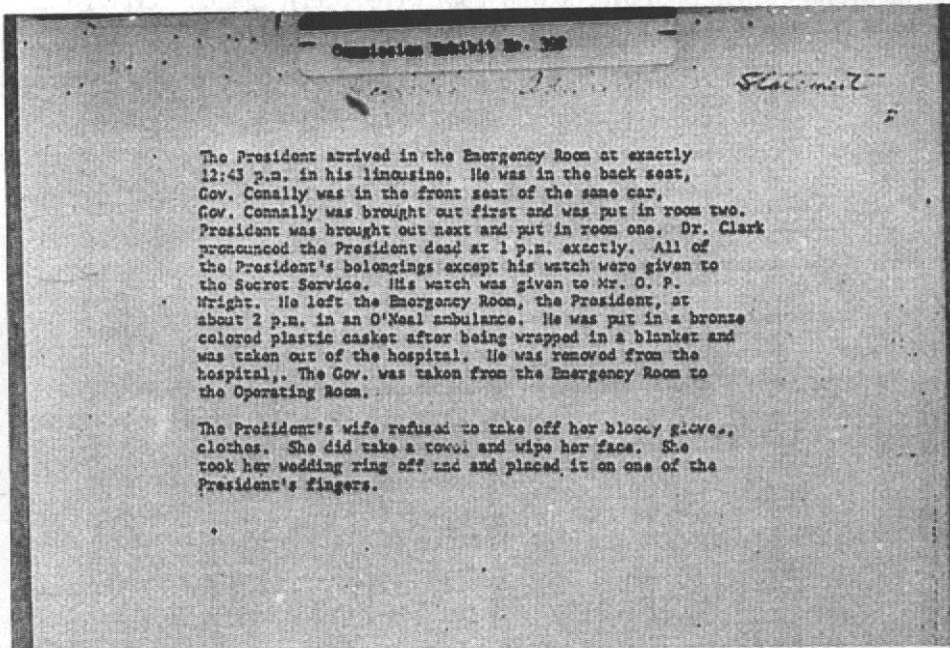


APPENDIX VIII

Medical Reports From Doctors at
Parkland Memorial Hospital, Dallas, Tex.



COMMISSION EXHIBIT No. 392

SUMMARY

The President arrived at the Emergency Room at 12:43 P.M., the 22nd of November, 1963. He was in the back seat of his limousine. Governor Connally of Texas was also in this car. The first physician to see the President was Dr. James Carrico, a Resident in General Surgery.

Dr. Carrico noted the President to have slow, agonal respiratory efforts. He could hear a heartbeat but found no pulse or blood pressure to be present. Two external wounds, one in the lower third of the anterior neck, the other in the occipital region of the skull, were noted. Through the head wound, blood and brain were extruding. Dr. Carrico inserted a cuffed endotracheal tube. While doing so, he noted a ragged wound of the trachea immediately below the larynx.

At this time, Dr. Malcolm Perry, Attending Surgeon, Dr. Charles Baxter, Attending Surgeon, and Dr. Ronald Jones, another Resident in General Surgery, arrived. Immediately thereafter, Dr. M. T. Jenkins, Director of the Department of Anesthesia, and Doctors Giesecke and Hunt, two other Staff Anesthesiologists, arrived. The endotracheal tube had been connected to a Bennett respirator to assist the President's breathing. An Anesthesia machine was substituted for this by Dr. Jenkins. Only 100% oxygen was administered.

A cutdown was performed in the right ankle, and a polyethylene catheter inserted in the vein. An infusion of lactated Ringer's solution was begun. Blood was drawn for type and crossmatch, but unmatched type "O" RH negative blood was immediately obtained and begun. Hydrocortisone 300 mgms was added to the intravenous fluids.

