

DISCUSSION

Although this study was undertaken initially in an attempt to discover whether it would be feasible to determine the environmental factors responsible for the increase of malignant mesothelioma in the State of Connecticut, it has suffered from the lack of detail in available records. ~~Table II and III illustrate one of the~~

~~major deficiencies~~ ^{ies} in the data available for study, ~~namely~~ ^{are} the low autopsy rate ~~for the pleural mesotheliomata and the inadequacy of the~~ ^{pathological material} ~~types of tissue~~ available and used for diagnostic purposes.

→ It has been our experience that occupational histories are not routinely obtained and included in hospital records. Smoking habits are not routinely recorded and no inquiries are made of patients admitted with suspected malignant disease regarding their hobbies or part-time activities.

In our search through the C. T. R. paper files (i.e. hospital records), we found job titles for only 17% of the mesothelioma cases. If we exclude from this group those merely designated as "retired", "housewife" or "student", the figure is reduced to 12%. We were only able to ascertain the type of industry in 7% of these cases. This data is applicable to 220 cases consisting of:

195 mesotheliomas in the Connecticut Registry, 1955 - 1977,

5 mesotheliomas from the Veterans Administration files, 1955 - 1977, and

20 ~~pleural tumors~~, not mesothelioma, recorded 1955 - 1977.

It is apparent from our study of these files that the awareness of this disease increased in the late 1950's and early 1960's and that this appeared to introduce a diagnostic bias which might partly account for apparent increase after 1955.

A00606

Comment on the significance of the findings on the slide review.

It is evident that until the physicians or hospitals investigating cases of malignancy appreciate the importance of ^{occupational +} environmental ^{or or} facts of the etiology of these diseases, no attempt can be made to apportion the blame to any particular factor unless adequate histories are available containing complete information on lifestyle, habits, hobbies, part-time activities and details of occupation and industry. It is also essential, particularly in the case of a rare tumor which may present diagnostic difficulties, to obtain sufficient tissue for study before the final diagnosis is made. Whenever a tumor is found where ^{an} association ^{is suspected} exists between it and a particular occupational or environmental factor, every attempt should be made to fully document all the ~~medical~~ facts and to subsequently verify the diagnosis by means of a full autopsy.

A00607

Letter to the Editor.—A 40-year-old woman was admitted to the hospital for investigation of weight loss and an upper abdominal mass. She had been treated for chronic recurring synovitis of the knees with dexamethasone in dosages from 0.5 to 1.5 mg daily intermittently for ten years. During this period, the skin of her forearms became extremely thin, and she experienced several episodes of subcutaneous extravasation of blood.

On the fourth hospital day, she was transported to the x-ray department, where it was noted that she had two superficial tears in the skin of the left forearm with gaping margins. Attempts were made to suture the skin edges together, but the sutures tore through the skin. The edges were held together with strips of sterile tape.

On one other occasion during her hospital stay, similar lesions developed during the course of transport to and from her bed for other diagnostic procedures. These lesions failed to heal during her hospital stay, and gross evidence of infection was not noted.

Comment.—Transport by handling of the forearms, even though carefully done, resulted in serious, poorly healing tears of the skin in this overweight, weak woman. Even though extra care was taken after the initial episode, there was recurrence. In this case there was no complaint or dissatisfaction expressed by the patient or the family, but such episodes have the potential for risk of compensable injury. Certainly there have been allegations of hospital-based injury with lesser justification.

It would be prudent for physicians hospitalizing patients who have been receiving steroid therapy to place a warning note on the chart advising hospital personnel to use extreme care when bathing, assisting, or transporting such patients.

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Carcinoma at the Site of Herpes Simplex Infection

To the Editor.—THE JOURNAL recently published a letter entitled "Carcinoma at the Site of Herpes Simplex Infection" (243:2396, 1980). My letter is to note further the occurrence of such a situation. I personally had basosquamous carcinoma develop on two occasions. The first occurrence was approximately five or six years ago at the site of a vaccination for small pox that I had received for traveling. After the vaccination site did not heal for one year, I became suspicious and had it excised at the local university hospital. I was approximately 55 years old at that time.

During the past year, a similar situation developed at the site of a localized herpes simplex infection that had occurred on my upper lip and had not healed for approximately one year. It was removed by a Mohs surgical procedure at a local university center, and a diagnosis of basosquamous cell carcinoma was made again. At that time, the dermatologist performing the chemosurgery mentioned how unusual the lesion was, inasmuch as there were not supposed to be such things as basosquamous carcinomas. Both wounds healed without any unusual event.

After the first occurrence, I contacted Dr. Herman Pinkus in Detroit, and he stated that there were about a dozen cases in the literature at that time. I saw him at a meeting shortly after the chemotherapy, and he commented on the unusual nature of this condition occurring more than once, though he was more aware of its occurrence than he had been before.

There is an embarrassing situation about this personally, and that is that I am a dermatologist.

There were no other forms of therapy used on these lesions with either surgery, antibiotics, or photodynamic inactivation, nor am I a smoker. I have had an occasional localized herpes simplex infection during the past 20 years.

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The Autopsy and Asbestos Exposure

To the Editor.—In the article entitled "The Autopsy: Past, Present, and Future" by Anderson and co-workers (242:1058, 1979), the fall in the rate of autopsies is decried, and several cogent reasons are presented for a return to the previous high number of such examinations, a goal formerly pursued by dedicated house officers.

One additional need for postmortem reviews has been given emphasis in recent years by the epidemiologic and clinical information gathered in connection with the asbestos-related disease. Because workers are now beginning to present radiological and altered physiological evidence of the effects of the inhalation of free asbestos fiber, years to decades after initial work exposure, a problem in worker's compensation adjudication has arisen. The changes elicited through clinical study, although present, most often do not have accompanying symptoms, as yet, nor have they caused any disability, as yet. There

will be disability, however, with the passing of time.

In those instances where death has resulted from pulmonary cancer or a thoracic or peritoneal mesothelioma, it is important to identify the tissue alterations directly attributable to occupational contact with the respirable asbestos fiber.

As we have counseled family survivors of such persons dying of asbestosis or its related disease states, or both, to request a necropsy to lend substance to a worker's compensation claim, it is strongly suggested that all physicians or house staff caring for such patients urge relatives to permit the examination. These procedures will not only aid the beneficiaries but will also prove of worth to physicians in familiarizing them with the findings characterizing a greatly underdiagnosed job-generated disease.

Furthermore, such postmortem data will aid in our knowing what actually happens to a worker under certain conditions of exposure and will help to rectify the inaccurate conclusions drawn from the current underreporting of occupationally associated disease.

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Safety of Ipecac Syrup

To the Editor.—On behalf of the American Association of Poison Control Centers, I am concerned about the titling of a recent JAMA article, "Death Resulting From Ipecac Syrup Poisoning" (243:1927, 1980). I am worried that the index skimmer or scanner—particularly if he is of the older school reared in an era of gastric lavage for management of poisonings—may inadvertently conclude that the typical emetic dose of syrup of ipecac was responsible. In reality, the dose was three to four bottles per day for three months—thus representing a long-term poisoning.

As noted by the authors, syrup of ipecac as an emetic agent has a remarkable safety record; its current availability over-the-counter and in the home permits an enormous saving of needless visits to emergency rooms for the treatment of accidental ingestions. I think that it would be unfortunate indeed were the inference drawn that single emetic doses were risky.

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