

Staff Meeting Bulletin
Hospitals of the . . .
University of Minnesota

Amputations

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume VIII

Thursday, October 22, 1936

Number 4

INDEX

	<u>PAGE</u>
I. LAST WEEK	38
II. MOVIE	38
III. BLOOD TRANSFUSIONS	38
IV. ABSTRACT	
AMPUTATIONS Clarence Dennis . .	38 - 46
V. GOSSIP	46 - 47

Published for the General Staff Meeting each week
during the school year, October to May, inclusive.

Financed by the Citizens Aid Society

William A. O'Brien, M.D.

I. LAST WEEKDate: October 15, 1936Place: Recreation Room
Nurses' HallTime: 12:15 to 1:15Program: Movie: Work of Atmosphere
Case Reports:
Heat Prostration. Retro-
peritoneal Hemorrhage.
Generalized Burns. Mil-
itary Tuberculosis.
Tuboovarian Abscess. Abor-
tion. Peritonitis.Present: 80Discussion: L. G. Rigler
R. M. Johnson
A. A. Nelson
C. J. Watson
E. T. Bell
R. W. Koucky
O. H. Wangenstein
R. E. Boynton
C. E. McLennanGertrude Gunn,
Record Librarian
-----II. MOVIETitle: Silence after TrumpetsReleased by: Minneapolis Community
Fund, 1936
-----III. BLOOD TRANSFUSIONS

The laboratory requests that it be notified of all transfusion reactions regardless of the degree of severity. Recently, a more sensitive method of cross-matching has been advocated. These cases of mild reactions provide excellent material upon which to study this new method.

IV. ABSTRACTAMPUTATIONS

Clarence Dennis

Introduction

There are still many unsolved problems concerning amputations. Study of the results here at this hospital shows that this is especially true for the cases resulting from circulatory insufficiencies which for the most part occur in older persons. In these older patients, the vascular changes often involve the circulation of the kidneys, brain, heart, etc., and the cause of death in nearly one-half is due to these changes remote from the limb in question.

Prophylaxis

Patients with circulatory diseases (Buerger's disease, arteriosclerosis and diabetes complicated by arteriosclerosis) together with diabetics without marked circulatory changes should be taught to observe the following hygiene of the feet: keep the skin soft with lanolin; keep the nails soft by soaking; cut the nails properly, i.e. straight across only; wear soft, properly fitted shoes; and massage feet daily. Corns and callosities should be avoided or, if present, should be removed by soaking rather than by cutting. Such patients should be warned to seek immediate attention to abrasions. They should carry out exercises several times daily and avoid wearing apparel which constricts the circulation. Buerger's exercises, consisting of elevation, depression and heat, are recommended. They are taught to avoid trauma. More than one-half of the cases of gangrene with circulatory deficiency give a history of trauma as the precipitating cause. Extremes of temperature are likewise to be avoided. This program is outlined to our out-patients.

Pre-operative Treatment

Before amputation is undertaken for either impending or actual gangrene, pre-operative treatment should be carried out unless other factors, such as infection, prohibit this course. It is the aim of

these conservative measures to control infection, relieve pain, stimulate the development of collateral circulation, and release vasomotor spasm. Local and general measures include rest in bed, heat to the involved extremity (dry heat), care of the skin in the region, avoidance of bedsores by frequent change of position, exercises, general supportive measures, and avoidance of smoking where there is a spastic element. In cases where there is a spastic element (as Buerger's, occasionally in arteriosclerosis, rarely in diabetics), nerve block, typhoid vaccine, and sympathetic gangliectomy may be tried. The value of Pavaex is very definite in many cases. The difficulty is in prognosticating before using this therapy which cases will be benefitted. It is absolutely contra-indicated in the presence of infection. These measures are essentially the same as the conservative methods of treatment when amputation is not indicated.

Indications for amputation

When gangrene extends so as to involve the deeper tissues or involves too great a skin area to heal under conservative measures, or when infection, especially in diabetics, becomes well-developed or spreads up the limb (usually via the lymphatics) amputation is imperative.

There are a number of clinical tests of the adequacy of circulation. The general appearance of the limb should be observed, i.e. whether there is a line of demarcation, whether there are trophic changes of the skin, or whether there is irregularity of the nails. Obvious anemia on elevation of the limb or rubor on depression is of aid. Buerger's angle of circulatory sufficiency should be observed, i.e. the number of degrees away from the vertical at which the anemia disappears and normal color returns.

