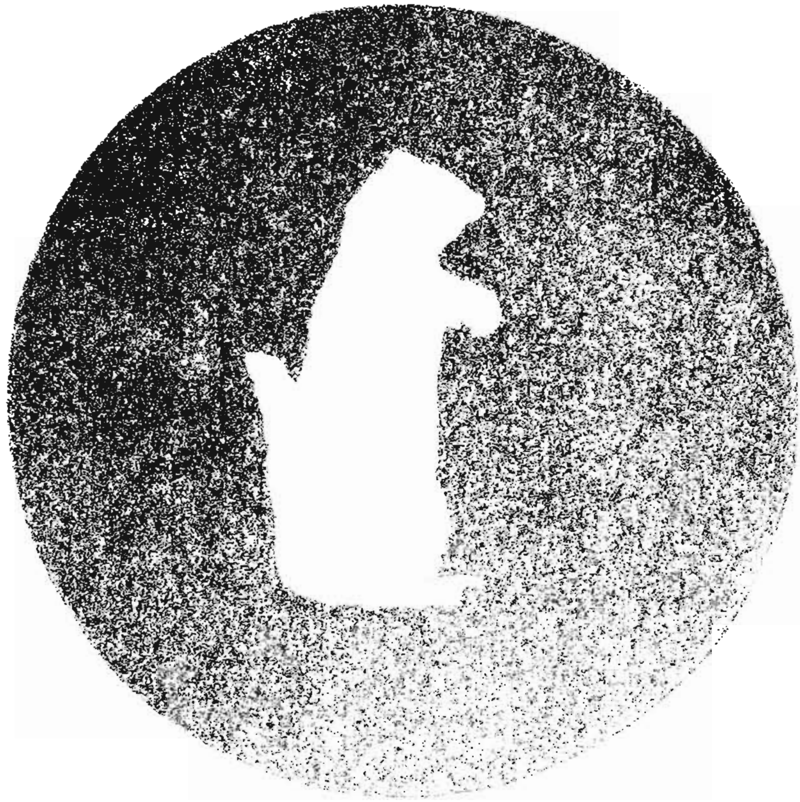

Appendicitis

Volume VI Thursday, November 15, 1934 Number 8

UNIVERSITY OF MINNESOTA HOSPITALS
Volume VI — Thursday, November 22, 1934 — Number 8

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I. CASE REPORTS

The diagnosis and treatment of acute appendicitis still presents a serious problem. We are reporting by way of example four cases illustrating some of the complications. This will be followed by a survey of our appendicitis situation and abstracts of reports from other institutions.

1. GANGRENOUS APPENDICITIS WITH PYELEPHLEBITIS AND LIVER ABSCESSES

Case is white male, 36 years of age, admitted to University of Minnesota Hospitals 10-9-34 and expired 10-20-34 (16 days).

Acute attack
10-1-34 - Pain in abdomen, nausea and vomitins. Temperature rose to 104 and patient experienced a severe chill. No diarrhea. Had an enema daily. Anorexia throughout illness. No history of previous attack.

Admitted
10-9-34 - Physical examination - Acutely ill, white male. No jaundice or edema. Diffuse abdominal tenderness and slight rigidity, the rigidity being most marked in the right lower quadrant. A palpable mass is present in this area. Rectal - shows mass on right side. Temperature 104.5. Pulse 130.

Laboratory
Blood - hemoglobin 94%, leucocytes 18,250. X-ray of abdomen and chest - essentially negative. As patient was returning from x-ray department he was seized with a severe chill during which he was irrational.

Chills
10-12-34 - Complains of pain in abdomen. Had chill lasting about 2 minutes. Blood transfusion of 700 cc. citrated blood.

Jaundice
10-16-34 - Icteric index 55 units.

10-18-34 - Surgical note: Chills, fever and jaundice suggest strongly the diagnosis of pyelephlebitis.

10-19-34 - Irrational. Fingers are cyanotic.

10-20-34 - 6:45 A.M. - Expired.

Essential findings at Autopsy

About 1000 cc. of greenish fluid in the Peritoneal Cavity. The distal part of the cecum is gangrenous and the appendix cannot be definitely made out. The entire mass is adherent to the posterior abdominal wall and is fairly well walled-off.

