

Wounded In Action, 4 July 1944, in Italy, by American artillery fire

Admitted to 12th General Hospital, 15 July 1944, from 56th Evac Hosp.  
from 33rd Field Hosp.  
from 109th Med. Bn.

Died, 23 July 1944, of hemorrhage, following breakdown of a surgically sutured bowel.

This 21 year old German soldier received severe abdominal wound and moderate wounds of right and left thighs. 1,000 cc. of blood and some plasma were given at a Medical Battalion before he was sent to 33rd. Field Hosp., where about 15 hours after injury the wounds were debrided, the abdomen opened and transected jejunum repaired end-to-end, sulfanilamide sprinkled in the abdomen and the wounds drained. He passed through the 56th Evac. Hosp. to reach the 12th General Hospital, where he arrived in poor condition, markedly undernourished, with abdominal wound partly open and infected. The patient complained of mild abdominal pain. The sutures were serving no purpose and were removed. He seemed "on-the mend" when, on 23 July 1944, he developed sudden distention, tenesness, rigidity, cyanosis, and air hunger. The hands and feet were cold, the body warm, the skin dry and the pulse almost imperceptible. Oxygen and gastric suction were of no help. Death occurred quickly after development of symptoms.

The salient autopsy findings were:

"The body is that of an ill-developed, poorly nourished young adult white male, measuring 5'4" in length and weighing an estimated 90 pounds. Rigor and dependent lividity are well established. There is a rather striking waxy pallor to all skin surfaces.

The intercostal spaces of the chest are prominent. The abdomen is emaciated and somewhat rigid. There is a fairly recent left upper rectus incision 16cm. in extent which has partially separated, exposing the peritoneum to the width of 2 cm. and a total length of 5 cm. The marks of irregularly placed stay sutures are evident.

There are small healing wounds of the left hip and right thigh, none of any extent.

A midline primary incision through nearly non-existent subcutaneous fat and muscle reveals about 1000cc of non-clotted blood in the abdomen. The source of this is evident when the lower end of the jejunum, which is found plastered by recent fibrin plaques in the lower end of the right colic gutter, is freed with the fingers. At once a quantity of partially digested blood pours into the belly through a rent in the bowel at this site. The remnants of suture material indicates that this was the site of surgical repair noted in the history. All small bowel loops are distended with blood, chiefly those of the ileum, but some is found in the duodenum also.

Lung (3 sec): There is a widespread pulmonary edema. Red cells are noted in bronchio and alveolar spaces. There is a "bronzing" of the tissues evidently from the action of gastric juices (HCL). A developing bronchopneumonia is evident.

Kidney (3 sec): There is an acute passive congestion. An occasional sulfa cast is evident in the collecting tubules. These casts are not numerous."

Clinical Diagnoses:

- (1) Acute peritonitis, cause undetermined.
- (2) Possible acute pancreatic necrosis.
- (3) Wound, penetrating, abdomen, with transection of jejunum.
- (4) Laparotomy and repair of injured bowel.

Pathologic Diagnoses:

- (1) Recent breakdown of jejunal suture.
- (2) Hemoperitoneum (1000cc); estimated 2000cc of blood in small bowel.
- (3) Aspiration pneumonia, early.
- (4) Chemical (reactive) peritonitis, mild.
- (5) Esophageal erosions, early, acute.
- (6) Partially separated left upper rectus surgical incision.
- (7) Emaciation.
- (8) Anemic pallor of skin.

Additional (histologica) diagnoses:

- (9) Sulfonamide nephropathy, minimal.