The level of abrupt temperature change is of importance; it usually can be adequately determined by palpation. Palpation of the main vessels is possible in four places: femoral, popliteal, posterior tibial and dorsalis pedis, and is of definite value in evaluating the circulatory status of the extremity. The

Pachon oscillometer is a device for measuring the total pulsation of a given segment of the limb, but only measures the ability of vessels to pulsate, i.e. there may be an adequate blood supply in rigid vessels which transmit little or no visual evidence on the oscillometer. The Mc-Clure-Aldrich intracutaneous saline absorption test consists of the injection of 0.2 c.c. of normal saline at intervals of 4 inches down the limb. Normally, the wheal lasts an hour, but in impaired circulation the absorption time is markedly reduced, also in edematous extremities. The histamine flare test is of similar importance and is similarly applied, using instead 0.1 c.c. of 1:100 histamine. This is normally followed by a cyanotic flush, then hyperemic flare, and finally wheal development; if the flare does not appear, amputation must be above this level. The pain of the histamine test may be eliminated by addition of 0.5% novocain to the solution. X-ray examination of the limb may show localized areas of osteomyelitis and calcification of the vessels; however, it may give no indication of the amount of collateral circulation. Arteriography has been championed by some but is regarded by most as an unnecessary added hazard.

Provided there is a marked spastic element, amputation may be sometimes avoided by sympathetic blocks. The importance of the spastic element may be determined by immersing the part in a warm bath, by intravenous typhoid vaccine injections, by paravertebral block, by spinal anesthesia, by general anesthesia, by diathermy to the lumbosacral region or cervical region as the case may be, or by peripheral nerve block, this last being the most used method. The increase of temperature and an increase in the oscillometer excursion is in proportion to the degree of the spastic element. The Moszkowicz test for spread of hyperemia after temporary interruption of the circulation is also of value. After any or all of these tests have been applied, there still is no formula by which either the necessity for amputation or the level can be determined. The experience and judgment of the clinician still are necessary. There is no single test for

determining the level for amputation.

In deciding the necessity for and the time of amputation in Buerger's disease, the marked tendency for the development of collateral circulation and the greater resistance to infection which characterizes this group of patients (largely because of their younger age) should be borne in mind. However, an early high operation may be necessary for progressive extension of gangrene in spite of conservative measures, for rapidly ascending infection, or for destruction of so much of a foot that insufficient structures remain to insure adequate weight bearing. Amputation may also be necessary for intractable pain.

In case of arteriosclerotic gangrene, the patients fall into an older age group (about 65 years), are more frail, the local lesions heal less readily, and they usually suffer from generalized arterial disease. There is little likelihood of developing a collateral circulation. Some of these patients are not ambulatory and are not likely to use their limbs again. They have a short life expectancy. Hence, it is not worth while to subject them to a long hospital stay in the hope of saving the limb.

Gangrene in the diabetic is a more serious problem even though these patients do fall into a younger age group (average 56 years) and they have a slightly greater tendency to develop collaterals. Gangrene is the cause of death in 13% of diabetics. "The combination of devitalized tissue from lack of arterial supply and the lowered general and local resistance to infection in diabetes mellitus renders much more uncertain not only the future of the part in question, but the life of the patient. There is no warning of the impending septicemia which frequently ensues" (McKittrick). Whether or not to amputate is decided with the following considerations in view. The diabetic is often as old as his age in years plus the duration of his diabetes; hence, his life expectancy is less than his years indicate. Beginning gangrene in a patient with diabetes is often associated with serious disease of the coronary and cerebral vessels, with failing vision and defective heart function. In most

cases, it is the beginning of a large economic load and a relatively short life expectancy. Prolonged sepsis and pain seriously damage the already poor heart and kidneys of these patients and undermine their morale. Once gangrene has started, the tendency to develop septicemia is greater than the tendency to develop adequate collateral circulation. Delay may result in lymphangitis or other spreading infection and necessitate a more hazardous operation. Therefore, it appears that early operation is preferable to continued pain and disability, the complete loss of morale and the risk of severe infection when ultimate operation is inevitable.

In those few cases in which gangrene in the diabetic is primarily infectious and but little due to the usually associated arterial changes, it is sometimes permissible to use the more conservative surgical measures.

