STAFF CONFERENCE

11-13-30.

CASE I.

HYPERTENSION

The case is that of a white male 49 years of age admitted to the University Hospitals on 10-4-30 and died on 10-27-30. At the time of admission the patient complained of 1. nosebleeds, 2. headaches, dizziness, 3. swelling of the legs, 4. defective vision, 5. marked weight loss. Patient stated that 2 years before admission he had occasional nosebleeds. Sometimes they were severe enough to lose a pint of blood at a time. Following the nosebleeds the patient felt relieved. Patient thinks that some of the nosebleeds were due to trauma of the nose. He was seen by a physiclan to stop the hemorrhage at one time. For the preceding 1½ years before admission to the hospital the patient had attacks of dizziness and headaches. These were much relieved by medications. Patient states that he also had swelling of the legs occasionally for the preceding two years. They have never been painful. The whole leg swelled up. He also states that the right lower extremity is swollen most of the time. Patient noticed that he had difficulty in focusing vision since July 1930. For one year preceding admission to the hospital the patient has lost weight, dropping from a weight of 220# to 138#. He attributes this to the fact that he has not been eating well. Patient also noticed that his tongue was dry from 6 - 8 weeks before admission. Gonorrhea 4 - 5 years ago, not treated. Chancre 3 years before admission, antipluetic treatment followed for several months. A history of chronic alcoholism until 2 years before admission to the hospital. Alcohol intake amounted to 4 - 5 bottles of spiked beer daily with occasional glasses of whiskey. in between the bottles of beer. Family history is essentially negative. Occupied as the proprietor of a soft-drink stand and bootlegger.

Physical examination shows slight brownish tinge all over the body. Skin is loose and shows a definite loss of subcutaneous fat. Conjunctiva showed no icteric tinge. Patient was edentulous. Chest is barrel-shaped showing marked emaciation. Systolic cardiac apical murmur, transmitted to the left axilla. Heart enlarged to the left. Examination of the abdomen revealed a solid mass extending 5 cm below the right rib margin which moved on respiration. Patient also presented a right inguinal hernia which was reducable and slight edema of the legs.

Neurological examination showed the knee jerks positive, positive Babinsky on the right. Blood pressure was 162/90. With these findings a staff diagnosis was made of hypertension and cardiac dilatation and hypertrophy, probable cirrhosis, anemia, type undetermined, possible carcinoma of the pancreas, possible lues.

Laboratory: 10-6-30 Hemoglobin 30%, Rbcs. 2,200,000, Wbcs. 5,500, with P 71, L 29. Icterus index same date showed 12 units. Larson and State Board Wassermans were negative. Spinal fluid Wasserman was also negative. 10-7-30 U.N. was 29.4 and on 10-9-30 was 32.67. Examination of the spinal fluid was essentially negative throughout. 10-23-30 B.U.N. was 38.87. Urinalysis on 10-6-30 showed spec. grav. 1010, acid, without sugar or albumen and with very occasional Wbc in the sediment. These findings remained essentially the same until the time of exitus.

A 6' heart on 10-7-30 showed a transverse thoracic of 29, m.l. of 11½, m. r. 7.8, total 19.3. The measurements due to rotation of patient were not entirely accurate. There was a marked enlargement of the heart to right and left and suggesting strongly left ventricular type of cardiac enlargement with generalized dilatation of all cardiac chambers. It was concluded that there was marked cardiac enlargement, probably generalized type and that examination with barium filled esophagus disclosed no displacement posteriorly or from side to side in the region of the left atrium.

Medications and procedures: Nose and throat cultures were taken. Tincture of digitalis 2 cc was given repeatedly. Morphine sulphate gr. ¼ was given repeatedly, as were Hinkle pills 1. Vena puncture was performed, dilated with homatropine 2%.

Luminal gr. 1½ given repeatedly. Gastric expression with histamine was performed. S. S. enemas were given. Ice packs were applied to the nasal and occoiptal region. Aromatic cascara was given. Intravenous therapy of 50% glucose was given.

