

CASE I.CARCINOMA OF THE LABIA

The case is that of a white female 52 years old, first seen at the University Hospital Out-patient Department May 16, 1928, died at the University Hospital 11-15-30. First hospital admission 5-18-28 to 6-12-28. Chief complaint: pain in the right side of pelvis radiating down right thigh. About 2½ years ago patient first noticed lump in right labium. Grew very slowly the first 4 months, but rapidly the 5th month. Began to be very tender and she developed a needle-like pain. Was operated on at Eitel hospital two years ago and growth removed. Pathological report - carcinoma. This was followed by radiation (radium). February 1928 went to William's Cancer Institute and no treatment given. Same month there seemed to be an abscess formation on the right leg at the site of a hypodermic injection. This was lanced at St. Mary's Hospital where she remained for 11 days. Tumor has been getting larger since then and pain has increased. Mother died of carcinoma of the uterus. Has not worked for past two years. First noted lump in January 1926, operation in March 1926. No recurrence until December 1926. Radium inserted February 1927, March, April, 1927. Last radium in July 1927.

Physical examination: fairly well developed, nourished female. Mouth in poor condition. Blood pressure 132/68. Right labium is enlarged to about 3 times normal size. Mass is very tender, fairly hard but not ulcerated. Two sinus drainage wounds with pus can be seen in the region. Inguinal glands palpable on both sides, larger on right. Old scar on thigh from abscess. Mass was incised and a small amount of pus escaped. Tissue showed carcinoma. Urine - many WBCs. Hemoglobin 93, WBCs 7700 Wasserman negative. Skin erythema 120% in dose of two treatments in 3 days was given to vulva. 100% to each inguinal region in one treatment each. Returned to hospital 5-7-29 and remained 7 days. Last x-ray treatment given February 8, 1929. Now returning to see if further therapy is indicated. Has been quite well except for burning and pain in vulva. Swelling and tenderness has been worse in this area for the past few months. Still shows infection, otherwise no complaint. Patient was advised to return to Ca. Dispensary. Came to hospital 7-12-29 and left 8-13-29 (32 days). Chief complaint: discharging fistula in perineal region. Examination revealed this to be a fistulous area involving the Bartholin gland on the right side. She also had considerable edema of the vulva in the region of the pubis. Sinus was injected with paste and it was found that it did not go in very far. Patient was discharged with little improvement in her condition. Is now taking codeine sulphate, aspirin and phenacetin, temperature of septic type. Returned 6-21-30 and died 11-15-30 (147 days). No new complaints except dizziness, spots before her eyes, nasal discharge for last 2 months. Chronic cough, swelling of right ankle. Had several attacks of cystitis. Parathesia of left hand. Weight loss 45# in 2½ months.

Physical examination: markedly emaciated in a very short period of time. Seems to be in constant pain. Very foul breath. Has been in bed most of the time before coming here. Vulva lesion has spread gradually until at present is a large craterlike mass about 5-6" in diameter and 2-3" in depth, foul odor. Filled with greyish necrotic material. Now being given morphine sulphate by mouth. Apparently her condition remained about the same except for occasional rise of temperature with same complaints and little change.

Laboratory: Urine shows pus. Hemoglobin 87. Wasserman negative. B.U.N. 10.26. 6-30-30 x-ray showed calcification of left hilum, probably an old tuberculosis. Gradually grew weaker until death occurred.

CASE I  
DIAGNOSIS:

1. Carcinoma of the vulva with extension to terminal rectum, anus, vaginal wall and soft tissue.
2. Subacute cystitis.
3. Brown and serous atrophy of heart.
4. Emaciation.
5. Passive congestion of liver.
6. Decubitus ulceration.
7. Old tuberculosis, left apex and hilum.
8. Mild arteriosclerosis.
9. Pelvic adhesions.
10. Hyaline plaques of capsule of spleen, liver and epicardium.
11. Old scar, right thigh.
12. Trophic ulcer of foot, with beginning gangrene.
13. Abrasion left knee.
14. Trophic changes in skin.
15. Slight cloudy swelling and fatty change in liver.

