UNIVERSITY HOSPITAL

STAFF MEETING

June 19, 1930.

CASE I.

CARCINOMA OF THE STOMACH.

The case is that of a man, 58 years old, admitted to the University Hospital 4-24-30, died 5-20-30, (26 days). First symptoms started in September, 1929. Complaints - weakness, weight loss 50 lbs. since that time, backache, fullness, feeling of gas and distension in abdomen, periods of constipation, frequent vomiting, worse since January, 1930, pain and cramps in the right leg (1 year), palpitation, dizziness, dyspnea since January. In good health to one year ago when he noticed cramps in leg (right). Hands and feet also get cold easily. Has tingling sensation. Feet go to sleep easily. Noticed in September that he was not as strong as before. Weakness has grown worse. Tires easily, especially when walking. Shortness of breath on slight exertion. Frequent dizzy spells following exertion. Heart seems to pound and go faster. Best weight 250 lbs. During this time he noticed a sensation of fullness in stomach after eating only a small amount of food. Seems hungry, but is not able to get the food down. Frequently passes gas and belches, which gives slight relief. Gnawing senation in stomach relieved by taking small amounts of food. Pain in lumbar region seems worse than gastric distress. Frequent vomiting sour material, several times noticed it was green. Has never noticed blood. Constipation since patient has not been eating so much.

Past history: Usual childhood diseases. No serious illness. Other complaints: Impairment of vision and hearing. Dryness of mouth. Slight pain and burning on urination. Nocturia. Stream not very large. No difficulty in starting or stopping. No venereal disease history.

Physical Examination: Well developed man with apparent weight loss. Striae on the abdomen. Skin moist and pale, sallow. Ambulatory. Does not appear to be in pain. Eyes negative. Hearing decreased. Upper and lower dental plates. Mucous membrane pale. Virchow's nodes not palpable. No axillary glands. Lungs negative. Heart negative. Blood pressure 140/55. Abdomen - tenderness in epigastrium but not rigidity, distinct nodule palpable under umbilicus, slight tenderness under right costal margin. Spine - tenderness on pressure over lumbar region. Reflexes negative. Prostate enlarged, both lateral lobes. Median fissure is not palpable. No rectal shelf.

Laboratory:- Urine negative. Hemoglobin 39, rbc. 2.800, wbc. 5.300, P. 63, L. 34, P. 2, E. 1. hypochromasia and slight anisocytosis, blood group 2, B.U.N. 23.33, van Slyke 50, chlorides 478. P.S.P. 40%, 25%, total 65%. X-ray: stomach, 5-2-30, shows scirrhous carcinoma, lesser curvature of stomach; possible polypi of pyloric end. Patient was given two transfusions which brought the hemoglobin to 60%.

Operation: 5-11-30, 10:03 to 1:40 P.M. Large tumor, involving the lesser curvature of the stomach was found. Lesion extended from upper portion of lesser curvature 2 inches from the diaphragmatic hiatus to the first portion of the pylorus. It apparently had projected through the pylorus into the duodenum for a distance of about 1 inch. Greater curvature free. Palpable nodes in gastrohepatic ligament and hepaticoduodenal ligament. There were also some small nodes in the greater omentum just below the lower end of the stomach. Mass not attached but brought up with difficulty because of extra gastric involvement. Operation partial gastrectomy with end to side anastomosis between upper third of stomach and jejunum (posterior Polya operation) Lesser curvature very short. Duodenum stump short, but closed without difficulty. No evidence of metastases. (distant).

Postoperative notes: Condition fairly good. Given medical transfusion, 500 cc. of blood, 200 cc. of saline. 5-13, Condition good, slight pain in abdomen. Later pulse became rapid. Temperature elevated. Patient felt warm. 5-14, Repeated voiding of small specimen. Patient catheterized, and 150 cc. obtained. Patient coughing, nonproductive. Probable findings in left base. Dry crackling rales in right axilla. 5-17, Patient restless, rales in right base. 5-18, Does not look well. Coughs feebly. 5-19, Patient critical, bilateral pneumonia. 5-20, Exitur. X-ray, 5-16-30, probable pneumonia, left lower.

