STAFF CONFERENCE

Thursday - April 24, 1930

CASE I.

CHRONIC ALCOHOLISM

The case is that of a man, 46 years old, admitted to the University Hospital 4-15-30 at 11:50 and died 4-18-30 at 6:30 A. M. Has been drinking for the past three weeks. Last Saturday(4-12-30), patient suddenly went out of his head and saw things and talked loudly. Has been like that ever since. Has not voided since 4-14-30 (P. M.); Impression - acute alcoholic psychosis.

Admitted to neurology and put in restraints. Has been drinking all winter rather steadily and has not been well. Complained of weakness, particularly of lower extremities, which have been painful on exertion. Lost about 25 or 30 lbs. since September, 1929. Has persistent cough. Stop drinking about one week ago and has had very little since. Has not had anything to eat for about one week. Had similar spell about three years ago, at which time he was taken care of at a sanatorium for about two weeks. Has had a G. I. upset (gall-bladder?) before his former psychosis.

Family history: Father said to be drinker. Had similar attack. Mother dead; cause unknown. Wife living and well. One child by previous marriage.

Physical Examination: Extremely restless and quite noisy. Talks in German, dehydrated. Rectal temperature 101.8. Chest examination unsatisfactory. Abdomen shows distension of bladder, relieved by catheterization. Pupils equal, regular, respond to light. No nystagmus. Knee jerks diminished but present. Abdomen - abdominal reflexes apparently absent. Babinski questionable on right.

Was put in restraints, catheterized, and enema given. Drinks small amount of water when given by spoon.

Laboratory: Bilirubin present. Urobilinogen present. Hemoglobin 60, rbc. 3.18, wbc. 8.75, P. 70, L. 26, M. 3, E. 1. Marked hypochromasia, polychromatophilia, moderate anisocytosis, and slight poikilocytosis. Blood sugar .088. B.U.N. 12.13. CO_2 40. Icterus index 20.

Progress notes: 4-16-30, Irrational, less restless than before, taking fluids well. Patient shows a marked icterus. Mass and tenderness right upper quadrant. 4-17-30, 7:00 A. M., Definitely worse. Pulse very rapid but strong and regular. Difficulty in breathing due to accumulation of secretions. Pupils small; does not respond. Chest shows many coarse rales. Distant bronchial breathing, left lower. Jaundice increased. Blood pressure 65/55. X-ray of chest shows congestion but no definite pneumonia.

Note: Patient states that he has had jaundice for the past three or four months, at times worse, then better. Sharp pain in the right upper quadrant on numerous occasions. Developed slight abdominal distension. Given proctoclysis. Definite mass in right upper quadrant. 4-18-30, Became weaker after midnight; did not respond to stimulation. Expired.

AUTOPSY DIAGNOSES: (1) Chronic alcoholism (clinical); (2) Cirrhosis of liver; (3) Fatty metamorphosis of liver; (4) Icterus; (5) Acute bronchopneumonia; (6) Cloudy swelling of heart and kidneys; (7) Deformity of chest; (8) Chronic cholecystitis and lithiasis; (9) Deformity of left ear.

CASE II.

MULTIPLE FRACTURES OF RIBS AND JAW.

The case is that of a woman, 50 years old, admitted to the University Hospital 4-9-30 and died 4-21-30 (12 days). She had been in an automobile accident near Gaylord, Minnesota, this noon; was taken to the Gaylord Hospital and given first aid; then sent directly to the University Hospital. Patient rational and does not appear to be in any great amount of pain. Pin point pupils.

Physical Examination: Fleshy woman of middle age up on back rest. Purplish area, size of dollar bill, over crest of left ilium posteriorly; smaller areas on left arm and elsewhere on body. Performs usual movements of extremities. Wound about 5 cm. in length on the medial aspect of the forehead. Second incised wound about 8 cm. in length just below the point of chin. Swelling of the left side of the face. Small cut on lower lip on right side. Complete fracture of mandible just to the right of the midline, the fractured ends pushing into the mouth cavity. The left side of the mandible appears very irregular as though it too were fractured. The teeth were in abnormal position because of the fracture. Neck swollen and tender. Clavicle and upper part of sternum tender to pressure; also the lower ribs on the left side and an area medial to the right scapula. Chest examination shows rhonchi. Heart negative. Blood pressure 128/86. Distension of bladder. Tenderness over spleen, liver, and kidney areas posteriorly.

