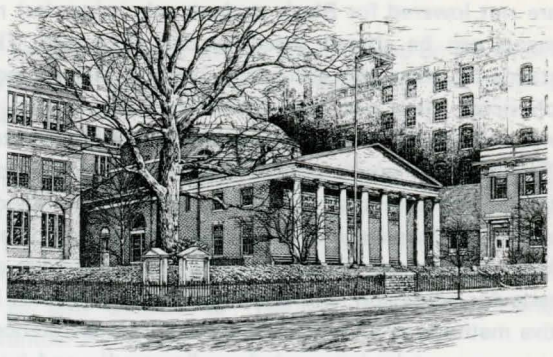
no. 2-3, oct. nov. '76

AESCLEPIAN

School of Medicine
University of Maryland



THIS IS THE WAY IT WAS . . . . .

All too often there seems to be a tendency to become so involved with present circumstances that it is difficult to remember our heritage from past graduates of the University of Maryland School of Medicine. We are lucky enough to have a good many years' worth of experiences, which not only are of interest to history buffs, but which comprise a legacy of which we may be proud.

Dr. Theodore Woodward has been kind enough to provide the Aesclepian *with a few historical vignettes which we would like to share, one of which concerns a graduate from the turn of the century.*

Dr. Samuel T. Darling led his class in scholastic honors here at the University of Maryland. After graduation in 1903, he received further training at hospitals in Baltimore, then joined the Public Health Service and went as a pathologist to Panama, where they were digging "that big hole." In 1905, just two years after graduation, he demonstrated in liver and spleen *histo*cytes and *plasma* cells of workers who had died of "tuberculosis", small bodies which had a dense central core and a halo. He was prompted to label his bodies as protozoans by a suggestion that they resembled those described by Leishman and Donovan to be associated with a disease resembling leprosy. Dr. Darling called his protozoans *Histoplasma capsulatum*, thinking the "halo" was a capsule. It was not until twenty years later that "Darling's disease" was shown to be of fungal etiology. Another name for Darling's disease? None other than histoplasmosis.

SPRING 1977
CASE-STUDY PROGRAM IN PHYSIOLOGY

Drs. Karpeles and Blake anticipate offering elective programs in Physiology during the Spring Semester. Dr. Karpeles will orient his toward the "case-study" approach, as in previous years, whereas Dr. Blake will emphasize an "in-depth" approach to physiology. No decision has been made about opting out of the final exam by writing a paper as in the past. Students interested in one of these programs should contact Dr. Karpeles or Dr. Blake prior to December 15th. No students will be permitted to sign-up after that date.

STUDENT AFFAIRS MOVES INTO NEW HOWARD HALL

The Office of Student Affairs has moved from room 547 of the old part of Howard Hall to room M-004 in the New Howard Hall. "M" stands for mezzanine and the new office is located above the information desk in the main lobby. Only the walls have changed – you will still find the same smiling faces eager to help you solve any and every problem. The *Aesclepian* mailbox will also be there waiting to receive all of your announcements, letters, and literary creations.

A PIECE OF MY MIND

The University of Maryland chapter of the Student National Medical Association, Inc., (SNMA), is concerned with the recent article by Mary Knudson entitled, "Do Blacks get into medical school easier than whites?" The article did a disservice to Black students in medical school by implying that they are unable to meet the challenges and demands of their training and that they will not measure up to their white counterparts because special advantages are extended to them that make their stay in school effortless. Federal legislation instituting a quota-type system ensures that such previous social injustices as excluding Blacks from medical professions, will not be continued. Today, more qualified Black students are applying to our country's medical schools, yet the percentage of their representation has decreased over the last five years. Black students who have studied at prestigious institutions and maintained good academic standing are applying to the University of Maryland in larger numbers each year. The absence of adequate Black representation is not an indication of their lack of preparation to be in medical school.

