CHRONIC BERYLLIUM POISONING OF LONG DURATION FROM FLUORESCENT LAMP MANUFACTURING

Report of a Case

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TREATMENT of patients for beryllium poisoning with cortisone and adrenocorticotropic hormone (ACTH) has lately been the subject of some discussion in relation to the actual value of these preparations in changing the course of the disease. The case herein presented affords evidence that would seem to indicate that in long-standing cases, at least, only temporary symptomatic relief might be expected. However, enough definite benefit was demonstrated to warrant the continued use of these hormones, especially in the cases diagnosed earlier in the course of the disease.

A white man of 43 years, married, employed by the Sylvania Company as a chemist, first started working with beryllium phosphors in December 1940, and his exposure continued through October 1945.

In spite of this long-continued exposure, he was symptom-free until October 1945, when a rather severe illness developed, diagnosed as "paratyphoid C." As he was recovering from this illness, a cough, which had come on during the course of the sickness, seemed to become rather intensified, and roentgenograms disclosed the typical appearance of chronic pulmonary inhalation disease. He did quite well, however, through January 1946, and his only complaints were of aching through his right knee and dry cough. His weight at the time was 170 lb. (77 Kg.).

Through March and April he noticed that his cough was continuing and complained of soreness and tenderness of the skin of his arms and legs and continued aching through his elbows, shoulders, hips and knees. His blood count and erythocyte sedimentation rate, however, were normal at this time. Through the rest of this year these complaints continued. He was never free of the dry cough and moderate dyspnea on exertion, and his weight gradually fell to 164 lb. (74.5 Kg.) in mid-August.

In January 1947 he had a rather "mean" acute respiratory infection, from which he made a good recovery and was sent to Florida for a vacation from February 5 to March 30. However, on his return his weight was only 162 lb. (73.5), and he still had the same complaints.

In May 1947 he was studied in New York under the auspices of the Sylvania Company. At this time his vital capacity was recorded as 3.2.

In June and again in August 1947 he had several attacks of renal colic and on one occasion passed a small reddish stone. Unfortunately, this was lost before it could be examined for its possible beryllium content.

On Christmas Day 1947 he had another attack of colic of the left kidney and through January 1948 he had several attacks of pain in the upper left quadrant of the abdomen and pain in the left testis. He also commenced to complain at this time of epigastric and abdominal distress. Roentgenograms of his gastrointestinal tract at this time showed a spastic colon. His weight was 160½ lb. (73 Kg.).

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