PITTSBURGH
PLATE GLASS COMPANY

GENERAL OFFICES
ONE GATEWAY CENTER, PITTSBURGH 22, PA.

April 23, 1963

Mr. Karl Baumler
Vice President of Manufacturing
Pittsburgh-Corning Corporation
One Gateway Center
Pittsburgh 22, Pennsylvania

Dear Mr. Baumler:

This is to confirm my visit to your Tyler, Texas operation on April 8 & 9, 1963.

This visit was made in the interest of plant safety and with the objective of working toward the high standards which are in vogue in Pittsburgh-Corning plants. Mr. J. W. McMillan, the Plant Manager, escorted me through the plant and showed me all the courtesy possible. He did a fine job of explaining plant operation and historical background. All plant people were courteous and helpful. Mr. McMurray, a plant supervisor, was most helpful and courteous.

A thorough audit of the plant safety effort was made and recommendations are attached which cover the important items which take priority. These items can cut costs on a long-range basis and are the basic or first steps that should be taken toward your high standards.

Attached is an Ansul Fire School schedule and a reproduction from Industrial Hygiene Journal on Asbestosis. The hygienic standards mentions "periodic" clynical examinations. The Foundation feels this allows latitude for judgment in the individual plant situation, depending upon exposure, dust concentration and other factors. A recommendation can be included in the dust survey report [illegible]. A dust survey can be made in the coming early summer. We will be advised of the date in due time.

The Foundation also offers a service which may be of interest. They have means for surveying the medical doctors in the plant vicinity, to determine who could be recommended as a company physician based on background in our particular need. They will assist him in setting up a program tailored to fit the need of the plant. This is recommended for serious consideration.

It was a pleasure to be of help in this matter.

Very truly yours,

J. E. Morrison, Asst. Manager
Safety and Plant Protection

JEM:rm
cc: T. W. Collins

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RECOMMENDATIONS

1. A dust survey by Industrial Hygiene Foundation should be made at an early date.

2. A front and side X-ray of the lumbar region of the back should be made as a part of the pre-employment physical examination along with the chest X-ray.

3. Several additional fire extinguishers should be placed in the shipping area and in the north end of the manufacturing building.

4. Employees should wear respirators in dusty atmosphere.

5. A 5-pound Ansul dry chemical fire extinguisher should be provided for each fork truck.

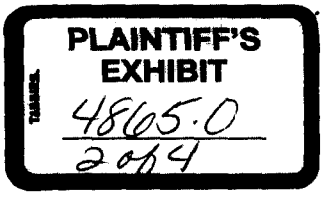
6. Horns should be installed on fork trucks.

7. Employees should have training in use of dry powder and other extinguishers.

8. Fire brigades should be activated.

9. Special oil storage house is needed.

10. Executive Safety Committee should be reactivated with the Works Manager as the Permanent Chairman.



C. RECOMMENDED CONTROL PROCEDURES: To prevent exposure to high concentrations of amorphous silica dust, process ventilation and/or enclosure are the best means of control. For some operations a dust respirator approved by the U. S. Bureau of Mines may be satisfactory.

IV. Specific Procedures

A. FIRST AID: None.

B. SPECIAL MEDICAL PROCEDURES:

(1) Preplacement: Clinical and chest radiographic examinations should be made on all persons prior to job assignment.

(2) Periodic: Since there is only limited information about the harmful effects of amorphous silica in industry, exposed personnel should have careful periodic medical examinations, including chest x-ray. Pulmonary function testing may be useful.

(3) Treatment: No satisfactory treatment other than removal from exposure, and therapy for any complicating infection.

Literature References

1. Cooper, W. C., et al: Industrial Hygiene Foundation Transaction Bulletin No. 30, 182–194.
2. Drinker, P. and Hatch, T.: Industrial Dust. McGraw-Hill Co., Inc. New York, 1954.
3. Fraser, D. A.: *AMA Arch. of Ind. Hyg. and Occ. Med., 8:* 412, 1953.
4. Lambie, J. S.: *Ind. Med., 7:* 470, 1938.
5. Policard, A. and Collet, A.: *AMA Arch. of Ind. Hyg. and Occ. Med., 9:* 389, 1954.
6. Scheffers, G. W. H., et al: *AMA Arch. of Ind. Health, 16:* 125, 1957; *ibid, 16:* 203, 1957; *ibid, 16:* 280, 1957; *ibid, 16:* 303, 1957; *ibid, 16:* 409, 1957.
7. Smart, R. H. and Anderson, W. M.: *Ind. Med. and Surg., 21:* 509, 1952.
8. Tebbens, B. D. and Beard, R. R.: *AMA Arch. Ind. Health, 16:* 55, 1957.
9. U. S. Public Health Service; California Department of Public Health; Nevada State Health Department; Oregon State Board of Health: Progress Report of Study of Pneumoconiosis Hazards in the Diatomite Processing Industry. 1955.