Dr. Robert McClelland, Attending Surgeon, arrived to help in the President's care. Doctors Perry, Baxter, and McClelland began a tracheostomy, as considerable quantities of blood were present from the President's oral pharynx. At this time, Dr. Paul Peters, Attending Urological Surgeon, and Dr. Kemp Clark, Director of Neurological Surgery, arrived. Because of the lacerated

SUMMARY

Page 2

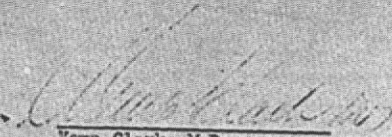
trachea, anterior chest tubes were placed in both pleural spaces. These were connected to sealed underwater drainage.

Neurological examination revealed the President's pupils to be widely dilated and fixed to light. His eyes were divergent, being deviated outward; a skew deviation from the horizontal was present. No deep tendon reflexes or spontaneous movements were found.

There was a large wound in the right occipitoparietal region, from which profuse bleeding was occurring. 1500 cc. of blood were estimated on the drapes and floor of the Emergency Operating Room. There was considerable loss of scalp and bone tissue. Both cerebral and cerebellar tissue were extruding from the wound.

Further examination was not possible as cardiac arrest occurred at this point. Closed chest cardiac massage was begun by Dr. Clark. A pulse palpable in both the carotid and femoral arteries was obtained. Dr. Perry relieved on the cardiac massage while a cardiachroscope was connected. Dr. Fouad Bashour, Attending Physician, arrived as this was being connected. There was electrical silence of the President's heart.

President Kennedy was pronounced dead at 1300 hours by Dr. Clark.


Kemp Clark, M.D.
Director
Service of Neurological Surgery

KC:aa

cc to Dean's Office, Southwestern Medical School
cc to Medical Records, Parkland Memorial Hospital

COMMISSION EXHIBIT No. 392—Continued

DATE AND HOUR: 11/22/63 1620

DOCTOR: Cassico

When patient entered emergency room on ambulance coverage had slow agonal respiratory efforts and seen cardiac beats in auscultation. Two external wounds were noted. One small penetrating wound of 1/2 inch in lower 1/3. The other wound had ruptured the calvarium and shouldered brain tissue present in profuse oozing. Pilo-erect on

Blood pressure were present. Pupils held dilated fixed.

A cuffed endotracheal tube was inserted and through the laryngeal scope a deep wound of the trachea was seen immediately below the larynx. The tube was passed past the laceration & the cuff inflated.

Respiration using the resp assistor on auto-pneum were instituted. Concurrently an IV infusion of lactated Ringer solution was begun via catheter placed in @ leg. & blood drawn for type and cross match. Type O Rh negative blood was obtained as well as hydrocortisone.

An view of tracheal injury & 4 BS on @ tracheostomy was performed by Dr Perry and Bilal chest tubes inserted.

1033

(OVER)

1767

ADMISSION NOTE

A normal IV infusion was begun & a
Dobutamine De Juhers began asap. A cardioplegia
machine, cardiac monitor & electrocardiogram attached
Solu Corfol IV given (300mg), attempt to control
shock coming from cerebral & cerebellar tissues via
picks instituted. Despite these measures as well
as external cardiac massage BP never returned
and EKG evidence of cardiac activity was never
obtained.

Charles J. Curcio M.D.

PARKLAND MEMORIAL HOSPITAL

ADMISSION NOTE

D.F. Kennedy

DATE AND HOUR:

22 Nov 1963

DOCTOR:

PERRY

Staff Note:

at the time of initial examination, the pt. was noted to non-responsive. His eyes were deviated and the pupils dilated. A considerable quantity of blood was noted on the patient, the carriage and the floor. A small wound was noted in the middle of the neck, in the lower third anteriorly. It was sending blood slowly. A large wound of the right posterior cranium was noted, exposing severely lacerated brain. Brain tissue was noted in the blood at the head of the carriage.

ulse or heart beat were not detectable, but slow spasmodic respiration was noted. An endotracheal tube was inserted and respiration was being assisted. An intravenous infusion was being placed in the leg.

