STAFF CONFERENCE

University Hospitals - Thursday, October 2, 1930

CASE I

HYPERNEPHROMA

The case is that of a white male 55 years of age admitted to the University Hospital 7/7/30 and died on 9/17/30. At the time of admission the patient complained of pain in the epigastrium, anorexia, loss in weight and weakness. The patient stated that the pain had been present since April 1930 and it was of a boring character and radiated to the back. There was also some radiation to the upper portion of the abdomen and the pain occurred both at day and at night. Pain was increased by food and worse when lying on the right side. The patient stated that he had lost about 25 lbs. since the winter of 1929. He also stated that the condition of weakness was gradually increasing since April 1930. The gastro-intestinal complaints have no relation to food. The patient's past history, marital history, family history are all essentially negative. Patient was a farmer. Physical examination revealed a well built, fairly well nourished man complaining of pain and weakness. Patient seemed to show some mental dullness. Physical examination was essentially negative until the chest was examined when there was noticed to be an increase in vocal fremitus and whispered voice over both apices. There was also dullness over both apices extending down to the lower border of the 2nd rib anteriorly and on ascultation increased whispered voice over both of these areas with bronchial breathing and fine crepitant rales over the left apex. There were also some of these findings over the right apex. Examination of the heart was essentially negative. The blood pressure was 115/70. Examination of the abdomen revealed a slightly palpable liver and a mass in the left upper quadrant extending to the midline and down to the level of the umbilicus. It was stated that the mass did not move with respiration. Muscles of the abdomen over thisarea were slightly rigid. The vertebral column was negative. Remaining physical examination was negative.

Laboratory: Blood 7/8/30 Hb. 67%, RBcs 3,630,000. WBcs 12,250, P 73, L 25, M c. B.U.N. 16.80. Sputum - no acid fast bacilli found. Many repeated examinations for Tbc were negative. P.S.P. 7/22/30 35% first hour, 20% 2nd hour. Blood culture 7/29/30 was negative. Gastric analysis with histamine showed presence of free Hcl before and after histamine. A blood culture 7/24/30 - short chains of large streptococci. Stool essentially negative. 8/27/30 another blood chemistry revealed U.N. 112 and a sodium chloride 660. 9/5/30 Van Slyke 46. P.SP. repeated at this time excretion in ½ hour of 15%, 1 hour 7%, and 1½ hours 5%. 9/8/30 U.N. was down to 24.26 and Van Slyke 43. 9/16/30 Hb. 25%, 2,200,000 RBcs. U Urine 7/11/30 showed spec. gravity 1012, acid, no sugar or albumen, with numerous hyaline casts and few WBcs in sediment. Repeated urine examinations showed consistently this same picture.

X-ray of chest 7/8/30 concluded that there was pulmonary tuberculosis of an incipient and fibroid type. A gastro-intestinal study on 7/9/30 concluded that there was an extra gastric pressure from enlarged liver and spleen. A pyelogram on 7/17/30 concluded that there was probable hypernephroma of the left kidney, possible polycystic kidney on the left, secondary erosion of the upper lumbar spine and secondary distortion of the ureter. 7/24/30 a pyelogram following the injection of uroselectan, demonstrated a deformity previously described. It was noted that the kidney pelvis was fairly normal. 8/6/30 examination of the colon by barium enema showed no evidence of intrinsic pathology, although it was stated that pathology in the region of the splenic flexure could not be entirely ruled out. 8/13/30 Examination of the colon by barium enema concluded

that there was displacement of the colon. Examination of the chest 8/26/30 showed no evidence of metastases. K.U.B. X-ray 9/12/30 showed the right kidney to be apparently normal, but the left kidney shadow could not be definitely made out. There was no definite evidence of stone in urinary tract but erosion of the upper lumbar spine was considered much the same as at the previous examination.

Urography 7/17/30 concluded that the most probable diagnosis was deformity of the kidney with displacement due to pressure from an extra-renal mass.

