STAFF CONFERENCE

Thursday - May 22, 1930

CASE I.

CARCINOMA OF BLADDER

The case is that of a man, 47 years old, admitted to the University Hospital 2-6-30, died 5-14-30 (97 days). Patient was sent to the University Hospital from the Minneapolis General Hospital, where he was admitted May 27, 1929 and discharged July 5, 1929. Complained of burning sensation in epigastrium, flatulence, nausea, hiccoughing, emesis (fresh blood), and insomnia. Gastro-intestinal study was done, and the findings were enlargement of liver, normal stomach, high cecum, normal colon. Developed hematuria, and a cystoscopy was done. Papilloma of the bladder was found June 15, 1929. The growth was ligated and removed with a cautery knife through a cystotomy opening. The base was cauterized with the actual cautery. Operative diagnosis - papillary carcinoma of the bladder. Pathological report - benign papilloma. Readmitted to the Minneapolis General Hospital 1-16-30. Complaints - hematuria, sharp pain at the end of micturition, frequcncy, urgency, vomiting, and tarry stools. G. I. study, 1-17-30, showed probable chronic gastritis. Cystoscopy, 1-24-30, showed recurrent papillary carcinoma of bladder at the scar in the vault. Patient also had basal cell type carcinoma of right cheek for which x-ray therapy was given.

On admission to the University Hospital complained of hematuria. since operation for tumor bladder June, 1929, clots of blood, and fullness in the head. Onset of tumor symptoms in March, 1929. The patient noticed interference with freedom of urinary tract. Urine dribbled out drop by drop. At the same time noticed marked hematuria. Past history - pertussis, dysentery, influenza, amputation of left index finger, left great toe, operation for hernia, hydrocele. Other complaints - headaches, nasal obstruction, posterior nasal discharge, enlarged nodes in neck, nocturia, hematuria, urinary frequency and burning. Family history - father dead 27 injury, mother 27 childbirth; no family history of malignancy.

Physical examination: White male, ambulatory, in apparently no distress. Localized lesion over right infraorbital region, present for 15 years. Lesion forms scab and then falls off, causing bleeding. Has had x-ray treatment. Membrane on part of right tonsil. Right cervical adenopathy. On left side, Virchow's node? Chest negative. Heart negative. Blood pressure 110/80. Pulse 110. Abdomen - midline scar from umbilicus to symphysis, another scar in lower left quadrant from hernia repair, tenderness in midepigastrium. Murphy percussion negative. Rectal examination showed prostate gland slightly enlarged, indurated, and nodular. Extremities - left toe and index finger amputated, varicosities in both lowers, slight edema of lowers, reflexes normal.

Laboratory: Urine bloody. P.S.P. 60 (2-9-30). Hemoglobin 92, wbc. 14,700, group 2. Urea nitrogen 15.4 to 50.4. Culture of urine, right kidney, colon bacilli.

Operation 2-13-30. Cystoscopic examination: marked cystitis, fine pedunculated tumor to medial side of right ureter. Right ureteral orifice was gaping and was catheterized easily. Left could not be found due to large recurrent carcinoma which involved the entire area. It was ulcerating and contained many pedunculated filaments. The base seemed broad. 2-15-30, Bladder reopened, and 11 seeds of radium emenation implanted in the periphery of the tumor, 1000 mch. Microscopic sections of tumor tissue removed showed benign papillomatous structure of filaments. Following treatment patient did not do very well, complained of pain. Operation March 22, 1930. Ureters were separated and transplanted into sigmoid. Operation done with some difficulty, but was also apparently satisfactory.

3-29-30, Patient feels better for first time since operation. 3-30-30, Fecal material draining through cigarette drain which is in bladder. Vomiting and unable to take fluids. 4-1-30, Patient is eviscerated during coughing spell.

