

ASBESTOS BIBLIOGRAPHY

(Revised)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health
Education and Information Division
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INTRODUCTION

This publication is a compendium of NIOSH research and recommendations on asbestos. It updates and supersedes the NIOSH document *Asbestos Publications* dated June 1992.

This publication is divided into three Parts:

- Part I consists of full or partial text of selected NIOSH documents on asbestos. These documents provide an overview of NIOSH research on the health hazards of asbestos and NIOSH recommendations on workplace exposure to asbestos.
- Part II contains a comprehensive bibliography of NIOSH documents on asbestos. It is divided into two sections: (A) NIOSH-authored documents (which include numbered publications, testimony, journal articles, and miscellaneous reports) and (B) NIOSH-funded documents (which include grant and contract reports). Each document citation includes the title and year of publication and bibliographic or ordering information (see below).
- Part III contains summary asbestos information from other Federal agencies.

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4. Copies of journal articles, book chapters, and proceedings may be obtained from public or university libraries using the bibliographic information shown in the citation.

PART I

**FULL OR PARTIAL TEXT OF SELECTED
NIOSH REFERENCES ON ASBESTOS**

OCCUPATIONAL SAFETY AND HEALTH GUIDELINE FOR ASBESTOS POTENTIAL HUMAN CARCINOGEN

INTRODUCTION

This guideline summarizes pertinent information about asbestos for workers, employers, and occupational safety and health professionals who may need such information to conduct effective occupational safety and health programs. Recommendations may be superseded by new developments in these fields; therefore, readers are advised to regard these recommendations as general guidelines.

SUBSTANCE IDENTIFICATION

Data in the following section are presented for various forms of asbestos: (1) Asbestos (mixed forms);

- (2) Chrysotile;
- (3) Amosite;
- (4) Crocidolite;
- (5) Tremolite;
- (6) Anthophyllite;
- (7) Actinolite.

If unspecified, data apply to all forms.

- **Composition:** (1) Not Available;
- (2) $3\text{MgO} \cdot 2\text{SiO}_2 \cdot 2\text{H}_2\text{O}$;
- (3) $(\text{FeMg})\text{SiO}_3$;
- (4) $\text{NaFe}(\text{SiO}_3)_2 \cdot \text{FeSiO}_3 \cdot \text{H}_2\text{O}$;
- (5) $\text{Ca}_2\text{Mg}_5\text{Si}_8\text{O}_{22}(\text{OH})_2$;
- (6) $(\text{MgFe})_7\text{Si}_8\text{O}_{22}(\text{OH})_2$;
- (7) $\text{CaO} \cdot 3(\text{MgFe})\text{O} \cdot 4\text{SiO}_2$
- **Synonyms:** (1) Asbestos fiber, serpentine, amphibole;
- (2) Canadian chrysotile, white asbestos, serpentine;
- (3) Brown asbestos, fibrous grunerite;
- (4) Blue asbestos;
- (5) Fibrous tremolite;
- (6) Azbolen asbestos;
- (7) Not available
- **Identifiers:** (1) CAS 1332-21-4; RTECS CI6475000; DOT 2212 (blue) 2590 (white);
- (2) CAS 12001-29-5; RTECS CI6478500; DOT 2590;
- (3) CAS 12172-73-5; RTECS CI6477000; DOT Not assigned;
- (4) CAS 12001-28-4; RTECS CI6479000; DOT 2212;

- (5) CAS 14567-73-8; RTECS CI6560000; DOT Not assigned;
- (6) CAS 17068-78-9; RTECS CI6478000; DOT Not assigned;
- (7) CAS 13768-00-8; RTECS CI6476000; DOT Not assigned

• **Appearance and odor:** A fiber or filament. asbestos may have a "fluffy" appearance. Colors may vary from white, gray, blue, brown, green or yellow. Positive identification requires microscopic examination.

CHEMICAL AND PHYSICAL PROPERTIES

• Physical data

1. Molecular weight: (2) 277.13; (5) 185.03
2. Specific gravity (water = 1): 2.5-3.0
3. Noncombustible solid

• Warning properties

Evaluation of warning properties for respirator selection: Warning properties are not considered in recommending respirators for use with carcinogens.

