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Mortality Among Employees of PVC Fabricators

Leonard Chiazze, Jr., Sc.D.; William E. Nichols, Ph.D.; and Otto Wong, Sc.D.

A cross-sectional mortality study of 4,341 deaths occurring among current and former employees of 17 PVC fabricators during 1964-1973 is presented. The objectives are: (1) to identify any angiosarcoma deaths among the employees of these fabricators, and (2) to examine the distribution of deaths by cause. No angiosarcoma deaths were found among the study group. Sex-race-cause-specific Proportionate Mortality Ratios (PMR's) were computed, using the corresponding U.S. mortality as the standard. Among white employees, there appears to be an excess in total cancer mortality, particularly that of the digestive system. Observed deaths were found to exceed the expected in cancers of the breast and urinary organs among white females. Deficit mortality was observed in cirrhosis of liver among both male and female white employees.

The January 1974 disclosure of three deaths from angiosarcoma of the liver in a single vinyl chloride polymerization plant and the attention focused on this new occupational disease are well known. A significant amount of information from animal experimentation and observation on humans engaged in the production of vinyl chloride followed.¹ However, there was no information regarding the possible adverse effects on employees engaged in polyvinyl chloride (PVC) fabrication, where potential exposures were thought to be low and to result from the release of unreacted monomer trapped in the resin. This issue was considered of great import because of the very large number of workers believed to be engaged in fabrication.

In March 1974, representatives of PVC producers, who are members of the Organization Resources Counselors (ORC), Occupational Safety and Health Standards Group, contacted ORC about the feasibility of a study of health risks to employees working with vinyl chloride and polyvinyl chloride. Since the National Institute for Occupational Safety and Health (NIOSH) was conducting a study of vinyl chloride and resin producing employees, the scope of the proposed ORC study was limited to employees of

companies engaged in the fabrication of PVC resin into finished products. A number of alternative study designs was considered, and it was decided that a proportional mortality study would best meet the urgent need for information. The study concentrated on deaths occurring during the ten-year period 1964-1973 among active fabricating employees plus retirees. Since it was not possible to identify those employees with only vinyl chloride exposure, the study focused on deceased employees who worked anywhere in those plants where PVC fabrication was carried on. The primary objective of the study was to determine whether or not any angiosarcoma deaths had occurred among employees of the fabricators under study. A secondary objective was to examine the distribution of all deaths by cause.

The relatively few producers of vinyl chloride monomer and of PVC resin are generally medium to large companies. PVC fabricators, however, range from large plants of major companies to very small job shops. Even in a large plant, there may be few employees who are in the vicinity of PVC resins. The range of company plant size and number of exposed employees help to explain the wide range of estimates of total employment dependent upon PVC resins. Fabrication is geographically disbursed, with at least some operation in almost every state. Typical fabrication products include coated wire, upholstery fabrics, floor and wall coverings, pipe and other construction materials, toys, recreational equipment, phonograph records, containers and container lining, and a myriad of novelty items. Since the fabrication of PVC resin into finished products is often a part of diversified product lines in a plant, raw materials other than resin are utilized. Thus, employees may be exposed to toxic agents other than vinyl chloride. Consequently, in the current study, it is not possible to isolate only the effect of vinyl chloride. Some departures from expectation may be due to exposures to vinyl chloride, to one or more other agents, to some combination, or to employee characteristics other than occupation.

Materials and Methods

The decision to focus on a cross-sectional mortality study rather than on an historical cohort study derived from several considerations. First, the primary study objective was to determine relatively quickly whether or not any angiosarcoma deaths could be identified among the study group, and this was best accomplished by examining causes of death among relatively recent

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(i.e., past ten years) decedents. The desirability of identifying an historical cohort for follow-up was recognized, but it was determined that it would not be possible to identify clearly and completely the necessary cohort of workers within a reasonable period of time, if at all. As a consequence, this study is based upon 4,341 deaths which occurred during the period 1964-1973 among current or former employees of 17 companies engaged in PVC fabrication. A total of 35 plants supplied data on all identifiable deaths since, as was mentioned earlier, it was not possible to identify those employees with only vinyl chloride exposure for the study.

