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HETA 93-0794-2621
Unimin Specialty Minerals, Inc. - Tamms
Tamms, Illinois

Margaret Filios, RN, ScM

PREFACE

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ACKNOWLEDGMENTS AND AVAILABILITY OF REPORT

This report was prepared by Margaret Filios, RN, ScM, of the Respiratory Disease Hazard Evaluations and Technical Assistance Program, Clinical Investigations Branch, Division of Respiratory Disease Studies (DRDS). Assistance was provided by Jean Cox-Ganser, Ph.D., Epidemiological Investigations Branch; Kathleen Fedan, BS, Clinical Investigations Branch; and Ken Ream, Examination Processing Branch. Desktop publishing by Terry Stewart.

Copies of this report have been sent to employee and management representatives at Unimin Specialty Minerals, Inc., Laborers International Union of North America, Local 773; Laborers Health & Safety Fund of North America; Mine Safety and Health Administration; Illinois Department of Public Health; National Industrial Sand Association; Glass, Molders, Pottery, Plastics & Allied Workers International; General Teamsters and Allied Workers; Oil, Chemical and Atomic Workers International. This report is not copyrighted and may be freely reproduced. Single copies of this report will be available for a period of three years from the date of this report. To expedite your request, include a self-addressed mailing label along with your written request to:

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Health Hazard Evaluation Report 93-0794-2621

**Unimin Specialty Minerals, Inc. - Tamms
Tamms, Illinois
January 1997**

Margaret Filios, RN, ScM

SUMMARY

In July 1991, the National Institute for Occupational Safety and Health (NIOSH) received a request for technical assistance from the Mine Safety and Health Administration (MSHA) to estimate the prevalence of silicosis at specific ground silica operations by conducting a medical evaluation of active and retired miners.

On September 17, 1993, NIOSH conducted a medical survey of current workers at Unimin Specialty Minerals, Inc.-Tamms, in Tamms, Illinois. Former workers were tested September 18-20, 1993. The survey included a questionnaire, spirometry, and a single view posterior-anterior (PA) chest x-ray.

The criterion for inclusion in the study population was one year or greater cumulative tenure since 1970 in the grinding area of the mill or in areas downstream of the grinding process.

A chest x-ray was defined as consistent with silicosis if the median, or middle, classification of small opacity profusion was 1/0 or greater. A total of 30 current and former workers participated in the NIOSH medical survey and of these, 5 (17%) had a chest x-ray considered consistent with silicosis; the prevalence among currently working participants was 5% (1/19). The highest median International Labour Office (ILO) profusion category was 2/2. Four participants, all former workers, had a chest x-ray consistent with progressive massive fibrosis (PMF). Two had "A" size large opacities, one had "B" size large opacities, and one had large opacities without a consensus on size, as classified by at least two Readers. None of the 13 participating current workers employed 10 years or less had a positive chest x-ray. Classification of chest x-rays from the ongoing company medical monitoring program for current workers who met the study criterion, yet chose not to participate in the medical survey, allowed the determination of the prevalence of x-ray evidence of silicosis among all 21 eligible current workers. The prevalence of silicosis among this group was 5% (1/21).

Pulmonary function testing revealed that nine (32%) of the 28 participants who performed spirometry had abnormal patterns. Four of the five participants with a positive chest x-ray had abnormal pulmonary function test results; three exhibited an obstructive lung pattern and one exhibited a combined restrictive and obstructive pattern.

The prevalence of x-ray defined silicosis among currently working participants who met the study criterion (one year or greater cumulative tenure since 1970 in the grinding area of the mill or in areas downstream of the grinding process) was 5% (1/19). In addition, there were four cases of silicosis among the 11 former workers who participated in the survey.

The prevalence of silicosis among all eligible current workers was 5% (1/21). There were no cases of silicosis among current workers with 10 or less years of tenure; however, because of the long latency usually associated with chronic nodular silicosis, this finding is not sufficient to conclude that current silica dust exposure levels are without adverse effect. Recommendations are presented in this report and include increasing the frequency of medical monitoring examinations.

Keywords: SIC 1446 (Industrial Sand), Silica, Silicosis, Mineral processing, Ground silica, Silica flour

TABLE OF CONTENTS

Preface	ii
Acknowledgments and Availability of Report	ii
Summary	iii
Keywords	iv
Introduction	3
Background	3
Methods	3
Study Objective	3
Study Population	4
Data Collection	4
<i>Posterior-Anterior Chest X-Ray</i>	4
<i>Spirometry</i>	5
Questionnaire	6
<i>Medical and Personnel Records</i>	6
Evaluation Criteria	7
Chest X-Ray	7
Spirometry	7
Questionnaire	7
Medical Monitoring	7
Silicosis	7
Results	9
Participation	9
Medical Survey	9
<i>Participants</i>	9
DEMOGRAPHICS	9
CHEST X-RAY RESULTS	9
OTHER DUSTY JOBS	10
CHRONIC SYMPTOMS	11
RESPIRATORY ILLNESSES AND CONDITIONS	11
SPIROMETRY	11
<i>Non-participants</i>	11
Company Records	11
Company Medical Monitoring	12
Discussion	13
Conclusions	15

Recommendations	15
References	16
TABLE 1	19
TABLE 2	20
TABLE 3	21
TABLE 4	22
TABLE 5	23
TABLE 6	24
APPENDIX I	25
APPENDIX II	36

INTRODUCTION

In July 1991, the National Institute for Occupational Safety and Health (NIOSH) received a request for technical assistance from the Mine Safety and Health Administration (MSHA) to estimate the prevalence of silicosis at specific ground silica operations by conducting a medical evaluation of active and retired miners.

The medical evaluation was part of a joint project between MSHA and NIOSH to study silica exposures and the prevalence of silicosis in workers in a number of ground silica mills. A protocol outlined the responsibilities of each agency (see Appendix I). Briefly, MSHA selected nine sites and was responsible for evaluation of silica dust exposures and dust control methods, while NIOSH was responsible for conducting medical evaluations at each site. The additional evaluation outlined in the Addendum to the protocol will be completed at a later time. This is a final report of the NIOSH medical evaluation conducted at Unimin Specialty Minerals, Inc. -Tamms in Tamms, Illinois.

On September 8, 1993, NIOSH representatives met with company and union representatives, and several employees, along with an MSHA representative, to discuss logistical and administrative considerations of the survey.

On September 14, 1993, an opening meeting was held with company representatives and a representative from MSHA, to discuss the ensuing evaluation and to address any last minute questions. On September 17, 1993, the medical survey of current workers was conducted. Former workers were tested September 18-20, 1993. All study participants received written notification of their spirometry results in September 1993. All chest x-rays were promptly reviewed by a pulmonary physician for acute health problems upon return

to NIOSH and prior to the classification process. All study participants, and two non-participating current workers who had a company chest x-ray classified by the NIOSH B Readers, received written notification of their chest x-ray results in November, 1994.

BACKGROUND

The Tamms plant began operation in the mid-1940's as Tammsco, Inc. and was sold in 1984. In July 1986, the plant was acquired by a subsidiary of Unimin and subsequently became Unimin Specialty Minerals in 1990. Of the 30 employees retained when Unimin acquired the plant, 13 were still working at the Tamms plant at the time of the survey. Ten of these employees began working at the plant prior to 1984. At the time of the survey, a total of 30 employees (including clerical and salaried personnel) worked primarily at the Tamms plant.

At the Tamms operation, microcrystalline quartz is surface mined and brought to the plant for processing where it is crushed, dried, milled, and bagged. The plant operates production processes 24 hours a day, 5 days a week, with three 8-hour shifts. The departments that are part of the Tamms operation are: Mining, Crushing, Milling, Bagging, Loadout, Maintenance, Clean-up, and Administrative or Supervisory personnel. The job categories affected by the grinding process at the plant are Crusher Operator, Mill or Fine Grind Operator, Bagger, Shipper, Maintenance, Clean-up Man, and Supervisory personnel (e.g., shift supervisor).

