STAFF CONFERENCE

Thursday - May 30, 1930

CASE I

1. Differantial diagnosis of alcoholism and cerebral injury
2. Differntial diagnosis and localization of cerebral injury.
3. Diagnosis and treatment of secondary hemorrhage
4. Surgical rating: (a) preoperative condition (b) preoperative diagnosis (c) Choice of treatment

The case is that of a man, 69 years old, admitted to the University Hospital 5-18-30 and died 5-19-30 at 1:00 P.M. Admitted about 10 P.M, with information that he had been struck by a car while crossing the street and thrown several feet, landing on his head. Patient clear mentally for 5 to 7 hours afterward, then became unconscious and has remained so ever since.

Examination in Admission Room revealed elderly man, unconscious, stertorous bre thing, superficial bruises about side of face, chin, right arm, and knee. Pupils fixed and small, right slightly larger than left. Slow movement of eyeballs from right to left (bilateral). Ear drums normal. Tongue dry. Moist rales in upper right chest. Blood pressure 110/70. Heart sounds slow and regular, fairly good, Abdomen soft, Bladder empty. Patient has urinary incontinence. Right arm shows moderate spasticity; left flaccid. Knee jerks present. Bilateral Babinski most pronounced on left.

Impression: Skull fracture with cerebral hemorrhage.

Neurological examination by Dr. J.C. McKinley revealed patient unconscious with stertorous breathing. At times breathes quietly. Only right disc could be seen because of eye movements and probably also because of cataract of left. Left pupil is smaller. Right disc shows papilloedema of about 2 diopters. Patient lies with eyes closed. Has external strabismus. Pupils are nearly normal in size although the right is definitely the larger and both are irregular. No definite paralysis. The right arm and both legs are definitely hypertonic. Marked muscular twitchings in both biceps, brachii muscles. History and findings suggest subdural hemorrhage. The findings show widespread central nervous system injury with somewhat greater likelihood of more injury in the left hemisphere than the right. Suggest left subtemporal decompression, and if nothing is found an opening on the right side.

Other findings were hemorrhage in membrane of right ear drum without rupture.

Patient sent to operating room 10 P.M. Bilateral parietal decompression was done. Diffuse hemorrhage found. No localized clots.

X-Ray shows fracture of right parietal region.

Medication: Spinal puncture (bloody fluid)-, Proctoclysis.

Nurses' notes; Returned from operatingroom unconscious. Cheyne-Stokes respiration, pulse slow and irregular, temperature 102,8, pulse 60, respirations 30. External heat applied. Noisy breathing, Condition remained unchanged for a time but still unconscious. Involuntary urination. Chokes and coughs when trying to swallow, Pulse became full and bounding. Breathing again stertorous and face highly flushed. Exitus.

Temperature 103 average.

Diagnoses:

1. Skull fracture, right parietal, due to auto accident

2. Diffuse subdural hemorrhage
3. Traumatic hemorrhage and softening of right frontal lobe.
4. Operation wounds.
5. Multiple superfinial abrasions and ecchymoses
6. Pulmonary congestion and edoma
7. Congestion of viscera
8. Chronic cholecystitis and lithiasis
9. Solitary cyst of kidney
10. Ganglion of right foot
11. Generalized arteriosclerosis
12. Fracture and separation of anterior portion of lower 8th and 9th ribs.

CASE II.

1. "Acute abdomen" two weeks
2. Differential diagnosis of bowel obstruction
3. Faulty history of past abdominal disease
4. Reference to service
5. Value of strong pulse in differential diagnosis of upper abdominal disease?
6. Localization of maximun - Point of Pain
7. X-ray diagnosis of free gas
8. Friable bowel at operation
9. Trochar puncture wound of bladder (pus)
10. Surgical rating: (a) Preoperative condition (b) preoperative diagnosis (c) Choice of treatment

The case is that of a man, 54 years old, admitted to the University Hospital 5-18-30, died 5-24-30 (6 days). Came to the hospital with history of acute illness for 2 weeks. On day preceding had a little "moonshine". About noon the next day seized with cramps in abdomen and vomited. Physician called who suspected bowel obstruction (intussusception) but succeeded in getting bowel movement by enema. Patient had continued to have pain and vomiting. For the past three days has retained no food. Stool and vomitus have been green. Morphine sulphate has been given five times, last time day of admission. Patient has lost considerable weight in past month and was feeling quite miserable for two weeks preceding present illness. For twenty-five years has had attacks simulatin gallbladder trouble. Attacks precipitated by acids not fat. Fat has always been well tolerated. Has had none of these attacks for twenty years. Was said to have been jaundiced ten years ago. Also states that urine has not been flowing freely the last few days.

Physical examination: Pale emaciated male, partially under the influence of morphine, acutely ill. Abdomen distended and tender. Tenderness more marked over McBurney's point. Bladder distended. Rectal examination shows hard prostate and mass in culdesac. Crepitus over McBurney's point.

