Long term effects on the olfactory system of exposure to hydrogen sulphide

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Abstract

Objective—To study chronic effects of hydrogen sulphide (H2S) on cranial nerve I (nervi olfactorii), which have been only minimally described.

Methods—Chemosensations (smell and taste) were evaluated in eight men who complained of continuing dysfunction 2–3 years after the start of occupational exposure to H2S. Various bilateral (both nostrils) and unilateral (one nostril at a time) odour threshold tests with standard odours as well as the Chicago smell test, a three odour detection and identification test and the University of Pennsylvania smell identification test, a series of 40 scratch and sniff odour identification tests were administered.

Results—Six of the eight patients showed deficits of various degrees. Two had normal scores on objective tests, but thought that they continued to have problems. H2S apparently can cause continuing, sometimes unrecognised olfactory deficits.

Conclusion—Further exploration into the extent of such problems among workers exposed to H2S is warranted.

Keywords: hydrogen sulphide; smell; taste disorders

Hydrogen sulphide (H2S), a colorless gas easily recognised at 0.025 ppm by its distinctive rotten egg odour, is well known to affect diffuse areas of the human nervous system including the cortex, subcortex, cranial nerves, and peripheral nervous system.1,2 Its effects on cranial nerves II, V, and VIII have been extensively documented, but its chronic effects on cranial nerve I (nervi olfactorii) have been minimally described.3,4 An acute effect of H2S on the olfactory nerve is temporary paralysis, or olfactory fatigue, which disables the sense of smell, rendering it a poor warning system for detecting the continued presence of the gas.3,5 Acute effects have generally been described as transient.

Chronic effects of H2S on the olfactory system have been described in only one instance: a 46 year old man working next to a sludge centrifuge at a sewage treatment plant was overcome and rendered unconscious for less than a minute. After regaining consciousness, a neurological examination showed reduced memory, impaired concentration, and complete loss of the sense of smell. His electroencephalogram (EEG) was normal at that time. Ten months after the accident, the patient continued to complain of tiredness, impaired initiative, expressive aphasia, and episodes of trembling. His loss of the sense of smell persisted, except that he was able to detect ammonia. Examination at that time showed impaired visual accommodation and fusion, but neuropsychological test results were normal. Two years after the exposure, CT, and EEG were normal, as were neuropsychological test results, and his sense of smell had returned to normal. Whether his sense of smell was objectively assessed or his subjective evaluation reported, however, is not documented.

Our purpose in the present study was to evaluate chronic effects on olfaction after exposure to H2S.

Methods

SUBJECTS

Eight men who came for medical evaluation of continuing problems with smell and taste had had accidental exposure to H2S during their jobs 2–3 years previously.

Patients 1–4

On 8 January 1993, 900 pounds of H2S were released into the environment over a 2.5 hour period at a construction site at a gas refinery in St Croix, Virgin Islands. Two years later we examined four of the workers, who had experienced various local irritating effects including lachrymation, eye irritation, nausea, vomiting, headache, sore throat, and skin irritation. They had also experienced chemosensory phenomenon consistent with H2S exposure, the smell of rotten eggs, and a strong metallic taste.6 None of the patients had lost consciousness during the accident. At the time of the accident, atmospheric H2S concentrations were not obtained, but in previous months the patients had been exposed to similar low level releases, when the recorded concentrations of H2S were as high as 243 ppm in the work area. The past exposures of these four patients is considered chronic.
Table 1  Clinical data 3 years after exposure to H$_2$S

