

GENERAL STAFF MEETING  
UNIVERSITY HOSPITALS

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## ANNOUNCEMENTS

1. New Appointments: Through an error the following new appointments were omitted from the Proc. Gen. Staff Meeting, University Hospitals, II; 1 (Jan.) 1931. Our apology for this unintentional omission and our welcome and best wishes to you.

Tsuneo Kuba, Tokio, Japan. Imperial University of Japan, B.S. Gekei Hospital Medical College, M.D. Internship - International St. Luke's Hospital, Tokio, one year. Surgical house man (3 years) Gekei Hospital Medical College. Appointment - Fellow in Surgery. Special assignment to Urology service.

Hedin, Raymond F., St. Paul, Minnesota. Red Wing High School. Pre-medicine - University of Minnesota, University of Louisville. Medicine - University of N. Dakota, University of Minnesota, B.S., M.B. Appointment - intern assigned to Medicine.

2. Clinico-Pathological Conference - Friday, Jan. 16th, at 11 A.M. Todd Amphitheater.

Case: Mitral stenosis, hypertension, coronary sclerosis. Complicated by multiple embolism after relief of decompensation. You are invited to attend. Compulsory attendance for all clerks.

3. Letter.- This is the kind we like to get. After a discussion of the details of the case, the writer says,

"I wish to thank you very much for your interest in this case. Incidentally I should like to say that I appreciated very much the new attitude that the University Hospital is taking toward men who refer cases there. My experience with the hospital has been that I received little or no help from them in connection with cases that I referred there. More recently I have been informed as to the findings, and treatment of the cases, which naturally has been helpful to me. Hoping that this instruction may be continued, I am - Very sincerely yours". The underscoring is ours.

4. Publications:

Roentgen Diagnosis of Small Pleural Effusions: A New Roentgenographic Position. Leo G. Rigler, J.A.M.A. 96:104 (Jan. 10) 1931.

Dr. Leroy Sante (St. Louis) in discussing this paper, said in part, "Some roentgenologists have felt that, while pleural effusions did possibly change their positions in the chest, they did not create a sufficient difference in appearance in the prone and the erect positions to be of diagnostic value. Dr. Rigler's presentation has removed this false impression, and has added a valuable procedure for the detection of small pleural effusions. The principal importance of his work is the roentgenographing of the patient with the affected side down. While most roentgenologists have used this position occasionally in special cases to determine the extent of the pathologic changes in the chest, few have used it as a general diagnostic procedure because of its natural cumbersomeness. Opportunity was afforded me a few weeks ago to review Dr. Rigler's paper. In an effort to verify his finding in the laboratory, I examined 25 or 30 patients with pleural effusions. There can be no doubt, at least in my mind, that Dr. Rigler's work has demonstrated the movability of effusions in the chest under certain conditions. Wessler and Jachs have contended that

pleural effusions move in the chest, but did not, as far as I know, demonstrate the efficaciousness of Dr. Rigler's position".

Would it not be a good idea to publish at monthly intervals the title of all staff publications? This custom would serve as a barometric index of our activity, stimulate those of us who do not write as frequently as we should, and acquaint us with the places we can find the publications of our associates. Please send prompt notification of publication of manuscripts, books, reviews, etc. to Miss Gertrude Gunn, Secretary. These will be compiled and published at monthly intervals.

5. Reprints:

For 1930 and before, will be appreciated so that they may be filed in the record room for reference. Please send them to Miss Gunn as soon as you receive them.

6. Meeting Reports:

Attended by staff members, should be reported at our weekly meeting. Make notes and we will be glad to publish your material in advance so that it may be filed for permanent reference.

7. X-ray Department Requests:

That internes fill out their requests for x-ray examination completely. Particular attention is called to the fact that the blank marked "service" must be filled out with the floor the patient is on as well as the service. Otherwise we do not know where to get the patient. Please try to indicate definitely what the purpose of every examination is. Please try to be conservative in requesting examinations. This is particularly true of the spine, where the tendency is to ask for the whole spine, whereas a great saving could be made if the part of the spine specifically involved were distinctly described. Some of the requests, coming especially from the new interns, would cost the patients \$60.00 or \$75.00 if done outside, and this appears to be unnecessary. It must also be clearly understood that no routine examinations can be done at this time, because of our inability to handle the volume of work. Every patient should be individualized, and as few orders for x-ray examination made as are consistent with a reasonable effort at making a definite diagnosis in that case.

8. Letters to Referring Physicians:

On all lethal cases are supposed to be sent within twenty-four hours. This is very important as many of the relatives go at once to the physician at home to talk the matter over. All autopsy reports are being uniformly abstracted before sending, so that **usually there is a** delay of about one week or ten days before this report reaches the physician.

9. Dispensary Staff Meeting:

Tonight, Thursday, January 15th. Dinner at 6:30 P.M. Report by **Macnider Wetherby** on follow-up of 1000 consecutive cases admitted to **Out-Patient Department**. General discussion on Dispensary problem.

