FILE NAME: Plant Insulation Company (PIC)

DATE: 1959

DOC#: PIC003

DOCUMENT DESCRIPTION: Worker's Compensation Claim

In the above-entitled matter, we have your letters of June 18, 1959, on Form 303, addressed to Plant Rubber & Asbestos Works, 537 Brannan Street, San Francisco, and to Paraffine Company, Inc. at this address. Each of these letters inquires as to the compensation carrier for the addressee.

The Paraffine Companies, Inc. is the former corporate name of this company, which was also formerly known as Pabco Products, Inc. This company, under its various corporate names, has been permissibly self-insured in this state for more than thirty years.

At one time one of our subsidiaries was known as Plant Rubber & Asbestos Works and that subsidiary was permissibly self-insured from 1928 until its dissolution on June 30, 1947. At or about that time we understand that certain customers were permitted to use the name "Plant." It may well be that one of these concerns adopted the title of Plant Insulation Company. Plant Insulation Company was not a subsidiary of this company and we do not have any information as to its coverage.

Very truly yours,

D. Hanson, Manager
Employer Insurance Department

DH:ca
cc: Mr. R. Sciaroni Jr.

Fibreboard

Paper Products Corporation

475 BRANNAN STREET, SAN FRANCISCO 19, CALIFORNIA

July 6, 1959

Miss Katharine S. Solomon,
Calendar Clerk,
Industrial Accident Commission,
501 State Building,
Los Angeles 12, California

Re: Erven O. McCarrell v. Armstrong Cork Co., et al., Case No: SE LA 176-654.

Dear Miss Solomon:

BEFORE THE
INDUSTRIAL ACCIDENT COMMISSION
OF THE
STATE OF CALIFORNIA

Case No. 56-L.A. 176-684

ERVEL O. MC CARRELL,

Applicant,

vs.

ARMSTRONG CORK COMPANY; et al. and PLANT RUBBER AND ASBESTOS WORKS; FIBREBOARD PAPER PRODUCTS CORPORATION; MARINE ENGINEERING AND SUPPLY COMPANY; OWENS-CORNING GLASS COMPANY; LARRY CARR doing business as LOS ANGELES MARKET REFRIGERATION AND ENGINEERING COMPANY; PARAFFINE COMPANY, INCORPORATED; J. T. THORPE INCORPORATED; JOHNS-MANVILLE SALES CORPORATION; PACIFIC EMPLOYERS INSURANCE COMPANY, a corporation; PACIFIC INDEMNITY COMPANY, a corporation; STANDARD ACCIDENT INSURANCE COMPANY, a corporation; FIREMAN'S FUND INSURANCE COMPANY, a corporation,

Defendants.

ORDER JOINING PARTIES DEFENDANT

LOS ANGELES OFFICE
INDUSTRIAL ACCIDENT COMMISSION
STATE OF CALIFORNIA
FILED: JUL 2. 1959
WILLIAM KAPLAN
ASST. SECRETARY

GOOD CAUSE APPEARING THEREFOR,

IT IS HEREBY ORDERED That:

PLANT RUBBER AND ASBESTOS WORKS
FIBREBOARD PAPER PRODUCTS CORPORATION
MARINE ENGINEERING AND SUPPLY COMPANY
LARRY CARR doing business as LOS ANGELES MARKET REFRIGERATION AND ENGINEERING COMPANY.
PARAFFINE COMPANY, INCORPORATED
J. T. THORPE INCORPORATED
JOHNS-MANVILLE SALES CORPORATION
PACIFIC EMPLOYERS INSURANCE COMPANY, a corporation
PACIFIC INDEMNITY COMPANY, a corporation
STANDARD ACCIDENT INSURANCE COMPANY, a corporation
FIREMAN'S FUND INSURANCE COMPANY, a corporation
OWENS-CORNING GLASS COMPANY

be joined as parties defendant in the above entitled cause.

William Kaplan
WILLIAM KAPLAN
Referee

INDUSTRIAL ACCIDENT COMMISSION

7-2-59

Parties served as per attached list dated 7-2-59.

Copy of application dated 12-14-56 served w parties 7-2-59.

py

Parties served: ~~William D. T~~ 12461 [illegible]

~~Ervey O. McCarrell, 12255 [illegible]~~
Hays [illegible], 6331 Hollywood Blvd., LA
Armstrong Cork Co., ~~[illegible]~~ [illegible]
Thorpe Insulation Co. formerly known as Plant Rubber & Asbestos Co.,
2741 S. Yates St., LA
United Cork Co., ~~[illegible]~~ [illegible] La.
Plant Rubber & Asbestos Works, 537 Brannan St., SF 7
Fibreboard Paper Products Corp., 475 Brannan St., S.F. 19
Marine Engineering & Supply Co., ~~[illegible]~~ [illegible]
Owens-Corning Glass Co., 5933 Telegraph Rd. LA
Larry Carr dba L.A. Market Refrigeration & Eng. Co. ~~[illegible]~~
Paraffine Co. Inc., 475 Brannan St., S.F.
J.T. Thorpe Inc., 948 E. 2 St., LA 12
Johns-Manville Sales Corp., 611 S. Catalina St., LA
Johns-Manville Corp., Box 9067, LA 20
Travelers Ins. Co., 510 W. 6 St., LA
Liberty Mut. Ins. Co. 714 S. Hill St., LA
Pacific Empl. Ins. Co., 1033 S. Hope St., LA
~~[illegible] 3450 Wilshire [illegible]~~ ~~[illegible]~~ 8/18/59 [illegible]
Standard Accid. Ins. Co. 548 S. Kingsley St., LA
Firemen's Fund Ins. Co., Attn: R.L. Shoop, 3440 Wilshire Blvd., LA 5
Horlihy & Horlihy, 422 W. 6 St., LA
Roy J. Cusick, 1210 W. 4 St., LA
Brobeck, Phleger & Harrison, 111 Sutter St., S.F. 4

