

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

Case Reports

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

Volume X

Friday, April 14, 1939

Number 23

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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 WEEK

Date: March 24, 1939

Place: Recreation Room
Powell Hall

Time: 12:15 to 1:10 p.m.

Program: Movie: "Hunting Thrills"

Besnier-Boeck-Schaumann's
Disease
John F. Wilson

Discussion
H. E. Michelson
H. S. Diehl
John F. Wilson

Present: 125

Gertrude Gunn
Record Librarian

II. MOVIE

Title: "Little Hiawatha"
A Walt Disney Feature

Released by: R-K-O.

III. ANNOUNCEMENTS1. SPRING PROGRAM

Center for Continuation Study

General Surgery
April 10 to 15, 1939

Diseases of Blood and Blood
Forming Organs
April 17 to 22, 1939

Obstetrics
May 1 to 6, 1939

Gastroenterology
May 8 to 13, 1939

Operating Room Nursing Supervision
May 22 - 24, 1939

Radiation Physics
June 12, 13, and 14, 1939

Medical Technology
June, 1939 (tentative)

2. MINNESOTA PATHOLOGICAL SOCIETY

The University of Minnesota Medical School
Institute of Anatomy

Tuesday, April 18, 1939, 8:00 P.M.

Annual Address: "The specific treatment
of the pneumococcic pneumonias: the
choice of a remedy."

Dr. Jesse G. M. Bullowa
New York City

3. CANCER INSTITUTE ADDRESS

Dr. Ludwig Hektoen, executive
director of the National Advisory Cancer
council of the United States Public
Health service, will come to the campus
Tuesday to deliver the annual Citizens
Aid society lecture.

Dr. Hektoen will speak on "Advances in
the Knowledge and Control of Cancer."
The lecture, sponsored by the Cancer In-
stitute of the University of Minnesota, is
scheduled for 8:15 p.m. in the Medical
Sciences amphitheater.

4. BABIES

BABY BOY CREEVY

Second son of Dr. and
Mrs. C. Donald Creevy, born April 9th.

Help - Irish name wanted.

JUDITH ANN

Second child of Dr.
and Mrs. H. O. Peterson Apr. 1--No fooling!

IV. CASE REPORTS1. BRONCHOGENIC CARCINOMA OF THE
LEFT LOWER BRONCHUS
(SQUAMOUS CELL CARCINOMA)John Kometani, and
Robert Brotchner

, 60 years of age.

The case is that of a white male, age 60, who was admitted to the University of Minnesota Hospitals 12-2-38 and expired 12-25-38 (23 days).

Presenting complaints

Dyspnea, orthopnea, cough, and pain in the left chest. Illness dated back to the middle of October, 1938. At that time he fainted while walking home. He felt a little weak, then everything became black, and he fell. He believed he was unconscious for a few moments. He had a similar attack 5 to 10 days later and another about the first of November. At that time he noticed severe pain in his left side, chest, and loin. His side was very painful when he touched it or when he would lie on it. When the patient tried to take a deep breath, the pain would cut like a knife. He became very dyspneic and orthopneic and began to cough and raise a little whitish sputum. At times he could not stop coughing and then would get a sharp headache which would go away when the coughing ceased. Marked nausea and vomiting were present, and he was unable to keep anything on his stomach. Thought that he had some fever and chills although his history of chills was rather vague. No palpitation, hemoptysis, or night sweats were noticed.

He was confined to bed about November 1st. In the middle of November, a physician was seen. Morphine was necessary on several occasions for relief of the pain. Symptoms had been reducing somewhat so that on admission to the hospital, he was able to lie on the left side at times. There was still dyspnea, cough, and orthopnea, but no vomiting had occurred for several days.

Past history was essentially negative. Varicose veins of the left leg had been noticed for many years. The patient had used large amounts of alcohol and "moon" but had had none in the past 2 years. His best weight was 202 lbs., and average weight was 168 lbs. He believed he had lost weight since the onset of the present illness. One brother died of carcinoma of the lung. No other carcinoma in the family.

