PLAINTIFF'S EXHIBIT

UC-4175

UNION CARBIDE

INTERNAL CORRESPONDENCE

UNION CARBIDE CORPORATION OLD RIDGEBURY F

Copy for YMI Subject files

To (Name) Ms. Sula Baye, Attorney
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H. B. Rhodes

Date June 25, -

Originating Dept HS&EA

Area P-2

Subject Testimony: Asbestos - OSHA Hearings

Please find attached a revised draft of the testimony which I propose to submit on July 12, 1984 at the informal rulemaking hearing on the OSHA Notice of Proposed Rulemaking on Occupational Exposure to Asbestos.

I have taken note of the comments received in response to my memo of June 12, 1984, and made changes to accommodate most of them. At the specific suggestion of Bob Cope, the "Introduction" has been expanded to include an expression of my opinion on the proposed exposure limit.

Please review this version of the draft document and let me have comments by July 6, 1984. I doubt if another major revision of the document will be possible before the date of my testimony, so please be as critical as you can!

Sincerely,

H. C. Lewinsohn, M.D.
Assistant Corporate Medical Director

HCL/pmb
Att.

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The strictest attention must be paid to the detail of radiologic and physiologic methods employed. It should always be borne in mind that the employee's attitude to periodic medical evaluation is far different from that to pre-employment evaluation since the concerns at the time of the latter are job suitability, whereas the concerns in the employee's mind at the time of the former are job retention.

LIFE-LONG SURVEILLANCE

Persons who may be potentially exposed to asbestos should not only be kept under surveillance while employed in the relevant trade or occupation, but because of the lapsed interval between first exposure and the detection of biological effects, should continue to be medically evaluated at periodic intervals for as long as it is feasible to do so. To expect their former employers to provide for this follow-up would be onerous and costly, but the need should be emphasized at the time of the employee's termination health review.

Retirees who receive pensions from employers may conceivably be easier to follow-up but this may not necessarily be less onerous or costly than for persons who sever employment prior to reaching retirement age. Employers may wish to advise employees of the value of remaining under medical surveillance after retirement. The follow-up of retirees may possibly be undertaken by means of a health questionnaire sent by mail incorporating a reminder to each one to see a physician and have a chest radiograph taken. It is possible that in some cases this could lead to the early detection of lung cancer and prompt institution of therapy may prolong life or alleviate suffering.

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CONTENT OF A MEDICAL SURVEILLANCE PROGRAM

Table 3 illustrates the complexity of designing an adequate medical surveillance program which satisfies the needs described in the preceding pages of this document. The following section is based upon recommendations from Organization Resources Counselors, Inc. (ORC) which were submitted to the Assistant Secretary of Labor for Occupational Safety and Health on June 6, 1983. (A copy of the relevant portion of this submission is attached hereto as Appendix 1).

The periodicity of the various components of the surveillance program has been empirically determined based on current thoughts and understanding of the subject within the international medical community. The following Tables 4-10 summarize the data in Table 3 according to the type of examination, its content and periodicity. (SLIDES #12 - 18)

It has been known for many years that asbestosis is one of the effects of exposure to respirable airborne concentrations of asbestos fibers. Furthermore, it is accepted that a dose-response relationship can be demonstrated for the radiologic features of asbestosis in terms of length of exposure and levels of exposure. Similar dose-response relationships have been demonstrated for lung function and physical findings such as basal rales (crackles). These facts have recently been well summarized. 26,27

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Based upon the knowledge of the dose-response relationship demonstrated, it would appear that the traditional routine of performing an annual medical evaluation of each and every asbestos worker is unnecessary and burdensone

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upon both employer and employee. With this in mind, the scheme suggested in Table 3 has been proposed to lessen the frequency of medical surveillance procedures by stipulating a periodicity based on either age or length of exposure at or above the action level. It is apparent that young people will be examined less frequently than older persons unless length of exposure overrides age considerations. It is considered reasonable that the annual medical evaluation not be obligatory until either after age 45 or 10 years exposure, whichever occurs sooner.

