PLAINTIFF'S EXHIBIT
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January 20, 1967

State of Washington
Department of Labor and Industries
Olympia, Wash.

Re: Cecil B. Lockwood
Soc. Sec. No: 518 09 6962
445 North 58th
West Richland, Wash.
Employer: Fiberglass Engineering

Dear Sirs,

Mr. Lockwood presented at my office on 11/1/66 with a complaint of headache, left-sided chest pain and dizziness. Because of the intensity of his complaints, he was hospitalized at New Valley Osteopathic Hospital on 11/1/66. He was discharged on 11/4/66 with a final diagnosis of: 1) Asbestosis. 2) Maxillary sinusitis.

PAST HISTORY:
As near as I can determine from the records that have been sent me by this patient's previous doctors, one in Kennewick, Washington, and x-ray reports, PA and left lateral chest report taken on 10/12/54, conclusion was an essentially normal chest. This was reported by R. W. Hanf, M.D. (practice limited to radiology). The attending physician at that time was Dr. John N. Pierson. Another chest x-ray report taken on 2/4/55 showed some slight pulmonary fibrosis with several areas suggesting bilateral bronchiectasis. The chest was otherwise unchanged. We sent for these films for comparison with our film and apparently, the films had been destroyed.

I have no other x-ray reports from other doctors since that time, but in the file of records received from Dr. Pierson in 1962, there is a note indicating exertional dyspnea of four years duration, and on previous notes, as near as I can tell, Mr. Lockwood was treated primarily for headaches, chest pain and upper respiratory infections. I first saw Mr. Lockwood in March of 1964 and at that time, admitted him to New Valley Osteopathic Hospital where he was discharged with a final diagnosis of frontal sinusitis. X-rays of the chest obtained were obtained at that time and showed what was suspected to be an asbestosis. No comparative films were available from previous occasions. Subsequent to that, he was readmitted to New Valley Osteopathic Hospital on 12/3/65 with a diagnosis of possible carotid sensitivity and poor ventilation due to asbestosis. Incidental diagnosis were duodenal ulcer and maxillary sinusitis.

His respiratory history indicated that he was having increasing dyspnea, but in 1965 he did not have any cyanosis and he was working at Hanford and had to climb stairs for a distance of about 40 feet and if he went slowly and stopped once or twice before he got to the top, he was able to make it. Apparently, this has become much worse recently and in any case, he has had to quit work on account of it.

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HISTORY BY SYSTEMS:
History by systems, otherwise, is not remarkable.

HISTORY OF PRESENT ILLNESS:
As near as the patient remembers, he was first told about the lung scarring by Dr. Pierson, apparently in 1953 or 1954. In 1958, he was treated for what was believed to be pneumonia, and later was thought to be asbestosis. Since that time he has become increasingly dyspneic and symptoms referrible to the respiratory system have become accentuated. I do not have the x-ray reports, nor the films obtained on this patient during the years subsequent to 1955, but the patient indicated that his physician reported to him that the changes in his lungs were becoming more profound. At the present time, the patient has occasion cough that is not particularly productive. He has occasional chest pain and at the present time, he is complaining of left sided chest pain.

PHYSICAL EXAMINATION:
Shows a well developed male who appears to be his chronological age. Temp 98.6, pulse 62, resp 20, wt. 175# and B.P. 120/70. Routine examination otherwise, was negative. Spirometry was performed which indicated a reduction in the patient's vital capacity.

The patient was discharged from the hospital with a final diagnosis of asbestosis of the lungs, and he was requested to see David H. Williams, M. D. of this city on consultation. A copy of Dr. William's consultation is attached.

IMPRESSION:
It is my impression that this patient has developed an asbestosis strictly due to his occupation. I believe that this asbestosis developed as a result of his occupation and probably did not become acute until about 1957 or 1959. Since then, it has become progressively worse and it is now to the point of where the patient is not able to work and if he does, he will get in such a situation that his work would possibly become very dangerous to him. From the standpoint not only of vertigo and dizziness and the possibility of falling and hurting himself, but from the standpoint of his ultimate health which will most certainly shorten his life expectancy if he continues his present occupation.

I feel that this is definitely an occupational disease and that as such, consideration should be give to his request to establish an industrially connected report of accident form with the Department of Labor and Industries.

This patient was first totally disabled from 11/1/66 through 11/13/66. He returned to work on 11/14/66 and worked up until 1/6/67, at which time he was advised not to return to work.

At the present time, I feel that the patient is totally disabled in so far as his present occupation is concerned and have advised him not to return to work as an asbestos worker. In addition, at least for the present, the patient is still

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experiencing some dyspnea and light headedness and I have cautioned him even about driving an automobile or putting himself anyplace where he may jeopardize himself by becoming dizzy and falling.

At this time, we are requesting his hospitalization be allowed by the Department of Labor and Industries.

Very truly yours,

LYLE F. GHORMLEY, D. O.

LFG:dr
Enc. 1
cc: David W. Williams, M. D.

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