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

# Ovarian Abdominal Hemorrhage

Volume IX | Friday, November 5, 1937 | Number 5

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

Volume IX | Friday, November 5, 1937 | Number 5

# INDEX



Published for the General Staff Meeting each week
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William A. O'Brien, M.D.

I. LAST WEEK

Date: October 29, 1937

Place: Recreation Room,
Nurses' Hall

Time: 12:15 to 1:20

Program: Movie: Electrons

Appendical Peritonitis
John M. Adams
Paul M. Bancroft
(presented by Dr. Adams)

Discussion: O. H. Wangensteen
Irvine McQuarrie
E. T. Bell
L. H. Fowler
C. A. Stewart
A. V. Stoesser
L. Sperling
John Adams

Present: 124

Gertrude Gunn,
Record Librarian

- - - - -

II. MOVIE:

Title: Rhapsody in Steel

Released by: Audio Production

- - -

III. ANNOUNCEMENTS

CENTER FOR CONTINUATION STUDY
University of Minnesota
Minneapolis

The next seminar for Medical graduates at the Center for Continuation Study of the University of Minnesota will be on Dermatology and Syphilology, December 6-11, 1937. The program will occupy the full time of the graduate physicians from Monday morning to Saturday noon. There will be no evening sessions. Five days will be devoted to Dermatology and one-half day to Syphilology.

The seminar will consist of clinics, round table discussions and lectures illustrated by lantern slides, charts or patients. The teaching staff has been selected from the Departments of Dermatology of the Medical School, Minneapolis, and of the Mayo Clinic, Rochester. The class meetings will be held in the Center for Continuation Study, and in the University of Minnesota Hospitals and affiliated institutions in Minneapolis and St. Paul.

It is to be noted that more than one-third of the seminar will be devoted to intimate clinical instruction or conferences. Those who plan to register should make their reservations as soon as possible so that proper arrangements can be made for the clinics. The instruction has been planned primarily for those who are interested in the diagnosis and treatment of skin diseases in general practice and for those who combine dermatology with another specialty in group practice.

Living Accommodations

Postgraduate physicians should plan on living in the dormitory of the Center. A double room with bath is $6.25 a week for each person; a single room without bath is the same price. Ample bathroom facilities on each floor are provided for those who select rooms without baths. Meals in the Center dining room are priced as follows: breakfast, 35 cents; luncheon, 45 cents; and dinner, 65 cents. Members of the physicians' families are welcome at the same rates. A large parking garage is in the basement; the daytime rate is 20 cents, and 24-hour parking is 50 cents.

Tuition

The tuition for the course is $25. This does not include living accommoda-

(Continued on Page 64)

## IV. OVARIAN ABDOMINAL HEMORRHAGE

### (RUPTURE OF GRAAFIAN FOLLICLE AND CORPUS LUTEUM)

Charles E. McLennan

As nearly as can be determined, there have been reported only some 350 cases of intraperitoneal hemorrhage resulting from rupture of luteal cysts or graafian follicles. More than two-thirds of the reported cases have appeared in the literature within the past 6 years. As yet, this important entity has not found its way into standard textbooks of surgery and gynecology, nor have record librarians seen fit to give it separate ranking in their systems of cross-indexing. Today the average medical student is graduating without a clearly defined picture of this condition which so often must be given strong consideration in the differential diagnosis of the so-called acute abdomen.

The exact incidence of this type of intraperitoneal hemorrhage is not known. Earlier reports do not distinguish with sufficient clarity between follicular and luteal rupture to warrant an estimate of the respective frequency of each, but recent surveys definitely indicate that luteal rupture is by far the more common lesion.

Frequently these ruptures are the cause of severe abdominal complaints. Since the symptoms simulate those produced by other pelvic or gastrointestinal disorders, the condition seldom has been recognized before operation. During the past year, for example, Jones reported 2 in 13 cases diagnosed accurately, Israel none in 10, and Kretzschmar and Arnell 3 in 17. One of the best case analysis reports is that of Hoyt and Meigs from the Massachusetts General Hospital; over a 6 year period, 17 of their 58 cases were diagnosed accurately before operation.

