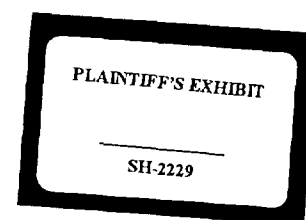




Shell Oil Company
Interoffice Memorandum



OCTOBER 27, 1989

FROM: L. C. WADDELL, M.D., CORPORATE MEDICAL DEPARTMENT

TO: R. HUGHES, M.D., MEDICAL DEPARTMENT
DEER PARK MANUFACTURING COMPLEX

SUBJECT: CONCERNING PULMONARY REGISTRY REVIEW
EMPLOYEE NUMBER

Occupational History: joined Shell as a general helper in February 1948. He was employed as an insulator for Shell beginning in August 1949, having worked as a general helper and pipefitter helper and asbestos helper prior to that time. He is currently retired from Shell.

He has been seen in consultation on several occasions by Dr. S. Fischer, a pulmonary disease consultant in Houston. The earliest report that I have in the record sent to me is dated June 27, 1987, however, in that report Dr. Fischer indicated that he had been seeing since 1970. The occasion for this particular consultation arranged by Dr. Barry Kern was an interval change on his chest X-ray between May 1986 and May 1987. There had been the radiographic development of blunting of the left costophrenic angle. There was also 15% decrease in his vital capacity that was noted. Dr. Fischer indicated that there could be some evidence of the development of parenchymal asbestosis as well at that time. This was speculated upon because of the development of a non-productive cough and the interval reduction of 15% in his vital capacity.

His most recent exam was June 2, 1989. At that time there were no complaints of either cough or exertional dyspnea. His most recent X-ray is dated 6/2/89. There continues to be blunting of the left costophrenic angle and pleural thickening beginning in the left costophrenic angle and extending up probably one half of the superior/inferior axis of the chest. There are several broad curvilinear shadows in the left base which probably are parenchymal. In the right chest, there is thickening of the pleura as well. There are several nodular shadows seen in the right lower lung zone. I cannot tell with any degree of certainty if these represent pleural shadows or if they are in the lung tissue. The upper two thirds of both lung fields, however, appear clear and do not show any changes that are suggestive of interstitial fibrosis. On the lateral view, a fairly dense area of diaphragmatic pleural calcification is seen approximately 60 mm in length and approximately 8-9 mm at its greatest width.

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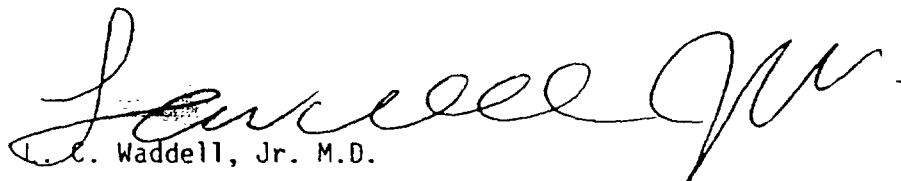
I have had an opportunity to review the chest X-rays. There is certainly radiographic evidence of bilateral pleural plaques and pleural calcification involving at least the left hemidiaphragm. There are also changes in the lower one third of both lungs. On the right, there is a zone of rounded irregularly shaped nodular shadows. It is not possible to determine with plain films if these shadows are parenchymal or pleural or both. Judging from anteriorly placed shadows on the left anterior oblique view, I believe that at least some of those right lower lung zone shadows are pleural. On the left side, there is different type of radiographic picture which is consistent with some combination of pleural shadow, subsegmental atelectasis and possibly interstitial fibrosis.

In terms of diagnosis as far as the OSHA 200 Log is concerned, it is my recommendation that the following entry be made on the OSHA 200 Log:
"Bilateral pleural plaques. Possible asbestosis."

It would appear from the clinical records that you have sent me that this employee has already been counselled about pleural plaques and is already considered to have possible asbestosis as well. However, it should be appreciated that much of the radiographic findings can be attributed to pleural disease. His reduction in vital capacity that was noted in Dr. Kern's referral letter to Dr. Fischer could have at least in part and perhaps entirely been accounted for by the interval development of a pleural effusion which seems to have occurred some time between the 1986 and 1987 film. Dr. Fischer had suggested at that time a CT scan might be done with the consideration at that time of a possible mesothelioma being present. Apparently, time passage has shown that was not the case. However, a CT scan is often helpful in sorting out pleural and parenchymal shadows. However, even if some parenchymal fibrosis would be demonstrated or suggested by CT scan, there would be no difference in clinical management.

Thank you for having sent this case to me for review.

If you have any questions, please give me a call.


L. C. Waddell, Jr. M.D.