The right lung weighs 1300 grams and shows marked congestion posteriorly and scattered areas of consolidation.

The liver weighs 3450 grams and extends 3 fingerbreadths below the costal margin in the right anterior axillary line. It is studded throughout with abscesses, the largest being about 1 cm. in diameter. The portal vein is infected.

The gall-bladder is distended with purulent bile and shows small abscesses in the wall.

Diagnosis
1. Acute gangrenous appendicitis.
2. Acute peritonitis.
3. Pyelephlebitis.
4. Liver abscesses.
5. Bronchopneumonia, right side.
6. Purulent cholecystitis with empyema of gall-bladder.

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2. GANGRENOUS APPENDICITIS WITH PARALYTIC ILEUS

Case is white male, 28 years of age, admitted to University of Minnesota Hospitals 9-7-34 and expired 9-11-34 (4 days).

Pain
9-2-34 - Seized with sharp abdominal pain while at a dance. Pain lasted only a few seconds. He danced until 2 A.M. and then went home to bed.

9-2-34 - Seized with second attack of pain. Took an enema and castor oil,

and went to bed.

Vomiting
9-5-34 - Hospitalized (outside hospital). Unable to eat. Marked vomiting. Given castor oil.

Admitted
9-7-34 - Physical examination: Slight distention of abdomen, no rigidity, no tenderness, occasional metallic tinkle heard over abdomen. Laboratory: Blood - leucocytes 7,550. Urine - negative. Progress: No fever at time of admission. Rapid pulse.

Pain
9-8-34 - Severe pain in lower abdomen. During night, he got out of bed.

9-9-34 - Still complaining of pain. Nasal suction started. Temperature rose from 99.4 to 101.

9-10-34 - 1:30 P.M. - Very weak. Perspiring. Thready pulse. Blood pressure not obtainable. Foot of bed elevated. External heat applied. Recovered from this attack and blood presure rose to 110/80. Chemical studies: non-protein nitrogen 123 mg. % blood urea nitrogen 99 mg. %, blood sugar 196 mg. %, blood chlorides 606 mg. %.

Exitus
9-11-34 - Irrational. Temperature 106 (R). Throat is filling with mucus. Blood transfusion given. Pulse weak and thready. 9:20 P.M. - Expired.

Essential findings at Autopsy

Appendix is gangrenous. Small amount of exudate about appendix. No peritonitis.

Gastro-Intestinal tract. The small bowel and stomach are distended with fluid, gas and a small amount of barium.

Diagnosis
1. Gangrenous appendicitis.
2. Paralytic ileus.

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3. ACUTE APPENDICITIS. SUBPHRENIC ABSCESS

Case is white male, 37 years of age, admitted to University of Minnesota Hospitals 3-30-34 and expired 3-31-34 (1 day).

Appendectomy
1-25-34 (about) - Appendectomy for acute suppurative appendicitis. Wound drained.

Pain - Chills
2-7-34 - Pain in right side of abdomen associated with chills.

Admitted
3-30-34 - Physical examination: Patient is critically ill, perspiring profusely, has extreme air hunger. Abdomen - not distended, 8 cm. scar in right lower quadrant covered with gauze, small amount of brownish material draining through. Lungs - impaired resonance over entire right side, anteriorly; dulness down to 3d interspace and tympany from 3d to 6th interspace with flatness below 6th interspace; breath sounds absent. On turning patient to the left side, there is a shifting tympany to the right axillary line. Signs of consolidation at the left base.

Laboratory
Urine - negative. Blood - hemoglobin 81%, leucocytes 27,200, neutrophiles 85%, lymphocytes 15%.

Progress
1350 cc. foul smelling pus obtained from right chest. Smears show numerous gram+ and gram- bacteria, rods and cocci. Temperature 101.4

3-31-34 - Placed in oxygen tent with little relief. 9:06 A.M. - Expired.

Essential Autopsy findings
Eight centimeter incision incompletely healed in right lower quadrant.

