for workmen where needed, early diagnosis and repeated x-ray studies of men engaged in occupations involving exposure.

Asbestosis. A. J. Lanza[1] (New York City) points out that asbestosis is pneumonoconiosis caused by inhalation of asbestos dust. Asbestos (Canadian) is a hydrated magnesium silicate containing no free silica but about 44 per cent combined silica, 43 per cent magnesium, nearly 13 per cent water and traces of iron and nickel. There are about 12,000 employes in the chief asbestos plants in the United States, of whom 10,000 might be exposed to asbestos dust. Of 11 fatal cases reported in the United States since 1927, three were complicated by tuberculosis. Death records of the Metropolitan Life Insurance Company reveal that asbestosis has been given as a cause or contributing cause of death in only 19 cases, since 1924, 15 of these since 1933. Diagnosis was supported by autopsy in six. The disease is quite different from silicosis. While the latter is predominantly parenchymatous, asbestosis is mainly interstitial; nor is it characterized by the nodular formation so distinctive of silicosis.

Clinical data were obtained from examinations of 126 asbestos workers—all with more than three years' exposure—selected at random. Sixty-three presented an x-ray appearance which probably indicated pneumonoconiosis, but the symptoms were inconclusive. The condition was called first stage. The condition in four presenting evident pulmonary symptoms and corroborative x-rays was termed second stage. Of these 67 patients, 20 had been exposed more than 10 years and 13 more than 15 years. Diagnosis centers on the x-ray. Pathologic changes are less evident in the films than in cases of silicosis; shadows are finer, more granular and softer. Distribution of shadows is somewhat different, occupying the lower third of the lung, except in far advanced cases when the shadows may occupy the major

(1) J. A. M. A. 106:368-369, Feb. 1, 1936.

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portion. A number of films showed enlarged heart. It is possible that the x-ray appearance of asbestosis may not be distinctive of this disease alone but uniform in appearance with pneumonoconiosis due to other silicate dusts. Much work must still be done on the subject. In the meantime there is a tendency for improvement in the conditions that produce the disease, as asbestos plants are being cleaned up and the dust is being controlled.

Hodgkin's Disease of the Lung. Ernest H. Falconer and Maurice E. Leonard[2] (Univ. of California) studied 29 patients with Hodgkin's disease and compared and amplified their data by investigating the literature. Nine patients showed clinical or pathologic evidence of pulmonary involvement, which coincides with the 40 per cent incidence of involvement. The lesion may be primary from lymphoid nodules within the lung parenchyma and the submucosa of the bronchi or secondary by invasion from the bronchomediastinal lymph nodes, the thoracic portion of the spine, ribs, pleura, pericardium or thymus. Grossly, the lesions may resemble metastatic tumor nodules, lobar consolidation, miliary disseminations or cavities, and histologically, typical granulomatous tissue invading and following peribronchial and vascular structures may be found. Pleural effusion may occur in association with infiltration of the lung or pleura or may be due to pressure on the great vessels by glandular masses. Five of the patients showed such effusions. Clinically, cough, dyspnea, chest pain, expectoration and hemoptysis are the commonest symptoms, and the physical signs are often those of the effusion. The roentgen picture is not characteristic, and the disease may be mistaken for tuberculosis or metastatic carcinoma, but in most cases there is evidence of Hodgkin's disease elsewhere in the body, and x-ray establishes the presence of pulmonary involvement.

The response to roentgen treatment may be of help in the differential diagnosis, especially in cases where

(2) Am. J. M. Sc. 191:780-788, June, 1936.

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