Examination

Revealed a moderately cyanotic, dyspneic, and orthopneic white male, age 60, who appeared very ill. Retinal arteries appeared constricted and somewhat tortuous. No hemorrhage seen in the fundi. No distention of the neck vessels. The chest was slightly emphysematous. There was dullness in the lower half of the right chest posteriorly. Numerous moist rales were heard in both lung fields, especially in the midaxillary line on the right. The heart was markedly enlarged to the right, somewhat enlarged to the left. Blood pressure was 102/74. No murmurs were audible. The heart tones were slightly muffled. Rhythm was irregular (probable auricular fibrillation). The liver was palpable 1 finger below the costal margin. The spleen was not palpable. Thrombosed varices were noticed above the right inguinal ligament. Rectal showed 2+ enlargement of the prostate. The extremities showed varices of the left leg. Impression was right and left heart failure with marked cardiac enlargement and dilation. Etiology was thought to be long standing hypertension or possibly coronary sclerosis. The possibility of a recent infarct of the heart was considered.

12-4-39, Dyspnea, orthopnea, and cyanosis were marked. X-ray showed generalized cardiac enlargement, suggesting pericardial effusion and pleural effusion. Apical impulse was not visible or palpable. Cardiac sounds were almost completely stamped out. The peripheral pulse was weak and thready. Edema of the legs was noted.

Blood pressure was 104/70. Bloody fluid (no bacteria found) was removed

from the pericardial sac twice, each time with marked improvement. The patient later became orthopneic and dyspneic again. Cardiac contour was that of effusion. Paradoxical pulse was present, weak, and rapid. Diagnoses considered were: 1. ruptured aneurysm of the ascending aorta, or of the coronary vessels; 2. malignant transplant. ity H1.44, H2.34. Control H1.48, H2.42. 12-13-38, Pericardial fluid, hemoglobin 34%, red cells, 2,190,000, white cells 1,650; hematocrit 25%, platelets 86,900; differential P.M.N.'s 37%, lymphocytes 59%. Tissue cells 13 per hundred white blood cells; tumor ? cells 23 per 100 white cells. Blood pressure 12-21-38 was 120/80.

Laboratory

Urinalysis 12-4-38: Specific gravity 1.022, albumin and sugar negative, fine granular casts, a few white cells, urobilinogen 9.4 mg. in 650 cc. of urine collected in 24 hours. 12-15-38 the urine showed a specific gravity of 1.032, no albumin, no sugar, 2 to 3 white blood cells per high power field. The hemoglobin varied from 68 to 82%, white count 15,000; neutrophils 84%. 12-11 to 12-17-38, The hemoglobin varied from 60 to 70%; white count 15,600 with 91% neutrophils.

12-8-38, Blood urea nitrogen 56.8, creatinine 1.3. Cholesterol 200 mg.; total proteins 5.9 grams, albumin 3.3, globulin 2.5. 12-16-38, Icterus index 9.

The Mantoux was positive. Sedimentation rate one hour 38 mm.; 2 hours 62 mm. Venous pressure was 10 cm. of blood on 12-2-38 and 12 cm. of blood on 12-4-38.

The pericardial fluid cell count was reds 3,490,000, whites, 3,400, 62% P.M.N.'s 38% mononuclears. Proteins were 45 grams per liter; icterus index 30; van den Bergh indirect; specific gravity 1.040. 12-7-38, Left pleural fluid, red blood cells 1,700,000, white blood cells 8,700; proteins 1 to 10 dilution; hemoglobin 38%; icterus index 31; van den Bergh direct; P.M.N.'s 89%; specific gravity 1.030.

12-6-38, Staff Note: "The character of the pericardial fluid with a large percentage of blood which does not clot on standing suggests that patient has malignancy of heart or pericardium, either primary or metastatic."

