(B)

8EHQ-0379-0146
"follow-up"

EPA SANITIZED

MP 11-5-85 PG 8EHQ-0379-0146 PS 88-8600025

hooker

222 RAINBOW BOULEVARD NORTH, BOX 728, NIAGARA FALLS, NEW YORK 14302 PHONE (716) 278-7000

March 1, 1979

Office of Toxic Substances
U. S. Environmental Protection Agency
Washington, D. C. 20460

RE: EPA Document Control No.: 8EHQ-0578-0146

ATTENTION: Mr. Joseph J. Merenda, Director - Assessment Division (TS-792)

Dear Sir:

In your letter of February 6, 1979 requesting additional information in reference to the above noted submission which had been submitted on May 12, 1978, you asked that the medical reports be submitted which had been prepared by the physicians who examined the exposed workers. Before attempting to gather together the medical reports on these many workers, we would like to emphasize that these medical records were from many examinations done as a result of and in preparation for litigation and are not the type of medical documentation that would ordinarily be available from the usual evaluation for investigative or normal health surveillance procedures. As a result, we suggest that rather than send all records, we attempt to get a sample of these records and send them for your physicians to evaluate. If after the evaluation your reviewing physicians determine that the remainder of the records are necessary in order to reach any conclusion, we will assemble from the legal staffs which were involved, those additional records.

The submission evaluation of June 14, 1978 authored by Joseph J. Merenda and directed to Warren Muir noted "no data relating tc intensity and duration of possible exposure to these chemicals are submitted. Therefore, it is not possible to even guess whether the complaints are related to these compounds". I would like to emphasize that because of the lack of relevant data we are no better able to give you any sort of quantitative estimate of intensity and duration of possible exposure to these chemicals now than we were at the time of our original submission.

We submitted our report of May 12, 1978, in our attempt to adhere both to the letter and the spirit of the Toxic Substances Control Act. In the same spirit we are sending you this representative sampling of the reports rather than burdening the agency with paper which is probably not useful.

We hope you will find this approach satisfactory.

Yours truly,

HOOKER CHEMICAL COMPANY

D. A. Guthrie
Acting Vice President
Environment, Health and Safety

DAG32Mbp

VOL IV

Exh E # 104

December 5, 1974

Mr. Carroll J. Guidry, Claims Adjuster
Liberty Mutual
3501 North Causeway Boulevard
Metairie, Louisiana 70002

RE: [redacted]
C075 - 75302HOD

Dear Mr. Guidry:

[redacted] was evaluated in our office and laboratory on December 2, 1974, at your request. This 42-year-old man worked as a carpenter for the Bravo Corporation at the Hooker Plant site in Taft, Louisiana, from October, 1973, to October, 1974. His employment was discontinued when the work force was reduced and he is now employed as a foreman elsewhere. He had an exposure to an irritant gas in November, 1973, while at work, and describes a green cloud emanating from the chlorine unit at the Hooker Plant. Although this gas appeared to be chlorine, he was told that it was "vinyl chloride". Symptoms at that time included shortness of breath, cough, chest tightness, vomiting, and burning of the nose and eyes. He went to the First Aid Station, was given oxygen and hospitalized overnight. He stayed home for a few days and then returned to work. There have been no other significant exposures since that time. The patient indicates that he has had exertional dyspnea since the episode in November, 1973, and that this symptom had not been present previously. He now becomes short of breath with such activity as climbing stairs, and he has not engaged in other exertional activities. He has also noticed easy fatigability. There is slight wheezing but no significant cough. Respiratory infections are infrequent, but when he has an infection it tends to "hang on". He has recently had documentation of a loss of taste and smell by Dr. Irwin. The patient indicates that he has always had good exercise tolerance and in 1959 was able to run five miles while serving in the Marines. There is no history of asthma, hay fever, allergies, heart disease, high blood pressure, diabetes, tuberculosis, pneumonia, chest pain, edema, paroxysmal nocturnal dyspnea or orthopnea. His past history includes a leg injury in Korea and a hernia repair in 1951. He has smoked up to one pack of cigarettes per day for 28 years.

EXHIBIT E

On physical examination, this is a slightly stocky man who does not appear acutely or chronically ill. Blood pressure 152/98, pulse 94. The examination of the ears, eyes, nose and throat was not remarkable but taste and smell were not tested. Examination of the chest reveals adequate thoracic expansion. There is slight delay of the expiratory phase with wheezes brought out by deep forced breathing. No crackles are heard. No cardiac abnormalities are detected, abdominal palpation is negative, there is no edema or clubbing of the extremities.

An EPA chest X-ray film reveals a normal cardiac silhouette. The lung fields are clear. An electrocardiogram fails to reveal evidence of myocardial disease.

Complete studies of pulmonary function were performed. Lung volumes including total lung capacity and vital capacity are normal. There is increase in the residual volume and residual volume to total lung capacity ratio, indicating a degree of hyperinflation. The maximum breathing capacity, forced expiratory volume and peak expiratory flow rate are within the normal range but there is reduction of the timed vital capacity and the forced expiratory flow 25-75%. Mild obstructive ventilatory impairment is indicated with slight increase of air flow after bronchodilator inhalation. Airway resistance is minimally elevated. The pulmonary diffusing capacity is normal and indicates adequate total alveolar gas transfer. Arterial blood gas analysis reveals slight reduction in oxygen tension at rest with improving oxygenation to within the normal range after the more homogeneous ventilation of exercise. Low PCO_2 indicates hyperventilation. In summary, the lung function studies indicate mild, partially reversible airways obstruction with hyperinflation and minimal hypoxemia at rest.

This patient apparently had a significant exposure to chlorine gas in November, 1973, at which time acute respiratory symptoms were noted. He has continued to complain of exertional dyspnea and exercise intolerance and on this examination is found to have minimal but definite obstructive ventilatory impairment and reversible disturbance in oxygenation. These findings are not uncommon in patients with early chronic

obstructive pulmonary disease found in the general population, and frequently related to cigarette smoking. However, because of the exposure to an irritant gas one year ago, a possible contribution of this exposure to the present functional changes can not be excluded. Whether these changes will persist can only be determined on follow-up examinations. It would be very helpful if the patient discontinued cigarette smoking in order to eliminate this as a possible cause for his respiratory disorder. The degree of pulmonary function impairment demonstrated would ordinarily not be expected to preclude tolerance for even moderately heavy physical exertion and it should not be difficult for him to continue his present job.

If I can clarify or expand on any of the above, please let me know.

Sincerely yours,

HW:nc

Hans Weill, M.D.

Name [redacted] Unit No. _____ Date 12/3/74

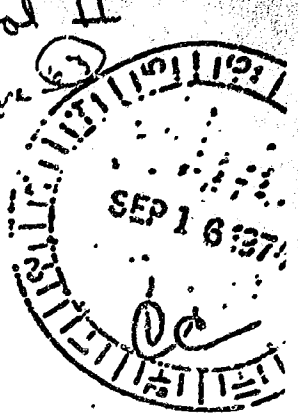
Age 42 Sex M - W Diagnosis _____

Height 65.5 Weight 163 BSA _____ Ward _____

LUNG VOLUMES AND CAPACITY	Observed	After Broncho-dilator	Predi or No
Vital Capacity (VC) in mls.	4052 (97%)	4143 (98%)	4180
Inspiratory Capacity (IC) in mls.	3377	3197	
Expiratory Reserve Volume (ERV) in mls.	675	946	
Functional Residual Capacity(FRC) in mls.		3403 (144%)	2370
Thoracic Gas Volume(at FRC) in mls.		2875 (121%)	
Residual Volume (RV) in mls.		2080 (139%)	1480
Total Lung Capacity (TLC) in mls.		6203 (110%)	5650
RV/TLC x 100		33%	25%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	130 (91%)	132 (93%)	147
Timed Vital Capacity: 1 sec.(in % VC)	68%	75%	>
3 sec.(in % VC)	84%	93%	>
Forced Expiratory Vol. 1 sec.(FEV_1)	2747 (82%)	3017 (90%)	3360
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	2.3 (50%)	2.4 (57%)	4.3 ±
Peak Expiratory Flow Rate in L/min.	505 (91%)	545 (99%)	553
Airway Resistance in cm H_2O/L./sec.		2.27	< 2
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		26.9 (97%)	27.8
ARTERIAL BLOOD	Rest	Exercise	
Oxygen Saturation (Sa_{O_2}) in %	95.1%	96.2%	9
Oxygen Tension (Pa_{O_2}) in mmHg	72	84	80-1
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg	33	33	35-
	7.44	7.39	7.35
Interpretation:		HCT - 46	

New Orleans 70112

September 12, 1974



Mr. Gerald Thomas LaBorde
LaBorde and Brooks
Suite 2102, Plaza Tower
1001 Howard Avenue
New Orleans, La. 70113

Dear Mr. LaBorde:

I recently examined your client, Mr. [redacted]. This 42 year old man relates exposure to vinyl chloride gas and was apparently made ill by free chlorine. His exposure lasted, he believes, about 8-10 minutes while he was working as a carpenter in a chemical plant. He states that he immediately developed nausea and vomiting and was thus prevented from wearing a protective mask so that exposure continued until he was clear of the area. He also suffered eye and nose irritation and began to cough and feel short of breath. He was taken to a hospital given oxygen, a cough suppressant and possibly another medicine and released after an overnight stay. He was advised to remain off work and did so over the next 5 days. His acute symptoms gradually abated.

Since this exposure in December 1973 he notes that he cannot climb 3 flights of stairs without some dyspnea and sudden shifts in position also cause momentary dyspnea. He also finds that he is now troubled on a daily basis with a dry hacking cough.

[redacted] has not had any other significant exposure to industrial pulmonary irritants. He has never had a previous lung illness and although he has smoked cigarettes (1 pack/day) since age 16 he relates no symptoms suggestive of bronchitis or emphysema.

[redacted] relates no other health problems at this time but does admit to being nervous and concerned about his health.

On examination he appears to be tense but in no distress. His chest is symmetrical and well developed. Breathing is easy and expansion is equal. Breath sounds are equal and strong and no rales or wheezes are heard. Percussion is normal. The heart is not enlarged. Sounds are of great quality and there are no murmurs.

Chest x-rays from the front and side were ordered by me and I reviewed the films. I believe that they are normal and do not show any pathology. Lung function studies were also done, and a copy is enclosed. They are borderline before bronchodilators and improved afterwards. This would be consistent with a bronchial irritation induced by chlorine gas exposure. There is good oxygenation of the blood at rest and chronic hyperventilation. The hyperventilation may be related to anxiety. [redacted]xercises well and is able to improve his oxygenation. He also hyperventilates more forcefully. This is to be expected with exercise.

In summary, [redacted]has a history of exposure to noxious gas and evidence by history and laboratory studies of mild dysfunction. He is not disabled at this time but should avoid similar exposure in the future and should stop smoking. The ultimate prognosis for exposures of this type is almost always good. It is unlikely that his dysfunction due to this exposure will worsen and may in time improve. His recovery would no doubt be hastened if he gave up cigarettes.

Thank you for referring[redacted]o me. If I can clarify any points in this report, please call me.

Sincerely,

Russell C. Klein, M.D.
Professor of Medicine

RCK:eg
Encl.

ORDERING PHYSICIAN		DATE DONE		TECHNICIAN	PERM PAT #
Dr. Klein		9-4-74		T. Amaleo	

HEIGHT		WEIGHT	B.S.A.
66 INCHES	168 CM	164 LBS	1.84 SQ M

MECHANICS OF BREATHING

	Predicted	Before Bronchodilator Observed	Before Bronchodilator % Predicted	After Bronchodilator Observed	After Bronchodilator % P.
Vital Capacity	4.5 L	3.5 L	78%	4.0 L	8[illegible]
FEV_1 Second	3.5 L	2.9 L	83%	3.1 L	89[illegible]
FEV_1 Second as % of VC	--- L	83% L	---	78% L	---
FEV_3 Second	--- L	3.3 L	---	3.8 L	---
Maximal Voluntary Ventilation (L/Min)	149 L/Min	112 L	75%	134 L	90[illegible]
Peak Flow (L/Min)	560 L/Min	390 L	70%	460 L	82[illegible]

VENTILATION

TIDAL VOLUME	.73
RESPIRATIONS PER MINUTE	9
MINUTE VOLUME	6.6
INSPIRATORY CAPACITY	2.9
INSPIRATORY RESERVE VOLUME	1.6
EXPIRATORY RESERVE VOLUME	1.2

BLOOD GAS VALUES

	Results: Rest	Results: Exercise	Normal Ra[nge]
pH	7.43	7.52	7.40 ± 0.05
PCO_2	29	20	40 mm Hg ± 5
Base Excess	-4	-4	0 ± 2
Buffer Base	42	42	46 ± 2
Std HCO_3^-	21.5	21.5	24 m Eq/L ± 2
PO_2	92	103	> 85 mm Hg on Room [Air]
Cal SO_2	97.4%	98.2%	97% ± 1
F_IO_2	Room Air	Room Air	

INTERPRETATION

Values are slightly low before bronchodilators but are normal thereafter. This suggests a mild degree of airway obstruction. Blood gases at rest show mild chronic hyperventilation and excellent oxygen tension. The hyperventilation and oxygenation increase with exercise. Subject performed treadmill exercise for 8 minutes and ultimately was walking 5 MPH on an 18% grade before becoming fatigued.

R. C. Klein MD

THOMAS M. IRWIN JR., M.D.
Otolaryngology and Maxillofacial Surgery

12 Westbank Expressway
Gretna, Louisiana 70053
(504) 362-4055

1430 Tulane Avenue
New Orleans, Louisiana 70
(504) 588-5451

November 6, 1974

Gerald LaBorde
LaBorde & Brooks
Suite 2102 Plaza Tower
1001 Howard Ave.
New Orleans, La 70113

NARRATIVE SUMMARY- [redacted]

[redacted] was examined on October 30, 1974, with complaints of decreased taste and smell subsequent to exposure to chlorine gas while working at Hooker Chemical Plant in November, 1973.

[redacted] related that he was hospitalized in St. Charles Parish for approximately 24 hours following exposure, at which time his main symptoms were those of a raw mouth and throat, nosebleeds, and nausea and vomiting. He noted decreased taste and smell approximately five days after exposure to the chlorine gas.

Physical examination of the head and neck was within normal limits, with the exception of the tongue, which appeared somewhat atrophic in its anterior two thirds, with a flattening of the papillae.

Taste testing on October 30, 1974, demonstrated no perception of coffee on the anterior two thirds of the tongue, perception of the taste of salt only at the base of the tongue, not in the anterior two thirds, and percepti of peppermint oil only at the base of the tongue, not in the anterior two thirds of the tongue. The odor of coffee was not detected. The odor of oil of peppermint was perceived, although he reported this to be a faint odor. On November 4, 1974, taste testing with an electrogustometer produced only a slight electrical sensation on the left under surface of the tongue, and no sensation of taste.

On the basis of these examinations, [redacted] does appear to have a bonafid reduction in his sense of taste, and a reduction in his sense of smell.

Sincerely,

Thomas M. Irwin Jr., M.D.

TMI:pkc

Otolaryngology and Maxillofacial Surgery

12 Westbank Expressway
Gretna, Louisiana 70053
(504) 362-4058

1430 Tulane Avenue
New Orleans, Louisiana
(504) 588-5451

November 27, 1974

Gerald LaBorde
LaBorde & Brooks
Suite 2102 Plaza Tower
1001 Howard Ave.
New Orleans, La. 70113

RE: [redacted]

Dear Mr. LaBorde:

On the basis of the examinations reported to you in November, 1974, on [redacted], I would rate his loss of taste as 70%.

Sincerely,

TMI:pkc

Thomas M. Irwin Jr., M.D.

NEUROLOGICAL SURGERY

RICHARD WARREN LEVY, M. D.
CARL F. CILICCHIA, M. D.
ROBERT L. APPLEBAUM, M. D.

NEUROLOGY AND ELECTRODIAGNOSIS

WILLIAM A. MARTIN, M. D.

