STAFF CONFERENCE NOTES

CASE I.

ACUTE MASTOIDITIS WITH RESULTING BRAIN ABSCESS

The case is that of a white male 28 years of age, admitted to the University Hospital 11-28-30 and died 12-7-30. Patient was first seen in the University Hospital Dispensary where he stated that he had a mastoidectomy on 11-4-30, following which he has had severe headaches. The operation was performed at Detroit Lakes, Minnesota, the patient being hospitalized for 10 days. 6-8 weeks before the operation the patient had an otitis media. Since the operation and development of headaches, the patient has been taking medications for pain. Associated with the headaches he has had no vertigo, visual disturbances, but has had definite nausea and vomiting, headache is worse at night. Patient's past history is essentially negative as is the family history.

Physical examination revealed a mastoidectomy scar posterior to the right ear which was still draining. The blood pressure was 110/78 and the remaining physical findings were essentially negative. The diagnostic impression was that of mastoiditis with an intracranial complication, by the admitting officer.

Laboratory: Urinalysis 12-2-30 specific gravity 1-17, no sugar or albumen, negative urinary sediment. Blood examination 11-29-30 hemoglobin 105, WBc 13,200, Pmn 79, L 21. 12-3-30 spinal puncture showed clear, colorless fluid, pressure 310 mm of water, cells 16. Wasserman and State Board both negative. Repeated spinal punctures essentially the same findings.

X-ray examination 11-28-30 of sinuses and mastoids concluded that there was a negative left mastoid, acute mastoiditis with destruction and possible abscesses on the right, bilateral maxillary sinusitis.

Medications and procedures: Nose and throat cultures were taken, aspirin, phenacetin gr. 5 each repeatedly, morphine sulphate gr. 1/6 repeatedly. Spinal puncture performed. Hypodermoclysis, proctoclysis, S.S. enemas, intravenous 5% dextrose and normal saline. Chloral hydrate by rectum. Nasal oil. Spinal punctures. Aromatic cascara dr 4 repeatedly. Caffeine sodium benzoate gr. 7 and one half repeatedly. Adrenalin mm 10, insulin units 20 intravenously. Atropine sulphate gr. 150th.

Nurses notes: 11/28/30 the patient was admitted. Marked nausea and repeated emesis were noted. Patient complained of severe pain in the right ear. Patient had a cold and was coughing some, had repeated emesis. 11-29-30 sent to the operating room. Returned in semi-conscious condition. Respirations shallow. Continued nausea and emesis-pain in the head. Complaining of severe headache continually from day to day. 12-7-30 listless and drowsy and did not respond well. On this date again sent to the operating room and returned with respirations shallow. Shortly after Cheyne-Stokes respirations noted. Patient very cyanotic. Exitus 11:55 P.M. 12-7-30.

Progress notes: 11-28-30 aspirin and phenacetin apparently sufficient to control the pain. Neurological examination on this date essentially negative. On this date it was stated that when off his guard the patient did not look like a very sick man. 11-29-30 following mastoidectomy patient returned from operating room in good condition. Blood pressure 100/64, pulse 96. 12-3-30 noted that headache was severe when patient was lying on his side. 12-4-30 the impression was that the patient presented intracranial pressure signs and that his course was downward. 12-5-30 Kernig's sign positive on the right. Slight opisthotonous present. 12-6-30 patient was operated upon and a small epidural abscess opened and drained. 12-7-30 spinal puncture showed a cell count of 50.

It was noted that the patient had an operation on the brain with drainage of two and one half oz. of pus from the tempero-zygomatic brain abscess. Post-operatively the patient's blood pressure had dropped from 180 to 104 systolic pressure. Pulse was 100, rapid, thready and weak. Temperature while in the hospital varied from 97.2 to 99.8 Consultation report - eye ground examination on 11-29-30 showed hyperemia of the fundi and discs and minor vascular changes. No evidence of neuritis. Moderate concentric contraction of both eye fields, more marked on the left than the right. Considered to be a fatigue phenomenon. Neurological examination 11-28-30 concluded that there was no evidence of organic nerve involvement but on another examination 12-4-30 concluded that there was a meningismus or a temporal abscess. It was repeatedly noted that the pulse rate was low, ranging between 40-50.

