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changed because of the conclusions drawn by Wedler (Lungentuberkulose bei Asbestose, 1947, Leipsiz: Barth) but in later years he has modified his opinion. The authors have, therefore, gone into the question anew and have accumulated a large number of cases. The particular conclusion of Wedler to be checked was that the accompanying tuberculosis ran a relatively favorable course independent of the degree of asbestosis and that it played no part in the occurrence and termination of an asbestosis. Up to the end of 1961, in the 613 known asbestosis patients, 40 of them had active tuberculosis, a proportion of 6.52%. Half of the 40 patients with the combined disease had died, 7 of tuberculosis. The total deaths in the 613 cases numbered 89. Tuberculosis was the fourth most frequent cause of death, after right heart failure, pulmonary carcinoma and carcinoma of other sites. The tuberculosis morbidity of asbestosis patients is higher than is generally admitted in Germany, but not significantly higher than that of the comparable age-groups of the rest of the population. An illustrative case of the combined disease is described. Treatment, including chemotherapy was not successful, and in this patient a mutually harmful influence was exerted by the two diseases. The authors press for this fact to be taken into consideration in individual compensation cases in Germany more than it has up to now. -- Bull. Hyg.

469 Comparison of Pneumoconiosis-Producing Properties of Silicon Structureless and Crystalline Asbestos Dust. K. Szymczykiewicz and E. Wiecek.
Med. Pracy (Lodz) 13, 85-97 (1962). Polish.

An amount of 40 mg. of silicon dust, structureless asbestos dust, and crystalline asbestos dust was introduced during ether anesthesia into the prepared trachea of guinea pigs divided into 3 groups (16 guinea pigs in each group). A different kind of dust was given to each group in 2 ml. of normal saline solution. The contents of colagene in the lungs as well as the SiO_2 in blood and lungs was estimated every 2 months. The lungs were subjected to histopathological examination. It was found that the pneumoconiosis-producing properties of the structureless asbestos are less than those of the crystalline asbestos as compared with the biological effect of the silicon dust. -- Public Health Eng. Absts.

PHYSICAL ASPECTS OF THE ENVIRONMENT

470 The Physiological Adaptations to Heat-Stress with a Classification of Heat Illness and a Description of the Features of Heat Exhaustion. B. A. King and M. E. Barry.
S. African Med. J. 36, 451-455 (June 9, 1962).

Africans engaged in deep-level mining in the Orange Free State are working hard in hot and humid conditions. Air dry bulb temperatures vary from 86 to 96°F, with a relative humidity of 90 to 96%. Adequate replacement of fluid and electrolytes lost in sweat, maintenance of a steady work rate, and repeated checks on body temperature and physical stress by trained supervisors, keep down the incidence of heat illness. The heat disorders commonly encountered include heatstroke, heat hyperpyrexia, heat cramps and salt-depletion heat exhaustion, and prickly heat. The authors review briefly the whole question of acclimatization to heat and of heat illness, then proceed to consider the clinical features of salt-depletion heat exhaustion. They draw from their own experience and from the bedside and laboratory findings in their last dozen or so cases of salt depletion. These patients suffered weakness, apathy, nausea and vomiting, dizziness, and muscle cramps; they were found in general to have the signs of dehydration, orthostatic tachycardia and syncope, a low oral temperature, hemoconcentration, a high blood urea, low serum and urine chlorides, and oliguria. Intravenous therapy was aimed at replacing approximately 5 liters of fluid and 25 g. of salt, and normal saline was used for the first 2 liters. The prognosis of the disorder is good. -- Bull. Hyg.

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