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July 16, 1986

Dr. B. Bennett
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Dear Dr. Bennett:

Thank you for the follow-up on Nuclear Magnetic Resonance Screening. While NMR is being used in the U.S., I am not aware of any use for screening purposes.

It would be a pleasure to meet with you during your visit in October. If appears that either the 7th or the 10th of October would be suitable, so that you can plan your visit in whatever way is most convenient for you and Dr. Torkelson/Dr. Cook.

Sincerely,



Harold W. Dietz, M.D.
Director
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Services

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Medical Department

• Dr H W Dietz
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JUL 15 1986

Your ref

Our ref

BB/MO

Date 8 Jul 86

Dear Dr. Dietz,

NUCLEAR MAGNETIC RESONANCE SCREENING

You may recall that I wrote to you on 30 Sep 85 concerning the above topic, and that I promised to inform you of the outcome of my visit to Aberdeen. I am enclosing, for your information, a copy of the report following a meeting which was held in Aberdeen on 20 May 86. I hope you will find it of interest.

At the present time the way forward would appear to be to provide financial help to Dr. Smith, the Consultant Radiologist and Specialist in Nuclear Medicine at Aberdeen Royal Infirmary, to enable him to build-up a bank of knowledge, which will place him in a better position to develop a screening test for ASL. This proposal is currently being considered.

As queried previously, do you have any experience of the use of this technique in the States? Is it of any value with reference to early diagnosis, treatment and prolonged life?

I shall be visiting the States in early October - I am lecturing at the VCM Safety Association meeting in Washington - and would very much like to visit you at this time. The dates when I shall most likely be in your area are 7th and 10th October. I should be most grateful if you could let me know if it will be convenient to you for me to visit and, if so, which date would be the more suitable to fit in with your programme.

I have written a similar note to Dr. Torkelson/Dr. Ralph Cook, Dow Chemical, suggesting that I visit on either 7 or 10 Oct, if they are free at that time.

I look forward to hearing from you.

Yours sincerely,

Brian Bennett

B BENNETT
M.A.
M.B., B.Ch., B.a.O.
D.Obst.R.C.O.G.
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The CIA VCM Medical Working Group (MWG) met at Aberdeen Royal Infirmary on Tuesday, 20 May 1986, at 10 a.m.

The MWG was accompanied by the Consultants as below, in the list of those present.

The MWG heard a presentation on Nuclear Magnetic Resonance (NMR) by Dr. Francis W Smith, Consultant Radiologist and Specialist in Nuclear Medicine at Aberdeen Royal Infirmary.

The presentation dealt with the fundamental physics of NMR and then outlined the progress made in using the technique for imaging.

Although he is a self-admitted enthusiast for NMR, Dr. Smith's presentation was scrupulously fair, modest and realistic.

It emerged that NMR is now an established and valuable aid to diagnosis in lesions of the CNS and cord (infarcts, metastases, syringo-myelia) and ventricular abnormalities, but that considerable basic work has still to be done to evaluate, let alone establish, its place in intra abdominal lesions. Ovarian cancer has been studied in depth (but is not yet ready for publication) and the results are encouraging. Ovarian tumours down to 5mm have been demonstrated.

However, Dr. Smith agreed in the discussion that followed his presentation, that NMR is probably not yet ready for use as a screening technique for angiosarcoma of the liver (ASL) for the following reasons :

A. TECHNICAL

1. The characteristics of an ASL lesion would need to be studied before differential diagnosis could be confidently made without the risks of false positives or false negatives.
2. The ability to show hepatic lesions as small as 5mm is not yet established.
3. At the moment, NMR cannot be used to obtain targetted liver biopsies of suspicious lesions, which may prove a draw back when compared to ultrasound or isotope scanning as an alternative method of imaging the liver.

B. LOGISTIC

1. The limited availability of NMR and the time needed for each examination (1 hr) confines the technique to use as an adjunct to diagnosis, and precludes its use as a screening method.
2. The rarity of ASL, even in 'at risk' groups, does not justify the use of scarce resources and skills in preference to those patients for whom the earlier diagnosis would increase the chances of their benefitting from treatment.

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3. The rapid growth of ASL (beyond that at which treatment might be feasible) would mean at least an annual examination of 'at risk' groups. The only treatments presently available are partial hepatic resection and transplant, both of which carry a high risk. The former would require a reasonable certainty that the other lobe was free of tumour. (See A.1 above).

C. MEDICAL

ASL is usually a multi-centric tumour. Transplant is therefore the only option available. This, particularly in older patients, carries a worse prognosis, in terms of life expectancy, than the natural progression of ASL. Until other treatments (e.g., chemotherapy) are better developed, advancing the date of diagnosis does not benefit the patient medically.

The MWG, however, agreed that, if a patient with possible ASL presented, subject to his permission and his clinical condition, then it would be entirely ethical to use NMR in his investigation. By this means, a body of knowledge and experience could be built up which might well enhance the range of NMR's diagnostic abilities. Images obtained from such examination could be sent to a "Panel" of specialists in nuclear medicine for discussion and evaluation. NMR could be used locally without the need for the patient to travel to Aberdeen.

The MWG thanked Dr. Smith for a most interesting and well presented session, and agreed to keep in touch with him, through BB, to be aware of developments.

Those present :

Dr D M J Williams	(Chairman)	Dr. Paul Smith
Dr B Bennett	(Secretary)	Dr Frank I Lee
Dr I M M Bagshaw		Dr Peter Trewby
Dr C E Baron		Dr Robin Walker
Dr Carol Bishop, Senior Employment Medical Adviser (Wales) H & S E		
Dr A E J Evans		
Dr A P Wright		

DMJW

1 Jul 86

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August 26, 1986

E. L. Beeler
Louisville

Pursuant to our telephone conversation on August 25, 1986
I am sending you the information we have on brain cancer at
Louisville.

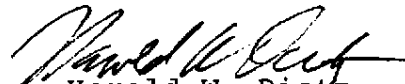
Attached are sheets showing ratios of observed and expected
cases and a list of those individuals involved. I have not
included individual department data because we have not been
receiving department number changes and job changes so that we
have old numbers with missing titles. However it appears that
no two cases were in the same department at the time of death
or diagnosis. Job histories might show common exposures in
the past, of course.

As I recalled, there appears to be an excess of brain cancer
deaths at Louisville, although with these small numbers, sta-
tistical significance is not reached. The number of cases
(morbidity) does not appear excessive when compared to all of
BFG. I cannot find any real explanation for this.

You will note that we have identified only four cases, while
I believe you indicated eleven. If you believe there are more
brain cancer cases, I would like to have, if possible, a list
of names, SS numbers and date of death or diagnosis to determine
if these are true brain cancer cases or why they have been missed.

The latest update of the epidemiology study of VCM/PVC workers,
a draft of which I have just reviewed, shows again an association
between brain cancer and VCM exposure. We do not see any excess
of brain cancer at the Akron Chemical Plant where Hycar is also
manufactured but no VCM exposure occurs.

Pending receipt of further information regarding other cases
and/or job histories, I am still inclined to attribute the
brain cancer cases at Louisville to the known association with
VCM exposure.


Harold W. Dietz

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