Joined 8/18/59 [illegible] { Plant Insulation Company, 2241 South Yates Avenue, L.A.
~~Victoria [illegible] Supply Company~~, 1820 So. ~~[illegible]~~, LA 14

~~Wingate & Tipton - 542 S. Broadway~~, LA 13

[illegible] K. [illegible], by [illegible]
Clifton & Kenny, by Robert Kenny

McCarrell

REGINALD M. SMART, M.D.
JOSEPH P. BOYLE, M.D.
JOHN K. SHIREY, M.D.
MEDICAL OFFICE BUILDING
1100 WEST SIXTH STREET
LOS ANGELES 17
TELEPHONE

February 21, 1957

The Travelers Insurance Company
510 West Sixth Street
Los Angeles 14, California

Attention: Joseph Bilchak, Representative

Re: B 8289902
Armstrong Cork Company
Re: E. O. McCarrell
56 LA-176-684

Gentlemen:

Mr. McCarrell was referred to our office by Dr. Kennicott for examination on December 7, 1956. We obtained the following history from the patient:

Residence history: The patient, aged 53, was born March 3, 1903, in Denton, Texas, where he lived for 16 years. Then he moved to Los Angeles and has remained here ever since with the exception of two nights spent in Porterville, California, in 1948.

Occupational history: Mr. McCarrell worked as a cook and manager in hotels and restaurants and also in his own places of business until 1940. From 1940 to 1943 he was employed by the Plant Rubber and Asbestos Works in Los Angeles where he did steam pipe and boiler insulation work in the shipyards. He stated that he worked in confined spaces such as engine rooms which were not ventilated and that he was exposed to considerable dust and fumes, particularly asbestos and magnesia. He did not wear a mask or respirator on this job.

Since 1943 the patient has been employed by the Armstrong Cork Company in Los Angeles. He has worked in various buildings, hotels, restaurants, steam plants, etc., throughout Los Angeles County, doing steam pipe installation in boiler rooms. He also worked with "dietrick block" (fiber glass) and did refrigerator insulation work (contract installation). He has worked with asbestos (15-85% magnesia), cork, Kaylo (silica) and foam glass, but does not believe he ever used diatomaceous earth. The patient stated there was always considerable dust and fumes from the above materials, the degree varying in the different areas he worked. No mask or respirator was worn at this job and the patient had been off work since December 4, 1956.

The Travelers Insurance Company February 21, 1957
Re: E. O. McCarrell.

Onset and course of present illness: While at work on November 14, 1956, the patient started to cough and "choked" on some "district block" dust after taking a deep breath. This was followed by an attack of coughing. He stated this had occurred three or four times within the past years but that following the last exposure the cough seemed to be worse and he consulted his family physician, Dr. Kennicott, for examination and advice. Chest x-rays were taken at The Hospital of the Good Samaritan and reported as showing "scar tissue on the lungs or fibrosis." The patient was studied by Dr. Motley on November 28, 1956, and a copy of his findings is enclosed. Mr. McCarrell was advised by Dr. Kennicott to avoid dust exposure and strenuous work.

The patient stated that he rarely had a cold although two months previously he had a head cold with increased cough but no fever. He was given some cough syrup which did not help.

Chief complaints:

(1) Fatigability for the previous six months.

(2) Shortness of breath which came on gradually about six months ago. The dyspnea was noticed especially on exertion such as climbing stairs but did not bother him when he walked or drove his car and did not occur after meals or at night. For the same length of time he has noticed difficulty in taking a deep breath.

(3) Cough which had been present for six or eight months but was more noticeable during the past month. The cough occurred at any time and was aggravated especially by exertion or deep breathing. It was usually non-productive but occasionally after hard coughing, the patient raised approximately one teaspoonful of clear, white sputum. There had been no hemoptysis or broncholiths. Mr. McCarrell added that he first noticed this cough when he "choked" on some Kaylo dust over one year ago. Then he had no further trouble until six or eight months ago.

(4) Dull pain in the mid-chest for the past six months which was aggravated by deep breathing and exertion.

Review of systems: failed to reveal any other symptoms. The patient's weight had been stationary around 195 pounds for the past two years and he denied having fever, sweats, or chills. Review of the eyes, ears, nose and throat, gastro-intestinal and genito-urinary systems was entirely negative.

Past medical history: Measles and chicken pox at the age of 39, both of average severity. The patient denied having other illnesses in the past except for a head cold about once a year with occasional "pleurisy" pains in the shoulders. Surgery: Repair of left hernia in 1946; hemorrhoidectomy in 1954 or 1955, both operations performed at The Hospital of the Good Samaritan.

The Travelers Insurance Company February 21, 1937
Rep. E. O. McCarroll.