METHODS

Study Objective

The primary objective of the study was to estimate and report the prevalence of silicosis among participating current and former

employees in the grinding area and/or downstream of the grinding area at each operation by tenure and job, if feasible.

Although not a primary objective, it was of interest to assess the direction and magnitude of possible bias in the prevalence estimate obtained from the medical evaluation as it applied to the study population as a whole. To do so, demographic characteristics and disease status of participants and living non-participants who met the study criterion were compared using company records.

Study Population

The criterion for inclusion in the study population was one year or greater cumulative tenure since 1970 in the grinding area of the mill or in areas downstream of the grinding process. Company records were used to determine employees' eligibility for inclusion in the study. Tenure data from company records were considered more accurate than information obtained by questionnaire during the medical survey, which is subject to errors from recall. Jobs within and downstream of the grinding circuit were ascertained using information from both the medical survey and company records and verified with MSHA.

To avoid inadvertent oversight of eligible current workers with prior experience in these areas, all current workers were invited to participate regardless of work area or length of employment. Using rosters provided by the company, letters were mailed inviting current and former workers to participate in the medical survey. Additionally, advertisements were placed in local newspapers to reach those workers who may have moved within the local area or otherwise may have failed to receive a letter. No further follow-up was made to eligible workers who chose not to participate in the medical survey.

Several employees had prior tenure at a second Unimin plant in close proximity to the Tamms plant, and/or may have had a position that required spending time at both plants. In these cases, individuals were considered an employee at the plant designated by Unimin and where, in most cases, they spent the majority of their time. Medical test results for these people are reported only once, for the site where these individuals were assigned. Tenure at Tamms alone was calculated, as well as combined tenure from both sites. Current and former workers who met the study criterion are the focus of this report.

Data Collection

Posterior-Anterior Chest X-Ray

Chest x-rays from company medical screening completed earlier in 1993 were provided by Unimin for all current employees, and were utilized for current workers who chose not to participate in the NIOSH medical survey. Participants in the NIOSH survey could elect to have NIOSH classify their 1993 company chest x-ray or have a chest x-ray taken by NIOSH.

NIOSH chest x-rays were taken on a full size (14 x 17 inch) film. All chest x-rays were read independently by three B Readers who, without knowledge of the participant's age, occupation, occupational exposure, smoking history, or any identifying information, classified the films according to the 1980 ILO International Classification of Radiographs of Pneumoconioses.⁽¹⁾

The NIOSH-certified pneumoconiosis B Readers used in this project had each classified at least 500 chest x-rays for the 4th round of the NIOSH Coal Workers X-Ray Surveillance Program (CWXSP). They had also participated in a pilot study which entailed a reading trial of over 400 films of anthracite miners in preparation for a current exposure-response study using National Study for Coal Workers Pneumoconiosis (NSCWP) films. After

determining that NIOSH B Reader certification was not due to expire any time between June 1993 and December 1994, the Readers were contacted and interest and availability to read chest x-rays for the present study were ascertained. The same three B Readers were used throughout the entire project.

The ILO classification method is used for epidemiological research, for the surveillance of workers in dusty occupations, and for clinical purposes. The method recognizes two major categories of opacity size, small and large.⁽²⁾

The profusion (i.e., number) of small opacities

are recorded using a graduated 12-point scale within four major categories (0,1,2,3). A major profusion category of 0 indicates no apparent abnormality, while 3 indicates substantial abnormality. Film classification is achieved by comparing the subject film with the appearance of "standard films" which define small opacity profusion. In classifying small opacity profusion, the final determination of major category is listed first. If a higher or lower major category has also been seriously considered, this category is also listed after a slash mark. If there is no question as to major category, the two listed numbers are identical.^(1,2)

Thus, the small opacity profusion scale is as follows:

0			1			2			3		
0/-	0/0	0/1	1/0	1/1	1/2	2/1	2/2	2/3	3/2	3/3	3/+

Size and shape of the small opacities are also classified, both being differentiated using the letters of the alphabet. Two letters are used to record size [in millimeters (mm)] and shape, the first listed letter indicating the predominant type.^(1,2)

Classification of Small Opacity Type

Shape	Size		
	Up to 1.5 mm	1.5 - 3 mm	3-10 mm
Round	p	q	r
Irregular	s	t	u

To record the distribution of the small opacities, the lungs are divided into six zones--three on the left and three on the right, for the upper, middle, and lower portions of the lungs.^(1,2)

Three categories are used to define large opacities according to size [measured in centimeters (cm)]: A, B, and C.⁽¹⁾ Category A is specified as an opacity >1 cm but <5 cm, or

several opacities >1 cm whose combined diameters are <5 cm; Category B is one or more opacities >5 cm whose combined area is less than the equivalent area of the right upper lung zone; Category C is one or more opacities whose combined area is greater than the equivalent area of the right upper lung zone.^(1,2)

The technical quality of the chest x-ray (or film quality) is graded and recorded using four

scores, 1,2,3, or 4. A “1” represents the highest score, or quality, while a “4” represents a chest x-ray considered by a Reader as “unacceptable” or “unreadable” for classification purposes.^(1,2)

Spirometry

Spirometry was performed using a dry rolling-seal spirometer interfaced to a dedicated computer. At least five maximal expiratory maneuvers were recorded for each person. All values were corrected to BTPS (body temperature, ambient pressure, saturated with water vapor). The largest forced vital capacity (FVC) and forced expiratory volume in one second (FEV1) were the parameters selected for analysis, regardless of the curves on which they occurred. Testing procedures conformed to the American Thoracic Society's recommendations for spirometry.⁽³⁾ Predicted values were calculated using the Knudson reference equations.⁽⁴⁾ Predicted values for African-Americans were determined by multiplying the value predicted by the Knudson equation by 0.85.⁽⁵⁾

Questionnaire

A modified version of the Medical Research Council (MRC) questionnaire⁽⁶⁾ on respiratory symptoms, supplemented with questions concerning demographic information, work history, cigarette smoking habits, physician-diagnosed respiratory illness, frequency and content of company medical evaluations, and participant's knowledge of prior test results, was administered by trained NIOSH personnel.

Medical and Personnel Records

Each company was asked to provide medical and personnel records of current and former employees who had worked at least one year since 1970, or subsequent to the opening of a plant.

Three types of company-held documents were identified from which the presence or absence of silicosis was ascertained -- ILO classifications, clinical radiology reports (a chest x-ray report by a radiologist), and miscellaneous documents (e.g., CT scan results, letters from physicians, etc.). The following case definitions for silicosis were established for each type of document:

1. An ILO small opacity profusion classification of 1/0 or greater on the most recent chest x-ray.

OR

2. A clinical radiology report which contained explicit words or phrases (e.g., “silicosis” or “pneumoconiosis”), or other descriptions considered consistent with silicosis (see “Results” section).

OR

3. A physician diagnosis of silicosis, or a diagnosis of pneumoconiosis if silicosis was considered as part of the differential diagnosis.

The case definition used in the analysis depended on the type of records obtained from the company. ILO classifications were considered ideal and the preferred document type for definition, followed by clinical radiology reports, and finally miscellaneous documents. Therefore, if all three types of documents were available for an individual, ILO classifications were used to identify silicosis (case definition 1). If company records contained both clinical radiology reports and miscellaneous documents, case definition 2 was used. Case definition 3 was used when only miscellaneous documents were available.

For those employees who worked at both Unimin plants, tenure, chest x-ray results, and cigarette smoking status were adjusted to reflect the period of time these employees spent at each respective plant. Participants who were

currently employed at one plant and were also a former employee at the second plant were considered a “participant” at the plant where they were currently working and a “non-participant” at the plant where they formerly worked. This procedure was followed since participation as a former worker could not be assumed.

The 1981 NIOSH recommendations for medical monitoring of workers exposed to ground silica (silica flour)⁽⁷⁾, and recommendations published by the National Industrial Sand Association (NISA) for workers exposed to crystalline silica⁽⁸⁾ were used as the basis to evaluate company medical monitoring practices.