12-7-38, Right pleural fluid, white blood cells 39,000; red blood cells 26,000; P.M.N.'s 84%, Capillary fragility cuff test negative. 12-12-38, Venous pressure 9.5 mm. Red blood cells fragil-

12-13-38, Pericardial tap 350 cc. He developed a few shotty nodules in the supraclavicular area, particularly on the right. 12-15-38, Smears of the sediment of the pericardial fluid showed a few large irregular atypical cells which were undoubtedly tumor cells. 12-13-38, Biopsy of cervical lymph nodes; "The lymphoid structure is almost entirely replaced by tumor cells; these are of the squamous epithelial type, large, and hyperchromatic. There is no cornification. Conclusion: Metastatic squamous carcinoma of the lymph node."

Electrocardiogram 12-2-38, left axis deviation, rapid tachycardia, multiple auricular extrastyles; possible fibrillation at times. 12-5-38, Rhythm normal, elevation of ST₁ and ST₂, left axis deviation. The record now had more characteristics of pericarditis. 12-9-38, Coarse auricular fibrillation was present.

12-20-38, Patient developed cachectic facies, marked bilateral edema of legs, thrombosis of veins, in the lower abdomen. There were also enlarged tender inguinal glands. Edema of the legs was thought probably on the basis of venous thrombosis. Hemoglobin was 36%.

12-24-38, Patient had moderate pitting edema of both lower extremities. Pulse was weak and dyspnea marked. Blood pressure 100/75. 1,000 cc. of bloody fluid removed from pericardial sac. Patient's condition became gradually worse, and he expired at 1:10 P.M., 12-25-38.

Autopsy

The body is that of a white male,

age 60, development good, nutrition poor, length 167 cm., weight approximately 135 lbs. There is pitting edema of the back, lower extremities and dorsum of the feet. Cyanosis is present in the lips, ears, and fingertips. Several 3 mm. shotty nodules are felt just above the left sternoclavicular joint. A nodule is felt just beneath the skin over the 3rd rib on the left, the nodule measuring $1\frac{1}{2}$ cm. in diameter.

The Peritoneum is normal.

The Right Pleural Cavity does not contain fluid. There are several firm fibrous adhesions binding the lateral aspect of the right lung to the lateral chest wall. The left lung is adherent laterally and at the apex and posteriorly almost throughout the entire extent of the posterior $\frac{2}{3}$ of the left chest. No blood or other fluid is seen in either pleural cavity. On removal of the left lung small portions of it are left adherent to the parietal pleura posteriorly. The Pericardial Sac is adherent to the left third interspace about 3 cm. to the left of the sternum over an area $1\frac{1}{2}$ cm. in diameter. It is thickened to a thickness of about 4 mm. in this area and extending from it into the intercostal margins to a point just beneath the skin there is a firm fibrous tumor mass. This represents the nodule that is seen externally and described above. The pericardial sac is markedly enlarged. It contains about 900 cc. of bloody fluid. Its thickness varies from a normal thickness over many areas to a thickness of 1 cm. in several areas. In the region of the left lung it is markedly thickened just anterior to the anterior border of the left lower lobe. The visceral pericardium has scattered over it many firm nodules varying from $\frac{1}{2}$ to 2 mm. in diameter. The process is more marked over the great vessels, particularly the pulmonary artery. On the posterior surface of the pulmonary artery there is one mass 1 cm. in diameter, and there are several smaller ones adjacent to it. On exploring the pericardial sac posteriorly one is able to approach the left 7th and 8th interspaces posteriorly so that the examining finger is 2 cm. from that intercostal space. It would thus be possible to reach the pericardial sac from a poster-

ior approach.