CASE II

POLIOMYELITIS

The case is that of a white male, 19 years of age, admitted to the University Hospital 11-16-30 and died on 11-19-30. The history was obtained from the patient's attending physician outside of the University Hospital. He stated that on November 8th while at a fraternity barn dance the patient had a sudden sharp pain in the region of the lower bicuspid teeth, extending to the back of the head and persisting for 2 minutes. There were no other symptoms until November 10th when at another party the patient again experienced a pain in the same region which persisted for approximately 2 minutes. This time, however, the patient was unable to speak for this length of time and the pain was excruciating. On November 11th the patient developed headaches but continued to work until 10 P.M. on that date the headache became definitely worse and the patient left work and went home. He there took cascara and aspirin without relief. At this time the patient noticed that he was unable to void. He was able to go to sleep at 4 A.M. on 11-11-30 although the pain in his head was intense and at this time extended down his back. On 11-12-30 patient's temperature was taken and found to be 102.2. He was given magnesium sulphate and aspirin with no relief. A physician was called on this date and his particular complaints at this time were: 1. Intense headache, 2. fever. Temperature at this time 103° and the pulse 110.

Physical examination by the attending physician at this time showed the pupils slightly dilated with definite rigidity of the neck without hyperextension, some sensitiveness over the bladder region, exaggerated knee jerks on both sides, negative Babinski on both sides, and a slightly positive Kernig's sign. Patient's past history is completely negative except for a tonsillectomy and an adenoidectomy. On 11-12-30 the patient was given repeated enemas as defecation was not otherwise possible. A urine sample was obtained at this time and was negative on routine analysis. His principal complaint consisted of headaches. 11-13-30 the pulse was 102, the temperature 101.8 and the patient was taken to the Fairview Hospital. Another physician was called in consultation and a provisional diagnosis of: 1. meningismus, 2. spinal meningitis, 3. poliomyelitis were made. Spinal puncture was refused at this time. Later in the day, however, permission was obtained for a spinal puncture. The fluid was clear and there were 304 white blood cells, globulin increase, sugar increase, no Rbcs, 65% pmn cells. The smear was negative and Tb. ruled out. On this date, 11-13-30 the patient was entirely unable to void or defecate. On 11-14-30 spinal puncture was again performed. It was bloody at this time, the blood being attributed to technique being faulty. Physical examination at this time showed pupils still dilated, definite rigidity

of the neck, that the headache had been relieved by spinal puncture, abdominal reflexes sluggish, left leg completely paralyzed, the right leg sluggish, almost paralyzed, reflexes absent and no Babinski reaction. 11-15-30 another spinal puncture was done. This specimen was clear with no blood present. Respirations at this time were impaired and labored. There was some mental sluggishness. On this date the patient was given 20 cc. of Roseneau's serum and amytol gr.  $1\frac{1}{2}$  to ensure some sleep. On 11-16-30 there was a definite impairment of speech and the patient was transferred to the University Hospital and placed in the Drinker respirator. On admission to the hospital the patient was given 20 cc of convalescent serum. Patient's family history shows that one brother died of . I. indefinite disturbances and spinal trouble diagnosed as Pott's disease. The remaining family history is negative.

Laboratory: 11-17-30 blood examination showed hemoglobin 123%, RBcs 4,650,000, Wbc 13,700 with a differential of 11 L, 4 M, 85 Pmns. Examination of the urine on the same date showed a specific gravity of 1020, acid, plus sugar, heavy cloud of albumen, and occasional wbc's in the urinary sediment.

Medications and procedures: 20 cc convalescence serum given intramuscularly. Catheterization performed repeatedly. Codeine sulphate gr.  $\frac{1}{2}$ . Nasal oil and ephedrine. Hyperventilation repeatedly.

Nurses notes: Patient was admitted on 11-16-30 and placed in the Drinker respirator at once. Respirations were labored. Patient was unable to void. Color of the patient was good. He was able to speak and stated that he had no pain. Positions of the arms were changed repeatedly. Temperature of the respirator was kept at about 86-88°. Patient was removed on 11-17-30 and did not become cyanotic. Patient was immediately replaced. On 11-18-30 there was some difficulty in swallowing. On turning the patient became slightly cyanotic. On 11-18-30 it was noted that speech was difficult. Later in the day his face became flushed, eyes bloodshot and mucous expectorated. Still later in the day the patient was unable to draw liquid through a tube. Pulse was 104 and a large amount of mucous was present in the throat. There was definite flaring of the nares and twitching present about the face and neck. The patient did not respond. Pupils were pinpoint. Later in the day the hands and nails were cyanotic. 11-19-30 the patient was hyperventilated. He did not respond. Pulse was of fair quality. Became more cyanotic and the pulse weakened. Exitus occurred at 12:45 A.M. 11-19-30.