The contention that medical school admission standards have been lowered to allow Black student matriculation is blatantly misrepresented. The article states, "Nowhere is competition more vicious than in pre-med schools where students . . . fight for every point . . . some resort to sabotaging other's lab experiments and cheating . . . to get a hair's breadth ahead of the next." Therefore, at least in some instances, these "standards" represent artificial indicators of achievement. The medical school's Assistant Dean of Student Affairs at the University of Maryland, Dr. Robert L. Harrell, Jr., comments "that standards indeed

CONTINUED - page 2

are not lowered for Black students admission; but requirements can be altered based on data presented. The best standards, than can accurately predict performance as a physician, have not been determined. For a long time it was easier to admit the purely academically superior students. Therefore, for one to say that standards have been lowered, falsely indicates that there is a certain high standard to which everyone else is measured against and compared with. More schools are discontent with present policies and criteria for admission, and are investigating different, innovative methods as a basis for selection. This difference, however, can not be interpreted as 'lowered'; and hopefully success with Black students will serve as a learning experience and model as to what qualities lend to excellent performance as physicians." Dr. Murray M. Kappelman, Director of Medical Education, stated, "the vast majority of Black students admitted to Maryland need not have been in a special category, and would have been accepted under any criteria. This particularly applies to the members of the Class of 1979."

In response to Mary Knudson's question, "Do Blacks get into medical school easier than whites?", I categorically answer *No!* As Knudson stated in her article, ". . . the number of Blacks entering medical school dipped . . .", which indicates that it is becoming more difficult for their admissions. Black student matriculation unfortunately depends on whatever the "current trend" is for admission committees. During previous years when it was not the "trend" to admit Black students, numbers of brilliant Black men and women, with a vision and a daring spirit, ventured to apply to medical school; and consequently successfully completed their medical training. Practically all of these physicians are board certified in area(s) of specialty; and there is no way for preferential treatment on any basis when taking these examinations. Once an individual successfully completes medical training, he/she has satisfied the requirements of objective and subjective evaluations necessary to earn the degree of M.D. This newly graduated physician is equipped and capable of practicing medicine with the competence required of all physicians.

Dorothea A. Stern
President
University of Maryland SNMA

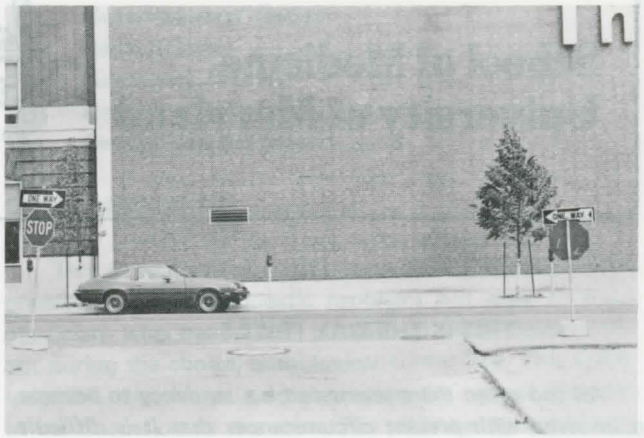
IN MEMORIAM

WILLIAM P. CUNNINGHAM
PROFESSOR OF LAW

AN ADMINISTRATOR AND TEACHER
WHOSE PRESENCE WILL SURELY BE MISSED
ON THE
UNIVERSITY OF MARYLAND AT BALTIMORE
CAMPUS

THE SOUND OF BUREAUCRACY

Leonard Frank



TO: All Personnel
FROM: Office
SUBJECT: Emergencies

Some time ago, we installed a number of RED telephones at strategic locations. It should have been obvious that these RED telephones were meant for EMERGENCY use only. But they have been used for frivolous purposes. For example, last week a RED telephone was used to report an overflowing toilet. Apparently, our personnel has little conception of what constitutes an EMERGENCY. The purpose of this communication is to explain how one should think about an EMERGENCY.

Definition of an EMERGENCY: An EMERGENCY is a happening which is BOTH surprising AND distressing. A happening which is EITHER surprising OR distressing is not an EMERGENCY.

For example: If you notice that the water level continues to rise in a just-flushed bowl, the happening may be surprising but it is certainly not distressing. After all, a rising water level can do no damage.