Analysis of Cases at the University of Minnesota Hospitals

(July 1, 1930 to June 30, 1935)

Arteriosclerosis (including all gangrene cases other than diabetic)

		No.	%
Toe amputation		11	
1 death (ruptured aortic aneurysm)		1	9.1
Gas cases		3	27.1
Later reamputated (two for gas infection)		3	27.3
Average age		63.2	
Leg amputation		11	
Deaths		0	0
Gas cases		5	45.5
Frozen feet	2		
Buerger's disease	1		
Arteriosclerosis	2		
Subsequently reamputated (recovered)		2	18.2
Reamputations		0	0
Average age		55.6	
Thigh amputations		22	
Arteriosclerosis	19		
Femoral thrombosis	3		
Deaths		7	31.8
Gas infection	1		
Reamputation	0		
Relation to age	0		
Gas cases		9	40.9
Death	1		
Reamputations		4	18.2
Average age		66.1	
<u>Diabetic Gangrene</u>			
Toe amputations		7	
Death (not gas) (Streptococcic septicemia)		1	14.3
Gas cases		4	57.1
Reamputated later (all surviving)		6	85.7
Average age		63.8	
Leg amputations		10	
Death (one died after reamputation at thigh)		0	
Gas cases		6	60.0
Reamputations		3	30.0
Subsequently reamputated		2	20.0
Average age		61.3	
Thigh amputations		23	
Deaths		11	47.8
Gas cases		11	47.8
Deaths	7 (63.3%)		
Drained	4 (all died)		
Reamputations		5	21.7
Average age		66.3	

Amputations with neither gangrene nor diabetes (trauma):

	No.	%
Toe amputation	3	
Death	0	0
Gas cases	0	0
Reamputations	0	0
Average age	28.7	
Leg amputation	15	
Deaths	0	0
Gas cases (1 was reamputated later)	2	13.3
Reamputations	0	
Subsequently reamputated	1	6.7
Average age	34	
Thigh amputation	25	
Deaths	0	0
Gas cases	4	16
Reamputation	1	4
Average age	34	
Upper extremity amputation	35	
Deaths	1	2.9
Gas cases	4	11.4
Reamputations	2	5.7
Arteriosclerotic	44	
Deaths	8	18.6
Diabetic	40	
Deaths	12	30
Others	78	
Death	1	1.3
Total amputations	162	
Deaths	21	13

Not brought out by the above statistics is the fact that all diabetic thigh amputations with postoperative gas infections resulted fatally (4 cases). Also not brought out is the fact that 14 patients developed postoperative gas infections when the amputations had been done in the absence of active infection and at apparently clean amputation; 2 of these were diabetic and died. Positive cultures without active infection are not here classed as gas infections. As

Manson has shown, 34.37% of chronic ulcers harbor pathogenic gas formers.

Our figures tally fairly well with those of other hospitals. At New Orleans Charity Hospital, the mortality figures are: (for gangrene)

Arteriosclerosis	39%
Buerger's	21.4
Diabetes	42.2
Embolic	100.0
Total	39.1

Complications

The most serious complication in amputations is infection, causing 56% of the deaths in McKittrick's series of diabetics. One author calculated that if all deaths from infection were excluded as avoidable, there resulted a "basal mortality" of 5.3% in diabetic gangrene, the unavoidable mortality which should be the ultimate goal. Eliason found that 42% of his wounds broke down with severe infection, with culture results as follows:

	<u>Cases</u>	<u>Mortality</u>
Alpha streptococci	3	67
Clostridium Welchii	11	78
Hemolytic streptococci	13	60
Staphylococcus aureus	5	20
Others	5	0

Pressure sores should also be included as a serious complication. McKittrick and Pratt avoid them as follows:

By:

- removing rubber sheets
- alcohol rubs every 2 hours, day and night
- a Balkan frame for patient to move self about
- putting a heavy sock on the remaining foot
- putting a small pillow under ankle to keep heel off bed
- daily foot massage.

The remaining deaths are due to cardiorenal complications, bronchopneumonia, and a variety of miscellaneous causes.

Gas infection deserves some mention as the largest single cause of death. The most important point in its treatment is early diagnosis. A rapid pulse, swelling near the wound, a more than correspondingly clear state of mind, crepitation about the wound, the characteristic odor, and

the characteristic discharge all are important in arousing suspicion or making the diagnosis. In this hospital, all cases of gangrene and most cases of trauma are cultured for *Clostridium welchii* and, in case of positive culture, a prophylactic dose of Welch and Vibron septique antitoxin, 1000 units, is given before amputation. In cases developing gas infection either before amputation or after amputation, debridement is carried out almost invariably. In case of thigh amputations, the wound is laid wide open. The patient is also given large doses of antitoxin (10,000 units every few hours). Excellent results with the use of x-rays have been reported recently, but the method is not yet accepted.