Progress notes: 11-17-30 it was noted by the staff that the patient was breathing only with the accessory muscles at the time of admission and a complete examination was not done for it seemed desirable to get him into the respirator at once. The lower extremities were paralyzed except a slight toe movement, the upper extremities extremely weak. No deep reflexes present. Cranial nerves all right. Moderate Kernig's. No neck rigidity. He was having considerable air hunger but was not cyanotic. Quickly relieved in respirator. 11-17-30 patient's upper extremities were completely paralyzed. He was reported as being cyanotic on being removed from the respirator for a position change. The speech was more difficult, the pupils smaller. Patient said he was very tired. The staff opinion was that the patient was worse, the prognosis as bad as it could be.

#### DIAGNOSIS:

1. Acute anterior poliomyelitis (clinical).
2. Bilateral and intense pulmonary edema and congestion.
3. Bilateral renal congestion.
4. Enlargement of the right lower extremity.
5. Posterior, purplish hypostasis.
6. Cyanosis of the lips, neck and finger tips.

CASE II (Cont.)

DIAGNOSIS (Cont.)

7. Hirsuties.
8. Bluish discoloration of the right calf.
9. Lumbar puncture wounds.
10. Left scapular laceration.
11. Old left forehead scar.

CASE III.

CHRONIC BRONCHIECTASIS: POSTOPERATIVE HEMORRHAGE

The case is that of a man first admitted to the University Hospital by transfer from Glen Lake Sanatorium 1-22-30, discharged 3-22-30. Admitted to Sanatorium 5-10-26 at the age of 23. Occupation - office worker, single. Diagnosis: pulmonary tuberculosis, moderately advanced, extensive bronchiectasis left lower lobe. Symptoms on admission: cough, expectoration up to 10 oz. a day, pleurisy pain, temperature up to 101, pulse to 96. Night sweats, 13# weight loss in about 3 months. In 1911 had a bilateral pneumonia. Since 1911 has had frequent colds during the winter and spring, with frequent involvement of the sinuses. Family history negative.

Physical examination: evidence of pulmonary tuberculosis in right upper lobe, bronchiectasis in left lower. Individual was very well nourished, 73" tall and weighed 156#. Had positive sputum in May and August 1926 and has been negative since. Has had frequent lipiodol injections for diagnostic as well as therapeutic purposes. Pulmonary tuberculosis gradually improved until now there is only evidence of a slight amount of fibrosis. He gained in weight, and on discharge weighed 200#. He still coughs and raises up to 8 oz. a day. Pneumothorax was given 8-21-28 to 8-7-29, attempting to collapse the left lower lobe. There was some improvement in symptoms but not enough to warrant continuation. Lungs were allowed to expand so that on 10-24-29 the left phrenic exeresis was done. Symptoms were somewhat abated. However, phrenic exeresis was followed by development of fluid at the left thorax which remained for about 6 days. Patient remained strictly in bed for 30 days, left diaphragm gradually rose but condition did not entirely improve. When first admitted to the University Hospital, he was 28 years old. Copious expectoration of foul smelling material, shortness of breath had been present for 14 years. There had been periods of fever, mainly in the afternoon for 5 years. Believes that his trouble started with rupture of abscess during convalescence from pneumonia in 1911. About 5 years after this had developed a chronic cough which at first produced only small amounts of material. Later, however, the expectoration increased, sometimes greenish in color. It was always very foul but did not contain blood. In the morning he produces large amounts of material. During the day he produces sputum constantly but in lesser amounts. He is not bothered very much at night. He has been up and about for the past two years. While out at Glen Lake he developed a cystitis which lasted for about a year and a half. He was told that the prostate was enlarged. He also had frequency, urgency and burning on urination. During this time he had an epididymitis on the left side, but this cleared up as did the ascites. Since the attack of pneumonia he had frequent colds. Sinusitis in 1925, with drainage. Mother living and well at 62, father dead of tuberculosis at 48. No other instances of tuberculosis in the family.

Physical examination: well developed, nourished adult not acutely ill. Able to be up and about. Clubbing of fingers and watch crystal type of finger nails. Tees also clubbed. Septum deviates markedly to the left. No discharge or bleeding.

No apparent obstruction. Tonsils present but not large. No palpable glands in neck. Chest well developed, left side is less well developed than right. Slight flatness of left chest. Heart normal. Slight lag left side, breath sounds distant, slight decrease of resonance on left, musical rales at base of left chest posteriorly. Few wheezing rales in right base. Abdomen and extremities negative.

