December Autopsies

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COURTESY OF CITIZENS AID SOCIETY

I. AUTOPSY REPORT FOR DECEMBER 1934

Alex Blumstein

1. , 73,
   Medicine,
   Carcinoma of prostate

   Comment:
   A 73 year old, white male with an eighteen month history of frequency, urgency and dysuria.

Interesting finding at postmortem; metastasis to a left supra-clavicular node, the node being about 5 cm. in diameter.

2. , 52
   Medicine,
   Essential hypertension

   Comment:
   Death from uremia.

3. ., 46
   Surgery, .
   Carcinoma of rectum

   Comment:
   A 46 year old, white male is admitted to University of Minnesota Hospitals 9-4-34 and discharged 9-17-34 (13 days); readmitted 11-19-34 and expires 12-3-34 (14 days). Total stay - 27 days.

Blood

Fall '33 - Noted blood in stools.

4- -34 - Frank rectal hemorrhage. Weight loss of 25 lbs.

Carcinoma

Aug. '34 - Seen in Out-Patient Department. Rectal mass found and biopsy made. Diagnosis of biopsy - adenocarcinoma of rectum, grade II.

Admitted

9-4-34 - Physical examination: Marked weight loss. Blood pressure 150/100. Rectal - anal fistula with redness of surrounding skin; purulent discharge; mass 10 cm. from anus, about 5 cm. in diameter and somewhat friable; it bleeds readily. Laboratory: Blood - hemoglobin 60%, erythrocytes 3,700,000, leucocytes 8,000. Urine - negative. Serologic test for syphilis - negative. X-ray of chest - negative. Barium enema - definite carcinomatous infiltration of rectum extending to about level of superior surface of symphysis pubis, the whole involvement is in lower portion of rectum.

9-6-34 - First stage Rankin operation done (single barrel colostomy). Convalescence uneventful.

9-17-34 - Discharged with colostomy bag.

Interval history: gained some weight.

11-19-34 - Readmitted.

Operation

11-27-34 - Combined abdominal and perineal resection is done.

11-28-34 - Nasal suction is used. Refuses medication. Restless and apprehensive.

12-3-34 - Placed in oxygen tent. Does not respond. Skin cold and clammy. Blood pressure 60/52. Pulse imperceptible. 2:30 A.M. - Expired.

AUTOPSY

The body is that of a poorly nourished, fairly well developed, white male, 46 years of age, weighing about 140 lbs. Slight rigor and posterior hypostasis. No cyanosis or jaundice. Pupils are equal. There are operative scars and wounds as noted in history.

Peritoneal Cavity no blood or pus. Cavity in the lower pelvis is well walled off. Pleural Cavities show no hemorrhages or excess fluid. Pericardial Sac same.

Heart weighs 300 grams. Valves smooth. No fibrosis of muscle. Root of Aorta is smooth. Coronaries soft and patent.

Lungs each weigh 400 grams. No consolidation. Spleen weighs 150 grams, no

nodules. Liver weighs 1600 grams, no nodules or hemorrhages. Gall-bladder markedly distended with bile. No stones.

Ileus

Gastro-Intestinal Tract. The stomach is markedly dilated but it contains only a small amount of solid material. The duodenum and jejunum are markedly dilated and contain fluid. The ileum is for the most part constricted. The part of the colon which is left contains a small amount of gas.

Pancreas - no hemorrhages or nodules.

Adrenals - no hemorrhages or tumors on gross examination.

Bladder - no tumor.

Each Kidney weighs 150 grams and is normal.

Head and Neck - not examined.

Diagnosis

1. Carcinoma of rectum.
2. Postoperative paralytic ileus.

Comment

ABSTRACT

Lockhart-Mummery, J. P.
Excision of the rectum for cancer.
Amer. J. of Cancer XVIII, #1: 1-15, (May) 1933.

The author records own experience and describes operative technique. One hundred and thirty-seven patients are over 60 years of age and 30 are over 70. The operation cannot be performed if the growth is at or above the recto-sigmoid junction, unless the growth is small and the sigmoid fairly long. The author uses low spinal anesthesia with 0.6 to 0.8 cc. of 10% solution of stovaine assisted by avertin as basal anesthetic; or alternatively, full scopolamine and morphin anesthesia. The operation can be performed in one stage, but it is usually advisable to perform it in two stages, the colostomy being done a week or fortnight before actual excision.

Mortality: In 330 cases the mortality is only 7%. In 167 cases from the author's private practice, there are 6 deaths, a mortality of less than 4%.