Staff Attendance

100 Score - 13 Meetings

Anderson, Arnold	8	McKinlay, Charles	5
Anderson, Karl	7	McKinley, J. Charnley	2
Berglund, Hilding	9	McQuarrie, Irvine	9
Berkwitz, Nathan	4	Madden, John	11
Blegen, Einar	13	Manaugh, Hursel - New Fellow 1/1	1
Carlson, Herbert	11	Manson, Melville	8
Creevy, Donald	10	Mead, Charles - To Gen'l Hospital 1/1	12
Diehl, Harold	5	Michelson, Henry	4
Dvorak, Harold	10	Moen, Joe	6
Erickson, Lester	11	Myers, Jay	1
Evans, Edward	3	Newhart, Horace	1
Exner, Frederick	10	O'Brien, William	12
Fallon, Madge	13	Pearson, Bjarne - New Fellow 1/1	1
Fellows, Fording	13	Peyton, William	9
Fjelstad, C. Alford	1	Radl, Robert	13
Gray, Royal	10	Reimann, Hobart	10
Hansen, Arild	11	Rice, Carl - To Rochester 1/1	11
Hanson, Cyrus	12	Rigler, Leo	11
Herbst, William	2	Rufe, Redding	2
Hubin, J. L.	2	Rusten, Elmer	5
Hutchinson, Charles	8	Sagel, Jack	11
Hymes, Charles	2	Salter, Reginald	2
Henrikson, Earl - New Fellow 1/1	1	Shapiro, Moses	6
Johnson, Reuben	2	Stenstrom, Karl	10
Kasper, Gene	11	Stewart, C. A.	2
Lane, Laura	2	Stoesser, A. V.	12
Lang, Leonard	9	Thompson, Willis	11
Leven, Logan	13	Ulrich, Henry	6
Litzenberg, Jennings	5	Wangensteen, Owen	12
		Wethall, Anton	2
		Wetherby, Macnider	13
		Wildbush, Frank	4

Interne Attendance

Benson, T. Q. - Finished 1/1	9	Korecky, Rudolph	13
Blumstein, Alex	12	Littig, John	12
Cabot, Clyde	10	Lynch, Francis -Skin Fellowship Oct. 1.	2
Fisher, L. J. -Glen Lake 1 Mo.	10	Macklin, Wm. -Finished Jan. 1.	11
Frery, Louise	11	Parsons, Ralph	10
Freeman, Leonard -Finished 12/1	8	Roe, Harold -Started Dec.	2
Gerdes, Maude	5	Samuelson, Gordon	10
Halpern, David -Glen Lake 1 Mo.	5	Schwegler, Raymond	13
Hedin, Raymond -Started Nov.	4	Thompson, Floyd -Started Jan.	1
Hillebos, H. E. -Started Jan.	1	Tuohy, Edward -Glen Lake 1 Mo.	10
Johnson, J. T.	8	Weisiger, Ross	10
Kahn, Samet -Started Jan.	1	Zachman, Leo	11

RECORD OF DAILY ENTRIES AND DAILY ATTENDANCE AT UNIVERSITY OF MINNESOTA HOSPITALS  
(OUT-PATIENT DEPARTMENT)

July 1, 1929 to June 30, 1930

Date	MEDICINE		SURGERY		SKIN		NOSE & THROAT		EYE		REFRACTION		GYNECOLOGY		OBSTETRICS	
	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance
1929 July	390	1,082	130	603	101	1,145	154	309	89	208	76	105	70	382	23	209
Aug.	334	1,113	97	705	95	1,142	124	262	129	291	96	132	52	404	31	196
Sep.	250	812	88	475	77	968	83	204	91	207	108	141	49	270	31	194
Oct.	306	857	98	459	62	1,019	90	229	104	217	81	101	69	277	30	198
Nov.	265	825	94	502	81	913	76	178	104	225	67	85	57	291	31	182
Dec.	280	800	100	520	73	1,049	80	220	85	209	59	73	52	283	22	165
Jan. '30	475	1,122	92	635	82	1,181	92	270	104	226	89	111	63	288	26	193
Feb.	359	1,272	103	515	85	1,048	109	309	142	239	95	112	76	311	48	218
Mar.	587	1,450	138	601	93	1,227	129	309	172	301	105	153	101	349	44	271
Apr.	563	1,420	164	617	84	1,044	95	279	130	280	116	152	107	437	36	268
May	513	1,449	145	548	73	1,074	87	206	122	249	109	147	115	425	41	232
June	554	1,423	178	634	77	1,091	88	184	121	252	109	136	84	323	43	229
	4,876	13,625	1,427	6,814	983	12,924	1,207	2,959	1,393	2,904	1,110	1,448	895	4,040	406	2,555

(Continued Below)

Date	NERVOUS		CHILDREN		GENITO URIN'Y		ORTHOPEDICS		OTOLOGY		DENTAL		TOTAL	
	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance	First Ent.	Attend ance
July '29	47	150	122	470	31	472	24	37	40	209	41	127	1,338	5,508
Aug.	33	108	123	438	28	496	34	66	41	191	38	132	1,255	5,676
Sep.	37	99	99	390	33	405	17	40	30	141	34	93	1,027	4,439
Oct.	45	105	111	403	35	433	26	46	37	143	20	79	1,114	4,566
Nov.	47	128	102	413	37	416	14	36	31	117	42	134	1,048	4,445
Dec.	43	128	71	356	21	499	22	44	38	135	46	154	992	4,635
Jan. '30	66	153	105	398	25	591	18	69	41	174	56	198	1,334	5,609
Feb.	57	148	97	457	17	603	44	95	38	130	59	204	1,329	5,661
Mar.	70	165	104	496	5	678	57	116	65	171	81	292	1,751	6,579
Apr.	69	156	107	478	6	597	40	107	53	150	49	179	1,619	6,187
May	59	132	111	446	4	678	38	92	31	164	49	160	1,497	6,002
June	61	139	150	474	5	599	47	111	45	180	26	99	1,588	5,874
	634	1,611	1,302	5,219	247	6,467	381	859	490	1,905	541	1,851	15,892	65,181

II.

