Case histories of deaths

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II

CASE HISTORIES OF DEATHS.

NOTE BOOK

GNR. WILLIAMS, KENNETH REG No. 1461141 ROYAL ARTILLERY

ADMITTED: 21-6-45.

HISTORY: Has always been a difficult patient, especially as regards co-operation. During the last month has not been eating his food. States that he has no wish to live & does not care about food. Has had Beri Beri & malaria.

EXAMINATION:- Thin. - weighs 32 Kilos. Sagging shoulders, whining voice, very pinched appearance.

C.V.S - Pulse regular, poor quality. H.S. Closed.

Resp. Syst. R.S. - clear in all areas.

Abdomen. Gaseous distension. Claims to have generalised pains, but tenderness elicited only below L.C.M. No palpable masses.

Bowels - Diarrhoea yesterday - 6 times

C.N.S - Pupils = + ve L.R.A Biceps, Triceps + ve Abd. - ve: K.Js sluggish.

Slight oedema feet, legs, thighs & buttocks.

℞ Ordinary Diet. 1 multiple vitamine tab. T.I.D.

Refused evening meal. Heart 20.30 hours became comatose. Breathing stertorous. R.R. 24. P.R. 80. ℞ Strychnine Sulphate gr. 60 hypo.

DIED AT 2400 hours 21-6-1945.

DIAGNOSIS: BERI BERI.

CARDIAC FAILURE.

Pte BARRY, MARTIN Reg No. 6915422 16 Bn. RECCE CORPS.

ADMITTED :- 12-6-45.

PAST HISTORY :- Diarrhoea noticed 4 weeks ago about 6 x/24 hours. Appetite good. 2 weeks ago stools increased to 7-8 daily. On the 1st of this month noticed increase in stool 5 days ago increased to 15 per day & 10 at night - marked increase in abdominal cramp. Appetite became poor : pain after eating. No previous history of diarrhoea.

EXAMINATION :- Thin, cachectic appearance, hesitant manner. STOOL - Bile stained, small amount of mucous & pus, plus flecks of blood. Cannot urinate without passing a stool at the same time. ABDOMEN - Tender on palpation over descending colon otherwise N.A.D.

Temp. 99.6. Pulse 100. Pm. T. 101.2. P.R. 100.

Had course of Sulphathiazole from 11th - 16th with no effect on the diarrhoea.

Rx Carbarsone 0.25 Gm. B.I.D. Fluid diet. Isolation of patients.

12 stools during day.

13.6 16 stools during night. Very small amounts passed. Ate breakfast. T.P.R. 100. 110. P.M. T.P. 100 ; 100. 17 stools during day. Night Rx morphia ½ gr. 4 stools / night.

14.6 During night this morning. T 101. P 120. 10 stools / day. All very small. - Tends to strain very much complains of severe lower abdominal pains.

10 stools / day. Rx ¼ gr morphine nocte. - poor night. - 10 stools Pm. Temp. 101.6

15.6 Am. T.P 101, 100 12 stools / day. One in afternoon with blood clot & slight mucous

Rx ¼ gr. morphia at night Pm. T. & P. 101, 104.

16.6 Am. T 99.2. P 104. 7 x / night. Rx Sulphathiazine Gm. 1 T.I.D. at 1000, 1400 1800 hrs. Continue Carbarsone. 9 x / day At 1600 hours passed a blood clot (20 cc) & a 6" Round worm. STOP Carbarsone (2.15 gm total). Continue Emphathiazine Gm. 1 4 hourly at night. Pm. T. 101.6.

17-6 Passed Round Worm (10") during night. 4 stools at night. morning stools - pure blood, no faeces - average 10-15 cc each time. Appears to have bleeding point on posterior wall just inside anus. Rx Plasma 500 cc. given over 1 hour.

Am. Temp. 98.6. P 100. 30 minutes after plasma: complained of shivering - temp. 99.2 Continue Sulphadiazine 4 hourly. Pm temp. 99.8. 10 stools during day - each time a little blood - about 120 cc blood loss during day. Troubled with hiccough - when it occurs he passes blood. Anal Sphincters very lax. Little control yet.

18-6 About 10 times during night - less blood, slight amount of faecal matter + a small Round worm - morning Temp. 99.0. Vomited a little gastric juice in morning, consequent on belching - Rx 250 cc Plasma; Passed 7 Round worms during day. Vomited 2 Round worms during night. Passed about 100 cc blood during night. C/O hiccough + low abdominal pain.

19-6 Severe hiccoughing during morning - vomited 1 Round worm at 1100 hours. About 1400 hrs. pulse increased to 140 - poor quality - looked like cardiac collapse. Improved in evening. About 100-150 cc blood passed during day. 1 Round worm passed this evening during night passed about 100 cc blood.

20-6 Vomited 1 Round worm at 0700 hours. Arms plugged. Pulse increased to 130 - weak. 1000 hours pulse much weaker Rx Camphor 1 cc.
1600 hours Vomited 1 Round worm (11")

21-6 Pulse not improved - 0900 hours PR - 140. T. 100.8. 1400 hours Rx Glucose 20 cc (50%) and See Medallen. Pulse weakening.

DIED at 03.50 hours 22-6-43

DIAGNOSIS. - ULCERATIVE COLITIS

ROUND WORM INFESTATION

REG. No:

SAPPER DENNIS YOUNG. 1869230 560 FIELD COY. R.E.

ADMITTED: 1-7-45

PAST HISTORY: Has had Anorexia & Diarrhoea for about 1 month, much worse during last week. Complained of lower abdominal pains which necessitate bowel movement, to relieve pain. Was Given Tetrachlorethylene 1cc followed by Mag. Sulph on 29.6. but no worms produced. Seizure Pneumonia yesterday 30.6. not belongs able to control stool.

EXAMINATION: Very thin. Tongue dry. Motions checked. Legs weak. but walks without support. C.V.S. Pulse regular full. H.S. closed. Resp. Syst. - N.H.D. Abdomen - Slight tenderness over lower abdomen. No palpable masses. Has piles. Stool - a very little mucous & water - doesn't pass a stool every time he goes to the latrine. Appetite very poor - can eat half ration with urging. Rx Paragoric 4cc 3 hourly. White Lice. Fluids. bulk. B x during day. Evening T 100. Rx morphia 1/4 gr.

2-7 About 15x/night - passed 1 round worm b.x. looks very haggard. Pulse irregular 88. T 98.4 Continue Paregoric 3 hourly

P.M. Temp. 96.0. Pulse 100. Very weak. Bowels 4x

DIED AT. 01.30 hours. 3.7.45.

DIAGNOSIS:- BERI. BERI.
PELLAGRA.
CARDIAC FAILURE

Reg. No.

Bdr. Wilson E. Herbert. 4338901 Royal Artillery

ADMITTED 13-6-44.

HISTORY Sick last month with Beri Beri - oedema of feet. Condition improved; then developed Bronchitis. On 11-6 developed Headache & fever - put on Gummine but no effect on fever. Tried on Thiacole for 3 days but had no effect on headache or fever. Since 10/6 has become confused mentally. — makes occasional irrational statements - passes urine & stool on floor

EXAMINATION - Apathetic, lethargic type. Walks unsteadily.

CNS - Pupils = small, sluggish to L + A. No nystagmus. Slight R. internal strabismus. Bicep ++. Tricep ++. Abdominal + ve. (but aged 41).
K Js +++. Plantar reflex - - has fanning of toes, but no definite Babinski response. No ankle clonus. No intention tremor. Past pointing with both hands.
C/o headache - persistant, located behind root of nose. ENT. Nose: deflected septum to R posteriorly. Tongue - small fissure anteriorly, coated.
Resp. Syst. - N.A.D. CVS. - N.A.D.
Abdomen - Tender below L.C.M. Spleen not palpable. No palpable masses.
Stool - normal, but tends to pass stool elsewhere than on commode.
Rx 10 mgm B_1. 2 mV 50 mgm. nicotinic Acid B.D.

14-6 Collapsed in afternoon. Was sitting on edge of bed when noticed to be holding head back & breathing badly. He swayed & was allowed to sink to the floor. CE - Reflexes normal on both sides of body. Light internal strabismus more marked. Speech slow, not slurred. After about 5 minutes I was answering fairly well. Put to bed, tended to lie with eyes shut. Half of evening meal fed to him. Evening temp. not elevated.

