October 27, 1947

Mr. Donald M. MacCready
Workmen's Compensation Board
State Office Building
Albany 1, New York

Re: No. 54204741
Claimant: [redacted]
Employer: Shell Oil Co., Inc.

Dear Mr. MacCready:

At your requested I completed the impartial examination on the above claimant on October 16, 1947. [redacted] is 47 years of age and married.

His chief complaint was extreme shortness of breath and pain in the chest on slight exertion for the past five years. However, this has improved during the past five months.

HISTORY OF PRESENT ILLNESS: He was well until July, 1942. During that month he began to notice "dizzy spells" while driving a tank truck for the Shell Oil Company. These spells forced him to pull over to the side of the road, and lasted for a few minutes. He was then able to continue. At no time did he lose consciousness. These spells became closer together until September, 1942, when he called in Dr. William Capowski of Milton, New York, who told him to stop work. Dr. Capowski was called because Mr. Miller "passed out" at home while resting. After Dr. Capowski's examination he was referred to Dr. Ferguson in Newburgh for a cardiac examination, and it is Mr. [redacted] statement that Dr. Ferguson advised him to rest for at least a month or six weeks. During the next five weeks, even though he did not work, and even though he rested continuously he became more dyspneic and lost weight. Because of this he was sent to Vassar Brothers Hospital where Dr. Capowski did a complete work-up without arriving at any diagnosis. In March, 1943 he developed a severe sore throat, which was diagnosed as a streptococcus throat, and at that time he changed doctors, transferring his case to Dr. Carl Meekins of Highland. Dr. Meekins treated him for various gastric and chest complaints without giving him any diagnosis. A peptic ulcer was suspected at that time but was not proven. In September, 1943 he was told that he had asthma and was advised to go west. He went to California and his condition there did not improve, in fact he felt it was worse, and he came hom. While in California he attempted to do a couple of days of work for an airplane factory but was unable to continue. On his return from California he was told to rest as much as possible and not to do any work. In February, 1944 he changed from Dr. Meekins to Dr. Blakeley in Highland. Dr. Blakeley has treated him since for a "cardiac condition" and "splenic disease."

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Mr. [redacted] worked for nine and a half years as a driver-salesman on a gasoline truck owned by the Shell Oil Company. His work consisted of delivering gasoline to various customers and at times required fourteen or sixteen hours of work a day. The trucks had capacities varying from 2,100 to 3,600 gallons. These trucks had to be filled four to five times a day in an open shed, but the patient claims to have inhaled fumes which contained tetra ethyl lead. At the present time he is severely dyspneic on the slightest exertion. He sometimes has chest pain following exertion, relieved by rest. He is definitely orthopneic and needs four pillows at night for comfort. He also complains of pain in the left upper quadrant.

PAST HISTORY: Mr. [redacted] claims that he was in good health except for an attack of lobar pneumonia in 1941.

Physical examination on October 15, 1947 revealed a dyspneic male. Mild cyanosis of the malar areas and of the lips. Dilated venules on the nose. Slight cyanosis of the nail beds.

Eyes: Pupils react to light and accommodation. Eye grounds show mild sclerotic change and tortuosity.

Tongue is coated.

Throat is not injected.

The chest is emphysematous in character. There is an increased anteroposterior diameter. The excursion is symmetrical with breathing mostly by means of the accessory muscles of respiration.

The heart is not enlarged to percussion. The sounds are muffled and distant and of only fair quality. Regular in rate, force and rhythm. There are no murmurs. B.P. 118/80.

Abdomen shows no masses and slight tenderness in the left upper quadrant. There is a small right inguinal hernia.

Neurological examination is normal, and there is no edema of the extremities.

Fluoroscopic examination revealed the cardiac shadow to be of normal size with some increased rounding of the left lower border. The cardiothoracic ratio was normal. There was impaired motion of the right leaf of the diaphragm, some increased bronchial markings on both sides, and increased aeration of both bases, suggesting emphysema.

Electrocardiogram is enclosed and shows no axis deviation, some slurring of the ventricular components in Lead 3 and in the chest leads. It shows an inverted T wave in CF_1, diphasic T. waves in CF_2 and CF_3.

X-ray reports from Dr. J. Spottiswood Taylor taken on October 6, 1947 and reported by Dr. Ingalls show the "stomach to be of normal type and position and well outlined. No deformities or filling defects are apparent. Peristalsis and motillity are normal. The duodenal cap fills well. There is no retention

at six hours and the barium has made usual progress. There is no evidence of an organic condition of the stomach."

Chest: "There is some hilar thickening with some accentuation of lung markings. Parenchyma of both lung fields is clear. There is no evidence of pleural involvement. The cardiac shadow is normal. There is some limitation of motion of the diaphragm. This is somewhat more marked on the right."

A count done on the same day at the Kingston City Laboratory showed hemoglobin of 108% Sahli, red blood cells 5,410,000, white blood cells 18,000. The differential count was neutrophilic myelocytes 4%, neutrophilic band cells 10%, polymorphonuclear cells 75%, polymorphonuclear eosinophiles 1%, polymorphonuclear basophiles 1%, large lymphocytes 4%, small lymphocytes 4%, large mononuclears 1%. The leucocytosis and the young forms on that examination were explained by the fact that Mr. Miller had an acute bronchitis when it was done.

Discussion: Mr. [redacted] has been ill since July of 1942, and has been unable to work since September, 1942. There appears to be more than one condition involved in this case. His original complaint consisted of some sort of syncope or threatened syncope, described by him as a sensation of "fainting or passing out." Apparently he made no mention at that time of dyspnea or chest discomfort on exertion. Gradually the story of dyspnea and chest distress enters the picture, but from the record this apparantly was first noticed two months after the original onset. In reviewing the voluminous file on this case there are certain things which remain constant. The apparent respiratory and cardiac embarrassment has been present on every examination except the original consultation by Dr. Ferguson. There is a definite change in the EKG from the one reported by Dr. Holcomb, and the present EKG agrees in substance with the one done by Dr. Ferguson in 1944.

Impression: I feel that Mr. [redacted] at present has a non-valvular heart disease, probably on the basis of coronary insufficiency, myocardial damage, and is in Class III. He also has chronic emphysema, the cause of which I am not able to ascertain from this examination, a partial paralysis of the left leaf of the diaphragm, and a small right inguinal hernia. The exposure to tetra ethyl lead is difficult to fit into the present picture. It is possible and perhaps probable that the original complaints of dizziness and faintness, apparently related to the cerebrum were on the basis of lead exposure, but there is nothing in the succeeding x-rays, EKG's and laboratory work upon which one can make a diagnosis of chronic lead poisoning. The cardiac picture impresses me as being a progressive, degenerative type of illness, which does not depend upon exposure to lead for its origin or its progress.

Respectfully submitted.

(Signed) R. T. LAPIDUS, M.D.
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