Nurses notes: the patient was admitted with no complaints. 10-6-30 the patient complained slightly of pain in the lower region of the back. 10-10-30 noted that the patient was out of bed, talking very irrationally. 10-12-30 patient was extremely violent and restraints were applied. Patient refused to eat almost constantly. Patient talked almost continually on various subjects without relation between them. 10-18-30 noted that the patient was involuntary. 10-19-30 tube feeding was instituted. 10-20-30 noted that patient had marked swelling about the left eye. 10-21-30 noted that patient had a marked swelling on the left side of the face. Ice packs were applied to the occipital and nasal regions. Patient had a considerable epitaxis. 10-23-30 slight purulent discharge from the right eye was noted. 10-26-30 noted that respirations were very labored and exitus occurred on 10-27-30 at 6:40 a. m.

Progress notes: 10-13-30 the patient was put in full restraints because of the psychosis. It was considered that the cardiac decompensation on the basis of hypertension might account for the psychosis but would not explain the marked anemia. 10-14-30 a transfer note was made stating that the patient had been very talkative, speaking of disassociated matters and continually refusing food and medications and refusing gastric expression and gastric x-ray. Medical diagnosis on this date was hypertension, cardiac hypertrophy, and dilatation. Cirrhosis of the liver without ascites and a toxic type of anemia.

DIAGNOSIS:

1. Generalized arteriosclerosis.
2. Icterus of the conjunctiva.
3. Edentulous.
4. Midline sacral decubitus ulcer.
5. Cardiac hypertrophy.
6. Myocardial fibrosis.
7. Bilateral pulmonary congestion.
8. Granular pitting of both kidneys.
9. Cerebral arteriosclerosis.
10. Cerebral hemorrhage, left?

CASE II.

CARCINOMA OF THE SIGMOID

The case is that of a woman 76 years old admitted to the University Hospitals 6-21-30 and died 7-24-30 (33 days). The patient was first admitted to the hospital on 1-3-30 complaining of vaginal discharge, diarrhea, weakness, insomnia and loss of appetite. Diarrhea was said to have been of 44 years duration. Weakness became marked one year previous to admission. Vaginal discharge since 1928.

Physical examination revealed perforation of nasal septum. Cervical adenopathy. Boot-shaped heart. Loud systolic murmur, blood pressure 165/60. Localized tenderness in abdomen. Proctoscopic examination was made and biopsy was made of a polypi. Pathological report: benign polyp of colon. Electrocardiogram showed an auricular extra-systolies. Eyeground sclerosis of the right vessels. Blood examination - anemia. X-ray of colon 1-8-30 revealed multiple polyposis. X-ray of heart showed cardiac enlargement. Patient was discharged 1-16-30 with diagnosis of multiple polyposis and possibly hypertension.

Returned 6-21-30 with history of increased weakness, some loss of weight, vaginal discharge. The history shows no c.c. in laboratory report of leukorrhea. No new symptoms except swelling of ankles for about last week. Pain in left side has become worse and is described as being very sore. Patient takes paregoric

constantly for diarrhea.

Physical examination: white-haired, elderly female, bright mentally but very frail, weight about 73 lbs. Blood pressure 140/60. Abdomen slightly distended and tender. Hard, doughy masses, probably fecal in left lower quadrant. The abdomen is distended with gas. Some edema of ankles and feet. Considerable vaginal discharge of watery consistency.

Laboratory: Hemoglobin - 70%, Wbcs 6.90, Rbcs 4.010, p 78, L 22, B.U.N. 9.33. Urine negative.
X-ray 7-8-30 multiple diverticulae are present in colon showing retention at this time. No evidence of obstruction.

Consultation Surgery (OHW) - no vomiting - edema of abdominal wall - mass on left. Patient not willing to permit rectal or vaginal examination.