These suggestions are in keeping with current thinking especially with regard to the frequency and periodicity of chest x-rays. 28 15

The approach adopted is that the employer shall incorporate certain procedures in the medical surveillance of persons exposed to asbestos at or above the action level. These mandatory procedures for pre-employment or pre-assignment examinations, periodic examinations and termination examinations are the obtaining of a medical history, which includes a respiratory symptoms questionnaire, physical examination of the respiratory system and digestive system, chest radiology and pulmonary function tests.

Insufficient positive evidence exists for the obligatory incorporation of sputum cytology in the medical surveillance program. In the NPR the question is asked as to whether it would be appropriate to screen asbestos exposed persons for colo-rectal cancer, including tests for occult blood in the feces. This question may well be redundant since colo-rectal screening by means of occult blood tests is a routine procedure already incorporated into

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many employer's medical programs. Recent evidence tends to suggest that the epidemiologic evidence for an association between asbestos exposure and gastro-intestinal tract cancer is very weak and the ~~grounds~~ reason for mandating the incorporation of colo-rectal screening ~~are~~ is inadequately supported on these grounds alone. 29

On page 14131-2 comments on issues pertaining to medical examinations in the construction industry including, those listed in the general industry discussion, are solicited. In this section of the OSHA proposal the logistic difficulties involved in developing an adequate medical surveillance program are discussed and it is suggested by OSHA that attention should be directed toward developing a generic standard for physical examinations and the identification and documentation of hazardous materials, processes, and work practices in the industry. OSHA's goals may be desirable but probably unachievable at the present time. By its own admission OSHA has insufficient "information regarding the variety of exposures to construction employees" since it requests more in the proposal. Construction workers, as described on page 14128, work across the board in many industries and the occurrence of asbestos-related diseases has been described in many of the occupations listed. If one of the main objectives of medical surveillance is early detection of health effects then it would appear that this potentially large group of workers may be excluded. One reason for the difficulties envisioned in keeping construction workers under medical surveillance is the annual medical examination requirement. If a more flexible scheme were available, based on Table 3 above, the possibility of keeping this group of potentially exposed persons under surveillance would be increased.

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COMMENTS

The prevention of asbestos-related diseases depends upon engineering technology and dust control. The role of the physician is to aid in the prevention of ill-suited job-placement and intervene in a timely manner at the interface between worker and work. The technique of medical surveillance is merely one cog in the wheel which comprises the total effort required to safeguard employee health. The active collaboration of employer and employee in the surveillance program may allow the achievement of significant results which could be of benefit to both.

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old and relates to happenings during the past 30 or 40 or even 50 years. Political pressures, not scientific considerations, have forced OSHA to propose a new standard. If a new standard is set, it should be one which is enforceable and achievable by industry. Industry has demonstrated that it can meet the present standard and in many cases, merely by doing so, has found that it can achieve even more rigid goals.(4) With this in mind, it would seem reasonable to propose a standard of 1 fiber/ml averaged over an eight hour period, effective in 1985. One year after the effective date the standard could be made more stringent at 0.5 fibers/ml TWA_8 hr., and within five years of the effective date, if new evidence has not emerged to support the 0.5 fibers/ml limit, the proposed 0.2 fibers/ml standard would become effective.

I should now like to consider the medical surveillance of persons exposed to asbestos. This dissertation on the medical surveillance of persons exposed to asbestos is in response to OSHA's request for comments in Section VI of the Proposal, namely: "Summary and Explanation of the Proposed Amendments and Other Issues Relevant to the Permanent Standard." Paragraph 11 (Medical Surveillance Program) on page 14126 discusses the proposed action level which will trigger the need for a medical surveillance program (a), and itemizes a number of proposed policy decisions [(b) - (e)]. These proposals are discussed in this document although not necessarily in the same sequence as in the NPR.

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to malignant mesothelioma of the peritoneum.(12) It may be difficult to distinguish ovarian carcinoma from peritoneal mesothelioma.