7 KELLS COURT
3600 PRYTANIA STREET
NEW ORLEANS, LOUISIANA

4500 TENTH STREET
METAIRIE, LOUISIANA 70

SUITE O
2301 HOUMA BOULEVARD
METAIRIE, LOUISIANA 700

March 13, 1975

Louis R. Koerner, Jr.
Attorney at Law
730 Camp Street
New Orleans, Louisiana 70130

Re: [redacted]
43/Cauc/Male
Performed: 3/12/75

Dear Mr. Koerner:

[redacted] states that he was in good health working as a carpenter until about one year ago when he was working on an extension of the Hooker Chemical Company plant when a valve blew exposing him to noxious gases including chlorine. He states that he was exposed for about five to ten minutes and developed difficulty breathing as well as nausea. He was evacuated and taken to the St. James General Hospital where he was admitted and kept overnight on oxygen. He was discharged the next day. Since that time he states that he has had more or less continuous pain over the chest and epigastrium which feels like"gas on the heart". He states that he has decreased strenght in his arms and legs. He develops shortness of breath after climbing one flight of steps or walking over three blocks. He has a more or less constant hacking cough. His eyes stay bloodshot and he has been found to have a seventy percent loss of taste and smell. He states that his muscles become fatigued quite easily, although there is no specific weakness limited to any specific muscles. The muscle fatigue and shortness of breath tend to develop together.

He denies significant headache, diplopia, tinnitus, dysarthria, focal weakness or paresthesia, vertigo, ataxia, syncope or seizures.

Neurological examination: The gait was normal including walking on heels toes and tandem. There was no Rhomberg sign. The examination of the motor system revealed no focal weakness or atrophy or fasiculation. Tests of coordination were performed without ataxia. Deep tendon reflexes were active and equal. There were no Babinsky signs. Sensory examination was intact in all modalities. The optic fundi wer normal. Visual fields were full to confrontation. The cranial nerves were intact.

Electrodiagnositc studies were performed upon all four extremities. Please see enclosed report. There is no evidence of electrical abnormality on either nerve conduction velocity studies or electromyography.

Re: [redacted]

Impression: The clinical neurological examination is completely within normal limits. There is no evidence of focal weakness, atrophy or muscular tenderness. Electrodiagnostic studies show no dysfunction in nerve conduction studies or in electromyography of proximal and distal muscles in any of the four extremities. The patient does not appear to have any specific disability or pathology in either the nervous system or the muscles on the basis of both the clinical examination as well as electrodiagnostic studies.

The patient's chronic fatigue seems to be part of a diffuse systemic syndrome, including chest pain, shortness of breath with exertion, hacking cough, bloodshot eyes, loss of taste and smell, and generally not feeling as well as he did prior to his exposure to the gas. The specific pathological process responsible these symptoms cannot be determined either from the clinical neurologic examination or the electrodiagnostic studies.

Thank you for referring this patient. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

William A. Martin

William A. Martin, M.D.

WAM:bja
enc

NEUROLOGICAL SURGERY

RICHARD WARREN LEVY, M. D.
CARL F. CULICCHIA, M. D.
ROBERT L. APPLEBAUM, M. D.

NEUROLOGY AND ELECTRODIAGNOSIS

WILLIAM A. MARTIN, M. D.

7 KELLS COURT
3600 PRYTANIA STR
NEW ORLEANS, LOUISIANA

4500 TENTH STRE
MARRERO, LOUISIANA 7

SUITE O
3501 HOUMA BOULEV
METAIRIE, LOUISIANA 70

March 13, 1975

ELECTROMYOGRAM

Re: [redacted]
43/Cauc/Male
Referred: Louis Koerner, Jr.
Attorney
Performed: 3/12/75

NERVE CONDUCTION VELOCITY STUDIES

Distal motor latency in the left median nerve across the carpal tunnel was 3.9 milliseconds. Conduction velocity from the elbow to the wrist was 56 meters per second.

Distal latency in the left peroneal nerve was 6.0 milliseconds. Conduction velocity from the head of the fibula to the ankle was 60 meters per second.

Distal latency in the right ulnar nerve was 2.6 milliseconds. Conduction velocity from the elbow to the wrist was 53 meters per second.

Distal latency in the right posterior tibial nerve was 4.5 milliseconds. Conduction velocity from the popliteat fossa to the ankle was 51 meters per second.

Electromyography was performed upon the right deltoid, pronator teres, quadriceps, and tibialis anterior muscles as well as the left extensor carpi radialis, first dorsal interosseous, hamstring and gastrocnemius muscles.

Insertional potentials were normal in all muscles with no positive waves. There were no fibrillations or fasiculations at rest. A full interference pattern was seen on maximum contraction. The individual motor units were normal in amplitude and duration.

IMPRESSION

Nerve conduction velocity studies on the nerves of all four extremities were in the middle to upper range of normal (normal is 44 to 60 meters per second). There is no evidence of a generalized peripheral neuropathy or an localized entrapment in the nerves studied.

Electromyography of a proximal and distal muscle in all four extremities was normal with no evidence of either acute or chronic denervation or myopathy.

In summary: Electrodiagnostic studies are normal in all four extremities.

Thank you for referring this patient. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

William A. Martin

William A. Martin, M.D.

WAM:bja

STANDARD FORM FOR

SURGEON'S REPORT

APPROVED BY I. A. I. A. B. C.

~~NEW ORLEANS ROSENBUSH CLAIMS SERVICE, INC.~~

STATE
NUMBER
OR.

FILE:
CARRIER:
EMPLOYER:

CARRIER'S FILE NO.

(THE SPACES ABOVE NOT TO BE FILLED IN BY PHYSICIA

THE PATIENT

1. NAME OF INJURED PER [redacted] AGE: 41 SEX: M
2. ADDRESS NO. AND ST. [redacted] CITY OR TOWN: [illegible] STATE: LA
3. NAME AND ADDRESS OF EMPLOYER: [illegible]

THE ACCIDENT

4. DATE OF ACCIDENT: 11-12-73 HOUR [illegible] M. LAST DATE WORKED?
5. STATE IN PATIENT'S OWN WORDS WHERE AND HOW ACCIDENT OCCURRED: [illegible]

THE INJURY

6. GIVE ACCURATE DESCRIPTION OF NATURE AND EXTENT OF INJURY AND STATE YOUR OBJECTIVE FINDINGS: [illegible]
7. WILL THE INJURY RESULT IN (A) PERMANENT DEFECT? [illegible] IF SO, WHAT?
   (B) FACIAL OR HEAD DISFIGUREMENT? [illegible]
   (LOSS OF WHOLE OR PARTS OF MEMBERS, FACIAL OR HEAD DISFIGUREMENT, ETC., MUST BE ACCURATELY MARKED ON CHART ON REVERSE SIDE OF THIS BL
8. WHAT IS CAUSE OF PATIENT'S CONDITION? [illegible]
9. IS PATIENT SUFFERING FROM ANY DISEASE OF THE HEART, LUNGS, BRAIN, KIDNEYS, BLOOD, VASCULAR SYSTEM OR OTHER DISABLING CONDITION NOT DUE TO THIS ACCIDENT? [illegible] GIVE PARTICULARS:
10. HAS PATIENT ANY PHYSICAL IMPAIRMENT DUE TO PREVIOUS ACCIDENT OR DISEASE? [illegible] GIVE PARTICULARS:
11. HAS NORMAL RECOVERY BEEN DELAYED FOR ANY REASON? [illegible] GIVE PARTICULARS:
12. HAVE YOU PREVIOUSLY TREATED THIS PATIENT? [illegible] GIVE PARTICULARS:

TREATMENT

13. DATE OF YOUR FIRST TREATMENT: [illegible] WHO ENGAGED YOUR SERVICES? [illegible]
14. DESCRIBE TREATMENT GIVEN BY YOU: [illegible]
15. WERE X-RAYS TAKEN? [illegible] BY WHOM? [illegible] (NAME AND ADDRESS) WHEN? 11-13-
16. X-RAY DIAGNOSIS: [illegible] (ATTACH REPORT)
17. WAS PATIENT TREATED BY ANYONE ELSE? [illegible] BY WHOM? (NAME AND ADDRESS) WHEN?
18. WAS PATIENT HOSPITALIZED? [illegible] NAME AND ADDRESS OF HOSPITAL: [illegible]
19. DATE OF ADMISSION TO HOSPITAL: [illegible] DATE OF DISCHARGE: [illegible]
20. IS FURTHER TREATMENT NEEDED? [illegible] FOR HOW LONG?

DISABILITY

21. IS PATIENT ABLE TO CONTINUE WORK? HAS PATIENT BEEN DISABLED?
22. PATIENT WAS / WILL BE ABLE TO RESUME REGULAR WORK ON:
23. PATIENT WAS / WILL BE ABLE TO RESUME LIGHT WORK ON
24. IF DEATH ENSUED GIVE DATE:

REMARKS (GIVE ANY INFORMATION OF VALUE NOT INCLUDED ABOVE)

I AM A DULY LICENSED PHYSICIAN IN THE STATE OF

I WAS GRADUATED FROM MEDICAL SCHOOL IN YEAR

GEORGETOWN UNIVERSITY MEDICAL CENTER
GEORGETOWN UNIVERSITY HOSPITAL
DEPARTMENT OF PATHOLOGY
SCHOOL OF MEDICINE
WASHINGTON, D.C. 20007

REPORT OF PATHOLOGIC EXAMINATION

Patient's Name [redacted] 46 Path. No. 78 S 2051

Hospital No. OP Date Received 3/23/78

Doctor Henkin

Pathologic Diagnosis SEE DESCRIPTION.

Clinical Summary Nasal mucous membrane
Removal of 2 or 3 mm. piece of nasal mucous membrane

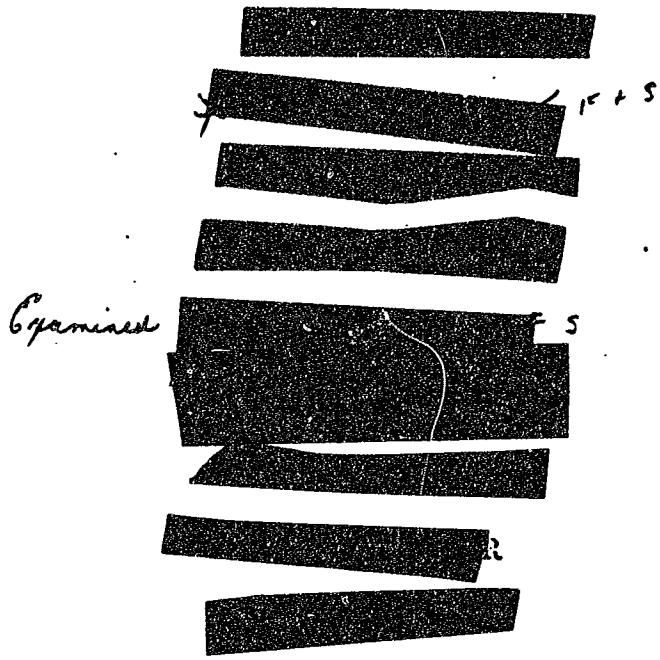
Pathologic Report The specimen is submitted in a single container labelled nasal biopsy. The specimen consists of a tan-brown piece of tissue measuring 2 or 3 mm.

Dravo employees
medical reports

TULANE MEDICAL SCHOOL

PULMONARY SECTION

DR. WEILL



HOOKER PROJECT 880

TAFT, LOUISIANA

DRAVO PERSONNEL
REFERRED
TO
TULANE

November 7, 1974

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

Re: [redacted]

Dear Dr. Peters:

[redacted] was evaluated in our office and laboratory on October 30, 1974, with the following results:

This 30-year-old man has worked as a welder for the Dravo Corporation at the Hooker plant site at Taft, Louisiana, for slightly over three months, and indicates that he has had frequent exposures to chlorine gas, although he has never used a respirator. Three of these episodes required medical attention, and he was given antibiotics, decongestants, and a cough medication. He has had periodic absences from work. His symptoms include burning and watering of the eyes, "sinus headaches", cough, chest tightness, shortness of breath and sore throat. Dyspnea persists and now occurs with marked exertion, such as climbing. He still has occasional headaches. His last exposure was during the previous week. There is no history of asthma, hay fever, or allergies, although he has a family history of asthma. Respiratory infections have been infrequent, and there is no history of heart disease, high blood pressure, pneumonia, diabetes, or tuberculosis. His past history includes a hernia and tonsillectomy. He has smoked three-fourths of a pack of cigarettes per day for twelve years.

On physical examination, this was a well-developed, well-nourished young man who does not appear acutely or chronically ill. Blood pressure is 144/96, and pulse 72. Examination of

the ears, eyes, nose and throat is not remarkable. Examination of the chest reveals adequate thoracic expansion, without delay of the expiratory phase. No crackles or wheezes are heard. No cardiac abnormalities are detected. Abdominal palpation is negative; there is no edema or clubbing of the extremities.

An EPA chest film reveals a normal cardiac silhouette and clear lung fields. The electrocardiogram reveals low T-waves in V6 and standard lead I; these changes are nonspecific, but suggest the possibility of myocardial disease.

Studies of pulmonary function were performed. Lung volume measurements, including total lung capacity and vital capacity, are normal, with slight increase in residual volume and residual volume to total lung capacity ratio. The maximum breathing capacity, forced expiratory volume, forced expiratory flow, 25-75, and peak expiratory flow rate, are normal, but there is slight delay of the timed vital capacity. Very mild obstructive ventilatory impairment is indicated, with complete reversibility of air flow obstruction after inhalation of a bronchodilator aerosol. The pulmonary diffusing capacity is normal, and indicates adequate total alveolar gas transfer. In summary, the lung function studies reveal minimal reversible airways obstruction, and slight hyperinflation.

This patient apparently has had several episodes of exposure to irritant gases, with the appropriate acute upper and lower respiratory symptoms, which have generally improved, but several of which remain. Slight exertional dyspnea is associated with a mild degree of ventilatory impairment, which perhaps will be reversed in the absence of further exposure to an irritant gas. Persistence to date of some functional impairment is not unexpected in view of the patient's history that his last exposure occurred only a few days ago.

Thank you for referring [redacted] this evaluation. If we can provide further information, please let us know.

Sincerely yours,

Hans Weill, M.D.

HW/pat

cc: Dr. Wilson Couch
Mr. George Morales

PULMONARY FUNCTION LABORATORY
ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. _____ Date 10/30/74

Age [illegible] Sex [illegible] Diagnosis _____

Height [illegible] Weight [illegible] BSA _____ Ward _____

	Observed	After Broncho-dilator	Pre or P
LUNG VOLUMES AND CAPACITY			
Vital Capacity (VC) in mls.	[illegible]	5237 (110%)	4930
Inspiratory Capacity (IC) in mls.	[illegible]	4580	
Expiratory Reserve Volume (ERV) in mls.	[illegible]	1057	
Functional Residual Capacity (FRC) in mls.		3001 (146%)	2660
Thoracic Gas Volume (at FRC) in mls.			
Residual Volume (RV) in mls.		2096 (138%)	1520
Total Lung Capacity (TLC) in mls.		7333 (124%)	5900
RV/TLC x 100		26%	23%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity (MBC) in L/min.	170 (101%)	218 (125%)	174
Timed Vital Capacity: 1 sec. (in % VC)	79%	83%	
3 sec. (in % VC)	91%	96%	
Forced Expiratory Vol. 1 sec. (FEV_1)	4500 (114%)	4894 (122%)	4020
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	5.0 (108%)	5.4 (116%)	4.6
Peak Expiratory Flow Rate in L/min.	[illegible] (103%)	[illegible] (103%)	[illegible]
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (DL_{CO}) in mls/min/mmHg(CO)		35.0 (103%)	34.0

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				
Oxygen Tension (Pa_{O_2}) in mmHg				80-1
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35
pH				7.3

Impression:

October 24, 1974

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

Re: [redacted]

Dear Dr. Peters:

[redacted] was evaluated in our office and laboratory on October 21, 1974, with the following results:

This 57-year-old man works as a structural iron foreman for the Dravo Corporation at the Hooker Chemical Company plant site in Taft, Louisiana, where he has been engaged in the construction of a new plant extension for the past eleven months. He has had periodic low level exposures to chlorine gas, as well as possibly other irritant inhalants, and specifically recalls that a chlorine unit was leaking on September 5, at which time he was downwind from this emission. On that day he experienced dizziness, headaches, aching of the left leg, slight cough, burning of the eyes, and anorexia, but no significant shortness of breath or wheezing. He was seen by Dr. Couch, where he was treated and was advised to remain off work for a few days. His headaches continued with recurrent irritant gas exposures. Numbness and tightness of the left leg have persisted, and he has also had eye irritation. He went on vacation on October 8, and has not been back to the plant since that time, indicating that he is feeling much better and that his headaches are gone. His leg symptoms have improved, but he still has aching and numbness after walking. There is no shortness of breath, cough, or wheezing at this time. He has smoked up to two packs of cigarettes per day for forty years. Alcohol intake was moderate in the past, but there is none now. Diabetes mellitus is being treated by an oral hypoglycemic agent. There is no history of heart disease, high blood pressure, tuberculosis or pneumonia. His weight has been stable. His past history includes a surgical procedure of the right femoral artery in 1959, with improvement of the symptoms

which he was having at that time. He also has had a torn tendon of the right shoulder, for which he was operated on in 1954.

