Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Out-Patient Department

Volume X | Friday, February 10, 1939 | Number 16

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

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Published for the General Staff Meeting each week during the school year, October to May, inclusive.

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William A. O'Brien M.D.

I. LAST WEEK

Date: February 3, 1939

Place: Recreation Room
Powell Hall

Time: 12:10 to 1:25

Program: Movie: "A Criminal is Born"

Announcements

Changes in the Retinal Vessels in Pregnancy

Robert R. Tracht

Discussion:

E. T. Bell
John L. McKelvey
Edward Burch
Irvine McQuarrie

Present: 133

Gertrude Gunn,
Record Librarian

* * *

II. MOVIE

Title: "The Moth and the Flame"

* *

III. ANNOUNCEMENTS

1. Postgraduate course in Dietetics will be held at the Center for Continuation Study February 13, 14, and 15, 1939. The program is planned primarily for dietitians in hospitals and institutions although there will be a good representation of teachers and public health nutritionists. The first day will be devoted to a consideration of the fundamentals of nutrition with Drs. Taylor, Palmer, Wilder and Stewart giving the main lectures. In the afternoon, Miss Thomas and her associates will give a demonstration of teaching nutrition to nurses: in addition there will be a display of special diets as used in this institution. On Tuesday the theme will be special diets. The low fat, diabetic, and potassium diets will feature the morning program. Mary Foley of the Mayo Foundation will tell of their work on the addition of minerals and of vitamin concentrates to the diet. In the afternoon the subject will be diet in allergy. Drs. Madden, B. A. Watson, and A. V. Stoesser will represent the medical faculty on the second day with Dr. Prickman of the Mayo Clinic presenting his work on the elimination diet in allergy. On Wednesday the program will be quantity cookery, food costs, personnel problems with field trips to a new hospital kitchen and a remodeled kitchen. The program will close with a round table by Clarence Smith, University purchasing agent. Beula Becker Marble of Huntington Memorial Hospital, Boston, will lead the daily discussions on research in dietetics and will give the dinner address on Monday evening. On Tuesday John L. McKelvey will tell of the nutritional problems in the orient. The course program is under the chairmanship of Gertrude Thomas of this Hospital. This is the first course for dietitians at the Center and there will be a large enrolment.

2. HOLIDAY. Monday February 13, 1939 is the official University holiday for the celebration of Lincoln's Birthday.

3. ADVANCE PROGRAMS. Notices were sent last week to remind those whose hospital staff programs are to be given in the spring quarter. Every meeting has been assigned and a splendid program is in prospect.

4. MEASLES. There is plenty of anti-measles serum in the Human Serum Laboratory. It may be used as a preventive agent in very young children or those who are not well, or as a means of modifying measles in any patient. A nominal charge is made for the serum as the enterprise is self-supporting.

IV. OUT-PATIENT DEPARTMENT

Macnider Wetherby

The hospital out-patient medical clinic and the adult admitting clinic are composed of the same personnel. This report will cover some of the procedures and activities of both the admitting department and the medical clinics.

The Admission of Patients

The patients admitted to the University Hospitals come from the entire state. We reject most of those coming from Ramsey County and the City of Minneapolis, because of our limited facilities and the adequate care provided at the Ancker and the Minneapolis General Hospitals. An exception has been made in the case of those with malignant diseases.

All patients admitted to the clinic must be in circumstances making them financially eligible and must be sent in by a local physician. A patient may be sent in with a note only, in which case he must pay nominal clinic and hospital expenses and care for himself while in the city. A patient may be sent in with papers certified by his county commissioner which will cover all clinic and hospital expenses. We have encouraged the guarantee of local room and board in a boarding house or rest hospital for indigent patients. Such a guarantee is usually made by the local town board on a form supplied to them. This procedure has progressed to such a stage that a large number of patients are being cared for in this way. The charge for board and room including transportation to and from clinics is usually $1.00 per day, and for rest hospitals $1.25 per day. The patients are placed in boarding houses and rest hospitals through the social service department and Miss Gilman's office.

