STAFF CONFERENCE NOTES

12-1 3-1

**CASE I.**

ARTERIOSCLEROSIC GANGRENE OF THE RIGHT LOWER EXTREMITY

The case is that of a white male 71 years of age admitted to the University Hospital September 25, 1930, and died on 10-6-30. At the time of admission the patient complained of pain and a black discoloration of the second toe on the right foot. He also complained of an infection under the big toe nail on the right foot. The patient states that he was well until November 28, 1929, when he waked up and found his right foot swollen and very painful. His left foot was also somewhat swollen but this condition in the left foot rapidly disappeared. The condition in the right foot, however, has never returned to normal. He has had almost constant pain in the right foot since the onset of this condition. The patient also noticed that following walking around and lying down again he would have considerable muscle pain which became so severe that he did not think he could stand it any longer. During this time the second toe of the right foot appeared edeamatous but otherwise perfectly normal. Very shortly however, it began to develop a purple color with red streaks extending up the dorsum of the foot into the leg. This was intermittent until 6 - 7 weeks before admission when the dark color remained there permanently. This condition occurred during extremely hot weather. He was seen by a physician 6 weeks before admission to the hospital and the nails were removed from both the great and the small toe. Since that time these toes have been constantly draining. At the time of admission the whole right foot was of a purplish color, the skin very dry; the second toe is somewhat atrophied and black and appeared non-viable. There was considerable pain in the foot on weight bearing. The patient's past history discloses that he has had vertigo for the past 10 years intermittently. He also had carious teeth. Patient also stated that he had a goitre many years ago and took medicine for it following which it was relieved. Patient states that he has had attacks of precordial pain and dyspnea. However, these attacks have not been present for the preceding 4 years. When these attacks occurred he also had edema of the cheeks. The remaining past history is essentially negative.

Physical examination showed many carious teeth, a papilloma of the skin in the left axilla, a blood pressure of 150/80, hyper-resonance on percussion and generalized dry skin. Examination of the extremities revealed a big toe on the right foot purplish in color and very dry. The second toe on the same foot is very small, black and defacated. The entire right foot is somewhat purplish in color and very dry.

Laboratory: Urinalysis 9-20-30 showed a spec. grav. 1020, acid, no sugar or albumen. Sediment revealed numerous Wbcs and small clumps of pus. These findings remained essentially the same until the time of exitus. Blood 9-26-30 showed hem. 80%, WBc 9,000, differential of P 83, L 13, M 2, Eo 2. This blood condition remained essentially the same until the time of exitus. The Wasserman by State Board was negative on 10-3-30.

Examination of the heart, legs and feet on 9-26-30 concluded that there was calcification of the arteries, exostosis of the tibia, and cardiac enlargement of the aortic or hypertension type in the 2nd stage. Injection of uroselectan into the femoral artery on 9-29-30 showed a moderated degree of visualization of the vessels about the knee and leg. Portable chest examination on 10-2-30 concluded that there was considerable congestion of the bases of both lungs, probably associated with early postoperative pneumonia. There was also slight congestion in the upper part of the lungs.

Medications and procedures: tincture of digitalis 3 cc given repeatedly. Codeine gr. 1, given repeatedly. Nose and throat cultures were taken. The affected leg was elevated. Vena puncture was performed. Light basket was applied over the affected leg. Mineral oil given repeatedly. Luminal gr. 1 1/2 given repeatedly. Lanolin rubs were given to the affected leg and foot. S. S. enemas were given. Cascara, oz. 4 given repeatedly. Amytol gr. 3 given. Urosblectan was injected intravenously. Hyperventilation was performed. Restraints were applied. Normal saline and 10% glucose were given intravenously. Continuous steam was given. Elixir terpin hydrate with codeine was given. Hyodermoclysis was given. Caffeine sodium benzoate gr. 7 1/2 and stropine sulphate gr. 1/180 were given.

Nurses notes: At the time of admission the patient complained of some pain in the left foot. On 10-1-30 the patient was sent to the operating room for amputation of the right leg. He was returned in a semi-conscious condition. The stump was elevated on a pillow. His condition was considered good. Later in the day he was irrational but otherwise his condition was good. 10-2-30 patient was still somewhat irrational and had become involuntary. He remained stuporous throughout the day. 10-3-30 patient was coughing and raising pus-like substance. On 10-4-30 it was noted that his condition was becoming weaker. The pulse was irregular and weak. He became involuntary again. 10-5-30 patient did not respond well. Later in the day he was cyanotic, the pulse was irregular, and condition was considered worse. 10-6-30 patient was still incontinent. At this time he developed severe dyspnea; pulse was still rapid and irregular. He was irrational intermittently. Later in the day he had considerable difficulty raising sputum. Still later in the day the patient became definitely cyanotic. Respirations became shallow and the pulse weak and irregular. The pulse was finally imperceptible and exitus occurred at 4:45 P.M. on 10-6-30