Because of its increasing and widespread use in the U.S.A. in many industries during the past 50 years, lasting up until very recent times, it has been suggested that millions of people may have been exposed in various ways to different varieties of asbestos due to a general lack of understanding of the seriousness of the associated health hazards.(13)

The asbestos-related diseases are not readily amendable to therapy. Asbestosis is slowly progressive, the outlook for the person with lung cancer is very poor and diffuse malignant mesothelioma of the pleura or peritoneum is invariably fatal within a short period of time after diagnosis. The physician practicing in the industrial environment is faced with a dilemma of severe proportions when attempting to intervene or prevent undue suffering on the part of exposed individuals, but with diligence and perserverence can definitely exert a meaningful influence.

Physicians whose practice includes providing a service to industry must be actively involved with workers and management, must be completely familiar with the properties of asbestos in use, must understand the manufacturing processes in the plant and have a clear concept of the plant design and layout. The doctor who has taken the trouble to become educated in this way will be better equipped to assist in the management of the health of people at work. In addition to gaining practical experience of the workplace the physician also needs to gain a thorough working knowledge of the etiology,

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Also we actually do this? No, I don't think so.

Is this absolute? I would think a person who worked in an industry where properly controlled exposure to coal occurred would not automatically be denied employment in an industry where properly controlled exposure to asbestos occurs

DRAFT

with a recognized dust hazard such as coal mining or stone quarrying, an existing pulmonary disability due to pneumoconiosis or from any other source, the presence of obstructive airways disease with or without emphysema, asthma, and organic heart disease. (Slide #4) Other contraindications to employment in dusty jobs including asbestos, which have been recommended are: (1) Nasal obstruction or deformity of such a degree as to make the wearing of a dust mask difficult or impossible, (2) gross physicial deformity of the chest such as scoliosis or kyphosis, or as a result of thoracic surgery, (3) chronic bronchitis, bronchiectasis or emphysema, (4) gross hypertension with cardiac impairment and (5) the presence of rheumatoid arthritis. (Slide #5)

any kind? - seems severely restrictive to employee

This seems unduly restrictive. RA can be mild. The arthritis associated with lung disease is

Apart from identifying people who should not be employed in dusty work, the pre-placement evaluation serves the purpose of establishing base-line data for longitudinal prospective follow-up. The data which should be incorporated in the medical records for this purpose are summarized in Tables 1 and 2.

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That's not all!

significantly delay the progress of asbestosis or the occurrence of other asbestos-related conditions.(17) - Medical surveillance also functions to learn of employee work practices, Counsel on health protection, advise on exposure levels and record health experience for possible future epidemiologic study.

The periodic evaluation should include a physical examination even though the present OSHA standard does not specify it. The examiner should concentrate on the physical signs associated with pulmonary fibrosis such as bilateral end-inspiratory fine crackles at the lung bases, finger-clubbing and breathlessness. In the case of long-service employees, especially heavy-smokers, the possibility of lung cancer should always be borne in mind. Transient pleural effusions occur in asbestos workers.

The aim of radiologic surveillance of asbestos workers is to compare serial roentgenograms taken throughout the exposure period at regular intervals in order to detect the earliest changes. Radiographic evidence of predominantly basal diffuse interstitial fibrosis is the characteristic change seen in asbestosis. The Medical Advisory Panel (MAP) of the Asbestos International Association has prepared a document entitled "Criteria for the Diagnosis of Asbestosis and Considerations in the Attribution of Lung Cancer and Mesothelioma to Asbestos Exposure".(18) The MAP recommend that to ensure comparibility of radiographs they must be of good technical quality, of full size (14"x17") and both costo-phrenic angles should be visible. Ideally inspiration should be such as to have brought the diaphragm below the fifth rib anteriorly and the tenth rib posteriorly. The recording of changes on the radiograph should be in accordance with the ILO International Classification of Radiographs of Pneumoconioses (1980).(19)

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many employers' medical programs. Recent evidence tends to suggest that the epidemiologic evidence for an association between asbestos exposure and gastro-intestinal tract cancer is very weak and the reason for mandating the incorporation of colo-rectal screening is inadequately supported on these grounds alone.(29)