Family history: The patient's father was living and well at 81 years. His mother died of unknown cause at 61. One brother and four sisters were living and well. One brother died in infancy of pneumonia. The patient was married and had no children. There was no family history of tuberculosis, cancer, diabetes or heart trouble.

Habits: The patient sleeps well eight hours at nights. He does not smoke or drink and was taking no medications.

Physical examination: Height 6 feet. Weight 200 1/2 pounds. Blood pressure 100/68. The patient was well developed and nourished, not acutely ill, but he had a dry cough whenever he took a deep breath. Head and scalp negative. Ears negative. Eyes negative except for slight arcus senilis. Nose slight discharge present. Teeth and gums negative. Tonsils three plus enlarged and cryptic, not injected. Pharynx negative. Neck nodes negative; questionable distention of jugular veins. Thyroid negative. Heart tones distant, regular sinus rhythm, not enlarged or displaced. P_2 equalled A_2. No murmurs. Chest: There was slight kyphosis (1+), increased a-p diameter, and slight lag. Breath sounds were diminished with harsh inspiration and prolonged expiration. There was moderately impaired resonance and a few fine rales present throughout both bases anteriorly and posteriorly. Abdomen no tenderness, masses, rigidity, or scars. Spleen negative. Liver palpable at the costal margin. Extremities no clubbing, cyanosis or edema.

Chest fluoroscopy: The diaphragm moved 3 cm. There was diffuse linear fibrosis throughout both lower lung fields.

Laboratory work performed in our office is as follows:

12-7-56: Skin tests: Intermediate tuberculin one plus positive. Coccidioidin negative. Histoplasmin one plus positive.

12-14-56: Sputum specimen: Wet mount for asbestos bodies: One group of structures characteristic of asbestos bodies were seen in the centrifuged sediment. Flotation concentration for acid-fast bacilli: Negative. Culture for M. tuberculosis: Negative.

12-28-56: Sputum specimen: Examination for asbestosis bodies: The sputum was divided and a portion digested with sodium hydroxide, a portion with sodium hypochlorite following by centrifugation. There is a scattering of long, slender refractory fibres 4 - 10 mcg. in diameter and varying in length from 1/2 to 2 times the low power microscopic field. A number of small amber amorphous bodies are seen. No structures characteristic of asbestosis bodies were seen in any of the preparations.

12-17-56. Complement-fixation tests for histoplasmosis: Negative.

PHYSICAL EXAMINATION (continued)

Head:	
Eyes:	Argous senilis; react to light and accommodation:
Nose:	Mild congestion:
Mouth:	No scars:
Throat:	Negative:
Teeth:	Good hygiene:
Chest:	Posture is poor.
Lungs:	Few rales after cough at right base.
Heart:	Negative to superficial examination:
Peripheral Arteries:	Not sclerosed:
Abdomen:	Flat; well muscled; no masses.
Genitalia:	Well developed; prostate normal configuration:
Lymphnodes:	None enlarged:
Bones & Joints:	Negative:
Extremities:	No edema.
Skin:	Very dry.
Reflexes:	Present and equal.

LABORATORY

Urinalysis:	Within normal limits:
Blood count:	Hemoglobin 90% or 13.6 gms: RBC 4,87 WBC 9,600: Index .92: Cell volume 46%. Polys 55 (Stab 5, Seg 50) Lymphs 31, Monos 5, Eosins 8, Basos 1. Sedimentation rate 35 mm (normal 0 – 9)
Electrocardiogram:	Normal tracings
Chest X-ray	Done at Hospital of the Good Samaritan: "Posterior-Anterior and Lateral Chest films show the transverse diameter of the heart shadow to be 15.5 cms. compared to 33.5 cms. for the transverse diameter of the chest. The left heart border is relatively prominent. There is increased mottled density throughout the mid and lower left lung field. There is moderate diffuse mottled density at the base of the right lung field. The apices are clear bilaterally. There is no evidence of pleural fluid".
Pulmonary function studies 11-26-56	These were performed at the Cardio-Respiratory Laboratory of the University of Southern California at the Hospital of

the Good Samaritan under the supervision of Dr. Munley Motley. Here with part of the concluding statements: "The significant abnormality present is the marked drop in the exercise arterial blood oxygen saturation due to shunting of blood through non-ventilated areas and this constitutes a rather serious change in function".

COMMENT:

This patient was first seen by me on November 10, 1944, for a general physical examination. At that time, X-rays of his lungs were made by Dr. Rolla G. Karshner. The stereoroentgenograms revealed a normal thorax, diaphragms, heart and vessel shadows. The lung fields were clear and there were no infiltrations, no displacements and no pleural shadows. The picture was that of a healthy adult chest.

Since that time Mrs. McCarrell has been employed in insulating, for a time using asbestos and of late years fiber glass.

Mrs. McCarrell was referred to Dr. Reginald Smart, chest specialist for further study and evaluation. You no doubt have received his report in this case.

DIAGNOSIS:

Fibrosis of both lower lung fields with marked drop in arterial blood oxygen saturation on exercise.

RECOMMENDATIONS:

This patient should not walk up steps or up hills. He should avoid living at altitudes other than sea level. He should not do heavy work because this drop in saturation noted with exercise constitutes acute hypoxia which elevates arterial pressure and further increases the work load on the right heart.

CONCLUSION:

I believe this man's bilateral fibrosis is a result of his occupation.

Yours very sincerely,

Robert Hele Kennicott, M.D.

