HISTORY

[redacted] Age 21 October 21, 1929

The past history of this man is unusually negative. He does not remember of being ill or of having symptoms of any nature before his present illness. His family history is negative.

Industrial History. Started to work about 1920 in butcher shop. There for one year. Machine shop four years. As machinist in stone cutting yard for one year. Drove a dray and trucks one year. Helped tinsmith about two years ago for about three months, did no soldering. With present company for one and one half or two years. No known lead exposure.

First started handling Ethyl Gasoline June 27, 1929. Work consisted of pumping gas from tank car to barrels and then from barrels into truck and subsequently delivering gas to filling stations. On June 27, 1929 (first shipment) 1645 gallons were handled in a period of four to five hours. On August 19, 1929 a shipment of 1638 gallons, and on September 23, 1929 one of 1657 gallons was received and handled in approximately the same time as the first shipment. This man states that he worked very rapidly using no precautions to avoid contact with the gasoline, and as a result was thoroughly soaked with the gas from above the waist to his feet. His hands during this period were constantly wet with the gas. The clothing after being wet was not changed and was worn every day up until his entrance to hospital. The man at this time had a habit of biting his nails and probably had his fingers in his mouth a great deal after filling his truck. The barrels were filled in a corner of a closed structure where two small doors offered the only

ventilation. The man first felt ill about September 1, 1929.

All sumptoms seem to have developed at about the same time and any one is not remembered as having developed befofe the others, excepting possibly headache.

He first noticed a dull headache which started in the morning about the time he arrived at work and lasted all day - sometimes throughout the night. Insomnia was present at about the same time. It was difficult to get to sleep and after sleep occurred would waken many times during the night. Was very restless. Pain in belly radiating around to back developed at about the same time. This abdominal pain was not localized and was dull and aching in character. There also was a steady fairly severe pain in epigastrium at about this time which seemed to radiate to throat. At this time patients bowels were moving 2-3 times daily and stools were loose. Evacuation did not affect pain. Vomiting developed at about same time. Vomiting occurred several times a day with no regularity or relation to meals. Frequently vomited after meals but if meals were avoided vomiting would occur nevertheless. After vomiting always felt that there was a taste of blood in mouth. He believes that vomitus was sometimes a pink color but is not certain of this. During this period an unusual taste was present. Is not described as sweet and when suggested sweetness is denied. Described as taste of old coin. There was definite severe malaise present at this time.

The abdominal pain was cramplike on only two occasions and before entrance to hospital. Loss of memory occurred and does not remember clearly his activities for several days before entering hospital. Vision was affected and described as being "blurred

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and jumpy". Complete loss of appetite developed shortly after headaches were noticed.

Consulted Dr. White September 17, 1929, who made a diagnosis of lead poisoning. Consulted Dr. Soncy September 18, 1929, who had no knowledge of Dr. White's diagnosis, and the same diagnosis was made. Entered hospital September 19, 1929, After entering hospital pain developed in legs and particularly in right deltoid. This pain was particularly severe when attempting to lift arm. Two days later an extensor weakness of right wrist developed with some pain at joint. This, however, was present only one day. Also noticed when getting out of bed toes had tendency to drag on floor.

On entrance to hospital his temperature was normal (98.4) Differential count 66% Polys.,34% Lymphocytes. Urine showed albumin trace and "very few pus and red cells". No white count was done. Red count and haemoglobin are said to have been done but are not recorded on chart. Blood pressure is not recorded on chart. Na sulphate was given once daily ZIII. Urotropin was given but dosage is not recorded. K I was given "teaspoon four times daily of a solution of Z I in Z VIIJ" according to verbal communication of Dr. Soncy. (This is approximately one grain to a dose).

Three days after entrance to hospital pain over right parotid region developed and Dr. Soncy thought a definite paratotis was present. This lasted about four days. Although nausea continued in hospital no vomiting occurred. Appetite gradually improved and symptoms abated.

On examination at hospital there was generalized tenderness

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over abdomen and flanks and back. There was no rigidity. On Dr. Soncy's first examination there was definite punctate pigmentation on the lower gums some distance from the teeth. On suggestive questioning patient thinks he was pale before going to and while in hospital. Dr. Soncy noticed no paleness. While in hospital patient noticed tingling or prickly sensation over entire body - described as sensation of harsh woolen blanket over nude body. This sensation recurred twice after leaving hospital. Patient was constipated for three days starting third day in hospital. While in hospital was given back rub with salve which caused very warm sensation and almost immediately after application a very distinct taste of "old coin" would develop in mouth. (This "Salve" was found to be composed of menthol, methyl salycilate and chloral hydrate)

A tremor of fingers and hands developed while in hospital and there is some evidence of incoordination. Says he "was not paralyzed but it was hard to do things with hands".

Maximum temperature during hospitalization 98.6.