Prognosis: There were 209 cases in which operation was done 5 years or more before writing the article. Of these, 100 patients survived the 5-year period, 92 had recurrence, 13 died of other causes, and 4 were untraced. A few recurrences are observed after 5 years but there is only one instance of recurrence after 7 years. Sixty-seven patients had survived operation 7 years, 37 ten years, and 14 fifteen years or more.

The author divides his cases into 3 classes:

"A. Very favourable cases, in which the growth has not passed beyond the bowel wall." The mortality in these cases is "nil" and "the proportion of cures is over 75%".

"B. Cases in which the growth has passed beyond the bowel wall, but in which there is no involvement of the lymph glands". In these cases, the proportion of cures is about 55%.

"C. Borderline cases, in which the lymph glands are involved". Proportion of cures about 30%.

Classification is made as the result of careful histological examination of the specimen after removal. "Cases are not counted as cures until they have survived the operation five years".

4. ., 26
Medicine,
Subacute Bacterial Endocarditis.

Comment:

Case is a white female, 26 years of age.

Rheumatic Fever

1918, 1920, 1926 - Attacks of rheumatic fever.

Between 1928 and 1934 - Attacks of cardiac decompensation manifested by swelling of the ankles and shortness of breath.

Thyroidectomy

1928 - Thyroidectomy done following which patient noted exophthalmos.

12-9-33 - Admitted. Physical examination: marked exophthalmos, heart enlarged to right and left, systolic thrill over pulmonic area, systolic and diastolic murmurs over apex, rate 200 at apex, 95 to 115 at wrist. Laboratory: Urine - many leucocytes. Blood - hemoglobin 76%, erythrocytes 3,920,000, leucocytes 17,000, neutrophiles 80%, lymphocytes 20%, basal metabolic rate - +57%; repeated +30%. Electrocardiogram: Auricular fibrillation. 6 ft. plate of heart - with esophagogram - double mitral heart, 3d stage; congestion of lungs.

Total Thyroidectomy

Temperature 97. Practically total thyroidectomy done. Microscopic sections of tissue - marked hyperplasia with lymphocytic infiltration. Basal metabolic rate (1-15-34) -6%. Following operation, there is hoarseness. Laryngoscopic examination - edema of larynx.

Bed Rest

1-20-34 - Discharged from hospital and advised to remain on strict bed rest and take tincture digitalis, 1 cc. daily. Clinical diagnosis: mitral disease, stenosis and regurgitation; hyperthyroidism.

Readmitted

2-20-34 - Very much improved. Nervousness disappears. If anything, she feels somewhat sluggish. Orthopnea and dyspnea gone. Physical examination: murmurs, as previously reported; auricular fibrillation persists; heart rate 76; blood pressure 110/78. Laboratory: Urine - negative. Blood - Hemoglobin 81%, leucocytes 10,000, neutrophiles 84%, lymphocytes 13%, monocytes 2%, eosinophiles 1%. Basal metabolic rate -13%.

Progress

Gradually gets up in a chair, starting with 5 minutes twice a day and increasing until she sits up for one hour twice daily. Continues to take 1 cc. of tincture of digitalis daily. On increased activity, she did very well. Pulse varied somewhat. Develops no edema or other signs of cardiac failure.

3-1-34 - Discharged with instructions to gradually increase activity until she is up a fair share of the day. Instructed to continue digitalis, 1 cc., daily.

Ambulatory Service

3-2 to 3-6-34 - There has been a rapid gain in weight. Heart is well compensated. Up and about.

4-5-34 - Basal metabolic rate -28%. Put on thyroid extract, gr. i, t.i.d. Advised to continue digitalis.

5-20-34 - Basal metabolic rate -5%.

Readmitted - 9-6-34.

9-14-34 - Attack of syncope. Stated heart beat rapidly and then she lost consciousness.

9-17-34 - Several attacks of syncope with convulsions. Attacks believed to be ventricle asystole due to quinidine. Pulse rate 42, probably due to slight overdigitalization.

10-6-34 - Discharged.

Readmitted - 11-12-34.

11-14-34 - Stated that she felt much better. Thyroid extract stopped. Hair started to fall out. Skin is rough. Heart became rapid and irregular. More digitalis and thyroid extract given.

11-15-34 - Discharged.

Readmitted

11-25-34 - States that she developed a dull aching pain just to the right of the umbilicus about 3 hours previous to admission. Became nauseated but did not vomit.