The Heart left in place in the specimen weighs approximately 325 grams. The right and left ventricles are normal. The pulmonary artery does not appear dilated. Posterior to the arch of the aorta and lying between the arch and the main bronchus there is a tumor mass with a thickness of $1\frac{1}{2}$ cm. Several large firm nodules measure from 1 cm. in diameter to $1\frac{1}{2}$ x 2 x 2 cm. By extension the process has reached the beginning of the right main bronchus. It does not grossly appear to infiltrate the right lung, beyond a distance of 1 cm. along this main bronchus. The branch of the left bronchus which supplies the left lower lobe is occluded by about 2 cm. from its origin by a firm fibrous tumor mass which on further section is seen to be part of a mass 5 x 5 x 4 cm. in the left lung. On section this mass has an irregular border and is a dense opaque white throughout, but centrally has a block diffuse infiltrate. The bronchi adjacent to this tumor seem to be thickened. Grossly it appears that the walls are infiltrated by tumor cells. The weight of the entire mass, RIGHT and LEFT LUNG, heart, and pericardium and a small portion of the diaphragm is 1980 grams. The right lung is very markedly edematous throughout. There is some congestion present in all three lobes. The left upper lobe grossly seems free of tumor. It is markedly congested and edematous. Small shotty nodes are felt throughout the remainder of the left lower lobe.

The Spleen weighs 85 grams. There is a small area of hyaline perisplenitis at the upper pole.

The Liver weighs 1250 grams. Serial sections 1 cm. apart reveal no evidence of metastatic nodules. The liver appears normal grossly. The Gallbladder shows no change.

The gastrointestinal tract is normal throughout.

The Pancreas shows nothing of note.

Each Adrenal contains a tumor mass

involving the entire medulla and a large part of the cortex.

The Right Kidney weighs 120 grams, the Left Kidney 130 grams. At the upper pole of the right kidney there is a white firm nodule protruding from the surface and extending into the substance. It is 1 cm. in diameter. There are scattered coarse pits over the surface. The cortex is normal. On the posterior surface of the left kidney there is a similar firm white nodule extending from the surface into the substance, ellipsoidal in contour, $1\frac{1}{2}$ cm. in the long axis, 1 cm. in diameter in the short axis. In the upper pole extending from the surface inward, there is an area with a base $1\frac{1}{2}$ cm. in diameter and a depth $\frac{1}{2}$ cm. which has a yellowish color, is somewhat softened on section and in the adjacent kidney tissue, there is a 1 mm. red border which may be inflammatory reaction. The bladder is very small. Its capacity when seen at autopsy is not more than 40 cc. The wall is very thick.

The prostate is slightly enlarged and fibrous. The urethral orifice seems quite adequate, however.

The Aorta shows a grade II atherosclerosis.

The thyroid is normal.

No lymph nodes can be seen in the region of the left sternoclavicular joint although there is a palpable nodule on the skin surface itself.

The meninges and brain appear normal grossly. There is no involvement of the spinal cord.

Microscopic:

The liver shows a moderate chronic passive congestion.

The adrenals show a moderate amount of necrosis and scattered throughout are masses of cells with large hyperchromatic nuclei and varying amounts of dark cytoplasm. The white firm nodule protruding from the surface into the substance of the right kidney microscopically is seen to be an area of

necrosis with masses of epithelioid cells extending into the kidney substance. The lesion at the upper pole of the left kidney which was yellow and somewhat softened grossly is seen to be an infarct, necrosis being present throughout. Normal portions of the kidney show no evidence of preglomerular arteriolar hyalinization. The white necrotic material in the pericardium shows necrosis and infiltration of masses of carcinoma cells.

Several sections taken from the tumor mass in the lungs show squamous carcinoma.

The spleen is normal.

Diagnoses

1. Bronchogenic carcinoma of the left lower bronchus (squamous cell carcinoma).
2. Metastatic carcinoma of the pericardium, epicardium, right kidney and both adrenal glands.
3. Hemopericardium.
4. Chronic passive congestion of the liver.
5. Marked secondary anemia.
6. Bilateral pulmonary edema.

Summary

This is a case of squamous cell carcinoma of the bronchus in which metastases to the parietal pericardium caused the clinical picture of hemopericardium. It illustrates the value of examining paracentesis fluids for cancer cells and also the value of biopsies of lymph nodes in the diagnosis of internal cancers.

2. CARCINOMA OF ADRENAL CORTEX

Robert Mooney, and
Lawrence Berman

80 years of age.

The case is that of an 80 year old

white male, admitted to the University of Minnesota Hospitals 2-28-39, and expired 3-14-39 (14 days).