Now, if the water level rises to the brim of the bowl and water begins to spill out, that is certainly distressing. But, obviously, it is not surprising since the water level was already known to be rising.

Thus, the overall happening described above does not constitute an EMERGENCY and it should not lead to the use of a RED telephone.

We realize that not everyone can be as familiar with these concepts as we. If you are not clear, during the happening, whether you are in the presence of an EMERGENCY, feel free to call us. But please use the ordinary black telephones. These are just as effective as the RED telephones since both types of phone use exactly the same wiring system.

Thank you for your cooperation.

GRADUATE FELLOWSHIPS FOR BLACK AMERICANS 1977-78

With the support of the Ford Foundation, the National Fellowships Fund is offering a limited number of graduate fellowships to Black Americans who intend to pursue a career in higher education. These fellowships are offered as part of a broader Ford Foundation program of assistance to historically disadvantaged minorities—such as Black Americans—whose opportunities for participation in higher education have been limited as a result of racial discrimination and/or other factors.

To be considered for one of these fellowships, applicants must meet all of the following qualifications:

1. They must be citizens of the United States.
2. They must be enrolled in or planning to enter an accredited U.S. graduate school offering the doctoral degree in their field of study.
3. They must be currently engaged in or planning to enter a career of higher education.
4. Have completed the equivalent of one academic year of full-time graduate study.

Eligibility is limited to (a) applicants who plan to pursue full-time study toward the doctoral degree in the Arts or Sciences or (b) applicants who hold a first post-baccalaureate professional degree—such as the M.D., J.D., or the masters in architecture, business administration, education, engineering, library science, public administration, public health, or urban affairs and planning—and plan to continue on to the doctoral degree in preparation for a career in higher education.

These awards are for one year only, but they are renewable upon reapplication if the fellow maintains satisfactory progress toward the doctorate. The fellow will be expected to study full time and to complete the requirements for the doctorate as soon as possible.

Fellowship awards for 1977-78 will include the full tuition and fees by the graduate school, an allowance of $300 for books and supplies, and a monthly stipend of $300 to help meet living costs. A married fellow may apply for an additional stipend of $50 a month for his or her spouse and each dependent child, provided that dependency can be substantiated. Applicants receiving Special Dissertation-Year awards may apply for a research allowance in lieu of the book allowance.

Twelve-month awards are available for applicants planning to study full time during the summer session of 1977 and the academic year 1977-78, starting with July, 1977. Ten-month awards are available for those planning to study full time during the academic year 1977-78, starting with September, 1977.

All applicants are required to submit scores on the Graduate Record Examination Aptitude Test and one Advanced Test. These tests will be administered on December 11, 1976, and the deadline for registering for them is November 10, 1976.

Arrangements for taking the tests should be made by the applicant directly with the Graduate Record Examinations, Educational Testing Service, Box 955, Princeton, New Jersey 08540. Applicants should request that their scores be sent directly to "National Fellowships Fund, Code Number R5487-4."

The deadline for submitting completed applications and all supporting documents is January 5, 1977.

Applicants will be notified of award decisions on March 25, 1977.

Application forms must be requested by the indiviual applicants. No applications will be sent to intermediaries. For application forms and additional information write to:

Graduate Fellowships for Black Americans
National Fellowships Fund
Suite 484
795 Peachtree Street, N.E.
Atlanta, Georgia 30308

CLINICAL QUIZ ANSWERS

1. Pelvic surgery without excessive bleeding 40 years previously; 2. a-e; 3. none; 4. 400-500 grams; 5. a, b, d, e, f; 6. Prothrombin consumption; 7. She has been exposed to tuberculosis; 8. a-d; 9. a, b, d; 10. a-c; 11. a-e; 12. Intracerebral and subarachnoid hemorrhage; 13. a-e; 14. c.