15-6 Cleaner this morning - answers questions better. No change in CNS findings. Ate all breakfast himself. Morning temp. - normal. P.M.T - normal. More responsive today

16.6 Morning temp. normal - mental reaction slow. Evening temp. 100.4. P. 80. Very lethargic during day - improved in evening

17.6 Am. T 99.0. P. 84. Almost stuporose. Cannot control bowels or bladder. Pm. T. 102.2. No change in condition

18.6 No change. Am. T 99.0

19.6 More alert but deteriorated during day. Pm. T 100.4

20.6 Improved again this morning

21.6 More confused this morning

22.6 No change

23.6 More confused. Temp. normal. Pm. T 97.0.

24.6 Morning temp. 99.8

25.6 No change. Am. T 96.2

26.6 Am. T 98.2 P. 80. Oedema of Right foot & leg slight, may be due to tendency to fall over to the right when sitting up. Very slight oedema of left foot. Appetite good. Still incontinent. No improvement in mental condition CVS Hrm. reflexes increased. K.J. -ve Ankle clonus +ve. especially Right

27.6 Morning temp. 98.2 No change in mental condition

28.6 " " 99.2 More drowsy. Developed fine tremor - especially of head & neck about midday. Gone off by evening meal time

29.6 Am. T 98.4. Spoke a little better then lapsed into usual apathetic stuporose state. All reflexes very brisk, only pupils very sluggish to light. No nystagmus or tremor observed. Neck slightly stiff. L.H.T. Buttocks! Pm. T 101.4

30.6 Am. T 100.2 Very drowsy. All reflexes increased Slight roughening of B.S. at bases. Pm. T 102.0.

1.7 Am. T 98.4. P 84. R 20. Still drowsy but can be roused. Does not answer when spoken to. Appetite failing off. Pm. T. 102.0.

2·7 Am. T 100·8. P 120. R 28. B.S. diminished Right base. P.N. same area slightly dull. otherwise no marked changes. P.M. T 102.2.

3·7 Am T 101·8. P 120. R 40. Breathing embarrassed. Signs of Broncho-Pneumonia both lungs. Pm. T 104·2

4·7 Fluid in Left lower lung. Increase in signs of Broncho Pneumonia. Appetite diminishing Am. T 104·2. Pm. T 103·6. P. 120. R 44.

5·7 Condition deteriorating. Developing venous stasis at all pressure points. Pulse 120 at 1600 hours, becoming weaker.

DIED AT 19·30 hours. 5·7·45.

DIAGNOSIS:- ? CEREBRAL TUMOUR (Frontal Lobes).

? GUMMA.

BERI BERI & OEDEMA.

TERMINAL HYPOSTATIC BRONCHO-PNEUMONIA.

Sig. McGeough, David: 2329611 Royal Corps of Signals

Admitted: 26-5-45.

Past History: Malaria 13 times. Bacillary dysentery. Wet & Dry Beri Beri. Suppurative Otitis Media; Recurrent Enteritis.

Examination: From 3-1-45, swelling of feet, tightness in knees, frontal & occipital headaches on going to bed. Anorexia. Weakness on getting out of bed. Recurrent Mild Enteritis. Failing memory. Loss of attention when reading, & blurring of vision. Slowly improved under treatment but has continued with mild enteritis & weakness in legs.

Since 6-5-45, worse again; pain left ear & neck, burning & aching legs, increasing weakness; cold perspiration. Last night T 101.6 for first time with Enteritis 4-5 x during night. Has been on 2 MV, 10 mgm B₁ for past 2 days, 9.75 mgm B₁ since 16-5-45.

PMT 100.0°F – Lies in bed weeping because of pain soiling self during night to go to commode.

Skin – pale dry

EENT Pupils = react to L & A. EOM normal. Conjunctiva pale. Tongue Cervical adenitis. No stiff neck.

C.R. – Lungs c & r. Heart not enlarged – Sounds moderate – R-76.

Abd – Soft, thin, Slight tympanites. No masses. No CA tenderness

Extremities – thin

CNS DTR + + =. Calf tenderness. Lasègue + ve. Babinski – ve. Gait weak unable to squat without support.

Dx 1) Beri Beri, polyneuritic; 2) Acute Respiratory Infection.
3) Recurrent Enteritis, mild.

Rx Ordinary diet + any specials. 2 MV. 10 mgm B₁; Codein Sulphate gr ss T.i.D.
Argyrol nose drops.

27.5 Nightmare last night, had codein twice to relieve pain in head & neck. No further Enteritis.
℞ MV tid. 10 mgm B₁ tid.

26.5 Vomited for first time after supper producing 1 round worm (10-12 cm). Appetite fair, but forces food down. Low grade fever T 100.0°

31.5 Gradual improvement, except for persistent headache & weakness.

2.6 Continued weakness, low grade fever T 100.0 – 100.6 yesterday. Am. T 99.7 today. Constipated since enema 5 days ago. Heart & lungs negative. Generalized abdominal tenderness, more marked L.V.Q. Spleen normal. ℞ Quinine Sulphate; Enema.

3.6 Am T 99.6. Pm. T 101.0. Double vision, blurring (similar complaint previously to Quinine)

4.6 Am T 99.7 headache, diplopia but converges on object prefers to lie with eyes closed, to weak to walk very far without support. Fairly alert & responsive. Stiffness of neck. this morning; diffusely tender, spastic abdomen, abdominal reflexes apparently absent, cremasterics present. D.T.R. 4+ = Babinski –ve; Cranial reflexes –ve. well normal EOM. Pm. T. 101.0.

5.6 Am. T 98.2. diplopia, mild headache, no stiff neck. Abdominal distension with apparent enlarged & tender bladder, weakness. Now on B₁ 25 mgm s/c. pd. P.M. T 99.8. Has not voided today..
℞ Force fluids.

7.6 Am. T 98.6. Diplopia & headache, right lateral nystagmoid movements. pain & stiffness neck beyond 50°. spastic abdomen. suprapubic tenderness. Bladder 4 cm above pubis. Voided in bed to weak & inattentive to call orderly?.
Differential ℞ Meningiomas; Encephalitis; Meningitis; Polioencephalitis; Cystitis secondary to cord bladder
℞ Stop Q. Sulph. Sulphathiazol 0.5 Gm. q 4°. Pm T 98.6

8.6 Am. T. 98.2. Voided in bed without noticing it. Diplopia & right sided nystagmus, spasticity abdomen continue. No neck stiffness. bladder n.m.c. Anorexia, but forces food. CT + Sod. Bic TID dribbles. Bladder dullness 4 cm above pubis. Catheterised with the release of 335 cc urine.
Later neurological exam. disclosed above signs, probable cord bladder, right pupil oval & 1 mm smaller than right, absent abdominal + cremasteric reflexes. No intention tremor, clonus, hyperactive reflexes Possible Acute Disseminated Sclerosis; Cord Bladder; Secondary Cystitis and nephritis

Pm. T 98.6

9.6 Am T 98.6 Pm T 98.4. Catheterised with release of 350 cc. initially; subsequently a total of 3475 cc - urine released in 6 hour period. Subjectively improved
A system of total drainage of Bladder + Kidneys with KMnO4 irrigation is being devised: urethral catheter clipped out again, preventing starting system tonight
10.6 Appetite much improved; ate 2 rations: Am T 98.6. Diplopia continues; pains less severe
Catheterised - 600 cc. Pm T 102.4. Total urine in ~~24~~ hours = 3100
11.6 Am T. 100.0. P 90. C/o slight headache. Urine during night 1500 cc Drainage system established
Abdomen softer - feels more comfortable. Total urine drawn off in 24 hours - 2000 cc.
Pm T: 100.8 P. 72.
12.6 Am T. 100.2. P 66. Diplopia. Neck tenderness. Calf muscles tender. Abdominal reflexes absent
K. Is +ve. Pupils unchanged. Tender in Renal L.R.Q. Appetite slightly better. Pm. T 102.2. P
13.6 Urine in 24-hours via drainage system = 1600 cc. Catheter removed + reinserted
Sulphanamide & Para tyrosine. Abdominal wall soft - slightly tender over pubis
C.N.S. No diplopia. Improvement in headache. Am T 99.2 P 70. Resp. Syst - chest clear.
Pm T 101.4. P 88 C/o headache
14.6 Am T 99.0. P. 80 Appetite fair. No diplopia. Rx Thiazole Gm. 1. T.D. TOTAL 42 Gm up to
10.00 hrs 14.6.45. Drainage system satisfactory - 1700 cc. urine. Pm T 101.6. Headache
Appetite fair. Bowels moved once.
15.6 Am T 99.2. Pm T 102.4 Fair day ~~night~~ except for headache.
16.6 Am T. 98.6 P. 76. Continue Thiazole. Diplopia continues. Pm T 101.6. P 92.
17.6 Am T 98.6 P 96 Catheter changed, also Sulphanamide drainage Am T 100.6
18.6 Am T 97.6. Urine 900 cc.
19.6 Continue Thiazine Gm. 1. T.D. Still diplopia. Tender R over bladder. Temperature curve swinging
20.6 Am T 98.4. Talking more freely Diplopia +.
21.6 Fair night. Good day.

22.6. Catheter removed - feels he can pass urine himself. Temperature settling. No urine passed during day.

23.6 Catheter remeasted, bladder drained - catheter removed at 1100 hours. No urine passed - catheter replaced at 1600 hours 675 cc. during night. Total for 24 hours = 1275 cc. No diplopia today.