REK/g

PAUL A. QUAINTANCE M.D. F.A.C.S.
837 WILSHIRE WESTLAKE BUILDING
3801 WILSHIRE BOULEVARD
LOS ANGELES 5, CALIFORNIA
DU-1-14 8-6727

January 22, 1957

The Travelers Insurance Co.
510 West Sixth St.
Los Angeles 14, California.

Re: Your case # B-5269902
E.C. McCarrell.
Exp: Armstrong Cork Co.
56 LA 176-684.
Date: About Aug., 1956

Attn: Mr. Joseph Bilchak.

Dear Mr. Bilchak:

Mr. E.C. McCarrell, 12255 Hart St., No. Hollywood, Calif., married white male aged 53 years; occupation asbestos worker; was examined by me at my office at your request on 1/15/57. Report of findings, conclusions and recommendations following examination and review of the medical report forwarded by your office is respectfully submitted.

OCCUPATIONAL HISTORY: The patient was a cook or a restaurant manager all his life previous to 1941.

From 1941 to Dec. 4, 1956 an asbestos worker and/or construction foreman.

"I apply asbestos in the field. The material we use we put around steam pipes. It comes in sections and we pry it apart and put it around the pipes. At the joints we take the powdered form of asbestos, mix it into a mud and mold it around the joints.

"When I have more than 3 men - which isn't very often - I just work as a foreman. The rest of the time I work along with the men.

"About 75% or more of our work is indoors, - in boiler rooms, heater rooms, etc.

"We work 8 hours a day, 40 hours a week.

"I haven't done any work since 12/4/56. I haven't been doing anything but sitting around.

"Some of the places we worked in were very dusty and some were not."

HISTORY OF PRESENT COMPLAINTS: "In about Aug., 1956 coughing started and I got tired too easily. I couldn't climb ladders without stopping to rest because of shortness of breath. The cough wasn't a deep cough and I had it only when I would exert myself and breathe deep. That's when I would start to cough. There wasn't much phlegm. It's more of a water white. When I did have sputum tests before and during the holidays there was about an ounce or so of watery stuff - no lumps that I could see - over a 3 day period. It hasn't changed any in amount.

"I went to Dr. Kennecott on 12/4/56. He sent me to Dr. Motley and Dr. Smart. They had x-rays at the Good Samaritan Hospital and also by Dr. Smart, too. Dr. Motley did pressure tests in the hospital - kept me there all day. I haven't had any treatment.

"As long as I'm not doing anything I feel as well as I ever did.

never wheeze any when I breathe.
"I've had a little soreness under my breast bone, especially in the mornings when I cough quite a bit. That's when that watery stuff comes up."

PRESENT COMPLAINTS: Shortness of breath on exertion; slight substernal pain or discomfort on exertion; cough mostly in the mornings with scanty watery phlegm since about Aug., 1956.
One vomiting spell occurred on 11/14/56.

FUNCTIONAL INQUIRY BY SYSTEMS: General - No fever; chills or sweats. No loss of weight.
Gastro-intestinal: Appetite good. Bowels move regularly every day. No intestinal complaints.
Cardio-respiratory: No tachycardia or palpitation or swelling of the feet or ankles. No nose bleeds or nasal discharge.
Genito-urinary: Day frequency 2 to 3 times with no nocturia or other symptoms.
Special senses: Hearing, vision, taste and smell are normal. Glasses are worn for reading. No burning or itching of the eyes.
Musculo-osseous: Negative.
Central nervous system: He sleeps well and has no nervousness or irritability.

PAST HISTORY: He recalls measles, mumps and chickenpox in childhood and has had occasional colds and sore throats but never pneumonia, bronchitis or asthma.
In 1946 he had a left inguinal herniotomy and in 1953 a hemorrhoidectomy.
He denies venereal disease and has had no serious injuries.

FAMILY HISTORY: His mother died at 41 years of an unknown cause. His father is living and well. One brother and 4 sisters are living and well. The patient knows of no asthma, hayfever or other allergic disease or tuberculosis in any of the members of his family.

MARITAL HISTORY: His wife, married in 1932, is in good health. There have been no children.

HABITS: He uses neither tobacco nor alcohol.

PHYSICAL EXAMINATION: General - The patient is a robust, large white male of 53 years apparently not his height 73"; weight 198 lbs., stripped; temperature 98.8 at 10:15 a.m.; pulse 102 with variable volume; respirations 22, quiet and rhythmical; blood pressure left arm 100/72, right arm 95/68.
Head: Hair is greying. Ear drums are normal. Whisper is heard at 6". Scleras are clear. Ocular movements are normal. Pupils and fundi appear normal. Nasal patency on the left is poor, on the right is good. The septum is deviated to the left and there is slight injection and mucus bilaterally. Pharynx is granular but not especially injected. The left tonsil is medium sized, the right is small and no debrisis expressed from either. The tongue is slightly coated at its base but is steady and does not deviate. There are several molar and bicuspid teeth are absent. There is much repair. Teeth and gums