Nurses' Notes: Preoperative gastric lavage, magnesium sulphate, morphine sulphate, S. S. enema, gastric lavage postoperative, hypodermoclysis, morphine sulphate, hyperventilation, medical transfusion. Patient complains of abdominal pain. Intravenous glucose, sharp stabbing pains in upper abdomen, very drowsy, mouth dry, codeine sulphate. Complains of general discomfort. Gastric lavage. Patient spits up foul smelling yellowish fluid. Fluid by mouth dicontinued. Small emesis continued. 5-15-30, Belching a great deal, emesis continued. Amytal, Noble's enema. Complains of air hunger. Oxygen tent 5-18. Complains of hands being asleep. Respiration labored. Cyanosis. Exitus.

Temperature 97 to 103. Pulse 70 to 120. Respirations 18 to 34.

DIAGNOSIS: (1) Carcinoma of stomach; (2) Operation for removal of; (3) Operation wound; (4) Absence of part of stomach and duodenum; (5) Acute fibrino-purulent peritonitis; (6) Ileus; (7) Acute bronchopneumonia; (8) Cloudy swelling heart, liver, and kidneys; (9) Cardiac hypertrophy and dilation (hypertension) (10) Coronary sclerosis; (11) Slight fatty metamorphosis of liver; (12) puncture wounds.

Note: The source of the peritonitis may have been the suture line in the stomach or the wound. The wound shows marked breaking down and cellulitis on the under surface.

CASE II.

ACUTE INFECTIOUS MYELITIS:

The case is that of a man, 51 years old, admitted to the University Hospital 5-31-30 and died 6-2-30 (3 days). Chief complaints - weakness, fatiguability of muscles, inability to sit up without help. Has had pain in left side for about 3 years following injury to left chest. Steam fitter by trade, and was injured while at work. Was told some time after the accident that a rib was broken, probably the 11th, that is now tender to pressure. For past week patient has felt very weak and has remained in bed. Says his legs went out from under him on Saturday, 5-24-30. Since that time his wife has been feeding him because he gets so tired. No difficulty in swallowing. No weakness of muscles of mastication. Has been told that has blood was poor. Has been given medicine for blood and heart according to patient.

Physical examination: Thin man. Eyes - pupils equal; react normal to light, although somewhat sluggishly. Throat red. Patient cannot sit up. Complains of pain when attempt was made to help him. Can roll from side to side. Chest normal. Heart - distinct bradycardia (42 per minute), regular, no murmurs. Abdomen - tenderness in upper left quadrant just beneath costal margin. There seems to be some resistance but cannot be sure. Margin of spleen not felt. Tender over 11th rib, left. Patellar reflexes reduced but present. Light touch normal. Areas of dullness to pain (pin prick) over dorsal forearms and thighs. Patient complains of numbness in those areas.

Admission note: Patient gives history of pain in left side beginning four years ago which has grown progressively worse, unassociated with any other complaints. Has a generalized weakness which became progressive. Seemed to have started in 1928; stopped work shortly afterwards and has not been able to do anything since. Last Saturday patient's legs suddenly gave out on him, and he thought it necessary to remain in bed because of extensive weakness.

Laboratory: Urine negative. Hemoglobin 100, wbc. 9,200, P. 55, L. 34, M. 6, B. 2, myelocytes 3. Many of the leukocytes show slight shift to left.

6-2-30, Patient says he feels better. Most noticeable still is the slow pulse rate, also low blood pressure and extreme weakness, being unable to rise in sitting position. Rectal examination - prostate small, very hard, elongated left lobe, no tenderness. Seemed to be irregular, indefinite feel as if something was abnormal in pelvis. 6-3-30, 7:45 A. M., called to see patient who developed sudden dyspnea. Was unconscious when nurse reached the bedside. When doctor arrived, patient had expired. It is quite possible that this was an Adams-Stokes syndrome.