Progress notes: 9-28-30 the record of a Moskowitz test on the right leg showed a pale pink coloration down to the tibial tuberosity; there gradually appeared pink areas lower down. The left leg showed a normal pink coloration. Conclusion of this test was that the right circulation was greatly limited below the tibial tuberosity and slightly limited above. In the left leg the circulation was considered normal. Blood pressure on 10-1-30 was 145/70 and condition was considered as postoperatively good. 10-2-30 it was noted that the patient had developed a pneumonia, probably of the coalescent bronchial type. Temperature at this time was 104.8°. Continuous steam inhalations were used at this time. 10-6-30 it was noted that the temperature continued high and the patient gradually weakening. Temperature reported as 108° just before exitus.

DIAGNOSIS:

1. Arteriosclerotic gangrene of right foot and toes.
2. Recent amputation of the right lower extremity, in the lower third of thigh.
3. Bilateral thoracic puncture wounds.
4. Left lateral thoracic mole.
5. Sacral midline decutitus ulcer.
6. Old adhesions of the omentum to the parietal peritoneum.
7. Left pleural affusion.
8. Coronary sclerosis.
9. Atheroma of the aorta.
10. Bilateral coalescent broncho-pneumonia.
11. Hyaline peri-splenitis.
12. Left multiple cystic kidney.
13. Left hydronephrosis.
14. Left renal atonex.

E II.

CIRRHOSIS OF LIVER (BANTI'S DISEASE)

The case is that of a man, 54 years old, readmitted to the University Hospital -22-30, died 5-9-30 (17 days). Patient left the hospital January 6, 1930, with a diagnosis of cirrhosis of the liver and possible spenic anemia. Ascites occurred, nd he has been tapped since his discharge from this institution twice. He returned ecause of ascites. There is no marked edema of the legs. Patient says he is much eaker now than on previous admission.

Physical Examination: White male, fairly well developed and poorly nourished. mpairment of hearing. Ashen grey color of face. Head and neck negative. Chest egative. Heart slightly enlarged to left, soft systolic murmur over entire pre- cordium. Blood pressure 120/66. Abdomen markedly distended. Site of tapping on ight side (4-23-30) is very tender to palpation. Liver and spleen could not be palpated because of distension. Dullness in the flanks extends high toward anterior abdominal wall. Fluid wave present. Slight pitting edema of lower extremities. Patient has a hydrocele.

Laboratory: Urine negative. Hemoglobin 32, rbc. 2.31, wbc. 6,500, P. 82, L 16, B 1, M 1. Marked anisocytosis and poikilocytosis, hyperchromasia (anachromatic type) no stippling, no polychromatophilia, no nucleated reds. B. U. N. 51.33. Wasserman negative. P. S.P. 55%. Stool, Gregerson, slightly positive. Liver function 14% dye retained. Recalculated on 5 mg. basis equals 35%, grade 2 5-9-30, B.U.N. 40, van Slyke 28. Smear of ascitic fluid gram stain, full of long chain streptococci. White count 45,050. X-ray, 5-9-30, no bowel obstruction could be demonstrated.

Progress: 4-24-30, 3 liters of fluid removed. Enlarged spleen and liver can now be felt. Liver is also tender. 5-8-30, Umbilical hernia painful, red, warm, cannot be reduced. Impression - incarceration. Taken to surgical operating room and transfused with 750 cc of whole blood. Later, Noble's enema, hot packs to umbilicus. Fluid intake increased. Patient has ileus. Operation not advised. Very restless, quite irrational. 5-9-30, 4:00 A.M., patient got out of bed and fell, injuring his head, quite irrational. Hernia hot. Temperature 102.2. Later patient became comatosed. Given 1000 cc 10% glucose. Condition grew worse. Caffeine sodium benzoate. Marked abdominal discomfort. Put hand on left side over upper lumbar region as if pain centered there. Morphine sulphate given. Gulped up brownish fluid shortly before exitus at 8:15 P.M.

Therapy: Cascara, paracentesis, opium and belladonna suppository, magnesium sulphate, salt free diet, ammonium chloride, caffeine citrate, novasurol, codeine sulphate, luminal, salyrgan, Noble's enema, calcium chloride, morphine sulphate, hot packs, intravenous glucose, caffeine sodium benzoate, hypodermoclysis.