Neck: Presents no spasm; restricted motion or palpable glands.
Chest: Symmetrical, slightly barrel shaped but expansion is equal and fair. On deep inspiration chest girth is 42½"; on full expiration 39½".
Lungs: Slightly hyper-resonant at the bases and normally resonant elsewhere; Breath sounds are a little distant. No rales are heard on deep breathing or coughing and cough is unproductive; Antero-posterior compression of the chest elicits slight complaint in the lower sternal region; Lateral compression of the chest elicits no pain complaint. No retraction of the intercostal spaces or activity of accessory respiratory muscles is observed. There are no pulsations in the neck.
Heart: The left border on percussion is just inside the nipple line. The right is under the sternum. Tones are clear; regular but slightly variable in volume.
Abdomen: Rounded, non-tender and soft. Liver dullness extends from the right 6th rib to the subcostal margin. Splenic dullness is normal. There is an oblique left (herniotomy) scar. The left external abdominal ring admits the fingertip snugly, the right easily where a slight impulse is felt on coughing.
Genitalia: Normal externally.
Rectum: Digital and anoscopic examinations are negative. The prostate gland is normal to palpation.
Musculo-osseous: The trunk is symmetrical with a slightly rounded upper dorsal kyphosis. There is no tenderness, spasm or restriction in motion.
Upper extremities: There is slight clubbing of the fingers with perceptible cyanosis of the nails. The palms are soft and clean. There is no palpable adenopathy or nerve tenderness.
Lower extremities: There are dry calluses in both infrapatellar region, no edema or cyanosis of the legs. Motion of the thighs on passive flexion is carried to 60 degrees with the legs straight without pain complaint. Rotation at the hips is slightly subnormal.
Skin: There are scattered papules over the back but none on the hands or forearms. There is no abnormal pigmentation.
Nerves: Tendon jerks are equal and slightly hypotonic. No paresthesias are noted.

FLUOROSCOPY & X-RAYS: Fluoroscopy of the chest reveals some increase in size and density of the hilar and lower trunk shadows. The outlines of the pericardium are shaggy. There is some increase in linear markings, especially in the mid and lower lung fields where there is a rather diffuse haziness extending almost to the bases. The latter are slightly emphysematous. Diaphragm excursion is about 1" and the contour of the hemidiaphragms is rounded. There is no evidence of fluid in the costophrenic angles. The apices are clear. The heart-great-vessel silhouette is normal in size, shape and position. The mediastinum is clear.

X-rays # 2232, 1/16/57, Paul A. Quaintance, M.D., are interpreted as follows: -

Stereoscopic postero-anterior films of the chest reveal moderate increase in size and density of the hilar shadows with several minute calcifications on either side. There is considerable widening of the lower trunk shadows extending almost to the diaphragm on the

so on the left where they reach almost to the periphery laterally. There is slight early modulation in the central portion of the left lower lobe, the nodules having a fuzzy outline. There is a superimposed slight haziness over the upper and middle portions of the lower lobes. The apices are clear. The upper lobes appear to be slightly emphysematous as do the extreme bases.

The cardiac great vessel outline is shaggy but not increased in size or altered in position or shape. The trachea deviates slightly to the right at the level of the first intercostal space and second rib.

The hemidiaphragms are dome shaped and rest at the level of the 10th rib on the right, at the level of the 10th intercostal space on the left.

A lateral film of the chest reveals moderate emphysema in the anterior portions of the bases of the upper lobes and slight emphysema at the posterior bases of the lower lobes.

Roentgenologically, the findings are consistent with some fibrosis of the asbestos type; chronic bronchitis and emphysema. Bronchiectasis would have to be considered as a possibility.

ELECTROCARDIOGRAM: "Sinus rhythm: Rate about 85.
1/18/57 PR interval: 2 secs. QRS interval: .04 secs.
QRS Complexes: Small in lead 2.
Mainly downward in lead 3.
Very low in amplitude in AVF.
There are no Q waves in the chest leads.
Tiny Q waves are seen in AVL.
S waves are seen through V5.
S-T Segments: No significant deviation.
T Waves: Normally inverted in AVR.
Upright in all other leads.
Conclusion: Semi-horizontal electrical position.
There is no graphic evidence of conduction defect or myocardial ischemia."
(Signed: James F. Anderson, M.D.)

REVIEW OF FILE: Doctor's First Report of Work Injury dated 1/14/57 signed Robert H. Kennicott indicates date of first examination as 11/20/56. History is that "patient states that about one year ago he began to cough; no history of respiratory infection; cough most marked in A.M.; has high substernal tightness on taking deep breath. Later on he began to cough up a clear mucus with little fine particles."

Physical examination was negative "except for a few rales after cough at right base." X-rays were reported to show "relative prominence of the left heart border, and increased mottled density throughout the mid and lower left lung field. There is moderate diffuse mottled density at the base of the right lung field."

"A marked elevation of the sedimentation rate to 35 mm." is reported together with an eosinophile of 8%.

Dr. Hurley L. Motley's report of pulmonary function studies is partially quoted. "The significant abnormality present is the marked drop in the exercise arterial blood oxygen saturation due to shunting of blood through non-ventilated areas and this constitutes a rather serious change in function. This man should not walk up steps or hills. He should avoid living at altitudes other than sea level. He should not do heavy work because

Dr. Kennicott also reports that on 11/10/44 Dr. Hollaender interpreted stereoroentgenograms of the lungs as showing: "A normal thorax; diaphragms; heart and vessel shadows. The apices and lung fields were clear and there were no infiltrations, no displacements and pleural shadows."

Dr. Kennicott's diagnosis is: "fibrosis both lower lung fields with marked drop in arterial blood oxygen saturation on exercise."