Bowel replaced and wound approximated. 4-4-30, Fecal drainage through fistula about symphysis. Temperature moderately septic type. Exitus 5-14-30.
DIAGNOSES: (1) Papillary carcinoma of bladder; (2) Cystotomy wound; (3) Transplant of ureters; (4) Fecal fistula; (5) Infected hydronephrosis; (6) Multiple abscesses of kidney; (7) Right perinephritic abscess; (8) Peritoneal and pleural adhesions; (9) Postmortem changes; (10) Acute bronchopneumonia; (11) Puncture wounds; (12) Absence of left index finger and left toe (great); (13) Old operation wounds.

CASE II:

PROSTATIC HYPERTROPHY:

The case is that of a man, 67 years old, admitted to the University Hospital 3-28-30, died 4-5-30 (8 days). Chief complaints - (1) dribbling and retention of urine, (2) bladder pain, (3) vomiting two or three times a week, (4) weight loss 35 lbs. since October, 1929. For the past two or three years patient has had trouble emptying bladder completely. There was always some residual left after urination. When bladder is full, patient is troubled by dribbling of urine, but can start urination all right. This trouble has been much worse the last six or seven months. Was told by a physician six months ago he had an enlarged prostate. Has passed a few drops of urine every ten to fifteen minutes. Pain over bladder has only been present the last few days. Had occasional sacral pain before this. For the last four or five months has vomited two or three times in the week. Has now been getting worse. When vomiting occurs, it comes on four to five hours after meals. It contains partially digested food. Doesn't seem to bother patient much. Says he can go right ahead and eat again. Greasy foods, cabbage bother patient. Never has had any epigastric pain. Past history - denies venereal infection. Family history - father dead 82, mother 78, cause unknown; one brother 75 living and well, one brother dead, cause unknown. No family history of malignancy. Occupation farmer. Other complaints - impairment of hearing, infrequent colds, dyspnea on exertion, no edema, occasional palpitation, feet always cold.

Physical examination: Well developed, emaciated male, resting quietly. Eyes negative. Mouth - teeth bad. Neck - no adenopathy. Chest negative. Heart - left border just medial to anterior axillary line, systolic murmur transmitted toward axilla, blood pressure 156/80. Abdomen difficult to palpate because patient holds muscles rigid. Tenderness over bladder. Bladder not palpable. Definite tenderness over right kidney on Murphy percussion. Prostate diffusely enlarged, no nodules felt, gland not hard.

Laboratory: Urine - albumen 2 plus, wbc., occasional granular cast. Blood - hemoglobin 46, rbc. 2.74, wbc. 6.050, P. 86, L. 14, group 2, moderate hypochromasia and slight anisocytosis. B U N, 3-31-30, 176. Creatinin 5.14. 4-2-30, B U N 217.8, creatinin 5.77. 4-4-30, B U N 254.8. Blood Wassermann negative. Smear from lesion on left anterior tonsillar pillar - few streptococci, diplococci, and bacilli, occasional Vincent organisms. Eye consultation - corneal opacity, optical iridectomy, no treatment.

Progress notes: 4-1-30, First seen by staff physician. Retention catheter ordered. Removed and catheterization done only when patient feels distended. Does not look very well. Has labored breathing and is apathetic. Prostate large and boggy. 4-2-30, Fluid given intravenously and subcutaneously. Drinks water poorly. 4-3-30, Patient's condition about the same. Large normal saline injection given intravenously (1625 cc.) Blood pressure 160/72. Coarse rhonchi in left base. 4-4-30, Poor day. Blood urea nitrogen very high. Throat red and dry. Tongue the same. Latter is cracked. Labored regular respiration. Breath is slightly uriniferous. Has considerable apathy. 300 cc. normal saline, hypodermoclysis, 2000 cc. 10% glucose intravenously, total 5280 cc., proctoclysis unsuccessful. Urine - 250 cc. turbid urine obtained, after passing approximately 100 cc. voluntarily. Blood pressure 162/72. Pulse 72. Heart tones very strong and regular. Moist rales at left base. Exitus 4-5-30.