History suggests peritoneal inflammation (1 week). No history of constipation which precludes diverticulitis. Pulse fairly strong. Suggested as a finding against upper abdominal disease. Catherization tried on admission; did not succeed because of obstruction in region of prostate. Patient passed about 200 cc. afterward. Hard abdomen. Visible veins. Marked dehydration, Skin dry.

Laboratory: Urine - albumen 1 plus, very many wbc., few rbc. Hemoglobin 78, rbc. 3.85, wbc. 12,400, P. 66, L. 12, M.4, myelocytes 4, metamyelocytes 14. B U N 44.8. X-ray - abdomen, 5-20-30, distension of bowel on left side of abdomen, but most of this probably represents colon, one distended loop in left upper quadrant which has theappearance of small intestine. In

lateral view the accummulation of gas can be made out close to anterior body wall. This may represent either free gas or possibly some in bowel. The former seems more likely.

Operation 5-19-30, 8:40 P.M. Sent to operating room 10:50, returned 11:20. Modified McBurney's incision made. Free pus and gas found. Perforation of loop of ileum uncovered. Drain put in right gutter, pelvis, abdominal cavity; and catheter put in loop of ileum. Preoperative complaint, nurses' notes - general weakness and pain in abdomen, emesis, morphine sulphate. Patient complains of pain in right side under ribs, nauseated, small emesis, very weak, did not void, complains of pain inside abdomen, feels very nauseated, vomited, pyramidon. Postoperative - 10% glucose intravenously, hypodermoclysis, emesis continued, voided, says he feels better than before operation, hypodermoclysis, intravenous saline, morphine sulphate, intravenous glucose, feels very weak, emesis, to operating room 5-20-30 at 12:30 P.M., pulse rapid, perspiring profusely, hypodermoclysis 5-21-30, foul serous drainage on dressing, none through tube, involuntary defaction, nausea and vomiting, hypodermoclysis 5-22-30, intravenous and subcataneous fluids, liquid stool, diffuse foul drainage, feels very weak, 5-23 continue with steam inahlation, intravenous fluids, feels very week, says he feels fairly well, no drainage through tube, many liquid stools, caffeine sodium benzoate, growing weak, pulse imperceptible, exitus 5-24-30, 11:40 P.M. Temperature 98 to 101. Pulse 80 to 130. Respirations 16 to 32. Fluid intake 2875, 2500, 3250, 3900, 2400, Output 675, 1000, 600, 1500, ?.

Diagnoses:

1. Perforated duodenal ulcer
2. Generalized ifbrinopurulent peritonitis
3. Subdiaphragmatic abscess
4. Operation wounds
5. Ileostomy
6. Emaciation
7. Acute bronchopneumonia
8. Cloudy swelling heart, liver, and kidneys
9. Slight pleuritis, right
10. Acute splenitis
11. Multiple puncture wounds

CASE III

1. "Acute abdomen" four days
2. Delay by patient
3. Prompt reference by referring physician
4. Operation delay due to getting permission from parents
5. Localization of maximum pain
6. Surgical rating: (a) preoperative risk (b) preoperative diagnosis (c) choice of treatment

The case is that of a 16 year old boy, admitted to the University Hospital 5-10-30, died 5-14-30, 1:45 A.M. (4 days). On the evening of 5-6-30, patient had a fairly good evening meal, following which he felt a vague discomfort across the lower portion of the abdomen but gave it no special attention. He went to bed andwas awakened in the middle of the night with rather severe pain in the abdomen. 5-7-30, in the morning, he ate some oatmeal for breakfast but promptly vomited it up. He dragged about his chores during the day and ate lunch but vomited as well. Developed diarrhea and ate no evening meal. Could not sleep that night. Onthe next day, 5-8-30, ate breakfast with the usual result. Left work about 9 A.M. and went home. Stayed around the house and gave himself an enema without

results. Ate nothing the remainder of the day except a glass of milk at noon which was promptly vomited. During all this time he had no definite localizing tendency for the pain, but it was mostly in the lower abdomen and seemed to be somewhat more severe on the left. Was very uncomfortable during the night, 5-8-30, and could not sleep. Called a physician 5-9-30, who made a diagnosis of probable ruptured appendix with generalized peritonitis and advised operation. Patient brought to hospital by a physician 5-10-30, 7 A.M. Patient had been given morphine sulphate before the trip.

Physical examination: Temperature 100.2, face flushed, rather ill. Abdomen - rigidity on both right and left sides, tenderness over both lower quadrants, rebound tenderness present, findings slightly more marked on right side. Tenderness marked per rectum on right side, none on left. Large bulging, tender mass on right side. Examination otherwise negative.