Prior to November, 1938, the patient had enjoyed good health. There was then a gradual loss of appetite, associated with weakness but no pain. In a period of three months beginning about January, 1939, the patient had lost about 40 lbs. in weight. There had also been increasing drowsiness and mental changes. Patient was disoriented at times. In February, 1939, the patient complained of anorexia, occasional nausea and vomiting, and pains across the abdomen, usually dull in character and in the right upper quadrant. Urine became dark in color about three weeks before admission. Jaundice appeared about the same time, and this was not accompanied by any chills or fever. There was no history of any infection. Six weeks before admission the patient was unable to take any solid food. He also began to complain of dysphagia about this time, but there was never any regurgitation of food.

Examination on admission

At the time of admission the diarrhea was quite severe. Temperature 98°, pulse 80, respirations 22. The patient was emaciated, stuporous, extremely jaundiced. The skin had a dark greenish yellow color, especially the face. The patient was easily aroused but was slightly disoriented as to time and place. Patient was fairly cooperative. There were numerous excoriations of the skin. The pupils were miotic, reacted to light, and there was a marked icteric tinge in the sclera. The neck was negative. The chest was entirely negative. The heart showed occasional extrasystoles with a systolic murmur over the base of the heart. Blood pressure 138/84. The pulse was strong. The abdomen showed a visible mass in the right upper quadrant moving down on inspiration. The mass was thought to be the firm, nontender edge of the liver 4 cm. below the costal margin, or an enlarged gallbladder. The spleen was not palpable. There were no palpable nodes. Rectal examination showed a prostate of normal size and consistence. The

extremities were negative.

Laboratory

3-1-39, Hemoglobin 49%, erythrocytes 2,430,000, leukocytes 13,200, neutrophils 82%, lymphocytes 15%, monocytes 0, eosinophils 3%; blood urea nitrogen 18.3 mg.%; blood sugar 114 mg.%; carbon dioxide combining power 54%; blood chlorides 598 mg.%. Total serum protein 6.4%, albumin 2.4%, globulin 4%. Blood cholesterol 241 mg.%. 3-2-39, Specific gravity of urine 1.017, reaction alkaline, albumin negative, sugar negative. On 3-10-39 it was 163; the van den Bergh was prompt direct. Wassermann was negative. Examination of the stools revealed the presence of occult blood. 24 hour urine specimen obtained 3-2-39 yielded a trace of urobilinogen. The hematocrit per cent was 26.16. Mean corpuscular volume 121.2 cubic microns; mean corpuscular hemoglobin concentration 30.7 per cent; mean corpuscular diameter 8.54 microns; the Cuff test was negative. The Ivy bleeding time 5 minutes and 55 seconds. On 3-4-39 the urobilinogen in the feces was .8 mg. per day.

Course

The patient's temperature on admission was about normal. On the 4th day it rose to levels between 101 and 102° and remained elevated at this level until the 8th hospital day when it remained at a more constant level between 100 and 101°. Treatment was palliative, consisting of the administration of intravenous glucose daily. Patient grew weaker gradually, lapsed into coma on about the 7th day, and the condition persisted until 3-14-39 at which time the patient expired.

Autopsy

The body is that of an undernourished white male, 173 cm. in length, weighing about 150 lbs. Severe generalized greenish yellow jaundice is present. There are about 2 liters of clear brown stained fluid in the Peritoneal Cavity. All the contents of the peritoneal cavity are bile stained deeply. The diaphragm arches to the 3rd interspace on the right and 4th interspace on the left. The liver edge is 3 cm. below the

right costal margin in the midclavicular line. The fundus of the gallbladder lies 3 cm. below the liver edge.

Each Pleural Cavity contains about 200 cc. of bile stained fluid. There is no excess of fluid in the Pericardial Sac.