EXPOSURE LIMITS

Only asbestos fibers greater than 5 micrometers (μ)m in length are considered for the following exposure limits. The current Occupational Safety and Health Administration (OSHA) permissible exposure limit (PEL) for asbestos is 0.2 fiber per cubic centimeter (cc) of air as a time-weighted average (TWA) concentration over an 8-hour workshift with an action level of 0.1 fiber/cc as an hour TWA. The National Institute for Occupational Safety and Health (NIOSH) recommends that asbestos be controlled and handled as a potential human carcinogen in the workplace and that exposure be minimized to the lowest feasible limit. The NIOSH recommended exposure limit (REL) is 0.1 fiber/cc (in 40-liter air sample) as a TWA concentration for up to an 8-hour workshift, 40-hour workweek. The American Conference of Governmental Industrial Hygienists (ACGIH) has designated asbestos as an AI substance (suspected human carcinogen, with an assigned threshold limit value/ TLV®) of 2 fibers/cc for chrysotile, 0.5 fiber/cc for amosite, 0.2 fiber/cc for crocidolite, and 2 fibers/cc for other forms, as a TWA for a normal 8-hour workday and a 40-hour workweek (Table 1).

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service Centers for Disease Control
National Institute for Occupational Safety and Health
Division of Standards Development and Technology Transfer

Table 1.—Occupational exposure limits for asbestos

	Exposure mg	Limits
OSHA PEL TWA	()	
Action level		
NIOSH REL TWA (Ca)†		
ACGIH TLV® TWA (A1a)‡		
Chrysotile		
Amosite		
Crocidolite		
Other forms	2.0	

* Fibers greater than 5 µm in length.

† (Ca): NIOSH recommends treating as a potential human carcinogen.

‡ (A1a): Human carcinogen with an assigned TLV®.

HEALTH HAZARD INFORMATION

• Routes of exposure

Asbestos may cause adverse health effects following exposure via inhalation or ingestion.

• Summary of toxicology

1. *Effects on animals:* Single intrapleural injections of asbestos in rats, rabbits, and hamsters produced mesothelioma (cancer of the chest or abdominal linings). In rats, chronic inhalation or oral administration of asbestos produced cancers of the lungs, stomach, kidneys, liver, or mammary glands. All forms of asbestos were found to be carcinogenic in treated animals.

2. *Effects on humans:* Exposure to asbestos has been found to significantly increase the risks of contracting asbestosis, lung cancer, and mesothelioma.

• Signs and symptoms of exposure

1. *Short-term (acute):* Exposure to asbestos can cause shortness of breath, chest or abdominal pain, and irritation of the skin and mucous membranes.

2. *Long-term (chronic):* Exposure to asbestos can cause reduced pulmonary function, breathing difficulty, dry cough, broadening and thickening of the ends of the fingers, and bluish discoloration of the skin and mucous membranes.

RECOMMENDED MEDICAL PRACTICES

• Medical surveillance program

Workers with potential exposures to chemical hazards should be monitored in a systematic program of medical surveillance intended to prevent or control occupational injury and disease. The program should include education of employers and workers about work-related hazards, placement of workers in jobs that do not jeopardize their safety and health, earliest possible detection of adverse health effects, and referral of workers for diagnostic confirmation and treatment. The occurrence of disease (a "sentinel health event," SHE) or other work-related adverse health effects should prompt immediate evaluation of primary preventive measures (e.g., industrial hygiene monitoring, engineering controls, and personal protective equipment). A medical surveillance program is intended to supplement, not replace, such measures.

A medical surveillance program should include systematic collection and epidemiologic analysis of relevant environmental

and biologic monitoring, medical screening, and morbidity and mortality data. This analysis may provide information about the relatedness of adverse health effects and occupational exposure that cannot be discerned from results in individual workers. Sensitivity, specificity, and predictive values of biologic monitoring and medical screening tests should be evaluated on an industry-wide basis prior to application in any given worker group. Intrinsic to a surveillance program is the dissemination of summary data to those who need to know, including employers, occupational health professionals, potentially exposed workers, and regulatory and public health agencies.

