C-111

WORKMEN'S COMPENSATION
THE INDUSTRIAL COMMISSION OF OHIO

Claim No. OD 10562

Claimant [redacted]

Eagle Picher Lead Co. (Former [redacted])

SPECIALIST'S REPORT

Address 952 W. Court Street - Cincinnati, Ohio

Date of Examination May 31st 1935 Age 40

NOTE: Submit report under following headings: (1) History. (2) Complaints. (3) Examination, including X-ray and laboratory work. (4) Discussion. (5) Opinion. Mail THREE copies to the MEDICAL SECTION—Retain one for your file.

1. HISTORY Patient worked last for above company on July 20, 1933 - working at that time for a total period of 6-7 weeks employed in the "shaking out" dept. where he was exposed to considerable lead dust - working from 5-8 hours a day depending on number of tiers of jars emptyed. During this work he wore a respirator. He also worked for same company for 8-10 days in 1930 or 1931 during which time he had no lead exposure.

On day he became ill he went home at noon, nauseated and with abdominal cramps - he vomited some after drinking water - he pains in his joints and leg muscles -there was a lead or metallic taste in his mouth - had loss of appetite - breakfast anorexia and he fatigued easily - He was seen by the company doctor for a time (about 3-4 visits at his home). He then saw a colored physician (Dr. W. R. Shell- 511-Olive Street) who has attended him since.

Previous to above illness has been well - no operations in past - thinks he had usual childhood diseases. In 1918 had rheumatism in left knee lasting from May until Oct. At this time he was given some "shots" in his arm. No history of venereal disease. Never seriously injured in past.

Above is married, has no children, and is now being given relief by the Assoc. Charities. He very occasionally does a day's work, helping on a truck or shovelling coal.

at times, but occasionally having epigastric pain, nausea, loss of appetite and persistent constipation. Occasionally vomits (blood streaked ?). Now weighs 157 pounds he states. He weighed 172 before working for company and 149-150 when he became ill. His appetite has been improving in general, he has no headaches, and sleeps fairly well. He seldom eats before the noon meal. The past 3-4 days he has had pain in the left lumbar region which he states is swollen. He still tires easily - short of breath on exertion and occasionally states he has a metallic taste in his mouth and tender gums. No definite history of arthritis or neuritis over any extended period. Eye sight is good. Has a nocturia 4-5 x without pain or burning - no other symptoms ref. to g. u. system. Besides shortness of breath occas. notes palpitation and swollen ankles - occas. unproductive cough.

3. Examination: Colored male - age: 40 years - height 5'10-1/4" - Weight: 157-1/2 Temp: 98.6 Resp: 18 - Pulse: 84 B.P. 190/128 (later 180/130)

Above is a well developed and fairly well nourished colored male not appar-

N19322

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On day he became ill he went home at noon, nauseated and with abdominal cramps; he vomited some after drinking water - he pain in the joints and leg muscles - there was a lead or metallic taste in his mouth - had loss of appetite - breakfast anorexia and he fatigued easily. He was seen by the company doctor for a time (about 3-4 visits at his home). He then saw a colored physician (Dr. W. H. Shell, [illegible] Olive Street) who has attended him since.

Previous to above illness has been well - no operations. Patient thinks he had usual childhood diseases. In 1918 had rheumatism in left [illegible] lasting from May until Oct. At this time he was given some shots in his arm. No history of venereal disease. Never seriously injured in past.

Above is married, has no children, and is now being given relief by the Assoc. Charities. He very occasionally does a day's work, [illegible] on a truck or shovelling coal.

2. Complaints With treatment he has improved since then, feeling fairly well at times, but occasionally having epigastric pain, nausea, loss of appetite and persistent constipation. Occasionally vomits (blood streaked ?). Now weighs 157 pounds he states. He weighed 172 before working for company and 149-150 when he became ill. His appetite has been improving in general, he has no headaches, and sleeps fairly well. He seldom eats before the noon meal. The past 3-4 days he has had pain in the left lumbar region which he states is swollen. He still tires easily - short of breath on exertion and occasionally states he has a metallic taste in his mouth and tender gums. No definite history of arthritis or neuritis over any extended period. Eye sight is good. Has a nocturia 4-5 x without pain or burning - no other symptoms ref. to g. u. system. Besides shortness of breath occas. notes palpitation and swollen ankles - occas. unproductive cough.