Patient taken to operating room and laceration of forehead repaired. Laceration of chin not fixed because of possibility of future operation. Given tetanus and gas gangrene antitoxin.

Laboratory: Hemoglobin 80, wbc. 12.150, P. 80, L. 20.

4-14-30, Urea nitrogen 10.26. Blood sugar .099. Urine shows sugar on two occasions, specific gravity 1026 to 1032, some lower figures given, occasional granular casts, many wbc., occasional rbc. X-ray, 4-9-30, shows comminuted fracture of mandible, negative skull, cervical, and dorsal spine, negative abdomen, possible small effusion of left base.

4-10-30, Patient complains of soreness across upper abdomen, more on left than right. Palpation reveals marked tenderness over spleen and also lower left ribs, unable to drink during night. 4-10-30, 6th, 7th, 8th, 9th ribs injected peripherally about 8 inches from spine on left side to relieve pain in the left side and to strap the chest. Because of possibility of fluid, puncture of pleural cavity was done and bloody fluid obtained. Takes fluids poorly by mouth. Hurts her when she swallows. Nasal tube was passed, but patient became cyanotic, and pulled tube out herself. Attempted tube by mouth with similar results, probably has edema about pharynx and larynx. Instructed to give frequent small feedings of nourishing liquid by mouth and to be hyperventilated. Intravenous glucose given. Back becoming discolored, getting steam inhalations. 4-12-30, Denuded area over left hip and both buttocks seen. Breath sounds becoming more normal over right chest. Resonance still impaired. Shows 2 plus sugar in urine. 4-13-30, Stitches removed from forehead. Chin healing in good condition. 4-18-30, Uncomfortable. 4-19-30, Complains of pressure in upper chest this morning; marked general discomfort. Temperature 103.6; pulse rapid and weak; face flushed. Few scattered rales in bases. Abdomen soft and flabby. Oxygen tent started. 4-20-30, Patient much more comfortable; breathing easier; temperature 100.4. Death occurred 4-21-30.

Other laboratory findings; 4-12-30, Probable congestion of right base, probable fracture of 4th, 5th, 6th, ribs, left. Sharp terminal rises of pulse and temperature to 103 and 130.

AUTOPSY DIAGNOSES: (1) Multiple fractures of ribs and mandible (automobile accident); (2) Subpleural hemorrhages and cellulitis; (3) Acute pulmonary congestion and edema; (4) Pulmonary atelectasis; (5) Acute bronchopneumonia; (6) Lacerated wounds of chin and forehead; (7) Multiple ecchymoses; (8) Cirrhosis of liver; (9) Chronic cholecystitis and lithiasis; (10) Slight splenomegaly (fibrous?); (11) Pleural adhesions; (12) Leiomyomata of uterus.

CASE III.

CHRONIC SALPINGITIS.

The case is that of a woman, 31 years old, admitted to the University Hospital 1-15-29, discharged 2-6-29 (22 days.). Chief complaint - pain in right hypochrondriac region (7 months); pain in right lower abdominal quadrant; nervousness; backache. Pain has no relationship to food. Was aggravated by heavy lifting and hard work. Has been so severe that it has caused her to double

up, and at times radiates to the right scapular region. Pain in right lower quadrant present since appendectomy 14 years ago. Had G. C. infection in 1924. Large meal causes her to feel bloated. Relief from attacks of pain when she lies in bed. No response to medication. Tires easily. Has had three children.

Physical examination: No apparent discomfort. Small nodule in right lobe of thyroid. Blood pressure 105/70. Tenderness in right upper quadrant. Scar in right lower quadrant. Pelvic examination showed lacerated cervix.

Urine negative. Blood and blood Wassermanns negative. Plates of gall-bladder and urinary tract negative. Cystoscopic examination normal bladder Pyelogram of right negative. Both ureters show no obstruction. Stated that the pain, which resulted from pyelogram, was similar to usual attacks.

1-29-29, Ten, eleven, and twelfth thoracic nerves injected with 1% novocain. Obtained relief from procedure for about one and one-half hours. It was thought that there was a psychic factor in the patient's complaint, and she was discharged after observation with instructions to rest as much as possible and to return if necessary.