General Peritoneal Cavity with certain exceptions noted below is free from adhesions, excess fluid, and the membrane is smooth and glistening. Post rior to

the cecum, there is an excapsulated abscess, containing about 2 oz. of thick grayish pus. The pus has burrowed down into the fascia of the psoas muscle. Right side of abdominal cavity, adjacent to ascending colon, is obliterated by adhesions. In right kidney area between under-surface of liver and kidney, there is an abscess cavity containing gas and about 4 to 6 oz. of thin, grayish pus. When pressure is applied to the bowel, gas bubbles out of this area. In the right subphrenic space, there is a collection of pus and gas. There is about 500 cc. of pus.

Pleural Cavities: The right side shows the lung to be slightly adherent to the chest wall. Most of the lung lies behind the elevated dome of the right diaphragm. The right lung weighs 600 grams and shows an extensive bronchopneumonia. The diaphragm is at the level of the 2d rib on the right side. The Left Lung shows extensive confluent bronchopneumonia, involving the lower lobe and part of the upper lobe.

The liver weighs 2200 grams and shows no asbcesses. The portal vein is patent.

Gastro-Intestinal tract: There is perforation of the anterior surface of the duodenum slightly above the ampulla. The serosal side is involved more than the mucous surface. Grossly, the perforation appears to be secondary erosion from the outside. The appendix is not found.

Diagnosis

1. Peri-appendiceal abscess.
2. Subhepatic abscess (gutter).
3. Subdiaphragmatic abscess with pneumoperitoneum.
4. Secondary perforation of duodenum.
5. Bilateral bronchopneumonia.

4. ACUTE APPENDICITIS. GENERALIZED PERITONITIS.

Case is white female, 15 years of age, admitted to University of Minnesota Hospitals 1-3-34 and expired 1-9-34 (6 days).

Pain

1-1-34 - 5 A.M., severe pain in mid-line of lower abdomen. Pain crampy at first but later became quite constant. During remainder of day, pain was localized in lower abdomen on right side. Experienced periodic attacks of generalized abdominal pain. Vomiting. Unable to eat.

1-2-34 - No bowel movements. Hot enema given.

Admitted

1-3-34 - Pain has been constantly in right lower quadrant. Frequent vomiting. Physical examination: herpes labialis, temperature 102, pulse 116. Abdomen - 3+ rigidity on right side, 2+ on left; tenderness and rebound tenderness throughout. Pelvic - negative.

Laboratory

Urine - 3+ albumin, occasional granular casts, few leucocytes. Blood - hemoglobin 90%, leucocytes 27,800, neutrophiles 89%.

Peritonitis

1-9-34 - Conservative treatment had been instituted because it was thought that the patient was suffering from generalized peritonitis. Intravenous fluids and transfusion given. Has marked distention which is somewhat controlled by nasal suction. Temperature 105. Pulse rapid and thready. 4:30 A.M. - Expired.

Essential Autopsy findings

Herpes labialis.

Peritoneal Cavity: A large amount of turbid, purulent fluid. Appendix is gangrenous in its terminal two-thirds. There is a fecolith in the mid-portion.

The Gall-bladder is edematous.

The Liver is soft and slightly yellowish.

Gastro-intestinal tract: There is marked dilation of the small bowel and colon.

Diagnosis

1. Gangrenous appendicitis.
2. Generalized peritonitis.

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II. SURVEY

APPENDICITIS EXPERIENCE AT THE UNIVERSITY OF MINNESOTA HOSPITALS

Compiled by Dr. Louis Sperling with the assistance of Drs. J. Myrick, M. Cook, J. Nelson, A. Okelberry.

Three hundred and fifty-seven (357) cases of appendicitis from January 1932 to January 1934 were studied.

A. Interval appendectomies: 121 cases (about 1/3), no deaths.

Complications in 7 cases:

Wound infection	3
Bronchopneumonia	2
Upper respiratory infection	1
Atelectasis	1

B. Infected Appendectomies

	Cases	Deaths	Mortality%
Simple acute non-perforated	110	1	.99(1)
Perforated appendix with abscess	59	4	6.7 (7)
Perforated appendix with local peritonitis	21	2	9.5(10)
Perforated appendix with generalized peritonitis	46	20	43.4(43)

Total mortality 7.5% (8), exclusive of general peritonitis 2.2% (2).

1. Simple acute non-perforated - 110 cases.

78 cases subjected to immediate operation
32 cases delayed operation

Reasons for delay:

a. Associated acute upper respiratory infection with mild appendicitis.

b. Subsiding appendicitis.

c. Long history, 5+ days.

d. Co-existing rheumatic fever, diabetes, urinary changes, heart disease.