DIAGNOSIS:

1. Otitis media (clinical).
2. Acute mastoiditis.
3. Right temporal brain abscesses.
4. Bilateral generalized pleural adhesions.
5. Bilateral pulmonary edema and congestion.
6. Slight acute congestion of the liver.
7. Small tumor of the liver.
8. Edema of the brain.

STAFF CONFERENCE NOTES

CASE II.

CELLULITIS OF THE NECK

The case is that of a white male 21 years of age admitted to the University Health Service Dispensary on 11-29-30, and died on 11-30-30. At the time of admission the patient complained of: 1. a boil on the lateral aspect of the neck which had been present for one week and which had been treated for that length of time in the University Health Service. On 11-28-30 the condition became much worse and he noticed that the septic process was spreading down the neck and that he had developed a high fever. Past history stated that he had had several previous boils over the same area in the past few months. The remaining history is essentially negative.

Physical examination showed a very extensive, severe cellulitis of the right posterior auricular and posterior cervical regions with a small superficial pustule just behind the ear which had been opened. There were multiple small superficial pustules forming and the area of greatest induration and redness was incised. A few scattered cheesy abscesses were encountered. There was no extensive slough noticed. The remaining physical examination was essentially negative.

Laboratory: None was obtained.

Medications and procedures: Continuous hot, moist packs to the neck, morphins sulphate gr. 1/6 repeatedly. Tepid sponges, proctoclysis, intravenous glucose 10% repeatedly. External heat. Codeine sulphate gr. 1/2, caffeine sodium benzoate gr. 7 and one half, adrenalin mm. 5.

Nurses notes: 11-29-30 patient was admitted with a temperature of 103. The neck was very swollen and red and stiffness was present. Patient was prepared for the operating room and sent there. Returned in good condition. He complained, following operation, of feeling fairly warm but did not complain of pain. 11-30-30 at 2:55 P.M. he was again sent to the operating room and returned in good condition except that the pulse was rapid and weak. Following this the patient was irrational, respirations became rapid, later on labored. Later in the day the fingers became cyanotic he became involuntary and exitus occurred at 11:05 P.M on 11-30-30. Temperature ranged from 103 on admission to 104.4 on the morning of 11-30-30 following which it dropped steadily to 98 at the time of exitus.

Progress notes: 11-30-30 after consultation with the Surgical Staff 250 cc of whole blood were given intravenously and 20 cc of blood injected around the margin of the cellulitis. An incision was made lower down in effort to locate pus but none was obtained. Patient was pulseless for a time before transfusion. The condition was slightly benefitted.

DIAGNOSIS:

1. Cellulitis of the neck.
2. Septicemia (clinical)
3. Recent right lateral neck incision.
4. Bilateral pleural effusion.
5. Bilateral pulmonary septic infarct.
6. Bilateral bronchopneumonia.
7. Enlarged spleen.
8. Slight fatty metamorphosis of the liver.
9. Postmortem autolysis of the esophagus and right adrenal gland.

STAFF CONFERENCE NOTES

CASE III.

CARCINOMA OF THE URINARY BLADDER

The case is that of a white male 71 years of age admitted to the University Hospital 9-14-30 and died on 10-20-30. At the time of this admission the patient complained of: 1. marked weakness, 2. loss of appetite, 3. frequent nausea, 4. loss of 10# in weight in one month preceding admission, 5. pain in the region of the urinary bladder. The patient was admitted to the University hospital for the first time April 23, 1930, at which time he gave the history of having had frequency, nocturia and burning on urination for the preceding 2 years. Since March 1930 the patient's symptoms increased in severity. At this time he noticed difficulty in commencing urinary flow and that the urine was cloudy and occasionally red in color. Patient stated that on approximately April 10th he was examined by a physician who told him that he had a sore in his bladder. Since that examination he has not noticed blood in the urine but pus has been present constantly. His past medical history was essentially negative.

