University Hospitals.
Staff meeting Surgical Number of the
University of Minnesota

STAFF CONFERENCE NOTES

CASE I. - ACUTE OSTEOMYELITIS.

The case is that of a 4 year old boy admitted to the University Hospital on 8-30-30 and died 8-31-30 at 6:50 A.M. Admission note: Child acutely ill, temperature 106.4. The child was perfectly well up until August 28, 1930 when he complained of pain just below the right knee. Also had fever and a watery diarrhea. August 29th fever seemed to be worse but watery stools ceased. He stopped talking and refused to eat, merely taking a little water. August 30th a physician was called who advised taking him to the hospital at once. Child was very toxic. The pupils were dilated, Does not respond well to questions. Skin very hot to touch. Objects with resistance to manipulation of right lower extremity. There is a definite swelling over the anterior right tibia. No apparent pain in the knee joint. Marked tenderness at the upper end of the swelling with an enlarged node in the right groin. Diagnostic impression - osteomyelitis of right tibia.

Physical examination: Revealed same findings with an additional remark on questionable fluctuation over the tibial mass.

Laboratory: W.B.C.s 15000, P 80, L 15, M 5. Smear from operation wound reveals gram positive cocci - probably staphylococci.

X-ray negative. Immediate operation done. Spinal ahesthesia. Cutting down over the mass marked edema of tissues was found. When bone was approached pus was found under the periosteum which was already stripped. A drill hole was made in the bone and pus escaped. A piece of bone 2" long by $\frac{1}{4}$" wide was removed by motor saw. Wound was packed with vaseline gauze and a posterior splint applied. On operating table patient had twitching movements of arms and head. Occasionally would stiffen out but no true convulsions. Left table in about same condition as before. 9:30 P.M. patient was a great deal better. Would respond to questions. Took small amounts of fluids. No nausea. Complained of pain in leg. 12:30 condition about the same. 2:30 condition much worse. Unconscious and delirious. Marked twitching of legs and arms. Neck slightly rigid. Pulse very rapid, and weak. Eyes rolled up, very sluggish to light. Lips and finger tips cyanotic. Extremities cold. 4:30 condition still serious. Baby slightly improved. 6:30 respiration rapid and shallow in spite of oxygen inhalation. Pulse could hardly be counted. 6:50 exodus. Highest temperature 108.

Medications: Codeine sulphate, retention enema of glucose unsuccessful. Hypodermoclysis of normal saline. Tepid sponge. Proctoclysis of 5% glucose. Ice collar to head. Ice water sponge. Oxygen tent. Caffeine sodium benzoate. Admitted 4 P.M. Operation 6:10.

Diagnosis:

1. Acute osteomyelitis of right tibia.
2. Operation wound.
3. Cloudy swelling of heart, liver and kidneys.
4. Pulmonary congestion and edema.
5. Pulmonary infarct (hemorrhagis).
6. Slight hemothorax.
7. Hemorrhage of retroperitoneal space. (pelvis).
8. Slight splenomegaly.
9. Fatty metamorphosis of liver.
10. Right inguinal adenopathy.
11. Puncture wounds.
12. Abrasion of nose.

CASE II. PERITONSILLAR ABSCESS - LUDWIG'S ANGINA

The case is that of a man 32 years old admitted to the University Hospital on 8/31/30 at 12:15 A.M. and expired 8/31/30 at 2:35 A.M. The patient was brought to the hospital by the physician who gave the following history: Patient had infantile paralysis at the age of 6 with resulting deformity of the right lower extremity. August 24th developed bilateral peritonsillar abscess. Drainage of pus from both sides on August 26th. Getting along nicely until swelling at base of neck appeared August 30th. The temperature rose to 103 and the patient became acutely ill.

Laboratory: W.B.C.s 25,000.

Physical Examination: Large, well developed male adult in excellent condition except for local change in throat. Entire base of neck in anterior portion is swollen, red and very hard. Pitting of skin present. The submaxillary region is soft. The mouth cannot be opened beyond 1½ cm. The voice is reduced to a whisper and breathing is done with marked effort. Laryngeal and bronchial noises due to mucous. Chest is negative except for loud noises transmitted from the throat. Diagnosis: Acute cellulitis of neck with partial obstruction due to laryngeal edema.

