

I. ANNOUNCEMENTS:**1. HOMECOMING**

Minnesota Medical Alumni Home-Coming Program, Eustis Auditorium, Elliot Hospital, Oct. 28, 1932.

Dr. H. P. Ritchie, Chairman.

9:00 A.M. -- "Non Specific Prostatitis,"
Dr. C. D. Creevy.

9:30 A.M. -- "Mechanics in Genecology or Posture in Relation to Diseases of Women,"
Dr. William Rumpf.

10:00 A.M. -- "The Recurrent Goiter,"
Dr. Martin Nordland.

10:30 A.M. -- "Painful Feet in Adults,"
Dr. M. S. Henderson.

11:00 A.M. -- "Medical Treatment of Acute Sinusitis," Dr. K.E. Phelps.

11:30 A.M. -- "Manual and Visual Examination of the Rectum,"
Dr. H. E. Hullseik.

12:30 P.M. -- Lunch, University Hospital.
Dean Richard E. Scammon.
Dr. H. L. Dunn.
Business Meeting.

Dr. E. D. Anderson, Chairman.

2:00 P.M. -- Skin Clinic. Dr. C.A. Boreen.

2:30 P.M. -- "Diseases of the Genito-Urinary System in Infants and Children,"
Dr. R. E. Nutting.

3:00 P.M. -- Department of Medicine.

3:30 P.M. -- "Serial X-ray Plates in Gastro-Intestinal Studies,"
Dr. R. Morse.

4:00 P.M. -- "Treatment of the Ambulatory Cardiac Patient,"
Dr. Moses Barron.

All interested medical men are cordially invited to attend.

Note: It is unnecessary to ask all to make a special effort to welcome the alumni and friends of this institution on this occasion. This school is as much theirs as ours; we are simply acting as hosts at this particular time.

2. PSITTACOSIS:

The Minnesota State Department of Health calls our attention to presence of psittacosis in Minnesota. It is an acute, highly invasive, infectious disease of parrots, parrakeets, "love birds," (members of parrot family) which may occur in canaries and probably all other bird species and animals? In 1929-30, 185 cases caused 35 deaths in United States. Carrier state in birds has been proven. Most cases to date have come from diseased imported birds.

Incubation period:

6 to 15 days. Exceptionally longer.

Sex: Usually females (because of home exposure).

Age: Adults from 20 to 55.

Symptoms:

Onset abrupt, usually with chills, headache and fever, or preceded by malaise. Temperature 100 to 102 with irregular remissions to 103 to 105 in second week. Pulse slow as compared with temperature. Others: nosebleed not uncommon. Tongue coated, heavy white or brownish, edges cracked. Anorexia, constipation, chest pains, dreams and insomnia, delirium with high fever, stupor, may be present.

Physical Signs:

Usually those of focal lung lesion (early or after few days). Unproductive cough at first. Later cough with expectoration may be present. Sputum not blood-streaked. Abdominal distention may be marked. "Rose spots" occasionally reported. Leucopenia after first few days, usually 3000 to

5000. Fever drops after 8 or 10 days, or may continue for 3 or more weeks. Disease at first resembles influenza, later typhoid fever with symptoms suggestive but not typical of pneumonia.

Diagnosis:

The above group of symptoms or any obscure illness? associated with exposure to birds recently acquired is sufficient to make diagnosis. Relapses not infrequent and usually begin with symptoms similar to onset but run a milder and shorter course. Most frequent complication is phlebitis.

September 24, 1932, Dr. J. Jordal, Sacred Heart, reported suspected psittacosis in one of two nurses who had cared for a woman with psittacosis. From September 24 to October 3, 12 cases occurred, all related directly or indirectly to a certain shipment of "love birds" from California.

The State Department of Health asks us to be on lookout for association of illness or disease resembling influenza, typhoid, etc. and sick birds. Report suspected cases directly to Division of Preventable Disease, University Campus.

3. Department of PATHOLOGY:

University of Minnesota, invites you to attend: Departmental Seminar every Monday, 12:30 to 1:30 in room 104, Anatomy Building; Departmental Conference every Tuesday, 12:30 to 1:30 in room 104, Anatomy Building. On Tuesday interesting autopsy reports from various divisions are made. Minnesota Pathological Society meets third Tuesday of each month of school year. Mark the date on your calendar. Call department if you do not happen to see notices of programs.

