October 27, 1955

Mr. Jerome Cohen
45 Church Street
Paterson, New Jersey

re: FRANCELLO, Anthony

Dear Sir:

Mr. Anthony Francello was examined by me on November 27, 1954, December 1, 1954 and December 8, 1954.

He is a 64 year old laborer who started work at the age of 8 as a mason. He came to this country in 1905. He worked in a brickyard, then in a glass factory, in a bakery and in a newspaper press room. He also worked as a laborer at Wrights. In December, 1943, he went to work for the Raim Asbestos and Rubber Company, first as a laborer for one year and then on a tie machine. This machine took split asbestos pipe and ratied them together. Much dust was present, principally because of the location of his machine in the "new room". In this room, much sawing of the asbestos pipe was done, producing a great deal of asbestos dust. Most of the time Mr. Francello wore a mask. On November 6, 1954 he was laid off.

At the time of my examination, he felt reasonably well. There was no cough, no sputum, no hemoptysis, no significant shortness of breath on exertion, he had noted no clubbing of the fingers and no chest pain was present. He did state that on the last day he was at work, while lifting iron pipe he strained himself and he thought he had a rupture.

Mr. Francello underwent a complete physical examination in my office and significant findings were present, almost entirely in the lungs. A soft systolic murmur was noted at the aortic area but otherwise his cardiovascular system was normal. Liver was palpable, one finger breadth below the costal margin and a left inguinal hernia was palpated. No clubbing was present in his fingers or toes, and rectal examination indicated a 1 + benign prostatic hypertrophy. The lungs showed no abnormal phy-

sical findings. Fluoroscopy showed poor diaphragmatic movement (less than one interspace) and the x-ray of the chest, taken on November 27, 1954 showed considerable abnormality. Besides a somewhat enlarged heart, which I consider correlated to his industrial exposure, a moderately fine disseminated nodular infiltration was noted in both lung fields, particularly in the lower lobes. The lower lobes, especially on the right, were also the sites of larger nodular (1 - 3 mm.), and fine linear infiltrations as well as moderate diaphragmatic adhesions, greater on the right than on the left and pleuro-pericardial adhesions with a similar distribution. The outer half of both lung fields showed marked diminution of vascular markings. Bucholin circulation time was 21 seconds, urine examination was normal, serological studies for syphilis were negative, as were sputum examinations for acid fast bacteria. Electrocardiogram was done on December 1,1954 and showed some abnormalities(low T wave in Lead I, Lead II, Lead V_5 and Lead V_6 as well as the presence of a small Q3, a qsvf and $q_{1,2}$ to $V_{5,6}$. The ST segments were elevated in V_4 to V_6 but all these changes are not definitely indicative of any abnormality.) Blood count was within normal limits. Pulmonary function studies were performed at the Cardio-Pulmonary Function Research Laboratory of The Mount Sinai Hospital in New York by Dr. Richard A. Bader and Dr.Mortimer E. Bader on August 3, 1955 and August 4, 1955. These completed studies did not indicate any significant variation from the normal.

Mr. Frascella is suffering from pulmonary asbestosis as the result of his exposure at the Raybestos Manhattan Company. This is evidenced by the moderate but definite roentgenological changes which are quite characteristic of pulmonary asbestosis. Nevertheless, these anatomical changes have not resulted in significant functional disability and this is evidenced both by the absence of significant symptoms, such as shortness of breath or cough, as well as our findings of normal results of the pulmonary functions tests presently available.

As a result of his pulmonary asbestosis, I should estimate that Mr. Fremocille is totally disabled to the extent of 15 % of total disability, basing this on the degree of anatomical change present in his lungs as a result of the pulmonary asbestosis. I do not take into consideration any disability which could conceivably later occur, such as pulmonary tuberculosis or carcinoma of the lung, to which this man's risk is significantly increased by the presence of pulmonary asbestosis.

Very truly yours,

Irving J. Selikoff, M.D.