Taken to operating room for incision and given nitrous oxide anesthesia. During induction patient suddenly ceased breathing and became cyanotic. Tracheotomy attempted. Large quantity of foul pus rolled out. Trachea not incised. Artificial respiration and adrenalin failed. After death the abscessed cavity was explored with a finger and apparently was partly subcutaneous but communicated with other fascial planes. Extended superiorly above the level of the hyoid, inferiorly below the upper border of the sternum for about 2 - 3 cm. Laterally to the sternomastoid muscles.

Diagnosis:

1. Peritonsillar abscess.
2. Cellulitis of neck.
3. Abscess of prethyroid tissues.
4. Acute mediastinitis.
5. Cloudy swelling of heart, liver and kidneys.
6. Pulmonary congestion and edema.
7. Old deformity of right lower extremity.
8. Operation wound.
9. Splenomegaly.

CASE III. RHEUMATIC ENDOCARDITIS.

The case is that of a woman 57 years old admitted to the University Hospital 6-28-30, died 7-12-30 at 6:20 A.M. (14 days). Chief complaint: dyspnea on exertion, varicosity of legs, abdominal hernia. Patient noticed dyspnea on exertion for a long time. Became much worse about 3 weeks ago. Tired very easily, smothering feeling over precordium, radiating to left scapular region, especially on exertion. Feet swell when standing a great deal. Dyspnea more marked when lying flat on her back. Varicosities for 25 years. Has worn rubber stocking for several years. No ulcers. After heart attack one week ago, she could not stand on legs because of pain, sharp, worse below the knees. Abdominal hernia 25 years ago during pregnancy. Small at first, gradually became larger, cannot be completely reduced. Wears a special corset for it. Some pain associated with it at times.

Past History: Scarlet fever, chicken pox, mumps. No history of rheumatic fever, no chorea, no tonsillitis. Slight impairment of hearing, right ear. Dental: 2 decayed lower teeth. Coughs in morning, raises a little sputum, no blood. Sweats while asleep last 2 weeks. Appetite poor 3 weeks, good before that. Pork does not agree with her. Very little gas. Has to take laxatives. Nocturia 1 - 2 years. Menstrual history negative. Grandparents all died of old age. Mother living, 77, father dead at 73. Mother has had stroke, father died of kidney trouble. No cancer in family history. Occupation: housewife.

Physical examination: Very obese. Blood pressure 145-90. Slight enlargement of tonsils with injection. Marked dyspnea when she sleeps. Few rales in bases. Heart enlarged to left, not very much. No murmurs, pulse regular. Large i umbilical hernia about 10 inches in diameter. Cannot be completely reduced. Hernia contains bowel. Varicosities with possible thromboses on inner aspects of both legs and thighs, tender to palpation. Reflexes negative.

Laboratory: Urine - occasional pus cell. Hemoglobin 80%. W.B.C.s 8,000. B.U.N.s 7/7/30 68 to 107.2 7/10/30. P.S.P. 37%. Eye ground examination: opacity of vitreous, peripheral lenticular opacity, arteries small and tortuous, veins engorged. Many hemorrhages in right eye, same change in left except for absence of hemorrhage. Slight blurring of discs.

X-Ray: Shoes bilateral pleural effusions, cardiac enlargement marked. Aortic or hypertension type, second stage.

Progress Notes: 7/4 - pulse rapid, almost imperceptible. Cyanosis, dyspnea, pinched expression. Morphine given. 7/6 rales in both bases. Very restless. Slight edema of back. 7/7 condition unchanged. 7/11 growing weaker, B.P. 90/70, heart rate 120, rales in bases. Patient has anxious expression. Grew progressively worse, abdomen developed marked distention, possible peritonitis developing. 7/12/30 6:20 A.M. expired.

Medications: Morphine sulphate, tincture of digitalis, limited fluid, S.S. enema, proctoclysis, intravenous glucose, caffeine sodium, benzoate.

Nurses' notes: :Pain in left leg, marked dyspnea, improved. Refuses food. Frequent liquid stools. Hands and face cyanotic. Nausea and severe pain in right side. Perspired profusely, very hot all day. Marked abdominal distension. Listless and drowsy, Emesis. Does not respond, breathing labored. Exodus. Temperature 97 to 104, irregular up to day before death when marked rise. Pulse 60 to 130, respirations 18 to 24. Intake 750, 750, 850, 2500, 1500, output 225, 200, 150, ?