At this point I noted that respiration was ineffective and while additional resuscitation was done to administer fluids + blood, a tracheostomy was effected. An ^{initial} injury to the trachea was noted. The tracheostomy tube was put in place and the cuff inflated and respiration assisted. Close chest cardiac massage was instituted after placement of sealed-drainage chest tubes, but

1033

(OVER)

1767

ADMISSION NOTE

without benefit. Electrocardiographic evaluation ~~was~~ ^{performed} that no detectable electrical activity existed in the heart. Resuscitative attempts were abandoned after the team of physicians determined that the patient had expired.

Malcolm O. Perry, M.D.
1630 hr 22 Nov 1962

(424)

COMMISSION EXHIBIT No. 392—Continued

PARKLAND MEMORIAL HOSPITAL

ADMISSION NOTE

DATE AND HOUR:

NOV 22, 1963

DOCTOR:

Note of Attendance to President Kennedy

I was contacted at approx 12:48 that the President was on the way to the emergency room having been shot. On arrival there, I found an individual taken in place a similar reputation, a left chest tube being inserted & cut down was going in one leg & in the left arm. The patient had a wound in the mid-line of the neck. On first examination of the wound, the right temporal & occipital bones were missing & the brain was lying on the table, with extensive maceration & contusion. The pupils were fixed & dilated later & equal. No pulse was detectable & respirations were (as noted) being supplied. A tracheostomy was performed by Dr. Perry & I, & a chest tube inserted into the Rt. Chest (2nd intercostal space anteriorly). Meanwhile 2 pint of O neg blood was administered by pump & response. When all of these measures were complete, no heart beat could be detected. Close chest massage was performed until a cardiograph could be attached which recorded no cardiac activity was obtained. Due to the extensive & irreparable brain damage, which was lethal, no further attempt to resuscitate the heart was made.

Charles H. Hapton MD.
 Chief of Surgery
 Emergency Room

1023

(OVER)

FEDERAL BUREAU OF INVESTIGATION UNITED STATES DEPARTMENT OF JUSTICE RECEIVED	
ADMINISTRATIVE SECTION	
To: <u>John F. Kennedy</u>	
DATE: <u>22 Nov 63</u>	DOCTOR:
<u>12:30 to 13:00 hrs.</u>	
<p>Called by 1500 while Vandenberg was in laboratory in Lab. Tech. Dept. The President had been blind. I arrived in the 1500 at 12:30-12:35 and the President was standing perfectly in the back of the head. There was a large amount of cerebral tissue present the part there was a smaller amount of cerebral tissue present also</p> <p>A traction team was being performed by Dr. Percy Barber and Dr. Chilton from the President's shoulder. The an- esthetic tube was in place and respiratory assistance was being given by Dr. Hadden & others. His pupils were dilated about 4 mm and his eyes were elevated upward and the right eye movement was lost</p> <p>The trach was completed and I noticed the neck tracheal tube a little later. The head was present in the anal region. Suction was used to remove the brain matter present with the tissue of the spine</p>	
COVER	

561

ADMISSION NOTE

The view was being that it suited above
was not correct point. Permanently
I have closed child marriage. A paper
was obtained at the court and funeral
made same.

Dr. Percy Olsen took over the
custody of the child as I could not take
the child in my hand.

Olsen was a large woman possessing an
able mind and put in lengthy time in
practical affairs. Much of the child's education
was at home in my home. She particularly
interested in reading books and papers.

Dr. Olsen was a little over 40 years of age.
There was no ill-treatment of the
child and no respiratory effect.
He was pronounced dead at 1:30 PM
by me.