RECORD OF DAILY ENTRIES AND DAILY ATTENDANCE AT UNIVERSITY OF MINNESOTA HOSPITALS  
(OUT-PATIENT DEPARTMENT)

July 1, 1930 to December 31, 1930.

Date	ADMISSIONS		MEDICINE		CARDIAC		CHEST		G - I		METABOLISM		NERVOUS	
	New Pts.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance
1930														
July	399	469	30	646	34	131	36	115	41	43	5	51	80	150
Aug.	419	647	19	636	48	152	30	102	27	29	5	50	58	140
Sept.	378	531	19	553	38	135	45	124	21	22	8	63	67	135
Oct.	421	595	64	546	50	171	16	102	44	44	14	91	99	196
Nov.	296	296	44	606	38	153	20	103	34	41	3	45	68	159
Dec.	288	288	58	689	39	137	15	95	27	29	5	53	74	162
	2,201	2,826	234	3,676	247	879	162	641	194	208	40	353	446	942

Date	SKIN		DERM		SURGERY		G - U		TUMOR		ORTHOPEDECS		EAR	
	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance
1930														
July	-	-	76	729	119	486	-	382	27	138	38	100	45	174
Aug.	30	517	60	228	119	465	39	465	37	191	75	131	50	145
Sept.	22	368	73	231	111	447	53	510	32	146	47	97	43	129
Oct.	18	349	80	303	112	479	28	629	32	178	55	121	45	143
Nov.	29	402	77	259	86	435	22	431	32	160	43	107	41	176
Dec.	9	380	36	218	95	452	31	523	26	156	37	91	31	161
	108	2,016	402	1,968	642	2,764	173	2,940	186	969	295	647	255	928

RECORD OF DAILY ENTRIES AND DAILY ATTENDANCE AT UNIVERSITY OF MINNESOTA HOSPITALS  
(OUT-PATIENT DEPARTMENT)

Date	EYE		REFRACTION		N & T		OBSTETRICS		GYNECOLOGY		PEDIATRICS		NUTRITION	
	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance
1930														
July	103	216	94	142	73	226	45	282	84	309	131	442	-	-
Aug.	174	319	94	131	112	257	37	247	116	320	198	552	-	-
Sept.	118	241	94	123	118	260	34	248	63	295	114	408	1	2
Oct.	133	262	82	125	94	215	58	255	86	395	116	431	-	-
Nov.	93	194	71	107	66	199	37	238	60	368	85	408	-	-
Dec.	61	183	78	126	86	236	38	244	45	257	95	342	1	3
	682	1,415	513	754	549	1,393	249	1,514	454	1,944	739	2,583	2	5

Date	DENTAL		F - U		GOITER		NIGHT CLINIC				TOTAL	
	First Ent.	Attendance	First Ent.	Attendance	First Ent.	Attendance	"L"		G - U		First Ent.	Attendance
1930												
July	20	83	-	-	-	-	5	259	4	220	1,489	5,793
Aug.	33	90	-	-	-	-	2	202	6	172	1,788	6,188
Sept.	32	88	-	-	8	12	3	183	4	222	1,546	5,573
Oct.	50	196	6	24	15	30	2	204	6	233	1,726	6,317
Nov.	40	139	4	12	12	24	-	120	4	191	1,305	5,373
Dec.	28	152	9	28	4	23	-	133	4	177	1,220	5,338
	203	748	19	64	39	89	12	1,101	28	1,215	9,074	34,582

The case is that of a white female 52 years of age, admitted to the University Hospital 12-20-30 and died 12-31-30 (11 days).

1894 Began having attacks of rheumatism?

1901 Badly lacerated following delivery of 2nd child. Pressure sensations in pelvis following this were relieved by physician who packed vagina off and on. Had been having pain in lower right quadrant many years. Worse when menstruating.

1915 Last of 8 normal pregnancies and deliveries.

1920 Occasional sharp, cramp-like pain in upper right quadrant radiating around to back.

1922 Developed swollen ankles in afternoon and evening. Tired easily after being on feet. Dizzy spells occasionally. Pains in right hip frequently. Says she dislocated hip during 3rd delivery.

1924 Became intolerant to greasy foods, bilious, jaundiced at times. Distressed after large meals. Went on diet avoiding fatty foods and meat, and has felt better since. She is constipated but no acholic stools. Considerable flatulence but very little belching.

1925 Patient stated menopause began? Menstruated every 3 weeks.

1926 November She bled? profusely for one month.

1927 Advised to have pelvic floor repaired. Rheumatism? troublesome.

1928 Menstruated for last time. R.L.". pain less marked.

12-20-30 Entered hospital complaining of discomfort due to "falling of the uterus" and itching of the labia majora. Diurnal frequency. Past history - measles, whooping cough, small pox, chicken pox and diphtheria in childhood. Sore throats frequently. Family history essentially negative. Six of 8 children living.

