(7)

Connolly, John B. 3

R ; 220 STATUS: Pvt

Other Individuals and Organizations Involved or Interviewed John Connally

UNIT # 26 36 99

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: 11-22-63 Thoracic Surg AGE: RACE: W/M

PRE-OPERATIVE DIAGNOSIS: Gunshot wound of the chest with comminuted fracture of the 5th rib

POST-OPERATIVE DIAGNOSIS: Same with laceration right middle lobe, hematoma lower lobe of lung

OPERATION: Thoracotomy, removal rib fragment, debridement of wound BEGAN: 1335 ENDED: 1520

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: M Giesecke

SURGEON: Robert Shaw, M.D DRAINS:

ASSISTANTS: Drs. Boland and Duke APPLIANCES:

SCRUB NURSE: King/Burkett CIRC. NURSE: Johnson CASTS/SPLINTS:

SPONGE COUNTS: 1ST Correct DRUGS I.V. FLUIDS AND BLOOD

2ND Correct

111-500 cc whole blood
11-1000cc D-5-RL

COMPLICATIONS: None

CONDITION OF PATIENT: Satisfactory

Clinical Evaluation: The patient was brought to the OR from the EOR. In the EOR a sucking wound of the right chest was partially controlled by an occlusive dressing supported by manual pressure. A tube had been placed through the second interspace in the mid-clavicular line connected to a waterseal bottle to evacuate the right pneumothorax and hemathorax. An IV infusion of RL solution had already been started.

Operative Findings: As soon as the patient was positioned on the OR table the anesthesia was induced by Dr. Giesecke and an endotracheal tube was in place. As soon as it was possible to control respiration with positive pressure the occlusive dressing was taken from the right chest and the extent of the wound more carefully determined. It was found that the wound of entrance was just lateral to the right scapula close to the axilla yet had passed through the latysmus dorsi muscle shattered approxi-

Description of Operation: mately ten cm of the lateral and anterior portion of the right fifth rib and emerged below the right nipple. The wound of entrance was approximately three cm in its longest diameter and the wound of exit was a ragged wound approximately five cm in its greatest diameter. The skin and subcutaneous tissue over the path of the missile moved in a paradoxical manner with respiration indicating softening of the chest. The skin of the whole area was carefully cleansed with Phisohex and Iodine. The entire area including the wound of entrance and wound of exit was draped partially excluding the wound of entrance for the first part of the operation. An elliptical incision was made around the wound of exit removing the torn edges of the skin and the damaged subcutaneous tissue. The incision was then carried in a downward curve up toward the right axilla so as to not have the skin incision over the actual path of the missile ben through the chest wall. This incision was carried down through the subcutaneous tissue to expose the Serratus anterior muscle and the anterior border of the latissimus dorsi muscle. The fragmented and damaged portions of the Serratus anterior muscle were excised. Small rib fragments that were adhering to periosteal tags were carefully removed preserving as much periosteum as possible. The fourth intercostal muscle bundle and fifth intercostal muscle bundle were not appreciably damaged.

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M.D.
Dr. Robert Shaw

RS:bl (continued)

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

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DESCRIPTION OF OPERATION (Continued): The ragged ends of the damaged fifth rib were cleaned out with the rongeur. The plura had been torn open by the secondary missiles created by the fragmented fifth rib. The wound was open widely and exposure was obtained with a self retaining retractor. The right plural cavity was then carefully inspected approximately 200 cc of clot and liquid blood was removed from the plural cavity. The middle lobe had a linear rent starting at its peripheral edge going down towards it hilum separating the lobe into two segments. There was an open bronchus in the depth of this wound. Since the vascularity and the bronchial connections to the lobe were intact it was decided to repair the lobe rather then to remove it. The repair was accomplished with a running suture of #000 chromic gut on atraumatic needle closing both plural surfaces as well as two running sutures approximating the tissue of the central portion of thelobe. This almost completely sealed off the air leaks which were evident in the torn portion of the lobe. The lower lobe was next examined and found to be engorged with blood and at one point a laceration of allowed the oozing of blood. This laceration had undoubtedly been caused by a rib fragment. This laceration was closed with a single suture of #3-0 chromic gut on atraumatic needle. The right plural cavity was now carefully examined and small ribs fragments were removed, the diaphram was found to be uninjured. There was no evidence of injury of the mediastinum and its contents. Hemostasis had been accomplished within the plural cavity with the repair of the middle lobe and the suturing of the laceration in the lower lobe. The upper lobe was found to be uninjured. The drains which had previously been placed in the second interspace in the midclavicular line was found to be longer than necessary so approximately ten cm of it was cut away and the remaining portion swas demonstrated with two additional openings. An additional drain was placed through a stab wound in the eighth interspace in the posterior axillary line. Both these drains were then connected to a waterseal bottle. The fourth and fifth intercostal muscles were then approximated with interrupted sutures of #0 chromic gut. The remaining portion of the Serratus anterior muscle was then approximated across the closure of the intercostal muscle. The laceration of the latissimus dorsi muscle on its intermost surface was then closed with several interrupted sutures of #0 chromic gut. ~~The subcutaneous tissue was th~~ Before closing the subcutaneous tissue one million units of Penicillin and one gram of Streptomycin in 100 cc normal saline was instilled into the wound. The stab wound was then made in the most dependent portion of the wound coming out near the angle of the scapula. Alarge Penrose drain was drawn out through this stab wound to allow drainage of the wound of the chest wall. The subcutaneous tissuewas then closed with interrupted #0 chromic gut inverting the knots. Skin closed with interrupted vertical sutures of black silk. Attention was next turned to the wound of entrance. It was excised with an elliptical incision. It was found that the latissimus dorsi muscle although lacerated was not badly damaged so that the opening was closed with sutures of #0 chromic gut in the fascia of the muscle. Before closing this incision the palpation with the index finger the Penrose drain could be felt immediately below in the space beneath the latissimus dorsi muscle. The skin closed with interrupted vertical mattress sutures of black silk. Drainage tubes were secured with safety pens and adhesive tape and dressings applied. As soon as the operation on the chest had been concluded Dr. Gregory and Dr. Shires started the surgery that was necessary for the wounds of the right wrist and left thigh.

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RS:bl

Dr. Robert Shaw

* There was also a comminuted fracture of the right radius secondary to the same missile and in addition a small flesh wound of the left thigh. The operative notes concerning the management of the right arm and left thigh will be dictated by Dr. Charles and Dr. Tom Shires.

As B+D not witnesses
Government system illegitimacy
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in ink is [illegible]