EVALUATION CRITERIA

Chest X- Ray

A chest x-ray was defined as consistent with silicosis if the median, or middle, classification of small opacity profusion was 1/0 or greater. For cases where only one Reader considered a film of unacceptable quality, an additional classification was sought if the participant met the criterion for inclusion in the study population. If the film was considered unacceptable a second time, it was then classified as unreadable (UR). However, if the film was able to be classified, this classification was used to determine the median, and the results were subsequently used in the data analysis. This procedure was followed so as not to give undue weight to the judgement of a single Reader. Progressive Massive Fibrosis (PMF) was defined as the presence of large opacities of ILO category A, B, or C classified by at least two Readers.

The overall shape of the small opacities was based on the predominant shape (i.e., the first listed letter) classified by two or more Readers. If only two Readers classified shape and the predominant type differed, the shape was considered "mixed."

Spirometry

Each examined worker's test results were compared to the 95th percentile lower limit of normal (LLN) values obtained from Knudson's reference equations to identify participants with abnormal spirometry patterns of obstruction and restriction.⁽⁴⁾ Five percent of a normal population will have predicted values that fall below the normal range, or LLN, while 95% will have predicted values above the lower limit.

Using this comparison, obstructive and restrictive patterns are defined as:

Obstruction: Observed ratio of FEV1 /FVC% below the LLN.

Restriction: Observed FVC below the LLN.

Questionnaire

The following definitions were established for the purpose of questionnaire analysis:

Chronic Cough a cough on most days for as much as 3 months during the year.

Chronic Phlegm the production of phlegm on most days for as much as 3 months during the year.

Chronic Dyspnea shortness-of-breath walking with individuals of similar age on level ground.

Chronic Bronchitis cough and phlegm on most days for as much as 3 months for 2 or more years.

Medical Monitoring

The 1981 NIOSH recommendations for medical examinations of ground silica workers include a medical and occupational history, chest x-ray, and pulmonary function testing (spirometry) for all workers prior to job placement and annually thereafter.⁽⁷⁾ NIOSH guidelines recommend a medical and occupational history, physical exam, and pulmonary function testing every two years. A chest x-ray is also recommended, although frequency is not discussed.⁽⁸⁾

Silicosis

Silicosis, a form of pneumoconiosis, is a chronic fibrotic pulmonary disease caused by the

inhalation, deposition, and retention of dust containing crystalline silica.⁽⁹⁾ Silicosis is usually diagnosed through chest x-ray and occupational history of exposure to silica-containing dust. Lung tissue reacts to the presence of silica dust in the lung by forming nodules, which on chest x-ray typically appear

discrete, round, and more prominent in the upper lobes, although other patterns have been described.^(7,10,11,12) Such radiographic abnormalities are often the first sign of silicosis. The following summarizes the clinical forms of the disease:

<u>FORM</u> <u>EXPOSURE</u>	<u>TIME TO ONSET</u>	<u>INTENSITY OF</u>
NODULAR		
-Chronic	10+ years	Low
-Accelerated	5-10 years	High
ACUTE	weeks-4 or 5 years	Extremely High

Each form is differentiated by time to onset of clinically apparent disease after initial exposure (induction period), intensity of exposure, and the rate at which the disease progresses.^(7,9,11,13) The percentage of crystalline silica in the dust, size of the dust particle, form of crystalline silica, and length of exposure also affect disease onset and progression.^(7,14,15) Ground silica (silica flour) consists of essentially pure crystalline silicon dioxide (quartz) particles, of respirable size (<10 micrometers).^(16,17) Particles of this size may be invisible to the naked eye and are small enough to be deposited in the alveoli. Freshly ground, or fractured, crystalline silica -- which is a typical form of silica in ground silica facilities -- may be more toxic or fibrogenic (i.e., produce more scarring of the lungs), than aged silica.^(18,19)

A continuum is thought to exist between the chronic and accelerated forms of nodular silicosis. Factors determining the progression of disease are unclear.⁽¹²⁾ Chronic silicosis (the presence of detectable, discrete, nodules <1cm in diameter on chest x-ray) is the most common form of silicosis and usually becomes evident after 10 years or more of exposure to dust containing crystalline silica.^(9,10,20) There may be few, if any, clinical symptoms; the most common symptoms are cough, with or without

sputum production and shortness of breath. There may be little or no decrement in pulmonary function. Accelerated silicosis is associated with higher exposures to crystalline silica and has a shorter induction period than chronic silicosis. Radiographic abnormalities usually appear within 5-10 years.⁽²⁰⁾ This form of silicosis often progresses after exposure has been discontinued.

Acute silicosis may develop in a few weeks to 4 or 5 years after initial exposure and is associated with exposures to extremely high concentrations of crystalline silica.^(9,10,20) In acute silicosis the lung is overwhelmed by crystalline silica particles and a proteinaceous fluid accumulates in the lungs as a reaction to the silica dust.^(7,9,21,22) On chest x-ray, the appearance is different from that of nodular silicosis, with very little of the typical nodular scarring.^(7,13,15) Consequently, it may often be mis-diagnosed as pulmonary edema, pneumonia, or tuberculosis. Respiratory impairment is severe with acute silicosis, and the disease is usually fatal within a year of diagnosis.^(13,15)

Both chronic and accelerated silicosis can become complicated by the development of infection and/or progressive massive fibrosis (PMF). Infections (i.e., tuberculosis and/or

fungal infections) are believed to result from the inability of the overwhelmed lung scavenger cells (macrophages) to kill the organisms that cause these diseases.^(23,24) Progressive massive fibrosis (PMF) has at times been called "complicated" silicosis, and is the result of silicotic nodules fusing into large masses. PMF profoundly affects both the structure and function of the lungs.^(9,10,11,13)

Evidence suggests that crystalline silica is a potential occupational carcinogen,⁽²⁵⁻²⁷⁾ and NIOSH currently recommends that crystalline silica be treated as a potential occupational carcinogen.^(28,29)

RESULTS

Participation

Of 30 current employees, 21 were eligible for entry into the study population; 19 (90%) participated in the medical survey. Of the estimated 45 living former workers (from available lists provided by the company), 32 were eligible for entry into the study population and 11 (34%) participated in the medical survey. The estimated total number of workers in the study population was 53: 30 were participants and 23 were non-participants (Table 1). The company acknowledged that records for many former workers were unavailable from the earlier owners. Records were missing for four participating former workers, although there was an indication that three of the four had worked at the plant (e.g., the participants' name appeared on a list of former workers with greater than one year of employment or the individual had participated in a prior NIOSH evaluation at this plant in 1979). In the one instance where there were no records and no indication of employment, the participant was included based upon information obtained during the medical survey.

Medical Survey

Participants

The following discussion of results concerns the 30 participants who met the study criterion. Because we found disease was not equally divided between current and former workers in this survey, the results for current workers will be presented separately from that of former workers.

DEMOGRAPHICS

All participants

All 30 participants were men, and the majority (83%) were white.

Current Workers

Among the 19 current workers, the median age was 35 years, and ages ranged between 25 and 58 years. Current workers were employed for a median of seven years. The number of years worked ranged between 1 and 17 years. Only one current worker had prior employment (7 years) at the nearby Unimin plant. The previously cited median tenure reflects only his tenure at Tamms. Ten (53%) of 19 current workers were "ever" smokers (that is, either a current smoker or an ex-smoker), and their median number of pack-years was 21 (one pack-year is equal to smoking an average of one pack per day for a year).

Former Workers

Of the 11 former workers, three were less than 40 years old, five were between 40 and 60 years, and three were over 60 years. None of the 11 were employed for 15 years or more: four were employed for less than five years, five were employed between five and 10 years, and two were employed for over 10 years. Six (55%) of the 11 former workers were "ever" smokers. The number of pack-years ranged between 33

and 58. Five years or less had passed since five of the former workers had left employment at the Tamms plant, between five and 10 years had passed since three had left employment, and three had left work over 15 years ago.