4. Department of MEDICINE SEMINAR.

Held every second week at 4:45 P.M. in room 109, Main Building. First program of year by Drs. McKinley and Berkowitz. Second, October 26, "Use of Laboratory in Diabetic Management" by Dr. J. W. Covett. Discussion by A. Beard and E. P. Herrmann. You are cordially invited to attend.

5. 24-HOUR SERVICE:

By laboratory technicians started

Saturday noon, October 22nd. Alternate technicians will remain on call from 5 P.M. to 8 A.M. daily, all day Sundays and holidays. Only emergency requests will be honored at these times. Service also covers blood grouping and matching. Call telephone operator for technician on duty. Please limit demands for such tests as are necessary as same technicians are on day duty as well.

6. MINNESOTA GENERAL HOSPITAL

is official name of this institution, at first popularly known as University Hospital, later as University Hospitals. In all official correspondence, the name "Minnesota General Hospital" is to be used. Because of association with University and confusion with Minneapolis General Hospital, old names probably will continue to be used (non-officially).

7. STUART WILLIAM HARRINGTON,

Assistant Professor of Surgery, Graduate School, Mayo Foundation, University of Minnesota, will address Medical students and faculty today at 2 P.M. in Anatomy Amphitheater on "Tumors of Thoracic Wall and Lungs; Surgery of Diaphragm." You are invited to hear him - it will be worth your while because of his unusual personal experience in this field.

8. CARL ALBION WITHAM, Med. '06,

Minnesota, prominent Minneapolis physician and surgeon, has given complete files of Surgery, Gynecology and Obstetrics, 1920 to date, to Departmental Book Collection, Surgical Division, Main II. These and certain other books and periodicals may be withdrawn for personal use. Sign for them when you go, erase when you come back.

II. CASE REPORT:

TERATOMA OF MEDIASTINUM AND RIGHT CHEST.

Path. Pearson.

The case is that of a white male, 16 years of age, admitted to the University Hospitals 5-26-32, expired 6-8-32

(13 days).

Pain - cough

9- -31 - Pain in right posterior thorax and mid-scapular regions. Pain intermittent but did not incapacitate him in any way.

12-? -31 - Caught cold and developed dry hacking cough with exacerbation of pain in chest. Physician made diagnosis of pleurisy. Pain continued and respirations became more rapid and shallow.

Fluid

1- -32 Right chest tapped and cloudy yellow fluid obtained. Few days after this, rib resection done.

Drainage

3- -32 Second operation. Cough continued all this time. Opening in right thorax drained continuously since time of operation. In bed most of time until admission and gained about 8 pounds. However, he lost about 16 pounds since onset of illness, became quite weak and tired very easily.

Worse

5-21-32 - Began to have more pain in right chest and dorsal region. Cough increased somewhat, but is still non-productive. Night sweats noted at this time. Severe pain now present.

Past health:

Very good. Had smallpox when a child but no scarlet fever, diphtheria, measles, whooping cough or influenza.

Admitted

5-26-32 - Physical examination: Poorly nourished, well-developed, lying in supine position showing respiratory distress.

Chest - rib resection scar in right thorax over 2nd to 4th ribs in axillary region; there is fungating growth in draining sinus on right side; percussion note: normal to hyper-resonance over entire left thorax, dullness in right apex; flatness over 4th spine posteriorly and anteriorly; occasional rales over anterior portion of left chest; breath sounds tubular in right apex; absence of breath sounds over flatness of right chest, both anteriorly and posteriorly. Heart - Rate 134; regular rate; displaced to left; harsh systolic murmur over apex which is not transmitted;

blood pressure 110/78. Abdomen - liver is down about 3 fingers below costal margin in midclavicular region. Bones and joints - no clubbing of fingers; nail cyanotic.