The Heart weighs 460 grams. There is hypertrophy of the left ventricle and dilatation of all the other chambers. The myocardium is soft and bile stained. There is a row of calcified nodules on the ventricular surface of the posterior mitral leaflet along its attached margin. There are calcified plaques at the base of the aorta over the orifice of the left coronary artery. The remainder of the aorta is perfectly smooth. There are no lesions of the pulmonary, tricuspid, or aortic valve. There is no gross evidence of myocardial softening, hemorrhage, or fibrosis. The coronary arteries contain atheroma and calcified plaques, especially in the midportion of the anterior descending branch of the left where the lumen is narrowed about 80% at one point in a segment about 2 mm. in length. There is slight narrowing of the midportion of the circumflex branch of the left, and slight narrowing of several portions of the right coronary artery.

The Left Lung weighs 400 grams. There are no scars on the surface. The entire lung is feathery and crepitant throughout. The large bronchi contain a small amount of hemorrhagic, mucous material, and the smaller bronchioles in the lower portion of the left lower lobe contain small mucopurulent plugs. The Right Lung weighs 390 grams. There are no scars on the surface. The large bronchi are injected and red, rough, and granular. Otherwise, the lung is feathery, crepitant, and dry throughout.

The Spleen weighs 210 grams. The capsule is thickened with numerous hyaline nodular areas each about 4 mm. in diameter. The pulp is deep purple in color, but it is firm. Trabeculations and corpuscles are visible. There is no gross evidence of tumor, hemorrhage, necrosis in the Pancreas or Right Adrenal Gland. The Left Adrenal Gland is replaced partly by a roughly spherical

tumor mass 3.5 cm. in diameter which contains numerous necrotic and cystic portions with bloody material, with the other parts of the mass having a distinctly yellow color.

Each Kidney weighs 150 grams. There are several cysts $1\frac{1}{2}$ cm. in diameter containing bile stained fluid in the left and right kidneys. On section the kidneys are bile stained deeply. A hemorrhagic cystic area in the left kidney about 1 cm. in diameter is in the lower pole near the pelvis. There are no lesions of the pelvis of the kidneys, ureters, bladder, prostate, testes.

The abdominal and lumbar parts of the Aorta are markedly calcified and ulcerated. There is a chain of aortic nodes starting at the superior mesenteric artery and extending almost to the bifurcation of the aorta. These nodes vary in size from 4 mm. to 2 cm. On section they reveal no gross evidence of tumor.

There is a confluent mass of nodes in the portion ligament at the lateral edge and adjacent to the common bile duct. This mass is 6 x 5 cm. and contains numerous portions consisting of tumor tissue similar to that found in the left adrenal gland. There is no compression on the common bile duct by this mass.

The common bile duct is of normal size and caliber. A probe can easily be passed from it into the duodenum. The Liver is deeply bile stained. There are numerous very much dilated intrahepatic ducts. Several contain purulent necrotic material, especially in the region of the main branches of the bile ducts. The Gallbladder is distended with blood and bile mixed together in a gummy mass, about 13 x 6 cm.

There are no intrinsic lesions of the cystic duct; however, the cystic duct is compressed by a tumor 8 x 5 x 4 cm. which surrounds the common hepatic duct and extends for a short distance into the liver. The common hepatic duct and both hepatic ducts are markedly

thickened and narrowed by the tumor mass. The mass is yellow in color and appears rough inside the lumen of the duct. There are no lesions of the small intestine or colon, but there is bloody material in the stomach and upper part of the duodenum. No definite source of bleeding can be determined.

There are no lesions of the prostate, seminal vesicles, or testes.

The thyroid is free of nodules.

Microscopic

Lymph nodes from lesser omentum - metastatic carcinoma.

Kidneys - occasional bile casts in the tubules; no evidence of hypertension.

Lungs - purulent bronchitis.

Left adrenal - carcinoma of cortex; most of the tumor consists of small dark cells, but there are frequent anaplastic portions composed of irregular dark cells, some of which are multinucleated. In numerous areas there are accumulations of hydropic cells; in these parts the structure resembles that of an adrenal cortex.

Common hepatic duct - metastatic carcinoma surrounds the duct and extends along it into the liver.

Liver - dense accumulation of lymphocytes in portal spaces with slight increase of connective tissue in these areas; there are large bile thrombi in the ducts.