On physical examination, this is a well-developed, well-nourished, plethoric man who does not appear acutely or chronically ill. Blood pressure 140/30, pulse 76. Examination of the ears, eyes, nose and throat is not remarkable. Examination of the chest reveals adequate thoracic expansion without delay of the expiratory phase. No crackles or wheezes are heard. No cardiac abnormalities are detected. Abdominal palpation is negative. Examination of the extremities reveals the right shoulder surgical scar. There is slight, bluish mottling of the left foot, with a slightly cooler than normal skin temperature. The right femoral artery is palpable, but the left femoral and both dorsal pedal and posterior tibial arterial pulses are absent. There is no edema.

The chest x-ray film reveals a normal cardiac silhouette and clear lung fields. An electrocardiogram reveals low to flat T-waves in leads I and AVL. These changes are nonspecific, but suggest the possibility of myocardial disease. Deep S-waves persist over the left precordium.

Studies of pulmonary function were performed. Lung volumes, including total lung capacity, vital capacity and residual volume, are normal with slight increase of the residual volume to total lung capacity ratio indicating a minor degree of hyperinflation. The absence of air flow obstruction is indicated by the normal values for maximum breathing capacity, timed vital capacity, forced expiratory volume, forced expiratory flow, 25-75, and peak expiratory flow rate. The normal pulmonary diffusing capacity indicates adequate total alveolar gas transfer. In summary, there is no evidence of significant pulmonary functional impairment.

Although this patient apparently has had several low level exposures to an irritant gas, presumably chlorine, significant respiratory symptoms have not resulted, and no pulmonary functional impairment is demonstrated at this time. The patient's primary complaint is indicative of intermittent claudication, involving the left leg, and there is evidence on physical examination of arterial insufficiency of the left lower extremity. In view of the patient's previous history of vascular surgery on the right leg, it is suggested that he be evaluated for a

corrective vascular procedure by an appropriate surgical consultant. There is, of course, no relationship between the peripheral vascular disease and exposure to an irritant gas.

Thank you for referring [redacted] or this evaluation.

Sincerely yours,

Hans Weill, M. D.

HW/pat

cc: Dr. Wilson Couch
Paradis, Louisiana 70080

Mr. George Morales
Dravo Corporation
P. O. Drawer E
Hahnville, Louisiana 70057

ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. _____ Date 10/21/74

Age 67 Sex M - W Diagnosis _____

Height 63.5 Weight 193 BSA _____ Ward _____

LUNG VOLUMES AND CAPACITY	Observed	After Broncho-dilator	Pre or P
Vital Capacity (VC) in mls.	4255 (100%)	4378 (101%)	4245
Inspiratory Capacity (IC) in mls.	3467	3693	
Expiratory Reserve Volume (ERV) in mls.	788	685	
Functional Residual Capacity(FRC) in mls.		2014 (115%)	2010
Thoracic Gas Volume(at FRC) in mls.			
Residual Volume (RV) in mls.		2193 (120%)	1620
Total Lung Capacity (TLC) in mls.		6471 (104%)	6250
RV/TLC x 100		34%	28
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	141 (103%)	157 (115%)	137
Timed Vital Capacity: 1 sec.(in % VC)	82%	80%	
3 sec.(in % VC)	93%	90%	
Forced Expiratory Vol. 1 sec.(FEV_1)	3513 (110%)	3432 (107%)	3200
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	4.7 (120%)	4.5 (125%)	3.6
Peak Expiratory Flow Rate in L/min.	630 (117%)	630 (117%)	537
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		25.1 (95%)	20.4

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				
Oxygen Tension (Pa_{O_2}) in mmHg				80
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35
pH				7.3

Impression:

October 24, 1974

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

RE: [redacted]

Dear Dr. Peters:

[redacted] was evaluated in our office and laboratory on October 23, 1974, with the following results:

This 41-year-old pipefitter has worked for the Dravo Corporation at the Hooker plant site for the past eleven months. Chlorine spills over approximately two to three days occurred two months ago, during which time the patient indicates that he was downwind and experienced a variety of symptoms, including sore throat, chest pain, cough, shortness of breath, watery eyes, burning nose, fever, and headaches. He was seen by the company nurse and referred to Dr. Couch, where he relates that he was found to have low blood sugar and was given medications. Most of his symptoms lasted for about two weeks, but right anterior chest pain has continued since that time, and is aggravated by cough, and thought to be related to the chest muscles. Chronic cough is productive of one to two tablespoons of black sputum each day, but his cough has generally improved lately. There is an indefinite history of exertional dyspnea with such activity as running, but is is questionable whether this represents a recent change. There have been no significant irritant gas exposures recently. He has smoked one pack of cigarettes per day for twenty years. Alcohol intake is limited to an occasional beer. There is no history of heart disease, high blood pressure, tuberculosis, diabetes, allergies, asthma, or hay fever. He had pneumonia four to five years ago.

On physical examination, this is a well-developed, well-nourished man who does not appear acutely or chronically ill. Blood pressure 148/96; pulse 68. Examination of the ears, eyes, nose, and throat fails to reveal significant abnormalities. Examination of the chest reveals tenderness and slight swelling or enlargement of the right pectoral muscle group. There is adequate thoracic expansion with no delay of the expiratory phase. Breath sounds are slightly coarse, but no crackles or wheezes are heard. No cardiac abnormalities are detected. Abdominal palpation is negative. There is no edema or clubbing of the extremities. The chest x-ray film reveals a normal cardiac silhouette and clear lung fields. An electrocardiogram fails to reveal evidence of myocardial disease.

Studies of pulmonary function were performed. Lung volumes, including total lung capacity and vital capacity, are normal, with slight increase of the residual volume and residual volume to total lung capacity ratio, indicating a minor degree of hyperinflation. The timed vital capacity, forced expiratory volume, forced expiratory flow, 25-75, and peak expiratory flow rate, are within the normal range and suggest the absence of air flow obstruction. The maximum breathing capacity may not represent an optimum effort by the patient. The pulmonary diffusing capacity is normal and indicates adequate total alveolar gas transfer. In summary, there is no significant abnormality of pulmonary function.

This patient has had the clinical picture of acute irritant gas exposure, presumably chlorine, with rather prompt resolution of most of the symptoms associated with this exposure. The persistence of pain and tenderness involving the right pectoral muscles and the finding of swelling (the patient is left-handed) suggests that there may have been an unrecognized injury involving that muscle group, and this probably should be evaluated by an orthopedic specialist. Although there is a temporal relationship between the onset of muscle to discomfort and the exposures which occurred two months ago, I can see no way to establish a cause and effect relationship.

Thank you for referrin[redacted] for this evaluation.

Sincerely yours,

Hans Weill, M.D.

HW/kr

ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. Dr. W. Legal Date 10/23/74

Age 41 Sex M-W Diagnosis

Height 64 3/4" Weight 162 1/2 BSA Ward

	Observed	After Broncho-dilator	Predi or Nor
LUNG VOLUMES AND CAPACITY			
Vital Capacity (VC) in mls.	4310 (105%)	4400 (107%)	4105
Inspiratory Capacity (IC) in mls.	3159	3114	
Expiratory Reserve Volume (ERV) in mls.	1151	1286	
Functional Residual Capacity(FRC) in mls.		3325 (145%)	2300
Thoracic Gas Volume(at FRC) in mls.			
Residual Volume (RV) in mls.		1810 (126%)	1440
Total Lung Capacity (TLC) in mls.		6210 (113%)	5525
RV/TLC x 100		29%	25%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	109 (68%)	120 (82%)	146
Timed Vital Capacity: 1 sec.(in % VC)	80%	84%	>
3 sec.(in % VC)	95%	95%	>
Forced Expiratory Vol. 1 sec.(FEV_1)	3520 (106%)	3678 (111%)	3325
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	3.7 (86%)	4.3 (101%)	4.37
Peak Expiratory Flow Rate in L/min.	485 (88%)	485 (88%)	542
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		25.9 (94%)	27.5

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				9
Oxygen Tension (Pa_{O_2}) in mmHg				80-1(
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35-
pH				7.35

Impression:

October 22, 1974

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

RE: [redacted]

Dear Dr. Peters:

[redacted] was evaluated in our office and laboratory on October 17, 1974, with the following results. This 52-year-old man has worked as a pipe fitter foreman for the past ten years, and during the previous twelve months has been engaged in construction of a new section at the Hooker Chemical Company plant in Taft, Louisiana. A chlorine spill apparently occurred at the Hooker Plant approximately two months ago, while the patient was at work, and he experienced nose burning, nausea, shortness of breath, chest pain, and cough productive of brown sputum. Twenty or thirty other workers were similarly affected at that time, and he, as well as the others, were seen by Dr. Couch. The patient indicates that he did not see a gas cloud, but that he was downwind from the gas source, and that respiratory protection (masks) were used only after the described symptoms had appeared. X-rays were taken and the patient received antibiotics and a cough medication. The majority of symptoms lasted approximately four days, but shortness of breath persisted although he returned to work promptly. Another chlorine leak apparently occurred on October 10, 1974, and, in addition, he feels that there was "an acid" component at that time. Again, no visible cloud appeared. He had the same symptoms with the addition of vomiting and diarrhea, and an increase in his shortness of breath. Twenty to thirty workers were again involved and seen by Dr. Couch. The patient tried to return to work but was hospitalized on October 14, and discharged on the 16th, during which time he had a gastrointestinal workup, which was apparently negative.

At present, the patient becomes short of breath with such activity as climbing stairs, but not on walking. He indicates that he had not had dyspnea previously. There is no wheezing, and only minimal cough productive initially of two tablespoons of brown sputum per day, and one tablespoon daily at present. There is no history of allergies, hay fever, or asthma, and no family history of atopic disease. There are no gastrointestinal symptoms now, and the patient sleeps well. He has never smoked cigarettes; alcohol intake is limited to an occasional beer. His weight is

stable. An episode of syncope, twenty-one years ago, lead to a brief medical workup, and he was told at that time that this may have been due to a heart disturbance. He had pneumonia two years ago, for which he was hospitalized at Baptist Hospital for four days. There is no history of high blood pressure, tuberculosis, or diabetes. Surgical procedures have included a hernia repair and an appendectomy.

On physical examination, this is a well-developed, well-nourished man who does not appear acutely or chronically ill. The blood pressure is 146/98, pulse 64. Examination of the ears, eyes, nose, and throat is not remarkable. Examination of the chest reveals adequate thoracic expansion, without definite, detectable delay of the expiratory phase. There are occasional expiratory wheezes with deep forced breathing. No inspiratory crackles are heard. No cardiac abnormalities were detected. Abdominal palpation is negative. There is no edema or clubbing of the extremities.

A chest film reveals a normal cardiac silhouette and clear lung fields. The electrocardiogram shows a small, but probably insignificant, Q-wave in lead III. There is a high, junctional take-off of the ST segment in leads II and V-6. These changes are probably of no clinical significance, and there is no definite EKG evidence of myocardial disease.

Complete studies of lung function were performed. Lung volumes, including vital capacity, and total lung capacity, are normal, with slight increase in residual volume to total lung capacity ratio, indicating minimal hyperinflation. The maximum breathing capacity is low normal, and there is slight reduction of the timed vital capacity and peak expiratory flow rate, with normal values for forced expiratory volume and forced expiratory flow, 25-75. Minimal airways obstruction is demonstrated with reversal after bronchodilator inhalation. Pulmonary diffusing capacity is normal and arterial blood gas analysis reveals a normal oxygen saturation and PO_2 at rest and after exercise. The low PCO_2 is the result of hyperventilation.

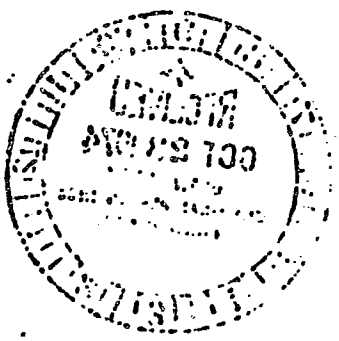
This patient apparently has had at least two episodes of an irritant gas exposure, presumably chlorine, but also possibly hydrochloric acid mist. These exposures have produced acute respiratory and gastrointestinal symptoms, but there appears to have been marked clinical improvement recently. A degree of exertional dyspnea has persisted but on pulmonary function studies only very mild reversible airways obstruction is demonstrated. This finding may, in fact, be a residual effect of this exposure, but presumably should resolve in the near future. Continuing acute exposures to an inhaled irritant would be expected to produce further respiratory symptoms and functional disturbance, but in the absence of such exposure, complete recovery is anticipated.

Thank you for referring [redacted] for this evaluation. If I can clarify or expand on any of the above, please let me know.

Sincerely yours,

Hans Weill, M.D.

HW/kr
cc: Faucheux, Patsy
Couch, Dr. Wilson



TULANE PULMONARY FUNCTION LABORATORY
ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. Dr. W. Level Date 10/17/71

Age 52 Sex Male Diagnosis

Height 6' 1/2" Weight 202 BSA Ward

	Observed	After Bronchodilator	Pred or N
LUNG VOLUMES AND CAPACITY			
Vital Capacity (VC) in mls.	4445 (122%)	4535 (125%)	364
Inspiratory Capacity (IC) in mls.	3592	3817	
Expiratory Reserve Volume (ERV) in mls.	853	718	
Functional Residual Capacity(FRC) in mls.		2700 (116%)	226
Thoracic Gas Volume(at FRC) in mls.			
Residual Volume (RV) in mls.		2025 (135%)	155
Total Lung Capacity (TLC) in mls.		6620 (122%)	545
RV/TLC x 100		32%	27%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	104 (80%)	126 (95%)	130
Timed Vital Capacity: 1 sec.(in % VC)	76%	80%	>
3 sec.(in % VC)	92%	91%	>
Forced Expiratory Vol. 1 sec.(FEV_1)	3457 (116%)	3614 (121%)	2930
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	3.5 (94%)	3.4 (94%)	3.6
Peak Expiratory Flow Rate in L/min.	400 (77%)	530 (102%)	521
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		35.1 (143%)	24

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %	95.6%	95.3%		
Oxygen Tension (Pa_{O_2}) in mmHg	79	83		80-1
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg	32	30		35
pH	7.39	7.32		7.3

Impression:

HCT:37

Exercise watts:75
Pulse: 120 at 2' 30"
Exercise time: 4' 30"

Studies of pulmonary function were performed. Lung volumes, including total lung capacity, vital capacity, residual volume, and residual volume to total lung capacity ratio are all normal. The absence of air flow obstruction is demonstrated by the normal values for maximum breathing capacity, timed vital capacity, forced expiratory volume, forced expiratory flow 25-75, and peak expiratory flow rate. Overall alveolar gas transfer is normal, as indicated by the normal pulmonary diffusing capacity. In summary, no abnormality of lung function is detected.

M[redacted] apparently had one exposure to moderate concentrations of an irritant gas, and two minor episodes, but seems to have recovered fully from the effects of these exposures. From a respiratory standpoint, no present abnormality is detected. Significant hypertension is noted, which should be brought to the attention of the patient's physician.

If I can expand on, or clarify any of the above, please let me know.

Sincerely yours,

Hans Weill, M.D.