25.6 Amt 99.0. Fairly Good day

26.6 Amt. 98.8. Slight headache. Catheter replaced

27.6 Amt 98.0. Less headache. No diplopia

28.6 Amt 98.2

29.6 No diplopia. No neck stiffness or tenderness. Arm reflexes +. Abdominal +. K.J. + Flexor plantar. Looking much better. Catheter removed. Trial to see if he can pass urine himself - failure. Catheter replaced 1930 hrs. Pmt 99.8

30.6 Amt 99.8 No diplopia Total Gm. 90 Thiazole up to evening.
℞ 0.5 Gm T.I.D Sulfaguanidine from 1-7-45. Pmt 103.2

1.7 Passed 300 cc. urine per urethra Amt 102.2. Total for day 750 cc. Pmt 104.2
Vomited evening meal. Delirious during night

2.7 Amt 102.6 Urine 1500 cc. Urine - acid smell, slightly cloudy. Diarrhoea during night Pmt 104.4.

3.7 Amt 102.2. P 100. Pus + from urethra Rx Sulfaguanidine 0.5 Gm T.I.D Delirious all day Pmt. 104.2.

4.7 Still delirious. Amt 102.6 Urine 24 hours 1750 cc Pmt 104.2. No improvement in mental state

5.7 Amt 102.8, not so confused. Diplopia + again. Resp. Syst. clear. Not C/O headache Appearance of Sepsis Pmt 103.2 P 140.

6.7 Semi conscious Amt. 101. P 150. - Faint. Breathing embarrassed.

DIED at 2315 hours DIAGNOSIS NEURITIC BERI BERI
URINARY TRACT INFECTION.

REG. No. 1804824 SGT. LE ROY. FRANK. H. 60th C. Regt. 4th AMERICAN SERVICE. P. 151.

ADMITTED: 27-7-45.

PAST HISTORY: Lost right Arm and Leg. Fracture clavicle right. Gunshot wound left supra scapular region during war. Multiple fracture with silver plating right foot. Treated infection.

EXAMINATION: Aching arms & legs 1942, 1944 improving Red Cross food vitamines. Since 18-1-45 recurrent headaches, retro-orbital aching. aching arms & legs, swelling of legs (at times) of body. weakness & buckling of knees. Condition only partially improved despite vitamin therapy (50mgs B. S/c since 16-4-45) restricted fluids. Tapeid Round worm after dewormin treatment recently. No diarrhoea at present but has right epigastric tenderness. Appetite Good. Generalised Dermatitis. T. 96.6.

Skin - Generalised thickening of epidermis, hyperkeratosis, scaling excoriated lesions with secondary infection (region of left ankle) Condition improved under treatment (Japanese "Terucot" Ointment)

E.E.N.T. Dental caries. Pupils = rr to lgt & Acc. EOM normal. conjunctivae pale Cervical adenitis, non-tender. Gums swollen.

C-R - Heart not enlarged, regular, rate 66. Sounds of moderate quality Lungs clear resonant. Basal TF, percussion No bronchial rales.

Abdomen. R.V.Q. tenderness. No masses, spasm. C-V tenderness.

Genetalia. Negative exc. for dermatitis

Extremities. Pitting oedema lower legs. K.J. + + =. Punctular infection with oozing left ankle. Scars right foot. Babinski - ve. right toe not responding.

Rx Elevation feet: restricted fluids: Vit B, 1cc (50mgm) s/c.

30-4 Oedema subsiding rapidly. Vesiculitis right upper arm. at injection site, onset yesterday 100.4°

1-5 AMT 99.4°

3-5 Afebrile past 3 days. No localisation, apparently improving - Oedema - ve. Restriction of fluids removed. Low-grade Enteritis

9-5 Mild oedema. Arm improved AD oil injection begun.
12-5 Oedema mild Arm same. Skin same.

15-5 Arm nearly normal. Stool watery - rice husks + partly chewed rice. P.M. sudden pains + tenderness swelling in arm, heat + pointing —.
16-5 Incision + drainage - puro-sanguineous fluid —
19-5 Much improved. Drainage fair - swelling continues
23-5 Swelling subsiding, less drainage. No further bleeding
26-5 Recurrence of bleeding, moderate, last night. Skin better. No longer feels cold all the time. No oedema
31-5 Bleeding under control with pressure dressing
1-6 Weight 47·8 Kilos (March 56·5; April 49·0) 3-6. Weight 45·2 Kilos.
4-6 Oedema + ve feet. Arm lesion subsiding & serous drainage. Mild irritative enteritis. Continues on B_1 ½cc - + AD oil beg injection. C 50 mgm.
8-6 Enteritis subsiding on diet of white rice. Oedema increasing after injecting salt
10-6 Enteritis back again: Motions watery. Arm now healed. Skin improved, except right arm, which has been splinted of necessity. Slight oedema feet. Ache leg continues. ℞ CHEBERSONE 2 caps. daily
11-6 Vomited Round worm - 8" Diarrhoea persists. Anorexia
12-6 Nauseated - no breakfast. C/o Abdominal cramps Vomited Round worm (5") in afternoon Bowels improved 3x day.
13-6 Ate breakfast. Made ineffectual attempt to vomit a Round worm in morning. Improved during day. Still feels worm in throat. Bowels improved 3x/day.
14-6 No bowel movement today
15-6 Bowels nil last night. STOP CHEBERSONE - TOTAL GM 2·5.
16-6 Epigastric pain all day
17-6 ℞ TETRACHLORETHYLENE 1cc. + hyoscy, 4 hours later.
18-6 More comfortable. Eating a little ℞ Enema.
19-6 Appetite better. ℞ Enema. Felt worm in throat this evening + had epigastric pain during night.

20-6 Rx Enema
22-6 Rx TETRACHLORETHYLENE 2cc.
24-6 No pains
25-6 Slight low abdominal pain during night. Rx Enema
26-6 Better today
27-6 Cramps during night.
28-6 Much better today
29-6 Rx TETRACHLORETHYLENE 1cc. after night pains

DISCHARGED 1-7-45

DIAGNOSIS :- BERI BERI & OEDEMA

ROUND WORMS.

READMITTED 20-7-45.

HISTORY - Since discharge on 1-7-45, has not been cooperating in treatment. About one week ago diarrhoea started - at present has frequent trips to stool - but generally passes only a little mucous. Stool is solid.

EXAMINATION: Dehydrated, face sunken. Oedema feet + legs slight.
CVS - NAD. CNS Pulse regular. HS. closed.
Rx B_1 5mgm. daily

20-7 Ate all Evening meal. Bowels frequent during night, but stool is solid.
21-7 Looks a little better this morning Rx Diarrhoea mixture (Japanese) 10cc tid. Bowels about once every ½ hour. Evening stool contained a little blood.
22-7 Frequent stools during night Rx DIAZINE GM1. 4 hourly. 1900 hours - fainted whilst sitting on commode. Pulse 120, weak, slightly irregular. HS - normal - faint. Rx DIGITALIS gtt10 CAMPHOR 1cc 4th. P.R 120 at 2000 hrs, stronger. Bowels 15x/night. Appetite very poor. Rx Fluid diet.

23-7 Bowels 10x/night. Stool small amount at one time - mainly mucous. Morning specimen - increased mucous & a little bloodstained fluid + small watery stool.
Continue Camphor 9gh. DIAZINE GM.1. 9gh. Fluids

Pulse deteriorated and patient DIED at 18-10 hours 23-7-45.

DIAGNOSIS: BERI BERI & OEDEMA.

DIARRHOEA.

CARDIAC FAILURE

Reg No 942991 CNR. MEDLOCK. ALONZO. ROYAL ARTILLERY.

ADMITTED: 23-7-45

HISTORY: Started vomiting 1 week ago - about once a day, but during the past 3-4 days has been vomiting 3 times daily. Sometimes as soon as he has eaten food, & at other times when he sees food. Appetite poor - has been eating little more than ½ ration. Has no pain before vomiting, but afterwards has a dull ache over lower abdomen. Has previously passed Round worms.

EXAMINATION: Thin, dehydrated, eyes sunken.

Abdomen - Tender below RCM. over descending colon. Remainder of abdomen not tender - some gaseous distension. Bowels 5x/day, 2x/night - watery stool. Tongue reddened, but clean.

CVS Pulse regular. HS - closed. Resp. Syst. - NAD.

CNS Bicips. Tricips +. K.Jo +. No oedema of legs. Amt 98.4° F.

23-7 ℞ White Rice pudg. Gruel. ASD Tab 1 T.I.D. AC. Observe vomiting. Vomits Gastric fluid & partly digested food. In spite of vomiting twice, ate meals.

24-7 Good night - no vomiting, bowels not moved. No actual vomiting - brings gastric juice into mouth & then spits it out, with Rice. Has eaten about ½ rice today.

25th Good night. Eating better today.

26th Bowels once during night. No vomiting

27th No change. Appetite poor. Vomited in afternoon. ℞ Glucose (30%) 20cc intra.

28th Lies Head - not making any effort. Bowels 4x/night.

29th Weak. - Ate breakfast. Pulse 84.

