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12th March, 1958.

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KACZYNSKI

Dear Bob,

I was most interested in the patient whom we discussed last night. I have looked up my notes on asbestosis and the rest of the letter will really consist of extracts from these notes relevant to this particular case:

Pathology – Kenneth M. Lynch, in the A.M.A. Archives of Industrial Health, 1955, Vol.11, P.185. – "Pathology of Asbestosis" describes 4 grades. In the first, small numbers of asbestosis bodies are found in the alveoli. This, he says, is an incidental finding. In later stages, asbestosis bodies are found with definite changes in the lung tissue.

Clinical Asbestosis – in the A.M.A. Archives of Industrial Health, 1955, Vol.11, P.204, Paul Cartier makes a survey of 4000 asbestos workers in Quebec. Between 1945 and 1953, 128 cases of asbestosis were discovered, 40 of whom died. Of the 128, 121 were diagnosed by x-ray and the other 7 on pathological study only, i.e. diagnosis was not made on the films, where changes, if present at all, were minimal. Of the 40 deaths, 6 were due to bronchogenic carcinoma. It is of interest, that in the other 3,000 odd employees, only 7 died of bronchogenic carcinoma. Of the 88 survivors with asbestosis, 55 were able to work without discomfort. Of the remaining 29, no good correlation between the degree of asbestosis and the clinical status was found.

However, in an article in the Post-Graduate Journal of Medicine by B. Wyers, 1949, Vol.35, P.635, in a survey of cases of asbestosis, dyspnoea is quoted as a universal complaint. The author also mentions that sputum may be occasionally blood-specked (this is the only mention of haemoptysis that I have come across). In this survey, the average exposure to asbestos was: – Males 16.2 years, Females 7.3 " } All cases 10.4 years.

In a survey of 53 cases, 29 were found to have finger clubbing. (Also 33 of the 53 had an accentuated pulmonary 2nd sound.

On the other hand, Kenneth W. Smith, in the A.M.A. Archives of Industrial Health, 1955, Vol.12, P.196, states that there are no typical clinical feature of asbestosis and clubbing of the fingers is a rare finding. He states that asbestos workers are not predisposed to intercurrent pulmonary infections. "However, when an acute pneumonitis develops in the presence of an established asbestotic fibrosis, the infection is slow to heal, relapses are frequent and the patient may be more susceptible to subsequent pulmonary infections."

In an article –"Silicosis and Asbestosis" – American

Journal of Surgery, 1955, Vol.90, P.118, Sanders, referring to asbestosis, states that radiologically it needs to be distinguished from chronic passive congestion, bronchiectasis, polycythaemia and infiltrating malignant metastasis from the mediastinum.

The best description of x-rays that I have read, as yet, is by L. J. Bristol, A.M.A. Archives of Industrial Health, 1955, Vol.11, P.193, in which he designates 3 stages. His description infers rather than states that the disease tends to follow a bilateral symmetrical configuration.

The Relationship of Cancer of the Lung.

Editorial: American Journal of Clinical Pathology, 1955, Vol.25, P.1388. The relationship appears to be established and there appears to be an diversity of histological types. Asbestosis cancer of the lung is a compensable occupational disease in Germany. It does appear that increased liability to cancer of the lung has limited the presence of asbestosis of the lung and does not extend to exposure to asbestos without the existence of a pneumoconiosis resulting therefrom.

In the British Journal of Industrial Medicine, 1959, Vol.12, P.81, by Richard Doll, gives various percentages of lung cancer in cases of asbestosis:

1949 - Merewether 31 out of 235 = 13%.

1951 - Glyenn 17 " " 121 = 14%.

In Merewether's figures, 17% of men and in Glyenn's figures, 19.5% of men with asbestosis had carcinoma of the lung. All of the subjects in whom two diseases were associated, had at least 9 years in conditions in which control of dust did not have to be undertaken, i.e. prior to 1931 in England. He states that the association of the 2 conditions has not been found in any person taken into employment since that date. This point is more significant when it is realised that between 1933 and 1953, incidences of lung cancer among men in the country at large, increased six fold.

Apart from the clinical urgency, it is important to establish whether or not this patient has a carcinoma of the lung. By this I mean that the shadow in the left mid zone, i.e. a slowly resolving infection, could be due to carcinoma of the lung and he has got the clubbing of the fingers. There seems to be evidence that the latter is of fairly recent origin and probably of fairly rapid progress. I rather tend to the opinion that this rapidity would be more in keeping with clubbing due to a carcinoma of the lung than that due to ~~silicosis~~.

If this patient has carcinoma of the lung, we are left with the asbestos bodies and the inconclusive shadow at the right base, to establish a claim for asbestosis. It certainly might be well worth-while going ahead with the claim under these circumstances but if we are certain that there is no carcinoma, then we have a much sounder case for asbestosis.

I wonder if it would be of help if you could get a specimen of sputum and if you could send it down to Professor Tonnelden with a view to having a search for carcinoma cells.

I do hope that these notes will be of assistance to you and I would like to hear the outcome of your investigations for I am very interested in this patient. Thank you for bringing this problem to my notice.

Yours sincerely,