In order to be included in this study, a deceased employee fell into one of the following categories: (1) employee died while actively employed, (2) employee died after retiring from the company with retirement benefits, and (3) employee died after terminating employment but with vesting in a company-sponsored life insurance plan. Deaths occurring among former employees with less than the number of years necessary for insurance vesting were not included in plant records and were, therefore, not available for this study.

An attempt was made to compensate for at least some of the "leakage" due to employees leaving the industry prior to the time they were vested in any insurance program by using the following procedures: Once death records for a given company were identified, death certificates were obtained and separated into two groups as follows: (1) all deaths with cancer (ICDA 140-205 up to 1967; ICDA 140-209 for 1968 on), or liver disease (ICDA 580-586 up to 1967; ICDA 570-576 for 1968 on), or suspected liver condition mentioned on the death certificate; and (2) all deaths from causes other than cancer or liver disease. Death records mentioning cancer or liver disease and giving a hospital as place of death were segregated and sorted by hospital. Where there were several death records for a single hospital or several hospitals in the same area, arrangements were made for a Registered Records Administrator (RRA) to visit the hospitals, review medical records, contact the hospital pathologist and review pathology records to determine whether there were any angiosarcoma cases in the hospital's pathology records. If so, an attempt was made to determine whether or not the angiosarcoma possibly could be related to vinyl chloride exposure. This procedure enabled us to identify whether any employees, who had left the industry prior to vesting in an insurance program and remained in the local area, had died from angiosarcoma of the liver. The hospital inquiry procedures turned up five deaths from angiosarcoma of the liver: according to company employment records, none were employed at any time in PVC fabricating plants. These deaths were reported to OSHA, NIOSH, and CDC for inclusion in the nationwide angiosarcoma survey.

Death certificates not mentioning a hospital as a place of death required an additional step to determine whether death occurred in a hospital or if a recent hospitalization had occurred prior to death. The certifying physician was queried by mail for information on recent hospitalization of the decedent and whether there was any indication that he or she had cancer or liver disease. Additionally identified hospitals were contacted as above.

Originally, it was planned that death certificates would be obtained from life insurance carriers. In practice, both company and life insurance records were used because of record retention practices and retrieval problems in the insurance carriers. All available death certificates were examined by a trained nosologist for mention of angiosarcoma anywhere on the certificate, and no angiosarcomas were found on the death certificates. Underlying cause

of death was classified according to the eighth revision of the International Classification of Diseases.²

Over the ten-year period under study, plant size was found to have changed drastically in many cases. In one instance, a plant employing 300 employees in 1973 employed fewer than 10 in 1964. At the other extreme, one plant employing 5,000 people in 1964 had only 2,000 in 1973. Some companies had gone out of business. Such developments show not only the rapid changes taking place but also the difficulty of determining average industry employment. The 17 companies covered in this report ranged from single plant, small companies (one with 70 employees) to multiplant large companies (one with over 7,000 employees). Average number of employees clustered between 300 and 500. Although total employment is difficult to determine precisely, it is estimated to have been between 65,000 and 70,000 at the end of 1973.

Since the population at risk could not be determined, mortality rates as measures of risk could not be calculated. Rather, results were summarized in terms of Proportionate Mortality Ratios (PMR) adjusted for the age distribution of the study group. The PMR uses relative frequencies of specific causes of death by age in a comparison population to obtain expected numbers of deaths from that cause in the study population. Selection of an appropriate comparison population poses some difficulties since it would be desirable to have a cause of death distribution for a similar group of workers dying during the same period, but not subjected to the factor under study. But such a comparison population was not available, and the study used mortality for the United States, specific for color and sex, for comparative purposes.³ Despite recognized deficiencies, the PMR can provide clues on unusual distributions of causes of death where true rates cannot be calculated.