On page 14131-2 comments on issues pertaining to medical examinations in the construction industry including, those listed in the general industry discussion, are solicited. In this section of the OSHA proposal the logistic difficulties involved in developing an adequate medical surveillance program are discussed and it is suggested by OSHA that attention should be directed toward developing a generic standard for physical examinations and the identification and documentation of hazardous materials, processes, and work practices in the industry. OSHA's goals may be desirable but probably unachievable at the present time. By its own admission OSHA has insufficient "information regarding the variety of exposures to construction employees" since it requests more in the proposal. Construction workers, as described on page 14128, work across the board in many industries and the occurrence of asbestos-related diseases has been described in many of the occupations listed. If one of the main objectives of medical surveillance is early detection of health effects then it would appear that this potentially large group of workers may be excluded. One reason for the difficulties envisioned in keeping construction workers under medical surveillance is the annual medical examination requirement. If a more flexible scheme were available, based on Table 3 above, the possibility of keeping this group of potentially exposed persons under surveillance would be increased.

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ABSTRACT:

This paper will briefly review the techniques which allow persons exposed to asbestos to be kept under surveillance.

The pre-placement evaluation procedure and its usefulness is discussed.

The periodic medical evaluation is described and an outline of the essential requirements is given. The role of radiological surveillance is briefly discussed.

The point is made that both the exposed persons and their management place reliance upon the physician to inform them of adverse findings so that the problem of alternative employment and future protection can be dealt with in a sound and equitable manner.

Medical surveillance should continue for the life-time of the individual once exposure has been documented and post-retirement or post severance examinations should be provided whenever practicable.

Asbestos-related diseases can be prevented by good industrial hygiene practices and engineering controls. The physician is able to intervene at the interface between worker and work and hopefully alter the final outcome to the good.

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INTRODUCTION

Exposure to asbestos in various industries and occupations has been associated with three major lesions involving the intrathoracic organs. Asbestosis, first recognised at the beginning of this century, is a form of interstitial pulmonary fibrosis which has been shown to be related to the dust levels in the workplace and to be dependent upon the duration of such exposure. Lung cancer in heavily exposed workers in industries such as insulation, construction, ship-building and asbestos textiles manufacture, has been adequately documented and related to asbestos exposure. Asbestos exposed persons who smoke cigarettes appear to have a 50 times greater chance of dying from lung cancer than non-smoking non-asbestos exposed persons.[1] The third condition to be associated with exposure to asbestos is diffuse malignant mesothelioma of the pleura (or peritoneum).[2] Unlike asbestosis and lung cancer, this rare tumor has been more difficult to characterize in terms of dose-response and pathologic features.

Less clear-cut associations have been described by some observers between asbestos exposure and cancers involving the gastrointestinal tract [3,4] and cancers in other organs such as the larynx[5] or renal organs.[6] Cancer of the ovary in women has been ascribed to asbestos exposure.[7] It is suggested that the cases described were actually of peritoneal origin and due to malignant mesothelioma of the peritoneum. It may be difficult to distinguish ovarian carcinoma from peritoneal mesothelioma.

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Because of its increasing and widespread use in the U.S.A. in many industries during the past 50 years, lasting up until very recent times, it has been estimated that millions of people have been exposed in various ways to various varieties of asbestos.[9]

The asbestos-related diseases are not readily amenable to therapy. Asbestosis is slowly progressive, the outlook for the person with lung cancer is very poor and diffuse malignant mesothelioma of the pleura or peritoneum is invariably fatal within a short period of time after diagnosis. The physician practicing in the industrial environment is faced with a dilemma of severe proportions when attempting to intervene or prevent undue suffering on the part of exposed individuals, but with diligence and perserverence can definitely exert a meaningful influence.

Physicians whose practice includes providing a service to industry must be actively involved with workers and management, must be completely familiar with the properties of asbestos in use, must understand the manufacturing processes in the plant and have a clear concept of the plant design and layout. The doctor who has taken the trouble to become educated in this way will be better equiped to manage the health of people at work. In addition to gaining practical experience of the workplace the physician also needs to gain a thorough working knowledge of the etiology, pathogenesis, epidemiology and therapy of work-related diseases. The physician should acquire a working knowledge and appreciation of the theory and practice of industrial hygiene, including an understanding of sampling and monitoring procedures.