HW/ker
cc: Dr. Wilson Couch
Mr. George Morales

ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. Local Dr. Yr. Date 11/19/74

Age 65 Sex M-W Diagnosis

Height 65 1/4" Weight 133 lbs. BSA Ward

LUNG VOLUMES AND CAPACITY	Observed	After Bronchodilator	Predicted or Normal
Vital Capacity (VC) in mls.	3467 (99%)	3355 (95%)	3530
Inspiratory Capacity (IC) in mls.	2432	2477	
Expiratory Reserve Volume (ERV) in mls.	1035	878	
Functional Residual Capacity(FRC) in mls.		2519 (112%)	2250
Thoracic Gas Volume(at FRC) in mls.		2395 (106%)	
Residual Volume (RV) in mls.		1111 (77%)	1450
Total Lung Capacity (TLC) in mls.		4466 (83%)	5400
RV/TLC x 100		25%	26%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	152 (109%)	144 (104%)	139
Timed Vital Capacity: 1 sec.(in % VC)	85%	86%	> 75
3 sec.(in % VC)	96%	94%	> 95
Forced Expiratory Vol. 1 sec.(FEV_1)	3085 (98%)	2994 (95%)	3150
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	5.5 (129%)	5.2 (120%)	4.3 ± 1.3
Peak Expiratory Flow Rate in L/min.	562 (105%)	635 (119%)	536
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		20.2 (110%)	26.2

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				95%
Oxygen Tension (Pa_{O_2}) in mmHg				80-100
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35-45
pH				7.35-7.
Interpretation:				

November 8, 1974

R. F. Peters, M. D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

Re: [redacted]

Dear Dr. Peters:

[redacted] was evaluated in our office and laboratory on October 30, 1974, with the following results:

This 54-year-old man has worked as a pipefitter for the Dravo Corporation at the Hooker plant site in Taft, Louisiana, for the past ten months. He indicates that he has had periodic chlorine gas exposures for two months, primarily since the wind has been coming from the north. His most significant exposure was apparently six days ago, when he put on his respirator and left the area. He developed chest burning, cough productive of mucoid sputum, shortness of breath, wheezing, and burning of the eyes. His symptoms were most prominent two to three hours later, and he remained off work for two days. He indicates that it is his opinion that the exposures have not been to only chlorine, since he worked at the Hooker plant periodically for the past five or six years, without difficulty. His respiratory symptoms have now improved, but he still has a productive cough and some exertional dyspnea associated with "congestion". He denies caronic cough, wheezing, and previous shortness of breath, and respiratory infections have been infrequent. There is no history of high blood pressure, diabetes, tuberculosis, pneumonia, asthma, hay fever or allergies. He was recently told that he has cardiac enlargement. There has been no edema. He has had anginal symptoms for the past eight years and a questionable history of rheumatic heart disease. He carries nitroglycerine tablets, but rarely uses them. He lives an active life, and his weight is stable. He has never smoked cigarettes. Past history includes surgery for diverticulosis, and an appendectomy.

On physical examination, this is a well-developed, well-nourished man who does not appear acutely or chronically ill. Blood pressure is 160/104, pulse 84. Examination of the ears, eyes, nose and throat is not remarkable. Examination of the chest reveals adequate thoracic expansion, with slight delay of the expiratory phase, and end-expiratory wheezes, brought out by deep, forced breathing. No inspiratory crackles are heard. Examination of the heart reveals a loud, harsh, systolic murmur over the entire precordium, most prominent at the left lower sternal border. Abdominal palpation is negative. There is no edema or clubbing of the extremities.

An EPA of the chest reveals that the cardiac silhouette is within normal limits in regard to size, with a cardio-thoracic ratio of 16:34. A small, round nodular density overlying the right sixth anterior rib is thought to be a nipple shadow, but probably this should be brought to the attention of the patient's physician and perhaps an oblique chest film should be performed to rule out the possibility of a small intrapulmonary lesion. The lung fields are otherwise not remarkable. An electrocardiogram reveals a low T-wave in lead I, with inversion of the T-wave in leads II and V6, the latter also demonstrating straightening of the ST-segment. The tracing is abnormal and strongly suggests coronary artery disease.

Studies of pulmonary function were performed. Lung volume measurements, including total lung capacity and vital capacity, are normal, with slight increase in residual volume and residual volume to total lung capacity ratio, indicating a mild degree of hyperinflation. Significant air flow obstruction is not demonstrated, as indicated by normal values for maximum breathing capacity, timed vital capacity, forced expiratory volume, forced expiratory flow, 25-75, and peak expiratory flow rate. The pulmonary diffusing capacity is normal. In summary, there is no significant impairment of lung function.

Although this patient has exhibited symptoms of an acute irritative effect from gas or vapor exposure, he seems to have had significant improvement of these symptoms, and at present demonstrates no evidence of lower respiratory disease or functional impairment. Obviously, further exposures to an irritant gas are likely to be associated with recurrence of these symptoms. Hypertension is noted, and an abnormal electrocardiogram is associated with probable angina pectoris. It would appear that this patient's primary

November 8, 1974

medical problems are related to the cardiovascular system, although these have not produced significant functional impairment.

Thank you for asking us to evaluate [redacted] there are points that I can clarify, please let me know.

Sincerely yours,

Hans Weill, M.D.

HW/pat

cc: Dr. Wilson Couch
Mr. George Morales

TULANE PULMONARY FUNCTION LABORATORY
ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. _____ Date 10/30/74

Age _____ Sex _____ Diagnosis _____

Height _____ Weight 155 BSA _____ Ward _____

LUNG VOLUMES AND CAPACITY	Observed	After Broncho-dilator	Predi ur No
Vital Capacity (VC) in mls.	4035 (131%)	4012 (130%)	3080
Inspiratory Capacity (IC) in mls.	3762	3914	
Expiratory Reserve Volume (ERV) in mls.	273	634	
Functional Residual Capacity(FRC) in mls.		3272 (154%)	2113
Thoracic Gas Volume(at FRC) in mls.		3012	
Residual Volume (RV) in mls.		2373 (155%)	1536
Total Lung Capacity (TLC) in mls.		7038 (137%)	5200
RV/TLC x 100		34%	29%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	149 (122%)	156 (128%)	122
Timed Vital Capacity: 1 sec.(in % VC)	79%	79%	>
3 sec.(in % VC)	94%	93%	>
Forced Expiratory Vol. 1 sec.(FEV_1)	3650 (133%)	3672 (134%)	2750
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	3.5 (98%)	3.3 (93%)	3.6 ±
Peak Expiratory Flow Rate in L/min.	555 (110%)	600 (119%)	503
Airway Resistance in cm H_2O/L./sec.		2.8	
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		30.0 (133%)	22.6

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				9
Oxygen Tension (Pa_{O_2}) in mmHg				80-1
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35-
pH				7.35

Impression:

October 28, 1974

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

RE: [redacted]

Dear Dr. Peters:

This 25-year-old man has worked as a welder for the Dravo Corporation at the Hooker plant site for the past five months. He indicates that on September 5, 1974, there was a chlorine emission from which he was downwind, and was exposed to this irritant gas for approximately one hour. He feels that there may also have been acid fumes in the environment at that time. His symptoms consist of shortness of breath, rhinorrhea, burning of the eyes, sore throat, chest tightness, and wheezing. There was no visible gas cloud, but a strong odor was apparent. The patient went to the company nurse, then to a private physician, and was off of work for two days. His respiratory symptoms persisted for approximately one and one-half weeks. He had another exposure to an irritant gas in late September with the same symptoms, which lasted approximately two weeks, although he continued working. Two weeks ago, another spill apparently occurred, and he experienced chest tightness and shortness of breath, and was off work for seven days. The patient indicates that he just returned to work yesterday. He feels well now, and his only complaint is occasional nasal obstruction. He specifically denies shortness of breath, wheezing, chest tightness, chest pain, or cough at present. There is no history of asthma, hay fever, or allergy, and the patient has never smoked cigarettes. Respiratory infections are infrequent. His past history includes only a tonsillectomy.

On physical examination, this is a well-developed, well-nourished young man, who does not appear acutely or chronically ill. Blood pressure 122/86, pulse 76. There is slight reddening and swelling of the nasal mucosa. Examination of the pharynx is negative. Examination of the chest reveals adequate thoracic expansion, without delay of the expiratory phase. No crackles or wheezes are heard. No cardiac abnormalities are detected. Abdominal palpation is negative. There is no edema or clubbing of the extremities.

Report: [redacted]
Page 2
October 28, 1974

A chest x-ray film reveals a normal cardiac silhouette with clear lung fields. An electrocardiogram fails to reveal evidence of myocardial disease.

Pulmonary function studies were performed. Lung volumes, including vital capacity, and total lung capacity are normal, with very slight increase in residual volume, and residual volume to total lung capacity ratio, indicating possible mild hyperinflation. The maximum breathing capacity is at the lower limit of normal, but the absence of air flow obstruction is indicated by normal values for timed vital capacity, forced expiratory volume, forced expiratory flow 25-75, and peak expiratory flow rate. The pulmonary diffusing capacity is normal, and indicates the lack of alveolar gas transfer impairment.

Although this young man undoubtedly has had several acute exposures to an irritant gas, presumably including chlorine, upper and lower respiratory symptoms, which were associated with these exposures, have, for the most part, resolved with only mild nasal symptoms persisting at this time. Specifically, there is no evidence of lower respiratory disease, either on the basic of clinical or pulmonary functional evidence. In the absence of further recurrent irritant gas exposures, one would not anticipate any residual respiratory problems.

Sincerely yours,

Hans Weill, M.D.

HW/kas
cc: Mr. George Morales
Dr. Wilson Couch

ROOM 7560, HUTCHINSON BUILDING

Name [redacted] Unit No. Dr. W. P.P. Date 10/25/71

Age 26 Sex M Diagnosis

Height [illegible] Weight [illegible] BSA Ward

	Observed	After Broncho-dilator	Pre or
LUNG VOLUMES AND CAPACITY			
Vital Capacity (VC) in mls.	[illegible]	[illegible]	[illegible]
Inspiratory Capacity (IC) in mls.	[illegible]	[illegible]	
Expiratory Reserve Volume (ERV) in mls.	[illegible]	[illegible]	
Functional Residual Capacity(FRC) in mls.		[illegible]	
Thoracic Gas Volume(at FRC) in mls.		[illegible]	
Residual Volume (RV) in mls.		[illegible]	
Total Lung Capacity (TLC) in mls.		[illegible]	
RV/TLC x 100		[illegible]	
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity(MBC) in L/min.	[illegible]	[illegible]	
Timed Vital Capacity: 1 sec.(in % VC)	[illegible]	[illegible]	
3 sec.(in % VC)	[illegible]	[illegible]	
Forced Expiratory Vol. 1 sec.(FEV_1)	[illegible]	[illegible]	
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	[illegible]	[illegible]	
Peak Expiratory Flow Rate in L/min.	[illegible]	[illegible]	
Airway Resistance in cm H_2O/L./sec.	[illegible]	[illegible]	
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion ($D_{L_{CO}}$) in mls/min/mmHg(CO)		[illegible]	
ARTERIAL BLOOD	Rest	Exercise	
Oxygen Saturation (Sa_{O_2}) in %			
Oxygen Tension (Pa_{O_2}) in mmHg			80-
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg			35
pH			7.3
Impressions			

He had pneumonia six years ago, and during childhood. There have been no surgical procedures.

Physical examination reveals a well-developed, moderately obese man who does not appear acutely or chronically ill. The blood pressure is 210/126, and pulse 75. Artificial dentures are noted. Examination of the chest reveals adequate thoracic expansion without delay of the expiratory phase. Breath sounds are slightly coarse. No wheezes or crackles are heard. Examination of the heart reveals a grade II/VI systolic murmur at the upper left sternal border. Abdominal palpation is negative; there is no edema or clubbing of the extremities.

A chest x-ray film reveals important cardiac enlargement with a cardio-thoracic ratio of 19:35. The cardiac silhouette suggests left ventricular enlargement. The lung fields are clear. An electrocardiogram reveals left axis deviation with low to flat T-waves in leads I, AVL, and over the left precordium. There is poor progression of R-waves in the precordial leads and the tracing is suggestive of myocardial disease.

Studies of pulmonary function were performed and reveal normal lung volumes including total lung capacity, vital capacity, and residual volume. There is slight increase in the residual volume to total lung capacity ratio. There is minimal reduction of the maximum breathing capacity, timed vital capacity, and forced expiratory flow 25-75, with normal values for forced expiratory volume, and peak expiratory flow rate. Very mild obstructive ventilatory impairment is indicated, without significant improvement of air flow after bronchodilator inhalation. The pulmonary diffusing capacity is normal and indicates adequate total alveolar gas transfer.

This patient has had several acute exposures to an irritant gas or gases, which have resulted primarily in acute upper and lower respiratory symptoms. During the second episode, a superimposed infection may have been present and was treated with antibiotics. His job location was changed three weeks ago, and since that time he relates that symptoms have completely resolved, and he now considers himself asymptomatic. Pulmonary function studies indicate very mild airways obstruction, which could be primarily related to the long history of heavy cigarette smoking. At any rate, the degree of functional impairment demonstrated would ordinarily not be expected to result in significant respiratory symptoms or exercise intolerance. Of greater medical importance is the demonstration of severe hypertension and marked cardiac enlargement, which should be brought to the attention of the patient's physician.

In the absence of further irritant gas exposure, a residual adverse effect on the lungs or airways is not anticipated.

Thank you for referring [redacted] for this evaluation. If I can clarify or expand on any of the above, please let me know.

Sincerely yours,

Hans Weill, M.D.

TULANE PULMONARY FUNCTION LABORATORY
ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. Legal Dr. W. Date 10/18/74

Age 27 Sex [illegible] Diagnosis

Height 70 3/4" Weight 233 1/2 BSA Ward

	Observed	After Broncho-dilator	Predi... or Nor...
LUNG VOLUMES AND CAPACITY			
Vital Capacity (VC) in mls.	4232 (90%)	4120 (87%)	4770
Inspiratory Capacity (IC) in mls.	3582	3532	
Expiratory Reserve Volume (ERV) in mls.	650	588	
Functional Residual Capacity (FRC) in mls.		2370 (104%)	2750
Thoracic Gas Volume (at FRC) in mls.			
Residual Volume (RV) in mls.		2027 (114%)	1780
Total Lung Capacity (TLC) in mls.		6250 (95%)	6600
RV/TLC x 100		32%	26%
MECHANICS OF RESPIRATION			
Maximum Breathing Capacity (MBC) in L/min.	110 (70%)	112 (72%)	154
Timed Vital Capacity: 1 sec. (in % VC)	72%	72%	>
3 sec. (in % VC)	85%	85%	>
Forced Expiratory Vol. 1 sec. (FEV_1)	3067 (84%)	3045 (83%)	3660
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	2.8 (66%)	3.2 (76%)	4.3 ± 1
Peak Expiratory Flow Rate in L/min.	530 (100%)	580 (100%)	578
Airway Resistance in cm H_2O/L./sec.			
PULMONARY GAS EXCHANGE			
Pulmonary Diffusion ($D_{L_{CO}}$) in mls/min/mmHg (CO)		32.9 (109%)	30.2

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (Sa_{O_2}) in %				9[illegible]
Oxygen Tension (Pa_{O_2}) in mmHg				80-10[illegible]
Carbon Dioxide Tension (Pa_{CO_2}) in mmHg				35-[illegible]
pH				7.35-[illegible]

Impression:

October 25, 1971

R. F. Peters, M.D.
Dravo Corporation
Neville Island
Pittsburgh, Pennsylvania 15225

RE: [redacted]

Dear Dr. Peters:

This 33 year-old construction foreman for the Dravo Corporation has been employed at the Hooker Chemical Company plant site for the past three months, and indicates that during August and September he experienced approximately three irritant gas exposures, at which times he was downwind from the emission source. Symptoms included burning and watering of the eyes, nasal irritation, sore chest, slight cough, and nausea. These symptoms have recurred during each of the gas exposures. He was seen and treated by Dr. Couch, and, since these episodes, indicates that nocturnal wheezing, shortness of breath, and cough have been present, and generally occur between 1:30 and 3:00 a.m. His sputum is mucoid in character, and there are continuing bronchial secretions, as well as rhinorrhea. Wheezing and shortness of breath, however, have improved during the past week. The patient indicates that he had bronchial asthma between the ages of 5 and 17, but there is no history of hay fever. Allergy workup revealed hypersensitivity to shellfish and house dust, and the patient has a family history of atopic disease. He has never smoked cigarettes regularly. At present, his exercise tolerance has improved since the exertional dyspnea experienced one to two months ago. There is a vague "pressure sensation" over the left anterior chest, but this, apparently, is not very severe. Respiratory infections are infrequent, and there is no history of heart disease, high blood pressure, diabetes, tuberculosis, or pneumonia.

