with marked symptoms and disability as well as a distinctive X-ray appearance, such as my colleagues and myself had been accustomed to find in our previous investigations of silicosis, our task in attempting to make a positive diagnosis and estimate the extent of the disease would have been easier. There is no doubt that, especially in the beginning, we were handicapped by endeavoring to evaluate astestosis with a silicosis foot-rule.

The X-ray appearances are not clear cut nor distinctive as in silicosis and do not lend themselves to ready grouping into progressive stages. There is less evident pathology in these films, the shadows are finer, more granular, and softer, than in silicosis. The asbestosis film gives the impression of ground glass and there is no nodulation with the consequent tendency of the nodules to coalesce and give dense opaque areas in the films. The distribution of the shadows is somewhat different, occupying the lower third of the lung, except in far advanced cases when the shadows may occupy the major portion of the lung. We noticed frequently the well marked outline of the interlobar septum on the right side. We also noticed that a number of the films of cases of asbestosis had enlarged hearts, and this might be expected when one considers that the pathological process tends to constrict the pulmonary blood vessels and they ramify along with the bronchioles. (7)

It is possible that the X-ray appearance of asbestosis may not be distinctive of this disease alone but uniform in appearance with pneumoconiosis due to other silicate dusts. Much more investigation and study of X-ray films of industrial workers exposed to all sorts of silicate and other dusts are needed before it will be possible to speak definitely on this, the most important phase of the diagnosis of pneumoconiosis.

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