### Etiology

Rupture of the graafian follicle is a normal occurrence in the ovarian cycle. Generally there is little bleeding because the point of perforation (stigma) is relatively avascular. Moderate bleeding may occur if abnormal conditions have caused hyperemia of the thecal vessels adjacent to the stigma. Novak thinks it is difficult to imagine that hemorrhage into a virile graafian follicle would be common, because the walls are relatively thick and there is only a moderate degree of thecal vascularity. Hemorrhage into atretic follicles, however, he finds is common. This type of follicle is lined with only one layer of epithelium and surrounding the follicle is the theca with a vascular wreath; the veins are large and distended. Primarily the hemorrhage is perifollicular, but soon the epithelium is broken through and blood fills the follicular cavity. The thecal cells of the atretic follicle often undergo a definite lutein-like transformation, and hemorrhage into a follicle surrounded by a zone of these theca-lutein cells is not always easy to distinguish from an old luteal hematoma in which the lutein cells have undergone marked retrogression.

Rupture of the corpus luteum is an unnatural phenomenon generally accompanied by frank bleeding. Premenstrual hyperemia and capillary hemorrhage form a luteal hematoma. If the hemorrhage is sufficiently great, it may rupture through the stigma, lacerate the adjacent thecal vessels and cause intraperitoneal hemorrhage.

Trauma occasionally is an exciting factor in the hemorrhage. Rupture of these structures has been reported following an abdominal blow, coitus, bimanual pelvic examination, and vigorous exercise, but is equally common during quiet sleep, while eating, playing bridge, typing, riding in an automobile, etc.

Miller offers the following classification of predisposing causes:

I. General

1. Infections: typhoid, scarlet fever, influenza, rheumatic fever.

2. Heart and lung disorders

producing venous congestion of abdominal viscera.

3. Anemias and purpuras.

II. Local

1. Passive hyperemia: torsion, thrombosis, retroversion.

2. Active hyperemia: prolonged menses, trauma, excessive coitus, straining at stool, sudden blow to abdomen, pelvic or vaginal operations.

Cases have been reported illustrating all of these causes.

## Pathology

The amount of free blood in the peritoneal cavity after ovarian rupture varies from a few cubic centimeters to several liters. A perforated graafian follicle may give rise only to serosanguinous fluid, but frank bleeding usually occurs when a corpus luteum ruptures.

The ruptured portion of the ovary frequently is adherent to the posterior surface of the uterus. The cavity of the hematoma presents a smooth, glistening interior of yellow hue. The yellow color may be derived from lutein cells, lipoid deposits, blood pigment within phagocytes or luteinized theca interna cells.

Histologically the origin of the ovarian hematoma may be 1) a true graafian follicle, 2) an atretic follicular cyst, 3) a maturing corpus luteum, or 4) a luteal cyst. The graafian follicle is distinguished by the membrana granulosa and the clumped cells of the theca interna. The atretic follicle cyst is recognized by the flattened, atrophic granulosa cells and the well preserved theca interna cells. A corpus luteum cyst usually contains a firm central hematoma which is separated by a dense fibrinous layer from the unrecognizably altered lutein cells. The mature corpus luteum has a loose central hematoma and a layer of large, well preserved lutein cells.

Other lesions have frequently been found in association with ovarian rupture. Hematosalpinx, ectopic pregnancy (unruptured) and acute appendicitis are the common ones.

## Signs and Symptoms

The condition may occur at any time during the child-bearing age, but is more common in young women. The average age of the patients is about 25 years. A few reports indicate that it is more common in single women.

There is a definite relationship between the time of rupture and the menstrual cycle. Follicular rupture occurs approximately at the mid-point and luteal rupture during the last half of the cycle. The majority of the reported ruptures have occurred during the week preceding the onset of menstrual flow. Rupture of the graafian follicle may be the cause of mid-interval pain in certain women (Mittelschmerz). A history of previous similar attacks at similar times during menstrual cycles is of some importance.