Average duration of symptoms, 2.2 (2) days; recurrent attacks, 63%, average hospital stay, 10.6 (11) days.

Symptoms	
Pain	100%
Nausea	82
Vomiting	53
Anorexia	51
Diarrhea	10
Catharsis	5
Chill	4

Findings		
Tenderness		100%
Rigidity		74
Rectal tenderness		70
Rebound tenderness		51
Rectal mass		2
Abdominal mass		0
Average temperature	99.6°	
Average pulse	92	
Average leucocytes	12,600	
Average neutrophiles		84

Complications	Cases
Wound infection	5
Culdesac abscess	4
Phlebitis	3
Bronchopneumonia	1
Pulmonary embolism	1
Parotitis	1
Intestinal obstruction	1
General peritonitis	1

2. Perforated appendicitis with abscess formation: 59 cases, 4 deaths, mortality 6.[illegible] ([illegible]).

Immediate operation	12	1 death from peritonitis
Delayed operation	38	1 d[illegible] drainage of [illegible]

Not operated upon 11 2 deaths

Average duration of symptoms before admission 7.8 (8) days; recurrent attacks 32%; average hospital stay 22 days.

Symptoms	
Pain	100%
Nausea	80
Anorexia	67
Vomiting	62
Catharsis	28
Diarrhea	17
Chills	15

Findings		
Tenderness		100%
Rigidity		94
Rectal tenderness		88
Rebound tenderness		83
Abdominal mass		59
Rectal mass		28
Average temperature	100.4°	
Average pulse	100.	
Average leucocytes	19,378	
Average neutrophiles		84

Complications	Cases
Wound infection	5
Secondary pelvic abscess	3
Upper respiratory infection	3
Fecal fistula	2
Intestinal obstruction	1
Parotitis	1
General peritonitis	1
Bronchopneumonia	1

3. Perforated Appendix with local peritonitis: 21 cases

Immediate operation 18 cases, 2 deaths (1 intestinal obstruction & bronchopneumonia) (1 while under anesthetic)

Delayed operation 2 cases

No operation 1 case

Average duration of symptoms 2 to 5 days; recurrent attacks 28%; average hospital stay 18.6 (20) days.

Symptoms	
Pain	100%
Nausea	90
Vomiting	71
Anorexia	71
Catharsis	14
Diarrhea	9
Chill	4

Findings		
Tenderness		100%
Rigidity		100
Rebound tenderness		90
Rectal tenderness		86
Rectal mass		4
Average temperature	100.5°	
Average pulse	101	
Average leucocytes	16,150	
Average neutrophiles		82

Complications	Cases
Wound infection	4
Pelvic abscess	3
Bronchopneumonia	1
Intestinal obstruction	1

4. Perforated Appendix with generalized peritonitis: 46 cases, 20 deaths, mortality 43%.

	Deaths	Mortality %
23 children, under age 15	9	45
23 adults	11	55
9 immediate operation	5	55
37 delayed or no operation	15	47

Of 20 deaths:
- 10 cases - no operation
- 5 cases - delayed operation (2 after pelvic abscess drainage; 3 after laparotomies)
- 5 cases - immediate operation

Of 26 recovered:
- 4 cases - immediate operation
- 19 cases - delayed operation
- 3 cases - no operation

18 cases of localized abscesses which were drained, 8 abdominal abscesses and 10 pelvic abscesses. There were 4 deaths in this series.

Duration of symptoms before entry to hospital - 3.7 (4) days for survivors, 3 days for fatal cases; recurrent attacks 30%; average hospital stay - 22.2 (22) days, of survivors 34.5 (35) days.