Impression: Diverticulitis with question of polyposis and superimposed malignancy. Inasmuch as inflammation is the chief feature, a complete diversion of the fecal current is the only procedure that offers anything. In the absence of obstruction, appendecostomy is of little use. Patient doesn't want operation.

Pelvic examination (GMK): contracted senile, external genitalia. No infiltration of abdominal wall. Because of tenderness impossible to make any definite findings. In left pelvis, extending from crest of ilium about 6 cm. is a mass, but it is impossible to make out its borders.

Medication: Aspirin, tincture opii camphorata, bella donna, special diet, saline enema, morphine sulphate, bismuth, subcarbonate, and calcium lactate.

Progress notes: note.

Nurses notes: Continuous watery stools. Eats very little because of distress. Profuse discharge from vagina. Feels very weak, dull headache, very nauseated, pain all over her body, difficulty in breathing, marked abdominal pain. Predicts death 7-12-30. Considerable pain in right thigh. Pain in back and legs. Irrational, chokes on liquids and solids. Developing decubitus, unconscious, cyanosis exitus. Temperature 97 -102, afternoon rises 70 to 130 - respirations 16 - 22. W Weight at exotus 74 lbs.

DIAGNOSIS:

1. Carcinoma of the sigmoid.
2. Perforation, ulceration with transplant in another loop of sigmoid,
3. and peritoneum.
3. Pelvic peritonitis.
4. Psoas abscess.
5. Brown and serous atrophy of the heart.
6. Fatty metamorphasis of liver.
7. Cloudy swelling of heart, liver and kidneys.
8. Atrophy of spleen.
9. Diverticulitis of lower colon.
10. Visceroptosis.
11. Generalized arteriosclerosis.
12. Chronic peritonitis.
13. Chronic cholecystitis and lithiasis.
14. Decubitus.

CASE III.

DIABETES MELLITUS

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The case is that of a white female 39 years of age admitted to the University Hospitals on 10-29-30 and died on 10-31-30. At the time of admission the patient complained of: 1. diabetes mellitus, 2. diarrhea for 3 years. Apparently due to the patient's short stay in the hospital an adequate history was not obtained. Patient was sent in to the hospital by a physician who had been treating her for diabetes mellitus. He also stated that she might have a severe hyperthyroidism or melancholia. At the time of admission the patient did state that she had had a diarrhea for 3 years which was controlled with paregoric, drams 1 q. 3 hours, but that the diarrhea had ceased spontaneously during this summer of 1930.

Physical examination on 10-30-30 by the resident staff showed the patient to be very nervous, respirations were rapid and deep, alternating with slow shallow respirations. Patient was very irritable and unco-operative. Tongue was dry, thyroid was palpable. Blood pressure was 140/60 and the heart rate 150 and regular. There was slight tenderness in the epigastrium, pigmentation over the lower abdomen probably due to hot water bottle application. There was a fine tremor of the hands.

Laboratory: 10-30-30 Urinalysis showed specific gravity 1018, acid reaction, 4 plus sugar and a trace of albumen. Examination of the sediment showed numerous clumps of pus. Acetone and diacetic plus. Examination of a 24 hour specimen on 10-30-30 showed a specific gravity of 1012, acid reaction, 3 plus sugar no albumen and negative sediment. There was no diacetic detected. Blood examination on 10-30-30 showed hemoglobin of 100%, Wbcs 19,250 with a differential of L 12 and P 88. Blood sugar analysis was .38. Van Slyke was 50 volumes %. Consultation: examination of the eyegrounds by the eye service showed beginning lens changes in both eyes, contracted veins and arteries, mottling of the retina, moderate sclerosis, no hemorrhage or exudate noted.

Medications and procedures: Bismuth subnitrate gr. 30 repeatedly, insulin units 20 repeatedly. Orange juice 150 cc. Luminal gr. 1½ repeatedly. Nose and throat cultures taken, vena puncture performed. Gastric lavage performed. Hypodermoclysis commenced. Eyes dilated with homatropine. Insulin, units 25 a.m., units 5 noon, units 15 p.m. Allonal tablets 2, triple bromides gr. 20, per rectum, morphine sulphate gr. 1/6. Intravenous 1,000 cc normal saline. Hot water bottles to abdomen. Caffeine sodium benzoate gr. 7½.