Physical examination White female age 52, with slight pallor of mucous membranes. No edema. Tonsils large. Lungs and heart negative. Abdomen relaxed, tender over gall bladder, appendix and epigastrium. External genitalia - slight reddening - no signs of infection. Pelvic floor relaxed. Anterior and posterior vaginal walls relaxed. Cervix - bilateral laceration. Cauliflower-like growth 2 cm. in diameter on posterior lip. May be Nabothian cyst. Corpus - 3rd degree retroversion, movable but too tender to be replaced. Seems normal in size, shape and consistence. Adnexa negative. Few small hemorrhoids. Diagnosis: 1. old laceration of pelvic floor and cervix. 2. Prolapse of anterior and posterior vaginal wall. 3. Retroversion of uterus. 4. Chronic cervicitis with possible malignancy. 5. External hemorrhoids. 6. Pruritis vulva. 7. Caruncle?

Laboratory Occasional Wbc. Hbg. 77%, RBcs 3,580,000, WBcs 7,200. Pmns 72, L 26, M 2. Group II. Blood Wassermann State Board of Health negative.

12-25-30 Comfortable. Mineral oil b.i.d.

12-26-30 7:50 A.M. - To Surgery. Operation under spinal anesthesia. The prolapsed anterior and posterior walls of the vagina were repaired and a uterine suspension performed. Gallstones were palpated. 11:30 A.M. returned from Surgery. General condition good. 5 P.M. unable to void. 6 P.M. catheterized (200 cc.). Drains 1 of 1% mercurochrome instilled - light basket to perineum. Hyperventilation. Fairly comfortable. 7 P.M. M. S. 1/4 for pain. T. 98.4-97, pulse 104-94.

12-27-30 3 A.M. Pain due to bladder distention. 3:30 A.M. catheterized (300 cc.). 8:20 A.M. very uncomfortable. M.S. 1/4. 9:30 A.M. catheterized (150 cc.). Mercurochrome instilled. 11 A.M. hyperventilation. 3:30 P.M. unable to void. 250 cc. urine by catheter. Mercurochrome 1%, drains 1 instilled. Perspiring considerably. Complains of burning. Unable to start flow. T. 99.4, pulse 100 - good quality. 5:30 cramp-like pains followed by involuntary urination. Urotropin? (Hexamethylenamin, methenamin, hexamina) and ammonium chloride begun. 6:30 P.M. M.S. 1/4 for pain. T. 98.6-98.8, pulse 92-108.



CASE I (Cont.)

12-28-30 12:30 A.M. Complaining of distention. 1:15 A.M. catheterized (400 cc.) Boric acid bladder irrigations. 8:30 A.M. Hyperventilation t.i.d. Complaining of pain in bladder region. 9:50 A.M. 500 cc. by catheter. Boric acid bladder irrigation. 1 P.M. very uncomfortable. Complains of cramps same as before catheterization this A.M. Catheterized (300 cc.) with relief. 3:30 P.M. uncomfortable. M.S. 1/4. 5 P.M. catheterized (200 cc.). Boric acid bladder irrigation. 1 oz. silver nitrate (1-3000). instilled in bladder. 8 P.M. pain in bladder region. 8:30 P.M. catheterized (80 cc.). 1 oz. silver nitrate and mercurochrome 2% instilled. 10:20 P.M. amytol gr. 7-1/2. T. 99.4-98.6. P. 88-110.

12-29-30 1 A.M. complains of frequent, involuntary urination. 4 A.M. general discomfort. Catheterized. Approximately 30 drops of urine obtained. Irrigated with boric acid. 1-3000 silver nitrate instilled. 7:45 A.M. very uncomfortable. Several involuntary urinations, always preceded by pain. 8:30 A.M. nauseated. Emesis 100 cc. grey fluid with some relief. Soda bicarbonate gr. 10. Hiccoughs. 2 painful urinations of 15 cc. each. Has R.L.Q. pain and distress. Urine bloody. Methenamina and ammonium chloride discontinued. 11:30 codeine sulphate gr. 1. (H). Frequent small involuntary painful urinations (15-30 cc.) 1 P.M. emesis of 150 cc. Very uncomfortable, sleeping at short intervals. 3:40 P.M. codeine. Voided 15 cc. 6 P.M. catheterized - no urine obtained. Silver nitrate irrigation. 9 P.M. Codeine gr. 1. (H). Voiding small amounts (30-80 cc.). T 99-98.8, P 104.