Temperature 97 to 99; pulse 58, 40, 48; respirations 16.

Medication: Adrenalin, caffeine sodium benzoate, artificial respiration.

Nurses' notes: Patient complains of general weakness, fairly comfortable, comfortable, fairly good night, 7:20 A.M. having dyspnea, 7:25 dyspnea more marked, does not respond, artificial respiration started, ceased to breath 7:45 A.M.

DIAGNOSIS: (1) Acute infectious myelitis; (2) acute congestion of liver, spleen, and kidney. (3) puncture wounds.

CASE III.

BRAIN TUMOR

The case is that of a woman, 49 years old, first admitted 1-22-30, dismissed 3-29-30 (66 days). Readmitted 5-27-30, died 6-5-30, 2:05 A.M. First admission - chief complaints dizziness, weakness, vomiting, numbness of legs and feet, side of face, weight loss 21 lbs. since April 1929, sore tongue, deafness in left ear. Never very strong but felt as well as usual until June, 1929, when she became suddenly dizzy on a street car. She got off the car but couldn't get to the curb. She has been dizzy every since. Was unable to walk in dark at first and now can hardly walk at all unless someone assists her. Few days after the street car accident she fell flat while crossing the street at home, went down very suddenly and was unconscious for twenty minutes although she wasn't hurt. Had no such attack since, but frequently has periods when she is not unconscious although unable to move. During winter of '28 and '29 had several attacks of dizziness, especially off and on during the same winters. She can see and hear people but is unable to talk. These periods never last more than twenty minutes, but she may get two to three a day. Numbness of legs from knees to toes began about the same time as dizziness. No pain or other sensory disturbances were noticed at the time. Knees got so numb that she couldn't walk. In April, 1929, hearing in left ear began to get poorer, and in a few weeks she became totally deaf. At the same time the left side of her face became numb. This numbness started with a small area in the cheek and gradually enlarged until the whole side of her face was affected. Shortly after onset of deafness she had continuous tinnitus in left ear which disappeared when deafness became total. She started vomiting in April, 1929. Didn't seem to be nauseated at any time, but would vomit a whole lot about twice a week; also belched a great deal of gas and has many sour eructations. Symptoms still persist. Tongue gets sore from time to time; doesn't bleed but is very painful. Says her vision is poor; can't see to sew with black thread. Hands tremble so she can't thread a needle. Gets hemorrhagic spots in skin. No neurological condition.

Physical examination: Well nourished female. Marked general pallor. Lips cherry red. Hyposthenic type, breathing easily, no distress. Right ear normal; left totally deaf to watch. Hypertrophic left middle turbinate. Upper and lower false teeth. Tongue glossy; papillae atrophic, pale. Tonsils submerged, full of cheesy material. Few small cervical glands bilaterally. Chest - few faint wheezes over both bases and in axillary lines which disappear after cough. Heart - systolic murmur with part of maximum intensity at 3rd intercostal space and left border of sternum, heard also at aortic area. Several palpable glands in inguinal regions; also one small node in right axillary region. Abdomen - thin, striae present, relaxed, tympanitic, small palpable masses which are about the size of hazel nuts, freely movable, not tender in left abdomen (fecal masses?) Spleen palpated under costal margin. Liver 2 cm. below costal margin. Neurological examination: Marked vertical nystagmus on upward, lateral nystagmus on lateral

vision. Quick component in direction in which patient is looking. Nerve deafness left ear. Vision about 20/60 right and left with reading chart at 20 inches. Left lid slits slightly larger than right. Probable slight weakness on left 5th nerve. Total analgesia and anesthesia of left 5th nerve. Corneal conjunctival absent on left. No nasal mucous membrane sensation present on left. Left eye not closed with as great strength as right. Marked fibrillary tremors, more marked on right side of tongue. Right side of tongue weaker than left. Babinski positive right, coarse left. Paresis left hand not closed so well or with as much strength as right. Patient drops finger to nose on fingers together suddenly about 4 or 5 inches from nose or other finger. Left heel to knee markedly incoordinated. Diadokokinesia bilaterally slowly done but with fair coordination, possibly not so well done on left. Station and gait show cerebellar type of ataxia without localization of falling. Sensory examination normal except in cranial nerves. Diagnostic possibilities: Probable glioma of pons and cerebellum, multiple sclerosis.

