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but points out that the woman was very young for a squamous growth.

As in the case of most other occupational tumours, it is commoner to find workers without the neoplastic reaction than with it, even after all the apparently necessary and sufficient conditions for its development have been found to exist. Many such cases have been amply described. We give one or two from the Continental literature.

Having worked for 22 years consecutively applying insulating (asbestos) material to articles, a man aged 40 years was killed in a street accident, never having complained of respiratory troubles. Franchini and Canepa (1949) performed the post-mortem and found a fracture of the base of the skull as the immediate cause of death. The lungs were massively and extensively fibrosed mainly in the middle and lower lobes, with lymphocytic infiltrations and thickened elastic tissue: many asbestosis bodies were found occupying the lungs and lymph nodes. No mention of neoplastic change is made. It is specially interesting that, as in so many other cases, the massive pulmonary changes should have been unaccompanied by complaint.

This is of importance because if after a period of exposure to asbestos dust a certain measure of fibrosis is developed and thereafter the industry is left, we may picture a static non-symptomatic, non-progressive fibrosis, but a continuing process of cancerization in a certain number of cases Whether the preceding fibrosis is necessary for the subsequent neoplastic process or whether the latter is conceivable without the former, it is not as yet possible to say.

The entry of any particles or fibres into the lung, even when they are soluble in water, produces a phagocytic response from the septal cells in the alveolar walls and giant cells with many nuclei soon develop. In the case of a soluble compound the ultimate degeneration of the dust cell permits the second stage of the absorption of the compound. This is readily shown experimentally with any of the common laboratory animals. The lung presents a temporary barrier to soluble particles; in the case of insoluble particles the barrier is more permanent, depending on the size of the particles. The smaller particles may be taken up by phagocytic cells arising from various sources and disposed of in lymph glands, in the interstitial tissue of the lung and even to some extent in organs from which they can be excreted Everything depends upon the size.

Phagocytic cells may, however, be completely frustrated both by the nature and size of particles. In such cases they surround the foreign material and a process of local fibrosis sets in, the foreign unattackable material remaining more or less *in situ*.

A small particle (2–3 micrograms) will ultimately enter the alveoli and the fibrous reaction will start from the alveolar walls and lymphatics, if it cannot otherwise be disposed of. If the particle is big (10–15 micrograms) and cannot therefore proceed into the ultimate air passages, it is held up and the reaction occurs more proximally in the bronchiolar tree

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