CLINICAL PATHOLOGICAL CONFERENCE

March 27, 1967

PROTOCOL

Case #001343

Don Gholston, M.D.

This 56 year old, white, male, Ohio resident was admitted to this hospital on the 28th. of November, with a chief complaint of cough, chest pain, and shortness of breath.

The patient, who was a chronic heavy cigarette smoker, was hospitalized two years prior to this admission for a radiographically proven right lower lobe pneumonia. He had several recurrences of right lower lobe pneumonia prior to the admission to this hospital. The etiology of these episodes was not known. The patient stated that with these illnesses he would become short of breath and wheeze. Two weeks prior to the admission, he developed subjective fever without chills. This was followed by worsening malaise, and frequent paroxysms of coughing. The patient gave a history of coughing up foul smelling sputum on several occasions and of having suffered hemoptysis on at least one occasion. The patient denied a history of exposure to toxic fumes, industrial dusts, or vapors. The patient gave no history of previous tuberculosis nor fungal disease of the lungs. The patient denied a history of chronic cough and dyspnea on exertion, and wheezing. He admitted to a recent weight loss. There was no history of the patient inhaling or expectorating foreigh material.

Review of systems revealed that the patient, over a period of approximately three months, had had several episodes of rapid, pounding heart beat, lasting a few seconds to a half minute. These spells were described as beginning and ending abruptly and being associated with tightness of the anterior chest. The patient also stated that with various forms of exertion, namely lifting heavy objects, running, or walking in a cold wind, he would experience tight, substernal and anterior chest pain, which did not radiate. The pain was described as being rapidly relieved by rest. There was no history of diabetes nor hypertension. The review of systems was otherwise negative.

Past History: There had been no significant illnesses, except as described in the present illness.

Family History: No family history of diabetes nor hypertension; no heart disease, excluding the father, who died of heart disease of unknown variety.

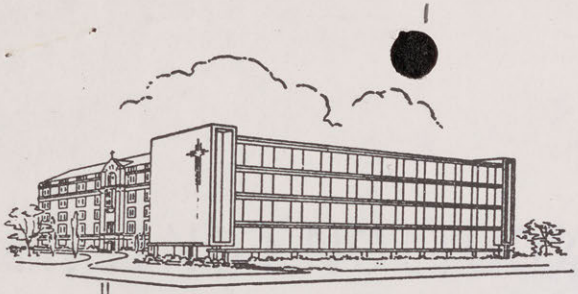
Physical examination on admission revealed this to be an acutely ill appearing, mesomorphic, well nourished, white male with pulse of 110, which was regular. The blood pressure was 130/80 and respirations were 20. The examination of the skin revealed no cyanosis nor palor. There was no evidence of recent weight change. Peripheral pulsations were not unusual, nor were the extremities There was no venous distention on examination of the neck. The trachea was in the midline, the thyroid was not enlarged. Exam of the lymphatics was negative, as was the exam of the abdomen. Examination of thechest revealed increased tactile fremitus over the right chest, posteriorly and inferiorly. There were prominent secretion noises throughout both lung fields and scattered fine and coarse wheezes. The percussion note was not altered. Examination of the heart revealed no enlargement and no abnormalities of the heart tones. There was no murmur and no unusual precordial activity.

Work up, after admission to the hospital, revealed the following findings: On the routine chest x-ray, there was increased density about the right perihilar area and infrahilar area. There were mottled densities noted in the right, fifth interspace anteriorly. Lateral view revealed increased markings in the posterior basal aspect of the lung field. Tomograms revealed a 4 cm. reticulated lesion in the right lower chest, also the lymphatic channels running to the right hilum were felt to be thickened. Numerous calcific nodules were noted in the right infrahilar area and several nodules were noted in the parabronchial location in the right lower lobe. Peripherally, there were several small radiolucencies. The bronchogram revealed poor filling of the bronchus to the medial segment of the right lower lobe, with constriction of the bronchus at its origin. Lateral and posterior basal segments were felt to reveal bronchiectasis. The patient was bronchoscoped, a lesion was noted near the origin of the right lower lobe bronchus. This was biopsied. All major bronchi were patent and no other abnormalities were noted. Bronchial washings were obtained, which did not grow out acid fast bacilli nor fungi on 6 weeks culture. Routine culture grew out alpha strep and coagulase negative staph albus.

Electrocardiogram, made on the 29th. of November, was normal and then, on the 1st. of December, revealed Digitalis effect. A cardiogram made later that day revealed a paroxysmal atrial tachycardia at a rate of 150. Routine CBC revealed a hemoglobin of 13.5, Hematocrit of 41, and White count of 22,300. There were 80 segs, 16 lymphs, 3 monos, and 1 eosinophil. The SGO Transaminase was 38, BUN 20, fasting blood sugar 178, serum sodium 126, Potassium 3.7, and CO2 was 28. Sputum culture grew out pseudomonas. Blood cultures were negative. Scalene node biopsy was negative.

This patient's hospital course was marked by recurrent temperature spikes until shortly before death. He developed 2 episodes of atrial tachycardia, shortly after admission, which responded to digitalization. A subsequent episode responded to carotid sinus massage. Then, the patient developed a persistent atrial tachycardia, some 36 hours prior to his demise. This did not respond to further doses of Digitalis, Prostigmin, Quinidine, Pronestyl nor to carotid massage. He likewise did not respond to acute elevation of the blood pressure with Vasoxyl. The patient became progressively dyspneic. A tracheostomy was done on the 5th. of December, as was a scalene node biopsy. The patient was treated with Keflin, Chloromycetin, Lanoxin, Solu-Cortef, Quinidine, Pronestyl, Prostigmin, aqueous Penicillin drip, Aminophylin, Potassium iodide drops, and positive pressure breathing. Following the first two episodes of tachycardia, the patient became reasonably comfortable. However, after that he became progressively more dyspneic and apprehensive and the last 24 hours of his life were marked by persistent tachycardia and characterized by worsening dyspnea. Several hours prior to death, the patient became extremely orthopneic and developed profound tachypnea. The vital signs remained reasonably good throughout the hospital course until the day of death, when there was a fall of blood pressure and an increase in respiratory rate. The atrial tachycardia persisted at rates varying between 140 and 160. The patient expired suddenly. An autopsy was done.

Case discussion: .....I. Dravin, M. D.



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St. Anthony's Hospital

Conducted by Sisters of Charity of the Incarnate Word

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Amarillo, Texas

Dear Doctor,

Enclosed is a copy of the Protocol of a Clinicopathological Conference to be discussed by Dr. I. Dravin. This will be the program for the March 27, 1967 meeting of the combined Sections of Medicine and Surgery of St. Anthony's Hospital.

You are urged to attend and hear this interesting program.

Section of Medicine