AUTOPSY REPORT

This case presents an unusual diagnosis, but one that should always be kept in mind when a patient has pancytopenia. It is a common disease, but not commonly associated with pancytopenia. The lungs, kidneys, bone-marrow, liver, pancreas, and almost every other organ in the body contained rounded red areas with no real encapsulation that proved to be tuberculosis with very few epithelioid cells. In some areas there was a beginning reaction around the tubercle with definite giant cells, indicating that the miliary spread was not very recent. This type of miliary tuberculosis is exceedingly active and myriads of tubercle bacilli were present. The lung also had a small encapsulated cavity that was obviously an old lesion. In the wall of a nearby bronchus the tubercles suggested that the terminal event might have been due to bronchogenic spread as well as a bloodstream infection. Attached to the lymph node there was a vessel containing a mural thrombus that was loaded with organisms.

The anatomical diagnoses were miliary tuberculosis, generalized, with pancytopenia, and muscular atrophy, severe, probably secondary to steroid therapy.

STUDENT COUNCIL MEETING MINUTES

The Aesclepian, *as the official publication of the Student Council of the University of Maryland School of Medicine, plans to begin printing the minutes of the Student Council Meetings. These minutes are being published to keep the student body informed about the discussions and activities of its governing council. The minutes will be printed in toto as they are submitted to the newspaper by the Student Council Secretary. The* Aesclepian *hopes that by keeping the students aware of the Council's business at hand everyone will feel more a part of the governing process. All UMAB students are invited to attend the Student Council Meetings and can participate in the discussions.*

STUDENT COUNCIL MEETING – SEPTEMBER 14, 1976

Members present –

Russell Wright. . . . . .AMSA President
David Otts . . . . . Freshman Class Rep. (MSI)
Michael Pratt . . . . . Freshman Class President (MSI)
Sally Lewis. . . . . Med. Tech. President. Jan/76
Jim Davis. . . . . Senior P.T.
Amy Davis. . . . . Senior P.T.
Bob Rovner . . . . . M.S. II
Alan Gaby . . . . . M.S. II President
Garry Ruben . . . . . .M.S. IV President
Frank George . . . . . M.S. IV Yearbook
Alan Davis . . . . . M.S. IV
Calvin Chatlis . . . . . .Vice-President Student Council
Blase Harris . . . . . President Student Council
Bill Dunlop . . . . . Treasurer

The items on the budget were discussed in light of last year's expenditure. Each group present submitted an indication of their budget request for this year 76/77.

ITEM	75/76	REQUEST 76/77	TOTAL REQUEST
CLASS ALLOTMENTS			
M.S. I	$ 400	$ 200	$ 600
M.S. II	400	200	600
M.S. III	400	200	600
M.S. IV	400	200	600
P.T. Sr.	270	. . . . .	270
P.T. Jr.	270	. . . . .	270
M.T. Jan/76	65	10	75
M.T. June/76	130	20	150
M.T. Entering 1/77	65	65	75
BANQUETS			
Med.	4,500	500	5,000
P.T.	475	75	550
M.T.	475	40	515
Yearbook	5,500	2,000	7,500
Aesclepian	1,895	105	2,000
Council Exp.	408	242	650
AMSA	600	100	700
SNMA	150	650	800
Sports	50	450	500
Travel and Conventions	1,325	675	2,000
TOTALS	$ 17,678	$ 5,677	$ 23,455

It is believed that approximately $21,000 will be available for the total budget. Medical School and M.T. student fees were increased. P.T. student fees remained the same.

Discussion centered around ideas to make the yearbook self-sufficient in 2-4 years by soliciting advertisements. It was generally agreed to make this a goal for the future. It was also decided that a secretary should be hired to take care of the minutes and correspondence. Payment would be $250/year. Representatives were asked to annouce this to their respective classes to find someone interested in the jobs.

Information necessary to obtain for the next meeting.

1. Find out amount of money in Med. School Banquet fund left over from last year's class and see if it can be used this year
2. Check on contents of SNMA charter and their proposed project for 76/77.