Therapy:- General diet, high caloric diet, urine withdrawn from bladder, mercurochrome instilled, decompression apparatus started. 4-1-30, removed and patient catheterized when uncomfortable. Pilocarpine hydrochloride, codeine sulphate, caffeine sodium benzoate, digitan, insulin, adrenalin.

Nurses' Notes: Complains of pain in right side of abdomen. Weak and drowsy. Difficult to force fluids. Uncooperative. Very sleepy. Very restless and fretful. Complains of pressure over bladder. Not taking nourishment. Throat very red. Respirations deep and labored. Body very sensitive to touch. Very dyspneic. Pulse rapid and weak. Respirations labored and loud. Tremor of hands. Breath uriniferous. Unconscious. Gasping respiration. Exitus.

Temperature: 97 to 101. Pulse 70 to 90. Respirations 20 to 24. Intake 2600, 2000, 2400, 3225, 5000, 3450, 5250. Output 1200, 1500, 1200, 980, 1200, 0, 0.

DIAGNOSES: (1) Hypertrophy of prostate; (2) Chronic cystitis and hypertrophy of bladder; (3) Bilateral hydronephrosis; (4) Chronic pyelonephritis; (5) Uremia (clinical); (6) Hypertension (left ventricular hypertrophy); (7) Pulmonary congestion and edema; (8) Puncture wounds; (9) Acute splenitis.

CASE III.

HYPERTROPHY OF THE PROSTATE:

The case is that of a man, 77 years old, admitted to the University Hospital 3-20-30, died 3-27-30 (7 days). Chief complaints - frequency, nocturia about 35 years, difficulty in starting stream 20 years, pain in penis on urination 17 years, dizziness 5 years. When the patient was about 30 years old, he began to notice frequency and nocturia. This came on slowly and gradually progressed. About 15 years later, he began to notice difficulty in starting his urine. This also came on slowly and progressed gradually so that he had to strain to start it. Several years after this symptom appeared, he noticed pain on urination. This was aggravated at times when he was cold and wet. Pain occurred intermittently. Patient has had trouble with attacks of dizziness for the past five years. Has never fainted. Has had diplopia and black spots before his eyes. Past history: Said to have been always well aside from measles, mumps, pneumonia, pertussis, scarlet fever, typhoid, diphtheria. Between 20 and 25 he was said to have had diabetes, but it disappeared after a doctor advised him as,to diet. He was rather indefinite on this point. Other complaints ; Intermittent pain and discharge from ears in early life, occasional epistaxis, discharge from nose 10 years, persistent cough, pleurisy pains, palpitation 5 years, no hematuria. Although he had a thin whitish discharge at the age of 30 denies venereal disease.

Physical examination:- Well developed, emaciated, pale, nervous, trembly, confused, disoriented, old man, short of breath, gives impression of being very sick. Bilateral opacity of lens. Marked dental caries. Chest thin, narrow, hyperresonant note, no rales. Heart not enlarged. Blood pressure 160/90. Peripheral vessels tortuous and hard. Extremities normal to hyperactive reflexes.

Laboratory: Urine - albumen positive, very many wbc. and clumps of pus. Hemoglobin 63, rbc. 3.00, wbc. 17.200, P. 90, L. 10, group 4. B.U.N. 73.8, 93.4, 72, 122.26, creatinin 2.83, 3.06, van Slyke 30. Blood Wassermann negative.

Operation 3-22-30, vasectomy preliminary to prostatic emucleation. Later followed by suprapubic cystotomy. Anesthesia local.

Progress notes: Hypodermoclysis. 3-23 - Bladder irrigated, boric acid solution. 3-24, Very drowsy, convulsive twitchings of extremities, is decompressed now, 1000 cc. 10% glucose given intravenously. 3-25, Somewhat better but still drowsy and rational. 3-26, Very irrational. Was out of bed. Syprapubic tube pulled out. Given 1000 cc. intravenous. Catheter reinserted. 7:30 P. M. 100 cc. of 50% glucose. Blood pressure 155/80. Respiration stertorous, and still irrational. 3-27, Does not respond, respirations rapid, beginning bronchopneumonia, right base. Given more intravenous solution and also glucose. Exitus 8:45 P. M.