Physical examination

There is tenderness in the right lower quadrant and right flank. No muscular rigidity or rebound tenderness. Leucocytes 12,300. Temperature 97. Urine - many pus cells, occasional erythrocytes.

Pyelitis?

Following admission, pain is confined chiefly to right lumbar region and it is

felt that she probably has acute pyelitis.

11-26-34 - Temperature rose to 102.8.

11-27-34 - Temperature 104.6. Thereafter fever declines and her general condition seems to improve.

Cerebral Accident

11-29-34 - Found lying in bed in semi-stuporous state. Mouth drawn to right, head to right, left eye closed, right eye slightly open, pupils equal and regular. Neurological examination - signs of left hemiplegia (thought to be on embolic basis, embolus thought to be from the thrombus in auricle). Rallies somewhat but later lapses into deep coma, temperature rises and expires 4 days later.

Exitus - 12-3-34.

AUTOPSY:

Showed some thickening of the mitral valve. There is a calcified lesion about 2 cm. long and about 15 mm. from the edge of one of the mitral cusps. Calcified lesion is somewhat ulcerated and has some fresh vegetations. There are infarcts in spleen and kidneys. There is an old hemorrhage in the region of the left internal capsule.

Comment:

ABSTRACT

Blumgart, H. L., Berlin, D. D., Davis, D, Riseman, J.E.F. and Weinstein, A. A.

Total ablation of thyroid in angina pectoris and congestive failure.

J.A.M.A. 104, #1: 17-27, (Jan. 5), 1935.

In contradistinction to our patient, no patient in this group of 75 shows signs or symptoms of thyrotoxicosis. Most of the patients are chronic invalids. Every patient had been incapacitated for long periods in spite of having received all available medical measures.

Table I. Etiology of Heart Disease of Fifty Patients with Circulatory Failure.

Type of Disease	Number of Cases
Rheumatic heart disease	29
Arteriosclerotic heart disease*	14
Hypertensive heart disease	3
Congenital heart disease	2
Syphilitic heart disease	1
Cor pulmonale	1

*Five of these patients also had hypertension.

Twenty-four of these patients maintain compensation and show decided improvement for from 2 to 18 months. Four patients are able to undertake only light work, while 20 patients are living a life of moderate activity; although not indulging in heavy labor, they are economically rehabilitated. Congestive failure reoccurred in 6 patients after operation.

The authors record their results in treatment of 25 patients with angina pectoris.

"Patients with malignant hypertension and similarly patients with rheumatic, syphilitic or arteriosclerotic heart disease who give a short but rapidly progressive history of congestive failure or angina pectoris are not operated on. Our present conception of the patient with congestive failure most likely to gain the greatest benefit from operation is one with rheumatic or hypertensive arteriosclerotic heart disease who, despite a long history of frequent episodes of decompensation after moderate exertion, nevertheless becomes compensated on rest in bed."

The basal metabolic rate should preferably be not lower than -10%. Only when the patient has become free of congestive failure can one obtain a true basal metabolism rate.

Postoperative mortality: Six patients in this group of 75 died; 8%.

Surgical hazards: The greatest surgical hazards are postoperative cardiac failure and terminal bronchopneumonia, recurrent nerve injury, parathyroid insufficiency and failure to remove the thyroid gland completely. Parathyroid insufficiency is not a serious complication. Laryngoscopic examination is done between lobectomies in order to prevent bilateral laryngeal paralysis.

"Secondary consequences and possible untoward effects of artificial myxedema. Most patients are kept at metabolic level between -25 and -30% by administration of one-fourth grain of thyroid (Armour) daily. At this level they are free from disturbing symptoms of myxedema and their hearts are required to do less work than at the higher preoperative metabolic rate."

The authors believe that myxedema heart does not become a serious complication in these patients if the basal metabolic rate is maintained at about -30%. As the basal metabolic rate is lowered, the serum cholesterol concentration becomes elevated.

Conclusion:

"The beneficial results that have been achieved by complete thyroidectomy in patients with congestive failure and angina pectoris warrant the further application of this procedure in patients who, in spite of all available medical procedures, are incapacitated. The precautions to be exercised in the selection of cases in the preoperative, operative and postoperative management, and in the treatment of the various complications, must be rigidly adhered to if the operative risk is to be reduced to a minimum and the fullest possible benefit is to be conferred on such patients."

5. ., 68
Urology,
Benign hypertrophy of prostate.
Bilateral hydronephrosis.