<table>
<thead>
<tr>
<th>Patient No</th>
<th>Age (y)</th>
<th>Loss of consciousness with exposure</th>
<th>Rate of exposure</th>
<th>Onset of taste problem</th>
<th>Onset of smell problem</th>
<th>Rate of deficit</th>
<th>Duration of deficit</th>
<th>Phantosmia?</th>
<th>Encephalopathy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>45</td>
<td>No</td>
<td>Chronic</td>
<td>3 Months after</td>
<td>1 Month after</td>
<td>Increased then</td>
<td>Unknown</td>
<td>No</td>
<td>Subclinical</td>
</tr>
<tr>
<td>2</td>
<td>39</td>
<td>No</td>
<td>Chronic</td>
<td>5–10 Months after</td>
<td>9–10 Months after</td>
<td>Increased then</td>
<td>Unknown</td>
<td>Yes</td>
<td>Clinical</td>
</tr>
<tr>
<td>3</td>
<td>44</td>
<td>No</td>
<td>Chronic</td>
<td>2 Years after</td>
<td>Immediate</td>
<td>No change</td>
<td>Unknown</td>
<td>No</td>
<td>Clinical</td>
</tr>
<tr>
<td>4</td>
<td>41</td>
<td>No</td>
<td>Chronic</td>
<td>2 Years after</td>
<td>1–1.5 Years after</td>
<td>Increased then</td>
<td>Unknown</td>
<td>No</td>
<td>Clinical</td>
</tr>
<tr>
<td>5</td>
<td>52</td>
<td>Yes</td>
<td>Acute</td>
<td>1–1.5 Years after</td>
<td>Immediate</td>
<td>No change</td>
<td>Unknown</td>
<td>Yes</td>
<td>Acute</td>
</tr>
<tr>
<td>6</td>
<td>69</td>
<td>Yes</td>
<td>Acute</td>
<td>1–1.5 Years after</td>
<td>Immediate</td>
<td>No change</td>
<td>Unknown</td>
<td>Yes</td>
<td>Acute</td>
</tr>
<tr>
<td>7</td>
<td>40</td>
<td>Yes</td>
<td>Acute</td>
<td>1–1.5 Years after</td>
<td>Immediate</td>
<td>No change</td>
<td>Unknown</td>
<td>Yes</td>
<td>Acute</td>
</tr>
<tr>
<td>8</td>
<td>61</td>
<td>Yes</td>
<td>Acute</td>
<td>1–1.5 Years after</td>
<td>Immediate</td>
<td>No change</td>
<td>Unknown</td>
<td>Yes</td>
<td>Acute</td>
</tr>
</tbody>
</table>

Rate of exposure: Chronic or Acute

Loss of consciousness with exposure: No or Yes

Onset of taste problem: 3 Months after or 5–10 Months after

Onset of smell problem: 1 Month after or 9–10 Months after

Rate of deficit: No change or Increased then

Duration of deficit: Unknown

Phantosmia?: No, Yes

Encephalopathy?: Subclinical, Clinical

Smell tests:
- UPSIT smell ID 30 of 40, 35 of 40, 35 of 40, 38 of 40, 29 of 40, 17 of 40, 23 of 40
- Chicago smell test (CST) 4 of 6, 4 of 6, 4 of 6, 6 of 6, 3 of 6, 3 of 6, 4 of 6

Amoore's unilateral thresholds: Normal, Abnormal

Mild hyposmia Normosmia Normosmia Normosmia Moderate hyposmia Anosmia

At refinery construction site (chronic) At petroleum plant gas leak (acute)

Patients 5–8

On 14 May 1993, four workers were sent as part of a crew to fix a gas leak at a petroleum plant in Texas. On their arrival at the site of the leak, the workers noted fumes coming out from underground. They also noted that in the surrounding area, the odour of rotten eggs was strong, the grass was brown, and birds lay dead. The workers descended into a trenching system 8 feet deep, 7 feet wide, and 12 feet long. None wore protective garb. While attempting to fix the broken pipe, all were overcome by the gas and were unconscious for several minutes before being discovered. They were treated for gas intoxication, were admitted to the intensive care unit, and spent at least a week in hospital. At the time of exposure, atmospheric H$_2$S concentrations were not obtained, but 3 days after the accident, the concentration of H$_2$S in the gas leaking out of the pipe into the trench was 2873 ppm as measured by the United States Department of Labor and the Occupational Safety and Health Administration (OSHA). When we examined the four patients, 2.5 years had elapsed since their acute exposure. There were no known past or subsequent exposures to H$_2$S in these subjects.