12-30-30 12 midnight. Nauseated and belching. Soda bicarbonate gr. XX with relief. Frequent small urinations. 1:30 A.M. codeine gr. 1. Sleeps very little. 8:20 A.M. uncomfortable. 9 A.M. Codeine sulphate gr. 1. 9:10 A.M. S.S. enema returned highly colored and with much flatus. Very tired. 11:00 A.M. Spitting up mouthfuls of fluid. 12 noon - (150 cc.). 1 P.M. Hcl XV in 1/4 glass water. Projectile emesis of yellowish brown fluid. 2 P.M. Noble's enema with very good results - with pituitrin 1 cc. 3 P.M. catheterized (15 cc.). Boric irrigation and silver nitrate instillation. 4 P.M. hiccoughs. Dil. Hcl. M XV. 5:30 P.M. sleeping. 6:30 rectal tube. 150 c.c. fecal colored mucus with considerable flatus. 7 P.M. codeine for pain. 9:15 P.M. milk and molasses enema, with good results. Perspiring freely. Pulse 118, poor quality. Pituitrin 1 cc. Abdomen distended. Skin cold and clammy. Pulse 128, poor quality, external heat. 10 P.M. caffeine sodium benzoate gr. 7-1/2. 10:30 P.M. caffeine sodium benzoate gr. 7-1/2. Gastric lavage 1050 cc. dark brown retention. 11 P.M. intravenous of 1000 cc. 10% glucose. 12:45 A.M. medical transfusion 700 cc. citrated blood followed by 500 cc. normal saline and 75 cc. hypertonic saline. 1:05 A.M. adrenalin 1 cc. (H). 2 A.M. voided 100 cc. Condition about the same. 2:15 A.M. gastric lavage. Retention of 400 cc. dark brown fluid. Distention relieved by lavage. 3 A.M. metrazal 1 cc. (H). Pulse rapid, thready and irregular. Struggling for breath. 3:15 A.M. Caffeine sod. benzoate gr. 7-1/2 (H). Unable to pass either glass or rubber catheter. 3:30 A.M. Metrazal. 3:40 A.M. adrenalin. 4 A.M. caffeine sod. benzoate gr. 7-1/2. 4:05 adrenalin 1 cc. into cardiac muscle. Artificial respiration. 4:10 pronounced dead. Temperature 98.6-97. Pulse 110-130.

DIAGNOSIS:

1. Laceration of pelvic floor (clinical)
2. Laceration of cervix (clinical)
3. Retroversion of uterus (clinical)
4. Prolapse of anterior and posterior vaginal wall (clinical).
5. Chronic cervicitis (clinical)
6. External hemorrhoids.
7. Pruritis vulva.
8. Repair of laceration, amputation of cervix, suspension operation on uterus.
9. Slight hemoperitoneum.
10. Slight hypertrophy of left ventricle.

DIAGNOSIS

11. Marked pulmonary edema.
12. Postoperative ileus.
13. Chronic cholecystitis and lithiasis.
14. Antecubital wounds.
15. Superficial ecchymosis & puncture wounds.
16. Slight emphysema of lungs.

COMMENT

The most significant postmortem finding was ileus (small intestine and stomach.) There was slight hemorrhagic discoloration of the small intestine in two places, but no thromboses could be demonstrated. No evidence of peritonitis. The small amount of blood found in the peritoneal cavity was not hemorrhage but simply the aftermath of an operative procedure. Note the clinical history of gallbladder disease since 1924 which was apparently preceded by sharp, cramp-like pains in the right upper abdomen radiating around to the back since 1920. The patient came for prolapse and not gall bladder disease.

CASE II. PERNICIOUS ANEMIA: BRONCHOPNEUMONIA

The case is that of a white male 50 years of age, admitted to the University Hospital 1-9-30 and died 1-10-31 (6 1/2 hours). According to the history the patient had pernicious anemia for the past seven years.

1927 - Discharged from the Minneapolis General Hospital after response to liver therapy.

1929 - Stopped treatment.

1930 - (Dec. 26) Began going down hill rapidly.

January 9 - Seen by physician who sent patient to hospital at once. Admitted at 7:55 P. M. by ambulance.

Physical examination: Extreme pallor. Lips and tongue almost white. Respirations deep and rapid. Coughing and raising serous, frothy sputum. Irrational and throwing self about in bed. Incontinent. Could give his name and said he had pernicious anemia. No other information obtainable. Breath foul. Pupils regular and react to light. Lungs - moderate coarse rales, both bases posteriorly. No dullness. Heart apparently not enlarged. No thrills, apex beat not seen or felt. Tones extremely faint, fairly audible. Abdomen - Negative. Reflexes - Biceps and triceps patellar and achilles present and equal. No Babinski. Right inguinal hernia present. Edema of ankles. B. P. 74/42.

Laboratory: Hb. 30%. RBCs 830,000, WBCs 20,000. Urine - Few WBCs. Temperature 98.8. Pulse 96. Respirations 16.

At 9:45 intravenous injection of 1000 cc. of 10% glucose solution started. It was noted that he was very weak and perspiring profusely. At 10:45 P. M. transfusion of 100 cc. citrated blood. Began to breathe deeply and noisily. Pulse weak. 1 cc. adrenalin injected intravenously and patient sent back to ward in coma. 12:20 A. M. digalen 2 cc. given. Pulse better. B. P. 110/70. Breathing easier. Intravenous glucose started again. 12:30 A. M. Better. Said he felt "pretty fair". Wanted to know "What was the matter with him". Became unconscious in about 30 minutes. B. P. 90/50. 1:25 A. M. Digalen 1 cc. (hypo). 1:30 A. M. Adrenalin gr. VIIss (H). At 2:30 A. M. expired rather suddenly.