Laboratory: Urine negative. Hemoglobin 100, wbc. 13.100, P. 85, L. 15, group 2.

Operation 5-11-30, Abdomen tense and tender, slightly distended, no vomiting. Profuse drainage from wound. Area of tenderness on right side only. 5-12-30, Started vomiting late yesterday evening, getting up considerable black material. Given lavage last night and again this morning. Pulse very rapid and weak. Abdomen tender. Temperature 102. Condition fair. Condition grew worse during the day. Respirations 54. Pulse 150. Temperature 102.4. Blood pressure 124/94. Given instravenous glucose, oxygen tent. Chest, however, is clear, but respirations are rapid and shallow. Condition serious, 5-13-30, Rales in right base. Respirations slower but still labored. Condition the same. Later in the day, pulse thready, irrational, respirations very labored. Rales in both chests, more numerous on right. Very restless, noisy. Condition poor. Exitus 5-14-30.

Pulse 90 to 160. Temperature 98.6 to 108. Respirations 20 to 40. Intake 4500, 3000, 2580, 2000. Output ?, 1000, 1212, ?.

Medication: Morphine sulphate, atropine sulphate, digalen, caffeine sodium benzoate, hypodermoclysis, intravenous saline, hyperventilation, gastric lavage, intravenous glucose.

Diagnoses:

1. Acute gangrenous appendicitis (perforation)
2. Absence of appendix
3. Appendectomy wound
4. Acute fibrinopurulent peritonitis
5. Ileus
6. Acute bronchopneumonia
7. Infarct of right base
8. Cloudy swelling of heart, liver, and kidneys
9. Acute splenitis
10. Puncture wounds
11. Postmortem erosion of esophagus

CASE IV.

1. Inability to convince patient of proper type of treatment
2. Progress of disease under Lugol's
3. Development of heart failure
4. Note on laboratory sheet of the source of glycosuria
5. Finding of calcified nodule in right upper lobe in patient with family history of bronchitis.
6. Marked temporary improvement under digitalis and Lugol therapy
7. Presence of cardiac complication
8. Question of ligation - X-ray treatemtn

The case is that of a woman, 58 years old, first admitted to the University Hospital 8-17-29, discharged 8-18-29 against medical advice, stay 1 day. First admission: Chief complaints - nervousness, ease of fatigue, palpitation (2 months). swelling in neck (10 yrs). Patient has typical toxic adenomatous goiter. Says she has no one to take care of her at home. Has been on Lugol's solution about 2 weeks. She was informed by the doctor who sent her to the hospital that she would be cured without operation. On being informed that this was the only means of cure, she refused to stay and insisted on going home. Seen by surgical staff who could not convince her to the contrary.

Readmission 5-7-30, died 5-24-30 (17 days). Chief complaints - extreme nervousness (1Yr.), edema of extremities (1 Mo.), lump in neck, extreme ease of fatigue. On former admission, B. M. R. was plus 56. Did not feel badly after leaving the hospital until the first part of December, 1929, when she went to the General Hospital and was told that she needed an operation, which she again refused. Took medicine from private physician for a time for relief of swelling of legs which was becoming worse. Cardiac condition, nervousness became steadily worse until two weeks ago when she came to this hospital. Lost considerable weight since leaving institution, 145 to 98 lbs., lost 47 lbs. since August 1929. General health prior to present condition good. Chief diseases - infantile paralysis (age 5) lameness in left leg, scarlet fever, measles, pertussis when child, pneumonia (18 years.). No family history of malignancy. Other complaints - occasional frontal headaches, occasional nose bleed, some interference with breathing, teeth poor, dyspnea and weakness, persistent cough (nonproductive), no precordial pain, definite tachycardia and palpitation, marked edema of extremities (1 yr.), appetite very good but fails to gain weight, constipated, requires physics, slight jaundice many years ago, considerable gas and flat0 ulence. Venereal history negative. Menses 13 years flowed 5 days, 28 day type; menopause at 50. Right leg about 3 inches shorter due to poliomyelitis at 5. No children. Married twice. Father died 61, bronchititis; mother died 30, bronchitis? (tuberculosis?)

Physical examination: Blood pressure 130/86. Thin, emaciated, elderly white female, lying in bed, appears ill, difficulty in breathing, pulsation of neck vessels. Skin, brownish pigmentation over face and body. Very nervous and irritable. Frequent persistent cough. Eyes - no ptosis or exophthalmus. Upper plate, lower teeth in poor condition. Assymetric enlargement of thyroid to right. Vessels of neck prominent and pulsating. Palpable thrill of neck vessels. Tumor, adenomatous mass, palpable just above sternum 2 to 3 cm. in diameter, another mass lies laterally just posterior to sternomastoid muscle. Skin not adherent. No thrill or bruit over gland. Chest - inspiratory retraction of third left interspace. Heart - slight enlargement to left, no palpable thrill, irregular numerous extrasystoles, pulse deficit, systolic murmur at apex and aortic area (auricular fibrillation), few moist rales in bases of lungs. Abdomen marked distended with gas. Passes considerable gas by bowel. Irregular pigmentation of abdomen. Left leg shorter than right, Marked edema of both ankles.