LABORATORY DATA: Urinalysis, 1/18/57 -- A.M. specimen: voided at office. Clear straw acid urine with specific gravity 1.013; negative for albumin; sugar ++. Microscopic: Few amorphous phosphates.

The Clinical Laboratory of Drs. Hammack & Maner reports as follows: --

Complete blood count; 1/19/57

Erythrocytes 5,500,000; hemoglobin 15.2 gms./100cc.; leucocytes 11,800. Differential: Neutrophiles 54%; eosinophiles 3%; lymphocytes 37%; monocytes 6%. Stained smear: The red blood cells are normal in size; regular in shape and take the stain evenly. No nucleated red blood cells found. Platelets appear normal in number.

Blood sedimentation rate (Wintrobe)

One hour reading 18 mm.; volume of packed red cells 46%; corrected rate 18 mm. (normal: 0 - 9 mm.)

Blood serology

Complement fixation test, Kolmer: Negative.

Standard Kline test: Negative.

Vital Capacity test

Maximum reading: 2,600 cc. Average of 5 readings: 2,320 cc.

Normal: 4,100 cc. Vital Capacity: 55% of normal.

(Signed: L.J. Tragerman, M.D.)

Blood chemistry; 1/21/57

Sugar: 95 mgs. per 100 cc. of blood.

(Specimen obtained at 9:45 a.m.)

Skin tests-

0.1 cc. intermediate strength Purified Protein Derivative of Tuberculin given intracutaneously, right forearm.
Results: Negative.

0.1 cc. Coccidioidin. 1:1000 dilution, given intracutaneously, left forearm.
Results: Negative.

Fresh sputum: examination for Asbestosis Bodies

Upon examination of multiple preparations, no asbestosis bodies were found.

(Signed: G.D. Maner, M.D.)

72 hour sputum: Culture for Tubercle bacilli, 1/22/57

Preliminary report

Approximetely 25 cc. of pale creamy-gray, opaque, mucoid fluid. Specimen was digested and smear and culture made from the centrifugalized sediment.

Stain for tubercle bacilli: None found.

Culture for tubercle bacilli will be reported on or about March 12, 1957.

(Signed: G.D. Maner, M.D.)

REVIEW OF ADDITIONAL FILE: The report of functional studies by Dr. Notley and medical report of Reginald Smart, M.D., received 3/2/57 is in conformity with the above recorded findings of my examination.

In reviewing the pulmonary function studies it is noted that residual air capacity of the lungs is in excess of normal which is consistent with emphysema and that a vital capacity of 90% of normal was recorded on November 23, 1956. This is considerably better than was recorded by the Clinical Laboratory on 1/19/57. It is noted also that while oxygen uptake is normal at rest, it is moderately reduced after step up exercise; indicating impairment in the function of air-gas exchange in the pulmonary air cells.

The physical findings recorded by Dr. Smart on December 7, 1956 are essentially the same as those found by me on January 18, 1957. Dr. Smart's interpretation of X-rays of the chest on 12/10/56 indicates findings identical with those in my own films 1/18/57 except that he makes no mention of the shaggy appearance of the cardiac outline I noted in my films.

DISCUSSION: Nature of original condition:- Occupational pulmonary fibrosis in all probability due primarily to the inhalation of asbestos dust with some degree of compensatory pulmonary emphysema. Although bronchograms have not been made, and in my opinion, are not indicated, the possibility of some degree of bronchiectasis is present. There is no evidence of nodular silicosis.

Present status:- At the time of my examination, 1/18/57 , the patient complained primarily of shortness of breath on exertion with slight substernal pain or discomfort and morning cough with a scanty watery phlegm since August, 1956.

The physical examination revealed a rapid pulse; low blood pressure; clubbing and cyanosis of the fingers, a granular pharynx, a barrel shaped chest with hyper-resonance over the basal areas of the lungs and heart dullness within the limits of normal.

Fluoroscopy and X-rays of the chest revealed old calcifications in the left hilus, moderate increase in hilar and lower trunk shadows and in addition a fuzzy mottling in the lower lobes with evidence of early nodulation in the left lower lobe and a shaggy appearance of the pericardial outline. The diaphragm is slightly elevated on both sides. The heart outline is not increased.

An electrocardiogram on 1/18/57 shows no graphic evidence of conduction defect or myocardial ischemia.

Pulmonary function studies in December, 1956 indicated an increased residual air capacity although vital capacity was only slightly below normal. Vital capacity now (1/18/57) is moderately subnormal. Oxygen saturation of the blood is reduced after exercise.

Although laboratory examination of the urine revealed a two plus sugar content, a blood sugar was normal.

A tuberculin test on 1/18/57 is reported as negative whereas Dr. Smart obtained a positive tuberculin test. The skin test for histoplasmosis and coccidioidomycosis both are negative. The slightly increased blood sedimentation rate indicates that some degree of infection is present but it does not appear to be specific.

This patient as the result of some fifteen years exposure to asbestos dust, has developed asbestosis and some compensatory pulmonary emphysema with a slight amount of superimposed non-specific infection. Some early bronchiectasis may be present.

The patient has disability for the type of work at which he has been engaged but I believe could carry on indefinitely with a sedentary occupation.

Although two examinations of the patient's sputum have failed to show the presence of asbestos bodies, it may be assumed that many of them are present in his lung tissues and that his pulmonary fibrosis will progress gradually for an indefinite period. The possibility of cor pulmonale and eventual right heart failure will depend upon the rate of progression of his pulmonary fibrosis.