Physical examination on this admission showed a poorly nourished, well developed male. Examination of the head, eyes, ears, nose and throat was negative except for enlargement of the tonsils. Chest and heart examinations were negative except for slight enlargment of the heart on percussion. Rectal examination showed a normal sized prostate but the presence of one small nodule in the left lobe.

Laboratory examination at this time showed a urinary spec. gravity of 1012 with many Rocs and numerous Wbcs in the urinary sediment. Blood examination showed a 14% lymphocytosis, 10% hemoglobin, 32,150 WBc. 86 Pmns. P.S.P. test varied from 20 - 40% at the end of 2 hours. Wasserman test negative. A urinary specimen from the bladder showed the urine to be thick with pus and full of blood cells.

K.U.B. Plate showed no evidence of urinary stone but the probable presence of multiple gallstones and chronic hypertrophic arthritis of the lumbar spine. Cystogram showed multiple diverticulum, extensive carcinoma of the bladder. Cystoscopic examination and biopsy showed squamous cell carcinoma of the urinary bladder and vesicle diverticulum. Diverticulum was 2 x 8 cm and surrounded by tumor tissue. During the patient's stay in the hospital retention catheter was placed in the ureter and the bladder daily irrigated with silver nitrate. In May 1930 2,430 mc. hours of radium was inserted into the portion of the tumor which had invaded the bladder wall. Suprapubic tube was reinserted. Patient was discharged and advised to return for deep x-ray therapy for treatments. On August 5th, 1930 the patient was readmitted to the hospital, essentially for re-examination. Since the previous admission the patient had gained 25 lbs. weight and was continually passing urine through the cystostomy tube which was inserted on his previous admission to the hospital. Urine examination on this admission showed 3 plus albumen, hb. 90%, Wbc 12,150. P.S.P. kidney function test showed a total of 80% in 2 hours..B.U.N. was 18.66. Cystoscopic examination showed the bladder to be contracted and classified as grade IV. There was diverticulum on the right wall which was larger than the bladder itself. An area of ulceration was found at the junction of the diverticulum in the bladder. On August 11th 6 gold implants were inserted into the carcinoma and the patient discharged.

Physical examination on the most recent admission showed the head, eyes, ears, nose and mouth, throat and neck to be negative. The thorax was negative except for the presence of a funnel chest deformity. The heart was considered to be negative. Examination of the abdomen revealed bilateral inguinal adeno-

pathy with some tenderness over these glands. Patient also had some tenderness in the left hip which he stated had been present for one week, the tenderness extending down the left leg to the knee.

Laboratory: Urinalysis 9-15-30 showed a specific gravity of 1012, alkaline, without sugar, but trace of albumen and negative sediment. These urinary findings remained essentially the same except that the urinary sediment showed continuously after the initial examination, the presence of considerable pus, varying from 6 - 100 Wbcs per microscopic field. Blood examination 9-15-30 showed a hb. 80%, Wbc of 29,650 with differential of Pmns 90, L 10. Blood was in group IV. P.S.P. test on 9-17-30 showed an excretion of 53% at the end of 2 hours. B.U.N. was 16.8. An intravenous P.S.P. test 9-21-30 showed a total excretion of 15% at the end of 2 hours. 10-2-30 B.U.N. had increased to 52.74 and the U.N. was 31.73.

A tissue examination on 9-18-30 made a diagnosis of squamous carcinoma, grade II of a biopsy from the urinary bladder. Examination by x-ray of the chest, pelvis and lumbar spine 9-20-30 concluded that there was chronic hypertrophic arthritis of the lumbar spine and hip joints, radium seeds in the urinary bladder and possible atelectasis or chronic fibrosis of the right lung. 9-25-30 an x-ray uroselectan series concluded that there was uroselectan injection, bilateral hydronephresis of a moderate degree and marked nephroptosis on the right, bilateral hydroureter, distortion of the right ureter and probable gallstones. 9-26-30 examination of the gall bladder concluded that there was cholelithiasis. 10-1-30 examination of the chest concluded that there was pleurisy in the left base, slight chronic lung fibrosis, carcinomatous metastaces to the right clavicle, and possible metastasis to the left mediastinum. 10-10-30 examination of the chest at the bedside showed a slight amount of congestion in both lower lobes but no definite evidence of consolidation. The hilus shadows were apparently widened and suggested the possibility of metastatic infiltration although this was not considered definite. The remainder of the lung fields was considered fairly clear.

