PLAINTIFF'S
EXHIBIT
DUP-2180

University of Arkansas for Medical Sciences

DIVISION OF PULMONARY AND CRITICAL CARE MEDICINE

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August 30, 1981

Department of Industrial Relations
Division of Industrial Accidents
Information and Assistance Bureau
ATTENTION: Ms. Diane Bustillos
525 Golden Gate Avenue
San Francisco, CA 94102

RE: [redacted]
LAMS #56-44-07

DUP 093392

Dear Ms. Bustillos:

[redacted] was seen in our Chest Clinic on June 12, 1981 for evaluation of asbestosis as requested in your letter of March 26, 1981. [redacted] related that he was first exposed to asbestos beginning in 1948 when he began working as a journeyman lagger. The following year, he became a mechanic and remained in that occupation for 1½ years during which time he had no asbestos exposure. From 1951 through 1956 he returned to his previous job as a lagger, continuing the same kind of exposure he had had previously. He joined Dupont in 1956, and had heavy primary exposure to asbestos until 1967. About two years ago [redacted] began having exertional dyspnea, which has been slowly progressing. Currently he states that he is able to ascend one flight of stairs, shovel dirt about five minutes, or walk about two blocks before being limited by dyspnea. He described his dyspnea as a feeling that he can move air appropriately, but "cannot get enough oxygen". He stated that his dyspnea resolved after about half hour of rest. He denied cough, sputum production, hemoptysis, and wheezing. He smoked approximately two packages of cigarettes daily for 30 years, stopping two years ago when he was informed of the high risk of malignancy due to smoking and asbestos exposure together. He denied allergies. He had a past history of peptic ulcer disease, for which he had taken cimetidine, but he was taking no medications at the time that he was seen.

Physical examination revealed a well-developed, well-nourished white man who appeared to be his stated age and was in no distress. Examination of the chest revealed no adventitious sounds, normal breath sounds, and no abnormalities on percussion. The liver spanned 10 centimeters to percussion, and there was mild right upper quadrant tenderness. The abdomen was otherwise normal. There was no clubbing of the fingers, cyanosis, nicotine staining of the fingers, or edema. There were no other abnormalities noted on physical examination.

PA and lateral chest x-rays revealed an extensive area of thickened pleura on the left, which had slightly increased in size in comparison with an x-ray made in 1979. There was a small approximately 1½ x ½ centimeter area of pleural thickening on the right, and calcification of the diaphragm was visible on the right side. Resting arterial blood gases were PaO_2 of 87 mmHg, $PaCO_2$ of 34 mmHg and pH of 7.41. Spirometry and lung volumes done by helium dilution are shown on the enclosed report. The lung volumes were normal; the FEV_1/FVC ratio was slightly decreased to 73%. The studies were interpreted as showing a borderline obstructive defect. An electrocardiogram demonstrates incompl. right bundle branch block without other abnormalities.

al Opportunity Employer

REDACTED

DIVISION OF PULMONARY AND CRITICAL CARE MEDICINE

August 30, 1981

RE: [redacted]
UAMS #56-44-07

DOB 0933928

An exercise test was performed on June 19, 1981 at Little Rock Veterans Administration Hospital by Dr. McKendree E. McNabb, a member of this Division. A copy of the report is enclosed. The pertinent findings were that [redacted] had normal cardiopulmonary function, including arterial oxygen saturation during exercise, and that he had a normal tolerance to exercise. During the exercise test he reached only 53% of the maximum breathing capacity predicted on the basis of the FEV_1. It is notable that during initial steady state testing at low work rates he had abnormally high ventilation, and that during subsequent testing at the same work rate he had normal ventilation. This suggests a psychogenic etiology for the initial hyperventilation.

A single breath carbon monoxide diffusing capacity was performed at Little Rock Veterans Administration Hospital on June 19, 1981. The results was 26 ml/min/mmHg, the predicted value being 30. This is considered to be a normal value.

Arterial blood gases drawn within two seconds of cessation of maximal exercise were as follows: PaO_2 97 mmHg, $PaCO_2$ 34 mmHg, and pH 7.41. The change from the resting blood gases represents a normal response to exercise. On the basis of his chest x-ray findings and his history, it is clear beyond any reasonable doubt that [redacted] has asbestosis. The slight decrease in FEV_1/FVC ratio noted is more likely related to his long history of cigarette smoking than to his asbestosis exposure. In any case, that degree of obstructive spirometric defect would not be expected to result in disability or, indeed, in significant symptoms.

I believe that [redacted] experiences the symptoms he describes, and that his life is significantly altered by them. Thorough evaluation does not reveal a physiologic basis. I believe that they are largely psychogenic in origin, and are related to [redacted] realization that he has asbestosis which he finds extremely threatening. I think his symptoms are probably increased by his relative inactivities causing deconditioning, which, in turn, increases his symptoms. In summary, I think his symptoms are due to his asbestos exposure and the resulting asbestosis, although I think the mechanism of symptom production is psychologic, not physiologic.

I would recommend follow up examinations in the future, to primarily consist of chest x-ray's. Obviously, the reason for this is that mesothelioma cannot be completely excluded in any point in time, and the only practical way to detect its occurrence would be to note a change on serial chest x-rays. In addition, it provides a means for detection of bronchogenic carcinoma, for which [redacted] is at increased risk. The only treatment other than the follow up examinations I would recommend would be an effort to overcome the respiratory symptoms probably. I should think that the best way to approach this would be

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