6. ., 83
Surgery, no autopsy.
Diabetes mellitus.
Arteriosclerosis.

7. ., 51
Medicine,
Pernicious anemia.

Comment:

Autopsy shows cortical abscesses of the left kidney besides the classical findings of pernicious anemia.

8. , 2
Pediatrics, no autopsy.
Cardiac Failure, Cause?

9. , 1 mo.
Pediatrics,
Otitis media, bilateral.
Antritis, bilateral.

10. ., 30
Surgery,
Congenital hemolytic jaundice.

11. ., 70
Urology,
Benign hypertrophy of prostate.

Comment:

A 5-year history of dysuria. Admitted in uremic state.

Autopsy shows bilateral hydronephrosis and pyelonephritis.

12. ., 68
Surgery,
Intracranial hemorrhage (fat embolism).

Comment:

Auto accident with fracture of tibia and fibula.

Autopsy shows punctate hemorrhages of brain (cerebrum and cerebellum). Stains for fat on lung and brain show droplets of fat in the capillaries.

13. ., 82
Surgery,
Carcinoma of sigmoid.

Comment:

One of the findings at autopsy is perforation of the cecum.

14. , 18
Surgery, A
Perforated esophagus.

Comment:

Case is white male, 18 years of age.

12-2-34 - 5 P.M. - Patient is cleaning a gasoline tank of a car. At the completion of this, he struck a match to see if any gasoline is left in the tank. An explosion follows. He is knocked down, but seems to suffer no particular injury except for first and second degree burns of face, especially around upper lip and nose. He then goes into his house and asks for a glass of water (about 10 minutes after the explosion). Immediately upon drinking this water, he is seized with a severe pain in his left chest, so severe that he falls to the floor.

Admitted.

11 P.M. - Physical examination: shows second degree burns about the face. Eyes are inflamed. Vision in both eyes is good. Chest - dulness over left side with increased breath sounds and increased vocal fremitus. Abdomen and extremities - negative. X-ray of chest at time of admission: shows presence of considerable fluid in the left chest with pneumothorax and collapse of left lung.

Progress

Respirations 38, pulse 115.

12-3-34 - Noon - Suddenly becomes more dyspneic, pulse rose to 140. Thoracentesis immediately done and 500 cc. of milky fluid, slightly blood tinged, is recovered. Air seems to be under considerable pressure in the thorax. A #16 catheter is inserted through the thoracic wall by means of a trocar, and suction is applied to this catheter. Large quantities of air and milky fluid are obtained. Examination of fluid - shows multiple fat globules. Diagnosis: rupture of lung with injury to thoracic duct.

By use of catheter and suction, the mediastinum which is markedly displaced to the right is brought back to the midline. Seems to be doing fairly well. Large quantities of fluid obtained from patient's chest (between 3,000 to 9,000 cc. fluid daily).

12-10-34 - When patient is allowed to take an eggnog by mouth, the drainage from the chest is immediately increased in quantity and seems to take on character of the material just swallowed. He is therefore given a small amount of methylene blue and this is immediately recovered from the chest through the catheter. It is then thought that the patient has rupture of esophagus with rupture of the thoracic duct. Continues to run temperature between 103 and 105. Pulse 100 to 120. Respirations 20 to 30 per minute.

12-13-34 - A.M. - Suddenly develops circulatory collapse and dies within a few minutes (11:05 A.M.).

AUTOPSY

Shows rupture of esophagus in upper third, mediastinitis, left empyema, and pericarditis. The thoracic duct is located. There is inflammation about it but the exact site of perforation is not found.

15. , 62
Urology, no autopsy.
Chronic pyelonephritis.
Uremia.

16. , 54
Neurology,
Psychosis of undetermined origin.
Bronchopneumonia.

17. , 17
Medicine,
Mediastinal tumor, probably metastatic carcinoma with primary in the lung, possible malignant degeneration of a teratoma.

Comment:

Mediastinal tumor which

did not respond to radiation.

18. ., 22
Medicine,
Chronic glomerulonephritis.
Infectious arteritis.

Comment:
Young female with glomerulonephritis associated with gangrene of the hand and hemiplegia due to infectious arteritis.

19. ., 27
Medicine,
Subacute Bacterial Endocarditis.

Comment:
Subacute bacterial endocarditis superimposed on old rheumatic valve defect. Rheumatic fever in 1929.

20. , 15
Pediatrics,
Brain Abscesses.

21. , 73
Surgery, .
Trigeminal neuralgia.
Postoperative death.