Medications and procedures: Nose and throat cultures were taken. Codeine sulphate gr. 1 and allonal tablets 2 were given repeatedly. Mineral oil oz. 1 was given repeatedly. Cystotomy irrigations were performed repeatedly. Petrol agar with phenol oz. 1 t.i.d. Opium suppositories and hot sitz baths were given. Urinary bladder was irrigated with boric acid solution and acriflavine, 1 - 10,000. Uroselecton injected intravenously. Intravenous normal saline given. 5% intravenous glucose given. Hypodermoclysis was performed. Morphine sulphate gr. 1/4 given repeatedly. 1-18-30 urography was performed as well as cystoscopy. Bladder was contracted, filled with pus and necrotic material so that satisfactory examination could not be made.

Nurses notes: at the time of admission the patient had no complaints but shortly developed pain over the bladder region. 9-24-30 noticed that the patient had developed a reddened area on the right hip, patient complaining continually of pain over the bladder region. 9-30-30 noted that there was a mild, purulent drainage around the suprapubic tube. 10-1-30 patient had a severe chill lasting for one hour during which the patient's face was very flushed and he was very uncomfortable. Perspiration was profuse. Patient also had an involuntary defecation during the chill. 10-3-30 had repeated onesis, complained of nausea and weakness. 10-3-30 patient complained of pain in the abdomen and generalized weakness. Patient was very flushed and later in the day became somewhat irrational. 10-4-30 noted that patient's hands were edematous, and that he complained of having a sore back. Patient later on was still irrational. 10-5-30 patient had a severe chill which lasted 25 minutes. 10-8-30

noted that the patient had edema of the feet. On same date he had a slight chill lasting about 10 minutes with a temperature of 102 and patient's respiration somewhat labored. 10-9-30 patient was very weak, pulse was irregular. 10-10-30 complained of pain in the right chest. 10-13-30 noted that breathing was definitely labored and noisy. 10-15-30 continually irrational and somewhat stuporous at times. 10-18-30 Cheyne-Stokes respiration was observed. 10-19-30 breathing was slow and labored, pulse irregular and the patient did not respond. Exitus occurred at 1:05 A.M. on 10-20-30.

Progress notes: October 1, 1930 noted that patient had a steeple-chase character fever for 3 days, that he had a chill the day before. Physical examination of the chest revealed an impaired resonance at the left base with suppressed breath sounds over this area. 10-2-30 examination of the chest showed bronchial breath sounds over both lungs posteriorly with occasional rales over both bases. The chest, however, was considered negative. 10-3-30 by the same examiner. Examination of the chest on 10-5-30 by the same examiner showed impaired resonance of the left base decreased breath sounds and audible respiratory sounds. Condition was considered to be a pleurisy but fluid was also considered. 10-8-30 by the same examiner the chest was considered negative. 10-10-30 after examination of the chest it was concluded that there might be a beginning pneumonia. 10-13-30 noted that there was pitting edema of both ankles. 10-18-30 this examiner concluded that there was pneumonia in the lower right lobe.

DIAGNOSIS:

1. Carcinoma of the urinary bladder.
2. Midline draining suprapubic wound.
3. Midline sacral decubitus ulcer.
4. 500 cc of ascites.
5. Bilateral omental adhesions to the parietal peritoneum.
6. Bilateral pleural effusions and adhesions.
7. Coronary sclerosis.
8. Arteriosclerosis of the aorta.
9. Congestion and edema of the lungs.
10. Carcinomatous metastases to the liver.
11. Cholelithiasis.
12. Bilateral pyo-ureters.
13. Bilateral pyelonephritis.
14. Gangrenous cystitis.
15. Enlarged pelvic lymph nodes.