The use of these institutions has made it possible to care for those who might not otherwise receive treatment. It has also helped to shorten the number of days of hospital care by completing preliminary studies as out-patients and in the convalescent care of those not ready to return home. There are certain objections to such institutions because of our lack of supervision; however, as a whole, they have served a very useful purpose. It is our hope that at some future time we may have a convalescent hospital under our own supervision. There is certainly a serious need of institutions to care for individuals with chronic illness at moderate cost.

Adult County and Per Diem Hospital

Admissions in October, 1938

	Number	Percent
Admitted from the Out-Patient Department	378	86.5
Admitted directly as emergency	59	13.5
Total	437	100

		July_June 1929 1930	July_June 1931 1932	July_June 1933 1934	July_June 1935 1936	July_June 1937 1938
1.	Admission		4860	5193	5153	5168
2.	Medicine					
	General	13625	14668	16526	19977	21685
	Cardiac		1485	1701	2103	2632
	Chest		2323	3430	3718	3984
	Gas.-Int.		288	717	1044	1046
	Metabolism		895	884	793	1101
	Neurology	1611	1762	1999	2349	2942
	Skin					
	"L" Clinic		6134	8093	6240	5883
	Dermatology	9529	3677	3376	4329	4816
3.	Surgery					
	General	6814	5408	7618	9947	8844
	Genito-Urinary	4028	3807	3965	2748	2989
	Goitre		367	596	699	912
	Reconstructive		53	181	379	358
	Tumor		2285	2897	3274	3444
	Gynecological		659	719	776	742
	Orthopedic	859	1238	1547	2200	2243
	Urology-Female		419	1270	1082	1299
4.	Ear	1905	3028	3390	2809	2635
5.	Eye					
	General	2904	2983	3347	3798	4297
	Refraction	1448	1274	1076	1016	1351
6.	Nose & Throat	2959	3183	3769	3946	3930
7.	Obstetrics	2555	2432	2110	2248	2540
8.	Gynecology	4040	3891	4980	5668	4350
9.	Pediatrics	5219	5197	5834	5543	5792
10.	Nutrition		438	535	564	590
11.	Dental	1851	1449	2879	223	509
12.	Night Clinic					
	Genito-Urinary	2439	1993			
	"L" Clinic	3395	1777			
	TOTALS	65181	77973	88632	92626	96082

The Selection of Patients for Admission to the Hospital is a difficult problem in many instances. There are more patients applying for hospital care than we can admit. This problem is much more serious on some services than others. This hospital has two primary functions; first, the service of care of the sick, and second, the teaching of medical students. Both of these must be considered in our admission of patients. The admitting policy of the hospital is to allow the selection of patients for admission, as much as possible at the discretion of the staff members of each service. This is done by the reference of all possible patients to the respective services in the out-patient department, and by calling staff members to pass on patients coming in for emergency consideration. It is of interest that an analysis of all adult new patients admitted to the out-patient department in a single month, showed that 27% of these were referred to the hospital for care. A study was also made as to the percentage of adult patients admitted after out-patient studies as compared with those admitted directly to the hospital as emergency admissions. In October, 1938 there were 437 county and per diem adult patients admitted to the hospital. Of this number 378 (86.5 percent), were seen as out-patients and referred to the hospital from the out-patient department. Fifty-nine (13.5 percent) were admitted directly to a hospital service as emergency admissions, without out-patient study. Nearly all of the emergency admissions were certified by a staff member.

There is often a problem in the admission of patients at night and on holidays. Patients coming at such times are seen first by the medical interne assigned to the admission service. There are several possible procedures to follow with patients coming after regular hours. If the patient does not require immediate hospital care, he remains at the home of relatives or friends that night and reports to the out-patient department the following morning. If no friends or relatives are available, the patient is placed in a boarding home or rest hospital for the night. These institutions will come for patients with a car. In a few instances when there is doubt as to the procedure to follow the patient can be placed in the hospital over night on the ambulatory service and either admitted to a regular hospital service or dismissed to the out-patient department the next morning.