Results

Table 1 gives the distribution of deaths among the employees of the 17 PVC fabricators within each of the ten years. An increase in the proportion of deaths taking place in later years of the decade may reflect a variety of factors, such as an increasing employee population, less complete availability of records for earlier years (e.g., in one company, there were no records for the first four of the ten years), increase in duration of exposure, etc. However, there is no reason to believe that any unavailable death records for earlier years would be concentrated in a few causes and thereby bias the distribution of deaths for those years.

Year of Death	No.	%
1964	225	7.5
1965	345	8.0
1966	400	9.2
1967	429	9.9
1968	499	11.5
1969	449	10.3
1970	465	10.7
1971	471	10.9
1972	528	12.2
1973	430	9.9
Total	4341	100

Table 2. — Distribution of Deaths Among Employees of 17 PVC Fabricators by Color and Sex, 1964-1973.

Race	Total	Sex		
		Male	Female	Unknown
Total	4341	3676	663	2
White	3848	3248	601	0
Nonwhite	204	180	24	0
Unknown	288	248	38	2

The distribution of deaths in the study group by race and sex is given in Table 2. Most deaths (84.7%) occurred among males. The vast majority (88.7%) of decedents were white and there were 288 (6.6%) for whom race could not be determined. Table 3 shows this distribution of deaths by age. For both white male and white female employees, more than half of the deaths occurred among those aged 65 and over (58.1% and 51.9% for white men and white women, respectively). The corresponding proportions of deaths which occurred after age 65 in the United States population in 1968 were 59% and 72%, respectively. The higher proportion of deaths among white women over 65 in the U.S. population compared to the employee population may indicate that relatively fewer women work to retirement age than do men. While the numbers of deaths among nonwhite employees are too small for any definite conclusions, the distribution of deaths by age among nonwhite men is roughly comparable to that for the total United States.

Tables 4 and 5 show the distribution of deaths for selected causes by sex for whites and nonwhites, respectively. Among white men, nearly 60% of the deaths are from diseases of the circulatory system (ICDA 390-438) and 20% are deaths from cancer (ICDA 140-209). The corresponding percentages for the total U.S. population of white males in 1968 (midpoint of the study period) were 54% for diseases of the circulatory system and 16% for cancer. Digestive and respiratory cancers account for somewhat less than two-thirds of all cancer deaths among the white males in the study group as compared to about 59% of all cancer deaths among U.S. white males in 1968. For white women, over 46% of the deaths are from diseases of the circulatory system (compared to 57% for all U.S. white women in 1968), and 30% were from cancer (compared to 18% for all U.S. white women in 1968). Somewhat over half of the cancer deaths among white women in the study were from cancers of the breast and digestive system,

about the same proportion as for all U.S. white women in 1968. About two-thirds of the deaths for both nonwhite men and women were from diseases of the circulatory system and from cancer. The numbers of deaths for most causes among nonwhites, however, are quite small making interpretation difficult and are presented mainly for completeness.

Age-adjusted PMRs for white male and white female employees of the 17 PVC fabricators are presented in Table 6 for selected causes of death. There were no similar analyses for nonwhites because for nearly all causes, the numbers of deaths were too small to produce stable PMRs. Expected numbers of deaths have been calculated on the basis of the sex-cause-age specific distribution of deaths among U.S. whites in 1968 applied to the total number of deaths by age among white men or white women in the study group. The midpoint of the study period (1968) was selected for the standard, since it is representative of the study period and provides U.S. mortality data coded according to the eighth revision of the International Classification of Diseases. Expected numbers are deaths for individual causes to be expected in the study group if the proportion of total deaths ascribed to a given cause were the same as for the corresponding U.S. race-sex group, while accounting for differences between the age distributions of deaths in the study groups and deaths for the United States. A PMR larger than unity would indicate that the relative proportion of mortality from that particular cause in the study population is higher than would be expected based on the 1968 U.S. mortality experience. Due to the nature of the data, formal significance tests and interpretation in probabilistic terms are deemed inappropriate.