Laboratory

Urine - 1.030. Hb. 71%, rbc's 4,080,000, wbc's 11,540, Pmn's 71%, L 25%, M 3%, E 1%. X-ray of chest - Extensive effusion on right, involving practically whole chest cavity. There have been several ribs resected on this side. Heart and mediastinum are pushed over markedly to left. Right diaphragm not visualized. Left lung field appears clear. Conclusions - Extensive hydrothorax, right with multiple rib resection. Displacement of heart and mediastinum.

Progress

Wound on anterior chest is probed and about 200 c.c. of purulent fluid obtained. Culture is taken of this but shows no bacteria. Great deal of pain. Morphine sulphate gr. 1/6 given. Temperature 101.4. Pulse 128.
5-28-32 - Pulse 150. Temperature 103.2.
6-1-32 - Great deal of pain and coughs some. Pulse 140. Temperature 103.2.

6-4-32 - X-ray of chest - The findings are practically same as last reported. There is considerable calcification in the thoracic cavity on the right side and is shown probably due to regeneration of the resected ribs.

Operation

6-5-32 - Using finger as enucleator, it was gradually inserted through old fistulous opening about mass and greater portion of tumor was enucleated in this manner. Gauze was packed in because of severe hemorrhage and several hemostats applied to bleeding points. A fair portion of tumor was left behind bleeding points. In a few moments, more packing was inserted. Pathological examination: Gross tissue removed is about 10 x 4 cm., whitish, soft and fleshy. In places, it looked myxomatous. On cut section, there are numerous sinuses and cyst-like areas, some of which contain whitish-mucinous material and others are somewhat purulent. Micro-

scopic examination shows tissue composed of varied structures, having numerous cysts lined by squamous epithelium. Some of the cysts are also lined by columnar epithelium. In one cyst, there is both squamous epithelium and columnar epithelium. Some of the columnar epithelium is ciliated. There are also areas of bronchogenic-like epithelium which is surrounded by muscle fibers. The glandular structures are very numerous and lone areas of smooth muscle tissue can be seen in the section.

Diagnosis: Teratoma.

Post-Operative

6-6-32 - Transfusion of 400 c.c. blood. Chloral hydrate gr. xxx (R). Pulse 128. Respirations 28. Intravenous of 500 c.c. of saline given immediately after operation. 1:15 P.M. - Complains of severe pain at the site of operation. Somewhat restless. Chloral hydrate gr. xxx. Became very cyanotic. 2:00 P.M. - Pulse 150. Respirations rapid. Caffeine sodium benzoate 2 c.c. and 1 c.c. of adrenalin. Intravenous 300 c.c. of normal saline and 500 c.c. gum acacia solution in triple distilled water. 2:50 P.M. - Blood pressure 110/60. Pulse very rapid. Respirations labored. 9:30 P.M. - Blood pressure 90/60.

X-ray of chest - Extensive density in right chest again shown. There are a large number of instruments attached to it. Within the density can be made out a number of areas of increased density suggesting bone or calcification. These may be regeneration of ribs, but might also represent areas of bone or teeth in deronid cyst.

Next Day

6-7-32 - Pulse 152. Respirations 44. Blood pressure 94/58. Perspiring profusely. Put in oxygen tent and continuous oxygen given. Tossing about a great deal. Chloral hydrate gr. xx (R). 3:00 A.M. - Pulse 136. Respirations 46. Pulse irregular. 5:00 A.M. - Chloral hydrate gr. xx (R). Very cyanotic. Caffeine sodium benzoate 2 c.c., ephedrine sulphate 1 c.c., gum acacia 1 ampule with 500 c.c. distilled water intravenously. Restless and moves about considerably. Dressings saturated with bloody drainage. Oxygen continuously. 10:30 P.M. - Blood pressure 93/76. Temperature 104.4 (R).

Exitus

6-8-32 - Very restless but responds. Chloral hydrate gr. xx (R). 4:55 A.M. Pulse imperceptible. 6:08 A.M. - Expired.