The greatest problem facing the admitting intern is in the disposal of patients who may require immediate hospital care. In such cases the intern must have the prompt assistance of responsible staff members. This refers to members of the special services involved and to the staff members of the admitting service. In most instances a responsible member of a special service decides as to the disposal of such a patient and signs his report on the chart. In a few cases where there is dispute as to service to which a patient should be assigned, a decision is made by a member of the admitting service. This is seldom necessary. There are also a few cases in which it is expedient to admit a patient to a hospital service for the welfare and reputation of the hospital, even though such patients may not always be the type of cases which the staff members would elect to admit. We are especially anxious to expedite the admission of ill patients to a hospital bed and to avoid keeping such patients waiting too long on cots in the admission department for a decision by a staff member. For this reason no patient for whom hospital care is being considered is to remain more than two hours in the admission examining room and will be put to bed in the ambulatory service if further studies are pending. There are some instances, however,when patients must wait in the examining room more than two hours because of the lack of an available bed.

General Medical and Admission Clinic

All patients are examined in this clinic on admission with very few exceptions. Routine procedures such as height, weight, temperature, and pulse are taken. Laboratory data including urinalysis, hemoglobin, and Wasserman tests are done on all new patients. A routine history and general physical examination

is done by a medical student on each patient and the student's findings are checked and further studies and treatments are outlined by a responsible staff member. Patients are referred freely to all the special clinics.

The clinic secretary explains any procedures ordered and gives the patients written instructions and definite written appointments to the various clinics.

We are now adding another routine procedure in this clinic; namely, the fluoroscopic examination of the chest of all patients admitted to the out-patient department or to the hospital, if such patients are in condition to have such a study.

We feel that our physical examination of the chest is often unsatisfactory, especially in cases of early pulmonary tuberculosis and that we are missing certain cases and occasionally admitting patients to hospital wards with tuberculosis. The Mantoux test has been done routinely on all patients admitted to the hospital in the past few years but has been a rather unsatisfactory check. Fluoroscopic chest examinations are to be done daily between 11 - 12 a.m. by a fellow from the x-ray department. Unexamined patients admitted to the hospital after 12 noon will be given appointments to return to the out-patient department on the following day for fluoroscopic examination between 11 and 12 a.m. Those unable to return should have chest plates made in the hospital to give us complete coverage of all patients admitted to the hospital. Patients whose fluoroscopic examination suggests a significant pathological condition will have chest plates taken. If there is a suggestive history of tuberculosis, a chest plate will be taken regardless of a negative fluoroscopic study.

Cardiac Clinic

The cardiac clinic, under the supervision of Dr. George Fahr, is held on Monday, Wednesday, and Friday afternoons. Patients referred to this clinic routinely have an electrocardiogram on the day of the clinic visit and have an orthodiagramatic tracing of the heart outline.

A number of patients with chronic cardiac conditions are placed in rest hospitals. The cardiac clinic is especially fortunate in having an associated visiting nurse who attends clinic and assists in the follow up care and observation of patients remaining in rest hospitals.

A cross index file of cardiac patients, according to diagnosis, has been kept for a number of years in this clinic.

Clinic for Peripheral Vascular Diseases

This has been organized recently as a joint medical and surgical clinic, and is attended by Dr. J.R. Paine and George Levitt. We are anxious to further our studies of peripheral vascular diseases and have excellent cooperation from the physiotherapy department in treating these patients. A series of patients with chronic thrombophlebitis have recently been treated with the Collens-Wilensky Cuff method with encouraging clinical results. A paper is soon to be published covering this treatment.

Chest Clinic

The chest clinic is under the supervision of Dr. J. A. Meyers and is held on Tuesday and Thursday afternoons. This clinic is primarily for the care of patients with pulmonary tuberculosis. Public health nurses are assigned to the clinic who assist in the follow up of patients and possible contacts.

A number of ambulant patients are treated in this clinic with pneumothorax on Tuesday afternoons.

Diabetic Clinic

This clinic is held on Tuesday and Thursday afternoons and is attended by a staff member and the medical fellow assigned to the out-patient department. An average of from 10 to 20 patients are seen each clinic day. The clinic has recently been reorganized to bring about a closer

relationship between the out-patient and hospital services. A dietitian assists in the dietary instructions to patients.