Medications and procedures: Nose and throat cultures were taken. Vena puncture was perrormed. S.S. enemas were given. 10% glucose intravenously was given. Hypodermoclysis was performed. P.S.P. tests were performed. Normal saline given intravenously. Uroselectan was given intravenously. Gastric expression with histamine performed. Sodium bromides gr. 40 and mineral oil gm 1 were given. 8/9/30 the administration of thymus extract, 1 cc daily, was commenced. The extract given intramuscularly and was continued from this date until the date of exoduc. Further intravenous therapy with 10% glucose and normal saline were given. Hypodermoclysis also repeated. From 9/4/30 until thedate of exodus intravenous therapy of 10% glucose was given almost daily.

Nurses notes: It was noted that the time of admission on 7/7/30 that the patient was not acutely ill but complained of some abdominal distress. 7/9/30 had a slight emesis of 50 cc of dark fluid. 7/10/30 patient felt somewhat nauseated and complained of pain in the lumbar region. 7/11/30 complained of severe pain in the lower abdomen and small of the back. This pain continued until 12/7/30 he stated that it was radiating on both sides. 7/13/30 patient was unable to retain nourishment and had repeated emesis. From this time on the patient complained continually of constant dull pain in the abdomen. 7/17/30 the patient developed diarrhea. From this date until 8/5/30 the patient was fairly comfortable and had no severe upsets except for the constant abdominal pain. However, on 8/5/30 the patient again developed repeated emesis and nausea. 8/10/30 the patient stated that his pain was much relieved and that his feeling of abdominal distention was gone since he had been receiving thymus extract which commenced on 8/9/30. From this date until 8/15/30 the patient did not complain of anything at all, had no complaints of pain, but on 8/15/30 developed an emesis of 500cc of greenish fluid. 8/16/30 the patient again complained of abdominal pain and he contimued to complain of this pain in the abdomen and lower back until the time of exodus and did not again think that the thymus extract given intramuscularly was giving him relief. 8/31/30 patient became very listless and involuntary and had emesis repeatedly. This condition persisted until 9/4/30 when the patient seemed somewhat brighter, the emesis ceased and the patient responded better. The patient then remained fairly comfortable until 9/11/30 when he again developed repeated emesis; During this time the abdominal and back pain had been present constantly. 9/16/30 in the evening the patient became considerably worse and very drowsy and listless. 9/17/30 patient became involuntary and finally did not respond and exodus occurred at 7:15 P.M. on that date.

Progress notes: 7/10/30 it was noted that the patient was complaining of epigastric pains and had an emesis repeatedly during the night. 7/15/30 it was noted that the patient complained of epigastric pain when he ate and that an application for admission to Glen Lake Sanatorium was made. 8/25/30 it was noted that the patient was vomiting frequently and that his fluid intake was insufficient. Also noted that he was then getting thymus extract intramuscularly. 8/27/30 it was noted that the patient was failing rapidly and that he was vomiting continually. 8/30/30 it was noted that the mass in the abdomen was decreased markedly in size but that the patient was practically morbund. On 9/15/30 it was noted that the patient had been in about the same condition for the preceding week but that the urea nitrogen level had dropped to normal following the continuous administration of glucose intravenously and saline subcutaneously. It was also noted that on

ON THIS date the patient had developed edema of the left leg following intravenous glucose into the saphena vein.

DIAGNOSIS:

1. Hypernephroma of the left kidney.
2. Bilateral, cubital and thigh puncture wounds.
3. Old amputation of the phalanges of the right 4th and 5th fingers.
4. Edema of the left lower extremity.
5. Bilateral pleural effusions.
6. Bilateral old apical adhesions.
7. Bilateral posterior hypostatis andpulmonary congestion.
8. Bilateral, pulmonary apical tuberculosis.
9. Metastases by direct extension of the hypernephroma to the jejunum.
10. Abscence of the left adrenal gland.
11. Metastases by direct extension of the hypernephroma to the left psoas muscles.
12. Metastases by direct extension of the hypernephroma to the 1st and 2nd lumbar vertebrae, with erosion of those bones.
13. Metastases by direct extension of the hypernephroma to the inferior vana cava.

CASE II

FRACTURE OF FEMUR.

