

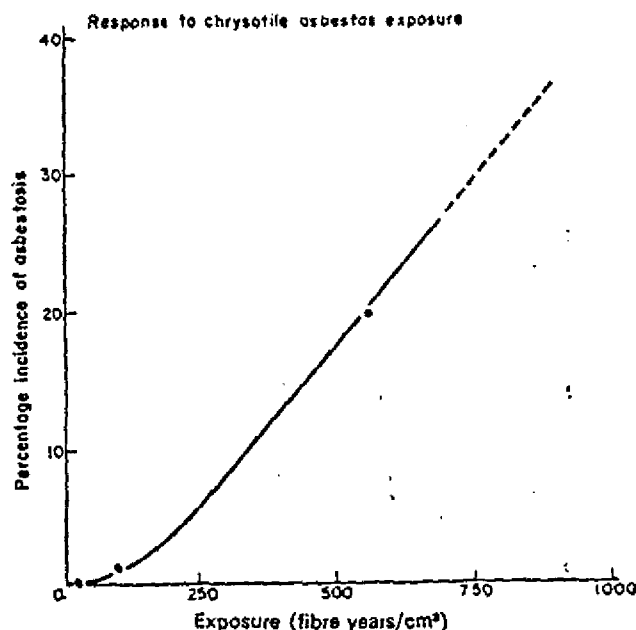


FIG. 3. Response to chrysotile asbestos exposure.

is shown on the horizontal axis, expressed in fibre years per cm^3 and the corresponding prevalence is on the vertical axis, showing the proportion of people with crepitant basal rales.

Basal rales is the earliest clinically demonstrable effect on the lung due to asbestos and there is a steadily increasing prevalence of basal rales with increase in dust exposure. Only groups with near zero dust exposure show zero prevalence of basal rales.

A problem arises when it is appreciated that there is no exposure which can be said to be absolutely free of risk. There is no single threshold exposure held in common by everyone. There is, consequently, this gradually increasing risk in relation to exposure. The application of dust control to meet a TLV, an MAC, MAK value, or other similar hygiene standard will limit and control the risk but is unlikely to reduce it to zero. It has to be remembered that asbestos is very widely used and brings real benefits to the community at large. A standard could be made so stringent that the cost of dust control is prohibitive, that the production and use of asbestos ceases to be economic, production and use is discontinued and the associated benefits are lost. The benefits gained by reducing the risk of asbestosis through reducing air contaminant exposure have to be weighed against the possible loss of direct and indirect benefits to the community from the use of the material.

One conclusion from the exposure-response curve fitted to the data was that for an accumulated exposure of 100 fibre years/ cm^3 , it is probable that the risk of being affected to the extent of having early clinical signs will be less than 1 per cent. That is, for example, a concentration of 2 fibres/ cm^3 for 50 years of such exposure while