CHEST X-RAY RESULTS

All participants

Overall, 17% (5/30) of the participants had a chest x-ray considered consistent with silicosis; the prevalence among currently working participants was 5% (1/19). The highest median ILO profusion category among the participants was 2/2. Of the five participants with a positive chest x-ray, three held their primary job (the job held for the longest period of time) as a Fine Grind or Mill Operator, and two worked in Maintenance.

A total of 24 chest x-rays were taken by NIOSH, and six participants chose to have their company chest x-ray used for classification. Of the 24 NIOSH films, 18 had a median quality score of 1 (the highest), five had a score of 2, and one had a film quality score of 3. This last NIOSH chest x-ray required an additional classification (the first Reader marked the film “UR,” or “unreadable”) and the results were used to determine the median classification. All six company chest x-rays had a median film quality score of 1.

The predominant shape of the small opacities was examined in relation to cigarette smoking status for the five participants with x-ray evidence of silicosis. The predominant shape of the small opacities for all five films was rounded -- none were irregular and none were “mixed.” All five participants were “ever” smokers (i.e., either a current smoker or an ex-smoker).

Current Workers

Table 2 lists the chest x-ray results by Reader for all 19 participating current workers. One (5%)

of the 19 had a chest x-ray consistent with silicosis. None of the 13 participating current workers employed 10 years or less had a positive chest x-ray.

Seven (37%) of the 19 participating current workers reported holding their primary job as a Mill or Fine Grind Operator, five (26%) as a Bagger, three (16%) as Maintenance, and two worked in supervisory or administrative positions. One participant reported a primary job as Clean-Up Man, and one worked as a Crusher Operator. Maintenance, specifically working in the baghouse making repairs or changing bags, was reported with the greatest frequency as the single dustiest job at the plant among current workers.

Former Workers

Table 3 lists the chest x-ray results by Reader for former workers. Four former workers had a chest x-ray considered consistent with silicosis; all four had PMF. Two had “A” size large opacities, one had “B” size large opacities, and one had large opacities without a consensus on size, as classified by at least two Readers.

Among the four participating former workers employed for less than five years, one had x-ray evidence of silicosis. Of the five former workers employed between five and 10 years, two had a positive chest x-ray, and one of the two former workers employed over 10 years had a positive chest x-ray. Two of the four participants with a positive chest x-ray were between 50 and 59 years old, and two were over 60 years of age.

Five (45%) of the 11 participating former workers reported holding their primary job as a Mill Operator, two as Baggers, and two as Maintenance. One former worker held his primary job as a Clean-up Man and one as a Shipper. Both Bagging and Mill Operator were reported with equal frequency by former workers as the single dustiest job.

OTHER DUSTY JOBS

All Participants

A total of nine participants reported previous employment of at least 10 years in occupations or industries other than a ground silica operation that might have been associated with exposure to fibrogenic dusts. Four of the five participants with a positive chest x-ray reported working at such jobs either prior to, or after, employment at the Tamms plant. One of the four reported working over 10 years at other dusty jobs. A second participant reported employment at other dusty jobs for over 15 years, and a third reported working for more than 20 years at another dusty job. One of the four former workers with PMF reported less than three months at another dusty job, and a second former worker with PMF reported never working at any other dusty job. The type of work reported included welding, construction, glass production, mining, and farming.

CHRONIC SYMPTOMS

Current Workers

As defined in the “Methods” section of this report, two of 19 participating current workers reported symptoms of chronic cough. Chronic bronchitis and chronic dyspnea (shortness-of-breath) were each reported once. All of the current workers who reported a chronic respiratory symptom were “never” smokers.

Former Workers

Among the 11 participating former workers, chronic bronchitis was reported by three workers. Chronic dyspnea was reported by four former workers. The distribution frequency of former workers reporting a chronic respiratory symptom by cigarette smoking status contained cells with numbers too small to be meaningful.

RESPIRATORY ILLNESSES AND CONDITIONS

Current Workers

Physician-diagnosed chronic bronchitis, emphysema, asthma, and tuberculosis were each reported once. Other physician-diagnosed lung conditions that were reported were chest x-ray changes relating to old infection or childhood injury. Fifteen participating current workers reported no physician-diagnosed respiratory illness or condition.

Former Workers

Among the 11 former workers, chronic bronchitis and emphysema were each reported twice, and asthma was reported once. None of the former workers reported a physician diagnosis of tuberculosis. Other lung conditions that were reported were silicosis and an unspecified chronic lung condition. Seven former workers reported no respiratory illness or condition.

SPIROMETRY

All Participants

Ninety-three percent (28/30) of the participants performed spirometry and 32% (9/28) of those had results below the normal range. Six of these participants exhibited an obstructive lung pattern, two exhibited a combined obstructive and restrictive pattern, and one exhibited a restrictive lung pattern. Three of the nine were current workers and six were former workers. Of the nine participants with abnormal patterns, five had never smoked cigarettes, two were ex-smokers, and two were current smokers. Table 4 shows pulmonary function status stratified by cigarette smoking and years of employment. Four of the five participants with a positive chest x-ray had abnormal pulmonary function test results, three of whom had PMF. Only one individual with PMF exhibited a combined

restrictive and obstructive lung pattern.

Non-participants

The availability of company chest x-rays for all current employees permitted the classification of films of the two current employees who met the study criterion yet chose not to participate in the medical survey. Each of the NIOSH B Readers classified small opacity profusion for both non-participants as 0/0, and both chest x-rays had a median film quality score of 1.

Company Records

The work history and medical surveillance records provided by Unimin of current employees and of those employees who were retained when Unimin acquired the plant appeared to be regularly updated and complete. Information was collected in a standard manner using the forms found in NISA's guidelines. The records of former workers employed prior to Unimin ownership were not as complete and many were not available. Table 5 presents a breakdown of the number and proportion of records that were available, and number and proportion of records that were missing, by employment status. Records containing information on age, tenure, smoking history, and small opacity profusion classification were available for all 21 eligible current workers, but only 56% (18) of the 32 eligible former workers. When examined by participation status, 87% (26/30) of the records were available for participants and 57% (13/23) were available for non-participants overall (i.e., both current and former workers).

The available data were examined by employment status for both participants and non-participants (Table 6). The two eligible non-participating current workers were of similar median age (32 years) to their participating counterparts (35 years) and had a similar length of employment, with a median of 10 years

versus 7 years. All 21 eligible current workers had an ILO small opacity profusion classification of 0/0.

Among those former workers for whom data were available, the median age of non-participating former workers was 35 years and of participants was 51 years; median tenure was six years versus nine years. Of 11 participating former workers, seven had a company chest x-ray with an ILO classification; one showed small opacities (profusion 2/2). Of the 21 non-participating former workers, 11 had a company chest x-ray with an ILO classification; one showed small opacities (profusion 2/2). The remaining chest x-rays were classified 0/0. All of the chest x-rays were classified by the same, single B Reader. For those individuals without an ILO classification (14), neither a clinical radiology report nor miscellaneous documents from which the silicosis case definition might be ascertained were available.

Company Medical Monitoring

Routine medical monitoring has been conducted at the Tamms facility since 1980. At that time workers began participating in annual screening, conducted by a local physician, which included pulmonary function testing, chest x-ray, and a physical examination. Starting in 1985 (just prior to Unimin acquiring the plant), chest x-rays began to be classified by a B Reader. In 1990, Unimin switched to a mobile health testing service, and annual monitoring continued through 1991. Since 1992, medical monitoring has been conducted every other year and includes a medical and occupational history and skin testing for tuberculosis, in addition to a chest x-ray and pulmonary function testing. If an employee is found to have any change or abnormality on their chest x-ray, the employee is referred to a physician for follow-up and/or for further testing. The company may then attempt to move the employee to a less dusty area in the

plant.

The plant keeps a copy of the examination results, and medical records are isolated from personnel records in separate files. Original examination results are kept at the corporate Safety and Health office in Virginia. The plant manager, safety and health supervisor, and corporate safety and health office have access to these records. Since Unimin ownership, employees are required to sign a document stating that they have received their examination results.

