IRVING GRAY, M. D., F. A. C. P.
FORTY-ONE EASTERN PARKWAY
(COPLEY PLAZA)
BROOKLYN, NEW YORK

April 10th, 1935.

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

My dear Dr. Kehoe:

May I ask your opinion relative to a patient I now have under my care?

A young man of 22 developed weakness in the left wrist four months after employment as a painter. He now has atrophy of the interossei muscles of the left hand and the neurologists believe that there is a pathological lesion in the anterior horn cells.

By a process of exclusion they believe that lead is the causative agent. This young boy never had an acute toxic lead episode and to date has shown neither lead in the urine nor stippling of the red blood cells. Biospectrometric analysis of the skin properly obtained and competently analyzed has shown a four plus line. The neurologists have stated that this has been shown to indicate an abnormal degree of lead retention and have therefore argued that lead is probably responsible for the clinical findings.

Clinically a diagnosis of lead poisoning does not seem justified to me. On deleading therapy we have never been able to find lead in the urine. Is it reasonable to assume that lead may be retained in the skin and at no time be present in the urine after deleading therapy?

I believe that it is reasonable to assume that if lead cannot be drawn from the bones and subsequently found in the urine that there is no abnormal storage in the body unless we assume that leas may be stored in the skin in abnormal amounts and not be stored in the skeletal structures.

I would greatly appreciate knowing what your opinion is in this matter. The article by Gaul and Stadd on Clinical Spectroscopy which appeared in the Journal of Nervous and Mental Diseases, March, 1935 is of great interest on this subject.

With kindest regards, I am

Sincerely yours,

Irving Gray, M.D.

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