County Of Sacramento

Department of Coroner
4800 Broadway, Suite 100
Sacramento, CA 95820-1530

Robert Lyons
Coroner

☒Autopsy ☐ External Examination

NAME: **BARKLEY, MELVA JEANNE** **CASE NO.** **06-03420**

POSTMORTEM DATE: 06/29/06 **TIME:** 11:15

INVESTIGATOR: M. Vargas

DATE OF DEATH: 06/24/06 **TIME OF DEATH:** 13:40

AGE: 60 **SEX:** Female **Ht:** 62" **Wt:** 217 lbs.

RACE/ ETHNICITY: White

AUTOPSY FINDINGS:

1. Acute fibrinopurulent peritonitis.
   a. Perforated duodenal ulcer (1.9 cm hole), anterior wall of duodenum.
   b. Fibrinopurulent exudates, all peritoneal viscera.
   c. Purulent ascites (2800 ml).
2. Acute bronchopneumonia with evidence of aspiration pneumonitis..
3. Glomerulonephrosclerosis with arteriosclerosis and hyalin arteriolosclerosis.
   a. Evidence of early ATN (shock kidney).
4. Metastatic ovarian cancer.
   a. Pelvic and left iliac lymph nodes replaced by adenocarcinoma.
   b. Local invasion of pelvic peritoneum by tumor.
   c. Status post supracervical hysterectomy and bilateral salpingo-oophorectomies, healing.
   d. Clinical history of metastatic ovarian carcinoma.
   e. Status post cutaneous-vesicular fistula placement for catheterization, healed.
5. Anoxic/ischemic encephalopathy.
6. Multiple white matter plaques, bilateral, consistent with clinical history of multiple sclerosis.
7. Cholelithiasis.
8. Contusion of left temporoparietal scalp.
9. Obesity (BMI = 39.7).
10. Anasarca.
11. Early decubitus ulcers over sacrum and left ischium.

Mark A. Super, M.D. 9-18-06
Chief Forensic Pathologist

MAS/gab
D: 06/29/06
T: 07/27/06

AUTOPSY ASSISTANTS:
J. Phillips, N. Coleman and J. Duran.

IDENTIFICATION:
The body is identified by a Coroner's ID tag attached to the left great toe, labeled with the subject's name and case number.

EVIDENCE OF MEDICAL TREATMENT:
Bulky gauze bandages cover the eyes, secured by fishnet material. A triple lumen catheter exits the skin over the right internal jugular area, anchored by tape and suture and dated 06/21/06 and initialed J.W. An EKG tab is on the top of the right shoulder. A linear grouping of EKG tabs is on the lower anterior left chest wall. An EKG tab is on the right forearm. An EKG pad is on the right lateral abdomen. There is ecchymosis of both antecubital fossae attributed to needle puncture wounds. An orange allergy alert bracelet encircles the right wrist but it is blank. An intravenous catheter exits the back of the right hand, anchored by tape. An intravascular catheter exits the skin over the left radial artery, anchored by tape and suture. A pair of hospital type identification bracelets encircles the left wrist, both labeled with the subject's name. A Foley catheter exits a healing recent surgical stab wound on the suprapubic mid-abdomen. The edges of this wound are granulating. No associated purulent inflammation or gross scar. On the mid-abdomen is a vertical 22 cm long healed surgical incised wound with evidence of early scar formation and focal residual crust. A hospital type identification tag is attached to the left great toe, labeled with the subject's name. Crusted needle puncture wounds with surrounding ecchymosis are on the back of the left hand. Ecchymosis is on the ventral right wrist without an evident needle puncture wound.

EXTERNAL EXAMINATION

The unclothed, unembalmed body is that of a normally developed, obese and markedly edematous, white female who appears consistent with the reported age of 60 years. The body measures 62 inches long and weighs 217 pounds, as received. Rigor mortis is absent in the cold body. Lividity is faint and posterior except over pressure points.

The scalp hair is red-brown with gray roots, wavy and somewhat sparse, averaging approximately 10 cm long. A sparse growth of facial hair is on the upper lip. The irides are brown, the corneas are cloudy, and the sclerae and conjunctivae are unremarkable. No petechiae. The ears, nose and mouth are free of foreign material or abnormal secretion. The nasal skeleton and facial bones are palpably intact. The lips are uninjured. The gums are edentulous. No oral lesions are seen.

