NORDMANN amplified our knowledge the same year with 2 new cancer cases w
asbestosis which he could dissect in Hannover in short intervals. The fi
patient was 35 years old. From her 17th to her 26th year, exactly 7 (?)
years she had worked in the carding-, spinning-, and weaving departments
an asbestos plant. Four to 5 years prior to death she suffered of a cough
shortness of breath. Under suspicion of tuberculosis, she started to recei
medical attention 9 months before she died. HORNIG gave a probability-diagn
sis: Cancer in the left lower lobe with a marked asbestosis, because clini-
cally, there were signs of atelectasis, and tomographically, the main bron-
chus had been displaced (moved). Anatomically, it concerned a horny plate-
epithelium carcinoma with a walnut-sized deterioration-cavity which was con-
nected to the bronchus of the lower lobe. There were pleura callosity and
metastases in liver and kidneys.

The second observation concerned a man, 55, who had worked for 7 years (fro
his 36th to his 43rd year) in the preparation of an asbestos plant. Thirtee
months prior to his death he grew considerably thinner and got bloody sputu
In the beginning he was suspected of having contracted tuberculosis. There
was a muffled and weakened breathing sound (respiration) over the lower left
lung. Roentgenologically, the left lower field showed opacity. The physicia
in charge diagnosed an asbestosis with lung cancer. The autopsy confirmed
this. In the left lower lobe the cancer had, in connection with the main
bronchus, deteriorated down to walnut size, and was interrelated to the peri-
cardium, the left ventricle, the diaphragm, the peritoneum of the left upper
abdomen, the retroperitoneal tissue behind the spleen, the lymphnodes there
and the lower chest- and upper loin vertebral column. Histologically, it a-
gain concerned a horny epithelium carcinoma. A beginning bronchial carcinoma
was also found in the right lower lobe of the lung.

NORDMANN added to these observations a thorough evaluation of the view-point
which seemed proof to him of an occupational cancer. He was the first one to
speak clearly of an occupational cancer of the asbestos workers.

WEDLER drew attention in 1939 to another observation in Germany which origi-
natet from SOHNE, but had not been communicated (made public). The man, 58,
had worked 10 years (1925 - 1935) as master workman in an asbestos plant. On
ly a few years after having been exposed to dust, he already had trouble wit
his respiratory organs. In 1928 he was sent for 2 months to a health resort.
Several times thereafter he took other rests at sanitariums, although no my-
cobacteria tuberculosis were found. Due to an increasingly worsening conditi
he quit his job 3 months prior to his death. In the hospital he showed signs
of a general emaciation, cyanosis and a catarrh which was especially noti-
cible over the lower part of the lungs. There were numerous asbestos cor-
puscles in the sputum but no mycobacteria tuberculosis. The erythrocyte sedi
mentation was strongly accelerated (57/95). On the left, above the 9th rib e
chestnut-sized swelling which was grown together with the skin, was found in
the enterior axillar line. It was removed and turned out to be a cancer mete
stasis. Roentgenologically, there were signs of an asbestosis as well as an
increase in markings in the right upper stories (regions). According to the
evidence at my disposal, there obviously was no diagnosis of a lung cancer
intra vitam. The patient expired of heart failure soon after the excision of
the metastasis. The findings of the postmortem examination were described as
follows :" The lungs were tightly grown together with the chest wall. The
heart was not enlarged, the musculature of a brown-reddish color and of a
somewhat flaccid consistency. The left lung was full of blood and fluid, the
lower lobe of solid (compact) consistency and of slate color. Upon removal,
the right lung tore in the area of the middle lobe. Its tissue looked yellow
reddish and completely deteriorated (decayed) and was showing extended cavit
and node formation. The upper lobe was rich in blood and fluid, of firm con-
sistency and free of air. The lower lobe was of a slatish, grey-reddish colo
and firm consistency. It was also free of air. The microscopical examinatio
of the lungs showed typical cancer tissue in the right middle lobe, whereas
the lower lobe presented all changes which are characteristic for asbestosi