STATE UNIVERSITY HOSPITAL

SYRACUSE, NEW YORK

DISCHARGE SUMMARY

PATIENT'S NAME	HOSPITAL NO.	ADMITTED	DISCHARGED
MERRITT, LESTER	416-138-6-029	7/23/82	7/26/82

LENGTH OF STAY 3 days

A. PROBLEMS ON ADMISSION

1. pulmonary asbestosis
2. Past history of gout

B. SIGNIFICANT PHYSICAL FINDINGS

1. bibasilar rales, diffuse rhonchi muscle use
2. serum uric acid 8.3 mg %

C. MANAGEMENT ANDINVESTIGATION OF PROBLEMS

49 year old white male with 23 yr history of talc packing who carries the diagnosis of pulmonary asbestosis first diagnosed 4/81 by open lung biopsy when he presented and in acute SOB and PND. Has had 1 SUH admission since then for worsening SOB and PND. Presently presents to SUH for 3 day history progressive worsening PND and SOB despite 18hr home O2. Additionally complains of 3 days of cough productive of clear, thin white sputum. Hospital course remained uneventful. Patient ambulated in halls without SOB, denied PND and admitted to improvement in cough. WBC remained wnl with no left shift in diffential. Pt remained afebrile, CXR revealed no significant changes from previous films. FEV1 was 1.2L, FVC 1.6 (last FEV_1 6/9/82 was 1.3) Sputum cultures revealed normal flora, gram stain showed 1-4 polys/HPF but no organisms. Nuclear V gram 5/81 showed ejection fraction 35% and patient was placed on digoxin. Admission dig level of 1.5 (therapeutic). Serum potassium remained therapeutic on his usual Lasix of 60 mg po qd. Serum uric acid increased to 8.3 mg %

D. STATUS AND DISPOSITION OF PROBLEMS AT DISCHARGE

See above.

E. CONDITION OF PATIENT AT DISCHARGE Improved

DISCHARGE DIAGNOSES

Pulmonary asbestosis

MEDICATIONS Digoxin 0.25 mg po qd, Lasix 60 mg po qd, FeSO4 1 tab po bid, Dalmane 30 mg po q hs, Allopurinol, 100 mg po tid

DIET As tolerated

TREATMENTS

LIMITATIONS As tolerated

FOLLOWUP Privately with Dr Auchincloss

ATTENDING Dr. Auchincloss

HOUSE OFFICER Dr. Bishop

AB/jr
D. 7/26/82
T. 7/29/82

EXHIBIT 14

(2)

MEDICAL RECORDS COPY

STATE UNIVERSITY HOSPITAL

SYRACUSE, NEW YORK

DISCHARGE SUMMARY

PATIENT'S NAME	HOSPITAL NO.	ADMITTED	DISCHARGED
MERRITT, LESTER	416-138-6-019	5/12/81	5/21/81

LENGTH OF STAY: 9 days

A. PROBLEMS ON ADMISSION

1. asbestosis

B. SIGNIFICANT PHYSICAL FINDINGS

1. rales to ½ way up lungs
2. guaiac ⊕ stools
3. ++ clubbing of nails

C. MANAGEMENT AND INVESTIGATION OF PROBLEMS

The patient is a 48 year old white male with a 23 yr history of packing talc in a factory. In Apiril 1980 a severe episode of PND lead to a hospitalization in Texas; subsequent open lung biopsy lead to a diagnosis of asbestosis. Left heart cath was normal. He now comes to SUH after being home 2 weeks; he c/o severe PND and DOE. He is comfortable at rest, however his resting PO2=50(or less) and his pCO2=50. He is to be sent home with home oxygen at 2 liters/min for 18 hours per day. follow up is with Dr. Auchincloss at chest clinic.

D. STATUS AND DISPOSITION OF PROBLEMS AT DISCHARGE

See above

E. CONDITION OF PATIENET AT DISCHARGE Improved

DISCHARGE DIAGNOSES

Abestosis, Congestive heart failure - mild

MEDICATIONS: Digoxin .25 mg po q am, Lasix 60 mg po q am, FeSO4 325 mg po bid, Allopurinol 100 mg po tid, Dalmane 30 mg po q hs prn

DIET Reg

TREATMENTS Home oxygen at 2 liters/min via nasal cannula for 18 hours per day

LIMITATIONS As tolerated

FOLLOW UP Schedule for chest clinic with Dr. Auchincloss in 1 month

ATTENDING Dr. Auchincloss

J H Auchincl

HOUSE OFFICER Dr. Hittman

M Hittman

ARLINGTON MEMORIAL HOSPITAL

Name: Merritt, Lester G.
Unit No:
Doctor: Richardson
Admitted:
Operation:
Discharged:
Dictated: 4-17-81
Transcribed: 4-17-81 mb

