A. RAY WILEY, M. D., F. A. C. S.
812 MEDICAL ARTS BUILDING
TULSA, OKLAHOMA

June 17,1936

Re: Hiram Baize vs Johnson Oil Refining Co.

Dr.Robert A.Kehoe
University of Cincinnati
Cincinnati,Ohio.

Dear Dr.Kehoe:

I am writing you at the request of the Johnson Oil Refining Co. and Mr.W.G.Hawkinson,local representative of the United States Fidelity and Guaranty Co.

These people recently asked me to examine Mr. [redacted] for them. This examination was made in reference to an alleged injury of July 3,1935 in which Mr. [redacted] claims that he received lead poisoning from some ethyl gasoline.

The direct object in writing you is to secure information on the effects of lead poisoning by ethyl gasoline; i.e., the symptoms and methods of determining whether or not an individual has received ethyl gasoline lead poisoning. I understand that you have had the opportunity to do considerable research work along this line and that you have some direct connection with the makers of ethyl lead used in gasoline. I am inclosing a copy of the physical examination made by me and two other local surgeons, on the patient mentioned.

I would also like to know if your office has record of a physical examination of [redacted] made before July 3,1935. I understand that the ethyl company makes periodic examinations of employees handling ethyl gasoline. I would appreciate any comments you have on this particular patient. Will you please send me reprints of reports of your work in connection with ethyl lead poisoning.

Your cooperation and opinion is earnestly desired to arrive at a accurate analysis of this patients true condition,both for his well-fare,as well as for the Johnson Oil Refining Company and the U.S.F.& G.Co.

#2RAK

Re: [redacted]

While I have no authority to incur any expense in this connection I feel quite certain that the insurance carriers would pay for any reasonable expense incurred by this consultation.

May I have the peasure of hearing from you at your earliest?

Very truly yours,

A.Ray Wiley M.D.

ARW/ael

cc WGH

May 22,1936

Re: [redacted],Claimant, vs Johnson Oil Refining Company

10/24

Mr. W.P.Hawkinson
W.S.F. & G. CO.
Tulsa,Oklahoma

Dear Mr.Hawkinson:

Mr. [redacted] reported to my office on May 21,1936 for physical examination. This examination was made at my office with Drs. Fred W.Cronk and W.S.White,being present. Examination was made in reference to an alleged injury on July 3,1935 when it is claimed that he was exposed to gasoline fumes.

The patient walks with a slight stooping posture and rather ambling gait and appears ill and feeble for his years. He gave his age as 59. He is 72½" in height and weighs 147 lbs.

There was a rather profuse papular eruption on the face and neck. This showed to continue on the upper portion of the chest and shoulders. The sclera of the eyes showed a slight yellowish tint and that the patient is apparently hard of hearing.. This man has been taking considerable Iodides & Bromides for a considerable time. This Dr. said he would discontinue them for a time 10/24

His past history of any illness is entirely negative with the exception that he had some slight illness in childhood,which he does not remember whether it was typhoid or pneumonia. In 1919 he had a rather severe fracture of the right ankle.

His complaints were that he became ill following exposure to gasoline fumes and that he has not been well since and is unable to work.

Examination: The ear drums are retracted. Definite test for acuity of hearing was not made,but the patient can hear ordinary conversation most of the time,but at other times the voice has to be elevated fairly well above normal to make him hear. The nose shows no pathology. The teeth are extremely poor. The gums show considerable pyorrhea,but no swelling of the gums. There is no bluishness about the gums as is some times found in lead poisoning. Tonsils are average in size and throat is moderately congested. Papular eruption of the face has been noted above. The eye grounds show considerable tortuousity of the blood vessels near the disc, but no other retinal changes were noted. The reflexes of the eyes are normal.

There is a slight increase in the size of the cervical glands of the neck,otherwise the neck is normal.

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The upper extremities are normal with the exception that he has a rather marked deformity of the right little finger, which he says was due to an injury in childhood. Reflexes of the upper arms are normal throughout.

The blood pressure 210/125. Pulse rate 110. Temperature 99.1.

The heart was pendulous type with slight hypertrophy, rather harsh, or sclerotic aortic sound, otherwise heart was normal.

Contour of the chest showed slight arthritic deformans of the spine with slight bowing of the upper dorsum. There was slight moisture in the posterior left chest with slight roughened breath sounds. The excursion appeared to be about normal.

The abdomen is normal in contour. There was rather marked upper abdominal rigidity. There appeared to be a fixation of the umbilicus and a questionable palpable mass just above the umbilicus. Patient stated that he had considerable distress in that region lately with a great deal of indigestion and soreness. There has been some nausea, but he had not at any time vomited any blood or blood stained vomitus. Visceral outlines otherwise appear to be normal. There are no hernias present.

Genito-urinary system normal. Anus and prostate normal.

There was rahter marked vericosity about the calf of the left leg. There was considerable deformity of the right ankle due to an old injury. The reflexes of the legs and abdomen were normal throughout.

The patient's ability to stoop and bend the body was somewhat limited. His manner and action were that of a man much older than the age stated.

His specimen of urine and specimen of blood for blood analysis and blood count were secured. A copy of these in detail are attached. These show nothing unusual, except there was some albumen in the urine.

Then Dr.White and Dr.Cronk, as well as this writer, considered it advisable to fluroscope the chest and to determine if possible the condition of the upper abdominal area. Fluroscopy of the chest showed considerable fibrosis throughout, extending fairly well to the periphery. The costophrenic angles were clear. The heart showed no unusual pathology. The post-cardiac space, however, was narrowed. The patient was given a barium meal. Barium entered the stomach. No obstruction in the esophagus. Stomach was fairly low. There was rather constant indentation on the greater curvature of the stomach, although this did not appear to be fixed. The ruggi of the stomach appeared to be normal. There was considerable deformity at the pyloric end of the stomach. A normally formed cap was not seen.

Physician: Dr.A.Ray Wiley

Patient: [redacted]

Date: 5-21-36

Blood count:

R.B.C.	4,770,000
Hgb.	107
W.B.C.	7,450
Seg.	60
Eos.	13
S.Lymph	27

Urinalysis:

Sp.Gr.	g.n.s.
Reaction	acid
Color	yellow(cloudy)
Albumen	positive plus.
Sugar	negative
Indican	negative.
Urob.	negative.

Microscopic: few pus cells. Occasional sq. bowled with amorphus urates.

Blood Wassermann: Negative.

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