IN REPLYING. ADDRESS THE
Chief Medical Officer

TREASURY DEPARTMENT
U. S. PUBLIC HEALTH SERVICE

UNITED STATES PENITENTIARY
LEAVENWORTH, KANSAS

June 3, 1939.

Justine K. Puller,
Medical Director,
U. S. Bureau of Prisons,
Washington, D. C.

Dear Dr. Fuller:

This is to acknowledge receipt of your letter of June 2nd, Air Mail confidential, making inquiries as to the physical condition, diagnosis and treatment in the case of T. J. Pendergast.

Following is result of our physical examinations, history and most recent acute set-back received in the case of this patient, together with our diagnosis.

Have history of luetic infection over 23 years. For past ten days has shown evidence of aortitis with dilatation and evidence of aortic regurgation.

History of acute coronary thrombosis three years ago. Electrocardiogram persistently shows a deep Q 3 wave.

History of many anginal attacks for past two months for which patient takes nitroglycerin and barbiturates frequently. History of cecostomy of which you probably have information. Had suprapubic prostatomy three years ago and patient at present has dysuria and frequency. Required frequent catheterization just prior to admission to the institution; and for past several days patient has been complaining of dyspnoea, precordial pain radiating to the shoulder and arm following the slightest exertion. On June 2nd, 8:30 PM patient was found to be extremely pale, cyanotic, especially around the lips and complaining of severe precodial pain radiating to the shoulder and arm. Pulse was thready, rapid and quite irregular.

Nitroglycerin was administered and patient was somewhat relieved but dyspnoea persisted. Patient was hospitalized at 9:30 PM on a stretcher and received morphine sulphate with atrophine. Nembutal was given at 1 AM June 3rd as patient was very restless and had not slept.

Blood pressure on admission to the institution

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was 116/76 and at 9:15 AM June 3rd, 102/76.

Our opinion is that the patient is having an acute coronary occlusion which is a possible recurrence of previous attacks and in our opinion is considered to be in a serious condition.

Our basic diagnoses todate are as follows:

1. Coronary occlusion with cardiac decompensation and frequent anginal attacks.
2. Syphilis, tertiary, with aortitis and aortic dilation.
3. Chronic cystitis following suprapubic prostatectomy.
4. Colostomy for relief of diverticuli of sygmoid.

His prognosis must be "guarded" due to the uncertainty of the condition in each cardiac episode.

His treatment at present consists of –

1. Nitroglycerin, grains 1/100 p.r.n. for anginal attacks.
2. Aminphylin tablets T.I.D.
3. Protioidide of mercury, 1/2 drams T.I.D.
4. Nembutol, grains 1 1/2 at bed time.
5. Morphine sul phate, grains 1/4 for severe attacks.
6. Special diet for colostomy.
7. Absolute rest in bed.

Respectfully,
C. H. WARING
C. H. WARING.
Sr. Surgeon, U.S.P.H.S.,
Chief Medical Officer.

CHW/w