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It is a familiar phenomenon in the occupational diseases and in environmental cancer. Among persons doing essentially the same work, some, apparently, get lead poisoning or develop cancer while their co-workers do not.

Age and sex differentials are not well understood, in general. But in the field of lung cancer, there are indications that there may be significant shifts both in age and sex incidence when, exogenous carcinogens are responsible. Thus, while the incidence of lung cancer is higher for men than for women, in the general population, this relative sex incidence may apparently be significantly altered in situations where women have the same occupational exposures as the men. Similarly, the incidence of occupational lung cancer appears to affect a somewhat younger age group than that characteristic for the population as a whole.

Safe Dosage and Prevention—Since toxicity is, in general, a function of dosage — where dosage is measured in terms of intensity and duration of exposure — the occupational diseases are amenable to control by well established industrial hygiene techniques. For that reason, it has been useful to develop safe standards for exposure to potentially toxic substances in industry. These are known as Maximum Allowable Concentrations (M. A. C.). While allergy, synergism and some other matters, which we need not go into here, present complications, these standards have proved invaluable for the prevention of occupational diseases. They are constantly being improved and extended as new scientific data become available.

It is unfortunate, therefore, that equally convenient and simple relationships between dosage, toxicity and carcinogenicity do not seem to exist in the field of environmental cancer. It is not helpful to know that a chemical substance is toxic because this does not apparently indicate anything as to its carcinogenicity and vice versa. Lead has already been cited as a toxic chemical which is not carcinogenic. Beta naphthylamine, conversely, is carcinogenic but has never been known to produce systemic poisoning. And so, the maintenance in a factory workroom of Maximum Allowable Concentrations will not necessarily insure safe working conditions, if a potential carcinogen happens to be present.

It has recently been suggested that there *is* a critical dose for each carcinogen of exogenous origin; and that cancer will ultimately develop once this dose has been reached, whether as a result of a single exposure or cumulative absorption over a period of time. But even could such dosage be accurately determined one would still, for purposes of prevention, face the formidable problems created by the fact that cancer may take a great many years to develop; that it may also develop after a relatively short exposure; and that there may be a lag of many years between the pertinent exposure and the development of the cancer.

Known and Suspected Carcinogens

Let us, now, turn to a consideration of specific factors in the industrial environment which are known to produce lung cancer, or which are suspect and under investigation.

1. Organic Chemicals

Among the organic chemicals, none, thus far, has been definitely shown to be capable of producing lung cancer. Many are still under investigation, but the data now available are inconclusive and contradictory.

The products of incomplete combustion of coal have been studied, as well as its various distillation and fractionation products. These studies have included such substances as tar, asphalt, pitch, oil, lamp blacks, carbon blacks and various types of soot. Thus far, the results in all cases have been either negative or inconclusive insofar as cancer of the respiratory tract is concerned.

Soot has always been of special interest because it was responsible for the classical scrotal cancer of chimney sweeps. However, these boys must have also inhaled considerable soot in the course of their work; and yet, no suggestion has come down to us to the effect that they also developed lung cancer. Perhaps the diagnostic techniques of those days were too inadequate. This historical background lends special interest to a statistical study made by Dr. Dorn of the relation of lung cancer to atmospheric soot from domestic and industrial sources. In this study he found the incidence to be *low* in Pittsburgh as compared with five other large cities.

Commercial soots prepared from natural gas and oil residues are also under investigation. The carbon black industry is now supporting experimental research in this field and further data of interest may be forthcoming in the near future.

Exhaust gases from diesel and gasoline engines have very naturally come under suspicion. But here again, investigations as to the incidence of lung cancer among persons heavily exposed, such as policemen, street cleaners, garage mechanics and automobile drivers, have all been negative.

Crude mineral oil and tar are still in the doubtful category. Inhalation of aerosols of processed mineral oil and shale oil; fumes from creosote and anthracene oil (3, 4 benzpyrene) and particularly crude paraffin oils or the heavier fuel oils are all under suspicion at present. They are being investigated, but no conclusive data are available thus far. Special attention is being given to tar fumes in tobacco smoke. Isopropyl oil, inhaled as a vapor, in connection with the manufacture of isopropyl alcohol, is the only chemical in the aliphatic group that is now suspect as a cause of lung cancer.

2. Inorganic Chemicals

Asbestos — The relation of asbestos to lung cancer, long suspected, has received new confirmation from the 1949 Annual Report of the Chief Medical Inspector of Factories in England. During the period from 1924 to 1946 inclusive, 235 deaths were reported either caused by asbestosis or in which asbestosis had been established at necropsy. Cancer of the lungs or pleura was found in 31 of these cases or 13.2 per cent. This is very high compared with a general incidence of 1 per cent for cancer of the lungs among all adults examined at necropsy in England. Moreover, the sex distribution seemed also to suggest the presence of an occupational carcinogen. The histologic character of the cancers—squamous cell, instead of adenocarcinoma—and their histogenetic derivation, in that the bronchial mucosa was involved rather than the alveolar epithelium, was interpreted to indicate the presence of a specific exogenous carcinogenic agent as the etiological factor; in this instance, inhalation of asbestos dust.

The development of cancer of the lungs is believed to be more directly related to asbestosis, the disease, than to the inhalation of asbestos dust per se. Differential diagnosis by X-ray between asbestosis and lung cancer presents all of the difficulties one would anticipate. It has been suggested that cytological examination of the bronchial secretions might well be made in workers exposed to asbestos dust, whenever clinical or X-ray evidence suggests the possibility of a pre-cancerous lesion. Careful histological studies of lung tissue, postmortem, in all such cases would also provide valuable data.

It has been estimated that approximately 20,000 workers are now employed in asbestos-producing industries in this country and Canada.

