



Editorial

Registry of diseases caused by asbestos. The importance of knowing the scale of the problem[☆]



Registros de enfermedades causadas por el amianto. La importancia de conocer la dimensión del problema

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The risks of asbestos for health are well known by the medical community, and the population as a whole is also becoming increasingly aware of the issue. This growing awareness is reflected in frequent reports in the media, most of which refer to specific cases with medical/legal ramifications. There is, therefore, growing alarm regarding the deleterious effects of asbestos, but what is the real dimension of this major health problem?

Spanish workers were exposed to asbestos on a massive scale throughout most of the twentieth century. The widespread industrial use of natural fibrous silicate stemmed from its insulating properties, and about 2.4 million tons were imported for use mainly in the asbestos cement industry and construction sectors.¹ It was also during the past century that we began to become aware of the harmful effects of this material, caused by the ability of these fibers to generate a slow-progressing, carcinogenic inflammatory reaction.² Exposure to asbestos is strongly associated with the development of plaques, fibrosis, pleural effusion, rounded atelectasis, asbestosis, lung cancer, mesothelioma of the pleura and peritoneum, cancer of the larynx, and ovarian cancer.³ At present, the use of asbestos is banned in many Western countries, although it is still marketed in many developing countries. The use and marketing of asbestos in Spain were prohibited in 2002, but taking into account the latency time for developing associated diseases (at least 20 years), the peak incidence of emerging cases has not yet been reached. In Spain, asbestos-related diseases are still being diagnosed in individuals exposed before 2002, as well as in workers who are currently involved in repairs and construction jobs in buildings and structures that contain asbestos. It must be borne in mind that in Barcelona alone, over 6,000 buildings and garages are thought to contain this silicate.¹

One of the problems that have hampered the fight against this epidemic is the lack of knowledge of its true impact on the popula-

tion. The figures emerging from the official registries reveal that not only are asbestos-related diseases clearly being underdiagnosed,⁴ but many identified cases have not been reported. A lack of reliable data on the impact of asbestos in our population obviously prevents us from precisely determining trends in the incidence of cases, leading to a loss of key epidemiological data that are essential for adapting diagnostic strategies and healthcare surveillance in the exposed population.

There is little doubt that in the next few years we will have to improve our understanding of the toxic effects of asbestos exposure in our population. Under Spanish law, exposed workers who are still employed must be monitored by company health and safety departments, while retired workers must be followed up by the public services of the Ministry of Health.⁵ PIVISTEA, a comprehensive program to monitor the health of workers who have been exposed to asbestos, is an initiative of the Ministry of Health that aims to detect and monitor exposed workers in Spain. To date, a total of 2,526 businesses that work or have worked with asbestos, and 56,373 workers who handle or who have handled this material in the past have been identified, of which 30,387 and 17,645 workers are post-exposure or currently exposed, respectively. A total of 6,570 individual cases of asbestos-related disease have been identified, of which 53% correspond to pleural plaques.⁶

Specialized registries are clearly a useful way of acquiring an overview of diseases that, for various reasons, are little known. The British THOR (formerly called SWORD) registry of occupational diseases best reflects the benefits of this type of initiative. During its lifespan of over 20 years, THOR has maintained a significant level of reporting, helping estimate trends in the incidence of the various occupational diseases seen in the United Kingdom.⁷ The Australian government uses a different design, in which individuals register themselves if they believe they have been exposed to asbestos.⁸ In Spain, we have the experience of the MOR general registry of respiratory occupational diseases, which is implemented in 3 autonomous communities. In this registry, reported cases of asbestos-related disease far exceeded the official statistics.⁹

In order to resolve the shortfalls mentioned above, SEPAR's EROM area is currently planning to give new impetus to the Spanish

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registry of asbestos-related diseases by implementing a voluntary registry that includes data on demographics, occupational, domestic, and environmental exposure, radiological findings and lung function. It will start with an initial phase in which current cases will be recorded, followed by a second phase, when emerging cases will be registered. The network of reporters will initially consist of respiratory experts working specifically with asbestos-related diseases, but it will be open to all SEPAR members, and we would also like to see the Society of Occupational Medicine becoming involved in the project.

In an early pilot phase, 10 Spanish centers recorded 100 cases of asbestos-related disease. These cases were individuals with an average age of 73 (43–93) years, mostly men (89%) and former smokers, with predominantly occupational exposure (87%). In most patients, the most prevalent diagnoses were pleural plaques (74%), asbestosis (22%), pleural fibrosis (10%), mesothelioma (6%), and lung cancer (6%). The most common employment sectors were the naval and asbestos cement industries.

The coming years will be a key period for determining in more detail the real effects of asbestos on the health of our population, in terms of case numbers and the likely future impact. The scope of the PIVISTEA program is generalized, and its results could be supplemented with data from the registry of asbestos-related diseases, as a reflection of diagnoses of this type made in specialized centers. To achieve this objective, we must convince treating physicians of the importance of recording cases as they are diagnosed. The time dedicated to this task is more than compensated by the value of a precise overview of the characteristics of affected individuals and

the incidence of the various diseases. The effectiveness of diagnostic programs and health surveillance depends largely on the data provided by registries of this type.

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