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The role of the physician is to insure that industry employs people who are suited to the tasks required of them and that they do not suffer injury or illness as a result of the work they are called upon to do.

PRE-PLACEMENT MEDICAL EVALUATION OF PERSONS EXPOSED TO ASBESTOS

The pre-placement medical evaluation is designed to determine the suitability of the employee for the job and the suitability of the particular job for the individual concerned. When asbestos exposure is likely the workplace conditions must be known before decisions can be made about a prospective employee with medical contra-indications to such employment. As the result of experience already gained in the development of medical surveillance programs, the suitability of prospective employees for the specific tasks in question may be estimated and based upon defined selection criteria.[10] Applicants should be appropriately counseled regarding their fitness or otherwise for employment in an asbestos-exposed occupation and if any restrictions need to be imposed on medical grounds they should be indicated to the applicant and the employer prior to placement in the job. There are certain broadly defined conditions which should contraindicate employment: a history of previous work in another industry with a recognized dust hazard such as coal mining or stone quarrying, an existing pulmonary disability due to pneumoconiosis or from any other source, the presence of obstructive airways disease with or without emphysema, asthma, and organic heart disease. Other contraindications to employment in a dusty job which

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have been recommended are: (1) Nasal obstriction or deformity of such a degree as to make the wearing of a dust mask difficult or impossible, (2) gross physical deformity of the chest such as scoliosis or kyphosis, or as a result of thoracic surgery, (3) chronic bronchitis, bronchiectasis or emphysema, (4) gross hypertension with cardiac impairment and (5) the presence of rheumatoid arthritis.

Apart from identifying people who should not be employed in dusty work, the pre-placement evaluation serves the purpose of establishing base-line data for longitudinal prospective follow-up. The data which should be incorporated in the medical records for this purpose are summarized in Tables 1. and 2. and conform with the requirements of the Occupational Health & Safety Administration's "Asbestos Standard".

The physician should take the opportunity which the pre-placement evaluation affords to counsel and advise the job applicant regarding the known facts about asbestos-related diseases. It is essential to emphasize the special risks the person will run if he or she smokes cigarettes and every effort should be made to discourage the habit.

It has previously been pointed out that the pre-placement medical evaluation "is an essential tool for use in the medical supervision of asbestos workers because it establishes the principles upon which future management will be based. It gives the prospective applicant an insight into the seriousness of the problem and enables the physician to recommend suitability, limited suitability or total unsuitability of the individual for the job. The opportunity which pre-

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placement physical examination provides for the medical staff to counsel the individual and establish raport is unique and should not be missed. This period in the career of the job applicant provides the best opportunity for the recording of identification details and verifying them, in order to establish the data base for long-term follow-up."[12]

PERIODIC MEDICAL EVALUATION

Persons exposed to asbestos in their occupation should be kept under medical surveillance. The object of periodic examinations is not only to determine changes in the physical condition, physiological status or radiological appearances of the exposed person but also to re-evaluate the workplace conditions and the individual's suitability to continue doing the same job. Medical findings can be recorded on an ongoing basis to allow comparison from one examination to the next. The periodicity of the evaluation process will depennd upon demonstrated need and available man-power as well as regulatory requirements. The Occupational Safety and Health Administration promulgated the Asbestos Standard (CFR 1910.1001) in July 1972.[11] Section 1001(j)(3) requires that every employer shall provide, or make available, at least annually, comprehensive medical examinations to each employee engaged in an occupation exposed to airborne concentrations of asbestos fibers. The minimum requirement is for "a chest roentgenogram (posterior-anterior 14 X 17 inches), a history to elicit symptomatology of respiratory disease, and pulmonary function tests to include forced vital capacity (FVC) and forced expiratory

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volume at 1 second ($FEV_{1.0}$)."

