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PLAINTIFF'S EXHIBIT
JM-2116

ECL/MW
12.7.73.

Professor Irving J.Selikoff,
Mount Sinai School of Medicine,
Fifth Avenue and 110th Street,
NEW YORK NY 10029,
U.S.A.

Dear Professor Selikoff,

We have recently received a transcript of a tape recording of your address to the American Industrial Hygiene Conference in Boston on 21st May,1973 which was sent to us because of its references to our work. If the copy enclosed herewith is a true representation of that address and the graph shown by you, we must tell you that we find your assumptions and conclusions to be extremely misleading.

The case made at the end of your paper appears to rest on the fact that the data which formed the basis of our Hygiene Standard[1] was scanty. You then attempt to extract data from the Figures in ECL's publication[2] in order to show a discrepancy between the original data and those Figures. We are astonished at your having communicated the contents of a private correspondence to the meeting which you addressed without having obtained our agreement. We are also very displeased at the manner in which you have used the information we provided in order to launch what seems to us to be a political campaign in the USA aimed at discrediting our Hygiene Standard for asbestos. We cannot accept the implication that the ECL publication allows doubt to be cast on the validity of the BOHS Standard and are of the opinion that such a conclusion is unwarranted.

Comparisons such as those you have made between the Knox data and the ECL data are invalid for the following reasons :-

1. The paper by ECL was not intended to justify or verify the BOHS Standard, and no reference is made in this paper to environmental dust measurements. The results presented in ECL's paper were preliminary results and in the discussion section it was clearly stated that 'from the information currently available only tentative opinions can be expressed '. We are

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surprised therefore that you have been able to read far more into the incomplete picture presented than the author was able to do or even intended to do.

2. The populations reported by Knox and ECL were not identical nor were 'the very large majority' of asbestos workers 'common to both surveys', as you suggested. 'Office personnel' were not included. The population studied by ECL consisted of workers in the recognised asbestos areas, together with maintenance, quality control and research staff.

3. Knox reported on 890 men (not 913 as stated by you) with at least 10 years exposure since 1st January,1933, when the Asbestos Industry Regulations 1931 took effect, and who were still in the Company's employ on the 30th June,1966. ECL on the other hand has analysed the X-rays of a much larger population (1,287) as of November,1970 irrespective of date of first employment; some were in fact first employed before 1st January,1933.

4. Knox sub-divided his population according to actual cumulative exposure whereas ECL's was sub-divided by decades elapsed since first exposure, irrespective of the actual number of years exposed. In view of these basic differences and others which we will point out in due course, we fail to see how you derived the relationship between cumulative exposure and percentage of individuals affected on the graph which you showed (copy attached). The heading on the graph is obviously misleading as ECL at no stage in his report equated the radiological changes with 'asbestosis'.

5. Because it was possible to estimate dust exposures for the Knox population, the BOHS Sub-Committee were able to arrive at figures for cumulative exposure expressed in fibre years/cc. No such exercise was ever attempted by ECL. This is a further invalidation of the graph since you have attempted to relate radiological features described by ECL to what we can only regard as speculative exposure data.

6. Knox only recorded X-ray changes as being present which are possibly asbestotic, after taking the whole clinical picture into consideration. 'Radiological changes considered significant included those of increased general opacity of the lower lobes, blurring of the cardiac outline, pleural thickening and adhesions'.[1]

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BCL on the other hand attempted to analyse his radiological findings according to the UICC/ILO classification, an entirely different set of criteria, and took no account of the clinical picture as a whole.

7. The BCRE sub-committee decided that basal rales were the 'key symptom' since all the men with X-ray changes, by the Knox criteria, had basal rales, but some with basal rales had no X-ray changes.[1] BCL points out in his paper that he has not yet attempted to correlate physical signs and X-ray changes.

8. We are obliged to point out that the use of the words 'pulmonary fibrosis' by BCL in his paper may have misled you, as they were used to describe small opacities which prior to the advent of the UICC/ILO classification may have been regarded as consistent with fibrotic changes. The use of this term does not allow for sub-division into profusion and type of opacity as is now possible with the UICC/ILO classification. For simplicity in presentation, BCL grouped all cases showing evidence of these changes together, irrespective of severity. Knox only included X-ray changes consistent with the clinical diagnosis of asbestosis. It is not possible to say, from the data that BCL has compiled, how many persons would fulfil the criteria for a clinical diagnosis of asbestosis, and to attempt to illustrate these two very different sets of data on the same graph is simply not permissible. The clinical significance of the radiological changes observed cannot as yet be defined.

You appear to have ignored completely the fact that the number of cases of asbestosis in 1960 among 335 employees (men and women) exposed for 10 years or more since 1933 in Rochdale and still employed, was 1.1% (i.e. 4 cases)[3] as compared with Merewether's finding of 44.4% (i.e. 59 cases) among 133 workers exposed 10 years or more in the same industry in 1929.[3] This lower incidence has occurred in spite of the fact that the Pneumoconiosis Medical Panels are better equipped to diagnose asbestosis than Merewether was. In addition, during the years immediately following 1933, there still was substantially greater exposure in certain jobs than in more recent times.

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