

...the clinical findings were characteristic of asbestosis. Underneath to the right above the lungs, the respiratory sounds were weakened. The clinical diagnosis was asbestosis and chronic irritative pneumonia, with rind (skin) to the bottom right. In addition to asbestosis with right lateral pleuritis and bronchiectasis, a decomposed cavity was found in the right lower lobe through pathological-anatomical examination, which was macroscopically taken as tuberculosis. Only through the microscopic examination was it possible to detect cancer of the pavement of the epithelium. There were no metastases to be observed. It is unusual to speak of simultaneous hyaline nodes in the lungs of asbestosis patients. The carcinoma originated from a bronchus with a metaplastic epithelium. The authors felt that this had been caused by chronic irritation of the bronchii. They spoke of the correlation between cancer and asbestosis as a "possible relationship" and tried to find parallels to other occupational diseases of the lungs.

In 1936, Egbert and Geiger (USA) reported on an additional observation which they felt was the first one of this type (with the exception of Gloyne's 1933 report). The 41-year-old male had worked for 18 years as an asbestos weaver. After 9 years in this job, he had a case of pneumonia, followed by coughing and shortness of breath. Eight months prior to a short treatment in the hospital, he began to have occasional back pains. He was emaciated and had trouble moving because of the pain; he coughed, had cyanosis and shortness of breath, as well as bloody and purulent expectoration. In addition to asbestosis, x-rays showed a cluster in the left bottom part of the lung, which had the appearance of an atelectasis or a pneumonic process, but which was recognized as a tumor, due to the fact that metastases were present in the pelvis and in the spinal column. In addition to asbestosis, autopsy revealed a 5.5:4 cm acinose cancer in the left lower lobe of the lung, which had caused the appearance of metastases in the lungs, in the left lateral hilus and aortic glands, in the right suprarenal gland, in the abdominal musculature, the pelvis, the spinal column and the skull. The origin of the tumor was formed by a large secondary branch of the left bronchial lower lobe. He felt that there was very likely an etiological correlation between the two diseases: "That the irritating effects of the inhaled asbestos particles may in this case have been a significant factor concerned in the development of the primary lung cancer seems sufficiently plausible to be worthy of consideration."

In 1936, Gloyne was able to add an additional observation to his three initial ones. He found a non-differentiated carcinoma of the left lower lobe in a 59-year-old male suffering from asbestosis, who had worked for 21 years in the asbestos industry.

In 1938, Sparks, without specific data, stated that in his autopsies, Gloyne had encountered 6 cases of lung cancer in patients suffering from asbestosis. Baader learned from Gloyne himself that these 6 cases of cancer were based on 50 autopsies.

In the same year, Nordmann provided us with two new observations of cancer cases in asbestosis patients that he had previously and consecutively