The case is that of a man 91 years old admitted to the University Hospital 9/5/30 at 3:10 P.M. and died 9/5/30 at 7 P.M. The patient fell 9/4/30 in the morning, hurting left hip. There has been extreme pain since that time, requiring 2 hypodermic injections. Admitted from Dispensary with diagnosis of fracture of femur. Patient is very obese and difficult to examine but pain is present in hip on passive motion and on pressure over the trocanter. Very tender over the left mastoid process. No history or evidence of skull fracture. There was 4 cm shortening, marked eversion, and extreme pain on motion. Patient was irritable and appeared somewhat irrational. The mental condition was difficult to distinguish from reaction to pain. 1/6th grain morphine sulphate given. Taken to operating room where a Whitman single spica cast in abduction and eversion after reduction under local anesthesia was applied. After return on ward appeared narcotized. Gr. 5 caffeine sodium benzoate given at 6:15 P.M. Called to see patient at 6:45 respirations very rapid, 28 a minute. When seen respirations were about 15 a minute and labored. Almost immediately became cyanotic, respirations shallow, and quickly stopped. Patient turned on back, tongue pulled out of mouth, and the pulse was imperceptible. Condition grew rapidly worse, intracardiac adrenalin given, respirations stopped, heart tones were inaudible, artificial respiration attempted. Pronounced dead at 7 P.M.

X-ray examination showed inter-trocanteric fracture of femur. Temperature 97.8, pulse 98 on admission.

DI AGNOSIS:

1. Fracture of femur (intertrocanteric).
2. Reduction (local anesthesia).
3. Obesity.
4. Atelectasis.
5. Pulmonary congestion and edema.
6. Marked ateriosclerosis.
7. Acute splenitis.
8. Cloudy swelling of heart, liver and kidneys.
9. Slight fatty metamorphasis of liver.
10. Hypertrophy of prostate.
11. Varicosity.
12. Pleural adhesions.

CASE III

CHRONIC SUPPURATIVE CERVICITIS

The case is that of a white female 58 years of age admitted to the University Hospital on 9/3/30 and died on 9/7/30. At the time of admission, the admitting officer was unable to obtain a satisfactory history from the patient or the relatives. It was merely stated that the patient had been in good health until the summer of 1930 when she developed a foul vaginal discharge, noticed 6 weeks before admission with an associated increasing weight loss, anorexia and constipation.

Physical examination showed the patient to be an elderly white female in a slightly stuporous condition. The patient was completely edentulous. A small, round, raw area 4 cm in diameter with associated slight serous drainage was noted on the right side of the mandible anteriorly. The remaining physical examination was essentially negative. Vaginal abdominal examination revealed some resistance in both lower quadrants and a marked muco-purulent discharge. Examination of the pelvic floor showed it to be lacerated and relaxed. The cervix seemed small and the corpus could not be definitely palpated. The adnexa were considered negative. Speculum examination revealed a purulent discharge from the cervix with some reddening around the os. A diagnosis of possible malignancy of the corpus was made.

Laboratory: Urine - 9/5/30 spec. gravivy 1026, acid, without sugar, but trace of albumen. Sediment showed many WBcs and occational RBc. 9/5/30 Hemoglobin 104%, WBc 28,100. P 19, L 81. Group IV.

Medications and procedures: Nose andthroat cultures were taken. Vena puncture was performed. Hot potassium permanganate douches 1-5000 cc were given q.i.d. Intravenous therapy of 10% glucose 1000 cc given. Gastric lavage performed. Hypodermoclysis was started. Adrenalin 1cc and caffeine sodium benzoate 2 cc were given.

Nurses notes: At the time of admission it was noted that the patient seemed irrational and very weak. She was involuntary and refused to eat or drink. This condition remained the same until on 9/6/30 the patient had several emesis and seemed much weaker. Respirations became very shallow and the pulse so rapid that the nurse was not able to count it. Later in the day the pulse was imperceptible and the skin cold and moist and hands cyanotic. At 7:48 A.M. on 9/6/30 the patient expired.

Progress notes: 8/5/30 the patient was incontinent. On 9/6/30 there was slight acetone odor to the breath.

DIAGNOSIS:

1. Chronic suppurative cervicitis.
2. Lobar pneumonia.
3. Right pleural adhesions.
4. Right pleural pericardial adhesions.
5. Small right mandibular ulcer.
6. Cholelithiasis.