STUDENT COUNCIL MEETING – SEPTEMBER 21, 1976

Members present –

Blase Harris . . . . . .President of the Student Council
Russ Wright . . . . . President, AMSA
Jerry Hunt . . . . . .Vice-President, SNMA
Dorothea Stern . . . . . President, SNMA
Michael E. Hull . . . . . Treasurer, SNMA
Allan S. Davis . . . . . MS IV
Jan S. Elliot . . . . . .MS III President
Bob Rovner . . . . . .MS II
Alan Gaby . . . . . .MS III President
Mark Bainum . . . . . MS I
Amy Davis . . . . . Senior PT
Jill Gruner . . . . . Senior PT Secretary
Jim Davis . . . . . Senior PT
Cindy Potter . . . . . Junior PT
Dave Sheer . . . . . Junior PT
Garry Ruben . . . . . .MS IV President
Calvis Chatlis . . . . . .Vice-President of Student Council
Jeanne Long . . . . . MT Jan., '76 Class
Bill Dunlop . . . . . Treasurer
Debbie Monk . . . . . Co-editor, Aesclepian
Diehl Snyder . . . . . Co-editor, Aesclepian
Frank George . . . . . Yearbook Editor

The voting members at this meeting number 10. ▪ The purpose of this meeting is to finalize the 76/77 Medical School budget and to cut off approximately $2,600 from the new requests. ▪ The AMSA request for $600 covered career day (where high school students come and tour the campus and listen to speeches from the dean). All three groups, MT, PT and the Med School are represented. $300 was budgeted for this. The rest of the money is for 2 seminars, one each semester. The first is a lecture by the AMSA Liaison Council from D.C. discussing the new budget that affects the Med School. The second is a discussion of insurance problems, both general insurance and malpractice. ▪ The Aesclepian budget remained the same at $1,895 which covered all printing costs. The purpose of this newspaper is to increase communication between all students in the Medical School and Allied Health. The Aesclepian comes out once a month. ▪ The PT request for the Junior and Senior Class remained the same as last year – $270 each. These funds are used for Open House and parties. ▪ The MT request of an increase of $10 for the January class, $20 for the June class and $10 for the entering class is used to cover expenses for the graduation party and a halloween party for the kids in the hospital. Their student activity fee is $20 per year. ▪ The budget for the Med School banquet was reduced to $4,200 (request). The cost of the banquet is $20 per person and the charge will be $15 per couple. If not all the money is used, the rest will be returned to the Council. Gary Rubin said that he will know the number of people attending the banquet by April 1. ▪ Physical Therapy requested an increase of $75 for their banquet. Their cost last year was $20 per couple. ▪ Medical Technology requested an increase of $75 for their banquet. Last year cost per couple was $35. ▪ The Yearbook request was for the bottom line price of a decent yearbook, $6,790 which was the cost of last year's yearbook. Books cost $20.58 each. This year, ads will be sold to suppliment the cost and to raise more money. ▪ The SNMA request of an increase of $650 was to cover their urban project, Upton Health Awareness, and their travel expenses to the SNMA conference in California. ▪ For the sports budget, an increase of $250 was requested to cover the cost of using a gym on Hollins Street and paying a custodian to take care of the place. ▪ There was a request of an increase of $675 to cover the cost of travel expenses to conventions and conferences. There was a proposal made to have travel expense requests submitted by November 9. At the following meeting of the Council, all of the requests will be considered and the appropriation of funds delegated. There was also a discussion of enforcing some type of feedback from those who attend conventions and meetings ▪ Next, there was a motion made that surplus funds from advertisments in the Yearbook go into a fund to cover future yearbook fees. ▪ The budget was discussed further and the final outcome was:

CLASS ALLOTMENTS	
Med School	
I	$ 900
II	900
III	900
IV	900
PT	
Junior	270
Senior	270
MT	
January	75
June	150
Enter	75

BANQUETS	
Medical School	4,100
PT	550
MT	515
NOTE TAKING SERVICE	200
AMSA	500
YEARBOOK	6,700
COUNCIL	658
SNMA	150
SPORTS	300
TRAVEL	1,000
AESCLEPIAN	1,895
TOTAL	$ 20,008

Calvin Chatlis opposed the $1,000 fund for travel. He wanted $1,500 alloted for this purpose. Three were opposed and 7 for, the motion was passed. ▪ The motion to fund AMSA $500 was also opposed by Calvin Chatlis. ▪ The meeting was adjourned.