Time and Site of Amputation

In Buerger's disease, amputation is contemplated when the conservative measures outlined at the beginning fail, or when the pain is intractable even in the absence of gangrene. The toe alone may be amputated if the following conditions are fulfilled:

Age less than 45

- Lesion involves one phalanx only
- Rubor on depression and anemia on elevation present only in toes
- Line of sudden temperature change is absent in other toes
- One artery is palpable in foot
- Pachon's test is positive in the foot
- Saline or histamine tests are normal to midtarsal joint.

Correspondingly, as these conditions fail to be satisfied, the level of amputation must be higher. As a general rule, it is the consensus of opinion in the literature that Pachon's test must be satisfactory at the chosen site, that rubor and pallor and the level of sudden temperature change must be ten inches below the site, and that the salt and histamine tests must be satisfactory at the site. In general, all the tests enumerated, together with the history, must enter into the decision, and surgical judgment rather than rule of thumb must apply. Every effort should be made

to get as good a functional result as possible in cases of Buerger's disease because these cases are in the younger age group and will use prostheses.

In arteriosclerotic and diabetic gangrene, the surgeon ceases to be concerned about the subsequent use of prostheses because most of these patients will never walk again because of their other arteriosclerotic manifestations; furthermore, in these cases, the operation is more life-saving than elective. The collateral potential is decreased. In the arteriosclerotic patient, the gangrene is usually dry in type and temporizing is possible unless there is spreading infection or a large area of gangrene, or pain. Amputation is done if the lesions fail to heal, if infection fails to be controlled, if gangrene includes all of one or more than one toe, if the gangrene is small but non-demarcated, or if there is deep or ascending infection. The level of amputation is determined much as in the case of Buerger's disease, save that it is usually better to go somewhat higher.

In the perfectly controlled diabetics, the gangrene is usually dry in type; however, the vast majority of them have been poorly controlled and the gangrene is moist and infected. Because of the lowered tolerance to infection temporizing is poorly tolerated. Conditions demanding amputation in the order of their importance are:

Gas gangrene
Gangrene with cellulitis
Moist or open gangrene (87%)
Dry gangrene

In contradistinction to the attitude ten years ago, it is now generally considered best to delay long enough to get the patient fairly controlled medically, now usually a matter of hours. Perhaps further consecutive measures are indicated as discussed.

The level of amputation is determined as above by the principles mentioned for arteriosclerosis save that it is better to operate at a slightly higher level. Most series show an increase in mortality of 15 to 35%, if reamputation is neces-

sary, so sufficiently high amputation is imperative at the start. Analysis of our cases in respect to higher mortality accompanying reamputation does not correspond to other experience.

Technique

In all these arterial diseases, the most careful preparation of the skin is needed, especially in view of the omnipresence of *B. Welchii*. The area of gangrene should not be exposed in the operating room. A tourniquet should never be used. In cases of infection, one may be used below to prevent milking of infected tissue juices into the wound. The type of operation depends on the presence of infection, the adequacy of collaterals, age of patient, economic status of patient, general condition of patient. In the presence of ascending infection or where a patient has remained febrile after conservative treatment, or where the general condition is poor, modified guillotine amputations are generally regarded as best. The Gritti-Stokes amputation is falling into disfavor because it requires more manipulation. The patient who could tolerate this usually can withstand an amputation ten inches below the tibial tubercle, allowing for a better prosthesis. Callander devised an operation just above the knee in which no muscle bellies were exposed, believing that he thus could prevent postoperative gas infection. His reported results are excellent; one death in 17. Our experience with the operation here have not been so favorable.

In cases, in which a modified guillotine amputation is not necessary, most authors seem to lean toward short flaps (anterior, posterior or lateral) with few sutures and only loose apposition of the skin with as few clips or skin sutures as possible. Some authors recommend no deep sutures at all. Better plastic surgery may be attempted in Buerger's disease. Authors are split into about even camps on the question of drainage.

There are also differences of opinion in regard to postoperative care.

McKittrick and Pratt leaving the stump alone for 5 to 7 days, Callander dressing his in a few hours. It is important to have the patient move as much as possible. Otherwise the care is as after any other operation.