AUTOPSY:

Defect

Body is that of well-developed but poorly nourished, white male, 16 years of age, measuring 167 cm. in length, weighing approximately 115 lbs. Rigor is present. Hypostasis purplish and posterior. No edema, cyanosis or jaundice. Pupils regular, each measuring 4 mm. in diameter. Opening in right chest, measuring 8 x 5 cm., through which a tumor mass can be seen. Several hemostatic forceps applied to bleeding areas? Peritoneal Cavity contains no fluid. Peritoneum is smooth and glistening. Diaphragm on right side is at 9th rib, on left side at 6th rib. Appendix retrocecal and free.

Tumor

Pleural Cavities. Left lung emphysematous. Heart pushed over to left chest. A large mass occupies anterior portion of mediastinum, reaching from 9th rib extending up to region of arch of aorta. Also occupies right chest except at operative site where a portion of mass is removed. Lung cannot be seen anteriorly on account of mass covering it and filling chest. Mass, both lungs and heart are removed together. Pericardial Sac contains minimal amount of fluid. Mass does not extend into pericardial sac or into any of chambers or vessels of heart. Mass is dissected free and found to be covered with pleura, adherent to diaphragm (slightly) and to vessels in region of neck (but can be easily peeled off.) There is only one place in chest where the tumor is adherent to chest wall itself and that is in the region of the opening in the right chest where it has to be cut across in order to free it. Tumor weighs 3100 grams, and measures approximately 25 x 15 cm. It is well-circumscribed and not infiltrated into adjacent tissues. When pleura is removed,

there are dilatation cysts present of varying sizes (from 3 cm. to about 6 cm. in diameter.) These, when cut into, contain a whitish mucinous fluid. The tumor is next cut longitudinally and similar cystic areas are found throughout. A great deal of sebaceous material is present in some of the cystic places, which is yellowish in color. Several areas of calcification are present throughout, also cartilaginous areas.

Heart

Chambers and valves are normal. Myocardium is normal. No evidence of disease in the heart itself.

Atelectasis - emphysema

Left Lung is hyper-expanded. Some congestion at base. Right Lung is very markedly atelectatic and is pressed against posterior chest wall by the tumor mass. Lung is practically non-air-containing except in one small portion at apex of right lobe which is emphysematous. Bronchi are traced out and no constriction by tumor mass is found. Trachea seems to be about in midline also esophagus, but the heart is pushed over to left. Aorta is not constricted or esophagus or trachea. Superior vena cava is somewhat constricted but not enough to cause any symptoms? No invasion of tumor mass into any of vessels.

Spleen

weighs 150 grams. The capsule is greyish and wrinkled. The pulp is somewhat soft. The trabeculae are prominent.

Liver

weighs 1850 grams. No evidence of tumor metastasis. A slight amount of cloudy swelling present.

Gall-Bladder, Gastro-Intestinal Tract, Pancreas (80 grams) and Adrenals normal.

Kidneys

weigh 150 grams each. Capsules strip easily revealing quite smooth surfaces. No evidence of any infection can be seen within the kidney pelvis or ureters.

Bladder is normal.

DIAGNOSES:

1. Teratoma of mediastinum and pleural cavity.

2. Recent and old operative incisions of right chest.
3. Atelectasis of right lung.
4. Slight compression of superior vena cava.
5. Displacement of heart to left.
6. Marked emphysema of left lung (Compensatory).
7. Cloudy swelling of liver and kidneys.
8. Emaciation.
9. Multiple puncture wounds.

Comment: Typical teratoma in microscopic sections.

III. ABSTRACTS

DERMOID CYSTS AND TERATOMAS OF CHEST.

Ref.:

1. Tumors and Cysts of Thorax; G. J. Heuer and W. DeW. Andrus, Dean Lewis' Practice of Surgery, V, Chap. V, 1931. Prior and Co.
2. Differential Diagnosis of Primary Neoplasms of the Mediastinum; C. D. Haagenson, The American Journal of Cancer, XVI, 723-782, (July) 1932.
3. Dermoids of Mediastinum; A. E. Hertzler, Am. J. Med. Sc. 152, 165-173, 1916.
4. Dermoid Cysts and Teratomas of Anterior Mediastinum; H. Christian, J. of Med. Res., VII, 54-71, 1902.

In literature, epidermoid and dermoid cysts and teratomas are considered together.