ATTENTION ALL SENIOR STUDENTS

Spring graduation will be held on June 3, 1977. It is not too early to fill out your graduation application form. In fact, if you keep putting the task off, you may forget and may be too late. The deadline for completing the June, 1977 graduation application is February 25, 1977. There is a $15 graduation fee which can be billed to you at home. So the next time you are in Howard Hall, stop in the Registrar's Office and sign the best looking piece of paper that you've ever seen. You don't want to miss out on this line!

★ ★ ★ ★ ★

CLINICAL QUIZ

This month's *Aesclepian* Clinical Quiz is taken in part from the "Case Records of the Massachusetts General Hospital", originally published in the *New England Journal of Medicine* 268:378, 1963. In each Clinical Quiz the questions and answers are formulated by the *Aesclepian* editors. Discussion and criticism of the Quiz format or content are welcomed and should be addressed to the *Aesclepian* as directed in the title block on the last page. All corrections along with an explanation will be printed in the next issue of the *Aesclepian*. As in the first Quiz, the case information and the questions are arranged to be read and answered in sequence. You will learn the most by committing yourself to an answer for each question before going on to the next one. You should complete the entire Clinical Quiz before checking any of the answers. The Autopsy Report and the answers the editors believe to be correct are given at the bottom of page 3.

HISTORY:

A seventy-five-year-old widow entered the hospital because of epistaxis. On the night before admission, blowing the nose caused bleeding, with a loss of about half a cup of blood over a twelve-hour period. Cauterization was required to control the persistent oozing. Less severe epistaxis had occurred several times previously.

The patient had always bruised easily after minor trauma, but there had never been a major hemorrage. A hysterectomy was performed forty years before entry because of fibroids, but no excessive bleeding was reported at that time. Several days before admission there was bleeding from the gums for a few hours after scaling of her teeth, but she had not noticed an increase in the bruising tendency. There was no history of hematuria, melena, fever, malaise or anorexia, but she reported an 8-pound weight loss during the five months before entry. She had not been exposed to toxic substances or ingested medications other than aspirin. She has traveled extensively abroad. The patient had always enjoyed good health, and a physical examination five months previously was reported within normal limits.

QUESTION 1: What historical item makes the possible diagnosis of hereditary hemorrhagic diathesis appear unlikely?

QUESTION 2: An 8 pound weight loss over 5 months, assuming the patient was not dieting, could be an early manifestation of which of the following conditions?

a. Diabetes Mellitus
b. Chronic Infection
c. Neoplasm
d. Congestive Heart Failure
e. Involutional Melancholia
f. Hypothyroidism

QUESTION 3: The basically unremarkable review of systems and the history of a normal physical examination 5 months prior to the admission provides conclusive evidence to exclude which of the conditions in Question 2 as diagnostic possibilities?

PHYSICAL EXAMINATION:

T. 98° F.
P. 90
R. 20
B.P. 140/75

She was a vigorous, well nourished, slightly pale woman with multiple ecchymoses in the skin of the legs and trunk. No lymph nodes were palpable. The lungs were clear, the heart was not enlarged. A Grade 2 precordial systolic murmur was audible. The abdomen was soft; the tip of the spleen was palpable on deep inspiration, but no other organs or masses were felt. Rectal examination was negative.

QUESTION 4: How much must a spleen weigh before it becomes palpable in an average adult?