HPI: This is the 1st AMH admission for this 47 y/o w/m who is visiting his daughter from New York and shortly after arriving he developed acute shortness of breath with PND and orthopnea. Several nights before admission he had to sit up all night to breath. He came to the E.R. and found to be in pulmonary edema, very short of breath, tachycardia, was admitted to CCU and diuresed 1400 ccs. within several hours. He was symptomatically much improved, however, continued to have tachycardia and shortness of breath. It took several days for his x-rays to improve, clear some of his pulmonary edema and the pleural effusion he had. He has a history of being exposed to talc for many years and it was felt that most of his problem may very well be due to this problem. He was taken to special procedures and had a left and right heart catheterization done where the left heart catheterization data was normal without evidence of coronary artery disease, normal left ventricular function. The right heart cath. pressures: pulmonary pressures normal except low pulse pressurein the pulmonary artery and an elevated left ventricular end diastolic pressure. His O2 saturation in the aorta was 87% and pulmonary artery was 57%. Dr. Kuppinger was consulted and recommended a lung biopsy which was done by Dr. Verzosa. This revealed interstitial fibrosis with organizing fibrinous pleuritis and ferruginous bodies consistent with asbestosis. Since he has been exposed to talc for many years this is consistent with that diagnosis. His hospital course has been prolonged due to his very slow response. Most of his time he could just walk a few feet, from the bed to the bathroom, and become very markedly short of breath and fatigued. The last several days he has been able to walk the halls at a slow pace and remain relatively comfortable. It has become apparent that during the 2 surgical procedures and the numerous amount of blood tests drawn he has become anemic with his latest hgb. being around 10.5, crit 32. The latest creatinine was 3-25-81 and was 1.9. Uric acid has been elevated up to 15. His liver function tests have been elevated including SGOT in the 700's, alkaline phos. 141 slightly elevated, and LDH in the 100 range. This is due to passive congestion of the liver. Acid fast organisms were not detected by smears on numerous occasions. Pulmonary functions revealed FEV 1.48 which is 42% of predicted, no response to bronchodilators. Total FEV is 1.84, 40% predicted. His DLCL was 28% of predicted. Severe restrictive ventilatory defect, no bronchodilator response. He is discharged today on Zyloprim 100 mg. daily x 1 week, 1 BID x 1 week, and then 1 TID, Lasix 40 mg. daily, Dalmane 30 mg. H.S. if needed, Feosol 1 BID with meals, and Tylox for pain 1 4-6 h. He is to see me around the 27th or 28th of April prior to going back to N.Y.

James A. Richardson, M.D.

cc: Dr. Kuppinger

DISCHARGE

Name: MERRITT, LESTER C, 2216-02
Unit No: 11169712
Doctor: KUPPINGER
Admitted: 3-24-81
Operation:
Discharged:
Dictated: 4-6-81
Transcribed: 4-8-81 vls

ARLINGTON MEMORIAL HOSPITAL

DATE OF CONSULTATION: 4-6-81.

ATTENDING PHYSICIAN: Dr. James Richardson.

REASON FOR CONSULTATION: Abnormal chest x-ray.

HISTORY: Mr. Merritt is a 46 year old white male ex-heavy smoker who was admitted for acute shortness of breath. Apparently he had recently traveled to Arlington from upstate New York to visit family, after two to three days here he became so severely short of breath, that he presented to the ER complaining of shortness of breath, orthopnea, PND, etc. His chest x-ray findings suggested an acute pulmonary edema and he was admitted to the Coronary Care Unit. In the CCU he was treated with IV Lasix, nasal oxygen and Nitrol plus Digoxin. On this regimen he gradually diuresed and has had progressively less dyspnea. Nevertheless, he is now at rest with his weight fairly stable and apparently in dry condition. He is dyspneic with mild exertion. He is quite dyspneic. He denies cough or sputum production, he has had no chest pain, fever, chills or night sweats. He is currently not being bothered by orthopnea or PND. He did have some peripheral edema when he came in but this has cleared now.

PMH: Is interesting in that he was a 2-2 1/2 per day smoker which he continued untal about 2 years ago. He has no known medical allergies prior to this admission. He has not been a medicine taker. He has no previous surgical history.

FH: Noncontributory.

OCCUPATIONAL HISTORY: Is significant in that he worked for some 23 years in talc mines in upstate New York, near Governuer New York. Seven years ago that operation closed down or was sold. He had a physical examination in Governuer by a local physician who checked him for talcosis and possible disabbility with chest x-ray and pulmonary function tests. According to the patient he was told that he had a little "dust" in the base of both lungs, but that he should have no problems in continuing to work and subsequently he then went to work for a drilling company. He is working with the drilling company and is said to be free of exposure to any dust, smoke, fumes, etc. He has noted for the past two years, modest shortness of breath, has had no clear episodes of decomponsations until now.

Examination reveals a white male who appears older than his stated age. He is in no acute respiratory distress.

HEENT: Grossly intact.

NECK: Supple, trachea is midline. There is no adenopathy or thyromegaly. There is no use of excessory muscles of respiration, nor is there any jugular venous distention.

LUNGS: Demonstrate bilateral medium to fine crackles both bases. No egophony or bronchophony is noted. There are no rubs heard.

HEART: Shows the PMI in the midclavicular line near the 6th intercostal space there is a normal S1 and S2. No gallop, murmur or rub appreciated.

CONTINUED ON PAGE TWO.