In addition to the numerical value of the PMR itself, the observed number of deaths is also of interest. The larger the number of deaths observed, the more reliable the PMR. There were two deaths of unknown age among the white males, one a digestive cancer (ICDA 153) and one an unspecified cancer (ICDA 199). These were included in the age groups with the lowest relative frequency for those causes, that is, less than 35 years for total cancer and digestive cancer and 65 and over for other and unspecified cancer. Such an assignment has a trivial effect on the expectation but is the most conservative way of handling these unknowns, since it serves to increase the expectation (and hence lower the PMR) by the least amount.

Based upon both the number of deaths and the value of the PMR, there seems to be an important excess in total cancer mortality among the white males in the study group. The distribution by specific cancer site suggests that any excess appears to be con-

Table 3. — Distribution of Deaths Among Employees of 17 PVC Fabricators by Age, Color, Sex, 1964-1973.

Color, Sex	All Ages		Under 35		35-44		45-54		55-64		65 & over		Unknown	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
White	3848	100	107	2.8	138	3.6	365	9.5	752	19.5	1886	49.1	2	0.1
Male	401	100	24	6.0	42	10.5	100	25.0	123	30.7	312	77.8	0	0
Female	180	100	21	11.7	24	13.3	26	14.4	30	16.7	68	37.8	0	0
Nonwhite	204	100	6	2.9	2	1.0	5	2.5	6	3.0	5	2.5	0	0
Male	24	100	6	25.0	2	8.3	5	20.8	6	25.0	5	20.8	0	0
Female	180	100	21	11.7	24	13.3	26	14.4	30	16.7	68	37.8	0	0
Unknown	288	100	20	6.9	5	1.7	32	11.1	66	22.9	131	45.5	12	4.2
Male	38	100	1	2.6	5	13.2	4	10.5	8	21.1	16	42.1	2	5.3
Female	2	100	1	50.0	0	0	0	0	0	0	0	0	1	50.0

Cause of Death	ICDA Sub Div.	Male		Female	
		No.	%	No.	%
All Causes		2248	100.00	801	100.00
All Cancers	140-209	645	28.50	181	30.12
Buccal Cavity and Pharynx	140-149	15	0.66	3	0.50
Digestive System	150-159	209	9.25	53	8.82
Stomach	151	41	1.82	8	1.33
Intestine	153	73	3.23	24	3.99
Rectum	154	85	3.77	8	1.33
Liver	155	6	0.26	0	0.00
Respiratory System	160-163	205	9.11	12	2.00
Lung	162	183	8.14	12	2.00
Borne, Connective Tissue, Skin, Breast	170-174	24	1.06	51	8.49
Breast	174	0	0.00	44	7.32
Genital Organs	180-187	44	1.95	19	3.16
Urinary Organs	188-189	38	1.69	11	1.83
Brain & Other Nervous System	191-192	18	0.80	4	0.67
Other & Unspecified	190, 193-199	58	2.57	18	3.00
Lymphomas	200-203, 208-209	42	1.87	9	1.50
Leukemias	204-207	13	0.58	1	0.17
Diabetes	250	42	1.87	11	1.83
Diseases of the Circulatory System	290-438	1391	61.45	281	46.29
Cerebrovascular Disease	430-438	289	12.85	85	13.99
Cirrhosis of Liver	571	42	1.87	3	0.50
Cholelithiasis, Cholecystitis, and Cholangitis	574-575	7	0.31	3	0.50
Accidents, Poisonings, and Violence	E800-E999	183	8.14	48	7.99
Accidents	E800-E949	134	5.96	38	6.32
Suicide	E950-E959	40	1.78	2	0.33
All Other Causes (Unkilled)		372	16.55	74	12.31