• Preplacement medical evaluation

Prior to placing a worker in a job with a potential for exposure to asbestos, the physician should evaluate and document the worker's baseline health status with thorough medical, environmental, and occupational histories, a physical examination, and physiologic and laboratory tests appropriate for the anticipated occupational risks. These should concentrate on the function and integrity of the respiratory system using the principles and methods recommended by NIOSH and the American Thoracic Society (ATS).

A preplacement medical evaluation is recommended in order to detect and assess preexisting or concurrent conditions which may be aggravated or result in increased risk when a worker is exposed to asbestos at or below the NIOSH REL. The examining physician should consider the probable frequency, intensity, and duration of exposure, as well as the nature and degree of the condition, in placing such a worker. Such conditions, which should not be regarded as absolute contraindications to job placement, include cigarette smoking, preexisting asbestos-related disease, and significant breathing impairment due to preexisting chronic lung diseases. In addition to the medical interview and physical examination, the means to identify these conditions may include the methods recommended by NIOSH and ATS.

• Periodic medical screening and/or biologic monitoring

Occupational health interviews and physical examinations should be performed at regular intervals. Additional examinations may be necessary should a worker develop symptoms that may be attributed to exposure to asbestos. The interviews, examinations, and appropriate medical screening and/or biologic monitoring tests should be directed at identifying an excessive decrease or adverse trend in the physiologic function of the respiratory system as compared to the baseline status of the individual worker or to the expected values for a suitable reference population. The following tests should be used and interpreted according to standardized procedures and evaluation criteria recommended by NIOSH and ATS: standardized questionnaires, tests of lung function, and chest X-rays.

• Medical practices recommended at the time of job transfer or termination

The medical, environmental, and occupational history interviews, the physical examination, and selected physiologic and laboratory tests which were conducted at the time of placement should be repeated at the time of job transfer or termination. Any changes in the worker's health status should be compared to those expected for a suitable reference population. Because

occupational exposure to asbestos may cause diseases of prolonged induction-latency, the need for medical surveillance may extend well beyond termination of employment.

- **Sentinel health events**

Delayed-onset SHE's include: Scarring of the lungs (asbestosis) and its lining (pleural fibrosis) and cancer of the lungs (bronchogenic lung cancer) and its lining (mesothelioma).

MONITORING AND MEASUREMENT PROCEDURES

- **TWA exposure evaluation**

Measurements to determine worker exposure to asbestos should be taken so that the TWA exposure is based on a single entire workshift sample or an appropriate number of consecutive samples collected during the entire workshift. Under certain conditions, it may be appropriate to collect several short-term interval samples (up to 30 minutes each) to determine the average exposure level. Air samples should be taken in the worker's breathing zone (air that most nearly represents that inhaled by the worker).

- **Method**

Sampling and analysis for airborne asbestos may be performed by collecting asbestos fibers with membrane filters and analyzing by phase contrast microscopy. A detailed sampling and analytical method for asbestos may be found in the *NIOSH Manual of Analytical Methods* (method number 7400).

PERSONAL PROTECTIVE EQUIPMENT

Chemical protective clothing (CPC) should be selected after utilizing available performance data, consulting with the manufacturer, and then evaluating the clothing under actual use conditions.

Workers should be provided with and required to use CPC, gloves, and other appropriate protective clothing necessary to prevent skin contact with asbestos.

SANITATION

Clothing which is contaminated with asbestos should be removed at the end of the work period and placed in nonreusable, impermeable containers for storage, transport, and disposal until it can be discarded or until provision is made for the removal of asbestos from the clothing. These containers should be marked "Asbestos-Contaminated Clothing" in easy-to-read letters. If the clothing is to be laundered or cleaned, the person performing the operation should be informed of asbestos's hazardous properties. Reusable clothing and equipment should be checked for residual contamination before reuse or storage.

A change room with showers, washing facilities, and lockers that permit separation of street and work clothes should be provided.