Spinal anesthesia is generally preferred. Ethylene and gas and light ether are also commonly used. Chloroform and much ether are to be avoided in the diabetics as they tend to produce acidosis.

Late Results

It should be clear that gangrene in these cases is a local manifestation of a generalized disease, and that consequently long survival is not to be expected, as shown in McKittrick's chart:

Diabetic gangrene: (Average age 64)

<u>Years after age 64</u>	<u>Normal expectancy %</u>	<u>Survival after amputation - %</u>
0	100	100
2	91.5	64
4	83	46
6	75	28
8	66.5	12
10	58	8

SUMMARY

1. Patients with arterial disease can delay gangrene many years by proper care and exercises.

2. In most cases, conservative therapy should be tried before amputation which includes alternating negative and positive (Pavaex) therapy, administration of vasodilator medication as alcohol, papaverine, foreign protein therapy, etc.

3. When these fail, amputation is essential.

4. Tests for circulatory sufficiency are outlined. It should be emphasized that all such tests are only supplementary to a careful physical examination of the involved extremity and to good surgical

judgment. There is no "test" which will determine the level at which amputation is to be made.

5. Criteria for the time and site of amputation are controversial, particularly in the presence of infection. Some consider the supervention of infection as indicative for emergency surgical treatment. Others believe this complication as indication for less radical surgical treatment, with amputation withheld until the infection is controlled, if possible. Blood cultures should be a routine in infected gangrene, especially in diabetic patients.

6. Hospital statistics show following mortality:

Arteriosclerotic amputation	18.6%
Diabetic gangrene amputation	30.0
Other amputations	1.3

The presence of gas infection raises the mortality for thigh amputation in diabetics from 33.3 to 63.6%.

7. Technique of amputation is discussed:

- (a) No tourniquet is used
- (b) Minimal trauma to tissue should be stressed.

8. Spinal anesthesia is preferred.

9. The late results in follow-up studies in the literature are far from encouraging in the diabetic gangrene group.

References:

1. Eliason, E. L.
Surgery of diabetic gangrene
Ann. Surg. 48:1, (July)1933
2. Eliason, E. L. and Wright, V. W. M.
Diabetic and arteriosclerotic gangrene of the lower extremities
S.G.O. 42:753, 1926.
3. Kelly, J. F.
Present Status of the X-Ray in the treatment of gas gangrene
J.A.M.A.107:1114, Oct. 3, 1936

4. Manson, M. H.
Arch. Surg. 24: 752, 1932.
5. McKittrick, L. S.
Indications for amputation in
progressive arterial obliteration
of the lower extremities
Ann. Surg. 102:142, (Sept.) 1935.
6. McKittrick, L. S. and Pratt, F. C.
The principles and results after
amputation for diabetic gangrene
Ann. Surg. 100:638, 1934.
7. McNealy, R. W. and Shapiro, P. F.
Vascular disease of the lower
extremities
S.G.O. 59: 650, 1934.
8. Orr, T. G.
Gas bacillus infections following
clean amputations
Ann. of Surg.: 25:113, 1934.
9. Peyton, W. T.
Circulatory tests previous to
amputations
Minn. Med. 13:896, 1930.
10. Steel, W. A.
Treatment of diabetic gangrene
Pa. Med. J. 39:22, 1935.
11. Stowe, C. J. Jr. and Holsinger, H. B.
The diagnosis and treatment of gas
bacillus infection
Va. Med. Monthly 61:200, 1934.
12. Veal, J. R. and McFetridge, E. W.
The surgery of gangrene of the
extremities, etc.
S.G.O. 60: 840, 1935
13. Warthen, H. J.
Gas bacillus infections
Va. Med. Monthly 62:275, 1935.
14. J. of Bone and Joint Surg. 28:577,
1931.
Report of committee on gas bacillus
infections in amputation stumps.

