

現代化的病歷整理法

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——主持 「甲狀腺癌」討論會後有感

當獲悉許多有關學校的動態時，我彷彿又回到四、五年前愉快的學生生活裏頭，其內心的興奮是難以筆述的。更感激綠杏社諸同學的努力，開闢此一多彩多姿的「校友欄」，使畢業同學得以集聚一堂，相互暢談生活趣聞，重溫舊歡。

在此底特律市，同班的同學有簡正義、張浩信、周建陽、洪碩人及張峰壽諸位開路先鋒，還算相當熱鬧，除張峰壽兄專攻婦產科之外，其餘均是再世「華陀」，拿刀子生活的外科醫師。

最輕鬆的莫過於週末的兩天了，電話鈴一響，準又是節目，不是開車去欣賞立體彩色電視，便是野餐、郊遊、溜冰、滑雪、打保齡球或到中國館打打牙祭了。又美國電話設備很是方便，只要多撥個“1”及地區代號，便到處可通；而且假日、週末晚間七點以後又差不多都半價優待；所以不管你在紐約也好，匹茲堡也好，甚至巴爾地摩或遠在加拿大，也照樣拿起電話聊個不停，因此往往忘記自己已是位在地球另一半的旅客！

偶而幾個同學在一起聊天的時候，都深感到美國醫院內醫師們傳讀最新醫學雜誌，三五成群討論醫學問題的風氣非常旺盛。依我個人的觀點，以為和他們學生服務的醫院有關。因為他們的醫院，不僅病人多，醫院儲藏病歷豐富，圖書館的藏書更是驚人，再加上研究設備，研究基金等的特殊環境，耳濡目染的關係，程度和學習態度自然提高不少。

所以我很希望能借這次主持「甲狀腺癌」討論會之後，由我在準備及收集資料中所經歷的某一角度上來介紹美國的醫學生，在美國醫學會所認可合格的醫院中的工作情形，尤其偏重他們的實驗報告和病歷整理。

當然，過去我因為都在婦產科，所以不太敢在甲狀腺癌的專門範圍下太深入的討論，還希望諸位外科和內科的前輩多多指教。

事情發生在幾個星期之前，有一天，突然獲得醫學教育部門主席的電話通知，雖然開始總勉不了，一些客套話噓寒問暖，再加上“Would you please try to…”或“Would you kindly…”使我不好意思加以拒絕。但想到要用夾雜著中、英、日、德、台口音的洋徑邦英文在那些金髮、綠眼、黑皮、白牙的大醫師前獻醜時「發作性心搏加速」及打躬作輯的老毛病便又復發了，但騎虎難下，不得不硬著頭皮闖關了。

準備期間最使我們佩服的是負責醫院病歷記錄的部門，不僅打字機、錄音機、複印機、射影……等，設備齊全之外，而且人員充備，甚至還有特別人員專門審查病歷記錄，如果有不完全的，立刻發回補寫。至於對一些早期的病歷，則一律用微粒射影（Microfilm）的方法加以保藏。譬如這個病例，在我告訴他們姓名之後，不到十分鐘，便能毫不費力的分別從26, 21, 10, 及3年前的病歷中，完整無缺地取出有關之病歷和膠卷。

此處的醫院圖書館，不僅醫學參考書、醫學雜誌的收藏豐富，而且整理得非常完善，如果需要的話，他們還能供給複印。醫院裏就有三架Xerox（複印機），隨時可以操作，有時有趣的病歷也可供人複印。另外，他們服務的態度又非常週到。有一次我想知道德國婦產科的進步情形，想我“Geburtshilfe und Frauenheilkunde”這本刊物，圖書館馬上就查到大學部的目錄中有，而且在電話中就很快地接洽妥當。甚至他們還能幫忙醫師們買書呢？每天從早上八時開到晚上十時，星期日並不休假。

整天都擠滿了撰寫報告的教授、學生和醫生們，很少能有空間被充作開會或其它的用途。

另外在放射線科的部門，醫師們都利用錄音機先錄音，然後由六、七位專門負責打字的人士打寫報告。因此放射線科的醫師們可以節省許多的時間，同時，醫院裡申請照射 X 光的手續也不像國內那麼複雜。病歷是與病人一齊送去放射線科的。而且如果放射線的醫師們如果有特殊的發見時，還可參予主治醫師們的討論，並作建議。