1. Incidence.

Uncommon intrathoracic tumors, first described by Gordon 1825.

To January 1926, 135 cases reported. More recent articles indicate that 300 have been reported. 520 cases of mediastinal disease, exclusive of heart and aorta, over half (280) were true tumors, and of these 10 were dermoid cysts.

2. Etiology.

Congenital lesions arising

from ectodermal or branchiogenic cells drawn into chest by descent of heart. Typically found in anterior mediastinum. Grow slowly, often remaining quiescent for long periods of time. 9 of 135 cases in literature were under 12 years of age; i.e. symptoms at that age. Majority come under observation in 3rd decade. Trauma and infection assigned as causes for rapid growth. Note: Was infection in our case primary or secondary? Sex equally divided.

3. Gross appearance.

Vary in size from pigeon egg to tumor larger than child's head. Most frequent location in upper portion of anterior mediastinum as follows:

Upper half of thorax	18
Lower thorax	8
Entire pleural cavity	6
Suprasternal notch	6
Imbedded in lung	4
Near hilum	1

Duval's classification, (retrosternal, cervico-retrosternal, mediastino-thoracic, ours? lateral thoracic). The group which project into the base of the neck are of interest (14%) as they may be treated as primary cervical tumors.

4. Structure.

Classified as to whether they contain one or more germinal layers. Epidermoid tumors are derived from ectodermal layer and consist of a cyst wall lined by squamous epithelium. Contents are usually cloudy, brownish fluid containing desquamated epithelium. Infection follows communication with bronchus. Middle group (dermoid cyst) considered to be distinct from epidermoid cysts and teratomas. Possess cyst wall as in previous type except that it varies in thickness. Lining resembles skin, may undergo calcification or contain bone cartilage and teeth. Hair, sweat and sebaceous glands and fat also present in many. Teratomas are less frequent than preceding. Derived from 3 germinal layers, solid structures, often cystic. Cysts resemble dermoid cysts in lining and contents but solid portions are made up of various derivatives of 3 layers. In 60 cases collected by Christian, 7 were of this type. Note: Our case belongs to this group.

5. Malignant degeneration.

Both carcinomatous and sarcomatous changes may occur. The distinction between benign and malignant growths (solid tumors) may be difficult. Infection is more serious complication. Our case, histologically, did not show the usual picture of malignant change, did not invade but apparently caused death by its growth and secondary infection. Is it malignant? Various reports give different frequencies for malignant degeneration. Infection may result from respiratory infection, rupture into bronchus, tapping, incision. Rapid growth usually follows, and rupture in suprasternal notch or in ribs may take place, also pleural cavity, giving rise to empyema. Rupture into pericardium or great vessels is rare.

6. Symptoms.

Due to pressure or irritation from tumor (reactive inflammation). Usual complaints - cough, dyspnea, pain and sensation of pressure. Some may be silent throughout life and rarely do symptoms occur before puberty. Of 101 cases, 33 gave symptoms between 17 and 30. Other complaints may be pleural effusion and hemoptysis. Pain may be sole symptom. Dyspnea may be paroxysmal but is usually associated with pain. Cough with or without mucoid expectoration, is sometimes followed by large amounts of foul material due to establishment of bronchial communication, occurred in over 1/3 of one series. Cyanosis of face and neck also present. Hair and greasy material may be expectorated.

7. Physical signs.

Some show bulging through chest or neck, others fistulae to surface. Other signs of mediastinal tumor - puffiness of eyelids, distention of superficial veins, cyanosis and edema of face upper chest, face and arms, unilateral or bilateral, hoarseness, aphonia, tachycardia and Horner's syndrome. Solid, non-pulsating tumors of slow progress often show increase of mediastinal width. Duration of symptoms varies from 1 to 15 years, in some instances even longer. X-ray is of value in demonstrating tumor and may

even show character of opaque areas are present, calcium, teeth, etc. Note: our case.

8. Treatment.

Resectable tumors may be removed. Simple drainage of infected cysts may or may not be helpful. If symptoms are minimal, treatment may be deferred.