The most prominent symptom is lower abdominal pain of sudden onset and variable intensity. Localization in the right lower quadrant is more common because of the more frequent involvement of the right ovary, although right-sided pain has been reported with left ovarian rupture. The reason for the preponderance of right-sided involvement has not been adequately explained.

All gradations of "the acute abdomen" may be encountered, depending upon the size of the perforation and the degree of hemorrhage.

Nausea is common, vomiting not infrequent.

A bearing down sensation in the pelvis and urinary frequency have been reported.

Referred shoulder pain may appear if free blood irritates the subdiaphragmatic peritoneum.

Shock may ensue in fulminating cases

with massive hemorrhage.

Moderate temperature elevation (99.5 to 102°F.) and leucocytosis (8,000 to 25,000) usually occur, varying somewhat with the amount of hemorrhage. Often the erythrocyte sedimentation rate is rapid. However, the laboratory findings are not sufficiently characteristic to be of diagnostic significance.

The iliac fossae usually are tender on palpation and the lower rectus muscle is rigid on the affected side.

Bimanual examination occasionally reveals the ovarian hematoma as a soft, tender adnexal mass. Motion of the cervix and corpus usually causes at least moderate pain. The cul-de-sac rarely bulges from the presence of free blood, although this is entirely possible if the hemorrhage is great enough.

## Diagnosis

Since there is no pathognomonic sign nor symptom, the diagnosis of luteal or follicular rupture must be based on a careful analysis of the history. Particular regard must be paid to the relationship of the symptomatology to the menstrual cycle.

Ovarian rupture most closely simulates acute appendicitis and ruptured tubal pregnancy. The attempt to distinguish between appendicitis and ovarian rupture should not be abandoned prematurely, because mild ovarian hemorrhage may not require surgical intervention.

The Friedman pregnancy test and preceding menstrual history aid in the differentiation from ectopic pregnancy. In fulminating cases, of course, valuable time should not be wasted in establishing the exact diagnosis, since laparotomy is indicated in either event.

Cul-de-sac puncture is recommended by some authors as a pre-operative procedure. The withdrawal of free blood more or less rules out appendicitis in the differential diagnosis.

Finally, it should be emphasized that statements to the effect that ovarian rupture cannot be diagnosed pre-operatively are no longer tenable.

## Prognosis

Generally speaking, the prognosis is excellent. It varies, naturally, with the degree of hemorrhage.

Many mild cases go unrecognized and recover promptly.

Isolated instances of death from massive ovarian hemorrhage have been reported.

Johnson's 77 collected cases included six fatalities (8%), but Hoyt and Meigs have recently reported 58 cases without a death.

## Treatment

Treatment must be individualized to a great degree. If appendicitis and ectopic pregnancy can be definitely excluded from the diagnosis, non-operative treatment often is applicable. However, careful observation is imperative in non-operative therapy.

Patients with signs of marked hemorrhage require immediate operation. Shock, if present, must first be combatted with the usual measures.

When operation has been decided upon, the incision should be either lower midline or paramedian. Whenever possible, the bleeding ovary should be treated conservatively. The cavity of the hematoma may be stripped of its lining and the walls approximated with fine catgut. Wedge-like resection of the affected portion of the ovary and subsequent closure of the defect with a running suture is quite effective. Oöphorectomy may be required in the rare case where bleeding is uncontrolled by suturing through ovarian tissue.

The opposite ovary should always be examined, since bilateral rupture may occur.

## Summary

1. Although several hundred cases of intraperitoneal hemorrhage following rupture of a graafian follicle or luteal cyst have been reported, the condition has not as yet gained widespread recognition.

2. The ultimate etiology of the phenomenon is not perfectly understood. Numerous predisposing causes are cited, many of them relating to trauma in one form or another.

3. Histologically the origin of the ovarian hematoma may be a graafian follicle, an atretic follicular cyst, a maturing corpus luteum or a luteal cyst.

