TRUDEAU SANATORIUM

DR. JOHN MICHAEL NICKLAS San. No.: 10,219

Summary of examinations

History given on admission: Dr. Nicklas stated that his illness had begun with what appeared to be influenza. He had pleurisy, pain in chest, cough, expectoration, languor, loss of appetite, weight and strength, fever, nightsweats, chills and hoarseness. For a time his progress had been satisfactory but his temperature again became elevated and his condition was diagnosed as atypical pneumonia, left lung. This was followed by an involvement of the right lower and pleurisy with effusion on the right. He developed phlebitis first left leg and later the right leg. He improved slowly. Bacteriological and virus study completely negative on examination of sputum and pleural fluid. He had frequent transfusions and numerous blood studies. February 3, 1939 he returned home and a month later went to Florida for one month. His cough increased and his sinuses were thought to be a factor. Later the cough became spasmodic. He did not make satisfactory progress and returned home April 7, 1939. Cough and expectoration were small in amount but weight gain and general condition were only fair. He had a chill the night before arriving home and on the day of his return had a cough with temperature elevation. Sputum examined and following X-ray study was admitted to the Tuberculosis Division at Grasslands Hospital. Direct smear, concentrated smear, culture and animal inoculation disclosed tubercle bacilli. Bronchoscopy showed ulceration of the trachea and right main bronchus, posterior wall just below the level of the carina, April 13, 1939. Three subsequent bronchoscopies revealed a progression of the endobronchial disease. Bronchoscopies were discontinued in June 1939 because at that time there was thickening of the left laryngeal cords with heaping granulations on the anterior two-thirds. Thickening and induration of the trachea wall with several small ulcerations not seen on previous bronchoscopies, and marked increase in piling up of granulations in the right bronchus almost occluding the lumen. No change was noted on the left. Rectal abscess developed in the fall of 1939 and was incised and drained October 23, 1939.

Admitted to Trudeau Sanatorium November 18, 1939
Classification on Admission: Far advanced pulmonary tuberculosis
Tuberculous Laryngitis
Tracheobronchial tuberculosis
Perirectal abscess

Physical examination of chest on admission:
Right Lung: Note impaired below 6 v.s. and in axilla. Breathing markedly diminished below 4 r. and 6 v.s. and vocal resonance diminished over the same area. Few moderately coarse rales from 6 to 8 v.s. Many rhonchi and coarse rales below 4 r. and 6 v.s. A loud high pitched wheeze is heard on both inspiration and expiration over right chest and is loudest to the right of the sternum over the 3rd and 4th costal cartilages.
Left Lung: Note, breathing and vocal resonance normal. No rales.

X-ray examination of chest on admission:
Right Lung: Infiltration more or less throughout, more marked at the base. Cavity 5 cm. in this region. Thickening of the pleura throughout.
Left Lung: Infiltration in the middle third.

Radiographic and fluoroscopic examination of the intestinal tract, November 21, 1939, failed to reveal any important features. Radiographic and fluoroscopic examination of gastro-intestinal tract, November 7, 1941, showed definite altered physiology of the small bowel, in that the loops of the ileum and jejunum were visualized for a longer period of time than usual. Radiographic and fluoroscopic examination following administration of barium enema, April 3, 1942, showed the enema had flowed freely and had filled the colon throughout. The unusual haustration in the distal colon suggested the possibility of a nontuberculous colitis.

Illnesses: On admission patient complained of productive cough, copious expectoration, slight pleurisy, some soreness of throat, hoarseness and occasional fever. During the first year of residence his temperature most of the time reached a daily maximum of about 100°F., with occasional elevations of more than this. Subsequent to the first year of residence his temperature remained in the neighborhood of 99° as a daily maximum. His chief complaints have been belching and fulness after meals, gas, distention of the abdomen, pain in the epigastrium, vomiting, abdominal discomfort, indigestion, eructations, distention over R.U.Q. and subscapular pain.

Laboratory Examinations:

| | Admission | Residence | Discharge |
|---|---|---|---|
| Sputum (concentrated smear) | Positive, Gaffky viii | Gaffky x to viii first year; mostly Gaffky ii or i since; occasional negative | Gaffky |
| Urine (routine) | Negative | Negative | Negative |
| Blood sedimentation, Cutler | 22 mm. | 29 to 21 mm. 1st yr. 17.5 to 4mm. 2nd yr. 14.5 to 5.5mm. 3rd yr. | 6mm. |
| Kahn | Negative | | |
| Weight | 166 lbs. | Maximum 195 January 1942 | |

Special examinations: Periodic X-ray examinations of the chest showed almost consistent slight improvement in the lesion on the right and an almost stationary lesion on the left. The cavity on the right alternately became slightly larger and smaller but it has not been definitely outlined for the last two years.
Radiographic examination of the gall bladder following oral ingestion of dye, was made March 31, 1942. Films 16 hours after ingestion failed to reveal the shadow of the gall bladder. There was revealed in the gall bladder region a number of irregular densities which did not have the characteristic pattern of gall stones. At 18 hours, two hours after the usual fatty diet, there was still no shadow of the gall bladder, However, the previously mentioned densities were still present.