9. Differential Diagnosis.

- Malignant:
- a. Lymphosarcoma
 1. Small, round cell (lymphocytoma)
 2. Large, round cell (Reticulum cell sarcoma)
 - b. Hodgkin's disease
 - c. Leukemia
 - d. Leukosarcoma
 - e. Thymoma
- Benign:
- a. Dermoid cysts
 - b. Other cysts (ecchinococcus, ciliated epithelial, etc.)
 - c. Ganglioneuroma
 - d. Fibroma, chondroma, myoma, etc.

Lymphosarcoma occupies thymic region, occurs in children, metastasizes widely, composed of small round cells, no Hassel's corpuscles, radiosensitive. Probably tumor usually reported as malignant thymoma? Large round cell tumors are radiosensitive growths, probably from lymph nodes, (Hodgkin's disease to many people).

Hodgkin's disease is usually associated with involvement elsewhere, forms massive tumor, presses on surrounding structures, frequently invades lung, radiosensitive.

Lymphatic leukemia seldom involves thymus. Mayo Clinic series 32 cases at autopsy, thymus not involved in 28. Tumor at time may be massive.

Leukosarcoma combination of lymphosarcoma and leukemia. Frequently located in anterior mediastinum, involves pericardium and great vessels, not so radiosensitive.

Thymoma (carcinoma) encapsulated tumor in normal position of thymus, shows structures resembling

Hassel's corpuscles, usually widespread metastasis, radiosensitive (?).

Dermoid cysts see discussion, not radiosensitive. Incomplete extirpation and drainage may be harmful. Surgical intervention desirable in cases in which symptoms have developed without previous surgical attempts. Malignant changes not radiosensitive.

Neurogenic tumors (ganglioneuromas) have been previously discussed. (See neurofibromatosis, last year). Often occupy posterior mediastinum, may become sarcomatous, not radiosensitive, usually of slow growth. Usually from 15 to 20 years of age when symptoms recur. One of valuable means of differential diagnosis in these tumors is radiation. Test doses should be given in all unless diagnosis can be made otherwise.

Impressions:

1. Dermoid tumors usually classified together (dermoid, epidermoid and teratomas) in literature.
2. Tumors are uncommon. First reported in 1825, approximately 200 since that time.
3. Over half cases of mediastinal disease in literature were true tumors. (May not be true in practice?).
4. Tumors arise from ectodermal or branchiogenic cells drawn into chest by descent of heart.
5. Typical location is anterior mediastinum with extension into chest or neck.
6. Seldom give rise to symptoms before puberty. Commonest age of patient with complaints is 3rd decade.
7. Trauma and infection cause more rapid growth? There seems to be some relationship to general growth of the body?
8. Vary in size from pigeon egg to larger than a child's head. Case reported today is one of largest. (Literature).
9. Tumors may be simple or complicated cysts of solid growths. Commonest complication is infection. Malignant degeneration is reported.
10. Symptoms usually due to pressure or infection. Cough, pain and dyspnea are commonest.

11. Some tumors may be silent or only give slight symptoms throughout life.

12. Communication of cyst with bronchus is not infrequent. Expecterated material may give clue to diagnosis.

13. In differential diagnosis, radiosensitivity, examination of blood and biopsy of other lesions may be helpful.

14. Usual physical sign is increased dullness of mediastinum. May be confirmed by x-ray and even structure determined.

15. Incomplete removal and drainage are not effective. Surgical intervention should be reserved in some cases, attempted in others.

Abstract by BJarne Pearson

IV. PERSONAL

1. FREDERICK BLYTHE EXNER

Fellow in Radiology, reported our experience with radiation therapy of the Uterine Corpus at the Autumn-meeting of the Minnesota Radiological Society, in Duluth, Minn., Saturday, Oct. 22, 1932. 42 cases have been treated, results too early to report. Among others J. R. McNutt, Duluth, read a paper on Roentgen Findings in Pneumoconiosis; M. H. Nicholson, Duluth, Roentgen Visualization of the Urethra, Normal and Pathological; Dr. F. Hirschboeck, Duluth, a paper on Atelectasis of the Lungs. Round Table discussion on Problems of Roentgen Diagnosis and Therapy was conducted by Gsge Clement, Duluth, at the Informal Dinner at Hotel Duluth. The principal address was "Diaphragmatic Hernia", Roentgen Aspect by B. R. Kirklin, Rochester; the Surgical Aspect by S. Harrington, Rochester. Members were urged to bring difficult or unusual case records and films for the round-table discussion.