4. The signs and symptoms are not definitely pathognomonic. There is a definite relationship between the onset of symptoms and the menstrual cycle. Sudden lower abdominal pain, nausea, slight temperature elevation, mild leucocytosis, shoulder strap pain and the presence of a small, tender pelvic mass are suggestive.

5. The clinical picture most closely simulates acute appendicitis and ruptured tubal pregnancy. Since surgery is not necessary in the mild cases, the attempt at differentiation should not be abandoned too hastily.

6. The prognosis is excellent in the average case, although isolated instances of death have been reported following massive ovarian hemorrhage.

7. Treatment must be individualized to fit the case at hand. When operation is performed, every effort should be made to conserve at least a portion of the affected ovary. Mild cases respond rapidly to rest alone.

## Bibliography

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10. Moore, E. C.
Intra-abdominal hemorrhage from ruptured corpus luteum.
Ann. Surg., 75:492-500 (1922).

11. Novak, E.
Abdominal hemorrhage of ovarian origin.
J.A.M.A., 68:1160-1162 (1917).

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Hematomata of the ovary, including corpus luteum cysts.
Bull. Johns Hopkins Hosp., 28:349-354 (1917).

13. Phaneuf, L. E.
Intraperitoneal hemorrhage from ruptured ovarian cyst.
J.A.M.A., 83:658-662 (1924).

14. Wilson, R. K.
Ovarian hemorrhage simulating acute appendicitis. A series of 7 cases.
Lancet, 214:1221-1224 (1928).

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Case Reports

(I.) White housewife, age 29, para 6. Admitted 7-27-34 at 5 P.M. from Out-Patient Department as possible ectopic pregnancy. At that time her expected menstrual period was four days overdue on the basis of past experience. She complained of intermittent, knife-like pelvic pains of two weeks' duration, accompanied by dysuria and pain on defecation. She had fainted on three occasions and had right shoulder strap pain the day prior to admission.

Pelvic examination: revealed a small, cystic, tender mass in the cul-de-sac, adherent to the posterior aspect of the uterus. Motion of the uterus was painful. Corpus was about normal in size.

Temperature 99.4°F., leucocyte count 9,500 with 77% neutrophiles.

Examination by the house staff seemed to strengthen the diagnosis of ectopic pregnancy, so laparotomy was performed 6 hours after admission. An adherent mass of clotted blood and a small amount of fresh blood was found in the cul-de-sac. The left ovary contained a ruptured luteal cyst; this was removed by resecting a wedge of ovarian tissue and the defect was closed with a running suture of catgut. Both tubes were normal. The appendix had been removed at a previous operation. The patient made an uneventful recovery and left the hospital on the 12th day.

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(II.) White, unemployed, epileptic female, age 24, was admitted at 10 P.M. 1-31-35, having been referred by her home physician with the diagnosis of acute appendicitis. At 9 A.M. on day of admission, while straining at stool, severe pain suddenly developed in the right lower quadrant of the abdomen and spread rapidly across the entire lower abdomen. The pain radiated down the right thigh. She was nauseated but did not vomit. A similar attack six months previously had subsided without treatment. The last menstrual period had occurred 1-4-35, thus bringing her into the last week of her cycle at the time of admission.

Examination showed generalized abdominal rigidity and rebound tenderness over the right lower quadrant. The pelvis seemed to be normal. Temperature 99.2°F., leucotyte count 11,500 with 80% neutrophiles. Hemoglobin 75%.

One hour after admission she was taken to the operating room with a presumptive diagnosis of acute appendicitis When the peritoneum was opened through a McBurney incision, fresh blood gushed from the wound. After enlarging the original incision, there was found a ruptured cyst on the right ovary, 3-4 cm. in diameter, bleeding actively from the edges of the rupture. It was estimated that there were 300-400 c.c. of free blood in the abdominal cavity. A right oöphorectomy was done in the usual manner. The appendix appeared to be normal; it was not removed. The patient made an uneventful recovery and left the hospital on the 8th day.

