Bill 7.50

AMERICAN LEAD PLANT

NATIONAL LEAD COMPANY

Chicago Branch

Manufacturers of DUTCH BOY PRODUCTS

Telephone
Imperial 4447 - 4448

R. W. McKITTRICK,
Plant Manager

1600 East 21st Street
Indianapolis 18, Indiana

November 8, 1954

Dr. Robert A. Kehoe
Kettering Laboratories
Eden & Bethesda Ave.,
Cincinnati, Ohio

Dear Dr. Kehoe:

We attach medical correspondence involved in Indiana Compensation Case No. O.C. 977 regarding alleged loss of eyesight due to lead intoxication, of our employee [redacted]. We also attach letter from Mr. Hall Cochrane, Attorney, who has been retained to pursue the matter before the Indiana Industrial Commission.

As explained to you by phone this morning, we wish to have authoritative opinion and testimony in this matter and therefore, have come to you.

Later this morning we received a call from Mr. Kestenbaum, of our Insurance Department, who stated that he had been in communication with a specialist on internal medicine who pointed out that should penicillin have been administered prior to spinal fluid analysis, there could be no evidence of syphilis in the fluid. Therefore, if penicillin were administered the timing of the injection with relation to syphilis test of spinal fluid referred to in A. T. Symmes letter of November 2 may have a very important bearing on this case.

Should you determine that we have a basis for fighting this claim, and we wish to do so if we have any case at all, perhaps it would be indicated for you to send someone to Indianapolis to discuss the matter with the medical people involved. I can be available in Indianapolis whenever you should wish me to be here.

Please send copies of correspondence to Mr. E. G. Kestenbaum, Hamlin & Co., 52 Broadway, New York 4, New York.

Very truly yours,
NATIONAL LEAD COMPANY
CHICAGO BRANCH

C. Wickemeyer
General Superintendent
(Office) National Lead Company
900 W. 18th St.,
Chicago, Ill.

C.Wickemeyer/r
cc: E. G. Kestenbaum
P. J. Pater
R. W. McKittrick
Hall Cochrane

(COPY)

ROBERT WM. HARGER, M. D.
804 Hume Mansur Building
Indianapolis 4, Indiana

Melrose 1-3112

Mr. A. L. Payne
129 E. Market St.,
Indianapolis, Ind.

Dear Mr. Payne:

The following summary of medical facts should be pertinent in the case of MR. [redacted] C. M. 48, 1409 Columbia Avenue ME 69617, and employee of National Lead, of this city.

He has suffered gradual loss of vision until the right eye has become completely blind, and the left eye has only 5% vision or less. He has bilateraloptic atrophy and retinal arteritis characterized by yellow (gliosis) scarring of the optic nerves and very advanced narrowing of the vessels of the retina associated with sheathing termed perivasculities. This has been a slow and relentless process and has been dismissed by the medical advisors of National Lead as due to tertiary syphilis involving the optic nerves and retinal vessels. Dr. E. B. Haggard, 806 Board of Trade Building, ME 55735, is the plant physician, and his eye consultant was Dr. E. O. Alvis, 320 Hume Mansur Building ME 44539. The basis for their diagnosis has been stippled red cell counts, ranging between 500 and 3320, and positive serologic blood tests for syphilis.

Cecil's Medicine Text quotes stippled cell counts of over 1000 in chronic lead poisoning, and repeated consultations recorded in his hospital chart at IGH do not confirm the diagnosis of the type of shyphilis that could cause this condition. He has most certainly had lues, but apparently not of the brain and nervous system.

Because of the general medical symptoms in addition to the eye findings, one of our bright young internists was called in consultation and Mr. Brooks was hospitalized last summer for study. Dr. Alfred T. Symmes, 635 E. 38th, HI 8649, will send in a summary of his findings and review of the IGH record. From my follow-up in the matter, it went something like this: for fear of CNS lues, we gave a round of penicillin therapy during which the remaining vision in the left eye was lost. This subsequently has returned to only less than 5% of his vision. His studies failed to substantiate the diagnosis of CNS lues, but did reveal a marked deficiency in kidney function, wasting of sleletal muscle and abnormal neurological findings of peripheral nerves. His blood lead was not done, but the urinary excretion findings were in the very upper limits of normal or lower limits of chronic lead poisoning. This urinary lead determination was done in July and his last exposure must have been in early May when he last worked with the furnaces. He actually stopped work altogether on 24th June this year.