J. J. Campbell M.D.

22 Nov 1963
1615 Ave -

PARKLAND MEMORIAL HOSPITAL

ADMISSION NOTE

DATE AND HOUR: Nov. 22, 1963 4:45 P.M. DOCTOR: Robert N. M. C. Cl. Hand

Statement Regarding Assassination of
President Kennedy

At approximately 12:45 P.M. on the above date I was called from the second floor of Parkland Hospital and went immediately to the Emergency Operating Room. When I arrived President Kennedy was lying attended by Drs. Malcolm Perry, Charles Bantz, James Carica and Ronald Jones. The President was at that time comatose from a massive gunshot wound of the head with a fragment wound of the trachea. An endotracheal tube and assisted respiration was started immediately by Dr. Carica on duty in the EOR when the President arrived. Drs. Perry, Bantz and I then performed a tracheotomy for respiratory distress and tracheal injury and Drs. Jones and Paul Peters inserted bilateral anterior chest tubes for pneumothoraces secondary to the tracheo-mediastinal injury. Simultaneously Dr. Jones had started 3 cut-downs giving blood and fluids immediately. In spite of this, at 12:55 he was pronounced dead by Dr. James Clark the neurosurgeon and professor of neurosurgery who arrived immediately after I did. He

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(OVER)

COMMISSION EXHIBIT No. 392—Continued

ADMISSION NOTE I

Cause of death was due to massive head and brain injury from a gunshot wound of the left temple. He was pronounced dead after external cardiac massage failed & ECG activity was gone.

Robert T. M. (William) M.D.
Asst. Prof. of Surgery
Southwestern Med.
School of Univ. of Tex.
Dallas, Texas

COMMISSION EXHIBIT No. 392—Continued

PARKLAND MEMORIAL HOSPITAL

ADMISSION NOTE

DATE AND HOUR:

Nov. 22 1963 4⁴⁵_{PM}

DOCTOR:

BASHORE

Statement Regarding Assassination of the President
of the USA, President Kennedy -

At 12⁵⁵_{PM}, we were called from the 1st Floor of Parkland
Hospital and told that President Kennedy was shot - Dr D Seldin
and myself went to the emergency room of Parkland - upon
examination, the President had no pulse, no heart beat,
no blood pressure - The microscope showed a complete stapedium.
The President was declared dead at 12⁵⁵_{PM}.

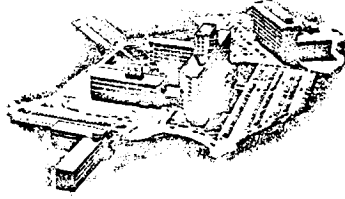
J. Bashore MD

Associate Professor of Medicine
Southwestern Medical School
Dallas - Texas -

COMMISSION EXHIBIT No. 392—Continued

THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL SCHOOL
DALLAS

M. T. JENKINS, M.D.
PROFESSOR AND CHAIRMAN
Department of Anesthesiology



Clinical Departments of Anesthesia
PARKLAND MEMORIAL HOSPITAL
CHILDREN'S MEDICAL CENTER

November 22, 1963
1630

To: Mr. C. J. Price, Administrator
Parkland Memorial Hospital

From: M. T. Jenkins, M.D., Professor and Chairman
Department of Anesthesiology

Subject: Statement concerning resuscitative efforts for
President John F. Kennedy

Upon receiving a stat alarm that this distinguished patient was being brought to the emergency room at Parkland Memorial Hospital, I dispatched Doctors A. H. Giesecke and Jackie H. Hunt with an anesthesia machine and resuscitative equipment to the major surgical emergency room area, and I ran down the stairs. On my arrival in the emergency operating room at approximately 1230 I found that Doctors Carrico and/or Delaney had begun resuscitative efforts by introducing an orotracheal tube, connecting it for controlled ventilation to a Bennett intermittent positive pressure breathing apparatus. Doctors Charles Baxter, Malcolm Perry, and Robert McClelland arrived at the same time and began a tracheostomy and started the insertion of a right chest tube, since there was also obvious tracheal and chest damage. Doctors Paul Peters and Kemp Clark arrived simultaneously and immediately thereafter assisted respectively with the insertion of the right chest tube and with manual closed chest cardiac compression to assure circulation.

For better control of artificial ventilation, I exchanged the intermittent positive pressure breathing apparatus for an anesthesia machine and continued artificial ventilation. Doctors Gene Akin and A. H. Giesecke assisted with the respiratory problems incident to changing from the orotracheal tube to a tracheostomy tube, and Doctors Hunt and Giesecke connected a cardioscope to determine cardiac activity.

