which is apparently invaginated bowel, blood on withdrawal of the finger.

Laboratory: Urine negative. Hemoglobin 85, wbc. 10.900. Blood group - father, mother, patient group 4. X-ray (4-2-30) - marked distension of small bowel is shown with gas throughout its extent. Numerous fluid levels could also be made out in upright and inverted positions. No apparent distension of colon or rectum. Conclusions: Intestinal obstruction with gas distension. Barium enema attempted. Barium seemed to enter rectum, fill ampulla, and from that point no further barium could be seen, the rest being expelled as fast as given. Gentle manipulation over the mass allowed some barium to permeate further up the bowel toward the splenic flexure. No further attempt at reduction.

To operating room 10:05 P. M.; returned 11:00 P. M. Under spinal anesthesia, left lower rectus incision made and mass palpated through the abdomen was found to be ileum which had intussuscepted into the colon and traversed the entire colon from cecum around to anus. Reduced easily except near cecum where slight difficulty encountered. At this point, bowel was hemorrhagic and gave evidence of impairment of nutrition. Abdomen closed in layers. Child taken back to bed, where subcutaneous saline was given, 450 cc. preoperatively, 600 cc. postoperatively.

4-3-30, 1:30 A. M., Condition appeared poor. Pulse imperceptible. Respirations rapid. Temperature 107.8.

Therapy: Caffeine sodium benzoate, adrenalin, adrenalin injections into heart, hypodermoclysis, became very cyanotic, respirations were labored, artificial respirations used, pulse and respirations ceased.

DIAGNOSES: (1) Intussusception, (2) Operation wound, (3) Slight hemoperitoneum, (4) Puncture wounds, (5) Upper respiratory infection (clinical).

CASE III.

LITTLE'S DISEASE.

The case is that of a 3 year old boy, admitted to the University Hospital 4-9-30 and died 4-12-30 (3 days). He had never been well. Was a premature baby. No history of birth trauma, but baby never developed in normal manner. Three years of age, never sat up nor held its head up. About one month before admission to hospital had an attack of diarrhea and vomiting, lasting several weeks. Then developed a persistent brassy cough with fever (103) and marked weight loss. Mother stated the labor was 4 hours. The weight of the infant 5-1/2 lbs. Sixth child. Breast fed entirely for 9 months. Parents thought that the child did not sit up at the usual time because of prematurity. At 1 yr. of age had bronchitis and possibly pneumonia. Parents were told at this time that the child was subnormal as a result of birth injury. Recovered from this respiratory infection in about 2 wks. Was fed cow's milk, potatoes, cereals, vegetables, eggs after weaning. Always has had a poor appetite. Gradually put on general diet, but bottle feeding retained three or four times a day. Patient has never made any voluntary motions. Has never talked, but apparently sees and hears. Mother

thinks that child understands simple statements. All of the other children in the family are well. Father 37, mother 35.

Physical examination: Patient is defective emaciated child. When stimulated, starts a paroxysm of coughing and wails in a peculiar manner. Head large. Small lower jaw. Thin face with senile appearance. Pupils dilated, do not react to light. Dentition normal. Throat, no redness. Muscles of neck are prominent. Skin pale, apparently no subcutaneous fat. No glandular adenopathy. Chest - flaring of lower ribs, moderate fine crackling rales over entire right lung anterior and posteriorly, dullness to percussion at angle of scapulae, left side negative. Abdomen - thin, Back negative. Extremities - upper very thin, muscles stand out like an adult; left hand is held in claw position; right hand is less spastic; knees are adducted and inwardly rotated, very emaciated and spastic. Babinskis negative. Knee jerks and Achille's positive.

Laboratory: Hemoglobin 44, rbc. 3.63, wbc. 9.420, P. 60, L. 38, M. 2. 4-9-30, Chest plates and skull. Skull is turricephalic type. Cranial fossae are extremely deep. Chest shows diffuse mottling throughout both lungs. Impossible, however, to get good definition because of rapidity of breathing. Suggestion - capillary pneumonia or miliary tuberculosis. Suggest reexamination.