In order to clarify his ocular situation, I had my findings compared with those of Dr. Fred M. Wilson, Chairman of the Dept. of Opthamology at the Medical Center and Dr. Paul D. Thompson, 404 Hume Mansur. Both of these consultants feels that Mr. Brooks has optic atrophy secondary to optic neuritis which cannot be dissociated from the industrial hazard of his 20 years of molten lead exposure. Especially significant of course is the fact that his findings do not indicate central nervous system syphilis.

I personally feel that this man has had both syphilis and lead poisoning, that his secondary optic atrophy is not due to the syphilis, and thus we are left with chronic lead poisoning as the cause: 2-1 is 1.

SUMMARY: Mr. [redacted] has lost almost all his vision and has other signs including gravely reduced kidney function which we feel is due to chronic lead poisoning following 20 years of exposure to molten lead at the National Lead Works of this city.

With kindest personal regards,

Robert Harger, M.D.

(COPY)

May 3, 1954

E. O. Alvis, M. D.
320 Hume Mansur Building
Indianapolis, Ind.

National Lead Co.
1600 E. 21st St.,
Indianapolis, Ind.

Re: [redacted]
1409 Columbia Ave.

Gentlemen:

The above named was examined for you at the request of Dr. E. B. Haggard. Mr. Brooks aged 48 informed me that his distant vision was alright but that he could not see to read. He has never worn corrective lenses but does wear goggles at work. He has done the same type of work for twenty two years and looks in on hot slag every day. He has noticed bad vision for over a year. About two and one half years ago his right eye was injured when struck by a milk bottle.

Examination revealed his eye lids to be normal. There was no congestion, tears or secretions about either eye. His pupils were moderately dilated and hardly responded at all to light stimulation. Finger tension was normal in each eye. Distant vision in the right eye was confined to hand motion and the perception of light. Distant vision in the left eye was 20/200 which is only 20% normal. Efforts to improve vision in each eye with lenses were not successful. Slit-lamp microscopical examination of the anterior segments of each eye did not show any pathological changes. There were no corneal scars or microscopical evidences of injury.

Inspection of the interior of each eye through the already moderately dilated pupils showed bilateral optic atrophy. Some of the smaller arteries were silver streaks meaning that some time in the past he has had an arteritis. The retina as well as the macular area of each retina were normal. If his eyes had been damaged by the glare of hot slag then there would have been found changes in the macular areas of each retina. No changes were found. The refracting media including the vitreous, lens and aqueous were normal and free from exudates. The cause of this visual failure is systemic in origin. It is not industrial. He informed me that he has taken some "shots" at the General hospital and that his eyes were examined there last December. He also answered saying that he has a 4plus blood and that Dr. Alexander is giving his shots to "build him up."

Yoursvery truly,

E. O. Alvis, M.D.

EOA:ja

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E. B. HAGGARD, M. D.

806 Board of Trade Bldg.,

Indpls., 4, Ind.

June 28, 1954

onal Lead Co.
0 E. 21st St.,
ty.

Re: [redacted]

Gentlemen:

On 6/24/54, I was notified by you that the above had gone to Indianapolis General Hospital and that the hospital had told you that the admission diagnosis was lead poisoning.

Our medical records on the above show:
He was ill with pneumonia and in the hospital in Feb. and March, 1954. His stippled cell count has been negative and very low, his highest count ever was 3,000. Not long ago, I examined his eyes and found his eyesight to be 20/200 in each eye. Further examination by an eye specialist shows that he has Argyll—Robertson pupils and some optic atrophy, both due to syphilis, in the optnion of the eye specialist. The eyesight is not correctible, in the opinion of the specialist. A blood test, taken by me, showed a 4 plus Kline and Mazzini with Mazzini qualitative 16 units. After this eye examination by the specialist, his job was changed to one demanding less accurate eyesight.

He has been working steadily for about 3 months. He left his job about noon on 6/24/54 to go to the hospital. I last had seen him on 6/23/54 for his weekly interview, and he made no complaints to me on that date. Apparently he made no complaints of any kind to management on 6/24/54, the day he went to the hospital. I saw him at the hospital on 6/25/54 and he said he was in the hospital because of his eyes and because of the lead. His doctor is: A. T. Symmes, M.D., 605 E. 38th St., City, an internal medicine specialist.

