

中皮腫登録制度 イタリアの場合

- 1) 諸外国で導入されている、癌登録制度のひとつである。
- 2) 中皮腫を担当した主治医が一定書式に記載し、
中皮腫登録委員会(全国数地域)に報告する。
- 3) 中皮腫登録委員会は公的な制度で、常勤医1名と職歴環境曝露歴調査に精通した常勤職員数名からなる。
- 4) 委員会は、職歴や病理等の追加調査等を指示し、必要に応じ職員が極力生前の本人と面談し情報を収集する。
- 4) 月1回以上検討会議を開催し、病理医、産業医、石綿濃度測定専門家、石綿関連物質専門家が参加する。
- 5) 検討会議で、原因の判別を行い、労災該当者、環境曝露、建物曝露、家族曝露等を決定する。補償制度の判別や診断精度の向上に寄与する。

中皮腫登録と石綿救済法(仮)

- 1) 中皮腫登録等の調査機能のない石綿救済法(仮)だと、職業起因の80%の「労災保険該当中皮腫」が自分や医療機関で十分な職歴調査ができない中新法該当者とされ、本来の環境被災者の救済の法律目的と反する事態が予想される。
- 2) 新法救済対象の多くは、「純粋な」環境曝露となると予想される。
 - <1> 家族曝露 横須賀造船所(従業員2万人家族数万人で家族中皮腫3人) その他現在日本での報告通算で10数名?
 - <2> 公害的環境曝露 尼崎・鳥栖・奈良 通算で100名程度?
 - <3> 建物の曝露 日本で1名 (世界で数十例のレベル)
 - <4> 「純粋」環境曝露 中皮腫5~10% 2004年50~100名
 - <5> 労災時効者 過去の80%(数千名) 今後は少ない
 - <6> 特別加入未加入 対象不明(調査必要)

アスベストセンターの中皮腫登録活動

- 1) アスベストセンターの活動は、中皮腫登録と同じである。相談に応じ個人票作成し、病理検査報告書確認
- 2) 追加の聞き取り、追加の病理検査の依頼を指示。
- 3) 相談員を全国に派遣し、生前に本人から聞き取り。
- 4) 月1回カンファレンス開催し、産業医、時に病理医、ケアナース、石綿測定専門家参加。
- 5) 建物曝露、尼崎環境曝露を初めて明らかにした実績。
- 6) 公的な中皮腫登録と、先進的なNPOの共同も、日本では必要ではないか？

LIGURIA MESOTHELIOMA REGISTRY: OCCUPATIONAL AND ENVIRONMENTAL ASBESTOS EXPOSURE IN 850 PLEURAL MESOTHELIOMA PATIENTS

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The Mesothelioma Registry of Liguria completes clinical information with detailed occupational and environmental anamnestic data in order to identify working and living areas at risk for asbestos-related pathologies. The Registry has been operating since 1994 in Genoa (city) and since 1996 in the entire Liguria Region (1,640,000 inhabitants, nearly 130 new cases per year). As to March 2004, 1193 patients have been registered (20% females).

Out of 987 cases with ascertained or probable diagnosis of pleural malignant mesothelioma, complete information on any asbestos exposure has been gathered for 850 subjects (86%). Among them, exposure to asbestos (ascertained, probable or possible) has been documented for 664 subjects (78%).

First *ascertained* occupational exposure to asbestos was registered for males (388) in shipyards (156, 40%), docks and cargo handling settings (64, 16%), iron and steel industries, metal and mechanical engineering (43, 11%), constructions (41, 11%), and others (84, 22%). Thirteen female patients had an *ascertained* occupational asbestos exposure, primarily in the non-metalliferous minerals manufacturing and textile industries.

Non-occupational asbestos exposure (environmental, domestic, hobby) was documented for 50 patients, 20% females.

MALIGNANT MESOTHELIOMA AND THE WORKING ENVIRONMENT: A VIEW FROM THE OCCUPATIONAL PHYSICIAN

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An overall strong scientific evidence supports the causal association between malignant mesothelioma (MM) and occupational exposure to asbestos. Such exposure may significantly occur in a great variety of job tasks in many industrial and non industrial settings, and it involved – and may still involve – many workers. The proportion of cases caused by such exposures is quite different across the populations: estimated attributable risks generally vary from 30 to 80%. Epidemiological studies and mathematical modelling demonstrated a relationship between incidence of MM and dose, type of fibre, type of industry and time since first exposure. Although a clear dose-response relationship has been demonstrated, there seem to be no evidence of a threshold level below which there is no risk of MM. In general, the minimum latency period is about 15 years, while 40 years is the average. In practice, there are no other occupationally relevant etiological factors for MM.

The occupational physicians (OP) are key health professional in MM evaluation. In fact, their contribution is valuable for design and conduct of epidemiological studies, for expert exposure assessment, in the process of etiological diagnosis, especially for attribution of the MM to occupational asbestos exposure, in active research and evaluation of MM cases stemming from particular areas or populations. A fundamental role is also played by OP when preventive actions are planned and implemented in workplaces.

Experience from the Province of Brescia, where MM incidence is about 3 cases/10⁵, highlights the multifaceted role of OP. In fact, the local MM registry, instituted and managed by OP belonging to local health authority, observed about 300 MM cases from 1977 to 2003; the local university hospital service of occupational health, hosted in a university hospital of a national relevance, evaluated about 180 cases in the last decade, coming from various Italian regions. The main results from these experiences are better exposure assessment, the relevant contribution to Regional and National Registries, epidemiological estimates of attributable risks, incidence and survival rates, medico-legal assistance and compensation consequences, scientific publications, teaching opportunities, cooperation between oncologists, pathologists, surgeons, pneumologists, practitioners and OP.

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