30th Weaker. Pulse 88 - irregular - not so strong. Collapsed and

DIED AT 1200 HOURS 30-7-45

DIAGNOSIS - ACUTE MELANCHOLIA; CARDIAC FAILURE

Reg No. 1888599 SPR HARPER FREDK. ARTHUR ROYAL ENGINEERS

ADMITTED: 8.8.45

PAST HISTORY: Had Beri Beri in February 1943, again in June '44. Reported sick 11th June with oedema of legs +. Since then improved till about 2 weeks ago when he began to refuse to eat his food. For last week has had to be fed - operation taking as much as 5 hours. Swelling increased on 6th Aug. with further reluctance to eat.

EXAMINATION: Oedema of feet + legs +. Scrotum -ve. Abdomen ascit. Very slight oedema of Right forearm + hand. K. Js +ve. Biceps, triceps +.

Resp. Syst - A few rhonchi in lower Right Chest in front. CVS - HS. closed, weak. Pulse 80. regular but poor quality

General condition - looks pale. Is deaf, slow in response to questions but acts and speaks rationally.

Rx No fluids. Glucose 20cc. intrav. + B1 10mgm.

1800 hours. Deterioration of pulse - much weaker - P.R 88. Rm.T 99.0.
Refused to eat evening meal.
DIED AT 00.10 hours 8-8-45

DIAGNOSIS:- BERI BERI & OEDEMA.
CARDIAC FAILURE.

Reg. No 2325960 SGMN. MASSEY. STANLEY R.C. SIGNALS

ADMITTED: 5-8-45.

PAST HISTORY. Patient's story is that he reported sick 5 days ago with pain in the legs & left shoulder these pains keep him awake at night. At present feels very sleepy & tired. Says date is April 15th 1945 - otherwise talks rationally. Reported sick 7 days ago with fever T 100.0, no shivering. Fever maintained at 100.0 for 3 days. Since then has been 99.0 & normal. For last 3 days has been behaving abnormally - has not attended sick parade & has been careless personally especially with regard to cleaning up after stool. Appetite good. Bowels normal.

Started on Hebron 0.1 Gm. T.I.D. on 5-8-45

EXAMINATION: Listless, mild ptosis, not asleep, reactions slow when spoken to. General condition fairly good. CNS Pupils +ve. L.A. No nystagmus - lateral or vertical. Biceps, triceps +. Abdominals +ve. KJ's ++. R plantar flexor, L ? extensor.

CVS. Pulse regular 72. HS. closed. Resp. Syst. - RN resonant. BS. unaccompanied. Has slight cough - no sputum. Alimentary System - Tongue clean & moist. No palpable abdominal masses. No tenderness.

5-8. Amt. 98.4. Continue Hebrine. Pm T 98.4.

6th - Amt. 99.2. More lethargic today. Pm T 98.4.

7th - Oedema of face - especially eyelids. Right arm swollen. Cyanosis in dorsum of Right Hand. CNS Reflexes ++: L. extensor plantar reflexes. Rx Glucose 20cc. intrav + B. 25 mgm. intrav. Amt. 98.2°. Difficult to rouse. Says today's date is July 26th. More confused Pm T. 101.0. Has eaten fairly well today

8th Am T 98.4. Rx Plasma 250 cc. & Glucose 20cc + B. 25 mgm. Slightly more responsive when spoken to. Appetite good. Neck muscles stiff. Very lethargic.

9th Becoming comatose. Am T 98.4. P. 80 fair quality. Not responding to stimuli Resp Syst. - Developing HYPOSTATIC PNEUMONIA - TERMINAL. Pulse deteriorated rapidly in afternoon.

DIED AT 20.35 hours. DIAGNOSIS:- ENCEPHALOPATHIC BERI BERI.
CARDIAC FAILURE.

REG. No. 2090120 PTE. KITTRELL. DOUGLAS 65th Coast Arty. Regt

ADMITTED: 5-8-45.

PAST HISTORY: Sick since 26-3-45 with Beri Beri c̄ Oedema - chronic condition, not improved by non-cooperation in treatment. During past week oedema of legs has increased, & he has difficulty in getting about especially to the latrine.

EXAMINATION: Oedema - feet, legs++ especially knees. Scrotum +. Penis normal. Abdomen slightly distended - fluids & gas. Face puffy. CVS Pulse rapid, regular, poor

CNS - NAD. Resp. Syst NAD.

℞ B1 10 mgm. M.V.1. T.I.D

6th. Urine not recorded. Oedema less thus. 5 stools during night - urine passed at same time

7th 175cc urine. Passes urine in stool. Improvement in oedema ℞ RODEALIN 1cc. a/c

8th 50cc. urine. Oedema clear of knees.

9th 50cc. L. tibia painful to touch. Oedema Rt. leg much improved. - no change in L. leg. Not making effort to eat rice.

10th No record of urine. Fluid + from L. foot. Oedema decreasing

11th Very lethargic, oedema improving. Appears slightly confused.

12th 25cc recorded. Urine still passed with stool. Dull mentally. Oedema of legs diminishing. Cardiac condition very poor at 1800 hours. Pulse weak. Slight cyanosis. ℞ Digitalis gr. to P.R. 120. Pulse deteriorated during night.

13th DIED AT 01.10 HOURS 13-8-45.

DIAGNOSIS: BERI BERI c̄ OEDEMA.

CARDIAC FAILURE.

Reg. No. 35718 45 7 — Pte. BIRCH. THOMAS — 1st MANCHESTERS

ADMITTED 5-8-1945

HISTORY. Sick from 3-4-45. with Beri Beri & Oedema. Chronic type of oedema - little evacuation, though improved & was walking for a short time at the beginning of June. Has had diarrhoea for past 2 days & has difficulty in straight latrine from weakness.

EXAMINATION: Oedema - 4+ feet & legs. Scrotum very slight. Penis ++. Abdomen + fluid ++.

CVS Pulse irregular - poor quality. H.S. Closed. Resp. Syst. BS unaccompanied. CNS NAD

℞ B_1 (10 mgm) M.V.I. T.i.D. Pil. Creosote B.I.D.

6th Urine 150 cc. Less oedema of penis. Bowels 1x/night.

7th Bowels 3x/night. 200 cc. Slightly less oedema.

8th Bowels 5x/night. 275 cc. No change.

9th No urine recorded. Bowels 3x/night. Bowels 10x/day - all watery stools.

10th Diarrhoea persists. No urine recorded.

11th Diarrhoea - very liquid stool. Oedema improving. Not making any effort to get to latrine b/ pass stool.

12th Continue Pil. Creosote. Urine 10 cc. No change in oedema.

13th Pulse weak & steady at 0800 hours. ℞ Camphor 1½ c.c. s/c. Abdominal paracentesis - 6½ litres withdrawn. Pulse deteriorated. -

DIED AT 13.05 HOURS 13-8-45

DIAGNOSIS: BERI BERI & OEDEMA.

CARDIAC FAILURE.

Reg. No 188886 SPR. CARPENTER, JAMES. ROYAL ENGINEERS.

ADMITTED: 2-7-45

HISTORY: Had been bere early in 1944. Feet & legs started to swell 2 weeks ago. On 29-6-45 marked increase in oedema of L. leg from foot to thigh muscles, especially on movement. At the same time T - 102.0 - no shivering unlike Malaria. Since then fever has remained high. 100 - 102.0°F. On 1st fully dorsum of foot red & painful. Concurrently has had vomiting after only a few spoonsful of rice or stew. Complains of no pain or nausea before or after meals.

EXAMINATION Small & thin. Oedema - Rt foot & lower leg to knee +; Left leg - oedema ++ from thigh to foot. Skin of dorsum dusky. Tender from adductor canal along line of femoral artery & just below popliteal fossa. Palpable inguinal glands L.

CVS. Pulse 100. 0°F. HS Clear. regular Adm T. 101.0°F

Resp. Syst. N.A.D. Abdomen - No palpable masses. Bowels 1-2x/day.

℞ Sulphadiazine Gm 1. T.i.D. B. - 5 mgm.

2nd Pm T 100.0. Vomited after 2 spoons of evening rice

3rd Adm T 97.8 Oedema - L. leg much decreased. Pain over femoral artery only. Oedema Rt. leg slight. Pm T 100.2. Appetite poor

4th Adm T. 98.6°F. Oedema of both legs decreasing L femoral artery NT so tender. No pain behind knee.

5th Adm T 98.0°F Slight tenderness in popliteal fossa. No change in oedema. Pm T 98.0

6th Very slight oedema right leg & left leg. Very little tenderness behind knee. STOP DIAZINE - TOTAL GM 15. Pm T. 101.4. P. 92 Analysis C/o Abdominal pains.

7th Adm T 98.4°F. Appetite better. Pm T 100.2.

8th Adm T 98.4°. Legs improving

9th Am.T. 98.4°F. Legs almost normal. Pm.T 99.6 Diarrhoea 6x/day
10th No change in oedema. Bowels settling Pm.T 99.6
11th Am.T 98.6 Very slight oedema of L. foot, slight oedema R. No pain in leg now Pm.T 99.8.
Appetite poor - eating about half rice.
12th Am.T. normal Bowels 5x/night. Oedema of legs decreasing. Pm.T. 99.6°F. Poor appetite.
Vomited some rice
13th Oedema unchanged Am.T normal
14th Vomited after breakfast. Is to move around more
15th No change in oedema Pm.T. normal.
16th No change. Appetite poor
17th Pharyngitis. Oedema feet slight. Pm.T. 99.2.
18th No improvement in appetite. Pm.T 100.0. Bowels 12x/day - watery
19th Bowels 4x/night.
20th Epigastric pain - cannot eat breakfast. Slight oedema of feet.