On 6/25/54 I gave to Dr. Dyke, Medical Director of the Indianapolis General Hospital a note, detailing Brooks blood counts together with the information on his eyes, and in the note I asked that the hospital to be sure to check on the accuracy of any diagnosis Dr. Symmes might make, and to record accurately whether or not his condition was in any way due to lead, and particularly to note whether or not he had any real disability from work (as distinguished from the impairment- not disability- from his eye condition).

In my opinion [redacted] was not disabled from working on 6/24/54 or 6/25/54. He has an impairment of his eyesight but he is just as able to work as he has been since his job was changed after the eye examination.

I reported all the foregoing to Mr. Wickemeyer over the phone on 6/25/54 and told him I would write two copies of this report so that he could have one.

I intend to talk to Dr. Symmes, but have not yet been able to get ahold of him.

National Lead Co. Re: [redacted] 6/28/54

SUMMARY:

Max Brooks has some lead absorption, but does not have lead poisoning. His lead absorption has not been disabling from 15 March 1954 (the date I began to work at the plant) to date, and will not become disabling--certainly not as long as he is away from work.

He has permanent impairment of his eyesight, due in my opinion to syphilis. This impairment is not due to his work and has not disabled him from work.

Yours,

E. B. Haggard, M.D.

(COPY)

E. B. Haggard, M. D.
806 Board of Trade
Indpls., 4, Ind.

4 May, 1954

National Lead Co.
1600 E. 21st St.,
Indpls., Ind.

Re: [redacted]

Gentlemen:

The above was sent to Dr. E. O. Alvis, an eye specialist, after my examination showed Max to have very poor vision. I found that the sight in his right eye was worse than 20/200 and the left eye was 20/200, both with and without glasses.

The examination by Dr. Alvis shows that his trouble with vision is due to optic atrophy, an affection of both optic nerves. I took a blood test which shows 4 plus, with a quantitative of 16 units. This blood test, together with the optic atrophy and the failure of both pupils to react to light make me say that all these are due to his having had syphilis. The quantitative indicates that treatment is probably NOT needed at the present time. Glasses will not correct the condition.

We have here a man who has no useful vision in his right eye and very poor vision in his left eye. He cannot do any work requiring accurate eyesight, and his poor eyesight will make him clumsy in trying to do many things. If you keep him at work, he should be put on work not requiring accurate eyesight and also where he runs the least chance of being injured because of his poor eyesight. For instance- I believe he would be very poor at tapping the furnace because he would miss his target when thrusting with the ramming rod or tapping rod.

Yours,

E. B. Haggard, M.D. (Signed)

(COPY)

HALL COCHRANE,ATTORNEY

2063 N. Meridian St. (Address Correspondence)
Indianapolis, Ind.

November 3, 1954

Mr. C. Wickemeyer,
General Supt.
National Lead Company
P. O. Box 7000A
Chicago 80, Ill.

Re: [redacted] - Occupational
Disease Claim No. O.C. 977
Our File No. Mc-1-(7)

Gentlemen:

Since my last correspondence to you I have received from Dr. E. O. Alvis, M.D. of this city a copy of his medical report addressed to you under date of May 4, 1954, and a copy of same has in accordance with Industrial Board rules been forwarded to the claimant.

I have further received a letter from E. B. Haggard, who is apparently undergoing operations for eye cataracts and will be away from his office for the next two or three weeks, and who suggests that we are going to need expert testimony on lead poisoning and further recommends that I contact you in this regard.

I received a second communication from Dr. Alvis, who now admits that the loss of eyesight might be due to absorption of lead but that it would take an examination by a toxicologist to determine these facts. I have contacted the Indianapolis Industrial Clinic for reference to a toxicologist and they have informed me that they are in a position to perform the services which we seem now to require and that as an alternative or secondary source of information have given the name of Dr. Spolyar, as also being competent to assist us. They pointed out that these examinations are extensive and are rather expensive, however, I feel that we hardly dare face an Industrial Board hearing on this claim with our medical evidence being in its present condition, for as things now stand we are faced with what I believe will result in an absolute case of liability. Will you therefore please review this matter at once and favor me with your directions and authority to carry them out.

Yours very truly,

HALL COCHRANE, ATTY.

cc: Hamlin & Co.
Eugene McIntire Adjustment Co.

ALFRED T. SYMMES, M. D.
625 East Maple Road
Indianapolis 5, Indiana

November 2, 1954

Arthur L. Payne
129 East Market Street
Indianapolis 4, Indiana

Dear Mr. Payne:

This is a summary of the pertinent facts on Mr. [redacted], 1409 Columbia Avenue, Indianapolis, Indiana.