Symptoms

Pain		100%
Nausea		95
Vomiting		95
Anorexia		80
Catharsis	(13 cases) (9 died)	28
Diarrhea		26
Chills		7

Findings

Tenderness		100%
Rigidity		100
Rebound tenderness		93
Rectal tenderness		93
Abdominal or rectal mass		10
Average temperature	101.5°	
Average pulse	114	
Average leucocytes	17,400	
Average neutrophiles		83

Complications

Fatal Cases	Cases
Pelvic abscess	6
Bronchopneumonia	4
Atelectasis	1
Intestinal obstruction	1

Survivors	Cases
Pelvic abscess (2 resolved)	15
Intestinal obstruction	2
Fecal fistula	1
Postoperative hernia	1

Total Acute Cases - 236

Immediate operation	117 or 49.5%	(50)
Delayed operation	96 or 40.6	(41)
No operation	23 or 9.7	(10)

Total Complications

Wound infections	17 (4.7% (8) of all cases)
Respiratory complications	22 (6.1% (6) " "
Intestinal obstruction	6
Pelvic abscess	27

Mortality Statistics of University of Minnesota Hospitals cases from January 1, 1920 to January 15, 1929 (Drs. Tasche and Spano):

	Cases	Deaths	Mortality %
Interval (about 1/2)	339	1	.3 (.3)
Acute suppurative	72	1	1.4 (1)
Acute suppurative with local peritonitis	156	4	2.5 (3)
with abscess	112	11	9.7 (10)
with diffuse peritonitis	21	8	38.0 (38)
Total	700	25	3.4 (3)

It is to be noted that the incidence of general peritonitis 1932-1934 is four times that from 1920-1929; i.e. 12.8 (13)% as compared to 3% of total cases. The higher incidence of interval cases (half) in the earlier series as compared to approximately one third in the latter group would indicate that we are now seeing cases of greater severity. These figures are ample to account for the apparent increase in mortality- 7.5 (8) % as compared to 3.4 (3) % in the earlier group. The mortality exclusive of general peritonitis of the two groups was 2.5 and 2.3%, respectively.

III. ABSTRACTS

(Sperling and Blumstein)

1. INTRA-ABDOMINAL POST-OPERATIVE COMPLICATIONS OF APPENDICITIS

Alton Ochsner, J. M. Gage and Earl Garside
Annals of Surgery 91: 544-572, (April 1,) 1930.

In 193 cases of acute appendicitis studied at the Charity Hospital, the following figures were presented:

67 (29.2%) - presented localized abscess.
23 (11.9%) - presented diffuse peritonitis.

72 (37.3%) - sufficient evidence of peritoneal involvement.

There were 39 deaths (20.21%).
Of the 23 diffuse peritonitis cases, there was a 58% mortality.

Ileus
The authors state that ileus is a complication in 6 to 15% of all postoperative complications in appendicitis. The cause of the ileus may be either mechanical or the ileus may be of the "adynamic" type.

Pyelephlebitis
They state that the incidence varies from .1% to 1% of cases with acute appendicitis, and 5% of patients dying with peritonitis. Appendicitis is the most frequent cause of this condition. The complication is rare in cases of appendicitis without perforation.

2. ACUTE APPENDICITIS

Arthur C. Taylor and E. R. Schmidt
Internat. Surg. Dig. 17: 195-202, (April) 1934.

The authors present a statistical study of 358 cases in the State of Wisconsin General Hospital (1923 to 1931, inclusive).

Summary
1. Four-fifths of the cases occurred between the ages of 10 and 30 with the average mean at 20 years.

2. Males predominated slightly.

3. The average temperature was 99.7°F.; the average pulse 97 per minute, and the average white count 17,800 cells per c.mm. These figures were slightly higher in the ruptured cases and slightly lower in the unruptured ones.

4. Nearly three-fourths of the patients entered the hospital on the first or second day of their disease.

5. The hospital stay averaged 16.5 days. Conservatively treated cases and cases which received appendectomy with drainage stayed three weeks.

6. Previous attacks seemed not to influence either rupture or mortality.

7. A cathartic raised the acute appendicitis mortality by one-half and more than doubled the ruptured cases with their attendant tenfold increase in death rate for the patient.

8. One-third of the cases seen after 24 hours were ruptured, and one-half of those seen after 48 hours. In all, one-fourth of the cases were ruptured with a mortality of 16%. In the first, and after the fourth, decade nearly two-thirds of the cases were ruptured.

9. OneOtenth of the cases suffered complications irrespective of whether they received operative or conservative treatment. Complications, however, were six times as likely to occur in the ruptured cases as in the unruptured.

10. Tenderness was nearly always present, and spasm and rigidity were present on about half of the cases. Only 6.7% showed a palpable mass.