Workers should be required to shower following a workshift and prior to putting on street clothes. Clean work clothes should be provided daily.

Skin that becomes contaminated with asbestos should be promptly washed with soap and water.

The storage, preparation, dispensing, or consumption of food or beverages, the storage or application of cosmetics, the storage or smoking of tobacco or other smoking materials, or the storage or use of products for chewing should be prohibited in work areas.

Workers who handle asbestos should wash their faces, hands, and forearms thoroughly with soap and water before eating, smoking, or using toilet facilities.

COMMON OPERATIONS AND CONTROLS

Common operations in which exposure to asbestos may occur and control methods which may be effective in each case are listed in Table 2.

Table 2.—Operations and methods of control for asbestos

Operations	Controls
During asbestos removal	Process enclosure, wet process (when possible), personal protective equipment
During the production of asbestos or the manufacture of products containing asbestos	Process enclosure, local exhaust ventilation, wet process (when possible), personal protective equipment
During the demolition of buildings	Water spray, personal protective equipment

EMERGENCY FIRST AID PROCEDURES

In the event of an emergency, remove the victim from further exposure, send for medical assistance, and initiate emergency procedures.

- **Eye exposure**

Where there is any possibility of a worker's eyes being exposed to asbestos, an eye wash fountain should be provided within the immediate work area for emergency use.

If asbestos gets into the eyes, flush them immediately with large amounts of water for 15 minutes, lifting the lower and upper lids occasionally. Get medical attention as soon as possible. Contact lenses should not be worn when working with this substance.

- **Skin exposure**

If asbestos gets on the skin, wash it immediately with soap and water.

- **Rescue**

If a worker has been incapacitated, move the affected worker from the hazardous exposure. Put into effect the established emergency rescue procedures. Do not become a casualty. Understand the facility's emergency rescue procedures and know the locations of rescue equipment before the need arises.

SPILLS AND LEAKS

Workers not wearing protective equipment and clothing should be restricted from areas of spills or leaks until cleanup has been completed.

If asbestos is spilled or leaked, the following steps should be taken:

Asbestos dust may be collected by vacuuming with an appropriate high-efficiency filtration system or by using wet methods and placed in an appropriate container.

WASTE REMOVAL AND DISPOSAL

U.S. Environmental Protection Agency, Department of Transportation, and/or state and local regulations shall be followed to assure that removal, transport, and disposal are in accordance with existing regulations.

RESPIRATORY PROTECTION

It must be stressed that the use of respirators is the least preferred method of controlling worker exposure and should not normally be used as the only means of preventing or minimizing exposure during routine operations. However, there are some exceptions for which respirators may be used to control exposure: when engineering and work practice controls are not technically feasible, when engineering controls are in the process of being installed, or during emergencies and certain maintenance operations including those requiring confined-space entry (Table 3).

In addition to respirator selection, a complete respiratory protection program should be instituted which as a minimum complies with the requirements found in the OSHA Safety and Health Standards 29 CFR 1910.134. A respiratory protection program should include as a minimum an evaluation of the worker's ability to perform the work while wearing a respirator, the regular training of personnel, fit testing, periodic environmental monitoring, maintenance, inspection, and cleaning. The implementation of an adequate respiratory protection program, including selection of the correct respirators, requires that a knowledgeable person be in charge of the program and that the program be evaluated regularly.

Only respirators that have been approved by the Mine Safety and Health Administration (MSHA, formerly Mining Enforcement and Safety Administration) and by NIOSH should be used. **Remember! Air-purifying respirators will not protect from oxygen-deficient atmospheres.**

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Table 3.—Respiratory protection for asbestos