Placed on a diet of milk and cereal, egg yolk, forced fluids, enemas of glucose. Condition grew progressively worse and death occurred.

DIAGNOSES: (1) Little's Disease (spastic paraplegia), (2) Malformation of skull (turricephaly), (3) Emaciation, (4) Probable bronchitis.

CASE IV.

PREMATURITY, BIRTH TRAUMA.

Mother's history: Mrs. [redacted] ([redacted] & [redacted]) first admitted 3-12-30, discharged 3-16-30 (4 days). Chief complaints - pregnancy about 7 calendar months. Did not show she was pregnant until October, 1929. Irregular menstrual periods at beginning. Came to Dispensary in October because of cessation of menses and was told to return as no definite diagnosis could be made. Came back in a month, and at that time was told that she was 6 weeks pregnant. Did not come back until the latter part of February, 1930, when she was told that she was larger than she should be for the length of gestation and that it might be twins. On day of admission, while straining at stool, bag of water ruptured. Had no pains at the time but came to the dispensary at once, and she was sent to the hospital. Complaints - 1st trimester none; 2nd trimester - epistaxis, spots in front of her eyes for about 3 wks., noticeable only when patient bent over, felt life in December, 1929; 3rd trimester, - nausea following meals, shortness of breath, pitting edema of ankles. Gave birth to normal female infant December 28, 1922, uneventful pregnancy and post partum. In labor 10 hours at the time. Mother is one of twins. Had rheumatic fever at 17 years, and has been nervous since. Recent respiratory infection (2 weeks). Pleurisy about 1 year ago. X-ray of chest 1920 negative. Hemorrhoids in 1923. Erythema nodosum 1920.

Physical examination: Head and neck negative. Chest negative. Heart no abnormality. Blood pressure 118/80. Examination of abdomen revealed head palpable and movable in fundus in midline, another head at pelvic inlet soft parts on both sides. Fetal heart heard left lower quadrant and right upper quadrant, rates 150 and 140. Extremities - few varicosities. X-ray reveals twin pregnancy, one vertex, one breech.

Was given morphine sulphate, gr. 1/4; chloral hydrate, gr. 30; atropine, gr. 100; elixir turpine hydrate; mineral oil, and sent home on the fourth day.

Readmitted 4-1-30, discharged 4-11-30. Since leaving the hospital patient felt fine except for a slight gastric distress, pain in region of right scapula and shoulders, frequent urination, and heavy feeling in pelvis, edema of left leg, and slight headaches. Entered hospital 4-1-30, 7:00 A. M. Labor pains started at 5 A. M. Baby girl delivered at 8:56 A. M., boy at 9:15 A. M., placenta 9:17 A.M. Position O. L. A.

Put in premature basket. Respiration regular. Color fair. Considerable mucous. 9:45 A. M., respirations loud and rather labored. Color poor. Left side of face and arms showed subcutaneous hemorrhages. 10:00 A. M., respirations

spasmodic, artificial respiration and oxygen given. 10:45 A. M. baby expired.

DIAGNOSES: (1) Prematurity, (2) Birth trauma, (3) Laceration and hemorrhages of tentorium, (4) Congestion and edema of pia-arachnoid, (5) Partial pulmonary atelectasis, (6) Congestion of viscera, (7) Hemorrhages of liver and epicardium, (8) Puncture wounds.

CASE V.

PREMATURITY, BIRTH TRAUMA.

History same as Case IV.

Following delivery, put in premature basket. Breathing fairly good. Color poor. Stopped breathing at 9:00 A. M. Gives an occasional labored gasp. Given oxygen. Heart still beating. Does not breath, color poor. 10:00 A. M. condition apparently the same. 10:15 A. M., baby expired.

DIAGNOSES: (1) Prematurity, 7-1/2 months, (2) Probable birth trauma, (3) Hemorrhages of falx and tentorium, (4) Congestion and edema of pia-arachnoid, (5) Partial pulmonary atelectasis, (6) Congestion of viscera.