I do not believe that the progression of his pulmonary fibrosis will be affected in the least by any form of treatment available today. I believe some transient temporary relief of his symptom of dyspnea might result from intermittent positive pressure breathing. However, the patient at present has no dyspnea at rest and does not experience it until he has engaged in moderate exercise.

I believe the sputum should be cultured for organisms and sensitivity tests carried out to determine whether or not antibiotic therapy might control the slight degree of infection present in his bronchial tree.

Thank you very much for the privilege of having examined this patient.

Yours very truly,

Paul A. Constantine, M.D.

Paul A. Constantine, M. D.

ADDENDUM: This report on culture of the sputum for tubercle bacilli will be forwarded as a supplemental report on or about March 12, 1957.

The laboratory reports and your file are being enclosed herewith.

3/14/57 The Clinical Laboratory report on culture of the 72 hour specimen of sputum for tubercle bacilli started on 1/21/57, received this morning, is negative for tubercle bacilli.

This would tend to confirm the diagnosis recorded in my report dated 1/22/57 and would support the recommendation made then that the sputum be cultured and sensitivity tests run to determine to which antibiotics the organism responsible for the infection in the patient's respiratory tract is sensitive. If it is your wish that this be done kindly advise.

PAC

JOHN H URABEC, M D

12 October 1959

The Travelers Insurance Company,
510 West Sixth Street,
Los Angeles 14, California.

Re: McCARRELL, ERVEY O.,
56 LA 176-684
Armstrong Cork Co. & Johns-
Manville Corporation,
B 8289902 & 8789244

Gentlemen:

Mr. Every O. McCarrell came to my office on September 4, 1959 for an examination and an evaluation of his present pulmonary condition. At the time of his visit the following medical history and physical examination were obtained.

Age: 56; Occupation: Asbestos worker; Marital Status: Married; Birthplace: Texas, March 3, 1903; In California since 1922.

Family History: Father: Age 84, living and well; Mother: Deceased at the age of 41, cause unknown; Brothers: Three, living and well; Sisters: Three, living and well; Children: None.

Present Illness: The patient stated that he was in apparently good health until the latter part of 1956. At that time while at work at the Valley Steam Plant he had an episode of strangling allegedly due to the inhalation of dust in his working environment. He subsequently developed a severe cough and was seen by Dr. Robert Kennicott of Los Angeles. He was examined and had a chest x-ray taken. Because of the nature of the findings he was referred to Dr. Reginald Smart who at the present time is still his attending physician. He was advised to stop his work immediately. His cough continued and has been present ever since. It has however slightly diminished since he is not exposed to irritants. He has a slight hurting in his chest in the substernal area. He is short of breath with slight exertion. As part of the study he was referred to the laboratory of Dr. H. Motley-where exercise tests were performed. He stated that the diagnosis of his case in part was based on Dr. Motley's report. Sputum studies were also performed but no definite diagnosis was made from the study, at least if any diagnosis was made, he was not told anything about it. For some time now he has been seeing Dr. Smart at intervals of every six to eight weeks and Dr. Motley at intervals of about every six months.

At the present time he stated that he has a hurting in his chest and the ends of his fingers and toes become sore. He is not particularly aware of these unless he exercises. His principal complaint at this time is his cough which he stated was very embarassing and which makes him very nervous and shaky. He has been receiving cold shots to keep from getting colds. Previously, he stated that he had only mild colds but seemed to catch them easily. His throat at this time seems to be irritated all of the time. He has had no nasal stuffiness and he is not a mouth breather. He wears glasses for reading only. He has had no headaches or symptoms relative to his ears. He has had no night sweats or fever. He has had no orthopnea, nocturnal dyspnea or ankle edema. His digestion is good. His bowel movements are regular. He denied any nausea, vomiting, diarrhea, constipation, jaundice, rectal bleeding, souring or gas. For a time some pills that were prescribed tended to upset his stomach but he is now receiving another pill to combat this. He stated that he has had no recent bleeding from hemorrhoids. He denied any symptoms relative to the genito-urinary system. He stated that his energy was poor. He lacked ambition and drive. He was moderately tired at the end of the day. He slept well and felt fairly rested after a night's sleep. If he exerted himself he tired very easily but he admitted that he recuperated very easily as he could relax easily. He also stated that if he exerted himself in any way he became breathless more easily as he did not seem to have the "respiratory reserve". At the onset of his illness he weighed about 185 lbs. He now weighs about 196 lbs. On his forearms he has had intermittent episodes of small capillary hemorrhages.

Habits: He denied using tobacco and alcohol. He drinks about three to four cups of coffee a day.

Past Medical History: He denied any previous serious illness. He has had slight attacks of tonsillitis in the past but he has not had his tonsils removed. He had a left herniorraphy in 1947. He had a hemorrhoidectomy in 1954.

Occupational History: He stated that he started to work with asbestos materials about 1939. For about five years he stated he worked with the Plant Rubber and Asbestos works doing marine insulation work. For about ten years he worked for the Armstrong Cork Company insulating steam pipes and boilers. He worked in the field at boiler houses and steam plants. He stated that this was moderately dusty work most of the time. No masks were worn in this type of work. In addition to the above occupations for several years he drove a lunch wagon and did various types of work in different restaurants.