2. OWEN HARDING WANGENSTEEN

attended meeting of the American College of Surgeons in St. Louis, Mo., Oct. 17-21, 1932. Discussed Symposium on Teaching of Surgery by Elliott C. Cutler, George J. Heuer, Allen O. Whipple, Irving S. Cutter, Fred C. Zapflee. Commission has been studying surgical teaching via questionnaire and opinion

route. Outstanding feature of meeting was report of personal experience in 5 year malignancy cures (more than 8,000 on record.) Director Halbert Louis Dunn also attended meeting and is now visiting various medical centers and hospitals in middlewest and east. Surgeon Wangensteen reports visit with Fellow Herbert Carlson, now on leave at Washington University, doing special work in Chest Surgery.

3. BJARNE PEARSON

Born in Oslo, Norway, 1900, came to America at age of 8, settled near Pelican Rapids, Minn. Student: St. Olaf College 1920-24. Degrees: University of Minnesota, B.S. 1929, M.D. 1930, M.S. 1932 (Pathology). Intern at Minneapolis General Hospital 1929-30. First appointment to special fellowship established by Citizen's Aid Society. Resigned Oct. 15, 1932 to be associated with Arthur Reigel, Taylors Falls, Minn. and St. Croix Falls, Wis. Will assist in surgery, do general practice and take care of pathological work of 18 bed hospital. Shrewd, adroit, industrious, obtained his education under great handicaps. One time leader of dance orchestra, clothing store operator, Ford garage owner, special detective, book salesman, theme expert, general counsellor for hundreds of students, he was a remarkable fellow, practically unknown to all except his intimate associates. Few men have his ability to collect and tabulate literature from any language. His contribution to the development of better pathological service at this institution was not sufficiently appreciated. Many staff meetings were the entire result of his labors. He goes with the best wishes of all for continued success. The material today was prepared by Dr. Pearson as he was leaving for his new location.

4. WALLACE PARKS RITCHIE

Grandson of Parks Ritchie, Professor of Gynecology and Obstetrics, beloved second Dean of the Medical School of the University of Minnesota. Son of Harry Parks Ritchie, Associate Professor of Surgery, known far and wide for his interest and skill in

reconstructive surgery and personal solicitous care of defective children in this institution, takes Dr. Pearson's place. The third of the illustrious line of Ritchies started his education at St. Paul Academy where he graduated in 1923. Yale University, B.A. 1927; Johns Hopkins University, Medical School 1931; Internship, Union Memorial Hospital, 1931-32. Modest, industrious, very competent, the newest Ritchie has already won a place for himself in our organization. We extend to him our personal greetings and best wishes at this time.

5. TEAM WORK

as result of Dr. Rigler's suggestion last week, we intend from time to time to collect your suggestions for improved service. The following are submitted:

- (1) Do gastro-intestinal studies after other procedures (bone, genito-urinary, etc.) or wait sufficient time for barium to clear.
- (2) Get x-ray reports before discharging patients (any type).
- (3) Limit requests to emergencies only of technicians on night, Sunday and holiday service.

These are personal matters between us.

What are your suggestions?

6. MEETING

Date: October 20, 1932.

Place: Interns' Lounge, 6th Floor, West Building.

Time: 12:15 to 1:15.

Program: See Staff Bulletin.

Present: 85

Discussion: H. A. Reimann
Henry Ulrich
Donald McCarthy
Leo G. Rigler

Theme:

In our experience cortin does not prolong life, evidence that it ever does (experience of others) is inconclusive, excellent for crises if potent, chemistry of gland has changed (4 active principles now known), minor pigmentation is or is not significant in borderline cases. Remember Addison's disease in differential diagnosis of acute abdominal conditions. Do not operate on patients with Addison's, sudden death may occur at any time; calcification may be observed in region of adrenal, is it the gland?

Gertrude Gunn,
Record Librarian