As Dr. Robert Harger has already written, Mr. [redacted] main complaint, when first seen by me, June 26, 1954, was burning of the eyes for one and one-half years. At the time of the first examination, he had difficulty seeing, but was able to get around with his remaining vision. Other than this, Mr. [redacted] gave no other complaints.

The past pertinent history included a head injury in 1953 for which he was hospitalized at Indianapolis General Hospital for a period of approximately three weeks. Apparently there were no lasting effects from his injury. He was again hospitalized in December, 1953 in Indianapolis General Hospital due to: 1) bronchial pneumonia, 2) hypertensive cardio-vascular disease and 3) infarction of the myocardium due to arteriosclerotic coronary thrombosis.

The family history is non-informing.

The physical examination revealed the following:

General appearance - The patient appears weak and is thin. His speech is somewhat slurred. (This may have always been so.). He walks with hesitation.

Hair - Black

Head - Normal Contour

Ears - Normal

Eyes - Pupils do not react to light and accommodation. (Medication?) He had bilaterally small, pale discs of optic atrophy. Vessels are scarce and reveal two plus construction.

Nose - Negative

Mouth - Upper compensated edentulism. Very poor lower teeth and gums. Darkening at edge of gum conceivably due to lead.

Neck - Negative

Chest - Negative except for poor airation right lower to auscultation and percussion.

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:omen - Negative

:. - Bilateral cystocele with small remaining testes, otherwise neg ve.

:tal - Normal prostate and normal fecal material on rectal finger.

:cular System - Good peripheral pulsations throughout.

Glandular - Large inguinal and femoral lymph nodes bilaterally which non-tender.

Neurological -

	Right	Left
Biceps	2-Plus	2-Plus
Triceps	2-Plus	2-Plus
Radial-Periosteal	2-Plus	2-Plus
Hoffman	0	0
Abdominals		
Upper	2-Plus	2-Plus
Lower	2-PLus	2-Plus
Cremasteric	2-Plus	2-Plus
Patellar	2-Plus (Contra)	3-Plus to 4-Plus
Achilles	2-Plus	3-Plus with sustained ankle clonus

Vibratory - Normal
Rhomberg - Negative

Legs - Multiple scars on both legs. There is one plus leg edema on the left. Legs had trophic changes with thickened skin.

Laboratory Reports:

Blood Work

12-30-53 to 2-2-54
Hb. - 8 gms to 10.2 gms.
WBC - 12,700 to 15,600

12-30-53
No stippling seen

12-30-53
Kolmer - 44441
V.D.R.L. - 4-Plus
Kahn - 4-Plus

1-20-54
Bilirubin - 0.332
T.P. 7.70, alb. 4113, glob. 3.57
Cholesterol - 179, esters 92
Ceph. Floc. 24 hr. - 9, 48 hr. - 1-Plus
Alk. phosphatase - 3.6

6-25-54
Kahn - 4-Plus
V.D.R.L. - 4-Plus
Kolmer - 4-Plus
BUN - 35 mg%

6-26-54
Hb. - 12 gms.
Hemat - 30 Mm
Sed Rate - 30..Hr. (corrected)
WBC - 6,550
Differential Polys - 78%
Lumphs - 10%
Eosin - 10%
Mono - 2%
Test for sickle cell - Negative
RBC - Normal
Platelets - Infrequently seen

7-8-54
BUN - 80%

7-14-54
Hb.-9.92 to 10.96 gms.
Hemat. - 35 mm
WBC - 5,800
Differential - Polys - 61%
Eosin - 18%
Lymphs - 19%
Mono - 2%
RBC - 3.24 to 3.5

Urines

1-6-54 to 1-11-54
Sp. gr. - 1.010 to 1.015
alb. - 2-Plus
WBC - 30-40
RBC - 100-200-Plus
Casts-several

6-26-54
sp.gr. -1.022
ph-4
sugar -0
albumin - plus 1

6-27-54
24 hr. Lead Excretion
0.18 mg/1000 c.c.
No Arsenic

7-14-54
24 hr. Lead Excretion - 0.114 mg/1000 c.c.
Blood lead level - 0.100 mgm %

7-14-54
Urine - Alb-trace; Occasional finely granular cast
PSP test - 15 min-0%; Total hour - 22%
Urea Clearance tests - Test I - 6%; Test II - 18%

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Spinal Fluid

1-25-54
WBC-0, RBC-0, sugar 70 mg %
Chlorides - 126.5 meq.
Culture - no growth
Wass. - no report
Gold curve - 1112210000

6-25-54
Lump-2
WBC-2
RBC-30
Sugar-05
Chlorides - 123.1 meq.
Protein - 21 mgm.%
Kolmer - negative
Gold curbe - 0112100000

Chest Plates

1-25-54
Reveals clearing of the lung fields
Heart prominent transversely

2-2-54
Cardiomegaly - most left ventricle. There is continued clearing of the lung fields.