(III.) White housemaid, age 24, admitted 2-7-35. Her last menstrual period occurred 1-20-35 to 1-25-35, with considerable pain the first day, which was not unusual. She was referred to the hospital for acute appendicitis by her family physician. Right lower quadrant pain had begun 2-3-35 on the 15th day of her menstrual cycle. The pain resembled that which occurred with her menses, in that it was accompanied by a bearing-down sensation. From 2-3-35 until admission the pain gradually became generalized over the lower abdomen. There was nausea and anorexia, but no vomiting.

Physical examination showed tenderness and slight rigidity over the right lower abdominal quadrant. Temperature 99°F., leucocyte count 12,700 with 70% neutrophiles. Urinalysis negative. Pelvic examination revealed second degree retroversion of the uterus, mild pain on motion of the corpus, generalized tenderness over the peritoneum of the cul-de-sac and in both adnexal regions, without the presence of any definite masses.

During a week in the hospital her temperature did not rise above 99°F., the leucocyte count dropped to 10,900, and the abdominal pain gradually disappeared. Surgical and gynecological consultants thought the patient's symptoms did not warrant operation and concluded that the most likely diagnosis was ruptured graafian follicle with slight hemoperitoneum. The patient did not return to the Out-Patient Department for further observation.

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ANNOUNCEMENTS (Continued)

tions. In order to register for the seminar a fee of $3 should be sent in advance. This payment will be applied on the $25 tuition fee when registration is completed. In case the registrant fails to complete his registration the advance payment of $3 will be applied on the tuition for any future seminar.

Information

Address all correspondence to the Director of the Center for Continuation Study, University of Minnesota, Minneapolis.

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Program

Monday, December 6, 1937

| | | |
|---|---|---|
| 9:00-10:00 A.M. | General Diagnosis | H. E. Michelson |
| 10:00-11:00 A.M. | Acne | Francis Lynch |
| 11:00-12:00 noon | Precancerous Lesions | Carl Laymon |
| 2:00- 4:00 P.M. | Clinic - Wilder Dispensary, St. Paul | H. N. Klein |
| 5:00- 6:00 P.M. | Round Table | D. N. Turnacliff |

Tuesday, December 7, 1937

| | | |
|---|---|---|
| 9:00-10:00 A.M. | Diagnosis of Leg Ulcers | John Madden |
| 10:00-11:00 A.M. | Penile Lesions | L. H. Winer |
| 11:00-12:00 noon | Allergic Dermatosis | Elmer Rusten |
| 2:00- 4:00 P.M. | Clinic - Minneapolis General Hospital | S. E. Sweitzer and staff |
| 4:00- 5:00 P.M. | Erythema Multiforme and Nodosum | C. A. Boreen |

Wednesday, December 8, 1937

| | | |
|---|---|---|
| 9:00-10:00 A.M. | General Therapy | S. E. Sweitzer |
| 10:00-12:00 noon | Problem of Resistant Syphilis | Paul O'Leary |
| 2:00- 4:00 P.M. | Drug Eruptions | Louis Brunsting |
| 4:30- 5:30 P.M. | Round Table | Louis Brunsting |

Thursday, December 9, 1937

| | | |
|---|---|---|
| 9:00-10:00 A.M. | Cancer of the Skin | H. E. Michelson |
| 10:00-11:00 A.M. | Leukemia of Skin | Francis Lynch |
| 11:00-12:00 noon | Lupus Erythematosis | Carl Laymon |
| 2:00- 4:00 P.M. | Dermatology and Internal Medicine | Hamilton Montgomery |
| 4:30- 5:30 P.M. | Round Table | Hamilton Montgomery |

Friday, December 10, 1937

| | | |
|---|---|---|
| 9:00-12:00 noon | Clinic - Ancker Hospital, St. Paul | John Madden |
| 2:00- 4:00 P.M. | Clinic - University of Minnesota Hospitals | H. E. Michelson |
| 4:30- 5:30 P.M. | The State and Syphilis | H. G. Irvine |

Saturday, December 11, 1937

| | | |
|---|---|---|
| 9:00-10:00 A.M. | Fungus Infection of Hands and Feet | John Butler |
| 10:00-11:00 A.M. | Seborrhoea and Psoriasis | E. C. Gager |
| 11:00-12:00 noon | Round Table | H. E. Michelson |

