The President arrived in the Emergency Room at exactly 12:43 p.m. in his limousine. He was in the back seat. Gov. Connally was in the front seat of the same car. Gov. Connally was brought out first and was put in room two. President was brought out next and put in room one. Dr. Clark pronounced the President dead at 1 p.m. exactly. All of the President's belongings except his watch were given to the Secret Service. His watch was given to Mr. G. P. Nix. He left the Emergency Room, the President, at about 2 p.m. in an O'Neal ambulance. He was put in a bronze colored plastic casket after being wrapped in a blanket and was taken out of the hospital. He was removed from the hospital. The Gov. was taken from the Emergency Room to the Operating Room.

The President's wife refused to take off her bloody glove. clothes. She did take a towel and wipe her face. She took her wedding ring off and placed it on one of the President's fingers.
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 matter 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 Jonas, another Resident in General Surgery, arrived. Immediately thereafter, Dr. M. T. Jenkins, Director of the Department of Anesthesia, and Doctors Glesheke 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 mgm was added to the intravenous fluids.

Dr. Robert McColland, Attending Surgeon, arrived to help in the President's care. Doctors Perry, Baxter, and McColland 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...
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 cerebellar 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 relived on the cardiac massage while a cardiotachoscopy was connected. Dr. Foutz 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

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

COMMISSION EXHIBIT NO. 392—Continued
When patient arrived emergency room on ambulance carrying fish glass agonal respiration efforts and open cardiac manipulation我当时两外伤伤口未触及，two external wounds were made in the small posterior wound of the midline in lower 1/3. The other wound had involved the colonum and involved brain tissue present to produce stopping the pulse on blood pressure was present, probe inserted, book field, a cuff and intravenous intubation was essential and through the laryngeal scope was passed. Wound of the trachea was seen immediately below the larynx. The tube was passed and the larynx and the cuff inflated. Aspiration using the suprascope was not possible. The aspiration was intubated. Concurrent in the infusion of lactated ring solution was begun via catheter placed on 2 L ring blood drawer for type and crossmatch type O. No negative blood was obtained as well as hydrolate in

In view of divided injury of chest on initial evacuation was performed by the laryng and bolus chest tube inserted.
A second IV infusion was begun. In addition, the patient was given deep sedation, narcotics, and corticosteroids. A non-invasive monitor + defibrillator attachment was attempted. Valsalva maneuver, deep resuscitation efforts, and external cardiac massage were attempted, but no evidence of cardiac activity was noted. Charles [Signature]

Commission Exhibit No. 392—Continued
A patient who had undergone electrocardiography without benefit of electroconvulsive therapy developed a disturbance of cardiac rhythm. Examination revealed that no detectable electrical activity existed in the heart. Consequently, attempts were abandoned after the team of physicians determined that the patient had expired.

Malcolm O. Perry, M.D.
1636. 22/Nov/1962
I was contacted at approx. 12:10 when the person arrived. Arrived in the burn to the emergency room. Took history. On arrival there, I found an 8-year-old boy in the emergency room with a hand injury. The hand had a burn in the middle of the palm. The burn appeared to be on the middle phalanx. The fingers were separated. No pulses were detected. No sensation was noted. The hand was cold. Treatment consisted of burn care. The hand was wrapped with sterile dressing. The wound was cleaned with sterile saline solution. The patient was referred to the burn center.

Dr. M. Smith M.D.

Commission Exhibit No. 392—Continued
COMMISSION EXHIBIT No. 392—Continued
Statement Regarding Assassination of President Kennedy

At approximately 12:35 p.m. on the above date, I was called from the second floor of Parkland Hospital and went immediately to the Emergency Operating Room. Upon arrival, President Kennedy was being attended by Dr. Malcolm Perry, Dr. John F. cone and Harold Jones. The head injury at that time was composed of a massive gunshot wound of the head with a fragment wound of the back.