INITIAL LABORATORY STUDIES:

The urine was normal. Hemoglobin was 11.3gm/dl and the hematocrit was 34%. WBC's numbered 3000 with 60% polys, 32% lymphs, and 8% monocytes. Platelet count was 50,000/mm^3 with bizarre shapes on the smear. The reticulocyte count was 0.9%. The prothrombin content was 70%, and the prothrombin consumption 26%; the bleeding time was three minutes, and the clotting time was seven minutes. The total protein was 7 gm. per 100 ml. The electrophoretic pattern showed a slight increase in the gamma globulin. The bilirubin was 0.4 mg., the urea nitrogen 12 mg., and the serum iron 76 microgm. per 100 ml.; the alkaline phosphatase was 3.3 Bodansky units. A Coombs test and an L.E.-cell test were negative. A stool specimen gave a negative guaiac test. X-ray films of the chest were normal; films of the skull, spine and pelvis showed mild demineralization.

A sternal-bone-marrow aspirate was normocellular, and megakaryocytes were present in normal amount, but appeared immature and were not budding platelets; the differential count showed 22% erythroid forms, 1% promyelocytes, 15% myelocytes, 10% metamyelocytes and band forms, 1% neutrophils, 48% lymphocytes, 1% plasma cells, and 2% reticulum cells. A tuberculin skin test (intermediate-strength PPD) was positive.

QUESTION 5: Pancytopenia can develop in patients with?

a. Leukemia
b. Collogen Disease
c. Sickle Cell Disease
d. Evan's Syndrome (ITP and acquired hemolytic anemia)
e. Hypersplenism
f. Lymphoma

QUESTION 6: Which of the blood coagulation studies were significantly abnormal?

QUESTION 7: What significance can be applied to the positive intermediate-strength PPD tuberculin skin test in this patient?

CLINICAL COURSE

The epistaxis did not recur and no new ecchymoses appeared. Except for a temperature elevation to 100° F. on the second hospital day the patient remained afebrile. Prednisone, 80mg daily, was begun on the sixth hospital day. At the time of discharge on the ninth day, the platelet count was 150,000/mm^3.

The patient went to Europe on a vacation and continued the prednisone therapy. No further epistaxis occured, but petechial hemorrhages appeared on the trunk on several occasions. Six weeks after discharge she experienced excruciating pain in the lower legs. The pain was unrelated to exercise and was associated with marked weakness in both legs. The pain subsided, but the weakness persisted and she was readmitted to the hospital 2 months following her initial work-up.

Physical examination revealed numerous gingival petechiae and moderate atrophy of the quadriceps muscles, but was otherwise unchanged from the previous admission.

Laboratory studies showed that the urine was normal. The hemaglobin was 11gm. per 100 ml., and the hematocrit 38%. The white cell count was 2050, with 50% neutrophils, 13% band forms, 1% myelocytes, 31% lymphocytes and 5% monocytes. The platelet count was 113,000 per cubic millimeter, the reticulocyte count 2.6%, the prothrombin content 70%, and the prothrombin consumption 86%. A bone-marrow aspirate was hypercellular, with a myeloid-erythroid ratio of 1:2:1; the megakaryocytes appeared normal, and the differential count showed 4% megaloblasts, 30% erythroid forms, 7% promyelocytes, 32% myelocytes, 13% metamyelocytes and band forms, 10% neutrophils and 4% lymphocytes. The calcium was 9.6 mg., and the phosphorus 3.3mg. per 100ml.; the alkaline phosphatase was 3.7 Bodansky units. A stool specimen gave a negative guaiac test. X-ray films of the spine demonstrated osteoporosis: a barium-enema examination was negative.

The patient remained afebrile, and the prednisone was reduced to 60 mg. daily. She was discharged six days after admission.

QUESTION 8: The improvement in the bleeding diathesis between admissions with the patient on prednisone suggests?

a. A non-specific capillary effect of steroids
b. A preliminary immunopathologic mechanism was involved
c. An early induced remission of a neoplastic disease
d. A thrombocytogenic effect of steroids

QUESTION 9: The differential diagnosis for this patient's lower extremity muscle pain and atrophy included?

a. Multiple Myeloma with compression of the peripheral nerve roots
b. Steroid induced myopathy
c. Multiple sclerosis
d. Amyloidosis

FINAL HOSPITAL ADMISSION

Two months following her second hospital discharge the weakness increased, numerous ecchymoses appeared, and the patient was readmitted. The quadriceps-muscle atrophy progressed and exertional dyspnea developed. The prednisone was reduced to 40 mg. daily and testosterone, 5 mg. daily, was begun. Two weeks before entry the platelet count was 36,000 per cubic millimeter. Three days before admission she became febrile, with no associated chills or sweating. There was no recent epistaxis, melena, hematuria, hemoptysis or headache.