Name: MERRITT, LESTER G. 2216-02 **ARLINGTON MEMORIAL HOSPITAL**
Unit No: 11169712
Doctor: KUPPINGER
Admitted:
Operation:
Discharged:
Dictated: 4-6-81
Transcribed: 4-8-81 vls

ABDOMEN: Soft and nontender, the bowel sounds are active. There is no organomegaly, no masses noted.

RECTAL AND GENITALIA: Deferred.

EXTREMITIES: Show significant clubbing and nailbed cyanosis. There is no edema noted.

His chest x-rays on admission show large heart and bilateral alveolar infiltrates, vascular redistribution. The sequence of films then demonstrates progressively smaller heart size and clearing of the large part of the alveolar infiltrates but a harder reticular nodular infiltrate is seen throughout both lungs as residual, this is more pronounced in the bases than near the apices. There is an area of significant pleural thickening at the lateral chest wall. Dr. Richardson did left and right heart caths, I don't have all the data, but apparently arterial blood gases on room air showed an oxygen saturation of 87% while mixed venous gases showed an O2 saturation of 57%. Calculation of the shunt fraction revealed 25% venous admixture. H'a injection fraction done while the patient was on oxygen was 74%. I understand that his PA wedge pressure was 3, his left ventricular endiastolic pressure was 6. Cardiac output by Fick and by thermal dilution did not agree and at this point in time I am not sure which of the two determinations to rely on. The CO by Fick was 2.0 liters and the CO by thermal dilution was 3.9 liters per minute. Neither of these is particularly elevated. Both of these are low. We have one sedimentation rate taken near the time of admission which was elevated at 44, no ANA's, RA titers etc.

IMPRESSION: Widespread interstitial pulmonary fibrosis, uncertain etiology. There is associated left pleural thickening and chronic respiratory insufficiency. Rule talcosis, rule out other forms of pulmonary fibrosis, especially inhalational diseases, rule out pleural mesothelioma.

Pulmonary edema, now resolved. Probably secondary to myocardial decompensation, due to hypoxemia.

RECOMMENDATIONS: See orders.
The patient probably needs an open pleural and lung biopsy.

Will discuss with Dr. Richardson and the patient himself.

ADDENDUM: The patient's pulmonary function test demonstrated severe restrictive ventilatory defect. There was no bronchodilatory response. His diffusing capacity was 7.05 which was 28% of predicted.

M. Kuppinger, M.D.

CC: Dr. James A. Richardson
CONSULTATION

STATE UNIVERSITY of NEW YORK

College of Medicine
Department of Medicine
(315) 473-4480

Upstate Medical Center
750 E. Adams Street
Syracuse, New York 13210

February 11, 1982

Thaddeus B. Oot
Oot & Fallon
501 East Washington Street
Syracuse, NY 13202

Dear Mr. Oot:

I received via Lester Merritt today a request for an updated report to the Workmen's Compensation Board. The question was raised as to whether talcosis results in permanent and total disability in this patient and whether his pulmonary condition aggravates his heart condition. The answer to both of these questions is "yes". The patient's forced expiratory volume in the first second was 1.35 liters today, and this is a very much reduced value. The patient inhales oxygen a great portion of the time. I did not measure the oxygen saturation today because it has been measured in the past and found to be much reduced. Also, it is necessary to remove the patient from oxygen for several minutes in order to have the oxygen saturation a valid reading. Such removal from oxygen can cause discomfort. The patient has an increased heart rate of 100 beats/minute, and I found the blood pressure difficult to hear today. It was 80/60 and has been 100/60 in the past. Thus, the patient has pulmonary and cardiac disability, and this is no surprise because the patient was in this condition in the hospital. In answer to the question as to whether the pulmonary condition aggravates the cardiac condition, I can say that the cardiac condition probably would not exist without the pulmonary condition. The patient has what is called "cor pulmonale", an ancient Latin term which is used to describe the presence of cardiac failure in patients with advanced pulmonary disease. From a medical point of view he has an obvious case of this condition because he has severe pulmonary disease accompanied by a deficit in oxygenation of the arterial blood. These are the only two features that one must have for a plausible diagnosis of cor pulmonale. The management of cor pulmonale has very little to do with treatment of the heart, in contrast to other forms of heart disease, and it is almost solely related to the avoidance of physical exertion and the use of oxygen in the home. Therefore, patients who have heart disease secondary to lung disease are particularly vulnerable to further attacks of severe failure, and the question of ability to work should not even be brought up.

I am glad to say that as a result of the oxygen therapy which I introduced and a very sedentary lifestyle and avoidance of work that Mr. Merritt is in surprisingly good condition. His survival to this point after the catastrophic illness of last spring is a matter of some surprise to me. Any return to work would create the conditions of last spring and would be unthinkable. I am glad that Dr. Aiello concurred with this opinion. Mr. Merritt's advanced state of illness represents the worst case of occupational lung disease that I have seen in more than 10 years, and I think that it shows that ideas that the problem of exposure to talc in Gouverneur, New York have been brought under control must be considered premature.

Yours sincerely,

J. Howland Auchincloss, Jr., M.D.
Chief, Pulmonary Disease Section

JHA/ms