During the progress of these activities, the emergency room cart was elevated at the feet in order to provide a Trendelenburg position, a venous cutdown was performed on the right saphenous vein, and additional fluids were begun in a vein in the left forearm while blood was ordered from the blood bank. All of these activities were completed by approximately 1245, at which time external cardiac massage was still being carried out effectively by Doctor Clark as judged by a palpable peripheral pulse. Despite these measures there was no electrocardiographic evidence of cardiac activity.

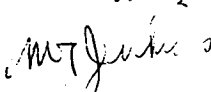
COMMISSION EXHIBIT No. 392—Continued

Mr. C. J. Price, Administrator
November 22, 1963
Page 2 - Statement concerning resuscitative
efforts for President John F. Kennedy

These described resuscitative activities were indicated as of first importance, and after they were carried out attention was turned to all other evidences of injury. There was a great laceration on the right side of the head (temporal and occipital), causing a great defect in the skull plate so that there was herniation and laceration of great areas of the brain, even to the extent that the cerebellum had protruded from the wound. There were also fragmented sections of brain on the drapes of the emergency room cart. With the institution of adequate cardiac compression, there was a great flow of blood from the cranial cavity, indicating that there was much vascular damage as well as brain tissue damage.

It is my personal feeling that all methods of resuscitation were instituted expeditiously and efficiently. However, this cranial and intracranial damage was of such magnitude as to cause the irreversible damage. President Kennedy was pronounced dead at 1300.

Sincerely,



M. T. Jenkins, M.D.

COMMISSION EXHIBIT No. 392—Continued

PARKLAND MEMORIAL HOSPITAL OPERATIVE RECORD DATE: 11-22-63 Thoracic Surg	ROOM: 220 STATUS: Pvt NAME: John Connally UNIT # 26 36 99 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: Thoractomy, removal rib fragment, debridement of wound BEGAN: 1335 ENDED: 1520

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: 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 <u>Correct</u>	DRUGS	I.V. FLUIDS AND BLOOD
2ND <u>Correct</u>		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 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. 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 the the axilla yet had passed through the latysmus dorsi muscle shattered approximately 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 ~~be~~ 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.

M. D.
Dr. Robert Shaw

.BS:bl (continued)

TO BE COMPLETED BY CIRCULATING NURSE

TO BE DICTATED BY SURGEON

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PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

CONNALLY JOHN G 267, 11
 WM 11-22-64
 John Connally
 # 26 36 99

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 its 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 than 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 the lobe. 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 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 diaphragm 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 was 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 innermost surface was then closed with several interrupted sutures of #0 chromic gut. ~~The subcutaneous tissue was then~~ 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. A large Penrose drain was drawn out through this stab wound to allow drainage of the wound of the chest wall. The subcutaneous tissue was 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 the was necessary for the wounds of the right wrist and left thigh.

Robert Shaw
 Dr. Robert Shaw

RS:hl

* 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 ~~Shires~~ Tom Shires.

1767

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

ROOM: 220 STATUS: Pvt.

NAME: Governor John Connally

UNIT # 26 36 99

DATE: 11-22-63 Ortho

AGE: W/M RACE:

PRE-OPERATIVE DIAGNOSIS: Comminuted fracture of the right distal radius, open secondary to gunshot wound

POST-OPERATIVE DIAGNOSIS: Same

OPERATION: Debridement of gunshot wound of right wrist, reduction of fracture of the radius BEGAN: 1600 ENDED: 1650

ANESTHETIC: General BEGAN: 1300 ANESTHESIOLOGIST: Giesecke

SURGEON: Dr. Charles Gregory

DRAINS:

ASSISTANTS: Drs. Osborne and Parker

APPLIANCES:

SCRUB NURSE: Rutherford

CIRC. NURSE: Schroder

CASTS/SPLINTS:

SPONGE COUNTS: 1ST _____
2ND _____

DRUGS

I.V. FLUIDS AND BLOOD

COMPLICATIONS:

None

CONDITION OF PATIENT: Fair

Clinical Evaluation:

OR EXT. POL BRUISE

also a partial transection of the superficial tendons

While still under general anesthesia and following a thoracotomy and repair of the chest injury by Dr. Robert Shaw, the right upper extremity was thoroughly prepped in the routine fashion after shaving. He was draped in the routine fashion using stockinette, the only addition was the use of a debridement pad. The wound of entry on the dorsal aspect of the right wrist over the junction of the distal fourth of the radius and shaft was approximately two cm in length and rather oblique with the loss of tissue with some considerable contusion at the margins of it. There was a ^{small} wound of exit along the volar surface of the wrist about two cm above the flexion crease of the wrist and in the midline. The wound of entrance was carefully excised and developed through the muscles and tendons from the radial side of that bone to the bone itself where the fracture was encountered. ^{It was noted that the tendon of the abductor palmaris longus was transected, only two small fragments of bone were removed, one approximately one cm in length and consisted of lateral cortex which lay free in the wound and had no soft tissue connections, another much smaller fragment perhaps 3 mm in length was subsequently removed. Small bits of metal were encountered at various levels throughout the wound and these were wherever they were identified and could be picked up and have been submitted to the Pathology department for identification and examination. Throughout the wound ~~there was~~ and especially in the superficial layers and to some extent in the tendon and tendon sheaths on the radial side of the arm small fine bits of cloth consistent with fine bits of Mohair. It is our understanding that the patient was wearing a Mohair suit at the time of the injury and this accounts for the deposition of such organic material within the wound. After as careful and complete a debridement as could be carried out and with an apparent integrity of the flexor tendons and the median nerve in the volar side, and after thorough irrigation the wound of exit on the volar surface of the wrist was closed primarily with wire sutures while the wound of entrance on the radial side of the forearm was only partially closed, being left open for the purpose of drainage should any ^{spontaneous} appearance.}

Charles Gregory, M.D.
Charles Gregory, M.D.

00:bl (continued)

COMMISSION EXHIBIT No. 392—Continued

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

Governor John Connally
26 36 99

11-22-63

Ortho

See exhibit

DESCRIPTION OF OPERATION (Continued): This is ~~insufficient~~ ^{insufficient} to the presence of Mohair and organic material deep into the wound which is prone to produce tissue reactions and to encourage infection and this precaution of not closing the wound was taken in correspondence with our experience in that regard.

In view of the urgency of the Governor's original chest injury it was impossible to definitely ascertain the status of the circulation ~~and~~ the nerve supply to the hand and wrist on the right side. Accordingly, it was determined as best we could at the time of operation and the radial artery was found to be intact and pulsating normally. The integrity of the median nerve and the ulnar nerve is not clearly established but it is presumed to be present. Following closure of the volar wound and partial closure of the radial wound, dry sterile dressings were applied and a long arm cast was then applied with skin tape traction, rubber band variety, attached to the thumb and index finger of the right hand. ~~The~~ An attitude of flexion was created at the right elbow, and post operatively the limb suspended from an overhead frame using tape traction. The post operative diagnosis for the right forearm remains the same and again I suggest that you incorporate this particular dictation together with other dictations which will be given to you by the surgeons concerned with this patient.

Charles Gregory
Charles Gregory, M.D.

