[redacted] - T/5, 887th Airborne Co., (CE) V.R.

Injured: 11 July 1944 by a M1 rifle bullet in Rome, Italy.

Admission: 11 July 1944 (Direct).

Died: 14 July 1944, of severe disseminated fecal peritonitis as result of his injury.

This 31 year old soldier was accidentally shot through the upper abdomen by a fellow soldier and was brought to hospital one-half hour later in profound shock. At operation shortly thereafter following 1000 cc transfusion, 2000 cc of blood was found in the belly mixed with bowel contents of peas and corn, ect. A 3 cm. tear was repaired in the mid-duodenum, two holes closed in upper 9 inches of jejunum and two perforations of transverse colon were exteriorized as double barrel colostomies. A further 500 cc of blood was given during operation, pressure falling from 110/70 to 90/70. Following operation the patient became cyanotic, pressure dropped to 60/40 where it remained until death. He seemed to remain in a condition of constant shock from which he did not recover. Distension required continuous suction. The hemotoerit remained at 40, Hb. 13 grams, plasma proteins at 7 & 7.2. A further 1000 cc. of blood and 2000 cc. of saline were given, but a relative anuria (130 cc. urine toilet) developed. NPH 5 hours before death was 45 mg %. He died with clinical picture of chronic cyanosis and shock.

The salient features of the postmortem were:

The abdomen is swathed in bandages, removal of same disclosing a bilateral double-barrelled colostomy, one in each hypochondrium. The clamps are still in place. There is also a recently sutured right rectus incision extending from the umbilicus to a point one cm. above the pubis. The abdominal wall is distended and somewhat rigid.

The midline incision discloses well developed musculature and a moderate amount of chest and abdominal fat. All peritoneal surfaces are hemorrhagic and plastered with a varying-sized plaques of fibrin, much of it stained with feces. A small quanity of gase escaped when theabdomen was opened. The ileum is considerably distended with gas and fluid; the remaining small and large bowel are flat. There is a developing subphrenic abscess between the right lobe of the liver and the diaphragm. The left diaphragm lies at the fourth interspace, the right at the level of the third rib.

The stomach shows considerable post-mortem erosion and contains about 200 cc. of foul smelling black, semi-fluid material mixed with bile. In the mid-portion-of the the duodenum is a surgically-sutured tear on the anterior surface that has broken down, the sutures beingwidely separated. Two cm. distal to the ligament of Treitz is a sutured 2 cm. laceration in the jejunum which has likewise broken down. About 18 cm distal to this is another sutured laceration which has shared the same fate. There are two lacerations in the transverse colon of similar dimensions, one just distal to the hepatic flexure and one just proximal to the splenic flexure. Both have been exteriorized through stab wounds, together with the proximal segment of the former and the distal segment of the latter.

(Clinical Diagnoses:)

(1) GSW, perforating, of abdomen.
(2) Peritonitis.
(3) Shock, prolonged, severe.

(Pathologic Diagnoses): (Gross)

(1) GSW of abdomen; point of entry 2 cm. below and 1 cm. to the right of umbilicus; point of exit 2 cm. to the right of lumbar spine at level of iliac crest.
(2) Fecal peritonitis, disseminated, severe.
(3) Perforations, sutured, of transverse portion of duodenum (1)-first tem inches of jejunum (2)-and transverse colon.
(4) Paralytic ileus, moderate.
(5) Atelectasis, post-operative, of major portions of all lung lobes, save left upper
(6) Bronchopneumonia, confluent, early, of collapsed lung areas.
(7) Exteriorization, surgical, of transverse colon.