October 1, 1936

TO WHOM IT MAY CONCERN:

This is to state that on or about 7:30 PM, July 31, 1936, Dr. Thomas E. Lowe, Houston, Texas, came into my office, which is located in the Park View Hospital, 7444 Harrisburg Boulevard, Houston, Texas, and introduced himself to me. During the conversation, he seemed very much worried over the condition of a Mr. [redacted] who was critically ill in Ward 208, of the Park View Hospital. He said that he would like for me to examine the patient.

EXAMINATION MADE OF MR. [redacted] ON JULY 31, 1936:

HEAD AND NECK: Pupils react slowly to light and were constricted (probably due to morphine -- no Wasserman was taken).

MOUTH: Dry.

TONGUE: Extremely dry and coated, and there was an exfoliation of dermis several days old (there was no lead line nor evidence of blue gum upon deposit of lead beneath the mucous membrane).

EARS: Tympanic membranes normal.

NECK: Nuchal rigidity of muscles present.

THYROID: Normal.

SCALP: No evidence of scars from old or new scalp injuries was found upon examination of scalp, that is, no trauma to skull or cranium.

CARDIO-VASCULAR: Heart: No murmurs; sounds distant and weak.

BLOOD PRESSURE: 135/105 (Taken by Dr. Lowe).

ABDOMEN: No abdominal tympanites. The abdomen was flat, scaphoid, and more of a starvation type, in contra-distinction to the abdomen seen in plumbism; that is, in plumbism, you have a distinct tender, colicky type of abdomen, with severe cramping. On palpating the abdomen deeply, of this semi-conscious patient, there was no facial expression of pain.

GENITO-URINARY: This patient passed only four ounces of urine during his twenty hours in the hospital (see Laboratory report).

SKIN, BONES, AND JOINTS: Skin was extremely dry and rough. All the muscles seemed to be in a state of spasticity. I saw no more evidence of wrist drop or ankle drop, than would ordinarily be expected in any unconscious patient in such a morbid state. (Both the nurse and Dr. Lowe said that previous to my seeing the patient, he had been very nervous and irrational, but sedatives they had given him had apparently overcome this).

PATELLA REFLEXES: Normal.

PELVIS: Normal.

SUMMARY:

A very sick patient; in fact, he was approaching death. The following is given with an attempt to draw a clear picture of the patient as I saw him:

(1) Pupils constricted and reacted slowly to light, due either to dehydrated brain or morphine (no Wasserman having been taken).

(2) Tongue coated, exfoliated, dry, showing a state of almost complete dehydration which is not found in plumbism.

(3) No evidence of trauma to skull and cranium.

(4) Breath fetid, "sweetish" as in acidosis.

(5) No lead line on gum.

(6) Skin dry, rough, cold, and clammy, as in dehydration.

(7) Nuchal rigidity; neck muscles spastic; pseudo-meningitis due to acidosis toxemia.

(8) No evidence of arterio-sclerosis (as usually seen in chronic plumbism) Blood pressure 135/105 (Taken by Dr. Lowe.).

(9) No abdominal tympanites (starvation scaphoid abdomen, flat, etc., not distended, cramping, colicky, as in plumbism).

(10) Anuria. Only four ounces of urine passed during twenty hours in the hospital which is seen in extreme dehydration. (in plumbism there is blood in the urine and not such a severe anuria).

(11) No stippling of red blood cells. No anemia. Blood count was not above normal as seen in acute plumbism; nor below normal as seen in chronic plumbism; but was perfectly normal.

(12) No wrist drop, nor ankle drop. No degeneration of peripheral nerves as in chronic plumbism. (Of course, when all patients become unconscious, there is a relaxation of most terminal extensor muscles, and a spasticity of their opponents, the flexor group, thereby simulating "drop").

(13) A delirium, or psychosis, which is associated with many diseases as the finis approaches, and which can be explained by the fact that the function of nervous tissues are the first to go in a severe dehydration and starvation of this character.

TREATMENT AND CONCLUSION:

I have no criticism of the case, in fact, some of the treatment was suggested by me in the firm belief that it was a true, tragic, extreme upset of this man's metabolism, especially his blood chemistry. A catabolism of his tissues, a burning up that, by heroic measures of Dr. Lowe, intravenous Ringer's solution and saline to replace fluids, and Glucose to replace foods, failed to stop.

During the summer months of any year is an extremely warm time of year, and many people are subject to a loss of body fluids by perspiration, and also we have noted many cases of food poisoning, so-called "summer diarrhea" at this time of year. An acute lead poisoning is more likely to happen in the colder seasons of the year when there is less likely cause of perspiration of laborers who work in closed rooms.

His history reveals that he was not ill in the past ten years, with the exception of a mild case of influenze three years ago.

It has been our experience with lead poisoning that the victims have frequent gastro-intestinal upsets, severe cramping in the abdomen, etc., with a gradual accumulation of a lead line on the gum.

It also seems, that if we had conscientiously had the least inclination that this man was actually suffering from lead poisoning, some antidote such as calcium intravenously or potassium iodid would have been instigated; but we honestly believed that on July 31, 1936, with a man's life hanging in balance, it to be a severe dehydration of the blood chemistry, and his reserve buffers of his blood were completely exhausted to such an extent that the power of intravenouses could not bring him out of the physical "hole" into which he had descended.

These summarized points point implicitly to a blood chemistry, metabolism upset, with resulting starvation to the vital centers, especially the nervous system, with a resulting death, even though heroic measures were resorted to by Dr. Lowe, and were rendered faithfully all night.

In my candid opinion, I believe the instigating, initial producing etiological factor of this vicious cycle was "food poisoning."

SIGNED: Dan W Scott M D
DAN W SCOTT, MD

DWS:WMc