All of the participants except one reported taking part in the company medical monitoring. Seventeen participants were able to recall their chest x-ray results as it related to the company monitoring. Four participants (three current workers and one former worker) either didn't know or didn't remember their results. The process of how employees were notified of results was not consistently reported among those current workers who gave us this anecdotal information; several workers reported receiving written notification only within the past few years. A few reported that previously the notification process was conducted verbally with written results provided to a worker upon request. Currently, participants reported receiving written results but did not indicate whether the results they received contained any detailed information other than whether their results were "normal" or "abnormal."

DISCUSSION

Five (17%) of the 30 current and former workers who participated in the medical survey had changes on their chest x-ray consistent with silicosis; four had PMF. The majority of workers with chest x-ray abnormalities were former workers, current or ex-smokers, and all five were over 50 years of age.

A population prevalence estimate based on results from a sample of volunteer participants

may result in an over-estimate if those who choose to participate are less healthy than those who do not participate. Available data on age and tenure indicate that participants, particularly former workers, were older and worked longer than non-participants. The proportion (44%) of missing information for non-participants is a potential source of bias, and the observed estimate, if taken from available records, would be questionable. The study population prevalence of x-ray defined silicosis among the 53 participants and non-participants could range from 6-49%, depending upon the number of cases among the non-participants. An explanation of how these upper and lower boundaries on the estimate were obtained follows. Neither of the two non-participating current workers had x-ray evidence of silicosis, either as determined by NIOSH or based on company records, and at least one of the non-participating former workers had a positive chest x-ray. Assuming the remaining 20 non-participating former workers had no radiographically-defined evidence of silicosis, and excluding the three participants with exposure to fibrogenic dusts at other jobs, yields the most conservative estimate, 6% (3/53). Conversely, assuming all 21 non-participating former workers had x-ray evidence of silicosis, and including all 5 participant cases, yields the highest estimate, 49% (26/53). The "true" study population prevalence lies somewhere between these two estimates.

The availability of chest x-rays and records for all 21 of the eligible current workers permits a determination of the prevalence among current workers that is unbiased by selective participation. The prevalence of x-ray evidence of silicosis among current workers who met the study criterion was 5% (1/21) with inclusion of the NIOSH results for the two non-participants.

Using only company records, none of the 21 eligible current workers had x-ray evidence of silicosis (defined as small opacity profusion 1/0 or greater). The difference in prevalence (which is due entirely to one participant's results) may

be a function of (a) the difference in methodology (i.e., use of the median classification from three B readings, all of which differed and one of which had a profusion of 0/1, versus classification by a single B Reader), or (b) progression of disease since the time of the company chest x-ray.

Generally, testing of active workers or recently active workers can result in an under-estimation of a prevalence due to a "healthy worker survivor effect". This effect, or bias, is a pattern typically found in working populations where healthy people are employed and remain employed while individuals who are less healthy tend not to be employed in the first place, and those who become ill tend to leave employment over time. Cases of silicosis that may have occurred among deceased former workers were not included in this evaluation. The number of cases among participating former workers is not unexpected, since silicosis can appear even after exposure has ceased. Additionally, the current workforce is fairly young, and 67% (20/30) have worked less than 10 years at the Tamms plant. One would not expect to see chronic nodular silicosis develop in less than 10 years from the time of first exposure. This factor, coupled with the low participation rate among eligible former workers (34%), the proportion of missing company records (44%), and the study design itself, may have reduced the likelihood of identifying and/or reporting more cases of silicosis.

Pulmonary function testing revealed that nine (32%) of the 28 participants who performed spirometry had abnormal patterns. Abnormal pulmonary function test results were identified among four of the five participants with a positive chest x-ray, three of whom had progressive massive fibrosis. Cough was the most frequently reported chronic symptom among participating current workers, and dyspnea was the symptom reported most frequently by former workers. Chronic symptoms did not appear related to cigarette

smoking in current workers. Five of the nine participants with abnormal spirometry patterns were "never" smokers and four were "ever" smokers. Pulmonary function data was examined by years of employment and cigarette smoking status. The cells of the table (Table 4) contain very small numbers, and the results are likely confounded (biased) by competing dust exposure from prior or subsequent employment in other dusty jobs. Occupational exposures to mineral dust have been associated with airflow limitation and chronic obstructive pulmonary disease.^(30,31) Literature suggests that pulmonary impairment, which may be greater among dust-exposed workers who also smoke, is associated with both cigarette smoking and cumulative dust exposure, irrespective of the presence of radiographically detectable disease.^(31,32,33)

A NIOSH evaluation at this same plant in 1979 found that 7 (27%) of 26 participating current and former workers with one or more years exposure had chest x-ray changes consistent with silicosis.⁽³⁴⁾ Three cases were identified among 15 current workers and four cases were identified among 11 former workers. The participation rate among all current workers (i.e., including those with less than 1 year of exposure) was 83% (25/30), and among former workers with one year or more exposure was 35% (11/31).

A similar evaluation at the same time at another silica mining and milling operation in the area found that 17 (44%) of 39 participating current and former workers with one or more years exposure had chest x-ray changes consistent with silicosis; three cases were identified among 15 current workers and 14 cases were identified among 24 former workers.⁽³⁵⁾ The participation rate among all current workers was 73% (30/41), and among former workers with one year or more exposure was 47% (24/51).

In 1980, a NIOSH evaluation at a plant in New Jersey found six (13%) radiographically-defined cases of silicosis among 47 participating current

and former workers.⁽³⁶⁾ Five out of the six cases identified during this evaluation were current workers. The participation rate for all current workers was 87% (26/30), and among former workers with one year or more employment since 1 January 1972 was 70% (21/30).

These previous investigations utilized similar procedures and the standard pneumoconiosis classification of the time, the 1971 ILO-U/C.⁽³⁷⁾ In contrast to the present study and to the studies referred to above, a 1985 study involving the classification (ILO-U/C 1971) of 1422 chest x-rays of non-exposed blue-collar workers found only 3 (0.21%) chest x-rays with a median small opacity profusion of 1/0 or greater.⁽³⁸⁾ The 1985 study also found only one chest x-ray with irregular small opacity profusion of 1/0 and no chest x-rays with rounded small opacity profusion of 1/0 or greater among over 700 males. More recently, Johnson and Busnardo⁽³⁹⁾ described a case of silicosis in a maintenance mechanic employed from 1976 - 1981 at a plant that manufactures ground silica.

In the present evaluation, the predominant shape of small opacities on all five of the positive chest x-rays was rounded. Although all five of the participants with a positive chest x-ray were current or ex-smokers, cigarette smoking alone does not explain the observed chest x-ray abnormalities. There is little evidence in the literature to suggest that smoking without occupational dust exposure results in pneumoconiosis-like opacities; and the opacities that have been observed have been predominantly irregular, not rounded.⁽⁴⁰⁾

In the present evaluation, two of the participants with a positive chest x-ray began working at the Tamms plant before MSHA's current silica dust standard came into effect (July 1974) and three began working after 1974. All five of these participants reported beginning their employment prior to 1984 when the plant was operated as Tammsco, Inc. Of the five, one participant began working prior to 1970 and a

second began working between 1970 and 1974. One had less than five years of tenure at the Tamms plant and one worked <10 years. Both of these individuals reported over 10 years of work at other dusty jobs. The three remaining participants reported beginning their employment after 1974; one of these participants reported prior employment of over 10 years at another dusty job.

