

ENVIRONMENTAL HEALTH

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Asbestosis and Carcinoma of the Lung

Case Report and Review of the Literature

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Pneumonocutis and, in particular, as-
bestosis have been the subject of many
complete reports as to etiology, prevalence,
etc.¹ However, the coexistence and possible
relationship of asbestosis and carcinoma of
the lung has been reported rather infre-
quently.²⁻¹¹ In particular, there are only 23
cases of asbestosis and lung carcinoma with
complete autopsy reports that have been
documented in the literature: Isselbacher¹²
reported 21 cases, Todd¹³ reported 1 case,
and Lynch¹⁴ reported 1 case. Lynch re-
ported two cases but only one with autopsy
findings. Doll¹⁵ reported necropsies on 105
asbestos workers, in which 18 had lung
carcinomas, 15 of which were associated
with asbestosis; complete autopsy data was
not given.

Rare reports, as the one by Cartier,¹⁶
attempt to disprove any relationship be-
tween the two conditions, but not enough
information is presented in this report for
evaluation.

Report of Case

A 52-year-old white man of Italian extraction
admitted to St. Mary's Hospital on May 8,
1959. His chief complaints were shortness of
breath on exertion and loss of appetite of four
months' duration. He denied nocturnal
sweats or ankle edema. He admitted, however, to
a chronic cough for approximately six months
which was productive of yellow mucus. There
were also two bouts of hemoptysis of minor degree
one and six months prior to entry. On each
occasion they lasted two days and were intermit-
tent.

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There was a 30 lb. weight loss over a six-month
period and considerable fatigue. He also noted
clubbing of his fingers for "some years."

For 30 years the patient had worked actively
as an asbestos insulator, working both inside and
out and in new and old buildings. This entailed
cutting, molding, and applying asbestos insulation
to pipes, boilers, etc. At no time had he or his
associates worn any protective mask. He had
worked full-time until one week prior to hospi-
talization. He also had considerable contact with
Fiberglas. He had not smoked in the past five
years, but prior to that he had smoked three
packages of cigarettes daily for many years. There
was a moderately heavy alcohol intake, primarily
wine, in the past six months.

Family history was negative for malignancy.
There was contact 20 years previous with a brother
who had tuberculosis.

Physical examination revealed an extremely
emaciated and dyspneic white man, appearing
clinically ill. The blood pressure was 140/100
in both arms, pulse 84 and regular, temperature
100.4 rectally, respiration 24, height 5 ft 10 in.,
weight 122½ lb.

There was marked clubbing of the fingers and
toes but no cyanosis. There was bilateral arecus
semilis. No abnormalities were noted in the neck.
The chest showed reduced excursion in both lung
fields. Dullness and both decreased breath sounds
and fremitus were noted on the right involving
the entire lower half of the lung field. Medium dry
rales which did not clear were heard anteriorly and
posteriorly in the inferior areas of both lungs. The
heart was not enlarged to percussion or palpation,
and no murmurs were present. There was a split
first sound at the apex. Complete examination
otherwise was within normal limits.

Laboratory studies on entry showed a Hg of
13 gm.; RBC 4.38×10⁶; WBC 8,850, with poly-
morphonuclears 78, nonsegmenters 7, lymphocytes
19, monocytes 2, and eosinophils 1; FBS 112 mg.;
BUN 16 mg.; serum albumin 3.5 gm.; globulin
3.1 gm.; thymol turbidity, acid phosphatase, direct
and indirect bilirubin, amylase, and electrolyte
panel were normal. The alkaline phosphatase was
6.5 and 5.9 Bodansky units on two occasions.
Urines showed persistent 1+-2+ albuminuria.
I.E.-cell preparation, Kahn and Kohnen, and blood

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