An orthopaedic and assistant surgeon were placed immediately by Dr. Cone on life in the EOR when the patient arrived. Dr. Perry, and I then performed a tracheotomy for respiratory assistance and control of injury and Dr. Jones and Paul Fike inserted bilateral aorto-cisternal tubes for cannulation secondary to the moderate arterial injury. Simultaneously, Dr. Jones had started 3 of 12 units of plasma fluid and David immediately, 8 units of blood at 12:35 p.m. He was pronounced dead by the time the emergency room and operation rooms were surgery was wound immediately after total 38
CAUSE OF DEATH WAS DUE TO ACUTE HEART FAILURE AND INJURY FROM A GUNSHOT Wound OF THE PENIS. HE WAS ANNOUNCED DEAD AFTER EXTERNAL CARDIAC MASSAGE FAILED & ECG ACTIVITY WENT GONE.

F. WALLACE TAYLOR, 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**

<table>
<thead>
<tr>
<th>DATE AND HOUR:</th>
<th>Nov 22, 1963 4:45 PM</th>
<th>DOCTOR:</th>
<th>Bashour</th>
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</thead>
<tbody>
<tr>
<td><strong>Statement Regarding Assassination of the President of the USA, President Kennedy</strong></td>
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<tr>
<td>At 3:30 PM, we were called from the 1st Flr. of Parkland Hospital and told that President Kennedy was shot. Dr. Z D. Schull and myself went to the emergency room of Parkland. Upon examination, the President had no pulsation, no brain stem, no blood pressure. The examination showed a complete ataxia. The patient was declared dead at 4:35 PM.</td>
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J. Bashour, M.D.

Associate Professor of Medicine

Southwestern Medical School

Dallas, Texas

Commission Exhibit No. 392—Continued
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.
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

PREOPERATIVE:
Gunshot wound of the chest with comminuted fracture of the 5th rib.

POSTOPERATIVE:
Same with laceration right middle lobe, hematoma lower lobe of lung.

OPERATION:
Thoracotomy, removal rib fragment, drain.

ANESTHETIC:
General

INDICATIONS:
Correct

COMPLICATIONS:
None

CONDITION OF PATIENT: Satisfactory

The patient was brought to the OR from the B3R. In the EDR a sucking wound of the right chest was partially controlled by an occlusive dressing supported by manual pressure. A tube was placed through the second interspace in the mid-clavicular line connected to a water seal bottle to evacuate the right pneumothorax and hemothorax. An IV infusion of Ringer's 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 and axilla yet had passed through the latissimus dorsi muscle shattered approximately half 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 but 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.

Dr. Robert Shaw

COMMISSION EXHIBIT No. 392—Continued
The ragged ends of the damaged fifth rib were cleaned out with the reamer. The plura had been torn open by the secondary missiles created by the fragmented fifth rib. The wound was opened widely and exposure obtained with a self-retaining retractor. The right pleural cavity was then carefully inspected. Approximately 200 cc of clot and liquid blood was removed from the pleural cavity. The middle lobe had a linear rent starting at its peripheral edge going down toward the hilum separating the lobe into two segments. There was an open bronchus in the depths 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 pleural 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 000 chromic gut on an atraumatic needle. The right pleural cavity was now carefully examined and small rib 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 pleural 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 midaxillary line were found to be longer than necessary so approximately ten cm of it was cut away and the remaining portion was sutured 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 water seal bottle. The fourth and fifth intercostal muscles were then approximated with interrupted sutures of 000 chromic gut. The remaining portion of the serratus anterior muscle was then approximated across the closure of the intercostal muscles. The laceration of the latissimus dorsi muscle on its intercostal surface was then closed with several interrupted sutures of 000 chromic gut. The subcutaneous tissue was then approximated with 000 interrupted sutures of 000 chromic gut. One unit of Penicillin and one gram of Streptomycin in 100 cc normal saline was instilled into the wound. The stab wound was 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 000 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 000 chromic gut in one 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 pins 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.

* 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 M. H. Tom Shires.
PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

DATE: 11-22-63 Ortho

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, BEGAN: 1600, ENDED: 1650.