DISCHARGED 20-7-45.

DIAGNOSIS:- BERI BERI & OEDEMA.

RE-ADMITTED: 4-8-45.

HISTORY: Discharged 20-7-45 with slight oedema of feet. Patient was not making any effort to eat food. Since discharge appetite has not improved. Recently has been bringing food to Hospital to eat, with a slight improvement in the amount eaten.

Today C/O dizziness + fainted. Temp. 100.8°F

EXAMINATION Slight oedema feet, very slight in legs. Thin - looks unwell. No abdominal pain. Diarrhoea on 3rd. following 1cc Tetrachlorethylene & Mag. Sulph. — R Warm vomited on 2nd No diarrhoea today. Mental attitude to eating is unsatisfactory - if he makes an effort, he will improve rapidly.

℞ Ordinary Diet. No fluids. I.M.V. T.I.D. P.C.

5th Bowels 3x/Night. Am T 98.4°. Resp. Sept. Inspiratory & expiratory rhonchi, especially in Right ~~upper~~ upper chest anteriorly. Coughing up tenacious sputum. Looking slightly better today. Pm T 101.0 - no shivering.

6th Am T normal. P. 92. Weak - regular in time & force. Says he feels very weak. Ate breakfast. Chest unchanged. At 1500 hours P.120. ℞ Digitalis g. 1/60. Ate very little supper.

7th Am T normal. P.R 100 - stronger. Ate almost all breakfast. Pm T 100.0°F. Weaker.

8th Pulse 120 - fair quality. Pm T 99.6. P.R 64 - weak. Looks haggard.

9th Am T normal. P.R. 60. Pulse poor in quality.

10th P.120 - weak. Dehydrated - eating very little. Pulse 110 at 20.00 hours.

11th Am T 98.4 P.R 84. Looks worse. Pm T. 101.2 P.R 110.

12th Am T 98.4. P.R 92.

13th Am T normal. P.R. 96. Stronger today. Pm T. 100.2 P.R 110 weak & irregular.

DIED AT 01.30 HOURS - 14-8-1945

DIAGNOSIS:- BERI BERI & OEDEMA.

ANOREXIA NERVOSA

Reg No 6907040 Pte. RETCHLESS, GEORGE. U.S. AIR CORPS

ADMITTED: 29-7-1945.

HISTORY: Fever began afternoon 24th. T 101·0°F. Quinine started morning of 26th. Temperature has been 100 - 102 since then

On evening of 27th c/o pain in abdomen.

EXAMINATION: Tender below R.C.M. - pain colicky in type. Recurrence of pain on 28th 29th AM T 100·4. P.R 92. Speech slow indistinct - some slurring of vowels. Is thinking slowly - more than usual even though normally he is slow.

Resp. Syst P.N. resonant. B.S. clear. No accompaniment. C.V.S - Pulse regular. H.S altered.

C.N.S - Pupils = + ve L.A. No nystagmus. Biceps, triceps ++, K.J +

Abdominals - ve. No neck rigidity

Abdomen. Tender from below R.Cm to Mc Burney's point - also in L.I.F. & R Kidney angle posterior. Examination at different times shows tenderness in these various positions no palpable masses. No pain when hips are flexed. Bowels normal, Tongue clean slightly dry. Sup appetite is good. When pain comes on, skin of a colicky nature, at back of umbilicus & nipple line - > worse.

Feet - no oedema.

℞ Ordinary Diet. Quinine Sulphate gr. 10 t.i.d.

PM Temp - T 103·0

30th AM T 99·4. Appetite +. PM T 102·4

31st AM T 100·0 c/o Frontal headache - & suborbital. P.M. T. 102·0. headache improved

→ AM T 98·4 Slightly confused during night.

1-8 AM T 98·4°F. No response to 6 days Quinine ℞ Sulfadiazine Gm 1. T.I.D.

2nd → No complaint of headache this morning. Speech slow & indistinct. Still confused & deteriorated PM T 100·6

3rd CNS - no change Amt normal. Neck tenderness, slight rigidity on flexion. PmT 99·2
confused, but actions are purposful
4th - Awake most of night. Amt 98·4 Still confused PmT 100·4
5th Amt 98·4 Very confused & lethargic. No change in CNS reactions PmT 100·8
6th Amt 98·8 Not confused. PmT 101·2
7th Amt normal. more alert. CNS reactions unchanged PmT 101·8
8th Rigor at 1000 hrs. more responsive this morning. Temp. at 1700 hours 105·2 - copious
sweat by 1900 hours PmT 101·0. Stop DIARRHOEA. Rx Quinine gr 3. DAILY.
9th Amt 101 more alert PmT 101·6
10th Amt normal. Brighter. PmT 103·2
11th Amt normal. PmT 102·6
12th Amt 101·0 not so alert. Chest clear PmT 103·0
13th Amt normal. Scattered rhonchi throughout chest PmT 103·4
14th Amt 98·4 B.S. diminished in Right Base
- Acute Cardiac Collapse -

DIED AT 15·10 HOURS - 14-8-45

DIAGNOSIS: MALARIA (B.T) (clinical).
BERI BERI & OEDEMA
CARDIAC FAILURE.

Reg No. 9961861. Gnr. Nixon, Walter Morris. 148 Field Regt Royal Artillery

ADMITTED:- 4-4-45

PAST HISTORY - Bronchitis; Pneumonia at 4 years of age. Malaria 5 times, since 1943. Beri Beri off & on for 2½ years. Leg injury - ulcerated. Swelling of legs in last month.

EXAMINATION: Skin dry. Scabies with secondary papulo-pustulo crusting dermatitis, especially over Abdomen & Buttocks. Oedema of legs, scrotum. Ulcer left tibia

N&T: Artificial denture. Halitosis.

C-R Heart not enlarged. Sounds regular, normal in quality. No murmurs.

Lungs C & R & normal I.F. No post tussive râles

Abdomen - soft.

℞ 3 MV daily. Normal or liquids - 1 week.

7th Oedema scrotum less, right leg. Appetite good. Temp 98.0 PR 83. Oedema back +

9th Oedema confined to legs, especially left

11th Oedema +

13 No change

16th Oedema less

18th No change. Lesion on leg closing in

21st Oedema +

24 Leg healing. Oedema +

27 No change

DISCHARGED.

DIAGNOSIS - BERI BERI & OEDEMA; CHRONIC ULCER, SUPERFICIAL OF LEFT TIBIAL CREST; SCABIES

RE-ADMITTED - 21-5-45

EXAMINATION: Oedema + ulcer discharge until 5-5-45 Despite denial of patient that he has taken any fluids, he is reported to be taking them + from 5-5-45 oedema became ++ severe, ulcer broke below in spite of increased B, (10 & 15 mgm daily

Temp. 98·6 Weight 65·6 Kilos (April weight 59·0 Kilos)

Skin Scabies with secondary pyodermia. Oedema ++ legs, scrotum, penis, back, face + legs. Ulcer enlarged (6×3 cm) sluggish.

EEN Pellagrous glossitis & atrophy of papillae. Pharyngitis

CoR Lungs Clr. Heart not enlarged. Sounds of fair quality, variable in intensity, regular. $P_2 > A_2$ replaced by soft brief systolic murmur, not transmitted. P.R. 76.

Abdomen - no fluid. Liver + fluid b.m.o.

CNS - plegiatic KJ + A.E. A.J. + E=. Babinski - ve. Abdomen. O.

Diagnosis - Beri Beri & Oedema! Ulcer, recurrent, left tibia: Scabies; Pellagra

℞ Ordinary diet, Strict bed, B, 15 mgm; No fluids: Sulfonamide dressings.

22nd Urine scanty, concentrated, dark amber. Output yesterday 150 cc. Today 150 cc Oedema face + neck increasing. Same respiratory distress. Oedema elsewhere the same. ℞ Caffein Soda-benzoate 5 gr. t.d.

23rd Urine output 150 cc. Dark amber. Oedema rapidly subsiding. Ulcer cleaner, - reading better, freshly granulating. Heart - no murmur; Sounds better quality, regular. Lungs - Clr. In view of concentrated urine & improvement, is allowed tea and milk at tiffin. At 1700 hours - swelling back again in face, neck + back. ℞ continue restricted fluids, diuretic

24th - Output 300 cc. - dark amber & precipitated phosphates. Oedema legs + face slightly improved - same in back - scrotum improved. Fluid rales left chest posteriorly. Cardiac findings same. Ulcer sluggish again

25th Output 225 ccs. Oedema continues. Chest - no rales. Ulcer slightly better. Urine output only 50 cc. through day. ℞ 1 cc B_1. DIGITALIS 4½ gr. stat.

