History

Check up on history taken February, 1941, yields little new information. He began work about January 1, 1941, cleaned still and autoclave 8 or 10 times in the ensuing 2 weeks, worked the greater part of the time at smelting, and recovery operations, and made all alloys. The onset of his illness was with insomnia and terrifying dreams one week after beginning work. There was definite, and in fact, considerable exposure to inorganic lead compounds, both as fume in smelting and alloy manufacture and from dust in sweeping and cleaning.

Progress Note

Left hospital on February 27, 1941. He was weak and ill at the time. Improved steadily until July 1, since then has been below par except for improvement in vision, which has been steadily better till last month. The rate of improvement has been slow and as the patient approaches normal, the changes from week to week are not apparent to him until some time has elapsed. The following symptoms persisted after leaving the hospital.

(1) Weakness
(2) Loss of weight
(3) Diplopia
(4) Cough and expectoration
(5) Increased sensitivity to tobacco smoke
(6) Sense of pressure in chest and inability to sleep on left side.
(7) Headaches and tinnitus
(8) Nycturia - 2 or 3 times
(9) Flatulence, abdominal cramps
(10) Diarrhea - 3 movements daily
(11) Vertigo

(1) Weakness

This gradually improved until July, but there has been little improvement since. Patient drives truck and handles 10 tons of coal a day now. Prior to illness, believes that he was able to handle 16 to 18 tons a day without excessive fatigue. He now tires easily and is fatigued at night and in the morning. His sleep is not adequate, as he does not always feel rested.

(2) Weight Loss

Prior to P.I., weighed 150 lb., P.W. 142. Most of the gain has been up to July 1, with little since.

(3) Diplopia

This recovered completely by September 1; was noted on looking to the left only. Until September when he was driving, often had visual hallucinations (large black object). Occasionally mistaken for autos and would interfere with his driving as he would stop when it appeared. He soon learned, however, that when he would focus or concentrate his vision upon this black object, the hallucination would disappear. It is questionable whether this was a true hallucination and was not an illusion as his stereopsis was noticeably poor, and the effect could have been produced by coincident vision in two planes.

Lacrimation has been continuous symptom since release. Improved slightly in recent months, but with very little change in the last month. Dark adaptation is very poor, night vision poor and has considerable difficulty with glare in driving or going from light to dark environment. There is no gross lacrimation, but the eyes seem unduly moist.

(4) Cough and Expectoration

This has been continuous since leaving the hospital, usually yellow m.p. exp. in the morning. It is not bad enough to interfere with daily work, and patient states that there has been no recent improvement. In the 2-hour period of the examination and for 30 minutes before and after, the patient did not cough once, but cleared throat once and hacked once in spite of the fact that the room was filled with cigaret smoke. The patient's description of the cough and its time relations strongly suggest that it is due to post-nasal drip.

(5) Smoking

Smoking more than 10 cigarets per day now makes the patient's chest sore and may precipitate coughing attacks. Previous to the present illness he smoked 20 to 30 cigarets without difficulty. Has been no recent improvement. (Patient smoked several cigarets during examination without cough.)

[redacted]

(6) Pain in Chest

This comes on especially at night and there is a cramping sensation in the lower left side which prevents sleep on that side. There is no recent improvement and the pain in the left chest is relieved by change in position.

(7) Headaches

Was relatively free throughout the summer, but these recurred much worse and have been coming on daily since the middle of September. Bouts are daily for from 1 to 2 hours and on occasion may last all day with an uncomfortable sensation in the head, but without acute pain. The type of headache is essentially the same but varies in severity. Left fronto-temporal distribution and may be associated with low-pitched tinnitus. There is no constant time relation to the headaches and he occasionally awakes in the morning with pain. At other times it comes on during the day. The patient is not certain that it has any definite time relation to eye strain from driving, etc.

(8) Nycturia

This has been regular 2 to 3 times since leaving the hospital. Night volume is not noticeably greater than the day. There was pain and burning for 3 months at least after discharge. Perineal pain was marked for several months, especially when bowels moved. There is no recent improvement.

(9) Flatulence, abdominal cramps

Gas and full feeling in the stomach have been distressing symptoms since leaving the hospital. There have been frequent abdominal cramps, which are not severe or colicky. There has been little change in the past 2 months. Hiccoughs are precipitated by spices, heavy foods and pepper. Unable to eat beans; passes a great deal of gas. Full history of these symptoms strongly suggest biliary disfunction and achlorhydria.

(10) Diarrhea

Bowels move 3 times daily and are somewhat loose. This has been unchanged for the past 6 months. Prior to P.I. there were 2 movements per day.

[redacted]

(11) Vertigo

If perspiring and suddenly is exposed to cool breeze, attacks of vertigo ensue. These are also very frequent when arising from stooping position. During the summer he had muscae voletantes and dizziness every time he rose from stooping position. This improved beginning in September, 1941. In the summer while working as a floor sander he was particularly annoyed by vertigo and spots when changing positions.

The patient sleeps well, there are no dreams or insomnia at present, but does not feel rested. There are infrequent pains in the wrist, worse on effort, so that it is sometimes difficult for him to hold a shovel. These pains occasionally radiate to the elbow, this being particularly noticeable immediately following his discharge from the hospital.

His memory has recovered well. The patient cannot concentrate as well as formerly and he believes there has been some slowing of the mental processes. There is increased irritability when fatigued, but no combativeness. He gets along well with people and says that he is a fairly agreeable person unless he is very tired.