CG:bl

COMMISSION EXHIBIT No. 392—Continued

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: Nov. 22, 1963

ROOM: 220 STATUS: Pvt.
 NAME: Connally, John
 UNIT # 263699
 A #24842
 AGE: RACE: W/M

TO BE COMPLETED BY CIRCULATING NURSE

PRE-OPERATIVE DIAGNOSIS: Gunshot Wound, Right Chest, Right Wrist, Left Thigh
 POST-OPERATIVE DIAGNOSIS: Same
 OPERATION: Exploration and Debridement of (*See below)
Gunshot Wound of Left Thigh BEGAN: 16:00 ENDED: 16:20
 ANESTHETIC: General BEGAN: 13:00 ANESTHESIOLOGIST: Geisecke
 SURGEON: Dr. Shires DRAINS: _____
 ASSISTANTS: Drs. McClelland, Baxter and Patman APPLIANCES: _____
 SCRUB NURSE: Oliver CIRC. NURSE: Deming and Schröder CASTS/SPLINTS: _____
 SPONGE COUNTS: 1ST Correct, PS DRUGS I.V. FLUIDS AND BLOOD
 2ND _____
 COMPLICATIONS: *This portion of the operation is involved only with the operation on the left thigh. The chest injury has been dictated by Dr. Shaw, the orthopedic injury to the arm by Dr. Gregory.
 CONDITION OF PATIENT: _____

TO BE DICTATED BY SURGEON

Clinical Evaluation: There was a 1 cm. punctate missile wound over the juncture of the middle and lower third, medial aspect, of the left thigh. X-rays of the thigh and leg revealed a bullet fragment which was imbedded in the body of the femur in the distal third. The leg was prepared with Phisohex and I.O. Prep and was draped in the usual fashion.
 Operative Findings: Following this the missile wound was excised and the bullet tract was explored. The missile wound was seen to course through the subcutaneous fat and into the vastus medialis. The necrotic fat and muscle were debrided down to the region of the femur. The direction of the missile wound was judged not to be in the course of the femoral vessel, since the wound was distal and anterior to Hunter's canal. Following complete debridement of the wound and irrigation with saline, the wound was felt to be adequately debrided enough so that three simple through-and-through, stainless steel Aloe #28 wire sutures were used encompassing skin, subcutaneous tissue, and muscle fascia on both sides. Following this a sterile dressing was applied. The dorsalis pedis and posterior tibial pulses in both legs were quite good. The thoracic procedure had been completed at this time, the debridement of the compound fracture in the arm was still in progress at the time this soft tissue injury repair was completed.

fs

Tom Shires, M.D.
 Tom Shires, M.D.

767

1079

PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: 11/24/63

Surg.

ROOM: ---- STATUS: S

NAME: Oswald, Lee Harvey

EOR
 UNIT # 25260

AGE: 24 Yr.

RACE: W/M

PRE-OPERATIVE upper
 DIAGNOSIS: GSW of abdomen and chest with massive bleeding

POST-OPERATIVE Major vascular injury in abdomen and chest
 DIAGNOSIS: Exploratory laparotomy, thoracotomy, efforts 1'15"

OPERATION: to repair aorta BEGAN: 1142 ENDED: 1307

ANESTHETIC: General BEGAN: 1142 ANESTHESIOLOGIST: Dr. M.T. Jenkins
 Dr. Gene Akin
 Dr. Curtis Spier

SURGEON: Dr. Tom Shires DRAINS: _____

ASSISTANTS: Dr. Perry, Dr. McClelland, Dr. Ron Jones APPLIANCES: _____

SCRUB NURSE: Schrader-Lunsford CIRC. NURSE: Schrader-Bell-
 Burkett-Simpson CASTS/SPLINTS: _____

2 counted sponges missing when body closed. Square pack count correct.

Sponge Counts: 1ST _____ DRUGS I.V. FLUIDS AND BLOOD
 2ND _____ Ca chloride - 3 vials 3-1000 cc. lactated
 Cedilanid - 12 Ringer's solution

COMPLICATIONS: One molar lactate-6 16- 500 cc. whole blood
 Isuprel - 24 6-1000 cc. 5% dextrose in
 Adrenalin 1:1000 - 3 lactated Ringer's
 solution

CONDITION OF PATIENT: Expired at 1307 Measured blood loss - 8,376 cc.

