

part of the observed discrepancy also may be due to differences in how ADL limitations were defined. Frattino et al. categorized individuals as functionally limited if they could not independently perform one or more of the following activities: bathing, dressing, going to the toilet, eating, continence, and getting in or out of bed. In our study, individuals were considered limited in an ADL if they responded that they had "a lot of difficulty" or were unable to do any of the following activities: bathing or showering, dressing, eating, walking, using the toilet, or getting into or out of bed or a chair.

The potential impact of population selection and differences in definitions reinforces the value of consistent methods for sampling and survey formulation. Our findings do appear to be consistent with those of Given et al. suggesting that at least 50% of individuals with cancer report limitations with ≥ 1 ADLs.² Population and definitional differences may have had a smaller impact on the prevalence of IADL limitations.

We are encouraged that research similar to ours is being conducted on the functional limitations of elderly cancer patients. Such research will focus attention on functional status as a vital outcome in the clinical management of cancer. We believe that the end result will be an improvement in cancer care.

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Cancer among Spouses: Review of 195 Couples

A recent epidemiologic report¹ highlights the pattern of cancer development among a cohort of spouses. The authors postulate that some of the dis-

ease incidence may be explained by shared risk factors. This concept appears to have received little attention in the literature previously.

Malignant mesothelioma shows a strong association with environmental asbestos exposure in at least 90% of cases.² Significant domestic exposure to asbestos has been documented in the wives of 1964 workers in an Italian cement factory.³ The data showed an increased incidence of pleural tumor deaths among the wives, although in only one case was a postmortem performed to confirm malignant mesothelioma. No malignant mesotheliomas among spouses appeared to occur in the series.

Highlighting cancer occurrence among spouses is important in establishing a role for environmental factors. I have documented postmortems in the case of a married couple who both died of malignant mesothelioma of the pleura within 5 months of each other. The husband had sustained heavy occupational asbestos exposure for many years in his work at a dockyard lagging boilers with asbestos. An autopsy performed 6 months after the onset of dyspnea and weight loss showed extensive malignant mesothelioma of the pleura with asbestos bodies present in the lungs. His wife had died 5 months previously from a histologically proven malignant mesothelioma, diagnosed at autopsy, also associated with fibers in the lungs. The couple both had right-sided pleural tumors of epithelioid type. It appears that the wife's exposure had been indirect, possibly through contamination of the husband's hair and clothing with asbestos.

Synchronous development of malignant mesothelioma in a married couple is exceptional and to my knowledge has not been documented previously. It serves to further emphasize the risk of developing asbestos-related disease away from the primary locus of exposure. Indeed, research in the U.S. has shown that domestic concentrations of airborne asbestos may be increased in the homes of asbestos workers.⁴

Oncologists should be aware of the potentially increased risk of cancer in a spouse and should be alert to the possibility of shared risk factors. Whenever such cases are identified, an assessment of the risks to other household members should be undertaken.

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