26th "Output 200 cc. Oedema ++ face, back, legs; + neck, scrotum, penis; dullness below 7th T left. 10th T right. Mentally clearer. Heart sounds improved in quality. $H_2 = P_2$; regular in rate & rhythm & equality; no murmurs. Relative emaciation arms, upper chest & thighs. Ulcer clean & granulating.

27th Output 400 cc. Dark amber. Oedema lessening. Scattered rales over back. Dyspnoea. Constipated. Protruding rosette - internal haemorroids. Rx Eczema, Tannic Ont. Shift position.

28th Output 850 cc.

29th Output 350 cc.

30th " 600 cc. Oedema dependent on left side of body - slowly subsiding. Ulcer closing slowly. Chest no rales, but dullness, diminished breath sounds 8-9½ T left 10th T right.

31st Output 610 cc.

1/6 Output 575 cc. Weight 70 Kilos (March 55 K: April 59 Kilos; May 64.0)

2nd Output 925 cc.

3rd " 1450 cc. Weight 66.8 Kilos. Begins Calcium Acetate 5cc. TID p.c. for 7 days.

4th Unchanged. Output 1450 cc. Anorexia.

5th Output 1400 cc. Weight 68.8 Kilos. Oedema subsiding, no dullness, diminished breath sounds in chest. Ulcer closing steadily. Anorexia continues. Rx reduce to Digitalis gr ½ daily: Stop Caffein Sod. Benz.

6th Output - 1100 cc.

7th Output - 1150 cc.

8th Weight 65.2 Kilos. Oedema subsiding well. Occasional rale left chest in zone of fluid. Output 1770 cc.

9th Output 3480 cc. Marked lessening of oedema; wasting of musculature now generally apparent. Eating better. Abdomen enlarged but less than before. Heart sounds of moderate quality. No murmurs. Dullness & diminished breath sounds below 9th T left. Ulcer granulating & clean.

11th 1620 cc - diminution may be due to absence of a diuretic

12th Output 1250 cc. Temp. Evening of 11th 100.2°F Amt-(12th) 99.6. C/o slight headache, otherwise N.A.D. Appetite poor. Weight 58.5 Kilos. Pmt 100.4. P.R. 72.

13th Output 725 cc, bowels 3x/night & each stool very watery. Oedema decreasing. Awoke Epigastric discomfort when bowels move. Amt 98.6. P.R. 80. Stools 7x/day; 3/night

14th Output 420 cc. Stools still watery. Appetite improved. No fever. Amt 96.2. P.R. Pmt 100.4 bowels improved.

15th Urine 800 cc. Stools still watery but 2x/night. Appetite better. Rx Tea cup tea with meals (1½ pints daily)

16th Output 1225 cc. Improving

17th Output 600 cc Pmt 101.6

18th Output 600 cc Amt 98.0. P.R. 72. Appetite poor C/o sweating around b. eye

19th 1150 cc urine

20th 825 cc. urine. Bowels 4x/night

21st 900 cc urine

22nd 1200 cc " Rx Atebrine 0.1 GM T.I.D. P.C.

23rd 1700. cc. Pmt. 100.2

24th 1500 cc. Fever in afternoon - continue Atebrine

25th 1500 cc. Pmt 99.8. Amt 100.2.

26 2400 cc Amt 98.8. Pm T 102.0.

27th Amt 99.6 Urine 1000 cc.

28th Amt 98.0 Appetite ~~poor~~ better. Output 1550 cc. Pmt 99.2

29th Amt 97.8. Urine 350 cc - Diarrhoea 3x/night & 7x/day. Pm T 102.4

30th Amt 98.4 Urine 450 cc. Oedema leg almost cleared. Lt left index finger much improved. Pmt 101.8

1/7 Urine 825 cc DISCHARGED TO MESS

RE-ADMITTED - 10.8.45

HISTORY. As above. Has not been cooperating in treatment - drinking to excess. Oedema has been increasing, especially this month. New oedema has reached proportions

which make it necessary to rehospitalise

EXAMINATION: Oedema feet + legs +: Penis ++, Scrotum +. Abdomen distended + +.

CVS Pulse regular, poor quality. Mitral systolic murmur.

Resp. System: N.A.D.

℞ Ordinary Diet. No fluids. 3 hrly. Caffein 1 cc daily.

11th Slight improvement in oedema.

12th Urine 225 cc.

13th " 300 cc.

14th Very slight oedema of penis scrotum. Oedema of legs less tense. Urine 155 cc.

15th Urine 250 cc. Slight improvement in oedema. Pulse Round bounding (90) by mouth. Pulse too - feeble. ℞ Camphor 2 hourly. Caffein 2 cc. Urine 300 cc.

Abdomen tapped - 700 cc. withdrawn.

DIED AT 11.15 hours.

DIAGNOSIS: BERI BERI & OEDEMA.

CARDIAC FAILURE.

REG No. 3859158 TPR SLATER. WILLIAM 18 Div. RECCE. BATT.

ADMITTED: 3-8-45

PAST HISTORY: Reported sick 30.7.45 with oedema of feet, abdominal pains and vomiting. Since then oedema has improved slightly, but he is not making any effort to eat food. Vomited yesterday (2-8) - mild diarrhoea.

EXAMINATION: Thin, looks miserable. C.V.S. Pulse regular. Heart sounds clear. Resp. System. P.N. resonant. Breath sounds clear. C.N.S. Reflexes all +. Abdomen. No palpable masses, has vague centralised tenderness. Tongue slightly furred. Stool - mild diarrhoea.

Mental Attitude is that he will not try to eat his food, & is not particular whether he lives or dies.

Oedema - Slight in feet, very slight in legs. Scrotum nil.

℞ Ordinary Diet: M.V. 1. T.I.D. P.C.

Vomited part of evening meal.

4th Looking better. Bowels ox/night

5th Looking better. 1 stool in past 24 hours. Very slight oedema of feet.

DISCHARGED.

DIAGNOSIS: BERI BERI & OEDEMA

ANOREXIA.

RE-ADMITTED: 14-8-45.

Oedema legs + feet +. Nil else. Nil discharge from anus. ℞ Ordinary Diet. No fluids. 1 M.V. T.I.D. P.C.

15-8. Fair night. ~~No fluids~~. eating all food. Less oedema. Stool - still mucous discharge - anal sphincter very lax.

16th Slight improvement in stools. / Oedema less.

17th Rx MV.4 (12 mgm B1) DIAZINE GM I. T.I.D

18th No change

19th Bowels improved - solid stool

20th Appetite a little better. Rx GLUCOSE 20cc intra. 15 mgm B1. Says he has coughed up some blood in sputum, but specimens does not show any signs of blood.

21 Coughing during night. Bubbling rales especially Rt & upper chest. Appetite poor. Oedema + Rt foot, very slight Rt leg.
Pulse peak at 1600 hours. Colour poor, breathing embarrassed

DIED AT 21.15 HOURS

DIAGNOSIS: BERI BERI & OEDEMA

'43

1070383 B.Q.M.S. COOKE. REGINALD. ROYAL ARTILLERY

ADMITTED - 10-8-45

HISTORY:- Beri Beri Œdema since April 1945. Recently œdema of feet has increased. Since July 26th has had a low grade fever - 7 days Quinine. + 5 days Atebrin. Fever persists at night

EXAMINATION: Œdema + feet & legs. Slight œdema scrotum & penis. Abdomen - slight distension. Dulness below L.C.M. C/o pain in lower left chest.

Resp. System - P.N. resonant. B.S. diminished L. chest anteriorly. Some rhonchi R. lower chest anterio-posteriorly. C.N.S. Biceps, Triceps K.Js +. C.V.S. Pulse regular. Heart Sounds closed.

Rx Ordinary diet. No fluids. B1 - 3 m.v. daily. Caffein 1 cc. PmT 100.8.

11th No change in chest. Rx DIAZINE GM 1. T.I.D. No change in œdema. PmT 101.0.

12th Better night. Coughing very strenuous - sputum + AmT. 99.0. No change in œdema

13th Looking better. PmT 101.7.

14th AmT normal. Good night. Urine 700 cc. Œdema + feet & legs + scrotum.
Rx Caffein 1 cc B.I.D. Resp. System. B.S. diminished in L. chest. Rhonchi - R. lower chest posterior. Pain in L. chest much improved. PmT. 101.2

15th AmT. 99.0. Better night. Urine 3100 cc. No change in œdema.
Resp. Syst. B.S. L chest amphoric. Feet tapped. Fluid +. PmT. 99.8

16th AmT. 98.4. Œdema legs slight. Scrotum slight. Urine 4000 cc. Looking better. AmT. 98.4

17th AmT. 98.4. Bad night. coughing. Urine 2700 cc. Fluid + from legs. Œdema much improved. Rx M.V. (15 mgm B_1) 3 cc B_1 œdn. (15 mgm) intrav. Dyspnoea during afternoon. PmT 98.4.

18th AmT 98.4 P.R. 30. Bubbling râles especially on Right side. Amphoric breathing throughout left side - ? a series of cavities. Right chest - ? cavity at apex. PmT 98.4

14th – Amt gd. Looking alright, better. Not so dyspnoeic. Some dyspnoea at 1200 hours. Pulse weakened and

DIED AT 14-25 HOURS.