IJS: md
enc.

Report on Anthony Franzelli
Age 66
B.S.A. 1.56 sq. meters

	Predicted	Lying	Standing
Expiratory reserve volume		490 cc	
Inspiratory capacity		2490 cc	
Vital capacity (calc)	3085 cc	2980 cc	
" (obs)	3065 cc	3300 cc	3200 cc
Functional Residual vol.		1690 cc	
Residual volume	995 cc	1200 cc	
Total capacity	4080 cc	4500 cc	
Residual Vol/Total cap.	24.4 %	26.6%	
MBC	63 L/Min.	70 L/Min	70 L/Min
N_2 residual after 7 min. of O_2 breathing	2.5%	2.6%	

BREATHING RESERVE

			RECOVERY				
	Rest	Exercise	1 Min	2 Min	3 Min	4 Min	5 Min
Ventilation	9.1	13.3	17.5	17.2	16.5	13.8	11.5
Breathing Reserve	61.9	56.7	52.5	52.8	53.5	56.2	58.5
Breath.Res. %	85%	81%	75	75	76	80	84

Dyspnea time - 1 minute

	Rest
VO_2 (O_2 consumption/min) in cc	259
" /M² in cc	166
VCO_2 (CO_2 prod. in/min) in cc	228
" /M² in cc	146
Resp. quotient	0.88
VE (Min ventilation) L/min	9.10
VE/M² in L/min	5.81
Respiratory rate	18
Tidal volume in cc	505
FE O_2	3.02
FECO_2	21.6
Resp. Dead Space (Physiological)	167 cc
Dead Space/Tidal volume	33%

ARTERIAL BLOOD	Normal	Observed at rest	On exercise
O_2 content vol %	19.5	18.7	19.1
" capacity " "	20.0	19.3	20.4
" saturation %	95	98	95%
CO_2 cont. (whole blood) vol%	45-50	45.2	
" " (serum) "	55-60	53.8	
pH	7.37-7.41	7.38	
pCO_2 mm Hg	37-41	40	

INTERPRETATION:

1 - LUNG VOLUME - Vital capacity and residual volume are within normal limits. Total capacity is slightly greater than predicted but is still normal.

2 - VENTILATION - (a) There is hyperventilation at rest without significant hyperventilation on exercise.
(b) Maximum breathing capacity is within normal limits.

3 - DIFFUSION OF INTRAPULMONARY MIXING - is normal

4 - BREATHING REHEVE - during exercise and recovery from exercise is normal.

5 - RESPIRATORY DEAD SPACE (Physiological) - is [illegible]% of the tidal volume. This figure is slightly greater than the upper limit of normal.

6 - ARTERIAL BLOOD STUDIES - reveal a normal pH, CO_2 content and pressure, and normal O_2 saturation at rest. O_2 saturation on exercise is normal.

CONCEPT:

There are no significant abnormalities to indicate any impairment of lung function.

/s/ Richard A. Bader, M.D.
Mortimer E.Bader, M.D.

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Re: Anthony Fr[illegible]cello

Laboratory Data cont.

Complete Blood Count

RBC - 4,[illegible]50,000
WBC - [illegible],[illegible]50
Diff:
Lymph - 4[illegible]%
Polys - 51%
Mono - 1
Eos - 2%
Stabs - 3%

Urinalysis

sugar- negative
albumin - negative
micro-negative
sp.gr.-1.017

Mazzini Test

negative

These laboratory data are all within normal range.

This examination shows the presence of pneumoconiosis due to asbestos infiltration. This fibrosis is of mild degree. The claimant indicates that he has retired from work on his own volition and not because of functional disability. The vital capacity and other clinical findings show only slight impairment of functional disability despite the X-ray findings. It should be noted that he also has an Essential Hypertension.

Thank you for referring Mr. Francello to me. I shall be pleased to discuss this with you in any further detail.

Sincerely yours,

J. Allen Yager, M. D.

jey;vv