Routine medical monitoring has been in place since 1980. Currently, comprehensive medical monitoring, which incorporates all of the elements recommended by NIOSH, takes place every other year. Chest x-rays are classified by a NIOSH-certified B Reader, and have been classified by the same Reader since 1985. According to a company representative, an effort is made to follow up on any abnormal results found during the monitoring and transfer affected employees to less dusty areas. However, the frequency of the medical monitoring differs from the frequency recommended by NIOSH for ground silica workers. Preplacement and annual medical examinations are recommended by NIOSH for all workers who manufacture, use, or handle ground silica or materials containing ground silica.⁽⁷⁾

CONCLUSIONS

The prevalence of x-ray defined silicosis among currently working participants who met the study criterion (one year or greater cumulative tenure since 1970 in the grinding area of the mill or in areas downstream of the grinding process) was 5% (1/19). In addition, there were four cases among the 11 former workers who participated in the survey. Two cases were identified among former workers who had little to no exposure to fibrogenic dust at other jobs. These cases most likely represent disease that occurred as a result of earlier working conditions at this plant when exposures were shown to be excessive.⁽³⁴⁾

The prevalence of silicosis among all eligible current workers was 5% (1/21). There were no cases of silicosis among current workers with 10 or less years of tenure; however, because of the long latency usually associated with chronic nodular silicosis, this finding is not sufficient to conclude that current silica dust exposure levels are without adverse effect.

RECOMMENDATIONS

1. The present company medical monitoring program should continue, with examinations conducted annually to facilitate early detection of clinically apparent disease. The data gathered from the program can be highly beneficial to all workers and should be used, in addition to environmental sampling, to provide feedback about the efficacy of environmental controls and in turn reduce worker exposure to crystalline silica.

2. Each employee should receive a copy of their company medical examination results in full detail, and ideally, the results should be reviewed with a health care professional at the

time the employee receives their individual results.

3. All cases of silicosis should be reported to MSHA by the company as required. MSHA requires operators to report any miner with a history of exposure to pneumoconiosis-producing dust with small opacity profusion of 1/0 or greater on chest x-ray, or a diagnosis of silicosis, or an award of compensation. Examining physicians or health care providers, and/or radiologists are encouraged to report cases of silicosis to the Illinois Department of Public Health using the reporting guidelines and surveillance case definition developed by NIOSH (Appendix II).⁽¹¹⁾

4. Both personnel and medical records should continue to be maintained separately and in a confidential manner, with access to medical records limited to health care personnel. These records should be kept for at least 30 years following an employee's termination of employment.

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TABLE 1
 Study Population and Participation Rate By Employment Status
 Unimin Specialty Minerals, Inc. - Tamms
 HETA 93-0794

Employment Status	N	Total # Eligible	Number of Participants	Number of Non-Participants	Participation Rate (%)
Current Worker	30	21	19	2	90
Former Worker	45	32	11	21	34
TOTAL	75	53	30	23	57

TABLE 2
 Chest X-Ray Results by Reader for 19 Participating Current Workers
 Unimin Specialty Minerals, Inc. - Tamms
 HETA 93-0794

READER A			READER B			READER C			MEDIAN	
Profusion	Size/Shape	Zone(s)*	Profusion	Size/Shape	Zone(s)	Profusion	Size/Shape	Zone(s)	Profusion	Film Quality
0/0			0/0			0/0			0/0	1
0/0			1/0	ss	2,5	0/0			0/0	1
0/1	qr	1,2,4,5	1/2	st	All	1/1	qq	1,4	1/1	1
0/0			1/0	ss	2,3,5,6	0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			1/0	pp	All	0/0			0/0	1
0/0			1/0	st	2,3,5,6	0/0			0/0	1
0/0			1/0	ps	All	0/0			0/0	1
0/0			1/1	st	1,2,3,5,6	0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			1/1	st	All	0/0			0/0	1
0/0			1/0	ps	All	0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	1

* 1,2, and 3 correspond to the right upper, middle, and lower zones, respectively; while 4,5, and 6 correspond to the left upper, middle, and lower zones.

TABLE 3
 Chest X-Ray Results by Reader for 11 Participating Former Workers
 Unimin Specialty Minerals, Inc. - Tamms
 HETA 93-0794

READER A			READER B			READER C			MEDIAN	
Profusion	Size/Shape	Zone(s)*	Profusion	Size/Shape	Zone(s)	Profusion	Size/Shape	Zone(s)	Profusion	Film Quality
0/0			0/0			0/0			0/0	2
0/0			0/0			0/0			0/0	1
0/0			0/0			0/0			0/0	2
UR			1/1, B	ps	All	1/2, B	rr	1,2,4,5	1/1, B**	3
0/0			1/1	st	All	0/0			0/0	1
0/0			1/0	ps	All	0/0			0/0	1
2/2, A	rq	1,2,3,4,5	1/2, A	qr	All	2/2, B	rr	1,2,4,5	2/2, A	1
2/2, A	rq	1,2,3,4,5	2/2, A	qr	1,2,4,5	2/1, A	qq	1,4	2/2, A	2
2/2	tr	1,2,4,5	1/2, A	qr	1,2,4,5	2/2, B	rq	1,4	2/2 @	1
0/0			1/0	ss	2,3,5,6	0/0			0/0	2
0/0			0/0			0/0			0/0	2

* 1,2, and 3 correspond to the right upper, middle, and lower zones, respectively; while 4,5, and 6 correspond to the left upper, middle, and lower zones.

** The additional small opacity profusion classification was 1/1, A with a film quality score = 2. The median column incorporates this additional reading.

@ Progressive Massive Fibrosis without a consensus on size

TABLE 4
 Lung Function Impairment by Years of Employment
 and Cigarette Smoking Status for 28 Participants*
 Unimin Specialty Minerals, Inc. - Tamms
 HETA 93-0794

Years of Employment	Non-Smokers		Smokers		Total	
	n	Number Impaired	n	Number Impaired	N	Number Impaired
1-5	6	2**	5	1**	11	3
6-10	5	3**	5	2**	10	5
11-15	2	0	3	0	5	0
16-20	0	0	2	1**	2	1
Total	13	5	15	4	28	9

*2 participants did not perform spirometry

**Each of these cells includes a participant with >10 years employment at a prior or subsequent dusty job.

TABLE 5
Number and Proportion of Company Records Available and Missing
for the Study Population by Employment Status
Unimin Specialty Minerals, Inc. - Tamms
HETA 93-0794

Employment Status	N	Number and Proportion with Records Available	Number and Proportion with Records Missing
Eligible Current Workers	21	21 (100%)	0 (0%)
Eligible Former Workers	32	18 (56%)	14 (44%)

TABLE 6
Age, Length of Employment, Cigarette Smoking, and Small Opacity Profusion
from Company Records by Participation and Employment Status
Unimin Specialty Minerals, Inc. - Tamms
HETA 93-0794

	PARTICIPANTS				NON-PARTICIPANTS			
	Current Worker N = 19		Former Worker N = 11		Current Worker N = 2		Former Worker N = 21	
AGE (yrs) [median]	35		51 ^a		32		35 ^a	
Range (yrs)	25-58		31-64		--- ^c		27-70	
TENURE (yrs) [median]	7		9 ^b		10		6 ^b	
Range (yrs)	1-16		2-13		--- ^c		1-30	
CIGARETTE SMOKING	NUMBER	%	NUMBER	% [®]	NUMBER	%	NUMBER	%
Ever Smoker	11	58	4	36	1	--- ^c	9	43
Never Smoker	8	42	2	18	1	--- ^c	1	5
Unknown	0	---	5	45	0	---	11	52
SMALL OPACITY PROFUSION \geq 1/0*	<u>NUMBER</u> 0		<u>NUMBER</u> ^d 1		<u>NUMBER</u> 0		<u>NUMBER</u> ^d 1	

^a Missing age for 6 participating and 10 non-participating former workers

^b Missing tenure for 4 participating and 10 non-participating former workers

^c Cell size too small (N=2).

^d ILO classification missing for 4 participating and 10 non-participating former workers

* As determined by the classification closest in time prior to the NIOSH survey by a single B Reader

[®] Percentages do not add to 100 due to rounding

APPENDIX I
PROTOCOL
MSHA/NIOSH GROUND SILICA MILL STUDY

This protocol describes a joint Mine Safety and Health Administration (MSHA) and National Institute for Occupational Safety and Health (NIOSH) project to study silica exposure and the prevalence of silicosis in workers in ground silica mills. MSHA selected the mill portions of nine ground silica operations, based on one or more of the following criteria: (1) one or more outstanding violations of MSHA's respirable silica standard and a history of overexposure to respirable silica; (2) size of the mills, both large and small, based on number of employees; (3) use of advanced control technology; and (4) a representative number of ground silica mills from each Metal and Nonmetal Mine Safety and Health District. Nine mills were chosen for the study rather than all sixteen because of the two year time frame (fiscal years 1993 - 1995) planned to complete the study. A list of the sixteen mills is provided in Attachment 1 and a list of the nine selected mills is given in Attachment 2. Noncompliance with MSHA's respirable silica standard is indicated on the attachments.

