CLINICAL SUMMARY: This 38 year old white male gave history of having bouts of severe abdominal pain. In December 1970 he was explored and appendectomy was done. Because of continuing pain, he was re-explored in 1/1971 to rule-out carcinoma of head of pancreas. At operation, a sclerotic and narrowed common duct, thickened gallbladder and enlarged retroperitoneal nodes just above pancreas. Pathology report at that time was sclerosing cholangitis. Liver biopsy normal. Cholecystectomy and choledochostomy with T-tube drainage performed. Post-operatively, patient had febrile course. He went on to develop marked weight loss of 37 lbs. Patient eviscerated following breakdown of operation site and admitted to NEBH on 3/4/71. At that time, T-tube cholangiogram was interpreted as being consistent with sclerosing cholangitis. He was given high caloric diet. His wound began healing and no further surgery was felt indicated. He was, therefore, discharged on 3/16/71 with T-tube still in place. At home, patient had further weight loss and recurrence of cramping abdominal pain. He also noted bile drainage from T-tube slowed down. After one and one-half months, patient was readmitted to NEBH for further evaluation. Examination of abdomen revealed abdominal T-tube in place and granulating wound at site of previous surgery. No other reported significant physical findings. Patient thought to have biliary colic and on 5/5/71, common duct exploration done. No stone found. Duct noted to be patent. Multiple adhesions noted in liver hilar area. Pancreas reported negative. Lysis of adhesions performed. Post-operatively, patient became hypertensive with blood pressure of 200/140. He remained febrile throughout most of his hospitalization with temperatures ranging up to 104°. T-tube culture reported to grow Proteus mirabilis and Staphylococcus, coagulase positive. White blood count on 14th post-operative day 15,000. On 22nd post-operative day, upper gastrointestinal series showed duodenal fistula. Methylene blue adminstered by mouthappeared immediately in region of Penrose drain at operative site. Because of patient's poor nutrition, it was decided a feeding jejunostomy tube should be placed in order to force high caloric intake. At this time, fistula draining about 2700 ml. of fluid per day. Patient continued febrile course with cough, congestion and rales. He was treated with Keflin and Chloramphenicol but no obvious response. On 37th hospital day, patient had black vomitus and became hypotensive. He was treated with Aminophylline and cardiac massage for one-half hour. Patient pronounced dead at 2:45 P.M. on 6/11/71.

PREVIOUS PATHOLOGICAL DIAGNOSES: 3/5/71 (#71-C-142): Hyperplastic lymph node; chronic cholecystitis; portion of bile duct with slight chronic inflammation and fibrosis; slight bile stasis in centrilobular area. 5/5/71 (#71-S-4011): Degenerated and necrotic, partially hyalinized nodule with focal acute inflammation.

EXTERNAL DESCRIPTION: Cachectic-appearing, well-developed white male measuring 173 cm. in length, weighing approximately 52 kg. No rigor or livor mortis. Black hair with normal male distribution. Blue-gray eyes