Second admission March 29, 1930 to April 13, 1930 (15 days). Chief complaints - (1) Spurious bleeding from vagina (5 weeks), soaked 8 to 10 pads daily. (2) Tenderness in abdomen. (3) General weakness and feeling of ill being. Has not felt well for past three to five years. Bleeding started five weeks ago, and has since continued. Abdominal pain is worse in the right lower quadrant. Other complaints - eye strain ([illegible] blurring when reading); discharge from left ear (off and on); occasional attacks of tonsillitis; sharp catchy pains in precordium, extending up to shoulder, no relation to exertion; dyspnea and palpitation on exertion. Says heart beats up on slightest excitement. Menstruation started at thirteen, twenty-eight day interval, four day type. Has been menstruating continuously since February 1, 1930. Best weight 138; at present 131. Family history negative. Spent four and one-half years in penal institution. Has been working for past six months.

Physical examination: Lying comfortably in bed. Slight inflammation of lid margins. Discharge from left ear, drum looks involved. Hypertrophied tonsils. Foul breath. Cervical adenopathy. Enlargement of thyroid, especially left lobe. Tender over right kidney area. Stria gravidarum. Old appendectomy scar. Slight protrusion of umbilicus. Tenderness right upper quadrant, especially under ribs on deep palpation. Damaged nail on index finger. Blood pressure 125/82. Pelvic examination - abdomen, hernia to umbilicus, diastasis recti, tenderness right lower quadrant. External genitalia normal. Pelvic floor competent. Cervix high, points to the back and right, deep bilateral lacerations, Uterus normal size, shape, mobility, symmetrical. Mass in left, not connected to uterus, probably ovary, enlarged about twice normal size. Right very tender; no masses made out. Later a more definite mass could be palpated on right. Diagnoses: Chronic bilateral salpingitis, chronic cervicitis, menorrhagia and metrorrhagia.

Laboratory: Urine negative. Hemoglobin 87, wbc. 6.65, P. 66, L. 32, B. 2. Blood Wassermann negative. No G. C. in smear. Gastric expression - chlorides 535 mg.

Operation 4-8-30. Specimens - ovarian cyst, 5 x 3 x 2 cm.; left tube dilated, ends in cystic mass; right tube distended with fluid and fluctuant; end field show extensive perivascular lymphocytic infiltration and few pus cells in serosa. Diagnosis - bilateral hydrosalpinx and salpingitis, follicular cyst of ovary.

Postoperative condition good. Given proctoclysis, hypodermoclysis. 4-10-30, Slight emesis, does not appear well. Temperature 99.8. 4-11-30, Condition about the same, no vomiting until late in day, when vomited small amount of material. Gastric lavage. 4-12-30, Fluids continued, 75 cc., 15% sodium chloride solution intravenously. Gastric lavage. Appears ill, very listless, hot. Abdomen distended. Temperature 103; pulse 160, strong and regular. 4-13-30, Failing, hands cold and clammy, body warm. Dullness in posterior chest, no rales. Oxygen tent. Given adrenalin, caffeine sodium benzoate, intravenous

saline. Became unconscious, and died 11:20 A. M.

Preoperative temperature 97 to 99; pulse 70 to 100. Postoperative, temperature 99 to 105; pulse 80 to 140; respirations 18 to 40.

AUTOPSY DIAGNOSES: (1) Chronic salpingitis (absent); (2) Left ovarian cyst (absent); (3) Operation wound; (4) Absence of appendix; (5) Adhesions of pelvis; (6) Acute fibrinopurulent peritonitis; (7) Hemo-thorax; (8) Acute pulmonary congestion and edema; (9) Acute bronchopneumonia; (10) Multiple puncute wounds; (11) Incision wounds of left antecubital; (12) Slight change of liver (Fatty).

CASE IV.

HYPERTENSION.