Periodic medical evaluation is designed to detect the biological effects of inhalation of asbestos as early as possible and hopefully at a stage when removal from further occupational exposure to asbestos may arrest or significantly delay the progress of asbestosis or the occurrence of other asbestos-related conditions. Epidemiologic evidence of the value of this procedure is not yet available and the changing environmental conditions in the workplace throughout the asbestos industry over the past fifty years only serves to confuse the issue when attempting to assess the value of early diagnosis.[13]

The periodic evaluation should include a physical examination even though the OSHA standard does not specify it. The examiner should concentrate on the physical signs associated with pulmonary fibrosis such as bilateral end-inspiratory fine crackles at the lung bases, finger-clubbing and breathlessness. In the case of long-service employees, especially heavy-smokers, the possibility of lung cancer should always be borne in mind. Transient pleural effusions occur in asbestos workers.

The aim of radiologic surveillance of asbestos workers is to compare serial roentgenograms taken throughout the exposure period at regular intervals in order to detect the earliest changes which would result in deciding whether the individual should be advised to consider alternative employment. Radiographic evidence of predominantly basal diffuse interstitial fibrosis is the characteristic change seen. The Medical Advisory Panel (MAP) of the Asbestos International Association has prepared a document entitled "Criteria for

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the Diagnosis of Asbestosis and Considerations in the Attribution of Lung Cancer and Mesothelioma to Asbestos Exposure" which will become available in early 1982.[14] The MAP recommend that to ensure comparibility of radiographs they must be of good technical quality, of full size (14"X17") and both costo-phrenic angles should be visible. Ideally inspiration should be such as to have brought the diaphragm below the fifth rib anteriorly and the tenth rib posteriorly. The recording of changes on the radiograph should be in accordance with the ILO International Classification of Radiographs of Pneumoconiosis (1980).[15]

Pleural lesions are often the first radiological indicator of exposure to asbestos. These changes may consist of diffuse or localized pleural thickening or circumscribed pleural plaques, with or without calcification, may occur and need not be associated with obvious parenchymal fibrosis. The pleural abnormalities can be sufficiently extensive to obscure the lung fields and may, in rare cases, lead to impairment of lung function.

Pleural plaques develop in the parietal pleura, seldom cause disability, and are not considered to be a compensable condition in certain countries, eg. Britain. Pleural effusions may be transient but some are chronic and may recur.

Diffuse pleural thickening associated with exposure to asbestos has become increasingly recognised. Both pleural layers are affected and restrict the expansion of the lung. The diagnosis depends on the exclusion of other causes such as tuberculosis and other infections, collagen diseases, trauma, chronic uraemia, and drug induced fibrosis.

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It has been shown that whereas parenchymal radiograhic patterns change in relationship to dust concentrations experienced over the course of time, pleural changes are related to length of exposure,

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irrespective of dose. Pleural changes probably represent an important radiologic sign which is part of a constellation of changes observed in low-grade exposure groups where parenchymal effects are less likely to be seen.[16]

Weill[17] has attempted to evaluate the basis for clinical decision making by the physician evaluating patients who have had occupational exposure to asbestos. In an asbestos worker definite radiographic evidence of diffuse pulmonary fibrosis, even if it is minimal in profusion or extent, should be an indication to advise the individual that further exposure to asbestos dust may increase the probability that the condition will progress with time. The greater the past cumulative dust exposure, the higher the probability of progressive pulmonary fibrosis according to Weill. Cessation of exposure is only likely to minimize the degree of progression of fibrosis and, because the excess risk for development of respiratory cancer has been shown to be dose-related, this should also be minimized by not adding further to the dust dose of individuals with radiographic signs of asbestosis.

Pleural thickening and pleural plaques are apparently related to length of exposure and time since first exposure but not to dose, and are not therefore likely to be influenced by modest additional exposure. Weill believes that when only pleural stigmata of asbestos exposure are present, continued medical surveillance and periodic evaluation is indicated but job transfer is not necessary. The patient should be told about the pleural lesions which have been noted so that the subsequent election to change to a job without further asbestos exposure can be considered if so desired.