Laboratory: Urine negative. Hemoglobin 99, WBCs 10,850, P 74, L 22, E 2, M 1. Blood Wasserman negative, sputum negative. Sputum shows 3 layers, upper prostrate, middle layer fluid, lower layer made up of sediment and solid material. No elastic fibers demonstrated.

X-ray 1-24-30 single plate of chest - marked irregular density right base, appearance being characteristic of an opaque solution which was no doubt injected at some previous time. It was probably iodized oil. Left space shows marked pleural adhesions, extensive infiltration suggesting old inflammatory process, possibly associated with the bronchiectasis. Right apex has slight infiltration of a fibrotic type with adhesions of the pleura, suggesting old, healed, tuberculous lesions. 2-11-30 chronic right maxillary sinusitis. 3-12-30 first stage thorocoplasty of lower ribs with very little collapse.

Progress notes: 2-24-30 lower stage thorocoplasty on left side done today under local anesthesia. Section of the 7th, 8th, 9th, 10th, 11th and 12th ribs were removed. Made a good postoperative recovery. 3-8-30 wound healed except at bottom which still drains some serous material. Still raises 6-7 oz. sputum daily, about the same as before. Postural drainage started yesterday. Emptied about 1 oz. Is using sand bags. 3-12-30 condition about same - up in chair. 3-16-30 wound has very small opening filled with granulation tissue. Temperature course 97-98-99, pulse 70-110, average range 70-90. Was sent home and advised to return which he did April 22nd, discharged 8-14-30 (114 days). Following operation cough seemed to increase, noticed especially at night. Coughing spell may last as long as a half hour and occurs every night. Choking sensation is so great he must sit up in bed to breathe. At present these coughing spells are no worse than when he left the hospital. However, he is not improving and he continues to lose sleep. Since operation he feels a little better in every other way and has gained 7# in weight.

Laboratory: Urine negative except for one trace of albumen. Hemoglobin 71, RBCs 3.49, WBCs 6.950, P 64, L 36. On discharge hemoglobin was 58%.

X-ray 4-22-30 showed partial thorocoplasty, chronic bronchiectasis with adhesions. 6-17-30 first stage thorocoplasty of lower left ribs, practically unchanged. 4-26-30 the 11th, 10th, 9th and 8th ribs were removed thus bringing the entire pleura in this region of the lung to the surface. Ethylene anesthesia, good postoperative recovery. An iodoform pack was inserted into the base of the wound so that the lung would become adherent. 3 weeks later the patient was again operated on at which time a first stage cautery pneumonectomy was performed. Made a good postoperative recovery. July 5 2nd stage of cautery pneumonectomy was done. Following this sputum was decidedly reduced, from nearly 200 cc prior to operation reduced to 60 cc. Discharged August 14th and instructed to return at a later date for completion of cautery pneumonectomy. Came back 10-30-30 and died 11-6-30 (7 days).

Physical condition is essentially the same as on previous admission. General condition is very good, gain of 25# in weight, Hemoglobin was 80%. 11-1-30 3rd stage of cautery pneumonectomy was done. Immediate postoperative convalescence was uneventful. Packing was changed November 4th and a large vaseline gauze pack inserted with pressure. 11-5 at noon had a small hemorrhage of about 200 cc. This stopped spontaneously, before any packing was reinserted. Wound was repacked and compression bandage applied. Was seen at 12:45 A. M. November 5th when he was in good condition. When next seen at 1:30 had died from a massive hemorrhage.

Operation was done under nitrous oxide. Bronchiectasis was found posteriorly in the lower lobes. Numerous, open, dilated bronchi seen in field. Graham technique used. No active bleeding was encountered.

DIAGNOSIS:

1. Bronchiectasis
2. Operation defects
3. Hemorrhage from artery

## Abstract

Treatment of Bronchiectasis - Multiple Stage Lobectomy. Report of Two cases.  
Vol N. Coryllos, M.D. Professor of Clinical Surgery, Cornell University Medical  
College. Arch. Surg. 20:767 (May) 1930.