Temperature 97 to 103.6. Pulse 70 to 120. Respiration 18 to 36.
Fluid intake 750, 575, 900, 800, 800, 800, 750, 800, 800, 900, 700, 500, 800, 875, 1200. Output 400, 300, 600, 450, 950, 500, 700, 800, 1600, 700, 775, 500, 900, 800.

FIRST ADMISSION: Admitted 11-6-29, discharged 1-6-30 (62 days). Chief complaints - swelling of feet, ankles, and abdomen since March, 1929, weakness since February 1929, itch since May, 1929. Quit work because of weakness in February. In bed most of the time during March. April, noticed swelling of feet, and later abdomen. Went to hospital in May, and stayed there until some time in September. Abdomen tapped twice in May, and about 1 gallon fluid obtained each time. Tapped several times in June, and several quarts obtained. In July, three times; in August, twice; in September, once. In September, removed six quarts. Fluid accumulated in about two weeks each time while patient was away from hospital. Scrotum tapped once. Numbness in right thigh since June, 1929. Formerly drank a little, none lately.

Physical examination shows palpable spleen and small liver. Hemoglobin 62, rbc. 3.30, wbc. 5,400.

Splenectomy considered, but not done as ascites could be controlled by restricted fluid intake and diuretics with the addition of salyrgan. Wassermann negative. B. U. N. normal. Barium enema reveals essentially small liver.

Medical treatment, ascites appeared to be well controlled. He was discharged with the understanding that he was to continue the same treatment.

DIAGNOSES:

1. Cirrhosis of liver (portal thrombosis)
2. Splenomegaly
3. Multiple infarcts of spleen
4. Acute generalized fibrinopurulent peritonitis
5. Umbilical hernia
6. Omphalitis
7. Paracentesis wounds
8. Secondary bacterial endocarditis (subacute)
9. Pulmonary congestion and edema
10. Anasarca
11. Puncture wounds

CASE III.

PRIMARY HEPATOMA

The case is that of a white male 22 years of age admitted to the University Hospital 11-3-30 and died on 11-20-30. At the time of admission the patient stated that he entered the hospital because of an ascites that had been progressive since May 1930. He stated that he was first admitted to the hospital February 7, 1930, complaining of epigastric distress after meals, jaundice, itching of the skin. He stated that these symptoms commenced in September 1929. Patient at this time had right upper quadrant pain which was colicky in character, associated with nausea and vomiting. Following this attack he had a dull pain in the epigastrium which was present continuously. During this entire time he was markedly jaundiced and he stated that his liver was palpable to the level of the umbilicus on physical examination by a physician. A resume of his findings at the time of admission showed that his icterus index at that time was 96. His stools were clay colored, and an X-ray examination of the stomach showed marked displacement to the left and posteriorly of that organ. No definite mass was made out. On February 3, 1930, he was operated upon and a diagnosis of inoperable carcinoma of the hepatic bile duct was made. No further operative procedure was done besides the exploratory laparotomy. He was discharged from the hospital and returned in May, 1930 complaining of pleuritis. His general condition was approximately the same as at the time of discharge. Examination at this time showed jaundice and a mass in the upper abdomen. The icterus index was 72 units, the bleeding time was 7-8 minutes, and coagulation time 7 minutes, 10 seconds. Intravenous calcium chloride did not improve the condition. He had gained 15# since March, 1930 which was the time of discharge from the hospital on his first admission. He was discharged from the second admission on July 3, somewhat improved. The patient states at this time that since the last discharge he felt about the same. He thinks also that he has gained some weight. He complains of a very dry mouth, distended abdomen which is very tender, and states that this abdominal distention has come on gradually and reached its greatest amount November 2, 1930. It was the extreme abdominal distention that caused him to enter the hospital.

Physical examination on this most recent admission shows a very jaundiced skin, very dry, marked jaundice of the sclera, photophobia, sluggish reaction of the

right pupil to light, excoriation over the anterior nose, dry lips and parched tongue, carious teeth, reddened pharynx. Examination of the chest revealed prominent interspaces, shallow, rapid respiration, diminished tactile fremitus below the third interspace on the right anteriorly and in the axilla, also over the lower lobe posteriorly on the right. The apex cardiac beat was palpable 1/2" medial to the nipple line in the fourth left inter-space. Chest percussion revealed dullness below the third interspace on the right anteriorly, the upper portion of both lungs were hyper-resonant. The heart sounds were distant on auscultation. Examination of the abdomen revealed marked distention, many dilated veins and capillaries, teleangiectasis over the abdominal wall, an old right rectus incision, a firm, nodular mass in the right upper quadrant, and a demonstrable fluid wave. Rectal examination was negative. Examination of the extremities reveal watch crystal nails.