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## V. UNIVERSITY OF MINNESOTA HOSPITALS REPORTS

### 1. Average Length of Stay Per Patient per Service

| Service | Jul.-Aug. Sept.1936 | Jul.-Aug. Sept.1937 | Service | Jul.-Aug. Sept.1936 | Jul.-Aug. Sept.1937 |
|---|---|---|---|---|---|
| General Surgery | 11.7 | 11.3 | Pediatric Surgery | 15.7 | 15.3 |
| Urology | 11.5 | 14.7 | Reconstruction Pediatrics | 19.5 | 13.7 |
| Orthopedics | 37.3 | 26.1 | Orthopedic Pediatrics | 34.4 | 39.8 |
| Tumor Surgery | 8.8 | 8.5 | Pediatrics | 8.9 | 11.7 |
| Reconstruction Surgery | 26.6 | 10.8 | Pediatric Ophthalmology | 11.9 | 12.4 |
| Tuberculosis Surgery | 62.5 | 36.8 | Pediatric Otolaryngology | 8.2 | 5.4 |
| Medicine | 16.1 | 16.9 | Ambulatory | 2.0 | 6.7 |
| Neurology | 18.8 | 22.6 | Health Service | 2.4 | 6.0 |
| Dermatology | 20.5 | 9.9 | Detention | 2.0 | 0 |
| Chest Medicine | 13.6 | 13.3 | | | |
| Ophthalmology | 12.2 | 17.4 | Total Patient Days | 31031 | 30960 |
| Otolaryngology | 4.6 | 3.1 | Patients Treated | 2112 | 2115 |
| Gynecology | 9.8 | 8.8 | Average Length of Stay | 12.4 | 12.7 |
| Tumor Gynecology | 12.3 | 7.2 | | | |
| Obstetrics | 11.3 | 10.6 | | | |
| New Born | 8.1 | 9.2 | | | |

## 2. DEATHS AND AUTOPSIES BY SERVICES

July 1937--September 1937

| Service | Deaths | Autopsies |
|---|---|---|
| Surgery | 17 | 14 |
| White Surgery | 12 | 8 |
| Gynecology | 3 | 3 |
| White Gynecology | 2 | 1 |
| Pediatrics (Inc. Newborn) | 23 | 16 |
| (Newborn) | (4) | (2) |
| Medicine | 30 | 23 |
| Urology | 6 | 1 |
| Dermatology | 1 | 1 |
| Neurology | 18 | 11 |
| Orthopedics | 1 | 0 |
| Oto-Laryngology | 1 | 1 |
| Ophthalmology | 1 | 1 |
| Neurological Surgery | 1 | 1 |
| Chest Medicine | 2 | 0 |
| Health Service | 1 | 1 |
| Out-Patient Department | 1 | 1 |
| | 120 | 83 |
| | | 70% |