In late 1991, when the selection was made, six of the sixteen mills were selected using criteria number one. U.S. Silica Company's Berkeley Mill and Columbia Mill, and the Nicks Silica Company Mill had no outstanding respirable silica violations. The Berkeley Mill uses many advanced controls and is the largest mill. The Columbia Mill, a large mill and Nicks Silica Company, a small mill in MSHA's Southeastern District, were selected using criteria number two and four. There are ground silica mills in four of the six Metal and Nonmetal Mine Safety and Health Districts and each of these four Districts are represented in the study. Three mills were selected from the South Central District and North Central District, two mills were selected from the Southeastern District, and one mill was selected from the Northeastern District.

MSHA will evaluate silica dust exposures in the 9 selected ground silica mills. NIOSH will estimate the prevalence of silicosis in active and former workers in the same 9 mills. At the completion of the study, MSHA will issue a report on findings of each mill and a summary of all mills.

I. BACKGROUND

Ground silica particles are hazardous due to their respirable size and high concentration of crystalline silica, a known cause of nonmalignant respiratory disease (silicosis) and possible cause of lung cancer. A NIOSH feasibility study of the adequacy of company records for a proposed NIOSH study of silicosis was released in 1990. Examination of four industrial sand facilities' B Reader reports found 27% of workers with > 20 years work experience had small opacities on x-ray.¹ The feasibility study was of industrial sand mills of which ground silica was a subset.

APPENDIX I (con't)

II. PROTOCOL OBJECTIVES & METHODS

The following protocol describes the joint MSHA/NIOSH study and identifies responsibilities for each part of the project.

1. NIOSH and MSHA will inform management and employee representatives about the project prior to initiation.
 - (a) Entrance and close-out meetings will be held with local management and employees or employee representatives at each site.
 - (b) All current and former employees will receive invitations from NIOSH to participate in the medical portion of the study.
2. NIOSH will radiographically examine current and former employees at the 9 selected ground silica mills for evidence of silicosis.
 - (a) Posterior-anterior radiographs will be taken, randomly mixed, and independently classified for pneumoconiosis according to the 1980 ILO system by two NIOSH certified B Readers. If the two readings do not agree on small opacity profusion, a third reading will be obtained and the median reading will be used to define an abnormality. A chest x-ray showing opacities of profusion category $\geq 1/0$ in a ground silica mill worker will be categorized as consistent with silicosis. The B Readers will not be informed of any exposure history and the films will be masked of identifying information. The same three B Readers will be used throughout the entire project.
 - (b) Participants with a recent chest x-ray (within 1 year of the current NIOSH survey) may provide the chest x-ray to NIOSH to be read, rather than have a new chest x-ray taken during this evaluation.
 - (c) All participants will receive written notification of their chest x-ray results. Persons found to have abnormal chest x-rays will be encouraged to consult their personal physician.
3. NIOSH will administer a questionnaire which elicits occupational history, demographic information, respiratory symptoms, and smoking history.
4. NIOSH will obtain pertinent records held by the companies.
 - (a) NIOSH will copy pertinent medical and personnel records

APPENDIX I (con't)

(b) Review company medical records for diagnoses suggestive of silicosis.

(c) Collect personnel records showing detailed work histories for current and former workers.

5. NIOSH will evaluate the pulmonary function status of the participants through spirometry testing.

(a) Spirometry will conform to the American Thoracic Society's criteria for screening spirometry.

(b) All participants will receive written notification of their spirometry results. Persons found to have abnormal results will be encouraged to consult their personal physician.

6. MSHA will determine exposure levels of employees at the 9 ground silica mills.

(a) Obtain and compare records of past respirable silica dust sampling performed by MSHA and the ground silica mill operators.

(b) Sample all job classifications in the mill portion of the nine selected ground silica mills.

(c) Cite, under MSHA regulations, any overexposure to respirable silica dust determined from MSHA samples.

7. MSHA Technical Support will evaluate the effectiveness of dust controls in the selected mills.

(a) Observe and measure the performance of dust controls. Evaluate maintenance, housekeeping and work practices and how they effect dust control.

8. MSHA will evaluate respiratory protection programs at the 9 ground silica mills.

(a) Evaluate respiratory programs to determine if they meet the minimum requirements of ANSI Z88.2-1969, Practices For Respiratory Protection, as mandated by Title 30 CFR, Part 56.5005, when respirators are required. The minimum requirements are listed in Attachment 3.

APPENDIX I (con't)

9. NIOSH and MSHA will report results of their surveys as follows:

- (a) NIOSH reports will summarize findings of medical surveys, including the prevalence of silicosis among participants overall, by mill, job, and tenure if feasible.
- (b) MSHA will issue reports combining findings of NIOSH and MSHA for each of the 9 mills selected as well as a summary report.
- (c) Each agency will review and comment on all reports prior to release.
- (d) Individual mill reports and summary report will be provided to the industry associations, national unions representing workers in the ground silica industry, participating mill management and employee representatives, and other interested parties.

III. STUDY POPULATION

All current (estimated 332) and former workers (estimated number unknown) of the 9 mills to be studied will be invited to participate. No further follow up will be made to eligible individuals who do not participate.

ADDENDUM: FURTHER STUDIES OF TWO SOUTHERN ILLINOIS GROUND SILICA MILLS PREVIOUSLY STUDIED BY NIOSH IN 1979 (11-01982 AND 11-02051)

I. BACKGROUND

In 1979, NIOSH was requested to provide Technical Assistance to MSHA at two ground silica mills.^(2,3) Through medical and environmental surveys, NIOSH determined that a significant health hazard existed at these mills due to overexposure to respirable quartz. Forty-four percent of workers with greater than a year experience in one mill were found to have x-ray evidence of silicosis. Twenty-seven percent of the workers with similar work histories in the other mills were also found to have x-ray evidence of silicosis. Of 65 current and former workers with ≥ 1 year exposure studied in the two mills, 7 cases of progressive massive fibrosis were discovered by NIOSH.

In response to these findings, NIOSH in 1981 issued Current Intelligence Bulletin 36, "Silica Flour: Silicosis (Crystalline Silica)", describing a significant respiratory hazard in silica flour mills from respirable quartz.⁽⁴⁾

APPENDIX I (con't)

II. OBJECTIVES AND METHODS

1. NIOSH will estimate the incidence of new cases of silicosis among workers at the two mills.

(a) The x-rays of current and former employees of the two mills will be compared with those previously taken in 1979 to identify any new cases of silicosis developing since 1979.

2. NIOSH will compare the prevalence estimates of silicosis found in the 1979 Technical Assistance surveys of two southern Illinois ground silica mills to the current estimates of prevalence for those two mills.

(a) Methods 2 (a) and (b) discussed in the study protocol.

(b) Reclassify the x-rays taken by NIOSH in 1979 at these two mills according to the 1980 ILO classification system. (The films taken in 1979 were classified used the 1971 ILO classification system). The B Readers will not be made aware when more than one film on an individual is to be classified. The films will be randomly mixed and classified independently. The same three B Readers will be used throughout the entire project.

3. NIOSH will evaluate the change in spirometry results among the workers previously examined in 1979.

(a) Compare an individual worker's 1979 spirometry results to those obtained in this study.