其他像病理室方面，大致與我們學校相同；只是這裏的實驗或其他與臨床有關的科目很進步，負責又可靠。這點在診斷及治療上對醫師有很大的幫忙。

最後，談談這個甲狀腺癌的病例吧！

根據美國癌症研究協會的統計，甲狀腺癌的死亡率平均是百分之零點四。男性為 0.3%，女性為 0.6%，比其他的癌症死亡率要少。有人根據組織病理將其又分為①低度惡性，②中度惡性，③高度惡性等；根據最近有關癌症的報告；甲狀腺癌在經過放射線照射後的 latent period 很長，一般平均是 21.5 年。至於我們這次討論的重點，則大概是子宮頸癌到底與甲狀腺癌是否有關；病人服用甲狀腺荷爾蒙的問題，和放射線與甲狀腺癌復發的關係，以及甲狀腺癌的治疗問題等等。

下面附上此次討論的病例，以供各位校友參考。

A 71-year-old white female was admitted to the Hospital for repeat isotope study and lung biopsy on February 18, 1970.

Present History: About 4 months prior to this admission, the patient had fever, general weakness, some dyspnea on exertion, and some changes in the voice with occasional respiratory stridor without productive cough, chest pain, or hemoptysis. A routine x-ray study at that time revealed a large mass measuring 5-6 cm. in diameter in the chest. One month later on December 11, 1969, the patient was first admitted for evaluation of the mass in the chest. At this time the isotope study was done, but was unsatisfactory, because of the previous thyroid medication which the patient has been taking since 1960. The patient was discharged with advice to discontinue the medication for approximately 4 weeks. The patient is now being readmitted for work up of the mass in the chest and a repeat isotope and lung biopsy.

Past History: A vaginal hysterectomy which followed by radium irradiation due to cervical cancer was carried in 1944. Acute appendicitis with peritonitis three years ago. Three previous thyroid operations - i.e. in 1949 subtotal thyroidectomy for hyperthyroidism. In 1958 excision of tumor mass on the neck. In 1960 excision of the remaining left lobe of the thyroid which was followed by cobalt-60 therapy.

Physical Exam: BP - 160/80, PR - 90/minute, BT - 98.6°F, The patient appeared to be well developed weighing 152 pounds and 5.4" in height. There were no palpable masses except an old thyroidectomy scar on the neck. Lungs - clear to auscultation. Heart - regular rhythm, no murmur. Abdomen: old appendectomy scar, soft, no tenderness and no masses or organs palpable. No peripheral edema. Neurologic examination within normal limits.

Laboratory Data: Serum thyroxine (T_4): 3.5 mcg% as iodine range 2.7-7.4 P.B.I.: 7.4 μ g. BUN - 24 mg%, Uric acid - 7.9 mg%, Alka. phosphatase 100 mu/ml., Hb - 12.7 Gm., Hematocrit - 37.7%, RBC - WBC - 7.1×10^3 with 62% neutrophils, Lymphocytes - 32%, Monocytes - 6%. Urinalysis showed a specific gravity of 1.010, PH - 5.6, Sugar and Protein - Negative. Microscopic examination showed 4 - 5 white blood cells per high power field, no crystals and one positive of bacteria. Blood chemistry revealed normal value including serum calcium - 10.3 mg%, inorganic phosphate - 3.6 mg%, total protein - 6.8 gm%, Albumin - 4.3 gm%, total bilirubin - 0.6 mg%, SGOT - 25.3 mu/ml, and LDH - 125 - mu/ml.

Pulmonary function test showed mild air flow obstruction. Bronchial washings for cystology and bacterial study which revealed coagulase negative staphylococcus were done. X-ray film and isotope were carried, E.K.G. demonstrated within normal limit.

Hospital Course: Following the laboratory study, the thoracotomy was performed on February 24, 1970. The prophylatic antibiotics such as Procain Penicillin and Streptomycin, the therapy of I.P.P.B. and two units of blood were given post-operatively. However, on the second postoperative day, numerous premature atrial and nodal conc. was noted by EKG which disappeared after the second day of digitalization. The chest tube was removed on February 28, 1970. The thyroid extract started on March 3, 1970. The last EKG on March 5, 1970 demonstrated mild antero-lateral ischemia, otherwise, the patient is asymptomatic at the present time.