DIAGNOSIS: BERI BERI & OEDEMA

CHRONIC BRONCHITIS

? ACUTE TUBERCULOSIS.

2071/188. [illegible] ADAM ATKINSON

ADMITTED: 21.8.45. From Hill Camp.

HISTORY: First sick 16-7-45 with Malaria. Developed Beri Beri about 3 weeks ago. Condition has deteriorated since, & he has shown signs of Pneumonia ~~Pat~~ Pericarditis.

EXAMINATION: Patient has just had a trip by stretcher & motor truck and is very exhausted. Pulse weak. H.S. faint. Lips cyanosed. Breathing shallow. Conscious, but speaks with difficulty. Very little oedema

Rx Camphor 1cc hourly s/c.

Admitted at 1800 hours. Condition worse by midnight.

DIED AT 03,25 HOURS.

DIAGNOSIS: MALARIA.

BERI BERI

19th – Amt 96.4. Looking slightly better. Not so dyspnoeic. Since dyspnoea at 1200 hours
Pulse weakened and
DIED AT 14-25 HOURS.

DIAGNOSIS: BERI BERI & OEDEMA
CHRONIC BRONCHITIS
? ACUTE TUBERCULOSIS.

2691788. GNR. PONTER. J.L. ROYAL ARTILLERY

ADMITTED: 21.8.45. From Hill Camp.

HISTORY: First sick 16-7-45 with Malaria. Developed Beri Beri about 3 weeks ago. Condition has deteriorated since, & he has shown signs of Pneumonia ~~Pat~~ Pericarditis.

EXAMINATION: Patient has just had a trip by stretcher & motor truck and is very exhausted. Pulse weak. H.S. faint. Lips cyanosed. Breathing shallow. Conscious, but speaks with difficulty. Very little oedema

Rx Camphor 1cc hourly s/c.

Admitted at 1800 hours. Condition worse by midnight.

DIED AT: 03,25 HOURS.

DIAGNOSIS: MALARIA.

BERI BERI

4756242. PTE. WEBB. C. W. 1/5th SHERWOOD FORESTERS.

ADMITTED: 25-8-45.

HISTORY: Sick with Beri Beri for 2 months, persistant oedema of legs. Has been celebrating normally today otherwise condition is the same as for last month.

EXAMINATION: Oedema - slight in feet & lower legs. Knees & thighs +. Scrotum slightly swollen. Very slight abdominal distension.

C.V.S. Pulse, regular & rapid. H.S. closed.

C.N.S - K.J's +, sluggish. Bowels - no diarrhoea.

℞ B, 20 mgm (intramus). 25 mgm orally. 3 times T.I.D. PC.

25th Has eaten all meals responds to questioning. Still mentally slow.

26th Ate breakfast. At about 0830 hours he became comatose and

DIED AT 09.15 hours.

DIAGNOSIS: BERI BERI & OEDEMA.

CARDIAC FAILURE.

974071. GNR. HAMLIN. C.F. ROYAL ARTILLERY.

ADMITTED: 21-8-45.

HISTORY: Diarrhoea for 6 days. Beri Beri & Oedema for 2 weeks. previously. Convoy from Hill Camp today has exhausted patient.

EXAMINATION: Stool. mucous, no pus.

Skin dry, pellagroid. Slight oedema lower legs.
C.V.S. Pulse regular - rapid 120. H.S. closed.
Resp. System: Moist rales Right Chest especially at apex.
Abdomen: Tender over descending colon. Spleen just palpable.

℞ O.D. Paregoric 4 cc. T.I.D. P.C. Glucose 20 cc + B, 0.5 cc intras.
B, 25 mgm (tabs) in V.3 T.I.D. P.C.

22 Looks better. Bowels 8x/night. ℞ SULPHADIAZINE Gm. i. T.I.D.
23 Less oedema in legs. Pulse weaker.
24 Dyspnoea during morning. Increased rales R. chest. Diarrhoea 15x/day.
26 Dyspnoea at 11.00 hours.

DIED AT 11.15 HOURS.

DIAGNOSIS: DIARRHOEA.

BERI BERI & OEDEMA.

8

#70976. GNR. WARNER. R.A. ROYAL ARTILLERY

ADMITTED: 15-8-45.

HISTORY: Discharged on 5-8-45 - eating well - no diarrhoea. Since then has not been eating and becoming progressively weaker.

EXAMINATION: Thin, emaciated. Physically no change from condition at previous admission.

℞ ad. lib. Creamte. 4 t.

17th Hysterical - claims he cannot hold head upright.
19th Eating better - can hold head upright perfectly normally.
21st Eating about half his food.
23rd No improvement. Weak.
25th No change.
26th Semi comatose after breakfast. ℞ Plasma 300cc, Dextrose 500cc. Revived afterwards & ate most of meals.
27th Became semi comatose at 0500 hours. Given 300cc Plasma but coma deepened & he died at 07-35 hours.

DIAGNOSIS: BERI BERI & OEDEMA.

ANOREXIA.

1089360. L/BDR. MAY. S.A. ROYAL ARTILLERY

ADMITTED: 17-8-45.

HISTORY: Has been in sick bay for about one month with Beri Beri - swelling of legs & scrotum increased during last week.

EXAMINATION: Oedema - feet, legs & thighs +. Scrotum +. Lungs slight. Resp. System. N.A.D. CVS - H.S. closed. pulse regular. Abdomen - tense. Bowels - 1x/day. CNS - K.J's +.

Rx B1 - 10 mgm tabs. 50 mgm (1cc. S/C).

18th Rx Glucose 20cc intravs. ⇒

19th Urine output 250cc. Oedema less tense. Constipated. Rx Calomel gr½ nocte.

21st Urine - 350cc. Oedema less tense.

23rd Urine - 600 cc. Oedema less tense.

25 Oedema much improved - very little in thighs, still + below knees. Scrotum much less. Bowels 3x/day.

26th Much less oedema. slight in lower legs & feet.

27th Diarrhoea - 15x during day. - all watery stools. Dehydrated this morning. Rx Plasma 300cc. Condition deteriorated during day. Pulse 90 at 1900 hours, weak. Rx Caffein 1cc. 4 hourly during night.

DIED AT 02.25 HOURS 28-8-45

DIAGNOSIS: - BERI BERI & OEDEMA

4/91409. GNR. ROBERTS. J.R. ROYAL ARTILLERY.

ADMITTED: 21-8-45.

HISTORY: Arrived from Jail Camp on 21st. Sick for about a month with Beri Beri. Condition has slowly become worse. Has had diarrhoea of 3 weeks

EXAMINATION: Oedema - feet + legs +. Abdomen distended + - fluid present. C.V.S. Pulse irregular. H.S. weak. Resp. Syst: Moist rales at both bases. Stool - watery & slight mucous.

℞ Sulfadiazine GM.1. T.I.D. P.C. Paregoric 4 cc. B.D.
B, 25 mgm. Glucose 20cc + 0.5 cc B, (25 mgm) intrav.

23rd Slight improvement in diarrhoea. Bowels about 12x/day, 6x/night. Slightly less oedema of legs.

25th Abdomen not as distended. Eating a little better

26th Pulse poor today. Cyanosis of lips. At 1500 hours attack of dyspnoea - lasted about 30 minutes, left patient very weak.

27th Bad day - eating badly, pulse weak & irregular.

28th Attack of dyspnoea at 1100 hours, became unconscious.

DIED AT 11.35 hours

DIAGNOSIS: BERI BERI & OEDEMA

33916H. PTE. BAIER. L.N.E. DUTCH NAVY

ADMITTED: 23-8-45.

HISTORY: Sick for 3 days - ↓ eating food. Diarrhoea about 10x/day, 4-6x/night. Poor mental & Attitude Towards eating.

EXAMINATION: Tall, thin. C.V.S Pulse regular. H.S. closed. Resp. System - N.A.D. Abdomen: No palpable masses. Stool - watery, no blood or mucous. C.N.S - N.A.D. Slight stiffness of sternomastoid muscles. No neck rigidity.
℞ Sulfadiazine GM.1. T.I.D. PC.

24th. Improving. Appetite better - bowels 6x/night.
26th Much better. Total stools 8x/24 hours.
27th KILLED AT 17.40 HOURS by being struck by a container of P.O.W. Relief Goods dropped from plane.
P.M. EXAM. Right side of chest wall anteriorly crushed. Skull fractured. Lower part of face absent. INSTANTANEOUS DEATH.

DIAGNOSIS: DIARRHOEA.

ACCIDENTALLY KILLED.

818736. GNR. RATHBONE. H. ROYAL ARTILLERY

Accidentally killed by being struck by canister of S.A.W. Relief Supplies dropped from 'plane 28.8.45.

Compound fracture right tibia. Fractured skull.

6856759. Sgt. WOOLLEY. F.E. U.S. ARMY ENGINEERS.

ADMITTED: 22-8-45.

HISTORY: Admitted from Hill Camp. Had Beri Beri & Oedema for 1 month. + Diarrhoea for 10 days.