Clinic for Rheumatiod Diseases and Arthritis

This is a division of the general medical clinic and is conducted daily from 1 - 3 p.m. The daily attendance averages from 20 - 40 patients.

During the past eight years, a series of nearly four thousand chronic arthritic patients have been treated with intravenous streptococcic vaccine. The basis for this has been the possible streptococcic infection factor in the etiology of a high percentage of cases and the work of Dr. B. J. Clawson of the department of pathology concerning the advantages of the intravenous route.

In a disease such as chronic arthritis, it is very difficult to definitely evaluate any form of therapy because of 1. the normal variations in the course of the disease, 2. the psychotherapeutic effect, and 3. that patients are trying to get better and are adding other therapeutic factors such as increased rest, avoiding trauma, cold, and exposure. An analysis of the clinical results in 1192 patients treated with vaccine is presented in chart form. This has seemed suggestive to us of the value of intravenous streptococcic vaccine but not conclusive in view of somewhat similar reports by others of therapeutic methods that have been of little, if any value, in our own experience.

With this in mind a control series of 80 patients were treated alternately with two unknown solutions A and B, one containing vaccine and the other saline solution. These patients were observed over a period of from four months to two years, and the analysis of results was checked by three staff members. The patients in the series could be termed as having "reumatoid arthritis" by those using a dogmatic classification.

Our interest in arthritis has not been confined to vaccine therapy and we have studied such clinical factors as the incidence of involvement of various joints, roentgenological findings, subcutaneous nodules in arthritic patients, and bacteriological and immunological studies in conjunction with Dr. Clawson.

Therapeutically we have tried various strains of vaccines and filtrates, sulfur therapy - high vitamin D therapy, and chaulmoogra oil. The treatment of chronic arthritis should by no means be confined to any one procedure, and each patient is treated as an individual problem. Unfortunately, the social and economic status of individuals necessarily influences the treatment given. Among therapeutic methods to be considered are:

1. Regulation of rest and activities
2. Avoidance of cold, exposure, and trauma
3. Palliative and supportive drug therapy
4. Possible Curative drug therapy
5. Physiotherapeutic procedures
6. Individual dietary regulation and the use of vitamines
7. The consideration of alleged foci of infection
8. Climatic change
9. The prevention and correction of deformities

This latter may vary from exercises to maintain the range of joint motion to orthopedic correction with plaster or operation. Recently, Dr. Knight has

been collaborating with us in using local anesthesia as an aid in increasing joint mobility. This has seemed especially helpful in rheumatoid conditions of and about the shoulder where a brachial nerve block is done.

ANALYSIS OF CLINICAL IMPROVEMENT FOLLOWING INTRAVENOUS STREPTOCOCCIC VACCINE FOR 1192 PATIENTS WITH CHRONIC ARTHRITIS

Months Since Beg. Treatment	Under 6 Months		6-12 Months		12-18 Months		18-24 Months		24 Months & Over		Entire Series	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Definite Improvement	171	81	131	69	226	77	173	73.5	194	73	895	75
Questionable Improvement	19	9	24	19	28	9.5	14	6	33	12	118	10
No Improvement	21	10	38	12	39	13.+	42	18.+	39	15	179	15
Totals	211		193		293		229		266		1192	

CLINICAL RESULTS IN CHRONIC "RHEUMATOID ARTHRITIC" PATIENTS ON INTRAVENOUS STREPTOCOCCIC VACCINE AND STERILE SALINE SOLUTION

Clinical Result	A Series (Vaccine)		B Series (Saline Solution)	
	No.	%	No.	%
Definite Improvement	33	82.5	16	40
Questionable Improvement	4	10	7	17.5
No Improvement	3	7.5	17	42.5

Allergy Clinic

This clinic is a division of general medicine and is held every morning except Saturday by Dr. Horatio Sweetser Jr. and Asher A. White. It is equipped with an adequate set of testing materials, including foods singly and in groups, epidermal contacts, common dusts, dried pollen, and extracts of various molds. Most of these except the molds are prepared by our own technician in conjunction with Dr. Ellis of the Student Health Service. Arrangements have been made with Dr. Ellis and Dr. Stœsser for making extracts for common use in the Health Service and the adult and pediatric allergy clinics.