Condition	Minimum respiratory protection*
Any detectable concentration	Any self-contained breathing apparatus with a full facepiece and operated in a pressure-demand or other positive pressure mode
	Any supplied-air respirator with a full facepiece and operated in a pressure-demand or other positive pressure mode in combination with an auxiliary self-contained breathing apparatus operated in a pressure-demand or other positive pressure mode
Planned or emergency entry into environments containing unknown or any detectable concentration	Any self-contained breathing apparatus with a full facepiece and operated in a pressure-demand or other positive pressure mode
	Any supplied-air respirator with a full facepiece and operated in a pressure-demand or other positive pressure mode in combination with an auxiliary self-contained breathing apparatus operated in a pressure-demand or other positive pressure mode
Firefighting	Any self-contained breathing apparatus with a full facepiece and operated in a pressure-demand or other positive pressure mode
Escape only	Any air-purifying full facepiece respirator with a high-efficiency particulate filter
	Any appropriate escape-type self-contained breathing apparatus

* Only NIOSH/MSHA-approved equipment should be used.

REVISED RECOMMENDED ASBESTOS STANDARD



**U. S. DEPARTMENT OF HEALTH, EDUCATION, AND
WELFARE
Public Health Service
Center for Disease Control
National Institute for Occupational Safety and Health**

DECEMBER 1976

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The Division of Surveillance, Hazard Evaluations, and Field Studies, National Institute for Occupational Safety and Health (NIOSH), having primary responsibility for development of a NIOSH position paper on health effects of occupational asbestos exposure, has critiqued all available data and prepared the following document for publication and transmittal to the Occupational Safety and Health Administration (OSHA), as requested by the Assistant Secretary of Labor. Primary responsibility for development of this document was shared by Richard A. Lemen and John M. Dement, with technical consultation provided by Dr. Joseph K. Wagoner. Individuals who served as the NIOSH review committee were.

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DHEW (NIOSH) Publication No. 77-169

REVISED RECOMMENDED
ASBESTOS STANDARD

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I. INTRODUCTION


When the asbestos criteria document was first published in 1972, the National Institute for Occupational Safety and Health (NIOSH) recommended a standard of 2.0 asbestos fibers/cubic centimeter (cc) of air based on a count of fibers greater than 5 micrometers (μm) in length. This standard was recommended with the stated belief that it would "prevent" asbestosis and with the open recognition that it would not "prevent" asbestos-induced neoplasms. Furthermore, data were presented which supported the fact that technology was available to achieve that standard and that the criteria would be subject to review and revision as necessary. Since the time that the asbestos criteria were published in 1972, sufficient additional data regarding asbestos-related disease have been developed to warrant reevaluation.

On June 7, 1972, the Occupational Safety and Health Administration (OSHA) promulgated a standard for occupational exposure to asbestos containing an 8-hour time-weighted average (TWA) concentration exposure limit of 5 fibers longer than 5 μm /cc of air, with a ceiling limitation against any exposure in excess of 10 such fibers/cc. The standard further provided that the 8-hour TWA was to be reduced to 2 fibers/cc on July 1, 1976.

As the result of a court case, OSHA decided that to achieve the most feasible occupational health protection, a reexamination of the standard's general premises and general structure was necessary. To this end, on October 9, 1975, OSHA announced a proposed rule-making to lower the exposure limit to an 8-hour TWA concentration of 0.5 asbestos fibers longer

than 5 $\mu\text{m}/\text{cc}$ of air with a ceiling concentration of 5 fibers/cc of air determined by a sampling period of up to 15 minutes. On December 2, 1975, OSHA requested NIOSH to reevaluate the information available on the health effects of occupational exposure to asbestos fibers and to advise OSHA on the results of this study.

This document contains an updated review of the available information on the health effects of exposure to asbestos. In addition, NIOSH's proposal for a new numerical exposure limit is included.


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V. BASIS FOR THE RECOMMENDED STANDARD

The first modern approach to the setting of an asbestos standard was proposed by the British Occupational Hygiene Society (BOHS 1968) in terms of fiber concentration. In 1968, a subcommittee of the Society evaluated data on 290 men at work in an asbestos factory. These data were provided by company sources. All the men had been employed after January 1933, following implementation of dust control measures mandated by the Factory Inspectorate in 1931. Estimates of the fiber exposure of these workmen were also provided by the company. Of the 290 individuals, 8 were stated to have x-ray evidence of asbestos disease and 16 had rales. Noteworthy in the 1968 data was the preponderance of individuals who had been employed less than 20 years. Only 118 of the 290 persons had worked for longer than 20 years and a scant 13 has been employed for 30 or more years.