Clinical evaluation

All patients were asked their subjective experience of anosmia, hyposmia (decreased odour sensitivity), hyperosmia (increased odour sensitivity), phantosmia (phantom smells), dysosmia (deranged sense of smell), hypogeusia (decreased taste sensitivity), phantomgeusia (the taste equivalent of phantosmia), and dysgeusia (the taste equivalent of dysosmia). All were asked to follow the instructions in the appendix in preparation for objective tests. They then underwent bilateral (with both nostrils simultaneously) odour detection tests according to the methods of Amoore and Ollman’ with the following standard odors at concentrations of 25 decismels (ds), a normally detectable level (the ds scale of odour levels is modelled after the decibel scale of sound levels): phenyl ethyl methylethyl carbinol (pm carbinol), isovaleric acid (iv-acid), 2,3 butanedione (diacetyl), pentadecalactone (pd-lactone), I-carvone, phenylethyl alcohol (pe-alcohol), and tetrahydrothiophene (thiophane). They also underwent the Chicago smell test, consisting of three forced choice questions pertaining to odour and three open ended questions pertaining to odour identification. Most also underwent other olfactory tests: the University of Pennsylvania smell identification test (UPSIT), a series of 40 scratch and sniff forced choice odour identification questions scored according to age and sex as described in the published guidelines for the UPSIT; and the unilateral (one nostril at a time) threshold tests of Amoore and Ollman for pm carbinol, paraethyl phenol (pe-phenol), naphthylacetone (pd-lactone), I-carvone, phenylethyl alcohol (pe-alcohol), and tetrahydrothiophene (thiophane).

Results

At the time of our evaluations, all patients had subjective complaints of chemosensory dysfunctions, which consisted of hyposmia (eight
patients), dysosmia (one patient), hyperosmia (one patient), phantosmia (one patient), hypoguesia (eight patients), and phantogeusia (one patient). Problems began immediately for three of the four patients who had acute exposure at the site of the gas leak, but for only one of the four patients exposed at the construction site. The onset of their problems ranged from immediately to 2 years after exposure (table 1).

Objective test results are summarised in table 1. Patients Nos 3 and 5 had normal scores on objective tests, but still considered subjectively that their chemical senses were deficient.

All three from the acutely exposed group who took the UPSIT odour identification test had poor scores, whereas three of the four in the chronic group had normal scores and the fourth was only mildly hyposmic.

Discussion
An impaired ability to identify odours along with a normal ability to detect them as shown by our patient No 7 has been described to occur with head trauma and may indicate the existence of a lesion of the central nervous system rather than a peripheral lesion in the olfactory nerves.19 All of our patients with acute exposure were deficient in their ability to identify odour. Such olfactory deficit could be due to the loss of consciousness and head trauma associated with falling.

Patient No 1, however, was mildly hyposmic on the UPSIT without having lost consciousness and without head trauma. This deficit in the case of our subjects, could be due to the neurotoxic effect of the H₂S on the olfactory receptor site or through the retrograde degeneration of the olfactory nerves as they project through the olfactory bulb and tract to the olfactory cortex.

As some of our construction worker patients had histories of considerable toxic exposures including use of alcohol which we have shown can induce olfactory deficit,11 it seems possible that our findings of olfactory deficits are unrelated to exposure to H₂S and instead are associated with confounding factors—such as collateral toxic exposures.

Conclusions
As long as three years after their exposure to H₂S, a high percentage if not all of our patients continue to have olfactory deficits. The long duration of this deficit indicates that it may be permanent.

Patients Nos 3 and 5 who complained of deficits yet were normosmic on tests may have permanent.

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The extent of such problems among workers exposed to H₂S and other industrial effluviums is a subject deserving of further careful exploration.

Appendix: Questionnaire
As we are testing abnormalities of smell and taste, the following precautions must be taken:

- You may eat or drink no caffeine for at least 48 hours before your visit (see list below of foods and beverages containing caffeine)*
- You may drink no alcohol for at least 4 days before your visit
- You may eat no pastry items for 24 hours before your visit
- From the midnight before your visit, you may have none of the following; food, gum, cigarettes, or any drink other than water

IT IS IMPORTANT THAT YOU FOLLOW THESE INSTRUCTIONS TO INSURE THE VALIDITY OF THESE TESTS

- From the midnight before your test day, you should use no scented soap, cosmetics, deodorants, shaving cream, aftershave, perfumes, or lipsticks. The only underarm deodorant you may use is Gillette roll on
- From the midnight before your visit, you may use only shampoo with no or minimal smell—that is, ivory shampoo
- You may brush your teeth, but we ask you not to use toothpaste
- All your usual medications should be taken and if you have diabetes you should eat.

*Foods and beverages containing caffeine that you should try to avoid:

- Chocolate
- Coffee
- Tea
- Cocoa
- NoDoz

Other over the counter products that are "stimulants"

be sure to read your labels