Examination of the feces, April 19, 1941: Benzidine test negative for occul blood. Re-examination January 5, 1943, revealed no parasites. Brine flotation method was negative for ova. Benzidine test was negative for occult blood and the specimen was negative for typhoid bacilli and dysentery. Gastric analysis January 28, 1941 showed anacidity. Repeated January 23, 1942. The first three specimens were positive for occult blood and the last three negative. Gram stain showed a moderate number of secondaries with gram positive cocci predominating. Occasional yeast cell and gram positive rods present. No free acid.
In June 1941 complained of frequency, urgency on urination. Mandelic acid given and during course of treatment all urine tested. Culture of urine in June 1941 showed a pure culture of B. coli. Several specimens were negative for secondaries on culture until October 1, 1941 when a few colonies of B. coli were found. Several cultures thereafter, including May 12, 1942 were negative for secondary organism. July 9, 1941, catheterized specimen negative for albumin, sugar and casts; showed 4 W.B.C. per h.p.f.
Examinations of sputum November 30, 1939 showed staph. albus predominating. Few S. viridans and gram negative cocci. Negative for spirochetes, fusiform bacilli and encapsulated organisms. Anaerobic culture showed a slight growth of staph. albus. Specimen December 18, 1939 showed a few secondary organism, staphlococci predominating; few S. viridans and gram neg. cocci; negative for spirochetes. Facultative anaerobes present. Culture for vaccine, March 18, 1940, showed a moderate number of secondary organisms: S. Viridans and staph. aureus predominating. Specimen of August 8, 1940 negative for Curschman's spirals; eosinophils not seen; very few intact cells in specimen. Specimen January 5, 1943 showed some gram positive bacilli with bi-polar staining. Virulence test (diphtheria) in guinea pig negative after 5 days. Negative for pneumococci, streptococci and spirochetes.
Blood counts: Nov. 27, 1939: R.B.C.5,080,000 Hb. 95%; C.I. 0.93; W.B.C. 9,300; polys 69%, Lym. 18%, Mono. 10%; Eos. 1.25%; Bas.05%; fil cells 70%, nonfil cells 30% Immature cells 1.25%
August 10, 1940: R.B.C.4,840,000 Hb. 98%; C.I. 1.01: W.B.C.7,700; Polys. 66.5% Lum. 24% Mono. 6%; Eos. 3.5%; fil, cells 88%, no fil 12%
Dec. 3, 1941: R.B.C.5,620,000 Hb. 115%-16.67 gms; C.I. 1.02; W.B.C 8,000 Polys. 60%; Lum. 30%; Mono. 9%; eos. 1%. fil. cells 90%, non fil 10%
October 31, 1942: R.B.C.4,960,000 Hb. 100%-14.5 gms. C.I. 1.0; W.B.C. 7,000 Polys. 62%; Lum.30%; Mono. 7%; Eos. 1%fil 90%, non fil. 10%
Jan. 21, 1943: R.B.C. 5,210,000 Hb. 106%, C.I. 1.01; W.B.C.6,400 Polys. 59%; Lum. 34%; Mono.6%; eos. 1%. fil. cells 92%, non. fil. cells 8%
Feb. 1, 1943: R.B.C.5,450,000 Hb. 108%;-15.66 gms. C.I. 0.99; W.B.C. 7,600; Polys. 59%; Lym. 34.5%; Mono. 6%; Eos.0.5%. fil cells. 92% non fil. cells 8%
Feb. 11, 1943: R.B.C. 5,590,000 Hb. 112%-16.24 gms; C.I. 1,0; W.B.C. 7,00 Polys. 52%; Lym. 41%; Mono. 5%; Eos. 2%; fil. cells 92%, no fil cells 8%

Patient was seen by Dr. W. W. Woodruff of Saranac Lake because of draining sinus following incision and drainage of perirectal abscess prior to admission. Examination revealed a 3 mm. incision just tothe right of the midline about 1½" anterior to anus. Very little surrounding infiltration. No rectal tenderness present (November 21, 1939.)
He was again seen by Dr. Woodruff April 20, 1942 because of abdominal discomfort. From a review of the patient's symptoms, Dr. Woodruff felt that a thronic cholecystitis, with or without stones, would explain a

large number of the chronic symptoms, which included belching and fulness after meals, expelling large quantities of gas, distention of the abdomen, pain in the epigastrium, vomiting, persistent formation of gas with fulness, abdominal discomfort, indigestion, eructations, distention over R.U.Q. and subscapular pain.

Patient was seen by Dr. George Wilson November 27, 1939 and periodically until March 1942. At first examination epiglottis and arytenoids appeared normal. There was some erosion deep and far down in the posterior commissure. Both vocal cords markedly thickened, infiltrated, red, soft, uneven, but not definitely ulcerated. A lesion in the right ventricle, rough, slight erosion, active. Subsequent examinations showed consistent improvement. Dr. Wilson advised against bronchoscopy. March 4, 1940, he thought he could see some roughness of the trachea just below the left cord. January 12, 1942 he found the larynx healed, cords pink, scar tissue in trachea just below left vocal cord. Examination of ears at that time showed no visible evidence of tuberculous otitis.

X-ray examination of teeth showed slight periapical infection upper left central incisor and slight pyorrhea.

Special treatments: Autogenous vaccine in April and early May, 1940: discontinued because patient thought it caused reactions.
Ultraviolet ray and cold quartz local application in treatment of tuberculous laryngitis.
Sulfadiazine from January 28, 1943 to February 13, 1943 because of intestinal symptoms.
Mandelic acid (noted above)

Discharged: February 26, 1943 Classification Disch. -Active-improved

Physical examination of chest at discharge:
Right lung: Note impaired to dull. Breathing and vocal resonance decreased throughout to 8 v.s., absent below 8 v.s. No rales.
Left Lung: Note good. Breathing and vocal resonance normal. No rales.

X-ray examination of chest at discharge, compared with admission films, show
Right Lung: More organization more or less throughout. Cavity cannot be made out.
Left Lung: A little more organization in the middle third.

Plans: Continue treatment elsewhere.

(signed) Fred H. Heise
Medical Director

FHH/RSW