The neck is mobile but symmetric.

The chest is palpably unstable. The breasts are edematous and pendulous, but symmetric, without gross lesions or palpable masses except for evidence of prominent dependent edema that expands the subcutis. The skin beneath the breasts is slightly darkened but not macerated. The abdomen is grossly protuberant and soft. Striae course over most of the abdomen. The skin within the panniculus is slightly darkened and has sloughed keratinous material but is not macerated and is free of any other gross lesions. There is a healing suprapubic therapeutic stab wound on the mid-lower abdomen as described above. The external genitalia are those of an adult female. The cutaneous and mucosal surfaces of the genitalia are covered by tan-gray mucoid material, which may be sloughed surface keratinous material and mucus. No evident injuries of the genitalia. There are no skin ulcers or masses.

The extremities are symmetric without angularity or deformity. The fingernails are uninjured and extend well beyond the fingertips. The fingernails are covered by residual chipped metallic pink-

red nail polish. The fingernails extend up to 0.5 cm beyond the fingertips. No clubbing of the digits. On the ventral right wrist is a longitudinal 1.5 cm long remote scar. Two horizontal, 0.5 cm long, remote scars are nearby on the palmar base of the right thumb. The soft tissue of the right forearm is edematous and there is focal postmortem skin slip. There are also patches of subcutaneous hyperemia on the dorsal right forearm and at the right antecubital fossa. On the lateral right upper arm are two red-blue contusions that measure up to 2 cm. No needle tracks. No tattoos. Striae are on the shoulders and both upper arms.

The legs are generally edematous. The toenails are unremarkable and essentially well kept. Multiple short horizontal remote scars are on the anterior right thigh and knee, averaging 2 cm long. Over the right knee is a 7 cm long, longitudinal curvilinear remote scar with crosshatches. Three remote scars with crosshatches are on the left lateral thigh varying from 2 to 4.5 cm long.

On the skin over the sacrum is a superficial area of early skin breakdown that has a red-purple color and a granulating base, 7.5 x 7.5 cm. Over the right ischial tuberosity is an irregular 3.5 x 1cm decubitus ulcer that extends just through the epidermis. The anus is unremarkable. There is prominent pitting edema of the posterior torso. Soft tissues bulge out from the sides of the body in a "waterbed" fashion due to generalized edema. Similar edema is evident in the dependent portions of all four extremities.

No external evidence of recent significant traumatic injury.

INTERNAL EXAMINATION

HEAD:

The scalp is reflected after making the usual intermastoid incision and reveals a large subcutaneous contusion hemorrhage over the left temporal scalp that measures 13 cm in greatest dimension. An ovoid subgaleal hemorrhage is in the left temporoparietal area, 3 cm in greatest dimension. The calvarium is intact. There is hyperostosis frontalis interna. No epidural or subdural hemorrhages. The brain weighs 1220 grams and is of the usual configuration covered by injected but glistening and transparent leptomeninges with clear cerebrospinal fluid. The vessels at the base of the brain pursue their usual anatomic courses and are patent throughout, without thrombosis or aneurysms. No evidence of coning or herniation. Recent or remote traumatic lesions are not noted on serial coronal sectioning in the fresh state. However, numerous white matter plaques are found throughout the brain, especially in the left cerebrum. These consist of irregular glistening gray-brown, focally cystic lesions situated along the gray-white matter interface and along the edges of deep gray matter nuclei. The largest is found in the right mid-brain adjacent to the basal ganglia. Plaques are also found in the left temporal, parietal and occipital lobes, left parietal lobe, and pons. No cerebral abscesses, hemorrhages or masses. The ventricular system is symmetric and free of blood. The bones at the base of the skull are without evidence of fracture. The atlanto-occipital membrane is intact.

NECK:

The hyoid bone and laryngeal cartilages are intact with immobile joints. The larynx and trachea are unobstructed and lined by hyperemic red-brown mucosa. Superficial mucosal ulcers are on both glottic folds consistent with prolonged endotracheal intubation. No laryngeal mucosal edema. No anterior cervical soft tissue hemorrhage. The cervical spine is intact. No anterior prevertebral fascia hemorrhage.