V. GOSSIP

Most efficient Eldora Lyford of the Record Room left last week to take a position with the State Board of Control in St. Paul. She will be missed and all join in wishing her success in her new place. Cousin of Branch Rickey of the St. Louis Cardinal Baseball System, her interest in baseball is mild.....Rabid Baseball Fan #1 of the Staff is gentle Eva Dawalt, who tells them "to sit and wait - that Health Service Director, Ruth E. Boynton, is expected shortly." Football is her second love. As she sits and waits during the long winter evenings for "play ball" she makes hooked rugs. One of her more unusual rugs was made in part from Superintendent Raymond Michael Amberg's other pair of pants.....
...The University of Minnesota Medical Alumni are preparing a program of Homecoming Clinics for Friday, November 6th, in the University of Minnesota Hospitals. It will consist of lectures, clinics, demonstrations, and a hospital luncheon. An opportunity will be afforded the grads to visit their old teachers in their offices. When the average graduate returns to his Alma Mater for that long anticipated visit, it usually turns out to be a dud. His old classmates have little in common with him and after a forced discussion of the old days they just sit and look at one another or walk away. His old teachers usually give him a blank stare and try to appear pleased that he has called. Football provides the natural common bond of interest between faculty, students and alumni, critics on over-emphasis of college sports to the contrary.....
...If plans materialize, there will be a homecoming medical tea and dance in the Recreation Room, Nurses' Hall, immediately after the game. All students, faculty and alumni of the "medical" courses of Medicine, Nursing, Medical Technology and Social Work are invited to attend. Watch for announcements.....
.....One of our patients sends in this contribution, which he entitles

"Suprapubic Cystotomy." It was supplied through the courtesy of Surgical Fellow A. Keller Doss.

"I'm nothing but a bladder
With a hole right through my belly
And no matter how you love me
Still I think you'd call me smelly.

I used to think I had a brain
But now it isn't working
And all my highbrow faculties
Are off the job and shirking.

Perhaps the time will come again
When I can write real verses
But All I do these long slow days
Is leak—and mind the nurses."

.....Surgeon Melville Husted Manson, the discussion leader today, is our piscatory (fish) expert--not only catching but also cooking them to a King's taste. While Irishers groan and choke on fish bones during Lent, he blithely haunts the fish markets for rare specimens of the finny tribe to boil, broil or bake or what have you. Although he does not own an automobile, he is the transcontinental airline trotter of the staff, spending his vacations flying around the country. "Tops" in Surgical Bacteriology, he quietly goes about mopping up on those less spectacular but most important phases of surgical practice. A salute to you, "Doc", from the girls and boys.....Surgical Fellow Charles E. "Tizzie" Rea paid this effort the questionable compliment of comparing it to the column written by a country woman in southern Minnesota. Other bon mots (terse witticisms) tossed this way include a comparison of our introductions of celebrities to the reading of obituary notices by the Chairman of the Necrology Committee. He is the most comparing person.....Clarence Dennis, the son of former Associate Professor of Surgery, Warren A. Dennis, deceased (1923), prepared today's staff meeting. The many friends of his father will be pleased to know that he is carrying on the splendid family tradition in medicine and is very well liked and respected by his associates.....James Drummond, Superintendent of the Worrell Hospital for the Kahler Corporation,

Rochester, was a hospital visitor on Saturday of last week, dropping in to see his good and faithful friend, Substitute Intern Walter Nickel. Superintendent Drummond, a silent, gaunt figure from the Texas plains, took time off while here to toss off a few philosophic pearls for those privileged to see him. He is also known as the most disturbing influence in Rochester as he is the official carillonneur for the Mayo Clinic (bell ringer).....The Associated Press took a series of pictures last week in the Medical School and Hospital for a rotogravure lay-out for national distribution. Many of our students and faculty were shot with a candid camera while at work. This is said to be the first time such a series of pictures has been attempted. The Press organization has had their ace photographers in this locality for some time to take pictures of our gangsters, kidnappers, politicians and football players. Because the country is looking this way, it was decided to tell them about some of our other activities. The photographer on the assignment had many interesting experiences to relate of taking pictures of tycoons, their ladies and just plain celebrities in Florida during the winter season.....His many friends will be glad to know that astute, rotund Paul Hill Fesler (see Hospital Bulletin Oct. 1, 1936, p. 2) has put another notch in his gun as he blazes his way forward in the hospital profession with a new building for Wesley Memorial Hospital, Chicago. George Herbert Jones, who came to Chicago in 1871 as a clerk and worked his way up to President of the Inland Steel Co. gave Wesley \$1,000,000 last week. The money will be used for building the first unit of a proposed new \$5,000,000 group of hospital buildings at Chicago Ave., Fairbanks court and Superior streets, directly across from Northwestern University's McKinlock campus. When completed, the group of hospitals is planned to be the greatest center in the world. The first unit will cost \$2,000,000 and work will start about July 1, 1937. Wesley has an endowment of \$2,000,000, half of which was given by the Deering family. It is hoped former University of Minnesota Hospitals Superintendent Fesler will have time to come back for homecoming so his friends can extend their personal congratulations.....