After a review of these data, the BOHS proposed a standard which was adopted with minor modifications by the British government in 1969, and implemented in May 1970. All fibers between 5 and 100 microns in length were counted by light microscopy. The standard required no action to be taken below 2 fibers/cc. Between 2 fibers/cc and 12 fibers/cc, control measures commensurate with the exposure circumstances (time and frequency of worker exposure) were prescribed; above 12 fibers/cc, full application of control measures, including respiratory protection, was mandatory. The BOHS predicted that the risk of being affected, to the extent of having the earliest clinical signs of asbestos exposure (rales), would be less than 1% for an accumulated exposure of 100

fiber-years/cc (2 fibers/cc for 50 years, 4 fibers/cc for 25, etc.). Data (Lewinsohn, 1972) from the same factory which formed the basis for the BOHS standard demonstrate that a greater prevalence of abnormalities now exist (Table V-1). These data, in addition to demonstrating a dose-response relationship for radiographically detected abnormalities consistent with asbestosis, further showed a 17% prevalence of abnormal radiographic findings (6% consistent with asbestosis) in individuals employed since 1950.

Weill et al (1975), when considering lung function and irregular small opacities, reported that there was little evidence of a dose-response relationship below 100 mppcf-years. They further concluded that a concentration of 5 fibers/cc could be cautiously considered as "safe". Ayer and Berg (1976), however, reported data which suggest that the BOHS standard, of an average cumulative exposure of 100 fiber-years/cc, for chrysotile asbestos may prevent significant decreases in pulmonary function only when combined with periodic spirometry and further reduction of exposure for affected workers. Holmes (1973) has since stated that the data upon which the BOHS standard was based were inadequate to set a standard to prevent asbestosis. The BOHS-recommended standard of 2 fibers/cc was based on data related only to asbestosis and the Society clearly cautioned that, since a quantitative relationship between asbestos exposure and cancer risk was not known, it was not possible at that time to specify an air concentration which was known to be free of increased cancer risk. (BOHS 1968)

Howard et al (1976), in a follow-up examination of the textile workers previously studied by Doll (1955) and Knox et al (1965, 1968) for cancer, and by Lewinsohn (1972) for asbestosis, reported a statistically significant increase in the risk of developing lung cancer (1.8 times the expected) among those first entering scheduled areas from 1933 to

1950. In the same study, they also reported an excess of deaths due to lung cancer (1.9 times the expected) after 15 or more years from initial exposure among those who started work subsequent to 1950, a period of improved industrial engineering control technology and regulation.

In a study of miners exposed to amphibole fibers (amosite) in the cummingtonite-grunerite ore series, with airborne concentrations of less than 2.0 fibers/cc (average concentration, 0.25 fibers/cc) and 94% of the fibers shorter than 5 μm in length, Gillam et al (1976) have demonstrated threefold increases in the risks of mortality from both malignant and nonmalignant respiratory diseases.

Newhouse (1969, 1973) and Newhouse et al (1972) have shown that the cancer risk to factory workers following mixed exposure to chrysotile, amosite, and crocidolite is dose-related. The women reported to have heavier exposures (as judged by their occupations) showed a sixfold excess of cancer following only 15 years' latency, whereas those with moderate or low exposures required 25 years' latency to demonstrate an excess. The rate of mesothelioma increased with both the severity and the length of exposure. However, even with as little as two years of asbestos exposure, six mesotheliomas occurred among female employees.

McDonald (1973) stated that the risk of developing lung cancer was essentially confined to persons with a dust index above 200 mppcf-years, and Enterline et al (1973) showed no direct dose-response for respiratory cancer below 125 mppcf-years. In a review of these two papers, Schneiderman (1974) concluded that, instead of being consistent with a threshold level at which no cancer risk exists, these data did not provide evidence for a threshold or for a "safe" level of exposure. He pointed out that in

the paper by Enterline et al (1973) there is no dose group for which the Standardized Mortality Ratio (SMR) is below 100 (100 = normal), but that the 95% confidence limits on the SMR's included 100 for two of the three dose groups below 125 mppcf-years. One of the dose groups (25-62.4) had a statistically significant excess mortality from lung cancer, whereas for the other two this mortality rate was insignificantly elevated above the expected values. Regarding McDonald's paper, Schneiderman stated that it is hard to determine what is excess since no expected numbers for each group were given upon which to base this comparison.