BODY CAVITIES:

The body cavities are entered in the usual manner. Testing for free air in the pleural cavities is negative. The peritoneal cavity contains 2800 ml of dark amber-colored, muco-purulent appearing, yellow-green fluid associated with large yellow-green muco-purulent exudates on peritoneal surfaces throughout the abdomen, especially the small and large bowel serosa. The

surface of the liver and spleen are dull and discolored yellow-green. This is associated with an open perforated ulcer of the duodenum further described below. A few scattered organized adhesions involve the surface of the liver with the right hemidiaphragm. There are also organizing fibrinous adhesions involving structures of the pelvis, further discussed below. The rectum and some loops of small bowel are crimped but there is no evidence of definite obstruction. The pleural cavities each contain slightly turbid, thin amber-colored fluid measured at 150 ml - right side, 100 ml - left side. The pericardial sac is free of excess fluid accumulation or adhesions. There are no pleural adhesions. The organs are in their usual anatomic locations. The lungs are expanded. The pericardial surfaces are smooth, glistening and wet. There is generalized acute fibrinopurulent exudate over all of the intestinal contents.

CARDIOVASCULAR SYSTEM:
The heart weighs 410 grams and is of the usual configuration covered by smooth glistening epicardium. No epicardial petechiae. Serial sections show slightly softened and pale red-brown fibrillar myocardium without recent or remote infarcts. The heart walls are not thickened. The chambers are dilated. The endocardium is thin and translucent. The heart valves are normally formed, pliable and intact. No vegetations. The coronary ostia are in their usual locations and are patent. The coronary circulation is right dominant. The coronary arteries exhibit mild atherosclerosis with focal calcification. Luminal narrowing by plaque is estimated at less than 20% at any point. No recent thrombosis. The aorta is intact and exhibits mild atherosclerosis without complicated plaques or aneurysms. The vena cava and pulmonary arteries are free of antemortem thrombus. The heart and great vessels contain many postmortem clots.

RESPIRATORY SYSTEM:
The lung weights are: right 710 grams, left 460 grams. The pleural surfaces are smooth and glistening and the lungs exhibit the usual lobation with mild anthracotic pigmentation. Sections show dependent congestion and mild dependent atelectasis. A moderate amount of serosanguinous fluid oozes from cut surfaces, with moderate overall congestion. Focal subpleural firmness suggestive of early pneumonic consolidation involves the posteromedial LLL and there are multiple areas of discrete peribronchial firmness in the dependent portions of all the right lung lobes. No frank abscesses. No masses, hemorrhages or infarcts. The tracheobronchial tree is hyperemic but unobstructed and without mass lesions.

LIVER AND PANCREAS:
The liver weighs 1740 grams and is covered by a generally smooth intact capsular surface with a few mucopurulent yellow-tan exudates and a few organized fibrous adhesions. Cut sections show softened and pale tan-brown cut surfaces with mottled areas of centrilobular congestion. No focal intraparenchymal lesions. Specifically, no tumor is seen. I can easily pass my thumb through 2 cm thick sections. The gallbladder is distended by approximately 50 ml of thin green bile and multiple yellow-tan, multifaceted gallstones that vary from 0.3 to 2.2 cm in greatest dimension. The gallbladder mucosa is unremarkable, without ulcers or masses. No stones are found in the bile ducts. No portal lymphadenopathy. The pancreas is firm, especially in the body and tail portions where sections show a few punctate areas of yellow-tan fat necrosis. There is also diffuse patchy fatty infiltration throughout the pancreas. No discrete pancreatic masses, fibrosis or hemorrhages.