Asbestos

I. Hygienic Standards

A. RECOMMENDED MAXIMUM ATMOSPHERIC CONCENTRATION (8 hours): 5 million particles per cubic foot of air (MPPCF).[1]

(1) Basis for Recommendation: Experience in industry,[1, 2, 3, 4, 5, 6, 7, 8, 9] and animal experiments.[5, 7]

B. SEVERITY OF HAZARDS:

(1) Health: Long continued inhalation of asbestos dust results in a form of pneumoconiosis known as asbestosis. The primary effect of inhalation is an interstitial pulmonary fibrosis. The disease is characterized by asbestos bodies in the lungs and sputum. Based on roentgenological examinations, asbestosis can be classified as minimal, moderate, and advanced. It is a serious disease in some instances, but more frequently it remains nondisabling for many years, even without appreciable symptoms, as long as some other serious disease does not supervene to cause death.[8] Chief symptoms of advanced asbestosis are variable cough, dyspnea, substernal chest pains, decreased chest expansion, weakness, emaciation, clubbed finger tips, and curved fingernails. Any appreciable decrease in the amount of asbestos dust in the breathing atmosphere will cause a decrease in the incidence and severity of asbestosis. Individual suceptibility varies.[6] There have been reports of an increased incidence of lung cancer in persons with asbestosis.[9]

(2) Fire: None.

C. SHORT EXPOSURE TOLERANCE: Not applicable.

II. Significant Properties

A fibrous magnesium calcium silicate which occurs in various combinations as white, greyish or greenish masses, either compact or of long silky fibers, flax-like and readily separated. About 95% of commercial asbestos is chrysotile, which is derived from serpentine, and is a hydrous magnesium

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silicate containing from 12 to 14 per cent water of crystallization.

III. Industrial Hygiene Practice

A. RECOGNITION: The spinning and weaving of asbestos, in combination with other textiles for fire proof and heat resistant cloth, results in dust exposure. It may be used by itself or combined with other materials for valve packings, gaskets, boiler lagging and pipe covering, protective clothing, shielding materials, and as automotive brake linings. In the building industry it is used in the manufacture of asbestos cement products, heat insulating, and fireproofing materials.

B. EVALUATION OF EXPOSURES: Asbestos dust may be sampled with the electrostatic precipitator or by the impinger method using alcohol or alcohol and water, as the collecting medium,[4,6] and dust counts made by the standard light field technique.[6] The recommended maximum atmospheric concentration of 5 MPPCF is based upon the impinger sampling procedure.

C. RECOMMENDED CONTROL PROCEDURES: Prevention of asbestosis depends entirely upon preventing exposure to concentrations of dust sufficiently high to produce the characteristic reaction. Enclosure or local exhaust ventilation are the principal means of dust control. U. S. Bureau of Mines approved dust respirators may be worn as protection for some operations.

IV. Specific Procedures

A. FIRST AID: None.

B. SPECIAL MEDICAL PROCEDURES:

(1) Preplacement: Clinical and radiographic chest examinations prior to job assignment.

(2) Periodic: Exposed personnel should have periodic clinical examinations for signs and symptoms of asbestosis. These should include examination of the sputum for asbestosis bodies, and chest x-rays of good quality.

(3) Treatment: No satisfactory treatment other than removal from exposure and therapy for any complicating infection.

V. Literature References

1. American Conference of Governmental Industrial Hygienists: *AMA Arch. of Ind. Health, 16:* 261, 1957.
2. Cartier, Paul: *AMA Arch. of Ind. Health, 11:* 204, 1955.
3. Doll, R.: *Brit. J. Ind. Med., 12:* 8, 1955.
4. Dreesen, W. C., et al: Public Health Bulletin No. 241, Supt. of Doc., Washington, D. C., 1938.
5. Drinker, P. and Hatch, T.: Industrial Dust. McGraw-Hill Book Co., Inc., New York, 1954.
6. Fairhall, Lawrence T.: Industrial Toxicology. The Williams & Wilkins Co., Baltimore, Md., 1957.
7. King, E. J., et al: Thorox I, p. 188, 1946.
8. Lynch, K. M.: *AMA Arch. of Ind. Health, 11:* 185, 1955.
9. McPheeters, S. B.: *J. Ind. Hyg. & Tox., 18:* 229, 1936.
10. Page, R. T. and Bloomfield, J. J.: *Pub. Health Repts. 52:* 1713, 1937.
11. Patty, Frank A.: Industrial Hygiene and Toxicology, Vol. 1. Interscience Publishers, Inc., New York, 1948.
12. Smith, K. W., *AMA Arch. of Ind. Health, 12:* 198, 1955.
13. Vorwald, A. J., et al: *AMA Arch. Ind. Hyg. and Occup. Med. 3:* 1, 1951.

Because of space limitations, it is impossible to list all methods of exposure evaluation. The selections have been made on the basis of current usage, reliability, and applicability to the usual industrial type of exposure. Any specific evaluation and/or control problem will involve professional judgment. This can best be done by professional industrial hygiene personnel.

Respiratory protective devices are commercially available. Their use, however, should be confined to emergency or intermittent exposures and not relied upon as primary means of hazard control.

A relative scale is used for rating the severity of hazards: nil, low, moderate, high, and extra hazardous.

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