EXAMINATION: Oedema to knees. Scrotum + Abdomen not involved.

CVS - H.S. closed. Pulse regular. Resp. Syst: N.A.D.

Stools - watery - about 6-8 x/24 hours.

℞ Sulfadiazine GM. 1. T.I.D. Paregoric Hcc. B.I.D.

B, 25 mgm. C o/c). + 20 mgm (Tab).

24th Less oedema. Appetite improving.

26th Diarrhoea increased. 15 x/day. All stools watery.

28th Injured by 500 lb. drum of Relief Supplies dropped from plane.

Simple fracture of R. Colles leg. Abrasions head + arms. Leg put in splint. Morphine 1/4.

TRANSFERRED TO MILITARY HOSPITAL.

DIED 29. 8. 45.

6466971. M/Sgt. PLISKA, A.E. HQ. MILITARY POLICE, PHILLIPINE SCOUTS

ADMITTED: 21-8-45.

HISTORY: Admitted on return from Hill Camp. Sick for 1 month with Diarrhoea & Beri Beri.

EXAMINATION:- Dehydrated, cyanosed, pulse rapid & weak. Stool - about 20 c/day, watery with mucous but no pus.
C.V.S. - H.S. closed Faint. Resp. System:- N.A.D. Appetite - very poor.
℞ Paregoric 4cc. T.I.D. P.C. Glucose 20cc + B1 0·5cc intrav. h.V. 3 T.I.D. P.C.

22nd. ℞ Plasma 300 cc.

24th ℞ Plasma 300 cc. Dextrose 5% - 1000 cc. Looks a little better. Diarrhoea persists - ℞ Sulfadiazine Gm. 1. T.I.D. P.C.

26th Appetite improving

29th TRANSFERRED TO MILITARY HOSPITAL.

DIAGNOSIS:- BERI BERI

DIARRHOEA.

DIED 29-8-45

5826979. — BANDSMAN. CLARKE, W.L. 4th SUFFOLK REGT.

ADMITTED: 16-8-45.

HISTORY: Swelling of feet for 1 week, during which time he has been eating very badly. Mental condition poor – will not make any effort.

EXAMINATION: Oedema – feet +, legs very slight.

C.V.S. Pulse irregular. H.S. clicked. Resp. System. P.N resonant. B.S. clear.

C.N.S. Reflexes normal. Abdomen – N.A.D. Diarrhoea with abdominal cramp.

℞ O.D. No fluids 3iv (Ung. B,). Tab creosote. B.I.D.

17th No change.
18th Improved mentally. Diarrhoea 6x/night.
19th Appetite better
20th Fair night. ℞ Glucose 20gr. t.d.s.
21 Still eating badly. Very slight oedema of feet.
23rd No change.
25th Tube feed this evening – broth.
26th Eating a little better.
27th Still weak.
29th TRANSFERRED TO MILITARY HOSPITAL.

DIAGNOSIS: BERI BERI c̄ OEDEMA ∴ DIARRHOEA.

DIED – 29-8-45.

2009990. SPR. BLOGG, N.C. ROYAL ENGINEERS.

ADMITTED: 30-8-45

HISTORY: Sick on return to this Camp from Factory Camp 18-8-45, - anorexia & vomiting. Since then he has been eating Sparingly. Had diarrhoea 3 days ago - 4x/day. Today he vomited about 3 pints of gastric contents. between 1300 & 1400 hours & became very dehydrated.

EXAMINATION:- Thin, dehydrated, eyes sunken. Claims that sweet fruit made him vomit. No oedema. No fever.

C.V.S. - Pulse regular but weak. H.S. closed. Abdomen: No palpable masses.

Resp. System: P.N. resonant. No accompaniments.

Stool: watery: no blood or mucous.

℞ Sulfadiazine, Tabs 2. T.i.d. P.C. 0,15 mgm. Plasma 300 cc.

Evening - Ate evening meal. At 2100 hours vomited about 6 pints of gastric contents & passed liquid stool - about 2 pints. Pulse feeble - 100.

℞ Paregoric 4cc. Codein gr ½. Caffein 1cc 4 hourly

2300 hours - Semi comatose - chronic spasms of limbs.

Pulse very weak & irregular.

DIED AT 23:35 hours.

DIAGNOSIS: ANOREXIA: DIARRHOEA?

DEBILITY.

H133376. PTE. ALLEN. R. 16th DIV. RECCE. BATN.

ADMITTED:- 22-8-45.

HISTORY:- Admitted from Hill Camp. Diarrhoea & Beri Beri for 3 weeks.

EXAMINATION: Oedema:- feet +; Legs above knees normal.
STOOLS:- about 20 x/24 hours. - watery & numerous. No blood or pus.
℞ B, 25 mgm. h.v 3 T.i.d. P.C. Sulphadiazine GM.1. T.i.d. P.C.
Paregoric 4 cc. B.n.d.

24th Slight oedema of feet. - No change in stools.

26th No oedema of feet. Stools less - about 12-15 x/24 hours

28th No change in number of stools.

TRANSFERRED TO MILITARY HOSPITAL 29-8-45.

DIED - 1-9-45.

—H—

889985. GNR. LINES, J.W.L. ROYAL ARTILLERY.

ADMITTED: 24-8-45.

HISTORY:- Admitted from Hill Camp. Diarrhoea, anorexia and epigastric pains for 3 weeks. Has improved since arrival in this camp on 21st. - appetite improved, bowels now about 6x/day, 2-3x/night

EXAM: Patient is very thin, wounded about himself.
C.V.S. - HS. clear. Pulse regular. Resp. System - N.A.D.
No oedema of legs. STOOL - watery, no mucous or pus.
℞ Parenteric 4cc. B.I.D. · Plasma 300 cc.

26th ℞ DEXTROSE · 1000 cc. Looking better.

28th Very distressed after accident. In ward when a dozen of Relief Supplies crashed through roof & partly demolished the ward.

TRANSFERRED TO 1st MILITARY HOSPITAL 29-8-45.

DIED 2-9-46

5774454. PTE WILDE. E. 6th BTN. ROYAL NORFOLK RGT.

ADMITTED:- → 1.9.45

HISTORY:- Sick on return from Hell Camp 21.8.45 having suffered from Chronic Malaria, malnutrition with oedema. Ascaris. Recurrent Diarrhoea. On arrival in this camp – Diarrhoea & Debility.. Admitted Hospital – Chronic Diarrhoea – profuse watery motions – no Bom. General Condition – Emaciated & anaemic, depressed mentally. Anorexia. No oedema of legs or feet – slight abdominal cramps.

℞ Sulfadiazine Grms. T.I.D. Paregoric 4cc T.I.D.

2nd Condition improved – more cheerful. Eating well. Still severe diarrhoea.
3rd. Still improving in appearance, but no improvement in diarrhoea.
4th At 0200 hours, orderly noticed stertorous breathing. Patient asleep at time – quickly became comatose and DIED at 02.05 hours.

DIAGNOSIS: ACUTE CARDIAC FAILURE.

MALNUTRITION.

ACUTE DIARRHOEA.

Q.M.C. 938. L/BDR. HOLMES. F. ROYAL ARTILLERY.

ADMITTED:
HISTORY - Ex Hospital patient with still some Beri Beri & slight oedema.
Developed diarrhoea was transferred to the Military Hospital at
Taihape where he died 5.9.45. presumably from
Beri Beri & Oedema.
Diarrhoea

6906772. Sgmn. MORAN, S.J. ROYAL SIGNALS

ADMITTED: 21.8.45.

HISTORY: Admitted from Hill Camp. Reported sick beginning of July with Beri Beri c̄ Oedema. Developed Broncho-pneumonia & recovered from it.

When admitted here, was almost moribund. Pulse weak - 120/min. cyanosed, rapid respirations. Oedema of feet +; Abdomen distended + c̄ fluid. Frequent passage of stools, but aware that he is about to pass a stool.

22nd ℞ Glucose 20cc. intrav. + B₁ 1cc (50 mgm) Milk ½ pint T.I.D. & biscuits. about 15 stools at night, watery, no B. or M. or pus.
℞ Paregoric 1cc. T.I.D. P.C. General condition slightly improved.
℞ Plasma 300cc.

24th More alert. Pulse stronger.

26th Oedema of feet & abdomen less.

28th Appetite better, but only for fluids.

30th Weaker today - bowels increased 10x/day - watery stool.

1/9 Diarrhoea 8x/night. ℞ Sulphadiazine Gm.1. T.I.D. P.C.

2nd Weaker today.

3rd Mucous râles both bases.

4th much weaker. R Glucose 300 cc. Dextrose 1000 cc..

5th Says he feels much better this morning but looks ill.

Became comatose at 11.30 hours. and

DIED AT 17.05 hours

DIAGNOSIS: BERI BERI & OEDEMA.

DIARRHOEA.

DEBILITY

RE- PATIENTS TRANSFERRED TO MILITARY HOSPITAL, AOMORI

- after their removal from this camp, no further case history is available except that in the case of a death, the date of death was given. Thus we are unable to give any a final diagnosis.

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