August 26th, 1936.

Mr. G. W. Mercer,
436 Bankers Mortgage Bldg.,
Houston, Texas.

Dear Sir:

At your request I am enclosing herewith a case report on Mr. [redacted], a refinery worker of the Shell Refining Company, who died on August 1st, 1936.

On Wednesday, July 29th, 1936, I was called to see Mr. [redacted] about 11 P. M. At that time he was complaining of severe nausea and vomiting. He gave the history that he had been perfectly well until Tuesday, July 28th, 1936, on which afternoon he began to feel badly. He stated that he felt tired and weak but that he returned to work the following morning, which was Wednesday, July 29th, 1936. During the day he became so weak that he was unable to continue working so he had to quit and lie down in the shade to rest. Some of his fellow workers took him home that afternoon. According to his statement, the first time he vomited was that morning.

On my first visit a thorough physical examination was made with the following findings:
Head & Neck: apparently normal.
Heart: apparently normal.
Lungs: Clear and resonant. No ralls.
Abdomen: He complained of slight pain in the abdomen and a very distressing feeling in the area of the stomach. There was no tenderness or rigidity in the abdominal region.
Extremities: apparently normal.
Reflexes: Normal.
Temperature: 98.6
Pulse: 78, full and regular
Blood Pressure: 124/84

There was no evidence of glandular enlargement.

On the first day he complained of a slight diarrhea and a tentative diagnosis of food poisoning was made. At that time he was given a prescription containing Wampole's Bismuth Hydrate Compound, which is a gastric sedative.

On the following morning, Thursday, July 30th, 1936, I called at his home and found that he was apparently no better, He had not ceased vomiting, but his diarrhea was checked. At that time he was given 50cc of 50% glucose by vein. This relieved him for a few hours, but that afternoon he seemed to be a little worse so I gave him

one-fourth gr. Morphine by hypodermic, which relieved him for a short while. The following morning, Friday, July 31st, 1936, he was no better so was given a gastric lavage, which relieved him only temporarily. During each of my visits I found his temperature always to be normal. On Friday afternoon about 6 P.M. when I called to see him he was much worse. He had developed a partial paralysis of the distal muscles of both the upper and lower extremities and also had a partial paralysis of speech. He had a drop wrist on both hands and drop ankle on both feet. At that time I became suspicious of an actue lead poisoning and asked him if he had come in contact with any lead. He muttered and finally told me yes that the day before he became sick he had loaded a large quantity of gasoline of high lead content into some drums. His wife also told me that at times he was a bit irrational. Therefore, I suggested that they send him immediately to the hospital. An ambulance was called and he was taken to Park View Clinic. Upon admission to the hospital a complete blood picture was made. Also urine analysis. Orders were given to look for stippling of the red blood cells, which sometimes occurs in lead poisoning. The red blood cell count was reported to be within normal limits. The total white blood cell count was within normal limits and also was the differential white blood cell count within normal limits. On admission to the hospital his fever had soared to 103 degrees F., which was attributed to the extreme toxic condition. Soon after being admitted to the hospital he developed a psychosis and was never rational until death. He was given 1000cc of 5% glucose by hypodermoclysis. About 1:30 A.M. the nurses at the hospital called me and stated that his pulse was becoming very weak. I immediately went to the hospital and he was given 1000cc of 5% glucose in normal saline and heart stimulants. He responded very well to this treatment. His pulse became stronger but still maintained an accelerated rate. I watched him closely until 6 A.M. At that time he seemed to be a little improved. About noon his pulse became weak again and he was given heart stimulants and 5% glucose in Ringer's solution by vein. He was also given 50cc of 50% glucose by vein. He reacted slightly to this treatment. His blood was matched for a blood transfusion and he was scheduled to receive the transfusion at 5 P.M. About two P.M. his pulse began to grow weaker and faster. Numerous stimulants were given that afternoon. The heart stimulants used were Colamine Civa, caffein, sodium benzoate was also given as a respiratory stimulant. He gradually became weaker and weaker and there became more congestion of the circulatory system. He died at 4:45 P.M. on Saturday, August 1st, 1936 from circulatory failure.

Conclusions:

When the patient was first seen it appeared that he was suffering from food poisoning, but he grew rapidly and progressively worse and did not react to any form of treatment, which proved to me that there was something behind his condition more serious than a food poisoning. As the symptoms developed and the typical wrist and ankle drop appeared in the face of the onset of nausea and vomiting with a slight diarrhea, which later became constipation, and the

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development of the peripheral paralysis and psychosis, and also the history of contact with a large quantity of lead the day before he became ill, it is my opinion that acute lead poisoning was responsible for his death. He told me just before I sent him to the hospital that his clothes became saturated with gasoline of high lead content the day he was loading the drums. With the acute onset and the rapidity with which the symptoms came on him, it is my opinion that this was an acute poisoning.

The body was shipped to New Orleans, La. early the next morning following his death and I was unable to contact relatives for a post mortem examination before they left town.

Respectfully submitted,

THOMAS E. LOWE, M.D.

TEL/s