22. , 61
Medicine, .
Essential hypertension.

23. , 42
Medicine,
Lobar Pneumonia, type I.

24. , 12
Medicine, no autopsy.
Acute suppurative appendicitis.

25. , 9
Pediatrics,
Chronic pyelonephritis.

26. Baby Girl , 0
Nursery, no autopsy.
Anencephalus.
Still-birth.

27. ., 51
Surgery, no autopsy.
Adamantinoma, right mandible.

28. ., 3
Pediatrics, no autopsy.
Scarlet fever.

29. 56
Surgery, no autopsy.
Carcinoma of stomach.

30. ., 9
Pediatrics,
Pneumococcic meningitis.

Comment:
The case is a 9 year old female who two weeks prior to illness had severe upper respiratory infection with profuse nasal discharge. This is followed by listlessness, anorexia and drowsiness. Her temperature rises. She has vomiting and vertigo, pain in the back of the head, and opisthotonos.

Spinal fluid shows 600 to 2000 leucocytes, sugar 150 mg. %, chlorides 609 mg. %, total protein 36 mg. Direct smear showed many pneumococci and pneumococci were grown on culture, type XIII.

Autopsy:
Reveals empyema of right sphenoid sinus and meningitis (not otogenous).

31. ., 48
Neurology,
Cause of death undetermined.

Comment:
There is a history of addiction to drugs. Patient has optic neuritis.

Autopsy:
Reveals no definite cause of death.

32. ., 63
Urology,
Benign hypertrophy of prostate.
Acute bacterial endocarditis.
Multiple abscesses.

Comment:
During patient's stay in hospital, he develops paronychia of right great toe. The following day his temperature rises to 105°. His condition grows progressively worse and he expires 4 days after onset of the paronychia. Non-protein-nitrogen, one day before death, 46 mg. per 100 cc. of blood.

Autopsy:
Soft vegetations on aortic valve. Heart weighs 425 grams. There are punctate hemorrhages on anterior surface of both lungs. The spleen weighs 400 grams and there is one large fresh infarct. There are miliary abscesses in the liver and cortices of both kidneys. There is a moderate degree of hydronephrosis and hydroureter. There is an area of softening in the right frontal lobe of brain with purulent exudate. The prostate is moderately enlarged.

33. ., 71
Urology,
Hypertrophy of heart (hypertensive).
Tuberculous pyonephrosis.

34. , 13
Medicine,
Portal cirrhosis.

Comment:
The case is a 13 year old female who had mild attacks of jaundice each winter (in cold weather) since 8 years of age. In March 1934, she is severely ill with marked tenderness of the abdomen, nausea and vomiting, and restlessness. She is deeply jaundiced. She is ill for about 4 months and is said to have had clay colored stools.

In the early part of December, 1934, she has a severe sore throat, her temperature is 104.8, her pulse 140. She has tenderness in the epigastrium. Her urine is deeply bile stained and her stools are clay colored. She is mildly delirious during the night. Her jaundice and fever persist. She is admitted to the University of Minnesota Hospitals on December 22, 1934.

Physical examination on admission shows a well developed and fairly well nourished white female. There is marked jaundice. The spleen, liver and kidneys are not palpable. There is a congenital anomaly of both thumbs.

Laboratory: Urine - negative except for bile pigment. Blood - hemoglobin 60%, erythrocytes 2,730,000, leucocytes 10,900, neutrophiles 86%. Icteric index - 56 units. Van den Bergh - biphasic reaction.

Course: December 28, 1934 - Has bleeding from mouth and nostrils. She grows progressively weaker and expires on December 29th.

AUTOPSY

The spleen weighs 335 grams, is somewhat fibrous. The liver weighs 1300 grams, is bile stained and slightly nodular. There are punctate hemorrhages in the mesentery. The meninges are bile stained but the brain substance itself is not bile stained. There is pus in the right mastoid.

Microscopic examination of the liver shows small adenomas and areas of fatty metamorphosis. The bile ducts are not distended. There is increased fibrous tissue in the portal spaces. There is only a mild degree of round cell infiltration. An occasional area shows the formation of new bile ducts.

Diagnosis: Portal cirrhosis.

Note: Dissection of the bile ducts shows no obstruction.

ABSTRACTS -

By Dr. R. A. Jensen

Sutton, T. L.
Cirrhosis of the liver in childhood.
Am.J.Dis.Child. 39:141-147.

