Standard Form 502
Rev. August 1984
Bureau of the Budget
Circular A-32

970087

CLINICAL RECORD	NARRATIVE SUMMARY	
DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED
2 July 1967	4 October 1967	

(Sign and date at end of narrative)

CLINICAL DIAGNOSIS: INFECTED HANGNAIL (RECURRENT)
IRON DEFICIENCY (UNTREATED)
PARANOID SCHIZOPHRENIA

The patient is a twenty-one (21) year old hospital corpsman who entered the hospital on 2 July 1967 after having complained of a hangnail of two days duration on the right first toe. The surgical intern graciously volunteered to treat this condition in the surgical clinic. This was accomplished under local anesthesia *and* the patient was instructed to stay off his feet and soak the toe three times a day for two days. The patient returned to the hospital that evening after being informed by the administrative watch that he could not be allowed off work without being admitted to the hospital. He was, therefore, admitted on a short form to Ward C by the medical intern on watch. A complete physical examination was entirely normal *and* the past history was not contributory. lie was placed on warm moist soaks to the right foot.

Admission laboratory data included a normal hemoglobin and hematocrit. The white blood count and differential were normal, although three lymphocytes were noted to be atypical. A urinalysis, BUN, PBS, two hour postprandial blood sugar, creatinine, uric acid, calcium and phosphorus were within normal limits. A throat culture grew Neisseria species, Alpha strep and Beta strep. On the basis of the atypical lymphocytes further laboratory evaluation was obtained. A Mono-screen was negative as was a heterophile titre. SCOT, SGPT, alkaline phosphatase, and serum bilirubin were normal. A febrile agglutination determination and an ASO titre were negative. '

The patient ran an afebrile hospital course and was asymptomatic until he complained of dizziness on returning from the laboratory on the third hospital day. By this time, it was the Fourth of July and the patient had been in the hospital forty-eight hours. lie could not be discharged from the hospital on a holiday because of his active duty status and, therefore, had to be worked up on a long form. The patient was worked up by the other medical *intern* who took a real interest in the case and re-ordered the initial laboratory data as well as a glucose tolerance test, a PBI, and 0800 and 2000 plasma steroids to attempt to explain the fainting episodes. These studies were all normal.

(Use additional sheets of this form (Standard Form 502) if more space is required)

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (Typed or written entries: last, first, middle; grade; date; hospital or medical facility)

SCHMUT, HARVEY L. HM3/USN/AD

REGISTER NO.	WARD NO.
970087	C

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In the meantime, however, the patient had developed an infection of the surgical wound incurred as treatment for hangnail. As he was already on penicillin for the strep throat, a culture and sensitivities was obtained. The organism was a Pseudomonas species, sensitive to Chloromycetin. This drug was given over a ten day course and the patient was followed with daily white blood counts and platelet counts.

After two weeks of intensive therapy, the patient was ready to be discharged. However, a recheck of the hemoglobin was found to be low and the patient was transferred to the Medical service for workup of his anemia. A blood morphology, red blood cell indices, serum iron, total iron binding capacity and a bone marrow determination were consistent with iron deficiency anemia. A complete workup for gastrointestinal bleeding was scheduled. The upper GI series was negative. The barium enema was likewise negative. Unfortunately, however, while the patient was evacuating the barium, prior to the post-evacuation film, he was locked in the head. As it was sixteen hundred hours, Friday, he remained in this unfortunate circumstance until Monday morning when he was discovered by the radiologist. At that time he was incoherent, suspicious, and uncommunicative. He was transferred at that time to ward L.

The patient was seen by the psychiatrist on weekly rounds and was described as a psychotic schizophrenic having an inordinate amount of hostility, mostly directed toward the medical profession. At that time the patient was examined accidentally by the medical intern who came out to admit another patient and was misdirected. The only abnormality noted was a recurrence of the hangnail on the right first toe. At this time the patient was being held for boarding prior to undesirable discharge. It *was* decided that a surgical consultation should be obtained to deal with the recurrent hangnail. Before this could be done, however, the patient left the hospital against medical advice.

At this time, his whereabouts is not known and he is on no medical treatment. His diagnoses are relapsing hangnail, iron deficiency anemia of unknown etiology (untreated) and paranoid schizophrenia. on return to this facility the patient will, of course, be subjected to disciplinary action. He also will have a complete evaluation of his rather complex medical problems which are felt to perhaps represent a heretofore undescribed syndrome or at least
a complex metabolic disorder. It is our feeling that he should be boarded out of the Navy without disability as this condition is undoubtedly one of congenital origin, and therefore existed prior to induction.