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CIN SCAN 05/04/2005

March 1, 2005

ROBERT DENNIS, MD
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RE: Patton, Richard
SS#: 271-58-0141

Dear Dr. Lamping,

I saw Richard Patton for the first time today. He is a very pleasant 39-year-old Caucasian male. He works at a chemical factory. He makes different paste ingredients. He works as a chemical engineer but is also exposed to various fumes.

OPERATOR

In January he was exposed to a high level exposure to a combination of isovalderhyde and some acetaldehyde. He developed some tightness in his chest and some discomfort. He had underwent evaluation at the plant that included pulmonary function tests performed. The PFTs that I have done that day showed his FEV₁ had dropped from his baseline at 3.96 to 3.82 and then a repeat set of pulmonary function tests on February 18 had come back up to 3.86.

The patient has no previous history of asthma or obstructive lung disease. He is a lifetime nonsmoker. He has actually been in pretty good health. He has worked for more than 20 years at this plant and has had pulmonary function tests at least since 1991. In 1991 his FEV₁ was 4.14 and over the last 13 years it gradually decreased down to 3.96 in May of 2004. He has never had a similar sort of heavy exposure although he had been exposed to acetaldehyde and other fumes over the years.

He does wear a respiratory full face at work and has been very careful to avoid any exposures or any irritants.

After his exposure he was evaluated but felt not to warrant any specific therapy. Specifically he was not placed on steroids, either inhaled or systemic. He continued to work for the next few days. He did then develop lower back pain and had to switch over to light duty which he is currently on now.

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He still feels somewhat uncomfortable in his chest. He feels as if he cannot get a deep breath. He has no cough at this time, no fevers, no chills.

He has no personal history for asthma either as an adult or a child. No one in his family has asthma that he is aware of. He is a lifetime nonsmoker.

On examination today he is a well-nourished, well-developed gentleman in no acute distress. Heent examination is unremarkable. Chest is clear.


Chest x-ray that we did today shows mild hyperinflation but no endobronchial lesions, no infiltrates or atelectasis.

Mr. Patton is at risk for developing bronchiolitis. The exposures that he has had at this plant have shown in the past other people working at that plant to develop bronchiolitis. He is aware of this and that is one of his concerns. A similar sort of exposure risk has been reported for people that work with microwave popcorn, something which he actually has been exposed to in the past as well.

At this point the testing that he has had is normally recommended. That is to undergo serial pulmonary function tests as he has had. However, I would still be a bit nervous about whether he has developed bronchiolitis to some degree. He has certainly very consistent exposure.

An alternative event could have been just airway hyperreactivity. In fact one of the problems.. in my mind about sorting these two out is bronchiolitis from reactive airway disease syndrome is that in bronchiolitis it can be irreversible. Often the patients that I have seen with this condition will have lost lung function and never really regain it back. In his case we know the exposure was relatively recently and my bias would be to give him steroids at this point to see whether he can improve it. Specifically I will place him on some Advair today and we will get pulmonary function tests including testing for small airway disease as well as get a high resolution CT scan with inspiratory and expiratory views. The latter is useful for looking for evidence of mosaic pattern, something one can see with bronchiolitis. I will see him back in a few weeks with his testing done.

Sincerely yours,



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Robert P. Baughman, M.D.
Professor of Medicine

RPB/jaw

c: Rich Patton
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