Monsanto

FROM (NAME & LOCATION) Dept. of Medicine & Environmental Health - G.J. Levinskas, A2SC

DATE: February 13, 1976

CC: D. Wood - B2SD
J.C. Weber - B2SK
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SUBJECT:

REFERENCE:

File PCB Indiana

TO FILE

On Wednesday, February 4, I received a telephone call from an indivudal with the North Indiana Public Service Company. The call came in on Dr. DeGarmo's line, and the individual indicated that a transformer containing PYRANOL had exploded. When I asked him the nature of the explosion, he indicated that it had arced over from an electrical discharge and that several individuals had been injured. Prior to going into a discussion on possible therapeutic measures, he stated that he would like to arrange a conference call between me and the physicians treating these people. Before I could get his name, he had hung up to arrange for the conference call.

Sometime later, I received a call from a Dr. Michael E. Kaplis, Director Toxicology Section, St. Mary's Medical Center, 540 Tyler Street, Gary, Indiana 46402. Dr. Kaplis stated that he was the Director of the Toxicology Section, and that he had not seen the patients. He had been asked to determine the toxicity of PYRANOL and to ascertain what therapeutic measures could be used. In turn, I told him that I was not a physician but that I felt I could answer whatever questions he had.

In the course of the discussion, I told him that PYRANOL was a trade name for dielectric fluids marketed by General Electric. While I was not sure of the proportion of the components, I was reasonably sure it consisted of an AROCLOR and trichlorobenzene. As a result of the conditions under which exposure had taken place, I would expect that individuals would be exposed to a smoke, mist or fume and that they would experience respiratory distress. This should be treated symptomatically, keeping an eye out for the possible development of a delayed pneumonitis response. Should an individual have been sprayed with the liquid, he would have suffered a thermal burn very similar to that produced by any hot oil. Other than that, there were no specific diagnostic signs that he could look for and there were no specific test we would recommend to follow these individuals.

During a subsequent dicussion, we talked about several things including the overall toxicity of the PCBs. The organ was mentioned as the specific target for PCBs, but it was pointed out that this was manifest only after prolonged and repeated exposure. While individuals sometimes developed dermatitis from working with these materials, I did not think that they would show any dermatitic effects other than those produced

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by contact with the hot oil. As a follow-up to this conversation, I will send Dr. Kaplis a summary or some literature dealing with the toxicity of PCBs. In turn, I asked him if he would be able to provide us with a write-up of the clinical histories of these people after this episode was over.

I asked Dr. Kaplis how many individuals had been exposed. He indicated that he was not too sure at the moment. There was one employee of North Indiana Public Service Company who had been sprayed with the fluid from the transformer. In addition, approximately five people had been exposed to vapor or mists from the transformer. The latter five individuals had either been in the basement of the department store where the transformer was located or on the floor directly above the transformer.

As a wrap-up to our conversation, I gave him Monsanto's central telephone number and told him that if they had further questions which arose later, they could call that number since it would be manned 24-hours a day. In the event that they called, the night watchman would get someone to return their call. Subsequently, I contacted Dr. Tillman to inform him what had transpired and to alert him to the possibility that he might be getting an evening call.

George J. Levinskas

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