On physical examination, this is a well-developed, well-nourished young man who does not appear acutely or chronically ill. Blood pressure is 110/78, pulse 72. Examination of the ears, eyes, nose, and throat reveals mucus on the posterior pharyngeal wall. Examination of the chest reveals adequate thoracic expansion, without delay of the expiratory phase. A few scattered expiratory wheezes are brough out only by deep forced breathing. No crackles are heard. No cardiac abnormalities are detected. Abdominal palpation is negative. There is no edema or clubbing of the extremities.

An LPA chest x-ray reveals a normal cardiac silhouette with clear lung fields. An electrocardiogram fails to reveal evidence of myocardial disease.

Studies of pulmonary function were performed. Lung volumes, including total lung capacity, vital capacity, and residual volume are normal, without evidence of hyperinflation. The maximum breathing capacity, forced expiratory volume, and peak expiratory flow rate are all entirely normal with very slight reduction of the timed vital capacity and a low normal value for forced expiratory flow 25-75. Minimal air flow obstruction is demonstrated with complete reversibility after the inhalation of a bronchodilator aerosol. The increase in pulmonary diffusing capacity indicates adequate alveolar gas transfer and is seen frequently in patients with bronchial asthma.

This young man has a history of asthma and such patients characteristicly maintain hyper-reactivity of the bronchial tree. It is not unexpected, therefore, that an irritant gas exposure would produce episodes of bronchial spasm, including those that he has had during the night since a "late" constrictor response is seen frequently. He seems to be improving recently, apparently seen there have been no gas exposures during the period of clinical improvement. Only very mild reversible airways obstruction is demonstrated and this degree of functional change would not be expected to interfere with exercise tolerance or be associated with significant symptoms. In conclusion, therefore, the present condition of his airways is good, and there is no reason to expect any residual changes associated with the irritant gas exposures of last month. Obviously, recurrent exposure to irritant inhalants can again be expected to produce a bronchial constrictor effect.

Thank you for referring [redacted] for this evaluation.

Sincerely yours,

Hans Weill, M.D.

HW/kr
cc: Mr. George Morales
Dr. Wilson Couch

TULANE PULMONARY FUNCTION LABORATORY
ROOM 7550, HUTCHINSON BUILDING

Name [redacted] Unit No. [illegible] Date 10/2?/7?

Age [illegible] Sex M-W Diagnosis

Height 70.5" Weight [illegible] BSA Ward

LUNG VOLUMES AND CAPACITY	Observed	After Broncho-dilator	Pred or N[illegible]
Vital Capacity (VC) in mls.			
Inspiratory Capacity (IC) in mls.	6269 (124%)	6493 (128%)	5970
Expiratory Reserve Volume (ERV) in mls.	4???	4522	
Functional Residual Capacity (FRC) in mls.	1223	1970	
Thoracic Gas Volume (at FRC) in mls.		3621 (131%)	2770
Residual Volume (RV) in mls.			
Total Lung Capacity (TLC) in mls.		1765 (109%)	1620
RV/TLC x 100		8258 (124%)	6650?
		21%	24%

MECHANICS OF RESPIRATION	Observed	After Broncho-dilator	Pred or N[illegible]
Maximum Breathing Capacity (MBC) in L/min.			
Timed Vital Capacity: 1 sec. (in % VC)	200 (114%)	210 (119%)	176
3 sec. (in % VC)	74%	79%	>
Forced Expiratory Vol. 1 sec. (FEV_1)	92%	94%	>
Forced Expiratory Flow (25%-75%) (FEF_{25-75}) L/sec.	4836 (119%)	5105 (125%)	4080
Peak Expiratory Flow Rate in L/min.	3.8 (93%)	4.7 (102%)	4.6 ±
Airway Resistance in cm H_2O/L./sec.	630 (102%)	630 (102%)	620

PULMONARY GAS EXCHANGE	Observed	After Broncho-dilator	Pred or N[illegible]
Pulmonary Diffusion (D_{LCO}) in mls/min/mmHg(CO)		48.9 (123%)	34.1

ARTERIAL BLOOD	Rest	Exercise		
Oxygen Saturation (SaO_2) in %				
Oxygen Tension (PaO_2) in mmHg				95
Carbon Dioxide Tension ($PaCO_2$) in mmHg				80-100
pH				35-4[illegible]
Impression:				7.35-[illegible]

Metairie, Louisiana 70053
(504) 362-4058

June 26,1975

1430 Tulane Avenue
New Orleans, Louisiana
(504) 588-5451

vol III
after Pearson report
by Martin

Koerner & Babst
730 Camp Street
New Orleans, Louisiana 70130

RE: [redacted]

Dear Sirs:

[redacted] 48 years old, was examined by me on May 23,1975, with a histo of having been exposed to chlorine gas while working at Hooker Chemical Plan in November, 1974. Mr. Nevels stated that he experienced nausea and vomitin and hemoptysis for two days following the exposure, and was short of breath for one week after the exposure. He stated that his taste was virtually absent for about one month follwing the chlorine gas exposure, but then he experienced a gradual return of taste. He stated that he was "tired all the time" for six months following the exposure. Mr. Nevels stated that at the time of my examination, he required copious amounts of salt to appreciate the taste of salt, and that sugar had a unpleasant taste.

[redacted] stated that he was subjective to a diagnostic work up at Methodist Hospital, New Orleans, in 1975, which disclose no significant abnormalities.

Physical examination of the head and neck was essentially within normal limit

Testing with the electrogustometer demonstrated perception of a taste sensati on both sides of the tongue, with slightly lower thresholds on the right side of the tongue. The taste of salt was appreciated only in the pharynx, not on the tongue. Vinegar was perceived as "faintly sour". Oil of peppermint was perceived along the edges of the tongue. Sugar was perceived on both sides of the tongue. Oil of cloves was identified along the left border of the ton

On the basis of this examination [redacted] appears to have an impairment of taste approximately 20 percent. This should not impair his physical abilities

Sincerely,

TMI: smp

Thomas M. Irwin Jr., M.D

(Con) Exhibit F

Harry L. [illegible]colough, M.D.

From (Attending Physician):

Donald J. Palmisano, M.D.

Urgent ☐
Elective ☐

1. Findings

2. Request

3. Signature _____ M.D.

Date:

1. Findings and diagnosis
2. Recommendations
3. Signature

CONSULTANT'S REPORT

This patient is a 48 year old, white male, admitted to the hospital w history of epigastric pain of short duration with nausea and vomiting The patient was admitted by Dr. Palmisano and I was asked to see him consultation because of a reported abnormal electrocardiogram.

The patient's workup thus far has included that the patient had an IV cholangiogram which after intravenous injection of the dye showed a normal common duct. delayed film however failed to show any significant opacification in the gallbladder it

The rest of the patient's workup thus far has shown a slight leukocyt of 10,600. The patient at this time is having moderate upper abdominal pain. The seru amylase is within normal limits, at 68. There is no hyperbilirubinemia and the alkalin phosphatase is within normal limits. The patient's original electrocardiogram showed a normal sinus rhythm to be present and a PR interval of 0.08 seconds, there was a small S wave in standard lead 1, and RS prime pattern in lead V1. This electrocardiogram, in my opinion is within normal limits, after having examined this patient and gone over hi history with him, I find no evidence of acute right ventricular overload or atrial sep defect. Please see below.

The patient has been in generally good health most all of his life ar had no previous serious medical or surgical diseases. He denies any previous past hist of heart disease of any sort, rheumatic fever, congestive heart failure, tachycardia, orthopnea, dyspnea, cyanosis, or angina pectoris. The patient works in construction ar done heavy labor most all of his life. He has done this without any significant proble serious physical difficulty. No cardiac related problems. No past history of heart m Patient is overweight by approximately 10-15 lbs. The patient has had no signs and s of hiatal hernia or previous gallbladder problem prior to this time. He was, however, admitted with a tentative diagnosis of biliary colic. The pain came on rapidly and in to maximum intensity rapidly and showed no definite colicky nature. The patient's past history is pertinent only in that he had renal stones approximately 15 years ago, was hospitalized for these, no past history of high blood pressure, diabetes, or other maj medical problems. Electrocardiogram interpreted on 2-24-75 by Dr. Edmonson indicated

CONT...

SIGNATURE: _____ M.D.

NAME [redacted] LAST [redacted] FIRST	HOSP. NO. 59809
ADM. TO SERVICE OF: DR. PALMISANO	ROOM NO 220C

CONSULTATION

Harry L. Colcolough, M.D.
From (Attending Physician):

Urgent ☐
Elective ☐

Donald J. Palmisano, M.D.

1. Findings & Impressions

2. Request

3. Signature _____ M.D.

Date:

1. Findings and diagnosis
2. Recommendations
3. Signature

PAGE 2

CONSULTANT'S REPORT

patient had an incomplete right bundle branch block with a QRS interval of 0.08 seconds. Otherwise, the electrocardiogram is within normal limits.

In view of the above lack of history of any significant heart disease, and in view of the fact that the patient has a cardiac shadow within normal limits, I feel there is no evidence at this time of significant cardiac disease. It is debated of whether the 0.08 seconds of the QRS complex is sufficient to indicate that this patient does have a right bundle branch block pattern. I would interpret this cardiogram as within normal limits for this patient and probably represents a normal variant. A repeat electrocardiogr has been requested, and again the QRS complexes are 0.08 seconds in duration. There is persistent S wave in V4, 5, and 6. A single PVC is present.

Physical examination of the patient at this time reveals normal developed white male, in no acute distress. The cardiac examination shows a normal sinus rhythm with no thrusts or heaves present, no opening snap, diastolic rumble, or gallop rhythm. The second sound splits normally without fixing. It has normal variation with respirations. I could find no evidence on physical examination at this time of a significant atrial septal defect.

Patient is desirous to go home and I feel that there is no evidence at this time of significant cardiac disease.

FINAL IMPRESSIONS: 1. Borderline electrocardiogram, showing possible incomplete right bundle branch block vs. normal variant. 2. Biliary colic with disease to gallbladder.

H.L. Colcolough M.D.

SIGNATURE: HARRY L. COLCOLOUGH, M.D. M.D.

HLC/dl
2/27/75

NAME LAST [redacted] FIRST [redacted]
HOSP. NO. 59809
ADM. TO SERVICE OF DR. PALMISANO
ROOM NO. 220C

CONSULTATION

DATE: 2/26/75

ORDER OF RECORDING

1. Chief complaint and present illness
2. Pertinent lab., x-ray & P.X. findings
3. Treatment
4. Condition on discharge
5. Disposition
6. Medications
7. Signature

This patient is a 48 year old, white male, admitted to the hospital with a tentative diagnosis of biliary tract disease. IV cholangiogram showed a normally appearing common duct and no opacification of the gallbladder at 2 hours. This is felt to represent definite evidence of gallbladder disease. was asked to see the patient in consultation because of the possibility of an abnormal electrocardiogram. The cardiogram is borderline at rest. In my opinion, it does represent a normal variant. The PR interval is at the upper limits of normal. A normal sinus rhythm is present. Original interpretation had indicated acute right heart strain, however, there is no evidence of this at this time and historical evaluation fails to demonstrate any evid of atrial septal defect or significant venous disease or pulmonary emboli.

Patient is desirous to go home at this time. His initial abdominal pain has resolved at this time, and Dr. Palmisano has indicated that he will release patient to home.

FINAL DIAGNOSIS: 1. Borderline abnormal electrocardiogram with possible incomplete right bundle branch block vs. normal variant. 2. Gallbladder disease with biliary colic. 3. Hypertension, labile.

ADDENDUM: The patient had a cardiac enzyme series done and the CPK, SGOT, and LDH were within normal limits. Multiple views of the chest with barium in the esophagus showed the cardiac silhouette to be moderately enlarged wit a CT ratio of 19 to 33.5 cm. Enlargement appeared to be generalized without any specific chamber enlargement. The arorta is somewhat elongated and compatible with hypertension. The patient, however, does not have hypertension on a clinical basis at this time.

Oral cholecystogram failed to visualize. Review of the patient's chart does indicate that there is borderline high values in the blood pressure, s values ranging in the 140-100 range, and the highest value recorded was 182/120 just after admission. This subsequently drops to 140/86 and 120/80 prior to discharge. The patient does seem to have a rather hyperkinetic type of personality, and there is probably an underlying element of tension anxiety with resulting labile hypertension.

H. L. Colcolough, M.D.

HARRY L. COLCOLOUGH, M.D.

HLC/dl
2/27/75

NAME: LAST [redacted] FIRST [redacted] HOSP. N 59809

ADM. TO SERVICE OF: DR. COLCOLOUGH ROOM N 22

DISCHARGE SUMMARY

DATE: 2/24/75

ORDER OF RECORDING

1. Chief complaint and present illness
2. Pertinent lab., x-ray & P.X. findings
3. Treatment
4. Condition on discharge
5. Disposition
6. Medications
7. Signature

[redacted] is a 48 year old man who was admitted to Methodist Hospi by me on 2/24/75 with acute abdominal pain requiring narcotics to relieve pain. It was in the epigastrium, right upper quadrant region. The patien later became asymptomatic with medication including Atropine. Workup included IV cholangiogram which showed a visualization of the common bile du but no visualization of the gall bladder with delayed films. This is diag nostic of gall bladder disease. A follow-up oral cholecystogram also fail to visualize the gall bladder. The patient has become asymptomatic in the hospital. His EKG was interpreted as normal. Dr. Colcolough, cardiologis was consulted to see him after evaluation. Dr. Colcolough concluded that the EKG was consistent with the patient's habitus and found a normal cardi status. The patient is anxious to go home. I have explained to him in al liklihood that he has a diseased gall bladder and I would recommend removal of his gall bladder. However, he is anxious to go home and states that he has business affairs to attend to and that he will follow-up with me in my office. I have given him a low fat diet and he has no fever and his white count is not elevated at this time. Therefore, he is not placed on antibiotics at this time.

DONALD J. PALMISANO M.D.

DJP/tl
t: 2/27/75

CC: Dr. Colcolough

NAME: [redacted] LAST FIRST

HOSP. NO 59809

ADM. TO SERVICE OF: DR. PALMISANO

ROOM NO 22

DISCHARGE SUMMARY

From (Attending Physician) Dr D Palmisano

Elective

1. Findings Abnormal EKG

2. Request Evaluate Cardiac Status / See EKG Report

3. Signature Dr D Palmisano / KK

Date:

CONSULTANT'S REPORT

1. Findings and diagnosis
2. Recommendations
3. Signature

48 yo WM admitted c hx of epigastric pain of short duration. Pt denies any previous hx of chest disease, [illegible] tachycardia, No CHF. Works at construction with heavy labor s previous difficulty. No hx of heart murmurs. Overweight 10-15 yrs. No S+S of hiatal hernia or GB problem. Pain max intensity after brief build up & short no colicky nature.

No hx of ARF, arthritis, kidney problems except stones (15 yrs) ago.

EKG - RSR' V_1, S - V_4-V_5. EKG consistent c pts habitus. Cor - NSR, no thrills or heaves, no OS diastolic rumble, no gallop. S_2 splits normally s fix. No evidence physically of ASD

Dx: Normal cardiac status & EKG

Rx: cardiac series & serial EKG's & enzymes

SIGNATURE: ______ M.D.

[illegible] drinks

[illegible] health good

ABP

[illegible]

RBBB

NAME	LAST	FIRST	HOSP. NO.
	[redacted]	[redacted]	2159?090
ADM. TO SERVICE OF: DR.	Palmisano		ROOM NO. 226

CONSULTATION

METHODIST HOSPITAL • NEW ORLEANS, LA.

