

concentrations are: Class I--up to 100 million particles per cu. ft.; Class II--10 million particles per cu. ft. Because of wide variation in limits for the two classes, careful representative sampling of the rock must be made by the Department. In numerous dust counts made in the industry in both Class I and Class II rocks, the average dust concentrations found were below 100 million particles per cu. ft. and above 10 million. From this it is concluded that dust control methods are unnecessary in Class I rock, but are required, according to the code, in Class II rock formations.

- 20 SILICOSIS IN A NORWEGIAN STEEL FOUNDRY. K. Evng. Nord. Med. Tid. 16, 1085-92 (1933). (Norwegian).
The author examined 29 employees who had worked in a small foundry for more than three years. Of them, 15 showed definite radiological evidence of silicosis and in two others it was suspected. The cases were distributed throughout the foundry in all of the occupations. The author points out that the results are indeed alarming and warrant studies in other similar foundries.
- 21 FINDINGS OF A MEDICAL EXAMINATION OF A GROUP OF FETTLERS. J. Chalmagne. Arch. Med. Soc. et Hyg. 1, 527-32 (1938). (Belgian).
Fettlers are those who use pneumatic tools to clean sand from castings before they are sent to the sandblast. Fifty-one of these men from four foundries were examined. The results are not reported clearly, and although x-rays were taken on 12, no reports are given of them. Most prominent symptoms found were dyspnea on exertion, cough, and pulmonary trouble which were more noticeable in the older men.
- 22 THE RESPIRATORY AND CIRCULATORY ADAPTATION TO ACUTE ANOXIA IN SILICOSIS AND CARDIOVASCULAR DISEASE. M.H. Seevers, Norbert Enzer, and T.J. Becker. J. Ind. Hyg. & Toxicol. 20, 593-654 (December 1938).
In spite of advances made in the past in reducing exposures to dust concentrations which rapidly produce the disabling pulmonary lesions, most workers will, over long periods of time, inhale enough dust to produce a detectable degree of pulmonary fibrosis. It is important then to know whether these minimal fibrotic changes cause any appreciable or measurable pulmonary disfunction. That the changes can cause a disfunction in terms of maximum capacity is granted but the important question is to know whether they can reduce his capacity to perform ordinary daily tasks. At the present time, no satisfactory methods are available which can rate the individual's ability or capacity to perform a given task and therefore rate his degree of disability. All depend on his cooperation which in many cases is unreliable. In the tests here reported the authors examined patients subjected to atmospheres of reduced oxygen content to study their reactions. Comparatively little has been done on this type of experiment, particularly in the older age groups, and many more tests are necessary in order to correlate results. Although the experiments serve as a method of studying the sensitivity of these mechanisms (heart, circulatory system, etc.) that compensate for the stress of reduced oxygen, it was found that there was no evidence of latent cardiac incompetence, over and above that occurring with age, in individuals with varying degrees of pulmonary fibrosis until the fibrosis was quite far advanced.
- 23 THE HEART IN PNEUMOCONIOSIS. C.B. Coggin, D.E. Griggs and W.L. Stilson. Am. Heart J. 16, 411 (1938).
The basis for this work is the study of 205 cases of pneumoconiosis over a period of 20 years. Of these cases 102 came to post mortem while 103 provided only clinical studies; 148 were classified as third stage and 55 as second stage pneumoconiosis. Cardiac enlargement was detected by clinical examination in

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