3. Examination: Colored male - age: 40 years - height 5'10-1/4" - Weight: 157-1/2
Temp: 98.8 Resp: 18 - Pulse: 84 B.P. 190/128 (later 180/130)

Above is a well developed and fairly well nourished colored male not appearing acutely ill. His m. membranes are of good color and no eruptions on skin.

Ears: hearing normal - canals and drums neg.

Eyes: Pupils reg. and equal. React well to Light - fair to Accom. E.O.M. normal. Both fundi and eye-grounds appear normal and the retinal vessels do not appear abnormally sclerosed. No nystagmus.

Nose: Essent. neg.

Mouth and Throat: Teeth dirty and discolored - fairly good - gums no pyorrhea - some early gingivitis, on right lower gum is a large bluish colored patch [illegible] has no relation to lead. No lead line noted. Tongue in midline and no tremor - tonsils not remarkable and pharynx clear.

Glands: Anterior cervicals palpable but not tender. Epitrochlears palp.

Chest: Expansion normal and equal - chest is clear on percussion and auscultation.

Robert A. Kelser M. D.
(Signature of Examiner)

(CONTINUE REPORT ON REVERSE OF SHEET—NOTE INSTRUCTIONS)

(CONTINUE REPORT *DOWN* FROM HERE)

Heart: Rate and rhythm regular. Sounds good qual. No murmurs heard. Ap is snappy. R.S.D. = 6-1/2 cm. R.C.D. 3-1/2 x 9 cm. P.M.I. - 8-1/2 cm. B.P. 190/128 - half hour later 180/130. Reaction time poor.

Abdomen: Liver and spleen not palp. No masses and no tenderness excepting over epigastrium on deep pressure. No hernia - inguinal rings intact. Over left lumbar region there is some fullness and is tender to pressure - no muscle spasm or local heat. No hyperaesthesia over this region.

Extremities: Essent. normal in form and function.

Reflexes:

Neurological: K.J. ++ Cren.+ Epigastric + Biceps + Abdom.+
Romberg neg. No ataxia.
No wrist or ankle drop but muscles of forearms and hands weak.

Dynamometer readings - Right 100 Left 90

Blood findings: R.B.C. 5,180,000 Wassermann - negative
W.B.C. 4,850 Kahn - negative
H.B. 80
Stippled Cell Count - 0

Diff: P.M.N. 57.5
Lymph 36.5
Mono 3.0
Eosin 1.5
Baso 1.5

Urine: Albumin - negativ
Sugar - Benedic
Reaction- acid to
Mic: -

Blood lead

Urine lead (spot

Urine lead (24 ho

nger) -

4. Discussion: There are two tems among the physical findings which might be construed to be sequellae of lead intoxication; namely - the hypertension and the weakness of the muscles of the h arms. In my opinion neither of these should be so construed. There i a hypertensive condition the peripheral circulation, whic th some degree of circulatory embarrassment, thereby constitut one most significant factor in the patient's present partial disability. It i generally believed that prolonged lead exposure may produce this picture. In thi instance the exposure was of short duration. Moreover the time elapsing since been sufficient to bring about the elimination of lead, as shown by ysis, so that it can scarcely be regarde as the exciting cause of the pre ypertension.

A point of view concernin above relationship might be expressed in certain medical circles to the e t that the initial lead intoxication resulted in vascular and perhaps renal da and that the present hypertension is evidence of residual damage. On the basi this concept the present partial disability would be held to be the result o lead intoxication. This point of view is stated here for the sake of fairness to e claimant, but this examiner does not regard i as plausible.

The hypertension may be a expression of luetic vascular disease. Although the clinical and serological information does not establish the diagnosis it does not exclude it. Provocative anti-luetic therapy might result in positive serologic evidence of syphilis. The weakne of the hands and forearms is slight and is probably the result of inactivity over a period of months. In any case it has not

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(See attached sheet)

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Claim No. OD 10562

Claimant: [redacted]

There is undoubtedly a tendency on the part of the patient to magnify his disability. Nevertheless some disability is present due to the circulatory condition. In my opinion this is slight and will not at present prevent the claimant from carrying on regular work of moderate intensity.

5 Opinion

This examiner is of the opinion that the claimant has only a slight impairment of his ability to work at present, but that his vascular condition will probably progress and produce a greater disability later; the partial disability is not, he believes, a residual effect of lead intoxication.

Robert A. Kehoe, M.D.