ORDER OF RECORDING

1. Chief Complaint
2. Present Illness
3. Past History
   a. childhood
   b. adult
   c. operations
   d. injuries
   e. drugs
4. Allergies
5. Family History
6. Social History
7. System Review
   a. general
   b. skin
   c. head-eyes-ears-nose-throat
   d. neck
   e. respiratory
   f. cardiovascular
   g. gastro-intestinal
   h. genito-urinary
   i. gynecological
   j. musculo-skeletal
   k. neurological & psychiatric
8. Signature

DATE 2/25

CC: Severe abdominal pain.

PI: This 48 year old man states that he was awakened at 4 thi morning with severe epigastric pain. The pain has been c tinuous and makes the man feel as though he wants to move around rather t stay still. In the Emergency Room, he was seen by Dr. Roy, the emergency room physician. He required 2 shots of Demerol, 75 mg. each, to relieve the pain. Dr. Roy evaluated the man and consulted me to evaluate him further for the etiology of the abdominal pain. The man's urinalysis sho 0-2 red cells, 0-2 white cells. His white cell count is 10.600 with 81% segs. On examination at this time, the abdomen is soft. He says he stil continues with deep pain although it is better now that he has received the medication. He says he has not been ill before, he does not have a regular doctor. He has had no operations. He has no history of distress with foods in the past. He states he eats any type of foods.

PH: c. None.
d. None.
No history of bleeding disease. No asthma or hay fever.

ALLERG: None.

SR: HEAD: No headaches.
EYES: No difficulty with vision.
EARS: No difficulty with hearing.
HEART: No history of heart disease, angina or chest pain.
LUNGS: No history of recent infection or chronic cough.
GU: No dysuria or nocturia.
NEURO: No history of convulsions.

DONALD J. PALMISANO, M.D.

DJP/tl
t: 2/24/75

NAME: LAST [redacted] FIRST [redacted]
HOSP. 398
ADM. TO SERVICE OF:
DR. PALMISANO
ROOM 220
HISTORY

ORDER OF RECORDING

1. General appearance and vital signs
2. Skin
3. Eyes
4. Ears, Nose and Throat
5. Neck
6. Chest
7. Breasts
8. Heart
9. Lungs
10. Abdomen
11. Genitalia
12. Lymphatics
13. Blood vessels
14. Back
15. Extremities
16. Musculo-skeletal
17. Neurological
18. Rectal
19. Vaginal
20. Provisional diagnosis
21. Signature

DATE 2/24/75

GEN: Well nourished, large, overweight man with blood pressu 210/150, pulse 88, respirations 20, weight 260 lb; height 5'9".

HEAD: Normal cephalic.
EYES: No icterus.
EARS: No drainage.
NECK: No masses.

LUNGS: Clear to auscultation.

HEART: Normal sinus rhythm. No murmurs.

LUNGS: Clear to auscultation.

ABDOMEN: Soft. No masses noted. Appears to have a midline eventration of bowel stasis.

GENITALIA: Testes present.

EXTREM: Scattered varicose veins and palpable dorsalis pedis pulses.

RECTAL: Not done at this time.

PD: Abdominal pain, etiology undetermined. R/O pancreatitis. R/O biliary tract disease, etc. Hypertension.

DONALD J. PALMISANO, M.D.

DJP/tl
t: 2/24/75

NAME [redacted] FIRST HOS 59

ADM. TO SERVICE OF: DR. PALMISANO ROO 22

PHYSICAL EXAMINATION

[redacted] 5-75-7 94 2/24/75

CHEMISTRY

BSP 0-5	%	GLUCOSE 65-105	mg.	NORMAL	RESULT
BILIRUBIN TOTAL TO 1.5	mg.	2 HR. P.P. GLUCOSE	mg.	SODIUM 135-150	MEQ
DIRECT 0.1-0.3	mg.	LIPASE 0-1	UNITS	OSMOLALITY 285-295 osm	UNITS
BUN 5-26	mg.	BETA LIPOPROTEINS	mg.	SGGT 5-37	UNITS
CALCIUM 4.4-5.2	MEQ	PHOSPHATASE ACID .0-2	UNITS	SGOT 5-19	UNITS
CO_2 (Content) 26-27	MEQ	PHOSPHATASE ALK. 85-235	UNITS	SGPT 4-24	UNITS
CHLORIDE 95-103	MEQ	PHOSPHORUS 2.5-4.5	mg.	URIC ACID 3-7	mg.
CHOLESTEROL	mg.	POTASSIUM 3.8-5.0	MEQ	TRIGLYCERIDE 74-172	mg.
CREATININE 0.5-2.0	mg.	LIVER BATTERY ALSO SEND SPECIAL CHEMISTRY SLIP		IRON 65-185	μg.
				BIND. CAP 300-350	μg.

DATE TO BE DONE — ELECTIVE / DRAW STAT / DO STAT
REQUESTED BY — DATE DONE 2/24/75 — PERFORMED BY GW — PICKED BY
080

LDH 29-92 — LDH ISOENZYMES

4031 J. BYERS, M.D. & H. ICHINOSE, M.D. PATHOLOGISTS — CHEMISTRY

METHODIST HOSPITAL NEW ORLEANS, LA.

PATIENT'S CHART

URINALYSIS

☒ URINALYSIS ☐ CATHETERIZED
☐ VOIDED ☒ CLEAN VOIDED

1116661 [redacted]

5-75-794-3
2-24-74

COLOR		PSP	
SP. GRAVITY	1.021	15 MIN	cc %
BLOOD	0	30 MIN	cc %
KETONES	0	TOTAL	cc %
GLUCOSE	0	UCG (PREGNANCY TEST)	
PROTEIN	0	SPERM COUNT	
REACTION	Acid	GASTRIC ANALYSIS	
BILIRUBINURIA	0		

FEB 24 8 58 A 75

DATE TO BE DONE — ELECTIVE / DRAW STAT / DO STAT
REQUESTED BY — DATE DONE 2-24 — PERFORMED BY CB — PICKED BY
085

SEDIMENT: 2-2 RBC's
2-3 WBC's
/H.P.F.

URINALYSIS - GASTRIC - PSP - UCG

4081 JOHN F. BYERS, M.D., H. ICHINOSE, M.D. PATHOLOGISTS — URINALYSIS

METHODIST HOSPITAL NEW ORLEANS, LA.

PATIENT'S CHART

HEMATOLOGY

☒ CBC STAT

1116659 [redacted]

5-75-794-3
2-24-74

WBC	10,600 cumm	DIFF		EOS COUNT	
Hct	42.0 %	MYEL		RETIC COUNT 0.5-1.5	%
Hgb	14.3 gm	META		MALARIA SMEAR	
RBC	5.31 /cumm	BAND		SICKLE CELL	
INDICES		SEG	81	OS FRAGILITY	
MCV 82-92	78 cu	LYMPH	15		
MCH 27-31	26.6 μμg	MONO	2		
MCHC 32-40	33.8 %	EOS	2		
SED RATE	mm/hr.	BASO			
MEN 0-10		NRC 100/100			
WOMEN 0-20					
CHILDREN 0-15					
LE PREP		ALK. PHOSPHATASE STAIN			
PLATELET CT appear adequate					
130,000-250,000 /cumm		G-6-PD			

FEB 24 27 A 75

DATE TO BE DONE — ELECTIVE / DRAW STAT / DO STAT
REQUESTED BY — DATE DONE 2-24-75 — PERFORMED BY
082

MORPHOLOGY:

4051 JOHN F. BYERS, M.D. PATHOLOGIST — H. ICHINOSE, M.D. [redacted] HEMATOLOGY

METHODIST HOSPITAL NEW ORLEANS, LA.

NAME [redacted] 575

ADMITTED SERVICE OF: ROOM
DR. H K Ray

LABORATORY REPORTS

2/25

0114925

459809 [redacted]
DR. PALMISANO, ET AL

CHEMISTRY

NORMAL	RESULT	NORMAL	RESULT	NORMAL	RESULT
AMYLASE 60-160	UNITS	CPK 0-70	54 UNITS	SODIUM 135-150	MEQ
BSP 0-5	%	GLUCOSE 65-105	mg.	OSMOLALITY 285-295 osm	UNITS
BILIRUBIN TOTAL TO 1.5	mg.	2 HR. P.P. GLUCOSE	mg.	SGGT 5-37	UNITS
DIRECT 0.1-0.3	mg.	LIPASE 0-1	UNITS	SGOT 5-19	14 UNITS
BUN 5-25	mg.	BETA LIPOPROTEINS	mg.	SGPT 4-24	UNITS
CALCIUM 4.4-5.2	MEQ	PHOSPHATASE ACID 0-2	UNITS	URIC ACID 3-7	mg.
CO2 (Content) 24-27	MEQ	PHOSPHATASE ALK. 85-225	UNITS	TRIGLYCERIDE 74-172	mg.
CHLORIDE 95-103	MEQ	PHOSPHORUS 2.5-4.5	mg.	IRON 65-185	µg.
CHOLESTEROL	mg.	POTASSIUM 3.8-5.0	MEQ	BIND. CAP 300-350	µg.
CREATININE 0.5-2.0	mg.	LIVER BATTERY ALSO SEND SPECIAL CHEMISTRY SLIP			

DATE DONE: 2/26/75 — 080
LDH 29-92: 48 | LDH ISOENZYMES

J. BYERS, M.D. & H. ICHINOSE, M.D. PATHOLOGISTS — CHEMISTRY — METHODIST HOSPITAL · NEW ORLEANS, LA. — 4031

0417374

459809 [redacted]
DR. PALMISANO, ET AL

SPECIAL CHEMISTRY

	BLOOD	URINE	FRACTION		NORMAL
FASTING			TOTAL PROTEIN	7.1	6-8 gm%
½ HR.			ALBUMIN	3.7	4.0-5.2
1st HR.			GLOBULIN	3.4	
2nd HR.			ALPHA 1	0.3	0.2-0.44
3rd HR.			ALPHA 2	0.7	0.4-0.8
4th HR.			BETA	1.0	0.6-1.17
5th HR.			GAMMA	1.4	0.7-1.5
6th HR.					

PLASMA Hgb <5 mg%
HAPTOGLOBIN 40-220 mg%

HEMOGLOBIN ELECTROPHORESIS
IMMUNOELECTROPHORESIS
IMMUNODIFFUSION

	PATIENT	NORMALS
IgG		
IgM		
IgA		

REQUESTED BY: SC — DATE DONE: 2/25/75 — PERFORMED BY: DM — 080

JOHN F. BYERS, M.D. PATHOLOGIST — H. ICHINOSE, M.D. PATHOLOGIST — SPECIAL CHEMISTRY — FORM 507 REV 2/74 — METHODIST HOSPITAL · NEW ORLEANS, LA. — 4033

2-25-75 am

0417373

459809 [redacted]
DR. PALMISANO, ET AL

CHEMISTRY

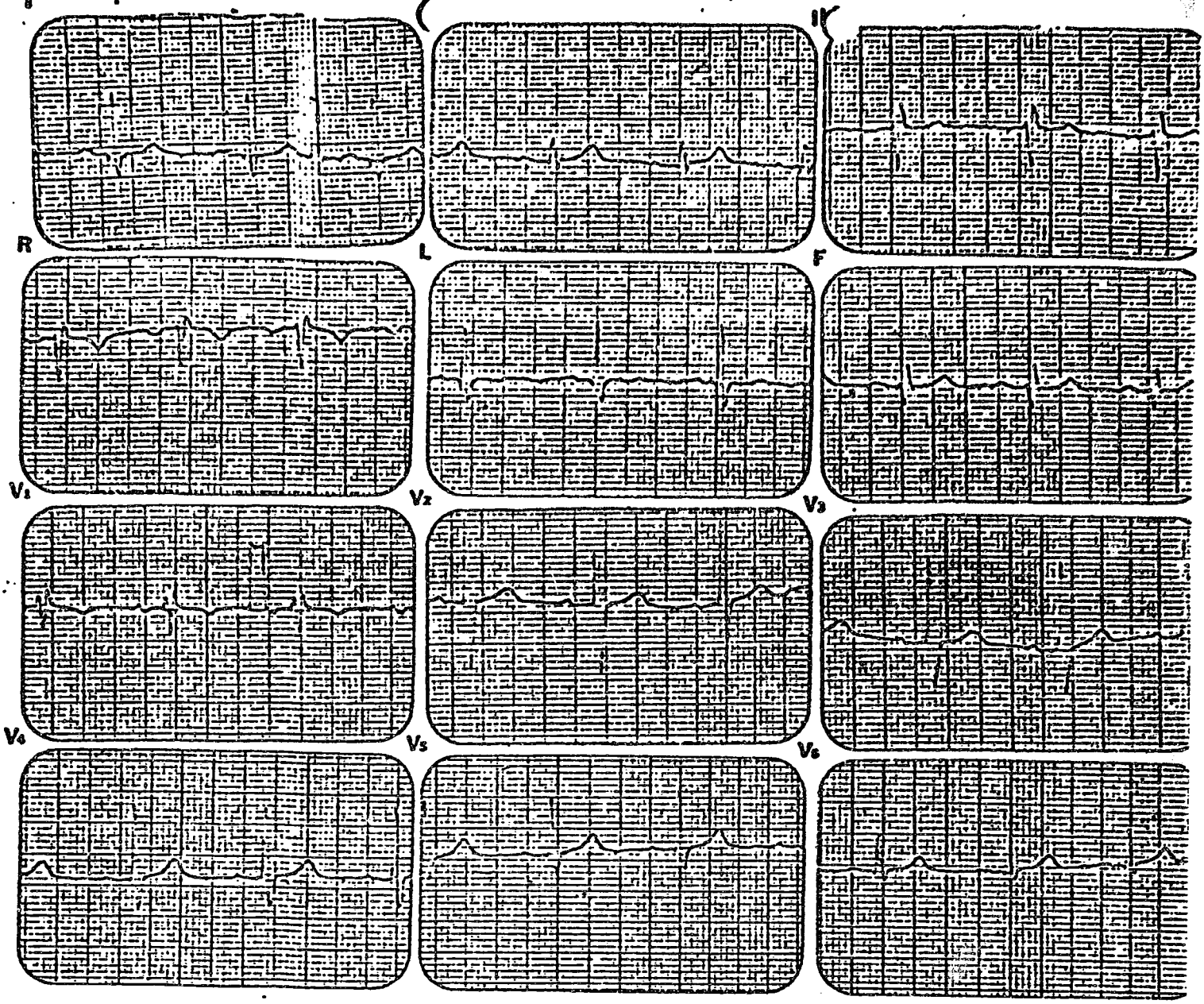
NORMAL	RESULT	NORMAL	RESULT	NORMAL	RESULT
AMYLASE 60-160	— UNITS	CPK 0-70	UNITS		
BSP 0-5	%	GLUCOSE 65-105	98 mg.	SODIUM 135-150	144 MEQ
BILIRUBIN TOTAL TO 1.5	0.8 mg.	2 HR. P.P. GLUCOSE	mg.	OSMOLALITY 285-295 osm	UNITS
DIRECT 0.1-0.3	0.3 mg.	LIPASE 0-1	UNITS	SGGT 5-37	24 UNITS
BUN 5-25	12 mg.	BETA LIPOPROTEINS	mg.	SGOT 5-19	14 UNITS
CALCIUM 4.4-5.2	MEQ	PHOSPHATASE ACID 0-2	UNITS	SGPT 4-24	UNITS
CO2 (Content) 24-27	31 MEQ	PHOSPHATASE ALK. 85-225	123 UNITS	URIC ACID 3-7	mg.
CHLORIDE 95-103	99 MEQ	PHOSPHORUS 2.5-4.5	mg.	TRIGLYCERIDE 74-172	mg.
CHOLESTEROL	mg.	POTASSIUM 3.8-5.0	3.6 MEQ	IRON 65-185	µg.
CREATININE 0.5-2.0	mg.	LIVER BATTERY (cancelled) ALSO SEND SPECIAL CHEMISTRY SLIP		BIND. CAP 300-350	µg.