The patients tested and treated in this clinic are mostly those suffering from hay fever, vasomotor rhinitis asthma and migraine; although a few are investigated for gastro-intestinal and genito-urinary complaints (border-line allergic conditions). Patients with allergic dermatosis are referred to Dr. Rusten in the skin clinic.

Student instruction is given for one hour on Wednesday morning to senior medical students in this clinic, at which time they test each other for pollen sensitivity and give each other a few intradermal tests. The students have three sessions in this clinic giving them an opportunity to see various positive and negative tests and to use some of the commercial testing materials as well as those prepared and used here.

A certain amount of investigative study has been done in this clinic on the relationship of asthma and cardiac failure and the circulation time in asthma. A number of cases of asthma have been sent to the x-ray department for special lipiodol studies. Dr. White has been carrying on studies in the relationship of the leucopenia index in allergic conditions.

The staff of the clinic are glad to cooperate in the allergic study of any patients either as out-patients or those on hospital services.

The Gastroscopy Clinic

The Gastroscopy Clinic, begun three years ago by Dr. J. B. Carey and since carried on by him and Dr. N. Logan Leven of the Surgical Service, is held Wednesday and Friday mornings. The Schindler flexible gastroscope has been used, and no harm has resulted from the use of the instrument itself in approximately 750 examinations. One sudden death occurred in a syphilitic man with cancer of the stomach during the period of preparation, which was discussed in a staff meeting as being a probable effect of the pantocain used.

INDICATIONS: In general, gastroscopy should be done in any patient presenting gastric symptoms which have not been adequately explained by employment of the usual diagnostic procedures. This method has been found especially valuable in determining:

Gastritis - the presence of and the type.

Ulcer - whether simple ulcer or a part of ulcerative gastritis;

- and to determine the stage of activity and progress of healing under treatment.

Post-Operative - presence of gastritis, recurrence of ulcer or malignancy.

Malignancy - to help in determining questionable or borderline malignancy and operability.

Hemorrhage - source of hematemesis or melena.

It is also helpful to gastroscope patients with proved duodenal ulcer, gallbladder disease, colitis, syphilis and other conditions, as these may

often show an associated gastritis which, if found, may guide or modify prognosis or therapeutic procedures. It is particularly useful in patients with supposed "functional" gastric complaints, to rule out any possibility of gastritis (and many patients with "functional" complaints have been found to have gastritis particularly of the atrophic type), and as further reassurance to the clinician and patient if the stomach is entirely normal. Cases showing anemia or weight loss not adequately accounted for may profitably be gastroscoped.

CONTRA-INDICATION: In general, the flexible gastroscope may be passed in any one in whom an Ewald stomach tube can be successfully and completely introduced. More specifically it should not be used in the presence of:

Acute upper respiratory infections

Pharyngeal or laryngeal disease or tracheo-bronchitis

Mediastinal tumors encroaching on the oesophagus

Enlarged aorta (aneurysm)

Oesophageal tumors or strictures or varices

Coronary disease with symptoms

Decompensated cardiac cases

Fixed kyphotic spine

Tumors at cardia of stomach

Threatened perforation of gastric ulcer

Psychoses or anxiety states where the cooperation of the patient cannot be had.

Age in itself in no contra-indication. We have examined the blind, the deaf, patients with only one arm or artificial legs, the lean, the obese, tall or short, and almost every other physical abnormality, provided the passage down the gullet is unimpeded.

Some conditions have been found which were not discovered by other methods, and some things were not discovered by the gastroscope which were evident by other diagnostic means.