CASE II. (Cont.)DIAGNOSIS

1. Pernicious anemia.
2. Acute bronchopneumonia.
3. Pulmonary congestion and edema.
4. Fatty metamorphosis of heart.
5. Hemosiderosis of liver.
6. Slight enlargement of spleen.
7. Hyperplasia of bone marrow.
8. Lemon yellow pallor of skin.
9. Puncture wounds.

COMMENT

January 9, 1930 a statistical summary was made of all deaths from pernicious anemia which occurred in the University Hospitals from 1920-30. During this time there were twenty-nine deaths. Eighteen had not received liver (transfusions, etc.) and eleven had received liver treatment. Three were complicated by syphilis and received specific treatment. There was some question as to the diagnosis of one of these cases, as he seemed to make a better response to syphilitic treatment than to liver. Two of these syphilitic cases occurred before liver and one after. The following table shows the entrance, minimum and maximum hemoglobin percentages of these patients. They are divided into two groups: those before liver (B.L.) and after liver (A.L.), and those with hemoglobin below 50 (<50) and those above 50 (≥50).

B.L. (18 cases)

A.L. (11 cases)

Hemoglobin	B.L. (18 cases)		A.L. (11 cases)	
	<50	≥50	<50	≥50
Entrance	15 (83%)	3 (17%)	7 (62%)	4 (37%)
Minimum	17 (94%)	1 (6%)	6 (54%)	5 (46%)
Maximum	13 (72%)	5 (28%)	5 (45%)	6 (55%)

The series is too small (29 cases) to use percentages, but it can be seen that there was a tendency for more patients to die with higher hemoglobin percentages after liver than before. That is, above 50. Entrance (17% compared with 37%), minimum 6% compared with 46%), maximum (28% compared with 55%). Other striking differences were: fewer large hearts and myocardial failures after liver than before (shorter duration of anemia?), and a marked increase in complicated deaths chiefly due to serious involvement of the nervous system, e.g. decubitus ulceration. This is a frequent complication of a bed-ridden patient with involvement of the nervous system and was found in only 11% (B.L.) compared with 63% afterward. It was suggested at that time that liver did not influence the cord changes (made them worse?). This became more impressive when the reported duration of the disease was studied (B.L. averaged 36 months and A. L. averaged 20 months). During 1930 a distinct change in death rates occurred. There was only one death in a typical case of primary anemia (aplastic?). The death just reported was due to absence of liver therapy (one year). The findings were more typical of the old type of pernicious anemia than those recently studied after liver. Except for slight beginning bronchopneumonia, death was due entirely to the disease. All of the characteristic features of the cases (B.L.) were found. A lemon yellow skin, bright yellow fat, marked absence of blood volume (watery blood), dark brown

CASE II. (cont.)

liver and kidneys, fatty heart with soft, flabby walls and tabby cat appearance, enlargement of the spleen and marked hyperplasia of the bone marrow. The following clinical report is very suggestive of the true value of liver therapy. It may be argued that we are not seeing as many pernicious anemia hospital patients as formerly. This is probably true as far as hospital admissions is concerned, but if they were going down under liver treatment, we would probably be getting them, as we did in the past.

"B. M. Baker, Jr., Bordley, James; and Longcope, Minnesota Medicine, 13:315 (Nov.) 1930 report forty-four cases of pernicious anemia in which there were symptoms referable to change in the central nervous system who have been treated by liver or a combination of liver and liver extract. Of the twenty-three cases followed for more than six months, improvement in symptoms and signs occurred in 55.17%. Twenty-one cases treated less than six months improvement was noticed in only 31.25%. In eight cases of outspoken subacute combined degeneration, treated for more than ten months, there was improvement in symptoms and signs of 58.9%. They state that it is essential that large quantities of liver or liver and liver extract be employed over long periods of time. They recommend 400 grams of liver or more daily or its equivalent. No results need to be expected in less than six to eight months. The longer the patient continues the treatments, the less liable it is for remission to occur."

CASE III. CARCINOMA OF PENIS: FEMORAL HERNIA: INTESTINAL DIVERTICULOSIS.

The case is that of a white farmer, 71 years of age, admitted to the University Hospital 12-27-30 and died 1-3-31 (7 days).

1929 (October) Penis red, swollen and tender in region of frenum. Slight, if any, pain or inconvenience for a year. No statement of previous condition of penis.

1930 (October) A marked swelling of prepuce developed, broke down, and discharged a considerable amount of pus. Since then it has become a rapidly growing ulcer until glans penis has become eroded.

1930 (November) Pain almost daily. No weakness. Weight loss of 40# in last 6 months.

1930 (Dec. 10) Consulted physician for first time. Informed he had cancer and was advised to come to University Hospital.

Past history: Measles in childhood. Venereal history negative. Corneal ulceration began at 22 years of age in right eye, causing blindness. Nocturia for years.

Family history: Essentially negative. Grandparents and parents died of old age.

Physical examination: White male, age 71, well developed and well nourished, resting comfortably in bed with no pain. Right eye old plastic iridocyclitis following perforating ulcer in lower quadrant. Left eye - cornea clouded. Pupil responds to light and sluggishly to accommodation. Evidence of old keratitis with nebulae corneae with what appears to have been a small perforation

Case III. (cont.)

at about 7 o'clock, with adherent iris pigment - suggestive of foreign body.