CARCINOMA OF BLADDER

References:

(1) Treatment of carcinoma of bladder by Surgical Deathermy. Herman L. Kretschmer, M.D., Chicago. J.A.M.A. 95:1728 (Dec. 6) 1930.

(2) Treatment of Bladder Carcinoma by Irradiation and Diathermy. G. G. Smith, M. D., Boston. J.A.M.A. 95:1830 (Dec. 6) 1930.

(3) Radium Treatment of Cancer of Bladder, B. S. Barringer, M.D., New York, 95:1734 (Dec. 6) 1930.

AGE (Kretschmer - 109 cases)

30-40	3
40-50	13
50-60	32
60-70	42
70-80	17
80-90	1
Not stated	1
	109

SEX (Kretschmer - 109 cases)
Males 87 Females 22 (4 - 1)

First Symptom (Kretschmer - 109 cases)

Hematuria	63
Frequency	26
Nocturia	9
Burning	3
Urgency	2
Pain on urination	2
Acute retention	1
Dysuria	1
Dribbling	1
Not stated	1
	109

(In 100 cases gross blood was noted by patient)

TYPES

I. (1) Benign papilloma? (2) Malignant papilloma; papillary carcinoma (3) Flat ulcerating or infiltrating tumors (Minnesota).

II. (2) Grade I, 10%, II 32% III 35% LV 23% (36 - 64). Hunt (Caylor) 480 cases. Differentiation I 100 to 75% II 75 to 50% III 50 - 25% IV 25 - 0%.

III. (1) Benign papilloma (none). (2) Papilloma with atypical cells or papillary carcinoma 52% (3) Infiltrating carcinoma 48% (Barringer - 98 cases using Broder's method?)

LV. (1) Benign papilloma (none) (2) Malignant papilloma or papillary carcinoma 35% (3) Infiltrating carcinoma 65% (Barringer - 128 cases including 98 cases - grading plus clinical observations).

V. (1) Benign papilloma (none) (2) Early 25% (3) Late 75% (Kretschmer 95 cases - clinical)

VI. (1) Epithelioma 95% (2) Adenocarcinoma (glands of Von Brunn) (3) Sarcoma: Age 1-5 and 50-60 (Caylor).

LOCATION

I. (1) About right ureter 23% (2) Left 25% (3) Both 14% (4) None 38%. Trigone 62%, (Kretschmer - 109 cases).

II. 63% touched the trigone (Barringer - 127 cases).

III. (1) 150 epitheliomas of base 64.6% (grades III, IV) (2) 214 epitheliomas of lateral wall and dome 53.6% (III, IV) Note the same comparison. Hunt (Caylor)

DIAGNOSIS (1) History (2) Physical examination (2) Urinalysis (Pus 99, blood 85, albumen 85) (Kretschmer 109 cases) (3) Cystoscopic (4) Cystogram (ulceration into wall) (5) Biopsy (cystoscopic, cystotomy). Beware of diagnosis of chronic inflammation, diagnosis of single lesion when many are present.

TREATMENT:

(1) Excision (lateral wall and dome)
(2) Fulguration, electrocoagulation, surgical diathermy (preliminary and total).
(3) Radium (one gold seed . 12 mc to 1 sq. cm. of tumor) B.
(4) X-ray (10-15 erythema doses needed; 1 to 1 and 1/2 possible) B.

RESULTS

I. Kretschmer (109 cases all surgical diathermy)
   1. Operative deaths 25 (7 pulmonary embolism) 1-22 days.
   2. Died after leaving hospital 45 (26 ca.) 18 and 1/2 months.
   3. Cured 23 (19 - 3 to 14 years; average cure 4.65 yr.)
   4. Recurrences 17 (Total 105 cases).

II. Smith - 50 cases

	No.	1.	2.	3. (2 year cure) as above
Excision	11	3	2	3
Coagulation	15	1	4	4
Radium	24	7	6	7
	50	11(22%)	12(24%)	14 (28%) (37 cases)

Radium 1 mc each 1 cm apart.