Clinical Evaluation: Previous inspection had revealed an entrance wound over the left lower lateral chest cage, and an exit was identified by subcutaneous palpation of the bullet over the right lower lateral chest cage. At the time he was seen preoperatively he was without blood pressure, heart beat was heard infrequently at 130 beats per minute, and preoperatively had endotracheal tube placed and was receiving oxygen by anesthesia
 Operative Findings: at the time he was moved to the operating room.

Description of Operation: Under endotracheal oxygen anesthesia, a long mid-line abdominal incision was made. Bleeders were not apparent and none were clamped or tied. Upon opening the peritoneal cavity, approximately 2 to 3 liters of blood, both liquid and in clots, were encountered. These were removed. The bullet pathway was then identified as having shattered the upper medial surface of the spleen, then entered the retroperitoneal area where there was a large retroperitoneal hematoma in the area of the pancreas. Following this, bleeding was seen to be coming from the right side, and upon inspection there was seen to be an exit to the right through the inferior vena cava, thence through the superior pole of the right kidney, the lower portion of the right lobe of the liver, and into the right lateral body wall. First the right kidney, which was bleeding, was identified, dissected free, retracted immediately, and the inferior vena cava hole was clamped with a partial occlusion clamp of the Satinsky type. Following this immobilization, packing controlled the bleeding from the right kidney. Attention was then turned to the left, as bleeding was massive from the left side. The inspection of the retroperitoneal area revealed

Tom Shires, M.D.
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TO BE COMPLETED BY CIRCULATING NURSE

TO BE DICTATED BY SURGEON

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a huge hematoma in the mid-line. The spleen was then mobilized, as was the left colon, and the retroperitoneal approach was made to the mid-line structures. The pancreas was seen to be shattered in its mid portion, bleeding was seen to be coming from the aorta. This was dissected free. Bleeding was controlled with finger pressure by Dr. Malcolm O. Perry. Upon identification of this injury, the superior mesenteric artery had been sheared off of the aorta, there was back bleeding from the superior mesenteric artery. This was cross-clamped with a small, curved DeBaKey clamp. The aorta was then occluded with a straight DeBaKey clamp above and a Potts clamp below. At this point all major bleeding was controlled, blood pressure was reported to be in the neighborhood of 100 systolic. Shortly thereafter, however, the pulse rate, which had been in the 80 to 90 range, was found to be 40 and a few seconds later found to be zero. No pulse was felt in the aorta at this time. Consequently the left chest was opened through an intercostal incision in approximately the fourth intercostal space. A Finochietto retractor was inserted, the heart was seen to be flabby and not beating at all. There was no hemopericardium. There was a hole in the diaphragm but no hemothorax. A left closed chest tube had been introduced in the Emergency Room prior to surgery, so that there was no significant pneumothorax on the left side. The pericardium was opened, cardiac massage was started, and a pulse was obtainable with massage. The heart was flabby, consequently calcium chloride followed by epinephrine-Xylocaine® were injected into the left ventricle without success. However, the standstill was converted to fibrillation. Following this, defibrillation was done, using 240, 360, 500, and 750 volts and finally successful defibrillation was accomplished. However, no effective heart beat could be instituted. A pacemaker was then inserted into the wall of the right ventricle and grounded on skin, and pacemaking was started. A very feeble, small, localized muscular response was obtained with the pacemaker but still no effective beat. At this time we were informed by Dr. Jenkins that there were no signs of life in that the pupils were fixed and dilated, there was no retinal blood flow, no respiratory effort, and no effective pulse could be maintained even with cardiac massage. The patient was pronounced dead at 1:07 P.M. Anesthesia consisted entirely of oxygen. No anesthetic agents as such were administered. The patient was never conscious from the time of his arrival in the Emergency Room until his death at 1:07 P.M. The subcutaneous bullet was extracted from the right side during the attempts at defibrillation, which were rotated among the surgeons. The cardiac massage and defibrillation attempts were carried out by Dr. Robert N. McClelland, Dr. Malcolm O. Perry, Dr. Ronald Jones. Assistance was obtained from the cardiologist, Dr. Fouad Bashour.

DESCRIPTION OF OPERATION (cont'd.)

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