Laboratory: Urine negative. Hemoglobin 37, rbc. 4.11, wbc. 5.70, P. 69, L. 20, M. 7, E. 4, marked hypochromasia, anisocytosis and poikilocytosis, slight polychromatophilia. Spinal fluid - froth on shaking, colorless, pressure 110, probably no cells, Nonne and Noguchi positive, queckenstedt normal, Wasserman negative. Bodies looking yeast were found; nothing on culture. Histamine expression - no free hydrochloric acid, total acidity 8, 7.5, 5, and 4. Patient given transfusion and hemoglobin rose to 52, rbc. 4.69. X-ray of heart showed cardiac enlargement, atypical, right heart type; possible congenital defect or pulmonary disease; no evidence of metastases in lungs. Plates of skull showed no change. Consultation Surgery: Condition sounds like cerebellopontine angle tumor without very much headache. Advise transfusion and operation.

Progress notes: Had series of convulsions. Says she has had them since she was six years old; had them almost daily at that time. Incontinent during attacks, bit her tongue, and slept for long period afterward. Were not checked by chloroform; finally stopped by hypodermic. Patient started to improve. Sensibility returned. Muscle strength seemed to improve. Change most marked after transfusion. Further consideration of operation abandoned for present. Patient to be discharged to return to Out-Patient Department for further study.

On second admission was in semi-comatose state. Would not stay awake long enough to give a history. Was oriented as to place and fairly well as to date and time. States that 5-23-30 she was at her daughter's when she began to feel dizzy and sleepy. Went into lie down and didn't awaken until the following day. Neurological examination: Pupils react to light, incomplete, possibly sluggish. Corneal conjunctival absent. Uvula, speech throaty, some dysphagia. Total deafness left ear. Twelfth nerve weak on both sides. Babinski positive right; questionable left. Gordon positive bilateral. Moves right arm less than left. No definite paralysis. Generally weak. Slight incoordination. Cooperates variably, sometimes poor. Diagnostic impression - probable cerebellopontine or pontomedullary new growth; advise craniotomy as soon as possible. Spinal puncture-fluid clear, colorless, pressure 110, increased pressure on coughing. Urine negative. Hemoglobin 63, rbc. 5.310, wbc. 11.650, P. 87, L. 12, M. 1. Marked secondary anemia. X-ray - negative chest, probably negative skull (examination unsatisfactory), possible pneumonia (left). Eye grounds negative.

During first admission patient had irregular elevations of temperature from 99 to 99.2. On last admission temperature varied from 98 to a terminal rise of 107, pulse 70 to 130, respirations 18 to 22. During last stay in hospital patient slept almost all the time. Fell asleep while talking to persons. Seems difficult for her to speak at times. Did not eat. Drank only an occasional glass of milk. Saw persons in the room who were not present and described their appearance. Occasionally saw two men looking over into water. Became stuporous and incontinent. Talked incoherently. Tube feedings given; finally homocaffeine, caffeine sodium benzoate, atropine sulphate, and adrenalin. Patient grew progressively weaker. Breathing became more labored, and exitus occurred.

DIAGNOSES: (1) Cerebellopontine tumor (glioma); (2) Old valvular disease (mitral and aortic); (3) Acute rheumatic endocarditis; (4) Acute bronchopneumonia; (5) Acute fibrinopurulent pruritus; (6) Splenomegaly; (7) Embalmer's wounds.