Among amosite workers with employment of 3 months or less, Selikoff (1976) reported excess cancer risks of 3.87, 1.68, and 1.65 times those expected for cancer of the lung, colon and rectum, and all sites, respectively.

Anderson et al (1976) have reported a significant excess of radiographic abnormalities of the chest characteristic of asbestos exposure (pleural and/or parenchymal) 25-30 years after the onset of household contamination. These abnormalities were observed in 35% of 326 otherwise healthy workers who had household contacts with amosite asbestos. In addition, four pleural mesotheliomas were found in this group.

VI. THE RECOMMENDED STANDARD

Available studies provide conclusive evidence that exposure to asbestos fibers causes cancer and asbestosis in man. Lung cancers and asbestosis have occurred following exposure to chrysotile, crocidolite, amosite, and anthophyllite. Mesotheliomas, lung and gastrointestinal cancers have been shown to be excessive in occupationally exposed persons, while mesotheliomas have developed also in individuals living in the neighborhood of asbestos factories and near crocidolite deposits, and in persons living with asbestos workers. Asbestosis has been identified among persons living near anthophyllite deposits.

Likewise, all commercial forms of asbestos are carcinogenic in rats, producing lung carcinomas and mesotheliomas following their inhalation, and mesotheliomas after intrapleural or ip injection. Mesotheliomas and lung cancers were induced following even 1 day's exposure by inhalation.

The size and shape of the fibers are important factors; fibers less than $0.5 \mu\text{m}$ in diameter are most active in producing tumors. Other fibers of a similar size, including glass fibers, can also produce mesotheliomas following intrapleural or ip injection.

There are data that show that the lower the exposure, the lower the risk of developing cancer. Excessive cancer risks have been demonstrated at all fiber concentrations studied to date. Evaluation of all available human data provides no evidence for a threshold or for a "safe" level of asbestos exposure.

In view of the above, the standard should be set at the lowest level detectable by available analytical techniques, an approach consistent with NIOSH's most recent recommendations for other carcinogens (ie, arsenic and vinyl chloride). Such a standard should also prevent the development of asbestosis.

Since phase contrast microscopy is the only generally available and practical analytical technique at the present time, this level is defined as 100,000 fibers $>5 \mu\text{m}$ in length/ m^3 (0.1 fibers/cc), on an 8-hour-TWA basis with peak concentrations not exceeding 500,000 fibers $>5 \mu\text{m}$ in length/ m^3 (0.5 fibers/cc) based on a 15-minute sample period. Sampling and analytical techniques should be performed as specified by NIOSH publication USPHS/NIOSH Membrane Filter Method for Evaluating Airborne Asbestos Fibers - T.R. 84 (1976).

This recommended standard of 100,000 fibers $>5 \mu\text{m}$ in length/ m^3 is intended to (1) protect against the noncarcinogenic effects of asbestos, (2) materially reduce the risk of asbestos-induced cancer (only a ban can assure protection against carcinogenic effects of asbestos) and (3) be measured by techniques that are valid, reproducible, and available to industry and official agencies.

However, some difficulties arise in that specific work practices and innovative engineering control or process changes are needed. But because of the well-documented human carcinogenicity from all forms of asbestos, these difficulties should not be cited as cause for permitting continued exposure to asbestos at concentrations above 100,000 fibers $>5 \mu\text{m}$ in length/ m^3 .

This standard was not designed for the population-at-large, and any extrapolation beyond general occupational exposures is not warranted. The standard was designed only for the processing, manufacturing, and use of asbestos and asbestos-containing products as applicable under the Occupational Safety and Health Act of 1970.