Diagnosis:

1. Old rheumatic endocarditis, of mitral, tricuspid and aortic valves.
2. Acute recurrent rheumatic endocarditis - same.
3. Thrombosis of mitral valve.
4. Hypertrophy and dilation of right auricle and ventricle.
5. Congestion of lungs, liver, spleen, kidneys.
6. Pulmonary edema.
7. Pleural, pericardial and peritoneal adhesions.
8. Infarct of spleen and kidney.
9. Fatty metamorphosis of liver.
10. Chronic cholecystitis and lithiasis.
11. Ileus.
12. Hyaline peritonitis.
13. Arteriosclerosis of kidneys.
14. Multiple superficial hemorrhages.
15. Old, healed miliary tuberculosis of spleen and liver.

16. Fibroid tuberculosis, right apex.
17. Old, healed tuberculosis, left apex.
18. Umbilical hernia. (transverse colon and omentum).
19. Slight edema of feet.

CASE IV. CONGENITAL HYDRONEPHROSIS - SPINA BIFIDA.

The case is that of a 7 month old boy admitted to the University Hospitals 7/10/30 and died 7/12/30 (2 days). May 27, 1930 infant suddenly became less playful. In the afternoon strained at stool and urination. Cried, clutched his mother and went into convulsions for about an hour. Taken to physician who removed obstruction at end of penis. Urine was bright red after this procedure and for a short time the patient felt better. Next few days no convulsions occurred but continued to strain on urination and would cry and become cyanotic and red in the face at these times. Grew progressively worse, and the urinary difficulty persisted. About 2 weeks ago infant threw up food and medicine. Could retain water only. Continued this 4 or 5 times daily, vomiting of projectile type. Abdomen now became distended, was more marked in distention last 3 days. No constipation.

Family history: patient is second child. Negative. Free of diarrhea. For last week, 4 - 6 watery green stools daily. Was nursed for one month, full term child, then given Eagle brand milk. Gained well.

Physical Examination: Fair state of nutrition and development. Acutely ill. Crys and seems to have an abdominal embarrassment to respiration. Marked abdominal distention. Head negative, anterior fontanel practically closed, lips dry, slight redness of pharynx, no exudate. Chest normal. Heart loud and clear, no murmurs. Abdomen shows large mass extending from symphisis to 2 fingers width below the zyphoid process, characteristic of huge, dilated bladder. #5 ureteral catheter inserted and 1000 cc of cloudy urine removed over 12 hour period, leaving bladder reduced to below the umbilicus. Urinary examination showed a large amount of pus but no red cells. Hemoglobin 76%, R.B.C.s 4.43, W.B.C.s 20700. P 55, L 39, M 6. Marked hypochromasia, slight aniscocytosis and poikilocytosis.

X-ray: 7/10/30 of chest and abdomen showed negative lungs, active rickets, abdominal mass displacing colon. 7/11/30 cystogram shows enormously dilated bladder and secondary displacement of the colon. Spine is shown fairly well on this examination and there is suggestion of a very marked deficiency of the laminae in the upper sacral and lumbar vertebrae, indicating a spina bifida.

Urethral catheter left in bladder to continue drainage, if possible. Temperature was 103 on admission and continued to rise.

Therapy: Pack, catheterization, gastric lavage, urotropin, ammonium chloride, normal saline intravenously, colonic flushes, caffeine sodium benzoate.

Nurses' Notes: First day very quiet, perspired profusely. Abdomen distended, labored breathing. Does not respond. Takes feedings poorly. Second day poor night. Catheter draining well. Crying most of the time. Abdomen softer than yesterday. Pressure sore on back of head. Extremities cold, breathing labored. Convulsion lasting 5 minutes. Very cyanotic. Has passed considerable urine since catheter was removed. Mucous in throat. Exitus. Highest temperature 107.2. Weight 8100 to 7100 grams.

**Diagnosis:**

1. Congenital hydronephrosis.
2. Trabeculation, hypertrophy, dilation of bladder.
3. Chronic cystitis.
4. Hydronephrosis.
5. Chronic pyelitis and ureteritis.
6. Bilateral, suppurative pyelonephritis.
7. Cloudy swelling of liver and kidneys.
8. Peri-urethral abscess (prostate).
9. Spina bifida.
10. Slight pulmonary atelectasis.
11. Ileus (gas).
12. Abrasion of occiput.
13. Edema of prepuce.
14. Puncture wounds.