2-30-30 - Dichloramine - T & mercurochrome packs to penis. Hopeless prognosis explained to patient who desires palliative amputation. Temperature 97-99.4.

2-31-30 - Operation: The external genitalia and inguinal nodes were excised widely, using the cutting current of the electrosurgical unit on the left side. Knife was used on the right side. The postoperative condition was good.

Mix. terpine hydrate with codeine for cough. 2000 cc. of saline given by hypodermoclysis. Temperature 97-98.6. Pulse 60-72, respirations 18-20.

1-31 - Complains of some pain. 9 A.M. emesis 75 cc. brownish fluid. Feels slightly nauseated. Later in the morning emesis of 200 cc. brownish fluid. Several emesis also during the afternoon. Condition appears good. 10 P.M. complains of pain, restless. M. S. gr. 1/4. Light cradle to wound. Sutures removed. 2000 cc. of 10% glucose intravenously.

2-31 - Slept fairly well. Pain in abdomen. Taking fluids well. Bulging, non-crepitant, non-fluctuating area in right inguinal region stabbed, and large amount of gas and medium amount of fluid expelled from stab wound.

Cultures show Clostr. Welchii. X-ray report: extensive loop of bowel projecting in femoral region on right side well beyond abdomen into the thigh.

4:45 P.M. Under gas anesthesia in bed, incision opened and femoral herniation of bowel found. Enterostomy done, bowel reduced, femoral ring closed.

5:30 P.M. Patient critical. Pulseless and comatose. B. P. could not be obtained.

6:30 P.M. 50 cc. perfringens serum given.

6:45 P.M. Hypodermoclysis begun.

7:00 P.M. Unconscious. Pulse weak and thready. Respirations shallow and labored, skin cool and dry. Condition grew better and worse intermittently in the next few hours.

Temperature varied from 99-101°. Respirations from 20-30.

3-31 Cheyne-Stokes' respiration.

8:00 A.M. 500 cc. citrated blood intravenously.

8:30 A.M. caffeine sodium benzoate, gr. 7 1/2. Respirations rapid and shallow; stopped breathing occasionally. Responded to stimulation, such as slapping chest and abdomen. 5:20 the patient died.

DIAGNOSIS:

1. Carcinoma of penis.
2. Amputation of penis, scrotum, testes.
3. Dissection of inguinal region.
4. Incarcerated femoral hernia.
5. Relief of obstruction
6. Enterostomy.
7. Partial gangrene of bowel.
8. Slight visceral congestion.
9. Slight ileus.
10. Pleural adhesions.
11. Slight hypertrophy of left ventricle.
12. Hyaline patches on epicardium, and liver.
13. Pulmonary congestion and edema.
14. Pulmonary emphysema.
15. Cloudy swelling heart, liver and kidneys.

CASE III. (cont.)DIAGNOSIS:

16. Multiple diverticulae of large and small intestine.
17. Hemorrhagic, edematous cystitis.
18. Hypertrophy of middle lobe of prostate.
19. Puncture wounds.
20. Chronic iridocyclitis.
21. Corneal opacity.
22. Dental caries.
23. Incised antecubital wounds.

Operation specimen: This specimen consists of the male genital organs including portions of the skin and subcutaneous tissues above and lateral to their location.

The distal half of the penis is replaced by a large sloughing ulcer with elevated edges characteristic of squamous carcinoma and the corpora cavernosa were indurated, particularly on the left, almost to the crura of the penis. One large hard gland in the right superficial inguinal group measures 4 cm. in diameter. There are numerous other smaller glands on this side. There are also a few small glands in the superficial inguinal group on the left.

COMMENT:

The clinical history does not state whether phimosis was present before the onset of the present trouble. There was a delay of 15 months before starting treatment. The specimen removed at operation showed no involvement of the corpus spongiosum which is in accord with other observers. There was a clinical diagnosis of metastases to the right inguinal group. The probable cause of the postoperative herniation of the bowel in the femoral region was deep invasion which required deep dissection. Although Clostr. Welchii was found in the mass on the right side, the origin was probably bowel? and not secondary contamination, although no point of perforation was made out. No definite finding of gas at the autopsy. The wound edges were black and partially separated, which is a common finding after amputation of penis.

IV. ABSTRACTS - TUMORS OF PENIS

1. BARNEY, A.S. ANN. SURG. 46:890, (1907)
2. BARNINGER, B.S. and DEAN, A.L. J. UROLOGY 11,497 (May) 1924
3. EWING, NEOPLASTIC DISEASES, W. B. Saunders Co., 3rd edition 914:1928
4. KEYES, UROLOGY, D. Appleton & Co., 642:1929
5. YOUNG'S PRACTICE OF UROLOGY, Vol I. W.B. Saunders Co., 698:1926

V. (Cont.)

Benign

1. Cysts (sebaceous, mucous, dermoid).
2. Lipomata, myomata, fibromata, adenomata (rare).
3. Vascular (venous varices, lymph varices, cavernous hemangiomata).
4. Verrucae, papillomata (confusion with malignancy?) associated frequently with infection, condylomata acuminata, horns.
5. Circumscribed fibrosis, osteomata, enchondromata, calcification (rare).