Cause of Death	ICDA Sub Div.	Male		Female	
		No.	%	No.	%
All Causes		180	100.00	24	100.00
All Cancers	140-209	39	21.66	8	33.33
Buccal Cavity and Pharynx	140-149	0	0.00	0	0.00
Digestive System	150-159	13	7.22	4	16.67
Stomach	151	3	1.67	0	0.00
Intestine	153	2	1.11	1	4.16
Rectum	154	1	0.56	0	0.00
Liver	155	1	0.56	0	0.00
Respiratory System	160-163	7	3.89	0	0.00
Lung	162	7	3.89	0	0.00
Borne, Connective Tissue, Skin, Breast	170-174	0	0.00	3	12.50
Breast	174	0	0.00	3	12.50
Genital Organs	180-187	4	2.22	0	0.00
Urinary Organs	188-189	3	1.67	0	0.00
Brain & Other Nervous System	191-192	1	0.56	0	0.00
Other & Unspecified	190, 193-199	6	3.33	0	0.00
Lymphomas	200-203, 208-209	4	2.22	0	0.00
Leukemias	204-207	2	1.11	1	4.16
Diabetes	250	2	1.11	0	0.00
Diseases of the Circulatory System	290-438	81	45.00	8	33.33
Cerebrovascular Disease	430-438	19	10.56	3	12.50
Cirrhosis of Liver	571	2	1.11	3	12.50
Cholelithiasis, Cholecystitis, and Cholangitis	574-575	0	0.00	0	0.00
Accidents, Poisonings, and Violence	E800-E999	33	18.33	3	12.50
Accidents	E800-E949	17	9.44	1	4.16
Suicide	E950-E959	2	1.11	0	0.00
All Other Causes (Unkilled)		22	12.22	4	16.66

centrated in digestive system cancer, given the large number of deaths (31% of all cancer deaths). For each of the sites within the digestive system, observed numbers of deaths are greater than expected. Although, except for intestinal cancer, the observed numbers of deaths are small. The PMR for liver cancer is rather high, but a definite conclusion is difficult with only six observed deaths. On the other hand, the PMR for cirrhosis of the liver suggests a deficit in mortality from that cause.

For white women, the PMR for total cancer appears high, as it did for white men, with cancer of the digestive system and, perhaps, cancer of the breast contributing a fair amount to the excess. The PMRs for individual sites within the digestive system are based upon small numbers but suggest an increase in intestinal cancer. The PMR for urinary cancer, though based upon only 11 deaths, seems strikingly high and may be an indication for further investigation. On the other hand, in contrast to the observation in white men, the PMR for respiratory cancer among white women is very close to unity. Similar to the observation in white men, mor-

tality from cirrhosis of the liver seems to be in deficit, but the corresponding observed number of deaths is quite small. Among both white male and female employees, diseases of the circulatory system account for a large percentage of total deaths. In each case, observed numbers of deaths are close to expected. There appears to be a somewhat different pattern among men and women for deaths due to accidents, poisonings, violence with the number of deaths somewhat low among men and high among women.

There were 39 cancer deaths among nonwhite men, somewhat greater than expectation, although the numbers by site are too small for meaningful analysis. Mortality from cerebrovascular disease appeared high (PMR = 2.11) but the finding was based upon only 19 deaths.

Discussion

The present study was designed with two objectives. The first was to determine whether or not any angiosarcoma deaths had