REQUESTED BY: SC — DATE DONE: 2/25/75 — 080
LDH 29-92: 48 | LDH ISOENZYMES

J. BYERS, M.D. & H. ICHINOSE, M.D. PATHOLOGISTS — CHEMISTRY — METHODIST HOSPITAL · NEW ORLEANS, LA. — 4031

NAME: [redacted]
HOSP. # 220
ADM. TO SERVICE OF: DR. Palmisano
ROOM 457

LABORATORY REPORTS



ELECTROCARDIOGRAPH REPORT

hythm SINUS Rate 70

R .20 QRS .08 QT .34 AXIS

NTERPRETATION

PRIME IN V1 WITH S IN LEAD 1. EKG IS WITHIN NORMAL LIMITS BUT THIS DOES ESENT AN INCOMPLETE RIGHT BUNDLE BRANCH BLOCK PATTERN, CONSISTENT WITH ACUTE IT VENTRICULAR OVERLOAD, CONSISTENT WITH AN ATRIAL SEPTAL DEFECT.

[redacted] AGE 48 ECG 11301

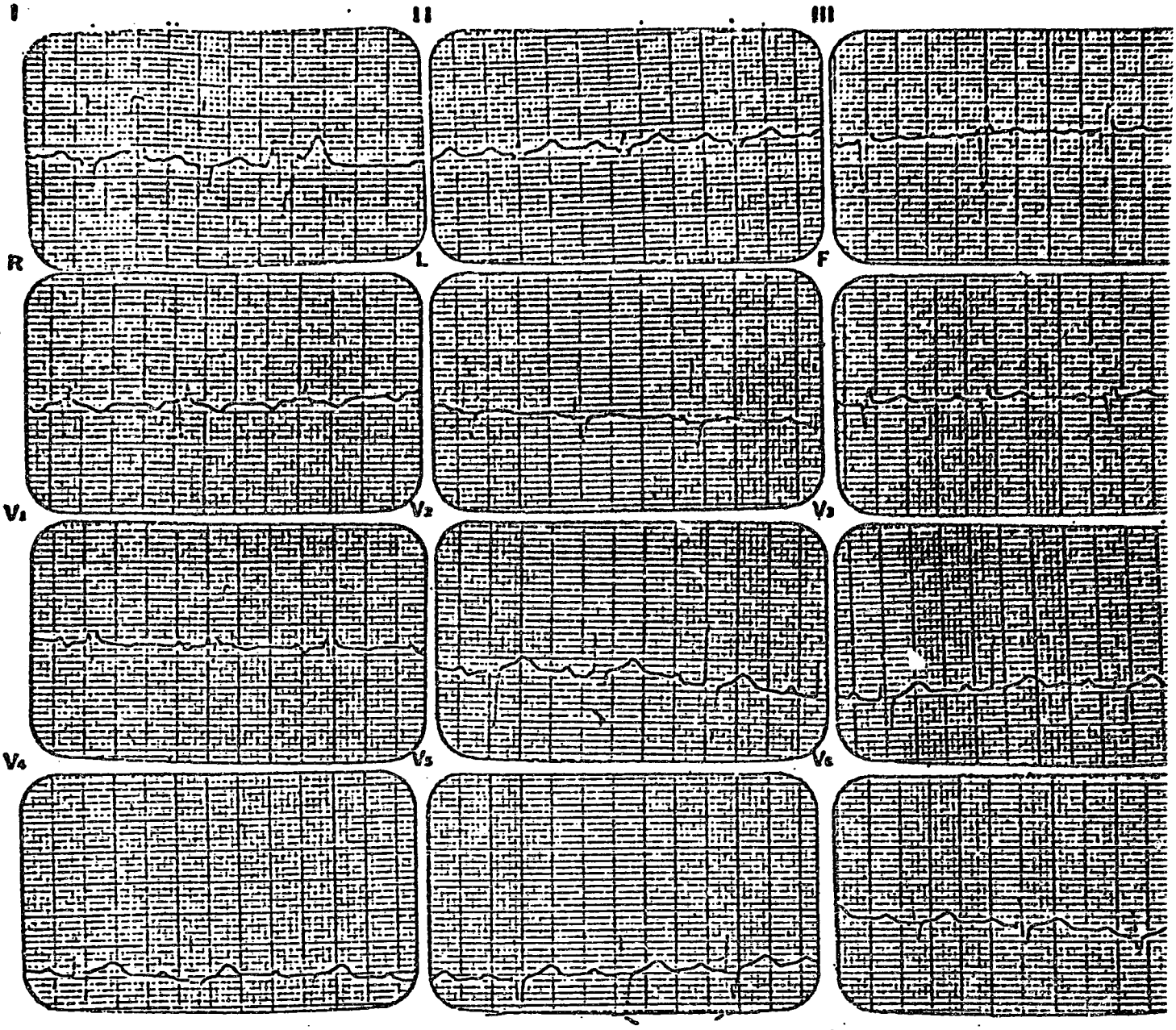
TIENT

PALMISANO M. D. NO. 234A RM 5K

INTERPRETED BY Robert E. Edmunson M. D.

DATE 2/21/75

METHODIST HOSPITAL New Orleans, La. 80



ELECTROCARDIOGRAPH REPORT

Rhythm SINUS Rate 85

PR .16 QRS .10 QT .36 AXIS

INTERPRETATION

R' IS PRESENT IN V1. A SINGLE PREMATURE VENTRICULAR CONTRACTION IS PRESENT. INCOMPLETE RIGHT BUNDLE BRANCH BLOCK. NO SIGNIFICANT CHANGE.

[redacted] 48 11301

AGE ECG

Interpreted by Robert L. Robins M.D.

M. D.

:RT FORTENBERRY, M.D.
DIRECTOR

X-RAY DEPARTMENT - METHODIST HOSPITAL

LOWELL HURWITZ, M.D.

me [redacted] Age 48 Address 220

:tor Palmisano Date 2/25/75

ay No. 4393

I.V.P.:

There is some residual contrast material in the G.I.tract. The renal and shadows are partially obscured but do not appear to be enlarged. No opaque calculi are identified.

Following injection there was prompt excretion bilaterally. The upper collecting systems and ureters appear within normal limits. The bladder shadow is not remarkable.

Radiologist: Robert Fortenberry, M.D. M.D.

RF/sd

Age Address

Doctor Palmisano Date 2/24/75

K-Ray No. 4299

I.V. Cholangiogram:

The common duct opacified promptly after intravenous injection. The duct is normal in course and caliber. A delayed film at two hours fails to show any significant opacification of the gallbladder itself.

Radiologist: Robert Fortenberry, M.D. M.D.

RF/sd

NAME: LAST [redacted]

HOSP. # 4398

ADM. TO SERVICE OF: —

DR. Galmisano

ROOM 434

XRAY REPORTS

ROBERT FORTENBERRY, M.D. DIRECTOR X-RAY DEPARTMENT - METHODIST HOSPITAL LOWELL HURWITZ, M.D.

Name [redacted] Age 48 Address 220

Doctor Colcolough Date 2/26/75

X-Ray No. 4497

Cholecystogram:

The gallbladder failed to visualize. A repeat study is suggested.

RF/sd

Radiologist: Robert Fortenberry, M.D. M.D.

Name [redacted] Age 48 Address OP 234

Doctor Palmisano Date 2/24/75

X-Ray No. 4299 75794

Chest: EPA and Lateral Views:

The cardiac and mediastinal structures are within normal limits. Both lungs are equally well aerated and shows no evidence of active parenchymal disease. The trachea is in the midline and the diaphragm is at normal levels and clear in outline.

Abdomen: Flat and Erect Views:

There is no evidence of free air. Thereis patchy gas in the colon. There are no distended loops or fluid levels. Liver, splenic, renal and psoasshadows are not cle delineated but do not appear to be significantly enlarged. The included bones are intact.

RF/sd

Radiologist: Robert Fortenberry, M.D. M.D.

NAME: [redacted] HOSP. N 498

ADM. TO SERVICE DR. Palmisano ROOM N 220

XRAY REPORTS

ROBERT FORTENBERRY, M.D.
DIRECTOR

X-RAY DEPARTMENT - METHODIST HOSPITAL

LOWELL HURWITZ, M.D.

Name [redacted] Age 48 Address 220

Doctor Colcolough Date 2/26/75

X-Ray No. 4497

Chest: EPA, Lateral and Both Oblique Views With Barium In the Esophagus:

The cardiac silhouette shows moderate general enlargement with a CT ratio of 19-33.5cms. The enlargement appears generalized without specific chamber change. The aorta is somewhat elongated and compatible with hypertension. Both lungs are well aerated without evidence of active parenchymal disease.

Radiologist: R Fortenberry Robert Fortenberry, M.D. M.D.

RF/sd

[redacted]

ADM. TO SERVICE

DR. Palmisano

HOSP. 159

ROOM 22

XRAY REPORTS

24 Feb 75 — Admit Note

48 y.o. man
with severe epigastric
pain — Onset 4 Am today —
Numerous episode —
Has Had 2 Shots Demerol
(relief?) —
abd soft Now —
Admit
ulu —
R/o pancreatitis
R/o Biliary tract
disease —
No allergies
Chest clear
Heart NSR
Hx & Px dictated

Hx: Renal Stones in past —
Oct IVP —

NAME: [redacted] [redacted]

ADM. TO SERVICE OF: DR. Ph[illegible]

HOSP. NO. 45980

ROOM NO. 234

PROGRESS RECORD

25 Feb - IVP today
NO V.Z of GB on IV cholangio
on Delayed Films -
Double Dose GBV in Am -
Stand Surg depends for
Abd Surg - No pain
today
Palmisano

2/25/75 Med consult - Cannot find any evidence of significant cardiac disease at this time. Would like a Cardiac series & BA - Will wait of Dr Pal wants to do BE first.

26 Feb - Non V.Z GBV -
Imp Gall bladder
disease -
patient has become asymptomatic
& Anxious to go home -
Explained to him findings
& Recommend Admission
of cholecystectomy
Palmisano

NAME: [redacted] [redacted]
ADM. TO SERVICE OF
DR. Palmisano
HOSP. NO. 459 8690
ROOM NO. 220C

PROGRESS RECORD

DATES	
2/26/75	Repeat EKG, - No acute changes.
	Baseline EKG represent normal variant.
	Possible labile hypertension.

NAME: LAST [redacted]

HOSP. NO. 5980

ADM. TO SERVICE OF DR. Palmisano

ROOM NO. 22

24 Feb Admit
R/O Biliary tract disease
R/O Pancreatitis
CBC & urinalysis done
EKG
Blood Sugar
Liver Bracket – Na K Bun CO2 Cl
Amylase
NPO
I.V. 1000 cc 5% D/Ringers
Lactate to alternate
with 1000 cc 5% D/W
Give 1000 cc q 8h
add 15 meq KCl to each I.V.
Add 1 Amp Solbesyn to one I.V. daily
EPA Chest
Palmisano
KUB Except all film
2-24-75 S Calvin R.N. 10 pm
General diet
Westcott diet
IV discontinued

DRUG ALLERGIES

NAME: [redacted]

ADM. TO

DR. Palmisano

HOSP. NO. 45980

ROOM NO. 234

2-24-75

11 pm

PHYSICIAN'S ORDERS

24 Feb [illegible] IVP today — Palmisano

[illegible] C.N. 3:20 P.M.

Atropine
grains 1/150 im now
& q 8h —

Demerol 75 mg im q 4h
prn pain

2/24/75 Daley — [illegible]
348

2/24/75 Do I.V.P. in early A.M.
P.O. Dr. Palmisano / C Nelson R.N.

8:30 P.M. C Nelson R.N.

2/25/75 Tuesday

1) Surgical consult [illegible]
2) Double Dose GBU in AM
3) [illegible] — dk

Notified — Consult Dr Colclough — Evaluate Cardiac Status — See EKG Report

DRUG ALLERGIES: none known 2/25/75

NAME (LAST) [redacted] FIRST [redacted]

HOSP. 159[illegible]

ADM. TO SERVICE OF DR. Palmisano

ROOM 2[illegible]

PHYSICIAN'S ORDERS

METHODIST HOSPITAL New Orleans, L[illegible]

2/25/75 Tuesday

KPG 1) Cardiac enzymes daily x 3 da
KPG 2) EKG - daily x 3, do V_4R ~~tracings~~ on tomorrows EKG.
3) Cardiac series c Barium ~~[illegible]~~ after when Dr. Palmisano or Upper GI series) - contact him for ~~[illegible]~~ or on above

930 2-25-75 [illegible] LPN

2/26/75 Wednesday
1) Discharge today (tonight) if OK c Dr Colclough - patient asymptomatic & anxious to go home - Appt to my office 1 week Low fat diet -
[illegible] LPN 7:25 pm

1) OK c Dr. Colclough to D/C pt. tonight. [illegible] Colclough, M.D.
P.O. Dr. Colclough / [illegible] LPN
[illegible] LPN 7:25 pm

[illegible] M.D. 4598

DRUG ALLERGIES
None Known

NAME: [redacted] [redacted]
ADM. TO S
DR. Palmisano

HOSP. NO
ROOM NO
227

PHYSICIAN'S ORDERS

GRAPHIC CHART

FORM 26

Hospital Day	Admit	2	3	4	5	6	7
P. O. Day							

Hour of Day: A.M. 4 8 12 | P.M. 4 8 12

TEMPERATURE: 105° 104° 103° 102° 101° 100° 99° 98° 97°

DATE: 2-24-75 | 2-25-75 | 2-26-75 | 2-27-75 | 2-28-75 | 3-1-75 | 3-2-75

PULSE: 110 100 90 80 70 60 50

RESPIRATION: 30 20 10

Roots

Right

NAME [redacted] ST

ADM. [redacted]

DR. Richmond

HOSP. No. 459809

HOUSE NO. 1011

I hereby authorize and direct Palmisano M.D.
y physician and/or associates or assistants or surgeons of his choice to do any therapeutic procedures that
ls) (their) judgment may dictate to be advisable for the patient's well being.
I hereby advise and direct the above named physician and/or (his) (their) associates or assistants to provide
ch additional services for me as he or they deem reasonable and necessary, including but not limited to the
rformance of services involving pathology and radiology and I hereby consent thereto.

[redacted]

X [redacted]
Signature of Patient

ne 10:20 AM PM

te 2/24/25

or _____
Signature of Parent or Guardian or such other person as is authorized to execute the above instrument in case patient is a minor or when patient is physically or mentally incompetent.

ıave been instructed that hospital is not responsible for valuables taken to room.

X [redacted]
Signature of Patient

ADMIT CHECK LIST

mit Date 2-24-25 Admission Time 10:20 Am Identa-Band Info. Checked ____

ysician's Admit Diagnosis Biliary Colic r/o Pancreatitis

utine urine collected: Yes ✓ No ____ Routine CBC collected: Yes ✓ No ____

ived via: Stretcher ✓ Wheelchair ____ Walked ____

parent condition: Good ____ Fair ____ Poor ____ Critical ____
(Describe) ____

Any allergies: Yes ____ No ____ Identify NKA

Any bruises, bedsores: Yes ____ No ✓ Identify ____

Dentures: Yes ____ No ✓ Identify ____

Prosthesis: Yes ____ No ✓ Identify: ____

Valuables: In Safe ____ Taken home ✓ None ____

Medications patient is presently using: ____

Did patient bring any medications to hospital? Yes ____ No ✓ Identify ____

P 120/110 T 97.6 P 88 R 22 Hgt. 5'9" Wgt. 260#

.S REPORTED BY PATIENT BY: [redacted]

ne: Last [redacted] First [redacted]

Hosp. No. 4598098

n. to service of Palmisano

Room No. 234A

CONSENT FOR TREATMENT

METHODIST HOSPITAL

New Orleans, La.
Form 143

GE DATE

75	02	53	A	234	A	45	S	SU	117	1	1	M-4	04	20	25	PRT	C	S

ATTENDING DR. PALMISANO, ET AL

[redacted]

SHREVEPORT [redacted]

[redacted]

INSURANCE INFO [redacted]

CONTRACT NO. GROUP NO. CONTRACT TYPE ADDN BENEFITS RIDER CODES CITY STATE SUBSCRIBERS NAME

ANCE INDIVIDUAL/GROUP SUBSCRIBERS NAME VERIFICATION

51846 CARPENTERS LOCAL

OLD AGE / DISABILITY | MEDICARE CERT. NO. | MEDICARE PART B YES NO | NAME OF PREVIOUS HOSPITAL UNDER MEDICARE | DISCHARGE DATE

ADMISSION NO X | PREVIOUS ADMIT DATE X | WHAT NAME | ADMITTING OFFICER JM | REQ. LET. OF G.