4. NIOSH will review the implementation of recommendations made in the 1979 NIOSH Technical Assistance survey reports (HETA Nos. 79-103-108 and 79-104-107). The following recommendations were made: engineering and work practice improvements to reduce free silica exposures below the NIOSH REL; periodic environmental monitoring of silica exposures by the operator; respiratory protection while the effectiveness of the engineering controls are evaluated; all workers exposed to silica dust not examined in the NIOSH study should undergo comprehensive medical examinations; workers with radiographic evidence of silicosis should be given the opportunity to transfer to jobs without silica exposure; current workers with pulmonary function impairment be evaluated by a qualified physician and advised whether to continue in a dusty trade; medical examinations should be performed at

APPENDIX I (con't)

first exposure to silica dust and at yearly intervals; bagged silica flour should be correctly labeled and contain appropriate health warnings.

- (a) Review company industrial hygiene records.
- (b) Review company respiratory protection program.
- (c) Review employee medical and personnel records.
- (d) Review product bag labels.

III . REFERENCES

1. Amandus H [1990]. A feasibility study of the adequacy of company records for a proposed NIOSH study of silicosis in industrial sand workers. Final report to Director, NIOSH. Morgantown, WV: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health, Division of Respiratory Disease Studies, DHHS (NIOSH).
2. NIOSH [1979]. Hazard evaluation and technical assistance report: Tammsco, Incorporated: Tamms, Illinois. Morgantown, WV: U.S. Department of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health, NIOSH Report No. HHE 79-104-107.
3. NIOSH [1979]. Hazard evaluation and technical assistance report: Illinois Minerals Company: Elco, Illinois. Morgantown, WV: U.S. Department of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health, NIOSH Report No. HHE 79-103108.
4. NIOSH [1981]. Current Intelligence Bulletin 36: silica flour; silicosis (crystalline silica). Cincinnati, OH: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health. DHHS (NIOSH) Publication No. 81-137.

APPENDIX I (con't)

ATTACHMENT 1

GROUND SILICA MILLS - 1991

	<u>Northeastern District</u>		<u>Employees</u>
46-02805	U.S. Silica Co.	Berkeley Plant	102
 <u>Southeastern District</u>			
38-00027	Spartan Minerals Co.	Pacolet Mill	21
38-00138	U.S. Silica Co.	Columbia Plant	50
38-00299	Unimin Corp.	Unimin-Lugoff	19
40-02937	Nicks Silica Co.	Nicks Silica Co.	13
 <u>North Central District</u>			
11-01013	U.S. Silica Co.	Ottawa Plant	94
11-01580	Unimin Corp.	Troy Grove Plant	18
11-01981	Unimin Specialty Min.	Plant (NC)	30
11-02051	Unimin Specialty Min.	Plant/Mill (NC)	22
33-01354	Central Silica Co.	Glass Rock Quarry (NC)	34
33-01355	Central Silica Co.	Millwood Sand Div.	25
 <u>South Central District</u>			
03-00299	Malvern Minerals	Malvern Minerals Sandstone (NC)	19
23-00504	American Tripoli, Inc.	American Tripoli, Inc. (NC)	12
23-00544	U.S. Silica Co.	Pacific Plant	30
34-00377	U.S. Silica Co.	Mill Creek Plant (NC)	50
41-01059	Unimin (Texas) Corp.	Unimin (Texas)	20

NC - Noncompliance

APPENDIX I (con't)

ATTACHMENT 2

GROUND SILICA MILLS - 1991

	<u>Northeastern District</u>		<u>Employees</u>
46-02805	U.S. Silica Co.	Berkeley Plant	102
	<u>Southeastern District</u>		
38-00138	U.S. Silica Co.	Columbia Plant	50
40-02937	Nicks Silica Co.	Nicks Silica Co.	13
	<u>North Central District</u>		
11-01981	Unimin Specialty Min.	Plant (NC)	30
11-02051	Unimin Specialty Min.	Plant/Mill (NC)	22
33-01354	Central Silica Co.	Glass Rock Quarry (NC)	34
	<u>South Central District</u>		
03-00299	Malvern Minerals	Malvern Minerals Sandstone (NC)	19
23-00504	American Tripoli, Inc.	American Tripoli, Inc. (NC)	12
34-00377	U.S. Silica Co.	Mill Creek Plant (NC)	50

NC - Noncompliance

APPENDIX I (con't)

ATTACHMENT 3

Minimum Requirements of ANSI Z88.2-1969

- (1) The operator must establish a written standard operating procedure governing the selection and use of the respirator.
- (2) The operator must select the respirators on the basis of the hazards to which the worker is exposed. The respirator must be MSHA/NIOSH approved for the specific hazards.
- (3) The respirator user shall be instructed and trained in the proper use of respirators and their limitations. The minimum training shall include the following (as quoted from ANSI Z88.2-1969):
 - a. Instruction in the nature of the hazard, whether acute, chronic, or both, and a complete appraisal of what may happen if the respirator is not used.
 - b. Explanation of why more positive control is not immediately feasible. This shall include recognition that every reasonable effort is being made to reduce or eliminate the need for respirators.
 - c. A discussion of why this is the proper type of respirator for the particular purpose.
 - d. A discussion of the respirator's capabilities and limitations.
 - e. Instruction and training in actual use of the respirator (especially a respirator for emergency use) and close and frequent supervision to ensure that it continues to be properly used.
 - f. Classroom and field training to recognize and cope with emergency situations.
 - g. Other special training as needed for special use.

Training shall provide the employees an opportunity to handle the respirator, have it fitted properly, test its facepiece-to-face seal, wear it in normal air for a long familiarity period, and, finally, to wear it in a test atmosphere.

- (4) Fit testing

All respirator wearers must be fit tested before using negative pressure respirators. ANSI Z88.2-1969 does not require fit testing of positive pressure respirators. Use a validated protocol for fit testing.

APPENDIX I (con't)

- (5) The operator must keep records to show that the proper respirator was issued to the respirator wearer. This is usually accomplished by recording the fit test results for each wearer, along with the date that the wearer received the respirator.
- (6) Respirators shall be cleaned and disinfected. Respirators used routinely shall be inspected during cleaning. Worn or deteriorated parts shall be replaced to maintain MSHA/NIOSH approval. ANSI states that cleaning and maintenance shall be done "as frequently as necessary to ensure proper protection is provided to the wearer."
- (7) Emergency-use respirators must be thoroughly inspected at least once per month and after each use. Keep a record of the inspection dates and findings.
- (8) Respirators shall be stored in a convenient, clean and sanitary location. The respirators must be stored in a manner that protects them against contamination, temperature extremes, and other potentially damaging conditions.
- (9) A single individual must administer the respiratory protection program. This individual shall regularly evaluate the effectiveness of the program. Monitoring will be conducted regularly to ensure that the selected respirators continue to provide appropriate protection to the wearer.

APPENDIX I (con't)

ATTACHMENT 4

PART II 2 (a) OBJECTIVES AND METHODS

Posterior-anterior radiographs will be taken, randomly mixed, and independently classified for pneumoconiosis according to the 1980 ILO system by three NIOSH certified B Readers. The median reading will be used to report an abnormality. A chest x-ray showing opacities of profusion category $\geq 1/0$ in a ground silica mill worker will be categorized as consistent with silicosis. The B Readers will not be informed of any exposure history. The films will be masked of identifying information. The same B Readers will be used throughout the entire project.

APPENDIX II ⁽¹¹⁾

SURVEILLANCE GUIDELINES: SILICOSIS

Reporting Guidelines

State health departments and regulatory agencies should encourage physicians (including radiologists, pathologists, and other health care providers) to report all diagnosed or suspected cases of silicosis. These reports should include persons with

- a physician's provisional or working diagnosis of silicosis, OR
- a chest x-ray interpreted as consistent with silicosis, OR
- pathologic findings consistent with silicosis

To set priorities for workplace investigations, State health departments and regulatory agencies should collect appropriate clinical, epidemiologic, and workplace information about persons reported to have silicosis.

Surveillance Case Definition

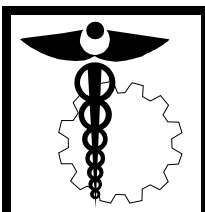
- A. 1. History of occupational exposure to airborne silica dust

AND

2. Chest x-ray or other imaging technique interpreted as consistent with silicosis

OR

- B. Pathologic findings characteristic of silicosis



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