The extensive use of iodized oil (1922) in the roentgenographic investigation of chronic pulmonary suppuration has shown an unsuspected frequency of bronchiectasis and permitted us to trace its beginning and course. Bronchiectasis is a very chronic disease, beginning frequently in childhood with variable symptoms which may never reach the classical, textbook picture (hopeless patient with pasty, septic look, harassing cough, clubbed fingers, copious foul expectoration, one whose obnoxious breath practically ostracises him from human association). The author advises greater boldness for the internist and conservatism for the surgeon (choice of procedure), earlier operation (surgical risk), which will mean more satisfactory results and fewer lobectomies.

Cause 1. Measles, scarlet fever, chronic sinusitis. 2. Chronic tuberculosis (20% complication). 3. Tumor of lung, foreign body (10% complication), extrinsic bronchial compression. 4. Chronic bronchitis (95%). 5. Some forms of asthma. 6. Chronic emphysema with bronchial fistula (complication). 7. Congenital cystic dilations. 8. Acute lymph-angitis and lymphadenitis (temporary).

Type 1. Bronchitic form (Oschner). Simple form only revealed by oil study of bronchi, frequently called chronic bronchitis. Treatment of sinuses; hot, dry climate, postural and bronchoscopic drainage often check disease. 2. Early uncomplicated form (Hedblom). Positive x-ray lesions, bronchi only (clubbing of fingers, no foul sputum or constitutional symptoms-- usually unilateral or mainly in one lobe). Treatment - same as bronchitic form with therapeutic compression of lung by pneumothorax, phrenicectomy or even thorocoplasty, associated with postural and bronchoscopic drainage of bronchi and anti-spirochoetal treatment, when necessary, give satisfactory results. The lesion is usually unilateral or at least more accentuated in one lung and more particularly in one lobe. 3. Complicated bronchiectasis with parenchymal involvement and typical picture of disease - foul sputum, persistent cough, septic appearance, fever, loss of weight and clubbing of fingers. Treatment same as second form, plus pneumonectomy. a. lobectomy (Saurbruch). b. cautery pneumonectomy (Graham). Exteriorization and ligation (Whittemore). 4. Bronchiectatic abscesses (unilobar, unilateral or diffuse).

Bronchiectasis is chronic, slowly progressive disease, and is amenable to treatment, that is, progressive treatment. The condition may also be acute, latent or chronic. The acute forms occur mainly in children and the chronic and latent forms both in children and adults.

Results of one stage lobectomy do not seem to warrant continuation of procedure. Graded lobectomy is probably the method of choice. From 1914 to 1929 there were eighty-seven reported operations of one stage lobectomy. Results: thirty-eight cures, one improvement, forty-eight deaths (55%). Multiple stage treatment showed eight operations, no deaths. Cautery pneumonectomy forty-five cases, twenty-four deaths, 69% free after three years, improved 7%. Other forms show about same results.

Death during or shortly after lobectomy can be ascribed to: 1. shock, cardiac failure (mechanical or reflex) or pleural shock; 2. embolism (air or septic); 3. hemorrhage during and after operation; 4. increased intrapleural pressure during the first days following operation, by pneumothorax or intrapleural fluid; 5. septic pleurisy and 6. septic mediastinitis.

Author reports two cases with complete cure by graded lobectomy (young females). Chief point of interest was relatively short duration of course, severity of symptoms and complete recovery following destruction of involved lobe.

MORTALITY REPORT - NOVEMBER, 1930

	<u>Age</u>	<u>Sex</u>	<u>Post</u>
Aortic insufficiency, due to rheumatic endocarditis	45	M	X
Bowel obstruction, due to adhesions following appendectomy	5	M	X
Brain abscess, left cerebrum	16	M	X
Carcinoma, cecum	58	M	X
Carcinoma, lung	57	M	X
Carcinoma, stomach	49	M	X
Carcinoma, stomach	66	M	O
Carcinoma, vulva	54	F	X
Cellulitis, neck - septicemia	21	M	X
Cirrhosis, liver	32	F	X
Cirrhosis, liver (portal)	63	M	X
Coarctation of the aorta	24	M	X
Diabetes mellitus - essential hypertension	60	M	X
Fracture, right hip - intertrochanteric	84	F	X
Hepatoma	22	M	X
Leukemia, lymphatic	3	M	X
Leukemia, myelogenous	9	M	X
Polionyelitis, acute with respiratory paralysis	19	M	X
Premature infant	1 day	M	X
Tuberculosis, pulmonary - chronic bronchiectasis, post-operative pulmonary hemorrhage	28	M	X

Total deaths - - - - - 20  
 Post mortens - - - - - 19  
 Percentage - - - - - 95%