III. Barringer 128 cases
Mortality (suprapubic - radium 3.6%)

(II)	Papillary carcinoma 45 cases - 3 yr. cures	55.5%
(III,IV)	Infiltrating carcinoma 82 cases 3 yr. cures	27.5%
	Controlled (II)	66. %
	" (III, IV)	36.5%
	Duration 1 - 14 years.	

IV. Hunt (Caylor) 370 cases Radical operation
   1. grades I, II - 65% 3 year cures
   2. grades III, IV - 35% 3 year cures.

CONCLUSIONS:

1. Carcinoma of the bladder is most frequent from 50-70 years (66%).

2. The age limits are from 30-90.

3. Males predominate (4 - 1).

4. The most common initial symptom is hematuria (58%); common urinary complaints (42%).

5. Hematuria (gross) is always an indication for cystoscopy (after 30). Albumen, pus and blood do not exclude tumor. When prostatic disease or stone is present tumor can be ruled out at cystotomy? Common urinary complaints are also an indication for cystoscopy (including pus and blood in the urine).

6. Broder's method of grading (minus group I?) is as efficient as usual pathological method of grading plus clinical observation (36-64%) (35-65%).

7. 95% of all bladder tumors are epitheliomas; 5% are sarcoma and adenocarcinoma.

8. (62% & 63%) are located at the trigone.

9. Biopsy should always be done. A diagnosis of chronic inflammation may be returned. All parts of the tumor show the same grade? Not all tumors (multiple) show malignancy.

10. One third of all tumors are favorable; two thirds are unfavorable.

11. Treatment depends on type and location.

12. About (22%-25%-38%-40%plus?) three year cures (3-14 years) are obtained in all cases.

13. Three year cures (3-14 years) in favorable group are (55.5%-65%) unfavorable (27.5-35%).

14. Radium has the lowest reported mortality (3.6%).

15. The usual dose of radium is too small? Deep therapy is not of value?

16. No note was made of the relation between duration of symptoms and results.

Duluth

Recent visit reveals remarkable sustained progress of profession. High lights: desire to excel, semi-isolation resulting in greater dependence on selves and frequent visits elsewhere; humility out of all proportion to accomplishment. Excellent pathological service, high percentage of postmortems, spirited weekly clinico - pathological conferences (inter-hospital) informal consultations, helping young men to learn to use wings, especially in surgery, active interest in civic affairs, speakers bureau for lay health instructions, good fellowship, remarkable command of literature, active society programs with outside speakers, remarkable attendance at such meetings (better than 60% of active profession) deep friendship for University, more interest in medical science than worry over medical economics. Truly a model profession. Interesting work at Duluth clinic - epituberculosis, trichomonas vaginitis, air inflation of barium "stained" colon, silicosis, metastatic tumor of bone, healed miliary tuberculosis, marble bone disease and leukemia, clinical approach to liver injury, active surgical tuberculosis service, excellent endoscopic work, dilation of oesophageal carcinoma, tetralogy of Fallot, pulmonary foreign bodies, psychiatric approach to reactions of patients, opportunities for young men, groups interest in medical history, old school hospitality and interest in extra medical affairs.

SALUTE

Leonard Freeman, University of Colorado
William Macklin, University of Minnesota
Maude Gerdes, " " "
Theodore Q. Benson, " " "

These internes have now completed their service at the University Hospitals Faithful to duty and loyal to the institution, they have contributed their share to Building their hospital. May they always have a deep interest in this place. Our best wishes go with them for a happy and successful future and we extend our appreciation for all they have done to develop and sustain the ideals of the University Hospitals.

Next

Meeting will be held January 8, 1931 on account of holidays, Christmas, Thursday December 25th and New Years, Thursday January 1, 1931.

Resolutions:

Include the University Hospitals in your New Year resolutions so that you may play your part in making the year 1931 even more successful than 1930.

Merry Christmas and Happy New Year from all to all.