2. Malignant

1. Melanomata (rare).
2. Endotheliomata (9 cases reported) starting as local nodule, then involving shaft (priapism) confused with carcinoma of urethra?
3. Sarcomata: Joelson (17 cases) starts as round nodule, then ulcerates, (all of the common cellular types have been reported).
4. Epitheliomata (commonest).

Epithelioma of Penis

1. Frequency 1 - 3% (Ewing)?

Figure too high and probably based on old statistics. 7881 malignant tumors--0.79% epitheliomata of penis - Andrews. 12,500 urologic cases at Brady Urologic Institute (35 carcinomata of penis, 500 vesical neoplasms, 600 carcinomata of prostate, 34 malignant tumors of kidneys).

<u>Age</u>	<u>Kuttner</u> '00	<u>Barney</u> '07	<u>Schreiner</u> '21	<u>Dean</u> '23	<u>Young</u> '26	
10-20	0	0	0	1	0	1
21-30	24	1	1	1	1	28
31-40	51	14	2	7	6	80
41-50	131	25	5	7	12	180
51-60	169	20	5	11	9	214
61-70	124	24	4	7	4	163
71-80	58	13	1	2	2	76
81-90	0	3	0	0	0	3
?					1	1
	<u>562</u>	<u>100</u>	<u>18</u>	<u>36</u>	<u>35</u>	<u>746</u>
	(4 Moham- medans)	(no Jews)		(no Jews)		

Note: the occurrence in younger individuals. The report of 24 cases (21-30) in 1900 by Kuttner is the only discrepancy in the entire series. Could they have been papillomata? The largest number occurs from 40-70. Approximately the same numbers from 31-40 as from 71-80. The occurrence of one case between the ages of 10-20 is unusual and is reported by Dean.

## IV. (cont.)

### Nationality

<u>Birthplace</u>	<u>Barney</u>	<u>Barringer &amp; Dean</u>
U. S.	53%	48%
Ireland	25%	27%
Italy	1%	11%
England (Scot.)	16%	3%
West Indies	6%	
Germany	3%	3%
	(Boston)	(New York)

Malignancy in general is equally prevalent among Hindoos or Mohammedans except in the case of carcinoma, where Hindoo admissions exceed Mohammedan by 80 at the Mayo Hospital, Lahore, India, a difference almost entirely due to 72 cases of epitheliomata of penis among Hindoos, an affection from which Mohammedans (who practice circumcision) rarely suffer.

### Precancerous lesions

1. Phimosis (Schreiner 6%, Young 54%, Dean 76%, Barney 85%) Especially when associated with balanitis or urethral discharge (Young - 54% of 38 epitheliomata of penis had had gonorrhoea).
2. Syphilitic scars.
3. Traumatic ulcers.
4. Papillomata? (really malignant).
5. Contact (carcinoma of cervix - no proof).

### Early Lesion

1. Wart-like excrescence.
2. Flat plaque often ulcerated (leukoplakia).
3. Superficial, weeping erosion (our case?).

### Origin

1. Glans or inside of prepuce (about half and half) in early cases.

Late cases show involvement of both.

### Types

1. Papillary.
2. Flat (ulcerated).

All squamous cell carcinomata with pearl formation. Mixed basal squamous types have been reported, but the metastases showed cornification.

Symptoms Delay of instituting treatment varies from 1 - 3 years, may be 5 - 15.

Itching frequently present. Pain in 43.5% of all cases (Barney), rarely severe and usually late. Usually no interference with urination.

Many have had discharge from under foreskin for a long time, but do not notice much difference until the discharge becomes very profuse and offensive. It may be necessary to split foreskin for diagnosis when this condition develops.

Ulceration brings patient to physician. Diagnosis of suspicious lesions made by biopsy.



IV. (cont.)Manner of Extension

1. Through erectile tissue (corpus cavernosa) and lymphatics (permeation). Corpus spongiosum is spared to last and may be exposed by the ulceration about it. Buck's fascia over ends protect this structure.

Note: in our case exposure of urethra and ulceration extending back of this.

2. Nodes in inguinal region enlarge with ulceration (hyperplasia and metastases). 75% enlarged in Barney's series. 60% of group malignant, 40% benign. Pelvic nodes not uncommonly involved. Distant metastases in 15% of Barney's cases, the liver being a common site. Involvement of lymph nodes is probably late.

Inguinal Adenopathy

	<u>Barney</u>	<u>Barringer &amp; Dean</u>	<u>Kaufman</u>
Enlargement	75%	63%) 71%	84%
Questionable enlargement		8%	
Carcinomatous	45%	30%	
Hypertrophic (Inflammatory)	30%	33%	

Treatment

1. Radium, deep therapy, surgery.

Dean: Best results by conservative treatment of inguinal nodes with routine x-ray treatment of all cases, withholding surgical removal until definitely carcinomatous. Then after removal the lymph channels should be irradiated. No surgery should be done to inguinal nodes if they are the site of pyogenic infection. The source of infection, the penis, should be dealt with first.

1. Superficial lesion less than 2 cm. in diameter with no metastases - 13 cases, no deaths.
2. Extensive or deep lesions with no metastases - 35 cases.
  - a. alive - 23
  - b. dead - 5
  - c. lost - 7
3. Postoperative irradiation without metastases - 2 cases, no deaths.
4. Postoperative irradiation with metastases - 25 cases.
  - a. alive and well - 3