GASTROINTESTINAL SYSTEM:
The tongue is without evident injury. The pharynx is unobstructed. The esophagus is intact and lined by unremarkable gray-tan mucosa. The stomach is essentially empty, containing approximately 5 ml of bilious stained, yellow-green mucoid fluid without identifiable food fragments, pill fragments or peculiar scent. The gastric mucosa is pale and mildly edematous, but intact, without ulcers or masses. However, situated 3.5 cm distal to the pylorus is an ovoid 1.9 cm diameter perforation of the anterior wall of the duodenum, which consists of the base of a

larger irregular mucosal ulcer of the anterior duodenal wall that measures 4 cm in greatest dimension. Intestinal contents flow freely from this large gaping hole. Just proximal to the large ulcer is a smaller 0.5 cm penetrating ulcer. The remainder of the small and large bowels is without evident mucosal abnormalities. The distal 10 cm of ileum is filled with tenacious, melenic stool, while the proximal small bowel contains semi-fluid bilious stained mucoid material. No frank blood clots. The colon contains a few narrow mouthed diverticula in the descending portion and rectosigmoid, which are filled with soft stool. The descending colon is also somewhat edematous and thickened. There are large patches of mucopurulent serosal exudates on the colon, especially the descending colon and rectosigmoid portions. No colonic mucosal ulcers, masses or hemorrhages. The colon contains soft, green-brown feces and is free of blood. The appendix is present and covered by purulent exudates. The lumen of the appendix does not appear to be particularly inflamed.

SPLEEN AND LYMPH NODES:
The spleen weighs 160 grams and is covered by a dull yellow-green, but intact capsule. Sections show softened and pale red-brown parenchyma without focal lesions. The lymph nodes adjacent to the rectum and along the left common iliac artery are enlarged up to 2.5 cm in greatest dimension and have softened but solid, gray-white cut surfaces suggestive of replacement by metastatic tumor. The lymph nodes at the carina and lung hila are mildly enlarged but have mottled gray-black and yellow-tan cut surfaces without evidence of metastatic tumor or granulomas. No enlargement of the lymph nodes along the aorta or in the mesentery.

ENDOCRINE SYSTEM:
The right adrenal gland has a small pea-sized 1 cm yellow-tan cortical nodule. No adrenal hemorrhages. No gross evidence of metastatic tumor within the adrenal glands. The thyroid gland is of the usual size, shape and consistency. No thyroid masses or cysts. The pituitary gland is unremarkable.

UROGENITAL SYSTEM:
The kidneys weights are: right 200 grams, left 190 grams. The capsules strip with ease to reveal moderately granular cortical surfaces with mottled pallor, alternating with congestion. The kidneys are softened and somewhat boggy. Sections show mild irregular cortical thinning with blurred corticomedullary junctions. The calices, pelves and ureters are unremarkable. The ureters are neither dilated nor stenosed. The bladder is empty. The bladder mucosa is unremarkable. There is a healed stoma at the dome of the bladder, through which exits the Foley catheter. This suprapubic tract is patent and without evidence of hemorrhage, purulent inflammation or metastatic tumor. The uterus and both adnexa are surgically absent. The uterus has been resected above the cervix (supracervical hysterectomy). Numerous sutures and evidence of Bovie cauterization are in the soft tissues at the base of the uterine stump. The cervical mucosa is free of masses or significant ulcers. The cervical os is unremarkable. The proximal vagina is unremarkable. There are several small gray-tan firm masses in the peritoneum adjacent to the hysterectomy stump that measure up to 1.5 cm in greatest dimension suggestive of tumor. An enlarged lymph node (described above) is situated posterior to the uterine stump and anterior to the rectum. It is enlarged and replaced by apparent tumor. Both ovaries and fallopian tubes are surgically absent.

MUSCULOSKELETAL SYSTEM:
The red-brown muscle is softened, but without focal lesions. No visible or palpable fractures of the bony thorax, vertebral column, pelvis or long bones of the extremities. The anterior surface of the vertebral column is removed exposing the vertebral marrow. This shows no space occupying or lytic lesions. The bone marrow is generally red-brown with somewhat thinned trabeculae. The abdominal fat averages 2.5 cm in thickness. Sutures embedded in scar involve the anterior

abdominal wall in the midline. None of these show evidence of involvement by tumor. The breasts are sectioned and show no significant cysts or masses.

TOXICOLOGY:
Samples of central and peripheral blood, vitreous humor, liver and bile are retained.

HISTOLOGY:
Sections of the left iliac and pelvic lymph nodes, tail of pancreas, duodenal ulcer, rectosigmoid colon, small bowel, diaphragm, liver, kidney, heart, lung, and brain are submitted.

PHOTOGRAPHS:
Digital photographs are obtained of external findings and some internal findings.

