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PLAINTIFF'S EXHIBIT

MON-2707

MEDICAL TOXICOLOGY CONSULTATION:

Robert A. Good
924 Orange
LaMarque, Texas 77568

Patient No.: 2387
Date of Visit: 2/11/82
Date of Birth: 5/7/22

The patient is a 59 year old career insulator referred by attorney Rex Houston for clinical evaluation regarding occupational exposure to asbestos materials.

OCCUPATIONAL HISTORY: The patient's initial exposure to asbestos materials occurred in 1947, when he first entered the insulation trades. He worked as an insulator through 1950, when he left to join the Armed Forces during the Korean conflict. In 1953 he returned to the insulation trades, and from that time to 1972, had regular contact with asbestos materials without benefit of masks or protective clothing. He therefore, has had 22 years total exposure to asbestos and 32 years since initial contact.

The patient currently owns his own insulation company. He reports no significant decrease in job performance due to health limitations because his job does not require physical exertion. He does, however, note significant decrease in exercise tolerance due to shortness of breath.

The patient gives a 10 month history of shortness of breath and cough. The shortness of breath is produced by a climb of two floors on a stairway. The cough is described as productive, and provoked by exertion, and occurring more so in the early mornings. He denies any chest pain.

PAST MEDICAL HISTORY: Previous hospitalizations include:

1981-Bronchitis

(At this time, the patient was told by a radiologist that he had the findings of asbestosis.)

1972-Back surgery
1964-Pneumonia
1962-Pneumonia

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REVIEW OF SYSTEMS: Review of systems reveals no significant additional symptoms.

FAMILY HISTORY: The patient's father died at age 45 following an accident. His mother, age 78, has no known ailments. There is no other reported family history of respiratory disease.

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PERSONAL HISTORY: The patient currently uses no prescription medications and reports the occasional use of aspirin for headaches. He currently smokes one pack of cigarettes per day, and has a 20 pack year smoking history. He currently consumes two cans of beer and two ounces of whiskey per day.

PHYSICAL EXAMINATION: Height: 6'0". Weight: 191 lbs. BP: 146/98. Temp.: 97.2°. Pulse: 78. Resp.: 18.

The patient is a well nourished, well developed white male, who at the time of examination is alert, oriented, and in no acute distress.

HEENT: The patient is normocephalic, atraumatic, with male pattern hair loss evident. Pupils are equal, round and reactive to light and accommodation with extraocular muscles intact. There is decreased light reflex on the tympanic membranes bilaterally. Slight deviation of the nasal septum to the right is noted as is rhinorrhea. No abnormalities of the mouth or posterior pharynx are noted.

CHEST: Chest expansion is symmetrical with respiration. Auscultation reveals cracking rales at both lung bases in an area 23 x 4cm on the left, and 21 x 4cm on the right. These rales are greater in intensity on the right than on the left and do not attenuate following cough. No other abnormal sounds are heard.

HEART: Within normal limits.

ABDOMEN: The abdomen is normal to auscultation and palpation.

GENITALIA/RECTUM: Not examined.

EXTREMITIES: No clubbing, cyanosis or edema is found,

SKIN/INTEGUMENT: There is an 8cm surgical scar extending vertically in the lumbosacral region of the back. No other abnormalities are noted.

NEUROLOGIC: The neurologic examination is physiologic.

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PHYSICAL EXAMINATION: (Continued)

LABORATORY: Laboratory examination consisting of CBC, Sed rate, urinalysis, and SMA 24 reveals acceptable normal limits.

ELECTROCARDIOGRAM: EKG is within normal limits.

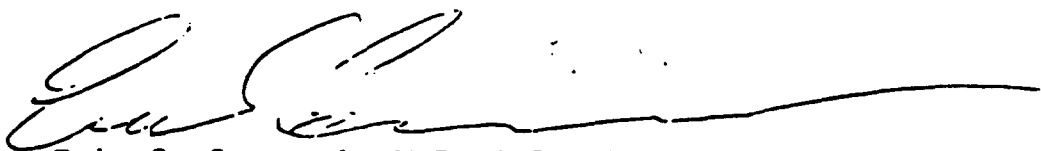
PULMONARY FUNCTION STUDIES: PFS reveal an FEF-75 of 15%, MMF of 38%, FVC of 61%. Residual volume was 192%, while total lung capacity is normal. Mild hypoxemia, interpreted as severe obstructive disease that cannot be differentiated from patient effort. That applies, however, to spirometry only.

CHEST X-RAY: Chest x-ray examination consisting of four views of the chest reveals bilateral interstitial fibrosis, and lobulated pleural based mass in the left midlung field. Follow-up CAT scan of the chest is recommended.

DIAGNOSIS: Asbestosis, based upon crackling rales and x-ray evidence of pleural and parenchymal disease.

DISCUSSION: The patient smokes currently, and is encouraged to stop. He is at high risk for bronchogenic carcinoma, and at a 10 to 20% risk for mesothelioma. He presently is partially disabled from work requiring physical exertion, based on pulmonary dysfunction.

DISPOSITION: The patient has been contacted for scheduling of a CAT scan. This is scheduled for March 5, 1982, for more discriminating examination of his pleural mass. This has been arranged by telephone.



Eric G. Comstock, M.D., A.B.M.T.

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cc: Rex Houston

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