Diagnoses

1. Carcinoma of adrenal cortex (left) with metastases to the common hepatic duct of the liver, nodes of the lesser omentum.
2. Jaundice.
3. Severe coronary sclerosis.
4. Hydrothorax, bilateral.
5. Hypertrophy of left ventricle.
6. Purulent bronchitis.
7. Hyaline nodular perisplenitis.

Summary

The tumor in this case is a primary carcinoma of the adrenal cortex, or true hypernephroma, with a metastasis to the common hepatic duct, giving rise to a picture which cannot be distinguished clinically from other forms of cancerous obstruction in the biliary tract.

V. GOSSIP

The Annual Meeting of the Medical Six O'Clock Club sponsored by Incus, honorary medical fraternity, was held at the Minnesota Union April 12 at 6:00 o'clock. Starting on time was apparently the first break with established tradition as the Medical Six O'Clock Club has always held its dinner at 6:30. Another difference was the large and enthusiastic crowd, very much in the holiday spirit. There were 340 diners when the last ticket was collected.In previous years, meetings were held once a quarter. In the less distant past, one of these meetings was an alleged dance at which various and sundry faculty people were invited as chaperones. With the passing of prohibition, there did not seem to be much reason for the dances, so they were discontinued. Back in the early twenties, the Medical Six O'Clock Club was actively engaged in supervision of the curriculum of the Medical School. Such faculty members as were brave enough to hear themselves discussed pro and con, were sometimes in attendance. A favorite stunt was to hold mock faculty meetings or to give imitations of teaching methods. One bewildered faculty member referred to the group as out-doing the Russians, who were then very active in annihilating their enemies. In those days, one Donald Tollefson was the ring leader, but he had plenty of assistance.....A more subtle form of cruelty is now practiced. A selected number of the faculty are told that the students desire to hear them, in their off moments. One Pathologist, Elexious Thomas Bell, is selected as toastmaster months in advance of the meeting. With the help of Joe Miller's joke book and a large departmental staff, an array of introductions second to none are pulled out of the professor's hat. A natural wit reinforced by a staff of radio-comic proportions is an unbeatable combination. The chief lamb for sacrifice was Long John McKelvey, the well-known speaker on China. Proud Father C. Donald Creevy, Ever Ebuilient Ernest M. Hammes and yours truly made up the rest of the quartet. The students responded in their usual style by laughing at anything and everything. The overtones and

undertones gave one the impression that some of the laughter was distinctly equine. The crowd recorded various reactions. Two students judged jokes and near jokes by stroking imaginary whiskers. It was noted that one speaker drew long and vigorous strokes. Another reaction which was rather strange was timing speakers. I learned that they thought it was a filibuster which was being staged.....As the evening wore on, the barbs became sharper and the comedy lower. The most unkind (unintentional) cut of all was the parting shot when the speakers and a very prominent member of the Medical faculty were thanked for their efforts. Many old customs were preserved. All the latecomers received a thundering welcome. One person apparently thought it was the real thing. It would be distinctly out of order to repeat any of the alleged jokes. Many of them will be put away in moth balls for another year. Others will be used over and over again in the interval.....At one time I was invited back to the same organization on two successive occasions, and the person who appeared on the program with me also received the same treatment. This intrigued me until I learned that the organization found it very difficult to decide which one of us was the worst. It will be interesting to note the selection for next year's Medical Six O'Clock Club Meeting.The climax of the evening's meeting was the announcement of the celebration of the fiftieth anniversary of the founding of the Medical School of the University of Minnesota. The first class enrolled 50 years ago last fall and finished their first year's work 50 years ago this spring. It was intended to remember the event this spring but, because of conflicts with other meetings, the program has been arranged for Oct. 12, 13, and 14, 1939. It is probable that classes will be recessed for the occasion and there will be a large attendance of alumni and distinguished visitors from other institutions. The theme of the celebration will be modern trends in medical progress with special reference to physiology and biochemistry. First two days, papers and round table meetings. Third day special clinics and Minnesota-Purdue football game.....