The case is that of a man, 44 years old, admitted to the University Hospital 4-16-30 and died 4-21-30 (5 days). Chief complaints - dyspnea on exertion, headaches, and dizzy spells (3 yrs.) Patient has had attacks of dyspnea on exertion for past three years. He feels as though a tight band were compressing his chest. It would come on while he is at work and cause him to rest, after which they disappear. Average duration 3 to 30 minutes. Has them every day. At no time does he have precordial pain, but he does have some pain in the forearms with the attacks. Worse during the past four months. Daily headaches, frontal and occipital. Neck becomes stiff at times. Dizzy spells at frequent intervals associated with headaches. Never has had any edema. Occasionally, a little puffiness of his lower eyelids. Saw a physician three years ago, who told him he had heart trouble and high blood pressure. Good health up to present illness. Family history unknown. Other complaints - blurring of vision, especially when reading newspaper; no epistaxis; occasional cough; slight expectoration; appetite good; food distress, meat and potatoes cause gas and distension, frequent belching; loss of weight 50 lbs. three years; no frequency as a rule; gonorrhea at 17; drank heavily alcohol up to 10 years ago, not much since. Married 20 years, three children living and well, wife living and well.

Physical examination: White male, comfortable, well developed, and nourished. Muscle tone slightly flabby. Peripheral arteriosclerosis. Head negative. Pupils dilated (homatropine). Slight yellow tinge of sclera. Tonsils atrophic. Chest negative. Heart no bulging, no heaving, enlarged to the left, tones distant and clear. Blood pressure 165/120. Second aortic sound snappy. Abdomen - spleen not palpated; liver down 2 cm. Extra digit attached to little finger of right hand. One removed from left hand several years ago? No edema of extremities. Reflexes normal. Impression - hypertension, coronary disease.

Hemoglobin 90, wbc. 7.15, P. 73, L. 26, M. 17. B.U.N. 18.66. Stool - Gregerson positive. Slight trace of albumen. X-ray showed cardiac enlargement, left ventricular type, first stage; negative lungs. Eye grounds - engorged veins, pale arteries, very tortuous in periphery, narrowing of crossing. Blood pressure-systolic 160 to 220, diastolic 120 to 130. Pulse 76 to 100. Temperature 97.6 to 99.4.

Medication: Euphylin, morphine sulphate. 4-21-30, 6:45 P. M., Appears very weak, perspiring profusely. No control of right arm and leg. Unable to speak. Nurse noticed before this that he was acting queer. From then on he went down very rapidly. Heart continued to beat, but respirations stopped, and death occurred at 9:10 P. M.

DIAGNOSES: (1) Hypertension; (2) Cardiac hypertrophy; (3) Cerebral hemorrhage; (4) Marked coronary sclerosis; (5) Myocardial fibrosis; (6) Acute pulmonary congestion; (7) Congestion of liver and kidneys; (8) Pleural adjesions; (9) Slight chronic cholecystitis; (10) Trabeculation of bladder? (11) Supernumerary digit, right hand; (12) Scar on left hand.

Twenty common causes as seen by M. T. MacEachern, M. D., Director of Hospital Activities, American College of Surgeons:

1. Losing sight of four major functions of hospital
2. Inadequately trained hospital executives and supervisory personnel
3. Failure of cooperation between superintendents and governing body and medical staff.
4. Failure of superintendent to carry out adopted policy
5. Insufficient care in extending hospital privileges to doctors
6. Inadequate medical staff organization
7. Misdirected staff conferences
8. Inefficient anesthesia service
9. Inadequate case records
10. Inadequate control of major surgery
11. Lack of follow-up and study of end results
12. Insufficient check on infections as to source and control
13. Too few consultations
14. Low percentage of autopsies
15. Inadequate care of the injured
16. Lack of Social Service activities
17. Poorly organized out-patient department
18. Failure to make hospital attractive or home-like
19. Lack of supervision of interns training
20. Failure to develop proper community relations

CAUSE OF WOE:

1. Staff (whole or part) 70%
2. Board 35%
3. Superintendent 30%

CRITICISM:

"When a mule is kicking, he can't pull; and when he is pulling, he doesn't kick. Constructive criticism should always be invited and welcome. Blessed is the man who can show us our defects and failures in our endeavor to develop and operate our hospitals and thrice blessed the man who can show us hot to remedy these defects and failures." Extract from "What Do You Do with the Brick-bats Shied at Your Hospital?" by George M. Smith, A. M., D. D., Superintendent, Methodist Hospital, Indianapolis, Indiana, "Hospital Management", Volume XXIX - Number 4, April 15, 1930, page 50.