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Cause of Death	ICDA Sub Div.	Male		Female	
		No.	%	No.	%
All Causes		2248	100.00	801	100.00
All Cancers	140-209	645	28.50	181	30.12
Buccal Cavity and Pharynx	140-149	15	0.66	3	0.50
Digestive System	150-159	209	9.25	53	8.82
Stomach	151	41	1.82	8	1.33
Intestine	153	73	3.23	24	3.99
Rectum	154	85	3.77	8	1.33
Liver	155	6	0.26	0	0.00
Respiratory System	160-163	205	9.11	12	2.00
Lung	162	183	8.14	12	2.00
Borne, Connective Tissue, Skin, Breast	170-174	24	1.06	51	8.49
Breast	174	0	0.00	44	7.32
Genital Organs	180-187	44	1.95	19	3.16
Urinary Organs	188-189	38	1.69	11	1.83
Brain & Other Nervous System	191-192	18	0.80	4	0.67
Other & Unspecified	190, 193-199	58	2.57	18	3.00
Lymphomas	200-203, 208-209	42	1.87	9	1.50
Leukemias	204-207	13	0.58	1	0.17
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		No.	%	No.	%
All Causes		180	100.00	24	100.00
All Cancers	140-209	39	21.66	8	33.33
Buccal Cavity and Pharynx	140-149	0	0.00	0	0.00
Digestive System	150-159	13	7.22	4	16.67
Stomach	151	3	1.67	0	0.00
Intestine	153	2	1.11	1	4.16
Rectum	154	1	0.56	0	0.00
Liver	155	1	0.56	0	0.00
Respiratory System	160-163	7	3.89	0	0.00
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Genital Organs	180-187	4	2.22	0	0.00
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Brain & Other Nervous System	191-192	1	0.56	0	0.00
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Lymphomas	200-203, 208-209	4	2.22	0	0.00
Leukemias	204-207	2	1.11	1	4.16
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Discussion

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Table 8. — Observed and Expected Deaths for Selected Causes Among Employees of 17 PVC Fabricators by Sex, White Only, 1964-1973.

Cause of Death	ICDA 9th Rev.	Male			Female		
		Observed	Expected	PMR*	Observed	Expected	PMR*
All Causes	140-208	688	561,997	1.19	181	137,699	1.31
Nasal Cavity and Pharynx	140-140	15	16,875	0.89	3	3,896	1.53
Digestive System	150-159	209	162,143	1.29	53	35,342	1.50
Stomach	151	41	31,507	1.30	8	4,961	1.61
Intestine	153	93	52,576	1.39	24	13,344	1.95
Rectum	154	25	19,531	1.27	6	3,877	2.04
Liver	155	6	4,190	1.43	0	0,633	—
Respiratory System	160-169	205	176,657	1.16	12	11,863	1.00
Lung	162	193	165,588	1.17	12	11,224	1.07
Bronch, Connective Tissue, Skin, Breast	170-174	24	15,117	1.59	31	39,861	1.43
Breast	174	0	—	—	44	32,397	1.36
Genital Organs	180-187	44	52,228	0.83	19	23,297	0.82
Urinary Organs	188-189	36	33,131	1.09	11	4,537	2.42
Brain & Other Nervous System	191-192	16	13,885	1.15	4	3,499	1.14
Other & Unspecified	190, 193-195	55	34,507	1.62	18	9,622	1.87
Lymphomas	200-203	42	22,382	1.30	9	7,531	1.18
Leukemias	204-207	19	23,364	0.81	1	3,005	0.20
Osteomas	250	42	40,600	0.85	11	13,436	0.71
Diseases of the Circulatory System	390-458	1,031	1,032,515	1.00	261	309,232	0.84
Cardiovascular Diseases	430-439	289	292,074	0.99	66	71,965	0.92
Cirrhosis of Liver	571	42	62,821	0.67	3	12,343	0.24
Osteoporosis, Osteomyelitis, and Osteitis	574-575	7	6,349	1.10	3	3,763	1.58
Accidents, Poisoning, and Violence	E800-E899	188	265,548	0.71	48	40,855	1.17
Accidents	E800-E849	134	180,268	0.74	38	27,931	1.36
Suicide	E950-E959	40	82,525	0.76	2	8,171	0.22

*PMR is the ratio of observed to expected where the expected number is calculated on the basis of the distribution of deaths for the total U.S. in 1968 specific for color, sex, cause, and age.