Nurses notes: The patient was admitted on 10-29-30 desiring to be in a private room due to extreme nervousness. The patient was perspiring considerably and crying. On 10-30-30 the patient complained of too much disturbance about the room, cramplike pains in the lower abdomen and she had an emesis of 200 cc of greenish fluid. Later in the day the pulse was rapid and she was complaining of very severe pain in the abdomen and the small of the back. Later in the day on 10-30-30 the patient complained of feeling cold and chilly. She commenced coughing still later in the day, pulse was rapid and weak and respirations were rapid and shallow. 10-31-30 the patient was involuntary, irrational at times, had repeated emesis, became cyanotic, respirations shallow and exitus occurred at 4:25 A.M. 10-31-30.

Progress notes: 10-30-30 at 8 P.M. it was noted that fluids were forced successfully, tongue was moist and general condition was better. Diagnostic impression at this time was made of diabetes mellitus with moderate acidosis, hyperthyroidism possible, chronic diarrhea etiology unknown, and questionable pancreatitis. 10-31-30 it was noted that the patient was complaining considerably of being very sick, and she had repeated emesis and her lips and finger tips were becoming cyanotic and that she was much weaker. Examination of the chest at this time was considered negative. A later physical examination found rales in both bases posteriorly and apparently the possible diagnosis of pulmonary infection was considered

On 10-31-30 a resume in regard to the case stated that the case had been followed by a physician for many years, and that the patient had had a diabetic condition during this time. It was considered that her diabetic range was very slight and that she could be precipitated into acidosis or insulin reaction very easily. Repeated B.M.R.s were made and the findings not given, but apparently on the basis of B.M.R.s a possible diagnosis of hyperthyroidism was ruled out.

DIAGNOSIS:

1. Diabetes mellitus, clinical.
2. Right pleural adhesions.
3. Chronic cystitis.
4. Cystic right ovary.

MORTALITY REPORT OCTOBER, 1930

	Age	Sex	Post
Abscess, pulmonary - left lower lobe	7	M	o
Carcinoma, bladder	71	M	X
Carcinoma, breast with metastases to liver	68	F	X
Carcinoma, onecum	58	M	X
Carcinoma, lung	66	M	X
Carcinoma, maxillary sinus	51	F	X
Carcinoma, ovary	51	F	X
Carcinoma, ovary	40	F	X
Carcinoma, pancreas	49	F	X
Carcinoma, pelvic colon	48	M	X
Carcinoma, pelvic colon	34	F	X
Carcinoma, prostate gland	73	M	X
Carcinoma, stomach	65	M	X
Carcinoma, testicle - left	43	M	X
Carcinoma, tongue	56	M	X
Diabetes mellitus	39	F	X
Embolus, fat to brain, tuberculosis of spine	23	F	0
Endocarditis, bacterial	24	M	X
Gangrene, arteriosclerotic - lower extremity	71	M	X
Glioma, of brain	51	F	X
Hydronephrosis, congenital	9	M	X
Hypertension, arteriosclerosis	49	M	X
Hypertension, myocardial insufficiency	74	M	X
Hypertension, myocardial insufficiency	63	M	X
Hypertension, rheumatic endocarditis	37	F	X
Hypertension, uremia	60	M	0
Lupus erythematosis	24	M	X
Obstruction, intestinal due to herniation	28	F	X
Osteomyelitis, acute	9	M	0
Prolapse uteri, with cystocele, rectocele	40	F	0
Stillbirth	0	F	X
Tumor, brain - frontal lobe	53	M	X

Total deaths - - - - 32
Postmortem - - - - - 27
Percentage - - - - - 84.37%