Libido returned after 2 months at home. He is now able 1 to 2 times a week, compared to 3 to 4 times prior. He erects with difficulty and has frequent collapse during intercourse. Orgasm is weak and uncertain and occasionally cannot attain. No contraceptives are used and there have been no pregnancies since P.I. Sexual functions have shown little improvement in the past month or two. Patient does not have an absolute impotence, but history is that of relative impotence due to weakness and fatigue.

Last seen by a physician (Dr. Work) in July, 1941. No medication or diet was given. There has been nasal discharge and catarrh in the mornings regularly. One or the other side of nose is stopped up constantly, and it is necessary to clear nose and naso-pharynx frequently in the morning.

Physical

T. 98.8 P. 74 R. 25 B.P. 115/76

G.A. Not ill, alert, cooperative, response normal and reasonable. Face is ruddy. Skin portions follow elsewhere.

[redacted]

Head	Negative, hair thick
Ears	Hearing OK
Eyes	Rt. equal lt. Wide, regular, reflexes OK. Slight hypus reaction (less than frequently seen in normals). Vertical - E.O.M. uncertain. Left eye tracks poorly and is irregular on up and down movement. There is weakness of the left internal rectus. Convergence is poor on the left.
Mouth	Tongue is red at edges with marginal glossitis and hypertrophy of many papillae. Teeth and gums OK, fauces good color. Palate and pharynx markedly injected. Tonsils are large, swollen and injected and edematous. Both ant. pillars are swollen and injected.
Nodes	Lt. tonsillar node enlarged, tender, left epitrochlear shoddy, others not remarkable.
Neck	Not remarkable. Both lobes and isthmus thyroid palpable.
Chest	Definite droop to right shoulder (right handed). Expansion fair, equal - fremitis equal. Insp. 34" - Full exp. 35½". Kr. I. rt. 7.0 lt. 6.0 P.E. rt. 3.0 lt. 5.0 R.S.D. 7.0 R.C.D. 3.0 x 11.5 P.N. clear both sides - W.V. and S.V. clear, equal, well transmitted. Apex rate 78, 25 hops 92, 2 minutes 80. Sounds clear, general circulation not remarkable.
Abdomen	Doughy, tense. Slight pain on deep pressure in the left upper quadrant. There are no masses, no muscle spasms and respiratory movements are normal.
Pelvis	Both rings admit the tip of the finger. Right is larger than the left. There is a slight sac on the right on heavy pressure. No pain. Genitalia - not remarkable.
Ext.	Negative. Numerous recent abrasions and scars on legs.
Rectal	Not done.
Reflexes	All hyperactive - 4 plus. No clonus. Are equal, superficial, active. Hyperreflexia no greater than that occasionally seen in normal young men.
Sensorium	Very acute - epicritic good. Tactile discrimation excellent. Perception good and clear. Kinaesthetic and proprioceptive good.

[redacted]

Muscles — Myotatic and myotactic irritability. Muscle tone good, power good and equal. No atrophy. Movements smooth - no muscle pain.

Tremors — None - extended fingers quiet. There is no static or locomotor ataxia - no adiadokinesia - pass pointing is good. Cranial nerves are OK. Tongue protrudes in the midline. Masseters and temporals OK. Function satisfactory.

Mental — Outlook good - sense of humor very good. Memory and orientation good - insight and judgment very good. Understanding of behavior and recollection of events of illness is excellent.

Diet — The patient eats 2 to 2½ lb. meat weekly. No milk and large amount of vegetables. Past few months has been limiting choice of foods because of G.E. tract disturbance.

Impression

(1) Convalescing T.E.L. intoxication with prolonged weakness.
(2) No evidence of organic residual damage.
(3) Chronic sinusitis.
(4) Subacute tonsillitis.
(5) Postural circulatory inadequacy.
(6) Cystitis and possible prostatitis.
(7) Potential inguinal hernia.

Comment

Patient is recovering slowly and requires general therapy. The circulatory inadequacies may have been contributed to largely by the prolonged period of convulsions and hyperactivity followed by extensive bed rest. There is no evidence of specific damage or of reflex instability in the circulatory system. The cystitis and the possible prostatitis are attributed to the frequent catheterizations in the hospital. The patient is below par as the result of prolonged serious illness, together with the persistence of chronic infections that he has undoubtedly had for some time.

Recommendations

(1) Regular medical visits with
(a) Benzedrine - 10 mg. in morning before arising, repeated at 10 a.m., if response is good change to paradrine.

(b) Fortified vitamin intake.
(c) Adequate diet - gall bladder type.
(d) Glasses to aid rectus weakness and fusion difficulty for the time being at least. The eye symptoms and difficulties are attributed to strain.
(e) Discontinue smoking.
(f) Treatment of the gastric symptoms - gastric analysis and therapeutic test with Ethamine and hydrochloric acid.
(g) Prostatic examination and examination for cystitis. Prostatic massage for impotence.
(h) Study of the response of the circulatory system to the postural changes.
(i) Nose and throat consultation, especially directed to examination of the posterior ethmoid and sphenoid areas. Cocainization of sphenopalatine ganglion at the time of an acute headache is suggested.
(j) Study of the night and day urinary volume with concentration and dilution tests. This symptom may be the result of cystitis or may be depended upon changes in circulation, as result of changes in posture.

(2) Continue at regular outdoor work as usual.

(3) Check on blood and urine lead content.

(4) Patient needs supportive and general therapy. Has not been seen by a physician since July, 1941.

(5) The question of the bronchitis may be investigated later, the chest however should be examined at the time of the periodic medical visit.

Dr. Ragnar J. Ness has agreed to follow this patient and will investigate recommended therapeutic procedures.

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