(1) Dec. 16'69

I-131 uptake: The thyroid uptake of radioactive Iodine 131 was found to be 2.8 per cent at two hours and 3.5 per cent at 24 hours. These values fall within the hypothyroid range.

Thyroid scan: A scintiscan and a photoscan of the thyroid gland were obtained following the 24hour uptake count. There is evidence of a small zone of functioning thyroid tissue within the right side of the neck apparently representing the lower pole of the right lobe of the thyroid gland. The functioning tissue in this region concentrates the isotope a homogeneous fashion. A very faint concentration of the isotope is evident on the left side apparently representing a very small amount of functioning tissue within the region of the lower pole of the left lobe. The patient states that she has had a previous thyroidectomy 15 years ago followed by radiation therapy. There is no evidence of substernal extension of the thyroid gland or an uptake of the isotope by any of the other soft tissue structures of the neck.

Conclusion: 1. The patient is hypothyroid.

2. There is evidence of a small zone of functioning tissue on the right in the region, of the lower pole of the right lobe of the thyroid gland.

Very faint concentration of the isotope is also evident on the left which may be incident to a small amount of residual functioning tissue in this area as well.

(2) X-ray report of Dec. 11 '69

Chest: PA and left lateral projections of the chest reveals evidence of a large round soft tissue mass measuring 7.5 cm. in diameter lying adjacent to the right lateral border of the heart. It is difficult to identify the medial border of the mass on the frontal projection. Although the mass may represent a paracardial or bronchial cyst there is evidence of a second nodular density within the right upper lobe measuring 1.2 cm. in diameter suggesting the possibility that we are dealing with a metastatic process. A third nodular density appears to be superimposed over the lower pole of the right hilum. This measures 2.2 cm. in diameter. This is not a hilar mass but is present within the lung behind the right hilum and superimposed over it on the frontal projection. The heart appears to be slightly enlarged and there is evidence of slight elongation of the arch of the aorta without evidence of aneurysmal dilatation. There is no evidence of free pleural fluid. A tiny nodular density measuring 0.5 cm. in diameter is evident within the left lower lung field and there is also evidence of another nodule of 6 mm. in diameter lying about the periphery of the large mass within the right lower lung field. All of these nodules point to a metastatic process. The bony thorax is grossly intact.

Conclusion: There is evidence of an extremely large soft tissue mass within the right lower lung field adjacent to the right lateral border of the heart in addition to multiple other nodules within the right lung and at least one small nodule within the left lower lobe. This indicates the presence of metastatic disease.

X-ray Report of Feb. 23 '70

Chest, multiple views: Comparison with the previous examination of 1-17-70 and 2-14-70 shows no change in the appearance of the large mass in the right lower lobe or in the appearance or size of the nodule in the right infraclavicular region.

Impression: No change in the appearance of the chest since previous examination of 1-17-70 and 2-14-70.

Pathological Description of Surgical Tissue and Diagnosis

GROSS:

The specimen is a round-shaped previously opened mass measuring 7 X 7 X 4.5 cm. The surface is covered by a glistening and hemorrhagic serous membrane and the opposite side, the area is hemorrhagic and rough. The surface area is generally smooth and pinkish and is grossly nodular. On cut section, in the central area of the sectioned surface, a thick fibrous band is running through the central portion of the tumor mass. The sectioned surface is greyish to yellowish with a rubbery consistency and is largely occupied by the nodules separated by thin fibrinous capsule. Also, the sectioned surface is grossly hemorrhagic with a soft consistency.

Also submitted, is a rib, measuring 15.5 cm. in length and 1.5 cm. in width and 0.8 cm. in thickness.

DIAGNOSIS: Adenocarcinoma, papillary and solid, metastatic to right diaphragmatic pleura, consistent with origin in thyroid gland.

NOTE: The tumor is a mixture of papillary, solid and occasionally microfollicular tissue. It is in part similar in appearance to a solid and papillary thyroid lesion removed in 1949 (Surg #65341), a papillary lesion removed from an unspecified site in the neck in 1958 (Surg #8970) and to a mixed papillary and solid adenocarcinoma of thyroid removed in 1960 (Surg. #21868).