Physical examination revealed a well developed, well nourished, adult white male who did not appear acutely or chronically ill. The skin of his face had a ruddy complexion and his lips were of a slightly dusky color. He had an intermittent dry unproductive cough.

Temperature: 97.6; Pulse: 72, regular; Blood Pressure: 106/72; Weight: 200 lbs.

Re: Ervey O. [redacted] Carrell
[redacted]

Head and Neck:

Eyes: reactions and movement s normal.
Ears: moderate amount of soft wax in both canals, drums grossly normal.
Nose: mucous membranes moist, slightly swollen, passages ample.
Mouth: oral hygiene fair.
Dentition: moderate number of molars extracted, moderate number of fillings, remaining teeth slightly tarnished.
Pharynx: mucosa diffusely reddened.
Tonsils: moderate size, smooth.
Neck: no adenopathy, stiffness or abnormal pulsations.

Chest: symmetrical, slight increase in the a-p diameter.

Lungs: breath sounds slightly diminished bilaterally, scattered fine moist rales in both lower lobes, at the bases posteriorly and laterally.

Heart: regular rhythm, no murmurs.

Abdomen: no masses or tenderness, well healed left herniorraphy scar.
Genitalia: normal.
Rectum: small external tags present.

Extremities: finger nail beds were dusky in color, the nails were widened and slightly curved and slight clubbing of the fingers was present. The toes were essentially the same.

Fluoroscopic examination of the chest showed an accentuation of the markings of a fine linear character localized principally to the lower halves of each lung field. The cardiac silhouette was not significantly enlarged. The diaphragms were round and smooth and moved about three centimeters with respiration.

A large series of chest films taken at the office of Dr. Smart as well as several films taken at the Hospital of the Good Samaritan X-ray Department as well as a few taken by Dr. Paul Quaintance were available for review.

The earliest films were those taken at the Hospital of the Good Samaritan and were dated 11-20-56. These films showed a scattered fine basilar infiltration in the lower halves of both lung fields. The minor interlobar fissure on the right appeared to be slightly depressed. Adhesions were present to the domes of both diaphragms more on the left than the right and some adhesions were also present at the heart border on the left. The apices and the costophrenic angles appeared to be relatively clear.

Re: Ervey O. McCarrell
4

The films taken at the office of Dr. Smart begin with a group taken on 12-10-56. In this group some of the overshot films show a fine infiltrative process in the lower lung fields bilaterally below the levels of the second interspaces. Films taken on 8-27-57 show no essential change. The films taken on 12-9-57 are also slightly overshot and show no significant change. The 2-5-58 and 4-4-58 films show no change. A Bucky film taken on 7-10-58 shows the infiltration to appear to be slightly more discrete but this might be due to radiologic technique. Subsequent films are dated 8-27-58, 10-10-58, 12-19-58, 1-27-59, 3-18-59, 5-14-59, 7-16-59 show no additional significant change. A Bucky film taken on the latter date shows the fine discrete infiltration to be in extent and in the areas noted in the original film of 11-20-56. There were 33 films in this series. In five of these films the dates were not discernible.

Six films from the office of Dr. Paul Quaintance were also available for review. These were dated 1-18-57 and 12-5-58. They were of rather poor quality and grossly did not show any changes from the films taken above.

There is no question about the appearance of this patient's lung fields which suggest the presence of a diffuse pulmonary fibrosis, which historically was not present in films taken by Dr. Rolla G. Karshner in November 1944. On the basis of this patient's occupation a diagnosis of an occupational pneumoconiosis has been made by several of his attending physicians. Although the x-ray appearance of the chest is compatible with such a diagnosis such an x-ray appearance could be simulated by other conditions. In this instance the diagnosis of an asbestosis and/or an occupational pneumoconiosis has not been confirmed with absolute certainty from the histo-pathological study of a lung biopsy.

From the review of the films it is my impression that no significant change has occurred in the appearance of the abnormal markings since the original film of December 1956. It must be remembered that with changes in radiologic technique slight differences in the appearance of the lung fields occur and such changes cannot always be attributed to actual pathological changes. In Dr. Smart's report of August 26, 1959 he speaks of changes due to a subacute bronchitis. I wonder if these changes are not due to x-ray technique rather than to changes in the underlying pulmonary pathology.

Some emphasis is placed on this patient's increased susceptibility to colds. No definite reason is given for this except that it is contented that immunizations with cold and flu vaccines will confer an immunity. This contention is based in part on the fact that this patient had allegedly freedom from colds the previous winter when he had received the above vaccines. If such were true the treatment of colds would be a relatively simple matter.

Re: Ervey O. McCarrell

With this extent of pulmonary asbestosis or pneumoconiosis I would expect a considerably greater degree of pulmonary function impairment. Certainly the pulmonary function studies done on February 10, 1959 do not indicate a disabling degree of pulmonary function considering the extensive pulmonary markings in both lung fields. His present physician intimates that his apparent present improvement is on the basis of his steroid and IPPB treatments. I do not know of any reference in the literature in which it has been demonstrated that the use of steroids has altered or improved a true parenchymal fibrosis. As regards the use of IPPB treatments this does improve pulmonary ventilation but in this instance if one accepts Dr. Motley's findings this has not been a particular problem during the period of observation.

Thank you for the privilege of being permitted to see Mr. McCarrell.

Very truly yours,

John H. Urabec, M. D.