Medication:- Morphine sulphate, adrenalin, decompression of bladder, aspirin, insulin, caffeine sodium benzoate.

Temperature septic type, 97 to 101, pulse 90 to 150. Respirations 14 to 32. Intake 2300, 2800, 2800, 3600, 3350, 4500, 3500. Output 1000, 2400, 2100, 2100, 1500, 1100, ?.

DIAGNOSES: (1) Benign hypertrophy of prostate; (2) Uremia (Clinical); (3) Bilateral hydronephrosis; (4) Aplasia of kidney; (5) Pyelonephritis; (6) Bilateral bronchopneumonia; (7) Chronic cystitis; (8) Operation wound; (9) Edema of external genitalia; (10) Diverticulum of bladder; (11) Fatty metamorphosis of liver; (12) Cloudy swelling heart, liver, and kidneys; (13) Acute splenitis.

CASE IV.

ERYSIPELAS:

The case is that of a woman, 53 yrs. old, admitted to the University Hospital 3-4-30 and died 3-5-30 (1 day). Had been in the hospital for 3 weeks one month ago. Was discharged with a diagnosis of erythema perstans. Has been failing since discharge, and yesterday was up and about during the day. At 7 P.M. was suddenly seized with chills and coughing spell, respiration rapid and difficult. Vomited several times during the night. Does not respond to one's questions. Physician called and said that she had infection of lip and fever. Did not pass any urine since yesterday. Has been drowsy for about one week. Has complained of blurring vision.

Physical examination:- Patient somewhat comatose, lying quietly in bed. Responds when touched with spasm of arms. Temperature 102.8. Respiration 24. Pulse 100, weak but irregular. Respiration not deep. Heart tones cannot be heard. Blood pressure 68/52. Over right lower lobe, many rales and broncho-vesicular breathing are heard. Slight edema of ankles. Catheterized urine contains albumen and white cells, red cells, and many casts. There is marked redness around the eyes. Mouth shows crusty, reddened areas. Unable to get pulse at a later date.

Laboratory: Urine has been described. Blood - hemoglobin 70, rbc. 4,460,000, wbc. 31,300, P. 68, L. 31, M. 1. Many of the pmn's are immature and show decided shift to the left. B.U.N. 47.6. CO_2 38, uric acid 7.07. X-ray shows slight pulmonary congestion, but no evidence of pneumonia.

Dermatology consultation: The lips are a form of noma. The erysipelas might account for the fever, but it is beyond my experience to see above 105 degrees. Therapy - wet packs for erysipelas.

3-5-30, Pulseless all day. Blood pressure not obtained. Temperature does not come down below 106 with cold packs. On previous admission, blood pressure was 160/100. Electrocardiogram showed left preponderance. Spleen and lymph nodes enlarged. Wbc. 4,900 with 61% lymphocytes. Biopsy showed lymphoid hyperplasia. B.U.N. 14.

Therapy:- Caffeine sodium benzoate, adrenalin, hypodermoclysis, cardiozol homocaffeine, proctoclysis, wet packs, digitalis, digitan, adrenalin.

Temperature 103 to 106.8. Pulse 70 to 110. Respirations 20 to 28.

DIAGNOSES: (1) Erysipelas; (2) Chronic lymphatic leukemia? ; (3) Erythema perstans (clinical); (4) Cloudy swelling heart, liver, and kidneys; (5) Splenomegaly; (6) Enlargement of lymph nodes, inguinal 3, cervical 1, inguinal 1, infraclavicular 1; (7) Fatty metamorphosis of liver; (8) Congestion and edema of lungs; (9) Arteriolosclerosis of kidneys.