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## VI. GOSSIP

The Medical School Digest, a sparkling new publication, with a foreword by Harold S. Diehl and R. E. Scammon, is out this week. Sponsored and edited by a group of medical students with faculty cooperation it will feature abstracts of all the seminars, conferences and meetings held at the medical school and hospitals each week. The students have long been interested in the extra curricular activities of the school but for various reasons have found it difficult to attend all. The subscription price is very modest, and the abstracts should have wide appeal. Further information may be obtained by addressing The Medical School Digest Editorial Board, 318 Millard Hall, University of Minnesota.....Which reminds me that the staff is finally getting over the bad habit of presenting scientific subjects without writing the manuscript (or at least a summary) in advance of the meeting. There has been great improvement in the promptness in turning in the summaries for each successive seminar at the Center for Continuation Study. If a lecture is well prepared, it is a simple matter to make out the summary.....We have as our guests today the members of the Institute on Surgical Diagnosis and Treatment. We hope that they have had a pleasant and profitable week; their visit has been most stimulating to us. Elsewhere in this issue will be found the program of the Seminar on Dermatology and Syphilology to be offered December 6-11, 1937.....Leo Rigler, Diagnostic Radiology's Head Man, left Monday on a six months' leave of absence to study radiology departments. It will not seem the same without Leo who always adds the punch to our meeting His work will be taken over by Drs. Ude, Borland, Morse, Naslund, Peterson, Truog, Friedell, Jensen and Pass, not to forget the entire staff of stenographers clerks and technologists. The complaints about your requisitions, requests for diagnoses before the films have been taken, etc., will be handled by Harold Peterson.....One of Notre Dame's synthetic alumni from Boston observed after their touchdown and goal that it was too bad that he had come all this way to see the Gophers scored on by the third team. Four ardent Gopher fans fell off their seats at this news. After the Indiana game, Bernie Bierman was told not to be so hard on the crowd Wait until the Notre Dame game if you think you have had a hard afternoon, opined Bernie. This has been a good season for the fans; their loyalty has been tested and found to be the real stuff.. ....Homecoming visitors to the Department of Surgery office will miss Miss Northfield, who has left for her new home in California. Nina Patton of Superintendent Amberg's office has also gone to California to join her family..... ..Axel, the genial operator of elevator No. 1 made the Minnesota Daily with a feature story this week. He commenced his hospital career when W. J. Mayo was starting his long climb up.....Charles McLennan (this week's program) and John Adams (last week's) both enjoy the unique distinction of having staff wives; Dr. Margaret Thomas McLennan and Dr. Carolyn Gaston Adams.....In an attempt to explain aerophagia to the class in Public and Personal Health #3, the following question was asked -- What do you call a horse who bites on

his manger, and swallows air at the same time? The answer from the far corner was -- a teether. Do you know the correct reply? The class laughed even though only one student knew the answer.....When Chief Surgeon Arthur A. Zierold, of Minneapolis General Hospital, went duck hunting this fall, he had unusually good luck. One by one the ducks were thrown into the bottom of the boat. When he pulled them out, he found that they had been soaked in machine oil which had run in from the motor.....Health Service Director Fowler, of the University of Oklahoma, was an interested visitor at the University this week.....The American Association of Medical Social Workers invites you to a Smörgasbörd at the Nurses' Hall, Sunday, November 21, 4:30 to 8:00 P.M. It will cost you 65 cents to get in; stretchers will be provided to carry you out. The engineers from the Department of Buildings and Grounds are going over the floors this week to determine if they will stand the strain of the groaning tables. Your ticket is being held for you at Miss Money's office, and speaking of food, the medical seminars at the Center for Continuation Study knock off every afternoon at 4 for tea, which in Minnesota is spelled C-O-F-F-E-E and really is.....The Idaho State Medical Association held its annual meeting in Boise August 30th to September 2nd, with headquarters at the Owyhee Hotel. How would you like to ask someone to direct you to that place? The meeting was an All-Minnesota affair with H. E. Robertson, W. F. Braasch, F. J. Heck from Rochester, and with Francis Lynch, W. P. Sadler and J. A. Myers from the Twin Cities. The program consisted of lectures, clinics and conferences, with each man taking his turn in regular rotation. Their pictures which appear in the program do not flatter any of the gentlemen, and evidently this did not keep the crowd away as a very successful meeting was held.....Dr. Morris Fishbein will be here next week to give the annual address for the Minnesota Public Health Association at the Nicollet Hotel Friday night. We are hoping that he will be our guest at staff luncheon.... ...The ever so efficient Miss Lavers, who for these many years has taken our worst copy and made sense out of it, at last has made a mistake. In our Koucky-Schenck story she put Dryberry Lake in Canada, 130 miles north of Minneapolis instead of International Falls. Miss Lavers, who knows more about getting out the staff meeting bulletin than anyone else on the campus, has never attended a meeting. She will be our honored guest in the near future.

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H O M E C O M I N G

November 12
Clinics and Luncheon

November 13
Football - Northwestern vs. Minnesota
Tea and Dance, Nurses' Hall 4-6 p.m.