REDUCTION OF FRACTURE OF THE RADIUS

ANESTHETIC: General

OPERATIVE RECORD

SURGEON: Dr. Charles Gregory

ASSISTANTS: -Brewer, Osborn, and Parker

SCRUB NURSE: C. Rutherford

RINSING NURSE: Schröder

CASTS/SPLINTS: None

SPONGE COUNT 1ST: 20

TYPICAL 

APPLIANCES: I.V. FLUIDS AND BLOOD

DRAIN: None

COMPLICATIONS: None

CONDITION OF PATIENT: Fair

Clinical Evaluation:

While still under general anesthesia and following a thoracotomy and a pair of the chest wound 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 the first metacarpal was approximately two cm in length and rather oblique with the loss of tissue with some considerable contamination at the margins of it. There was a 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 pollicis longus was transected, only two small fragments of bone were removed, one approximately one cm in length and consisted of lateral cortex and the other two cm 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 were picked up and have been submitted to the Pathology Department for identification and examination. Throughout the wound there was a lot of soft tissue debris 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 make spontaneous appearance.

Charles Gregory, M.D.
This is a reference 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 2nd index finger of the right hand. This was an attitude of flexion was created at the right elbow, and post operatively the limbs 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.

Commission Exhibit No. 392—Continued
**PARKLAND MEMORIAL HOSPITAL**  
**OPERATIVE RECORD**

**DATE:** Nov. 22, 1963  
**ROOM:** 220  
**STATUS:** Pvt.  
**NAME:** Connally, John  
**UNIT:** 263699  
**RACE:** W/H  
**AGE:**

<table>
<thead>
<tr>
<th>PRE-OPERATIVE</th>
<th>POST-OPERATIVE</th>
<th>DIAGNOSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GUNSHOT WOUND, RIGHT CHEST, RIGHT WRIST, LEFT THIGH</strong></td>
<td><strong>GUNSHOT WOUND OF LEFT THIGH</strong></td>
<td><em>See below</em></td>
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</tbody>
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<table>
<thead>
<tr>
<th>OPERATION</th>
<th><strong>EXPLORATION AND DEBRIDEMENT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BEGAN:</strong> 16:00</td>
<td><strong>ENDED:</strong> 16:20</td>
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| ANESTHETIC | General  
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>BEGAN:</strong> 13:00</td>
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<table>
<thead>
<tr>
<th>SURGEON</th>
<th>Dr. Shires</th>
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</table>

<table>
<thead>
<tr>
<th>ASSISTANTS</th>
<th>Drs. McClelland, Baxter and Patman</th>
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| SCRUB NURSE | Oliver  
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<tbody>
<tr>
<td>CIRC. NURSE</td>
<td>Deming and Schröder</td>
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<tr>
<th>CARRIAGE</th>
<th>I.V. FLUIDS AND BLOOD</th>
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**APPLIANCES:**

**Sponge Counts:**

<table>
<thead>
<tr>
<th>1ST</th>
<th>CORTIZONE, PS</th>
</tr>
</thead>
</table>

**DRUGS:**

**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:**

**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 embedded in the body of the femur in the distal third. The leg was prepared with Pidohex 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.

*Signature*

**COMMISSION EXHIBIT No. 392—Continued**
PARKLAND MEMORIAL HOSPITAL

OPERATIVE RECORD

ROOM: ---- STATUS: S

NAME: Oswald, Lee Harvey

DATE: 11/24/63 surg. AGE: 24 Yr. RACE: VIM

PRE-OPERATIVE.

DIAGNOSIS: GSW of abdomen and chest
with massive bleeding

POST-OPERATIVE.

DIAGNOSIS: Major vascular injury in abdomen and chest

OPERATION: to repair aorta

BEGIN: 1142 END: 1307

Anesthetist: Dr. M.T. Jenkins

Surgeon: Dr. Tom Shires

Anesthesiologist: Dr. Gene Akin

Dr. Curtis Spier

Assistants: Dr. Perry, Dr. McClelland, Dr. Ron Jones

Apparatus:

Scrubs: Schrader-Bell

Nurse: Schrader-Junsford

Nurse: Burkett-Simpson

Casts/Splints:

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

Sponge Count:

1st 2nd

Ca chloride - 3 vials 3-1000 cc. lactated
Cedilanid - 12 Ringer's solution
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:

Fluids and Blood:

Measured blood loss - 8,376 cc.

Drugs:

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. At the time he was moved to the operating room.

Operative Findings:

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.

COMMISSION EXHIBIT No. 392—Continued
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 ephinephrine-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.