6-28-54
Heart enlarged TCD 15.5 cm. (TTD 28.5 cm.). Lung fields are clear

7-9-54
"AP, lateral, and Town views of the skull again reveal multiple metalic shots scattered overlying the scalp, face, and cervical region. There is no change since the previous examination."

EKG Findings

12-30-53
Reveals rate of 114/min. There is elevation at the R-S-T segments in II, III, avf. Low voltage
Impressions:
1) Sinus tachycardia
2) Ischemia of posterior wall

12-31-53
Elevated S-T in II, III, avf, q in III, avr.
Inverted T in avl.
Suggestive of posterior wall infarction

1-15-54
There is slight elevation of the S-T segment in I, II, avf - slight q V6. P-R interval 0.22 sec. QRS 0.06 sec. Some

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depression of S-T in V5 and V6. Inverted T-V5 and V6.
Impression: Non specific St-T changes consistent with digitalis effect and/or myocardial damage.

(CONT)

Two EKG were done on the last hospitalization - revealed non-specific myocardial damage.

The following is a copy of a letter from Dr. E. B. Haggard that I received:

"Dear doctor:

Here is the information on the above that I promised to send you:

Stippled Cell Counts

Dec. 1953	3320	
	3000	
Apr. 8, 1954	Neg.	
23,	3000	
May 6, 1954	Neg.	
June 10, 1954	500	(Indianapolis Lab.)
10, 1954	2000	(Chicago Lab.)

Serology - 5/1/54 - Kline and Mazzini both 4-plus. Mazzini quantitative 16 units.

Dr. Alvis saw this man in May 1953 and reported:

Eyesight - right-hand movement and light perception only. left - 20/200. Eyesight not correctible with glasses. Pupils dilated and very slight - almost no reaction to light. Optic atrophy and retinal arteritis."

I have asked Dr. Alvis to forward you a complete copy of his findings

Yours,
/s/ E. B. Haggard, M.D."

Henderson, (Archives of Internal Medicine, Vol. 89, 1052) states that urine lead up to 0.075 mg. per liter is within normal limits and that blood lead levels above 0.08 mg. per 100 c.c. is elevated. He reports a case of lead poisoning in which there was great fluctuation in the urine from normal values to moderately high values.

Dr. Robert A. Kehoe, Lead Absorption and Lead Poisoning, (Medical Clinics in North America, July, 1942), states that in lead poisoning, stippled red cells per million red cells are 720 to 16,000; lead in blood is 0.07 to 0.35 mg. per 100 gms. Lead in urine (in small sample) is 0.07 to 0.35 mg. per liter. Lead in urine (in large sample) 0.02 to 0.33 mg. per liter.

Dr. Giannattasis et al, Lead Poisoning, (American Journal of Diseases of Children) Vol. 84, 1952, state that in their fourteen cases, the urinary excretion of lead revealed a value of 0.1 mg. per liter or more excepting in one case where the value was 0.08 mg. per liter. This latter patient had repeated convulsions, was in coma, but survived to be discharged blind.

(cont)

Mr. Br ' lead levels certainly were in the toxic range. The fact that s another organic disease, namely syphilis, would seem to be bes point. To summarize, Mr. Brooks has certainly had: 1) exposure to lead; 2) changing neurologic findings as reported above; 3) elevated basophilic stippling as reported by Dr. Haggard; 4) the reported urinary lead excretion which is elevated; and 5) a lead level which is in the upper limits of normal.

The diagnoses are as follows: 1) Optic atrophy; 2) Lead poisoning; 3) Syphillis, undiagnosed site; 4) Hypertensive cardiovascular disease; 5) Renal insufficiency; and 6) Azotemia.

Very truly yours,

/s/ Alfred T. Symmes, M. D.

ATS/me

[redacted] - Claim No. O.D. 17057

KE 0016452