ONAL DIAGNOSIS

R/O G.Bladder - pancreatic disease -

AGNOSIS AND/OR VERIFIED PATHOLOGICAL DIAGNOSIS (ABBREVIATIONS NOT ACCEPTABLE) | CODE NO.

Biliary colic — 5749

Diseased Gallbladder — 5769

401

4273

ECONDARY DIAGNOSIS OR COMPLICATIONS:

probable diabetes

hypertension

borderline abnormal EKG ē incomplete RBBB vs normal variant.

PERATION none

EMERGENCY ADMISSION

Per Dr. Palmisano, et al

Date 02-24-75 Time 9:25 A.M.

REASON Acute abd pain

Dr's. Initials

TS: ☐ RECOVERED ☐ IMPROVED ☒ NOT IMPROVED ☐ NOT TREATED ☐ DIAGNOSIS ONLY ☐ DIED | AUTOPSY: YES ☐ NO ☐

LTATION WITH. [signature] | CORONER'S CASE: YES ☐ NO ☐

I HAVE EXAMINED AND APPROVED THIS COMPLETED MEDICAL RECORD ON

[redacted]

WDF-254548

EMERGENCY ROOM CHARGES

ITEM	CHARGE	ITEM	CHARGE	ITEM	CHARGE	ITEM
EMERGENCY ROOM		DRUGS		CAST ROOM		PHYSICAL THERAPY
X-RAY		INHALATION THERAPY		PROCTO ROOM		E.R. Dr. Fee
LAB		TRAYS		EKG		
DRESSINGS		BLOOD		EEG		NET TOTAL
						AMOUNT PAID
						BALANCE

A.K. Roy III M.D.

[redacted]

BRIEF HISTORY DATE ___ TIME ___ OF ONSET

IF ACCIDENT STATE WHERE, WHEN AND HOW INJURED; IF ILLNESS DESCRIBE:

c/o pain severe abdominal pain upper abdomen - appears to be in great distress - No other complaints

NOTIFIED: RELATIVE ☐ POLICE ☐ CORONER

NURSE'S SIGNATURE Marilyn Pall R.N. OFFICER'S SIGNATURE ___ STAR ___ DISTRICT ___ TIME ___

PHYSICIAN'S REPORT

CONDITION ON ADMISSION

GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA ☐

WEIGHT 260 LB. HEIGHT 5'9 TEMP 95 B.P. 210/150, 100 B.P. 220/132

PHYSICAL FINDINGS

Chest - Clear

Heart - RSR

UA - Neg Abd - liver ↓ 4 FB's of RCM Non Tender

CBC - 10,600 c shift - Good Bowel Sounds, No Tender

X Ray - Neg

DIAGNOSIS

TREATMENT: TETANUS TOXOID ___ c.c. TETANUS IMMUNE GLOBULIN ___ UNITS

CBC, UA, [illegible] Chest, Amylase, EKG

Demerol 75 mg

Vistaril 75 mg > I M [illegible]

1000 D5 RL [illegible]

Demerol [illegible] @ 8 [illegible]

DATE OF LAST TETANUS TOXOID ___ ALLERGIES N.K.A. DISPOSITION OF CASE:

REFERRED TO DR. Palumo ADMIT NO. 4598090 ROOM NO. 234A

A.M. ☐ AMBULATORY ☐ POLICE ☐ OTHER

DISCHARGED P.M. ☐ ADMITTED ☐ CORONER

INSTRUCTIONS TO PATIENT

Admit

[redacted] M.

TIME

ATTENDING STAFF

No.5 767 5 [illegible]

[redacted]

[illegible] 2545 [illegible] EMERGENCY ROOM CHARGES PVT. PHY. [illegible]

ITEM	CHARGE	ITEM	CHARGE	ITEM	CHARGE	ITEM	CHARGE
EMERGENCY ROOM	12 50	DRUGS		CAST ROOM		PHYSICAL THERAPY	
X-RAY		INHALATION THERAPY		PROCTO ROOM		E.R. Dr. Fee	10
LAB		TRAYS		EKG			
DRESSINGS		BLOOD		EEG	[redacted]	NET TOTAL	22
						AMOUNT PAID	22
						BALANCE	

[illegible fine print] [redacted] SIGNATURE OF RESPONSIBLE PARTY

Dr. J Brown / Federline [illegible fine print]

[redacted]

DATE 3-26-75 TIME 500 [illegible] OF CHECK

BRIEF HISTORY

IF ACCIDENT STATE WHERE, WHEN AND HOW INCURRED. IF RAPE-BE DESCRIPTIVE:

Epigastric pain (Same as 3 weeks ago) - [illegible] pt. [illegible] nauseated and cold sweats from pain. Very restless. pt. feels like it's [illegible] now while in ER.

NOTIFIED: RELATIVE ☐ POLICE ☐ BY WHOM TIME

Hx - Gallbladder

Meds - None

NURSE'S SIGNATURE Monica Genzel R.N. OFFICER'S SIGNATURE STAR DISTRICT

PHYSICIAN'S REPORT

WEIGHT 265 LB. HEIGHT 5'9 TEMP 98.6 B.P. 170/80, 94 [illegible]

CONDITION ON ADMISSION GOOD ☐ FAIR ☐ POOR ☐ SHOCK ☐ HEMORRHAGE ☐ COMA ☐

PHYSICAL FINDINGS Pt. has diagnosed gall bladder disease several weeks ago which at the time was aggravated by fatty food. last night he fell off of his diet and began to have crampy generalized abdominal pain & nausea, no vomiting. Was asymptomatic & abd. [illegible]

DIAGNOSIS Biliary colic - resolved.

TREATMENT: TETANUS TOXOID ______ c.c. TETANUS IMMUNE GLOBULIN ______ UNITS

(1) ER Pr. sedation - got old chart - held pt. for Dr. J Br[illegible]

p/o Dr. J. Brown / Monica Genzel, RN

DATE OF LAST TETANUS TOXOID ______ ALLERGIES none known

ADMIT NO. ROOM NO.

REFERRED TO DR. Brown.

DISPOSITION OF CASE: 6 50 A.M. ☐ AMBULATORY ☐ POLICE DISCHARGED P.M. ☐ ADMITTED ☐ CORONER

INSTRUCTIONS TO PATIENT ______

[illegible signature]

[redacted] M.

DRS. LEVY, CULICCHIA, APPLEBAUM AND MARTIN

NEUROLOGICAL SURGERY

RICHARD WARREN LEVY, M. D.
CARL F. CULICCHIA, M. D.
ROBERT L. APPLEBAUM, M. D.

NEUROLOGY AND ELECTRODIAGNOSIS

WILLIAM A. MARTIN, M. D.

7 KELLS COURT
3900 PAYTANIA STREET
NEW ORLEANS, LOUISIANA 701

4500 TENTH STREET
MARRERO, LOUISIANA 70071

SUITE C
3501 HOUMA BOULEVARD
METAIRIE, LOUISIANA 70002

[redacted]

March 14, 1975

Louis Koerner, Jr.
Attorney at Law
730 Camp Street
New Orleans, Louisiana 70130

Re: [redacted]
37/Black/Male
Performed: 3/14/75

Dear Mr. Koerner:

[redacted] states that he was working as a rod buster on a construction project at the Hooker Chemical Plant approximately one year ago (did not remember month) when a valve blew approximately one hundred feet from where he was working exposing him to noxious gas including chlorine. He states that he ran to the first aid station where he collapsed. He was given oxygen and transferred to St. James General Hospital where he was admitted for twenty-four hours, treated with oxygen and released. He returned to work a few days later but noted that he did not feel well and that he fatigued very easily. He subsequently injured his low back on a job in May, 1974 and has been able to work even less since then. He has not worked at all since December, 1974.

He states that since exposure to the gas he has had almost continuous heartburn and has lost twenty-three pounds over the past year. He states that he develops dyspnea whenever he walks over two blocks or climbs a flight of steps and must stop and rest. He is unable to work for more than a half an hour at construction without severe fatigue. He complains of sexual impotency.

He has no significant headache. However, he does complain of intermittent blurring of vision at times associated with some doubling of his vision. This usually lasts two to three minutes, clearss if he opens and closes his eyes several times. He denies tinnitus, dysarthria, focal weakness or paresthesia, although the right third finger has been numb since a blood test two weeks ago. He has had no vertigo, ataxia or seizures.

Neurological examination: The gait was normal including walking on heels, toes and tandem. There was no Rhomberg sign. There was no focal weakness atrophy or fasiculation. Tests of coordination were performed without ataxia. Tendon reflexes were active and equal. There were no Babinsky signs. Sensory examination was intact in all modalities. The optic fundi were normal. Visual fields were full to confrontation. Cranial nerves were intact.

Electrodiagnostic studies: Please see enclosed report. There is no evidence of acute or chronic denervation or myopathy.

Impression: The patient has a syndrome consisting of dyspnea on exertion, easy fatigueability, chronic heartburn, and sexual impotency since exposure to noxious gases approximatley one year ago. His clinical neurological examination as well as his electrodiagnostic studies are completely within normal limits and would offer no explanation as to the etiology of any of the symptoms. This patient's nervous and muscular systems are completely intact at the time of this evaluation with no clinical or electrodiagnostic evidence of disease.

Thank you for referring this patient. If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

William A. Martin, M.D.

WAM:bja
enc

THOMAS M. IRWIN JR., M.D.
Otolaryngology and Maxillofacial Surgery

12 Westbank Expressway
Gretna, Louisiana 70053
(504) 362-4058

1430 Tulane Avenue
New Orleans, Louisiana 7011
(504) 588-5451

June 24,1975

Koerner & Babst
730 Camp Street
New Orleans, Louisiana 70130

RE: [redacted]

Dear Mr. LaBorde:

[redacted], 37 years old, was initially examined by me on November 15,1974, with a history of having been exposed to chlorinegas while working at the Hooker Chemical Plant in November 1974 [redacted] stated at that time his taste "goes and comes", that he "keeps a cold", and that he was experienci a more or less constant "heartburn". [redacted] stated that he smokes one and one-half pack cigarettes daily. Physical examination at that time was essentially normal for the head and neck, with the exception of dry oral muscous membrane. Taste testing at that time produced appreciation of salt a sugar in the hypopharynx only, and [redacted] denied perception of the tast clove of oil, peppermint, salt or sugar on the anterior tongue.

On May 23,1975 [redacted] was again examined. He denied perception of an taste sensation with the electrogustometer at the maximum power of the instru Retesting with salt and sugar produced results similar to those of November 1

On the basis of these examinations [redacted] appears to have approximatel an eighty percent reduction in his sense of taste. This loss of taste should produce no significant physical impairment.

Sincerely,

TMI:smp

Thomas M. Irwin Jr., M.

HANS WEILL, M. D.
1700 PERDIDO STREET
NEW ORLEANS, LOUISIANA 70112

February 24, 1975

Mr. Ellis Murov
Claims Adjuster
Liberty Mutual
3501 North Causeway Boulevard
Metairie, Louisiana 70002

Re: [redacted]

Dear Mr. Murov:

At your request [redacted] was evaluated in our office and laboratory on February 21, 1975, with the following results.

This 37-year-old man is a construction steel worker and was employed by the Dravo Corporation at the Hooker plant site in Taft, Louisiana, from October or November, 1973, until approximately May or June, 1974. He indicates that he stopped working at that time because of a back injury but he is not aware of a specific diagnosis. He remained under the care of an orthopedist until November, 1974, but claims that he continues to have low back pain on heavy lifting. He worked for approximately one month in November - December, 1974, being employed by Boh Brothers at the Avondale Shipyard. He had to discontinue this employment because of back difficulties and says he could not perform properly at his job. He has also had burning of the chest after eating for ten or eleven months, relieved by antacids but no workup for this condition has apparently been undertaken. Exertional dyspnea occurs with climbing stairs, running and carrying heavy objects. He dates this symptom from multiple exposures to chlorine gas which he indicates were essentially on a daily basis while at the Hooker Plant. One time, a valve broke and he apparently had a heavy exposure resulting in burning of the eyes, shortness of breath, cough, wheezing, and nausea. He went to the plant first aid station and subsequently was hospitalized overnight, this being the only time he required medical attention. The patient indicates that following this episode, his respiratory symptoms persisted. On the other occasions of gas emission in the area he put on a respirator and left the region whenever the warning whistle blew. At present he complains of easy fatigability, exertional dyspnea with some wheezing and productive cough, and reduced taste sensation. He also indicates that he is partially impotent. He says that these symptoms had never been present before going to work at Hooker. The patient smoked two packs of cigarettes per day for eight to ten years and says he stopped

smoking this week. Alcohol intake is limited to the moderate use of beer. His weight is stable. There is no history of heart disease, high blood pressure, diabetes, tuberculosis, asthma, hay fever, or allergies. He has occasional orthopnea and exertional chest pain. There is no history of previous illnesses and he specifically denies having had lues or rheumatic fever.

On physical examination, this is a well-developed, well-nourished man who does not appear acutely or chronically ill. Blood pressure 132/58, the pulse is "bounding" with a rate of 74. Examination of the chest reveals adequate thoracic expansion with very slight delay of the expiratory phase. There are transitory diffuse rhonchi heard; no crackles or wheezes are present. Examination of the heart reveals an aortic diastolic murmur, loudest at the third left intercostal space. There is also a soft systolic murmur, grade II/VI, over the precordium. Abdominal examination is negative. There is no edema or clubbing of the extremities.

An EPA chest x-ray film reveals a normal cardiac silhouette with clear lung fields. The diaphragms are in normal position. An electrocardiogram reveals low T-waves in leads I and V-6 and a flat T-wave in AVL. These changes are non-specific but suggest the possibility of myocardial disease.

Complete studies of pulmonary function were performed. Lung volume measurements, including vital capacity, total lung capacity, residual volume and residual volume to total lung capacity ratio, are normal. Forced expiratory volume in one second is normal, but there is minimal reduction of the maximum breathing capacity, timed vital capacity, forced expiratory flow, 25-75%, and peak expiratory flow rate. Mild obstructive ventilatory impairment is indicated with improvement of air flow after bronchodilator inhalation. Pulmonary diffusing capacity is normal and indicates adequate total alveolar gas transfer. Arterial blood gas analysis reveals normal values for oxygen saturation and PO_2 at rest and after exercise. The low P_{CO_2} is the result of hyperventilation.

This patient apparently continues to have some low back pain, but his orthopedic condition is not evaluated at this examination. An orthopedic consultation will be required to determine the status in regard to this complaint. Relatively mild bronchitic symptoms with exertional dyspnea are associated with minimal, partially reversible, airways obstruction.

This degree of functional impairment would not be expected to preclude tolerance for moderately heavy physical activity, but might interfere with sustained very heavy manual labor, perhaps including that of an iron worker during periods of climbing, heavy lifting and carrying heavy objects. The minimal functional disturbance demonstrated could be related to previous irritant gas exposures but the possibi that smoking has also contributed to the clinical and functional disorder demonstrated cannot be excluded. (There is no way to definitively separat the two possible causal factors except that with his short smoking history and if he stopped smoking recently, there should be gradual improvement in his bronchitic picture.) The cardiac findings suggest a diagnosis of aortic insufficiency. The wide pulse pressure (noted on the blood pressu reading) and the bounding pulse suggest that this lesion is hemodynamically significant; however, there does not appear to be evidence of cardi failure at this time. It is suggested that he be followed medically in rega to this finding. Bronchodilator therapy would be expected to have a beneficial effect in regard to the airways disorder and the longevity or permanence of his respiratory complaints cannot be predicted. It is also not possible to estimate the concentration of chlorine gas required to produce the bronchial changes seen in this patient.

Thank you for referring [redacted] for this evaluation.

Sincerely yours,

Hans Weill, M.D.

Hans Weill, M.D.

HW/kar