

of work activities that could affect the health of the individual, descriptions of work practices during brake maintenance and repair work, and the use of personal protection devices. Special care was taken to elicit information on previous exposures to asbestos and other dusts that might be pneumoconiotic.

The clinical examination, tests, and procedures consisted of:

1. complete medical history;
2. current and past uses of medications;
3. current and past symptoms;
4. physical examination;
5. complete blood count, including a differential count on individuals with an abnormal white cell count;
6. 20 channel blood chemistry analysis;
7. pulmonary function tests, including determination of complete flow-volume characteristics;
8. 14 x 17 inch, full size postero/anterior chest X-ray.

All chest X-rays, laboratory results, and examination findings were reviewed immediately for conditions that might require urgent attention. If such conditions were found, the patient was notified and, if he wished, his personal physician was called. The radiographs were subsequently interpreted using the ILO U/C International Classification of Pneumoconioses. Parenchymal changes of 1/0 or greater were considered abnormal as were pleural thickening, pleural plaques and pleural calcification. Additionally other abnormal disease conditions were noted. (See Appendix 2.)

Predicted values for spirometry were based upon the revised analysis by Miller et al. (1980) of data of Morris, Koski, and Johnson (1971). The criteria for individual spirometric abnormalities are listed in Table 3. After interpretation of the X-rays and review of all laboratory and clinical findings, a report and letter were prepared and sent to each participant. The two most important parameters for the assessment of health effects from asbestos exposure are the manifestation of small irregular opacities on an interpretable X-ray and restrictive pulmonary