11. The clinician's diagnoses were 2.3% incorrect, while the pathologist disagreed with the clinician in 6% of the cases.

12. Seven-eighths of the patients received operative treatment, and one-eighth conservative treatment.

The mortality for 1,049 cases of primary appendicitis was 1.9%. Sixty-one ruptured cases when operated upon yielded a mortality of 16.4% compared with 33 ruptured cases conservatively treated yielding a mortality of 18.2%. The unruptured cases operated upon had 1.2% mortality compared with no deaths in 12 unruptured cases treated conservatively.

3. ACUTE APPENDICITIS

E. M. Stanton
Surg., Gyn. & Obst. 59: 738-744
(Nov.) 1934.

The author reviews 10 articles, reporting 16,424 cases of acute appendicitis. There were 894 deaths, a mortality of 5.4%. The lowest mortality was 3.5% in a series of 600 cases, and the highest in a series of 900 cases. Twenty years ago, the author reviewed 4,343 cases. There were 279 deaths, a mortality of 6.2%. He points out that the operative mortality of acute appendicitis bears a definite relationship to the duration of the acute inflammatory process prior to the time of operation and, for practical purposes, the duration can be measured in terms of the day of the disease on which the patient is operated upon. He states that the mortality rate as observed from day to day in this disease is inseparably associated with a corresponding sequence of changes in the inflammatory process itself.

Peritoneal Reactions

"About 30% of the patients operated upon during the first day of the disease present noteworthy peritoneal exudates, but, be the exudate fibrinous or fluid, and regardless of its extent, the peritoneal surfaces are not yet seriously damaged and, if further contamination from the grossly infected appendix is prevented by removal of the appendix, experience has shown that the peritoneal surfaces are, in vast majority of cases, amply able to take care of any infection present. It is probably worse than useless to attempt drainage in these early cases; first, because it is unnecessary and, second, because the foreign body acts as a handicap rather than an aid to the natural processes of repair.

"During the second day of the disease approximately 40% of patients operated upon present noteworthy peritoneal lesions. The percentage of cases presenting peritoneal lesions has increased, and the histological characteristics, especially at some distance from the appendix, may vary considerably because not all peritoneal areas are involved at the same time--but, generally speaking, the peritoneal lesion in the immediate neighborhood of the appendix has reached the stage of capillary engorgement and marked leucocytic infiltration with beginning roughening of the peritoneal surfaces. Notwithstanding the much more formidable pathology encountered in patients operated upon on the second day of the disease, experience has shown that in the great majority of cases the peritoneum is still able to take care of whatever infection there may be after the appendix is removed."

On the third day, 60 to 80% of the cases referred to the surgeon present definite evidences of peritoneal involvement, "but this high percentage represents in part a selection of cases because by the third day many patients destined to run a mild course have already demonstrated to the satisfaction of the family physician that they will probably recover from their present attack without the necessity of calling a surgeon. By the third day, the operative mortality which began to climb in the cases in which operation was done during the latter half of the second day jumps suddenly to approximately 10% for all cases in which operation is done during the third day. This increased mortality is confined not alone to cases in which the patient presents generalized free fluid in the peritoneal cavity but also to cases which present only local peritonitis and so-called localized abscesses.

"This latter point should be especially emphasized because the terrific mortality encountered from the third day on in cases in which operation is done for so-called diffuse peritonitis has served to blind surgeons to the fact that in the aggregate a not inconsiderable number of the deaths following operations performed on the third, fourth, and fifth days of the attack really occur in cases in which the patients presented rather localized lesions at the time of operation."

He gives the following tables:

	Cases	Deaths	Death Rate %
Operated upon first day of attack	1507	20	1.3
Operated upon second day of attack	912	33	3.6
Operated upon third day of attack	663	56	8.9
Operated upon fourth day of attack	356	46	12.9
Operated upon fifth day of attack	443	49	11.6
Operated upon sixth day of attack	346	29	8.4
Operated upon 7th, 8th, and 9th days of attack	178	5	2.8
Operated upon 10th day of attack and later	288	7	2.4

Four series of cases studied by the writer show the percentage coming to operation during first 48 hours:

1899 to 1905	10%
1907 to 1914	42
1914 to 1923	65
1923 to 1933	80

Analysis of 116 cases of Acute Appendicitis treated 1907-1914

	Treated	Percent of Total	Died
Acute diffuse or gangrenous--operated on during first 48 hours	49	42.2	0
Acute--with slight or no peritoneal symptoms--operated on after 48 hours	18	15.5	0
Acute--with well marked peritonitis operated on 3d to 5th day of attack	8	6.9	4
Patients seen after 40 hrs. with well marked peritonitis. Ochsner treatment--operated on later	22	19.0	2
Mild cases. Ochsner treatment only	2	1.7	0
Late cases with localized abscess at time of admission to hospital	16	13.8	1
Rupture of old undiagnosed appendicular abscess into general peritoneal cavity. Moribund on admission	1	.9	1
	116	100.00 (6.[illegible])	6

Analysis of 380 cases of Acute Appendicitis treated 1915-1923

	Treated	Percent of total	Died
Acute diffuse or gangrenous--operated on during first 24 hours of attack	118	31.0	1
Acute diffuse or gangrenous--operated on during second 24 hours of attack	128	33.6	3
Acute, with slight or no peritoneal symptoms--operated on after 48 hours	46	12.2	0
Acute, with well marked peritonitis--operated on 3d to 6th day of attack	15	3.9	6
Patients seen after 48 hrs. with well marked peritonitis--Ochsner treatment	28	7.4	4
Mild cases, patients seen late and treated by Ochsner and later operated upon	4	1.2	0
Late cases with localized abscesses at time of admission to hospital	35	9.2	4
Rupture of old undiagnosed appendicular abscess into general peritoneal cavity	6	1.5	3
	380	100.0	(5.5%) 21

Analysis of 508 cases of Acute Appendicitis treated 1924 - 1933

	Treated	Percent of total	Died
Acute diffuse or gangrenous-operated on during first 24 hours of attack	279	55.0	3
Acute diffuse or gangrenous--operated on during second 24 hours of attack	125	24.6	2
Acute, with slight or no peritoneal symptoms--operated on after 48 hours	24	4.7	0
Acute cases with well marked peritonitis, patients operated on 3d to 6th day of attack	8	1.6	3
Cases seen after 48 hrs. with well marked peritonitis--Ochsner treatment	32	6.[illegible]	1
Mild cases seen 3d day or later and operation deferred--operated on as interval cases	18	3.5	0
Late cases with localized abscesses at time of admission to hospital	20	3.9	1
Rupture of old undiagnosed appendicular abscess into general peritoneal cavity	2	[illegible]	[illegible]
	508	100.0	(2.[illegible]) 11

IV. STAFF MEETING

Date: November 15, 1934

Place: Recreation Room, Nurses' Hall

Time: 12:15 to 1:25

Attendance: 92

Program: Hyperemesis Gravidarum

Discussion: J. C. Litzenberg
I. McQuarrie
N. J. Berkwitz
J. C. McKinley
Dr. Seeley

V. SOUND MOVIES

Title: Sound Waves and Their Sources --

by the University of Chicago - One reel.