CASE IV.

SURGICAL TUBERCULOSIS OF KIDNEY

The case is that of a man, 27 years old, who developed pulmonary tuberculosis in 1925 and was treated at the Glen Lake Sanatorium. A diagnosis of bilateral apical pulmonary disease was made. Because of a complaint of bladder symptoms, the urinary tract was investigated, and a positive diagnosis of renal tuberculosis on the right side was made. There was no evidence of involvement on the left side, and an operation was advised but refused. Patient left the sanatorium in

excellent condition, gained in weight and strength and was able to return to his work and marry. About one year ago his health started to fail, and upon examination was found to have a rectal fistula. In a short time he lost 40 lbs. in weight and became very ill. There was no evidence of very marked activity of the pulmonary disease at this time. He developed signs of an abscess in the right renal region which was drained. As the process did not clear up, nephrectomy was again advised and done on September 23rd. Patient's pre-operative condition was good as far as renal function was concerned. His general condition was not good. There was no evidence of involvement of the bladder at this time, and it was assumed that an autonephrectomy had taken place. Patient did not do well following the operation and died rather suddenly, September 27th, at 5:30 P.M.

DIAGNOSIS:

1. Tuberculosis of right kidney.
2. Perinephritic abscess.
3. Operation and drainage wound.
4. Emaciation.
5. Bilateral apical fibroid tuberculosis.
6. Fibrous occlusion of right ureter.
7. Normal bladder.
8. Puncture wounds.
9. Superficial hemorrhages.
10. Acute fibrinopurulent peritonitis.

HELP

The following letter was received from the Minnesota Department of Health, Division of Preventable Diseases, University Campus:

"Enclosed please find laboratory reports No. 4063 - 4067, inclusive, on blood specimens from the newborn. As you will see the reports indicate that the blood was hemolyzed in every instance. All of the above specimens were received September 23. The date of taking the blood specimen was not given on specimen No. 4063. The other specimens were taken respectively on September 14, 17, 11 and 11. "We trust that you will be able to use your persuasive power to have the Wassermann and other specimens submitted promptly to this office for examination."

WELCOME:

Dr. Irvine McQuarrie: Experimental Medicine. Born Utah. Graduate Utah State Normal School 1911. A.B. Utah 1915. Thompson scholar California 1916-18, Ph.D. 1918. Research fellow Hooper Foundation 1918. M.D. John Hopkins 1921. Assistant pathology California 1918-19. Resident House officer Henry Ford Hospital 1921-22. Physician in charge nutritional clinic 1922-24. Pediatrician in chief 1925-26. Instructor pediatrics Yale 1924. Assistant professor, School of Medicine, Rochester, 1926-29. Professor of pediatrics and head of department, University of Minnesota Medical School, 1930.
Contributions: Kidney function, antipyretics and the serum proteins, blood volume, isoagglutination in puerperal eclampsia, hydrogen-ion concentration of spinal fluid, the effect of cod-liver oil on the photographic plate, hemophilia, toxicity of bile, infant nutrition, metabolism in epilepsy. Member American Chemical Society, Society for Experimental Biology and Medicine, American Society of Experimental Pathology, American Pediatric Society, Eastern Society for Pediatric Research, American Society for Clinical Investigation, Fellow American Association for Advancement of Science, American Medical Association.

Dr. Hobart A. Riemann: Clinical and Experimental Medicine. Born Buffalo, New York. Graduate University of Buffalo 1921. Intern Buffalo General Hospital 1921-22. Resident physician, Buffalo General Hospital 1922-23. Assistant in hospital, Rockefeller Institute, 1923-26. Fellow, National Research Council, Pathology and Bacteriology, Prague, 1926-27. Associate Professor of Medicine, Peking Union Medical College, 1927-29. Associate Professor of Medicine, University of Buffalo Medical School, 1929-30. Associate Professor of Medicine, University of Minnesota, 1930. Contributions: Pneumococci, typhys fever, splenomegaly, trachoma, bronchomiliosis. Membership: Society of Experimental Biology and Medicine, American Medical Association, Alpha Omega Alpha, Nu Sigma Nu.