period 1947-1961. There was an excess mortality almost exclusively due to respiratory cancer and non-malignant respiratory disease, if compared with that for the entire population of the USA. There appeared to be no direct relationship between asbestos dust exposure and respiratory cancer mortality below 125 mppcf-years; important increments occurred somewhere between 100 and 200 mppcf-years exposure. In this study the effect of intensity and time of exposure was about the same.

Newhouse et al (1972, 1973a) studied records from British male and female workers. Workers with minor and short exposure showed no excess mortality; however among those with long periods of employment a significant excess from cancer of the lung (a few mesothelioma included ) was beginning to show 25 years after first employment. Among workers with severe exposure but short periods of employment, there was a significant excess of death from bronchial cancer after 15 years followup, particularly however in those who worked for longer than 2 years in the factory. There was no effect of sex on the cancer mortality if exposure was similar.

In the USSR Kogan (1972) investigated retrospectively cancer mortality among workers in the asbestos mining and milling industry between 1948 and 1957. For lung cancer the rates exceeded those of the general population in mines in men by 2 times, in those in mills by 2.1 times; in women 2.1 and 1.4 times respectively. No mesotheliomas were reported, but this may be due to insufficient mesothelioma experience of pathologists in that area.

In Finland Meurman et al (1974) also observed excess death due to bronchial cancer and asbestosis in workers exposed to anthophyllite: the relative risk of bronchial cancer was 1.4 for an asbestos worker who did not smoke, 12 for a smoker without exposure and 17 for a smoking asbestos worker.

From these and other studies the conclusion can be drawn that occupational asbestos exposure, of such an intensity that asbestosis occurs, greatly increases the risk of bronchial carcinoma, particularly in smoking asbestos workers. In many groups of asbestos workers, approximately 20% of all deaths are caused by lung neoplasms. There is suggestive evidence that if either no (long term or short term) intensive occupational exposure exists, the risk appears to be zero to minimal (BM) 1973). Such an occupational exposure is almost certainly greater than in "true" general air pollution with asbestos. It

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