Laboratory: Sugar on three occasions (intravenous glucose?), many wbc., no albumen in urine. Hemoglobin 90, wbc. 16,100, lymphocytes 52, P. 47, M. 1, group 4. X-ray of chest - bilateral pleural effusion, calcified nodule in right upper lobe, cardiac enlargement (type undetermined), possible pericardial effusion. Diagnosis indeterminate.

Progress notes: 5-8-30, Nervous and excitable to the point of being irrational, very disturbing, out of bed and mumbling and complaining, talking of leaving etc., given amytal. 5-9-30, Condition worse, apparently suffering from auricular fibrillation, blood pressure 138/84, pulse 176, very uncooperative.

5-11-30, Put in oxygen tent with slight improvement, but soon became restless, restraints required, edema increasing in abdomen, about the same in legs, respiration less labored, heart rate about the same, fibrillation continuous, put on serious, consultation with medicine, diagnosis toxic adenoma, probable crisis, auricular fibrillation, advise doses of Lugol's per rectum, digitalen and digitalis intramuscularly, should receive equivalent of 4 cc. of tincture digitalis daily for at least two days, consultation with dermatology, depigmented areas are vitiligo, condition has no relationship to thyroid disorder, fine rash over body may be iodine erruption. 5-21-30, Apparently improved up until yesterday when she again seemed more restless and mentally cloudy. Today heart seems more irregular, but her mental condition is worse. Edema improved. 5-22-30, Was progressing quite favorably until 5-20-30 when she became mentally cloudy again. Developed Cheyne-Stokes respiration, pulse of variable magnitude, stimulants were used including oxygen tent. Sodium bromides were given by rectum. Seemed slightly improved, and this evening is still irrational. Respirations are more regular. Condition grew progressively worse and exitus occurred 5-24-30 at 6:35 P.M.

Medication: Amytal, Lugol's, tincture of digitalis, allonal, morphine sulphate, digitan, caffeine sodium benzoate, homocaffeince, sodium bromides, hyperventilation, steam inhalation, oxygen tent, intravenous 10% glucose, ice bags, to heart, boric ointment to lips, proctoclysis, glucose and Lugol's, nasal gavage. Temperature 97 to 100.6, terminal rise to 102.4, pulse varied from 90 to 170. Respiration 20 to 68.

Diagnoses:

1. Adenomatous goiter (toxic-clinical)
2. Cardiac hypertrophy and dilation
3. Myocardial fibtosis
4. Infarct of lung
5. Hydrothorax and hydropericardium
6. Anasarca
7. Passive congestion
8. Decubitus ulceration
9. Peritoneal adhesions
10. Right pleuritis
11. Erosion of cervix
12. Myoma of uterus
13. Deformity of left leg (poliumyelitis)
14. Emaciation

COMMENT

One of our visitors last week stated that the University Hospital was the most improved institution he had visited in this country.

TRIPS

Fort Worth, Texas (Clinical Day); Oklahoma City; St. Louis, Missouri
Purpose - to deliver talks on "Recent Advances in our Knowledge of Malignancy" (Serious) and to give after dinner addresses (quackery), also to advertise coming Kidney Symposium at University of Minnesota.

MEETING

At Faribault, Minnesota, June 2nd, last of five scheduled appearances of University of Minnesota Hospital team on Obstetrics, Malignancy, and your Hospital.

PROPOSED

Dinner for graduating class at University $H_o$spitals dining rooms week of graduating exercises (complimentary).

SUMMER

New schedule announced for months of June, July, August, and September. Next meeting of staff to be held Thursday, June 5th, one week from today; no meeting June 12th; next regular meeting Thursday, June 19th. If you forget the date, watch for announcement in Staff, Room ask our Secretqry, Miss Gertrude Gunn, or mark the date on your own calendar, Proposed dates for July - the 3rd, 17th, and 31st.

CANCELLED

No clinical pathological conference on Friday in Todd Amphitheater during summer months.

GRADUATES

Fourteen graduates in Medical Technology with B.S. degree given by Medical School, three at end of summer session - largest class. Curriculum - English, scientific Franch or German, zoology, physics, general inorganic, qulaitative, quantitative, organic chemistry, sociology, psychology, histology, hematology, parasitology, general bacteriology, special bacteriology, immunity, physiology, physiological chemistry, patholo ical chemistry, preventive medicine and public health, minimum of three quarters spent in laboratory, including one full quarter in X-ray technique. All graduates have positions; demand greater than supply. University of Minnesota first and apparently the only school to give a regular course.