X-RAYS:
None.

EVIDENCE:
None.

MICROSCOPIC DESCRIPTION:
Small bowel: Serosa covered by thick fibrinopurulent exudate with mild chronic inflammation and many admixed particles of intestinal contents. Mucosa is autolyzed but without significant histopathology.
Rectosigmoid colon: Same as small bowel. No tumor seen except for rare multinucleated cell within the fibrinopurulent exudate.
Diaphragm: Peritoneal surface covered by mixed acute and chronic fibrinopurulent exudate. Evidence of edema.
Duodenal ulcer: Benign perforated duodenal mucosal ulcer with associated chronic inflammation. Mucosal autolysis.
Pancreas: Autolysis. Fatty infiltration. Mild intra-lobular fibrosis. Chronic inflammation in surrounding fibroadipose tissue.
Lung: Congestion and edema. Sections from both lungs show bronchicentric acute bronchopneumonia with evidence of inflammatory reaction to aspirated squamoid cells suggestive of aspirated of oral secretions. No tumor seen. However, one section of right lung shows focal pleural chronic inflammation with adhered malignant adenocarcinoma cells that appear to be artifact (floaters).
Heart: Mild autolysis. Mild interstitial myocardial fibrosis. No tumor, ischemic necrosis or myocarditis seen.
Lymph nodes: Both replaced by metastatic adenocarcinoma that displays a papillary pattern.
Kidney: Autolysis. Glomerulonephrosclerosis with arteriosclerosis and hyalin arteriolosclerosis. Evidence of early ATN. No tumor seen.
Liver: Autolysis. Capsular surface covered by thick fibrinopurulent exudate similar to that described above. Mild chronic capsular and portal inflammation. No tumor seen.
Brain: Autolysis and evidence of interstitial edema. Diffuse neuronal ischemic necrosis. One section shows a discrete area of demyelination at the grey-white interface consistent with an MS plaque.

MAS/gab
D: 06/29/06
T: 07/27/06
End: 16:30

LABORATORY REPORT

UC DAVIS MEDICAL CENTER CLINICAL LABORATORY
Ralph Green, M.D. Director

Patient: BARKLEY,MELVA JEANNE
Age/Sx: 60/F Loc: CORONER'S OFFICE/SACTO.COUN
DOB: 09/17/45 Acct: RC0000266739

SPEC #: 06:B0034472R
COLL: 06/29/06-1115
RECD: 06/29/06-1550
STATUS: COMPLETE
SOURCE: PERITONEAL FLUID SWAB
ORDERED: CULT AEROB,GS

PT ID: CASE#06-03420
PT PHONE: NOT PROVIDED
CLIENT: CORONER'S OFFICE/SACTO.COUNTY
SUPER,MARK A
CORONER'S OFFICE/SACTO.COUNTY

Procedure	Result

> GRAM STAIN **Final** (*a)

GRAM STAIN
2+ WHITE BLOOD CELLS
2+ GRAM POSITIVE BACILLI
2+ GRAM NEGATIVE BACILLI
1+ GRAM POSITIVE COCCI
1+ YEAST

> CULTURE AEROBIC, FULL **Final** (*a)

2+ YEAST, NOT FURTHER IDENTIFIED
1+ STAPHYLOCOCCUS AUREUS-MRSA
1+ MIXED FLORA

MRSA

	MIC	RX
CLINDAMYCIN	>4	R
ERYTHROMYCIN	>4	R
GENTAMICIN	<=4	S
OXACILLIN	>4	R
PENICILLIN G		R
RIFAMPIN	<=0.5	S
TETRACYCLINE	<=0.5	S
TRIMETH/SULFA	<=0.5	S
VANCOMYCIN	2	S

Staphylococcus aureus-MRSA: MIC, MICRODILUTION
Oxacillin-resistant staphylococci are resistant to all currently available B-lactam antimicrobics i.e., penicillins, cephalosporins, B-lactamase inhibitor combinations and carbapenems.

Organism of Infection Control Concern (MRSA)

8/14

(*a) Performed by: UC Davis Medical Center STC - Ralph Green, M.D. Director
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Report: REFERENCE
Printed: 07/05/06-0609
For activity: 07/04/06

** END OF REPORT **