Laboratory: 1-4-30 blood examination showed a hemoglobin of 47%, RBcs 3,380,000 and WBc 9,900 with a differential of P 84, M 3, L 11, B 2, hypochromasia, slight polychromasia and anisocytosis. Group II. 11-7-30 the bleeding time was 5 minutes, clotting time 9 minutes. Icterus index 11-7-30 was 60 units. 11-12-30 a B.U.N. was 25.2, a Wassermann was reported negative by the State Board. 11-19-30 the icterus index was 56 units and the U.N. 41.06. Urinalysis 11-4-30 showed a specific gravity of 1020, acid, without sugar or albumen, occasional hyaline casts, bile present, no urobilin or urobilinogen found. These urinary findings remained essentially the same until the time of exitus.

Examination by X-ray on 11-13-30 portable chest plate concluded there was moderate pleural effusion on the right. Temperature varied from 97.6 to 101.4.

Medications and procedures: morphine sulphate gr. 1/6, repeatedly. Paracentesis repeatedly. Dichlorimene packs to pressure abrasion on sacrum repeatedly. Mineral oil oz. 1 repeatedly. Codeine sulphate gr. 1, elixir terpin hydrate with codeine, Noble's enemas.

Nurses notes: On 11-3-30 the patient was admitted. He seemed to be quite ill. The color was yellow, he complained of pain in the abdomen. Complained of some pain in abdomen continually during his stay in the hospital. On 11-12-30 it was noted that the patient complained of dyspnea. On 11-13-30 following the removal of the ascitic fluid the patient seemed more comfortable. Coughed at intervals on this date. The following day he complained of being uncomfortable and of cough but no abdominal pain. On 11-15-30 the patient coughed a great deal and complained of general weakness and dyspnea. He appeared much weaker. 11-16-30 the patient expectorated bright red blood. He stated there was some bleeding in the mouth, however. 11-19-30 the patient developed hiccoughs. His memory became poor and he was somewhat irrational. 11-20-30 it was noted that his arms were cyanotic, he did not respond well, respirations were labored and shallow, pulse fairly strong. Later in the day Cheyne-Stokes respiration commenced. Patient was gasping for breath. Exitus occurred 6:20 P.M. 11-20-30.

Progress notes: On 11-3-30 paracentesis was done and 10,500 cc of fluid obtained of a greenish straw color. Patient was much relieved. On 11-7-30 icterus index was performed and found to be 60 units. Bleeding and clotting time was normal. On 11-13-30 a B. U. N. was 25.2, sedimentation time, bleeding and clotting time normal. Abdomen was distended and paracentesis yielded 13,200 cc of fluid, patient was very weak and placed on serious. 11-18-30 it was noted by the staff that since paracentesis it was possible to outline a mass in the midline extending about 5 cm below the liver in the region of the incision, and extending down to the level of the umbilicus. More laterally the mass was not so distinct and could not be definitely separated from the liver.

**DIAGNOSIS:**

1. Primary hepatoma
2. Direct extension of the tumor tissue through the hepatic ducts to the gall-bladder and the common bile duct.
3. Dilation of the common and hepatic ducts and gallbladder.
4. Enlarged, para-vertebral, pelvic, celiac and mediastinal lymph nodes.
5. Chronic, hyaline peritonitis
6. Right chronic, hyaline pleuritis
7. Marked generalized icterus
8. Marked emaciation
9. Icteric conjunctiva
10. Posterior, purplish hypostasis
11. Cyanosis of the lips and finger tips
12. Old right rectus incision
13. Bilateral, lower quadrant puncture wounds
14. Scaliness and bluish discoloration of the skin over the anterior lower thigh and upper leg
15. Marked dilation of the veins over the right lower thorax and entire abdomen.
16. 1,000 cc ascitic fluid
17. Marked vascular adhesions of the omentum to the anterior abdominal wall at the site of operative incision.
18. A rolling up of the omentum about the greater curvature of the stomach.
19. A fecolith of the appendix
20. Left anterior pleural adhesions
21. Right pleural effusion
22. Small, multiple, pleural hemorrhages
23. Icterus of the endocardium
24. Old tuberculous nodule in the left upper lung lobe
25. Multiple, calcified bronchial lymph nodes.
26. Marked enlargement of the mediastinal and bronchial lymph nodes
27. Icterus of the spleen
28. Dilation of both renal pelves.