Perhaps the greatest satisfaction in the study of this material by the gastroscope has been in the finding of gastritis of various kinds. By means of this method it has been made clear that certain abnormal conditions of the gastric mucosa obtain and apparently give rise to symptoms in a great number of people. Whether all of these changes seen may properly be called gastritis is a question; although the term gastritis has been universally accepted as applicable to certain mucosal changes, pending further more extensive study of histological material, it might be better to use more descriptive terms such as hyperplastic or hypertrophic or atrophic changes, submucosal hemorrhagic areas, etc. But even in so doing there may be error in that we have so far not been able to follow through any number of specific cases to any sort of pathologic or histologic examination. There is no doubt about ulcerative or erosive lesions, hemorrhage polypi, or other definite lesions, but the histologic evidence of what we see through the gastroscope and think to be hypertrophy or atrophy or some other morphologic change is not yet complete. There has been, so far, cordial and mutually helpful cooperation between the diagnostic roentgen department and the Gastroscopy Clinic. We are hoping that interest may be stimulated to carry out and correlate study of pathologic or surgical material on the one hand, and clinical therapeutic methods on the other.

V. .GOSSIP

Macnider Wetherby is back from Florida for his meeting today We mention this to give you some idea of the interest shown by our staff members in presenting their messages to us. There is also the possibility that his vacation time was up, although this seems remote. Cecil Watson is also back from a week at Sun Valley, where he has been enjoying his favorite winter sport. We will have to tolerate their mid-winter "tans" for ahile. Mary Malone, formerly of Superintendent Amberg's staff is now located in San Diego in medical record librarian's work. She also writes at length of the climate in California. All of this seems very inappropriate on this lovely winter day. Beula Becker Marble, research dietitian of the Huntington Memorial Hospital of Boston, who will lead the main discussions for the Dietitians Course at the Center for Continuation Study next week, is a wife of Dr. Marble, well known to many of us. Dr. Lester Evans, Medical Associate of the Commonwealth Fund, New York, is a hospital visitor today. He is here to study the progress made on the projects supported by his organization (postgraduate medical education, child psychiatry, growth and development, etc.) We expect to have as our guest Dr. Maxwell Lapham, assistant professor of obstetrics of Tulane University of Louisiana School of Medicine in New Orleans. He is coming to look over the work we are doing in postgraduate medical education. Charlie Rea looks rather the worse for wear as he goes about with his forehead covered with adhesive. The accident is said to have occurred in a very innocent way by bumping into a door. The enrolment in the Medical School in the various courses is interesting. In medicine proper, there are 589 students, including 124 interns. 390 nurses are in the process of receiving their education; this does not include 26 postgraduates. In medical technology, there are 240 students, including those in the preliminary course of two years in the College of Science, Literature and the Arts. Dr. Gaylord Anderson's department of preventive medicine and public health in addition to enrolment in courses taught to Arts College and Medical students has an enrolment of 140 public health nurses, physicians, and sanitary engineers. There are 12 graduate students in dietetics, and 12 graduate students in medical social service. During the year, there will be 40 students trained in hospital pharmacy in cooperation with the College of Pharmacy. The box-car numbers continue when we tell you that the medical sciences enrolment in the Graduate School is 530 (this includes the Mayo Foundation.) Since 1905 when the Graduate School was established 872 advanced degrees in medical sciences have been granted (Master of Science - 711, Doctor of Philosophy - 161.) In the 24 courses offered at the Center for Continuation Study in medical and hospital education since January, 1937, there has been a total enrolment of 900 with 638 faculty appointments. Nine more courses are to be offered before June 30. The numbers still pour in. In the Course for Hospital Administrators, 91 superintendents from 52 cities in seven states represented 73 institutions with a bed capacity of 10,356 and 994 bassinets. In the Medical Record Librarians course, 87 record librarians from 47 cities in 16 states represented 71 hospitals with a total bed capacity of 14,250 and 1684 bassinets. The growth of the Admissions Service of the University of Minnesota Hospitals has paralled the development of the rest of the Hospital. Some of us can remember the way patients used to be admitted, but we have had our present system so long that it is a hazy memory. It would also be of interest to some of our recent staff members to realize how much the Out-patient Department itself has changed. In the good old days it was a typical dispensary, and many of the staff members received the nicknames of the drugs which were their favorites. Today it is modernized to such an extent that ambulatory patients are given the same diagnostic and therapeutic consideration as in-patients.

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