Physical examination revealed a sallow, tachypneic woman with numerous petechiae and ecchymoses over the trunk and extremities. Moderate tenderness in the left supraclavicular fossa was elicited on deep palpation, but no lymph nodes were felt. The lungs were clear, and the heart was unchanged. The spleen could not be felt. Moderate quadriceps-muscle atrophy was present bilaterally; the deep tendon reflexes were active and symmetrical.

The temperature was 102° F., the pulse 80, and respirations 28. The blood pressure was 130 systolic, 70 diastolic, with 10mm. of pulsus paradoxus.

The urine gave a positive test for albumin and contained rare red cells per high-powered field; a culture grew out rare proteus organisms. The hemoglobin was 13.4 gm. per 100 ml., and the white cell count 800 (only 50 cells counted), with 64% neutrophils, 24% lymphocytes, 10% band forms and 2% monocytes; the smear showed markedly reduced platelets. The platelet count was 16,000 per cubic mm. A throat culture showed a normal flora, and a stool culture was negative for enteric pathogens. An X-ray film of the chest demonstrated several streaky densities in the right middle and lower lung fields.

Increasingly high elevations of the temperature occured daily, reaching 105° F. by the sixth hospital day. The pulse rate remained between 80 and 100. New ecchymoses and petechiae appeared, and the patient became drowsy and less responsive. Blood cultures were negative. Penicillin and tetracycline were given orally. Nuchal rigidity developed, and the deep tendon reflexes became sluggish, and the mental deterioration continued. A lumbar puncture on the seventh day revealed clear cerebrospinal fluid under normal dynamics that contained 110 red cells per cubic mm; the sugar was 73 mg., the protein 53 mg. per 100 ml. The blood pressure gradually fell to 90 systolic and 50 diastolic. The patient died on the ninth hospital day.

QUESTION 10: What conditions can present with a fever of 105° F. and a pulse of 80-100 beats per minute?

a. Enteric Fever (Typhoid)
b. Lymphoma with diffuse myocardial infiltration
c. Gram-negative septicemia in a debilitated patient
d. Thyrotoxicosis

QUESTION 11: The streaky densities on the chest X-ray give evidence for which of the following diagnostic possibilities?

a. Tuberculosis
b. Viral pneumonitis
c. Bacterial pneumonia
d. Bronchogenic carcinoma
e. Sarcoidosis

QUESTION 12: With this patient's CSF findings, what is the most likely immediate cause of death?

QUESTION 13: During her final admission there was edidence of pathology in which of the following organ systems?

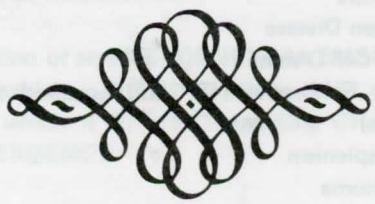
a. Musculoskeletal System
b. Renal System
c. Pulmonary System
d. Reticuloendothelial System
e. Central Nervous System

QUIZ CONCLUSION

This patient's fatal, multisystem, relatively acute illness presented serious diagnostic problems not only to those physicians who treated her, but also to the clinical discussant during the clinical-pathological conference. This knowledgeable clinician failed to mention the correct diagnosis in his discussion of the case. The all-knowing but always too late pathologist finally solved this diagnostic puzzle.

QUESTION 14: Given that the correct diagnosis is one of those listed below, which is your educated guess?

a. Diffuse collagen disease
b. Macroglobulinemia
c. Tuberculosis
d. Lymphosarcoma
e. Thrombotic Thrombocytopenic Purpura
f. Multiple Myeloma



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