Nickel Carbonyl—Exposure to nickel carbonyl in the nickel works in England has also been the subject of spe-

cial investigation and report by the Chief Medical Inspector of Factories. In a review of the incidence of nose and lung cancer between the years 1923 and 1948, inclusive, he found 47 cases of cancer of the nose, and 82 cases of cancer of the lungs among these workers. The average duration of exposure before the development of cancer was 23 years for the nose cases, and 25 years for the lung cases. The average length of time between diagnosis and death was short; and by the end of 1948, 46 of the nasal and 72 of the lung cases had died. The precise causative agent has not yet been identified and the matter continues to be under active investigation. There is no comparable experience in this country.

The Chromates—The etiological role of the chromates in the production of lung cancer has been pretty well established in this country in the last few years; and these findings have confirmed previous European experience.

In 1948, at the request of the chromium-producing industry, Drs. Machle and Gregorius made a study of deaths from cancer of the respiratory tract from 1937-1947, in five chromium-producing plants. Dr. Mancuso, the year following, examined the records of all employees who had worked one year or more between 1931 and 1949 in a chromate-producing plant in Ohio. Dr. Baetjer then reviewed all of the European and American experience, and reported on a study of her own in which she analyzed the records of two hospitals in Baltimore located near a chromate-producing plant. In each of these studies the incidence of lung cancer among the chrome workers was significantly high.

A total of 122 case reports, were thus collected, of cancer of the respiratory tract among workers exposed to chrome. Of these, 109 worked in the chromate-producing industries; 11 in the manufacture of chrome pigments; 2 in other industries. Sixty-three of the cases occurred in Germany, 57 in the United States, and 1 each in Switzerland and England. The chemical substances believed to be responsible are the hexavalent chromium compounds, particularly Na and K monochromate or dichromate; and zinc chromate, inhaled as dusts.

While the mechanisms are not known, certain observations were made which are of interest:

1) Most cases were found to be primary bronchiogenic carcinomas. In a few instances, the upper respiratory tract or the oral region were involved. The incidence of cancer in other tissues was not high.

2) In some cases, an exposure of four years appeared to be sufficient. In most cases, however, a great many years of exposure were necessary. In some instances there was a latent period of variable duration between leaving the exposure and the development of the cancer.

3) The intensity of exposure could not be evaluated in these cases. Presumably, however, in years gone by, this type of work was very dusty.

4) Lung cancer in these workers showed a somewhat younger age distribution than that for non-occupational lung cancer.

5) There was no indication that persons exposed to chromates in other occupations were more than normally liable to cancer of the respiratory tract.

In New York State there is exposure to chrome and its compounds in a variety of industries: In the mining and extraction of chrome ore, which is ferrous chromite; in the manufacture of chrome pigments, including zinc and lead chromates; in chrome-plating operations, where there is exposure to chromic acid and chromic acid mist; in the leather industry where chromium sulphate and sodium bichromate are used in tanning. Photo-engravers are exposed to ammonium bichromate and also to asphalt. Since both of these substances are under suspicion, the Division of Industrial Hygiene decided to make a special study of photo-engravers.

In photo-engraving, the copper plates are coated with a thin light-sensitive film of gelatin and ammonium bichromate, and the plate is then exposed to light behind a negative. The penetration of light through the transparent areas of the negative, causes the formation of a water insoluable chromium-gelatin film, which is resistant to acid. The parts not exposed to light remain soluble and are washed off. Prior to etching all large surfaces, which are gelatin-free and which would ordinarily have to be eaten away, are coated with an asphalt paint, which is resistant to acid. After the plates have been etched in a ferric chloride solution, these areas are reamed out with the aid of rotary electric cutting tools.

An unselected series of 684 photo-engravers were X-rayed in cooperation with the chest clinic of the New York City Department of Health. No pulmonary neoplasms were found. At the same time a preliminary examination was made, under Dr. Hueper's direction, of the health records of the Photoengraver's Union at its central headquarters in St. Louis. The results are inconclusive, thus far, however, and further study is necessary.

3. Radiation

Exposure to radiation is on the increase not only in industry but in hospitals and in research laboratories everywhere. Radium dial painting is booming again as a result of industrial expansion for defense. The examination of metal castings for flaws by the use of radium and X-ray has become routine in foundry operations. Radioactive cobalt is being used increasingly for this purpose at present. The fluoroscope has not only made its way into retail shoe stores, but is used in many industries as an inspection device — for the detection of misplaced nails in shoe manufacture; for examination of metal inserts in plastics; for the detection of foreign bodies in packaged foods, and so on. Radioactive static eliminators are utilized to prevent fires in dozens of industries and operations. These include publishing houses, plastic fabric manufacture, teletype machine installations, etc. Radioactive isotopes are stepping out of the expert hands of technical personnel, in research laboratories, and are now finding their way into the hands of lay workers, not at all familiar with the potential hazards to health which are involved; or with the precautionary measures which are essential for safety.

Wherever there is radioactive dust in the workroom air —however invisible to the naked eye—one is presented with a known etiological agent in the production of lung cancer. There is, as yet, very little information as to what constitutes a "safe" dust count; or how much radioactive dust one might, in general, anticipate in specific operations. Too few dust counts have, as yet, been made to provide this basic experience. However, standards for radon gas in the air of the workroom, emanating from radioactive materials present there, have been established; also for radon in the expired air of individual workers. Taking of the air samples is not too difficult. But these samples must be sent to highly specialized radiation laboratories for analysis, and this is fairly expensive.

In such plants there is usually simultaneous exposure to various types of external radiation. This type of exposure will not produce lung cancer; but adequate lead shielding and other control measures are nevertheless essential for the prevention of cancer elsewhere in the body.

(Continued in the July, 1952 issue)