VI. GOSSIP

The Interns' Touchball Team finally lost a game to one of the Law Teams. It begins to look as if there will be a four-way tie for first honors........ The original work of immunizing monkeys against poliomyelitis by "soap" toxin was done at the University of Minnesota by Drs. McKinley and Larson. Many monkeys were used in the experiments. This is the probable reason for our lack of enthusiasm for the reported possibilities of the use of the Kolmer preparation which is apparently an identical effort. For particulars, see Proceedings of the Society for Experimental Biology and Medicine 24: 297-300, 1927.........At the recent convention of the Minnesota State Horticultural Society, there was a remarkable exhibit of ornamental gourds, squash and pumpkins. Some were hollowed out, while others were preserved intact - all were coated with shellac. This organization which has a state subsidy is composed chiefly of amateurs. The president, who presided with poise, dignity and an excellent command of the English language is a city mail carrier in Red Wing. He became interested in horticulture while making his rounds delivering the mail. In addition to his regular duties, he also contributes to a column in a special horticultural magazine. One was much impressed by the character of the persons who found joy in this avocation........Former intern, W. P. DeRamus, the gentleman from the South, is now located at C.C.C. Camp #725 near Orr, Minnesota. By popular acclaim of the patients, he was voted the "best doctor" we had in his day........Art Clarkson, the English-Scandinavian Minnesota football player born and reared in China, who passes and kicks both right and left, is said to have pleaded with his team mates to avoid penalties when his touchdown number was called against Chicago. After many successful goal crossings, he finally succeeded in having his touchdown count last Saturday......There is an excitable gentleman in St. Paul who is well known to the medical profession as quite a problem when he becomes sick. Last week, his wife became ill during his absence from the city. A wire caused him to return promptly. Rushed by taxi to the Miller Hospital, he quickly learned the floor on which his wife was a patient. At the nursing station, in his desire to reach her side without more delay, he failed to get the exact location of her room. It was twilight and a much surprised woman, not his wife, was greeted in an affectionate manner. She is said to have sighed, "Oh, Doctor -------- (one of St. Paul's most distinguished ophthalmologists)....... ...The American Association for the Advancement of Science and the Minnesota State Medical Association will meet jointly in Minneapolis in June 1935. According to present plans, the scientists will meet at the University, the doctors at the Auditorium. There will be joint gatherings of the two groups. Special effort is being made to develop an excellent scientific exhibit at the Auditorium......A letter from former Intern C. T. (Beech) [illegible], noted product of Spring Valley, Illinois, is now located at the Kensington Hospital for Women, [illegible] Diamond Street, Philadelphia. The Surgeon-in-Chief is Edward A. [illegible] and Beech reports an excellent service. Among other things, he [illegible]

right, wonders if our critic is really interested in medicine and likes the "Gossip" column. He recently saw Wally Gleason, M.D. (1928) who is a resident at the Post-Graduate Hospital in Philadelphia.......Which brings up the important question, what is a resident? Is he an individual who receives part of his compensation in the form of maintenance or is he a staff member the next grade above an intern? It was this difference of opinion that lead to leaving our hospital off the approved list of residencies in the Educational number of the American Medical Association Journal. Our institution is included under the general heading "University of Minnesota Graduate School Approved"...... We have had an unusual opportunity to observe the effect of thorotrast on the liver postmortem. The results will be displayed in connection with Dr. Rigler's experience at a near future meeting of the Radiological Society in Memphis. We have not been able to get excited about its harmful effects on the liver......... There are three cases of erythremia in the house at the present time. Patient #1 industriously pumps his own stomach and washes it out about two hours after meals. In this way the gastric "stimulating" effect on the bone marrow is reduced and the patient's hemoglobin is reduced. He feels much better when it is lower. The latest additions to the colony have been nicknamed "Swedish Indians" by our #1 erythremia man.......Attendance at Freshman and Sophomore "pre-clinical" clinics continues to grow at an amazing pace. Ringside seats are at a premium, aisles are choked and the rafters crowded by most attentive students in the only medical courses which do not require attendance, or give examinations. Seldom is all the audience stumped when asked to make the diagnosis. This is the plan followed at many other schools and the activity comes under the most obscure unit of the Medical School - "The Division of Inter-departmental Instruction" with a faculty consisting of Surgeon Peyton, Neurologist McKinley, Internist Barron, and yours truly. The contributing staff of interns and fellows has been most helpful in supplying the right sort of material.......Former Superintendent Paul Fesler failed to come to last Saturday's hospital meeting. This probably establishes a world's record as few trips are missed by the rotund gentleman from Oklahoma, now located in Chicago.....Former radiological fellow, Jack Sagel and family, of the Methodist Hospital, Gary, Indiana, was a visitor during Homecoming. He reports himself well pleased with his place, very busy and speaks as if he might have become rather liberal in his political views.. ......One of our neighbors near the hospital suffered a fatal heart attack while repairing his roof. The body rolled down part way and lodged near the gutter. It was necessary to call the fire department to get him down....... The Annual Dinner of the M.P.H.A. will be held Friday, November 23rd, at 6:30 P.M. at the Nicollet Hotel. Among others, Esmond Long of Phipps Institute will speak. Tickets may be secured at the door. Thank you!

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NO MEETING NEXT WEEK -- THANKSGIVING DAY.

NEXT MEETING -- THURSDAY, DEC. 6, 1934

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