Cirrhosis of the liver is defined as thickening or proliferation of the elements that make up the stroma.

A classification of cirrhosis of the liver is suggested:

A. Primary
1. Atrophic (Laennec's, portal, nodular) shows periportal scarring with nodular hyperplasia of liver cells in place of normally arranged lobules.

2. Hypertrophic (Hanot's, biliary) with markedly irregular diffuse proliferation of connective tissue invading diseased liver tissue.

B. Secondary: Resulting from
1. Chronic passive congestion (cardiac) with cyanotic atrophy and fibrosis.

2. Chronic biliary infection and stasis (biliary) with no deep invasion of liver tissue by fibrosis.

3. Pigmentation.

4. Syphilis and possibly tuberculosis and malaria.

Children may develop any of the above types of cirrhosis. At the St. George's Hospital (England), there were 12 cases of portal cirrhosis in children (1865-1918). Woolley collected 90 cases in persons under 21 years of age, the average age in his group being 11 years. The condition is readily confused with Banti's disease. Some authors call attention to the association of spider angiomas of the skin with cirrhosis of the liver in children. Perhaps the most important differential diagnosis is that of catarrhal jaundice.

Calvin and Saffro.
Cirrhosis of the liver in children.
Am. J. of Dis. Child. 43: 914-930.

The authors record 36 reported cases of cirrhosis in children, 18 are males, 14 females, in 4 the sex is not stated. Seven give a history of alcohol. Syphilis is suspected in 3 cases. Twenty-five have jaundice, 5 no jaundice, 6 not stated. Ascites is present in 15 cases, absent in 12, and not stated in 9. All patients have a large liver. The spleen is enlarged in 21 cases, not enlarged in 4, not stated in 11. There are 17 autopsies, 7 classified as Laennec's cirrhosis, 2 as infection, and 8 are described as "hypertrophic" cirrhosis.

II. DIRECTIONS

For the Proper Use of the Ediphone Dictating Machine.

(Supplied by Mr. Williams, Company representative.)

1. Put the cylinder clear on. Do not be afraid of breaking it.

2. Be sure the indicator is pulled over to "Dictation".

3. Speak with the mouthpiece held lightly against the upper lip and about one or two inches from the lower lip.

4. Stop whenever the bell rings. Either the machine is not working properly or you have used up 90% of the cylinder.

5. Use the correction slip, marking your sign on the lower line.

6. Poor dictation is usually not mechanical in origin. Most of our troubles are due to not speaking into the mouthpiece.

III. WANTED

1. Physician for Linton, North Dakota. Dr. Wolverton died suddenly a short time ago. He had a large practice and a small hospital. The citizens are anxious to get a good man to take his place.

The town is located about 60 miles south of Bismarck and is the county seat.

2. House surgeon at fairly large General Hospital in North Dakota. Someone interested in a year or two of hospital surgery and the care of surgical patients should apply.

3. Physician for Medina, North Dakota. Said to be the best town between Bismarck and Jamestown. In good times, supports a physician very well. At the present, money is rather scarce, although a fair living can be made with the help of Federal Aid. Business men are very anxious to get a man at the earliest opportunity. Surrounding territory large and very good.

IV. FOLLOW-UP

Most incomplete follow-up studies represent failure on the part of the physician to keep an early, persistent contact with the patients. They are human after all, and appreciate interest in their welfare. Writing to a man five years after he is dead does not make a very good impression on the family. The successful follow-up in the Tumor Clinic is due to patient interest. The following letter is an example:

"Dear Mr. K.:

Since we have not heard from you for some time, would you be able to come to the Tumor Clinic on Thursday morning, December 20th, at 9 o'clock? If you are unable to come, kindly state at the bottom of this letter how you are.

Very truly yours,
W. T. Peyton, M.D."

"Dr. W. T. Peyton:

Dear Sir:

I thank you for your invitation and will be there at the time you state. I feel well excepting of a tickling throat cough, especially when I smoke.

I fully appreciate this kindness on the part of the personnel that goes to make up your great institution.

Very truly yours,
P.J.K. "

V. ALFRED WASHINGTON ADSON

Distinguished neurological surgeon of the Mayo Clinic will be here next week to lead the discussion on "Meningiomas". His annual visit is always anticipated with pleasure for he has taken a very active interest in our proceedings and makes a special point of being with us.

VI. MOVIES

The Minnesota-Iowa and Minnesota-Michigan Football Games - 1934.

Prepared and presented by Phil Brain, of the Athletic Department.