occurred among employees of the PVC fabricators under study. Since no angiosarcoma deaths were found among the employees studied, the first question has an unequivocal answer. A secondary objective was that of examining the distribution of deaths by cause among the employees under study. Implicit in that objective is the question of whether or not that distribution is, in some sense, unusual. There is no unequivocal answer to the latter question. Whether or not an observed distribution of causes of death is unusual clearly relates to the standard or comparison population as well as the analytic methodology.⁴

On the basis of a proportionate mortality analysis, there appear to be excesses in total cancer mortality among both white men and white women in the study, when compared to the distributions of deaths for the total United States specific for color and sex and adjusted for age. Excesses in cancer mortality appear concentrated in cancers of the digestive system and, in particular, in cancers of the intestine for both men and women. In addition, there is a suggestion that mortality from cancer of the breast and urinary organs among white women employees is higher than that for the total U.S. There are, however, several reasons why

definitive interpretation is difficult. It has, for example, been suggested that a Proportionate Mortality Ratio based on an external population may not be sufficiently discriminating in screening for potential hazards.⁵ In addition, an analysis using PMRs fails to take account of the absolute risk of dying in the population under study.⁶ Further, a number of studies have suggested an overall favorable mortality for industrial working populations, even in those where well-defined hazards increase risk for a specific cause.⁷ Factors such as these are meant to suggest that proportionate mortality analysis must be interpreted cautiously, with the intention of providing leads for further investigation.

Results consistent with those of previously published studies would be of particular interest. With no comparable working populations in the fabrication industry, potential contrasts may be found in studies of vinyl chloride workers. Monson, et al. provided a proportionate mortality analysis of 161 deceased workers (all presumably white males) in two plants, one where vinyl chloride monomer is produced and one where it is polymerized into polyvinyl chloride.⁸ Results of that study suggest a possible excess in total cancer mortality, primarily cancer of the

liver. However, there was a suggestion that cancers of the lung and brain also appeared with excess frequency. The current study, while suggesting an excess in total cancer, particularly digestive cancer, does not clearly point to marked excesses for cancers of the liver, lung, and brain among white men, although the PMRs for these cancers are greater than one. The observed-to-expected PMRs reported by Monson for vascular lesions affecting the central nervous system, circulatory diseases, and external causes are similar to those reported here.

Tabershaw and Gaffey, in a study of workers engaged in the manufacture of vinyl chloride and its polymers, conclude that no specific cause of death was statistically significantly greater than expectations based upon Standardized Mortality Ratios (SMRs) using the U.S. male population as the standard.⁹ By other criteria, however, the authors conclude there may be an excess risk for mortality from digestive cancer, respiratory cancer, cancer of other and unspecified sites, and lymphomas. At lower exposure levels, they suggest some excess for cancers of the buccal cavity and cancers of the other and unspecified sites.

The current study would seem to indicate that excesses of mortality from cancer of the digestive system are not sex-specific and are not limited to liver cancer. The majority of the PMRs for cancer among both white men and white women are in excess of unity. Such results must be interpreted with caution but, since they appear to be consistent with previously studied workers, they suggest the need for continued investigation.

Summary

Results of a study of 4,341 deaths occurring among current and former employees of 17 PVC fabricators during the period 1964-1973 are presented. The study was carried out to determine whether any angiosarcoma deaths had occurred among employees of these fabricators and to examine the distribution of deaths by cause. No angiosarcoma deaths were found among the study population. Distributions by cause of death among white male and white female employees were compared with those for

the entire U.S., specific for color and sex and adjusted for age by means of Proportionate Mortality Ratios. There appears to be an important excess in total cancer mortality among both white male and white female employees with digestive cancer, particularly that of the intestine, contributing to the excess. Among the women employees, cancers of the breast and urinary organs may also be in excess. No excesses were found for diseases of the circulatory system. There were deficits in mortality from cirrhosis of the liver among both male and female employees and a deficit in accidents, poisonings, and violence among men. The use of the Proportionate Mortality Ratio based on an external standard requires caution in interpreting these results, but the need for further investigations is indicated.

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