10/23/47

Dr. Robert Kehoe,
Lettering Laboratory
University of Cincinnati,
Cincinnati, Ohio.

Dear Doctor Kehoe:

I have sent you under separate cover, urine + blood specimens of Mr. [redacted]. These specimens were obtained 10/15/47 while the patient was hospitalized, and had been misplaced in a refrigerator since then.

[redacted] is a 42 yr. old white man, employed at Willard Storage Batt. Co. continuously since 1926. During this time he has worked in lead depts. (Paste and Assembly) until 9/18/47 when he was transferred to shipping. He has had no episodes of plumbism, though his stipple count has been as high as 23 (Sept. 1944) and has been 5 to 8 much of the time. He had an appendectomy in August, 1946, with uneventful recovery. He has been a heavy beer drinker for years.

Present Illness: acute onset 9/23/47 c abdominal pain, low down, accompanied by nausea, diarrhea, symptoms of shock. Gradual improvement over several days, though tenderness and abdominal distention continued. Bowels became regular, and no abnormality of G-u system developed.

P.E. Well developed, obese white man.
T 98.4 P 70 Resp 17 BP 130/86
Eyes good, no cyanosis or pallor.
Upper and lower dental plates.
Positive physical findings confined to the abdomen.
Abdomen large, rather firm as though distended ± ascites. No physical or roentgenological evidences of fluid in the abdomen. Generalized tenderness in mid abdomen, extending from flanks to flanks at the level of the umbilicus. (This tenderness is considerably lighter in the abdomen than the original pain + tenderness.
No masses felt abdominally or rectally.

Lab: Blood counts normal, differential normal, no stippled cells.
Urinalysis negative.
Stool 1+ occult blood
Icteric index 16
Bl. Chemistry normal.
X-ray kidneys, stomach, small intestine, colon, chest — all negative.
Gall bladder visualized poorly.
Cephalin flocculation 2+

Course: R. developed a high fever and abdominal signs of peritonitis. He was given penicillin without much effect. The addition of sulfadiazine in therapeutic doses brought rapid improvement in symptoms and signs.
He was discharged on 10/15/47, completely free of symptoms and with no signs of disease of any sort.

Final diagnosis: Peritonitis of unknown etiology —

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Impression: It is not thought that this man's acute illness has much direct relationship to lead poisoning. It seems most likely that he has some liver damage, possibly an early cirrhosis, responsible for the positive cephalin-flocculation reaction. The origin of his acute peritonitis remains obscure.

However, I do not know what effect the ingestion of small subtoxic amounts of lead over a period of years might have on a liver that was concomitantly being subjected to whatever toxic effect heavy beer drinking might produce. Further, this man had had a high fever for 6 days before these specimens were taken, and if such can mobilize lead these specimens should show an increased amount. Whatever organic disease he has must be considered still active and the role of lead in this case may assume a more important role later.

I'll be glad, indeed, to hear from you on this problem. Hope to see you again.

Very truly yours
James J Badal, M.D.

Med. Dept.
Willard Storage Batt. Co.

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