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In the past 5 or 6 years the use of computed tomography (CT) in the diagnosis of asbestos effects on lungs and pleura has shown that both types of lesion are seen more obviously than on conventional

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radiographs. This diagnostic technique is not yet a practicle tool to add to the medical surveillance armamentarium but it is useful in early diagnosis. Early pleural plaques can be reliably diagnosed and are not confused with "companion" shadows adjacent to the ribs as in chest radiographs. Fine interstitial parenchymal disease can also be detected on CT when not visible on the chest radiograph according to Kreel.[18] By the time the changes of asbestosis have become visible on the chest radiograph, the changes on CT scan appear gross. The same author states that in one third of cases with unilateral pleural effusion there will be evidence on CT of pleural plaques particularly in the contralateral hemithorax. CT scans may thus be very useful in the diagnosis of mesothelioma and Kreel postulates that the finding of pleural effusion, rib destruction, pleural plaques or calcifications, intrapulmonary nodules and thickening of pleura, pleural fissures and paramediastinal structures especially at the bases and posteriorly should suggest this lesion. He also feels that the delineation of tumor nodules within effusions allows this tumor to be analyzed sequentially and better evaluated following treatment thus leading to improved therapeutic modalities.

In the periodic evaluation of asbestos exposed persons it is recommended that tests of lung function be used to determine the earliest defects possibly resulting from exposure. The measurement of the timed vital capacity components, namely, forced vital capacity (FVC), forced expiratory volume in the first second of expiration ($FEV_{1.0}$) and the ratio of these ($FEV_{1.0}$/FVC), should be routinely

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recorded. A restrictive pattern is consistent with the development of pulmonary fibrosis (asbestosis) but other causes should first be ruled out. A predominantly obstructive pattern is uncommon in the absence of a smoking history. A comparison of periodic lung function test results over a number of years is of much greater value in the follow-up of an individual than a single observation where comparisons can only be made to the "predicted normal value". Where facilities exist for more complete studies they should at least include measurement of lung volumes and the single-breath carbon monoxide diffusing capacity.

No mention has been made thus far of the role of sputum examination for exfoliative cytology. A proposal has been made in the United States that this should be performed routinely on persons with 10 or more years of exposure to airborne concentrations of asbestos fibers or who are 45 years of age or older.[19] A large-scale multi-institutional program designed to evaluate periodic screening for early stage bronchogenic carcinoma among asymptomatic asbestos workers is currently in progress.[20] Interim results do not indicate that sputum cytology is of overall benefit to screened individuals and "early data from studies of smoking men at high risk of lung cancer indicate that only one fourth of asymptomatic lung cancers are detected by sputum cytology and the remainder are detected by chest radiography.[21]

The value of the periodic medical evaluation depends upon the manner and thoroughness with which it is performed. The standardization of the protocol will enhance its early diagnostic capabilities.

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The strictest attention must be paid to the detail of radiologic and physiologic methods employed. It should always be borne in mind that the employee's attitude to periodic evaluation differs from that to the pre-placement evaluation and whereas the concerns at the time of the latter were job suitability, the concerns in the employee's mind at the time of the former are job retention.

LIFE-LONG SURVEILLANCE

Persons who are exposed to asbestos should not only be kept under surveillance while exposed, but because of the lapsed interval between first exposure and the detection of biological effects, observation should continue at periodic intervals for the rest of their lives.

Retirees who receive pensions from employers should be easier to follow-up than persons who sever employment prior to reaching retirement age. Employers should endeavor to impress upon such employees the value of remaining under medical surveillance. The follow-up of retirees could be undertaken by means of a health questionnaire sent by mail and incorporating a reminder to each one to see a physician and have a chest radiograph taken. In some cases this could lead to the early detection of lung cancer and therapy which could prolong life and alleviate suffering.

COMMENTS

The prevention of asbestos-related diseases depends upon engineering technology and dust control. The role of the physician

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is the prevention of ill-suited job-placement and intervention at the interface between worker and work. The technique of medical surveillance is merely one cog in the wheel which comprises the total effort required to safeguard employee health. The active collaboration of employer and employee in the surveillance program allows it to achieve significant results of benefit to both.

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