Vermiculite, Respiratory Disease, and Asbestos Exposure in Libby, Montana: Update of a Cohort Mortality Study

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BACKGROUND: Vermiculite from the mine near Libby, Montana, is contaminated with tremolite asbestos and other amphibole fibers (winchite and richterite). Asbestos-contaminated Libby vermiculite was used in loose-fill attic insulation that remains in millions of homes in the United States, Canada, and other countries.

OBJECTIVE: This report describes asbestos-related occupational respiratory disease mortality among workers who mined, milled, and processed the Libby vermiculite.

METHODS: This historical cohort mortality study uses life table analysis methods to compare the age-adjusted mortality experience through 2001 of 1,672 Libby workers to that of white men in the U.S. population.

RESULTS: Libby workers were significantly more likely to die from asbestosis [standardized mortality ratio (SMR) = 165.8; 95% confidence interval (CI), 103.9–251.1], lung cancer (SMR = 1.7; 95% CI, 1.4–2.1), cancer of the pleura (SMR = 23.3; 95% CI, 6.3–59.5), and mesothelioma. Mortality from asbestosis and lung cancer increased with increasing duration and cumulative exposure to airborne tremolite asbestos and other amphibole fibers.

CONCLUSIONS: The observed dose-related increases in asbestosis and lung cancer mortality highlight the need for better understanding and control of exposures that may occur when homemakers or construction workers (including plumbers, cable installers, electricians, telephone repair personnel, and insulators) disturb loose-fill attic insulation made with asbestos-contaminated vermiculite from Libby, Montana.


Vermiculite is a naturally occurring mineral mined in the United States, Brazil, Argentina, Mexico, South Africa, Zimbabwe, Kenya, Uganda, Egypt, India, Russia, China, Japan, and Australia. Mined vermiculite ore is milled to produce vermiculite concentrate of various sizes and grades. When rapidly heated, vermiculite concentrate expands to form small, light-weight, accordion-shaped granules. Vermiculite is used in construction products (loose-fill attic insulation, acoustic finishes, spray-on fireproofing, gypsum plaster, concrete mixes for swimming pools), consumer products (packing materials, absorbent in laboratories), agricultural and horticultural products (animal feed, bulking agent, fertilizers, pesticides, seed encapsulant, hydroponics, potting mixes, soil conditioners), and in industrial products (brake shoes and pads, drilling muds, furnaces, filters, insulator blocks, paints, and sealants) [U.S. Environmental Protection Agency (EPA) 2006].

Vermiculite from the mine that operated near Libby, Montana, from the early 1920s until 1990 was contaminated with asbestos and other fibrous amphibole minerals, crystalline silica, and talc. The U.S. Geological Survey has characterized the respirable fraction of asbestiform amphiboles contaminating the Libby vermiculite as approximately 84% winchite, 11% richterite, and 6% tremolite (Meeker et al. 2003). The raw Libby ore was estimated to be 21–26% asbestos by weight; the mill feed was 3.5–6.4% asbestos; airborne dust in the dry mill was 40% asbestos (Wake 1962); and the vermiculite concentrate shipped to numerous processing plants in the United States and other countries was 0.3–7.0% asbestos before expansion (Amandus et al. 1987; Atkinson et al. 1981).

Previous studies of Libby workers documented increased risk of lung cancer and nonmalignant respiratory disease among highly exposed workers with at least 1 year tenure (Amandus and Wheeler 1987; McDonald et al. 1986, 2004). Reports of respiratory disease mortality among community residents and household contacts of Libby vermiculite workers suggested increased risk from transient exposure or ambient community exposure [Agency for Toxic Substances and Disease Registry (ATSDR) 2002; Schneider 1999]. Cross-sectional radiographic screening conducted in Libby for the ATSDR revealed that 6.7% of community residents with no occupational or familial exposure have radiographic evidence of asbestos-related disease (Peipins et al. 2003). These findings suggest that risk from asbestos-contaminated vermiculite may not be limited to those with high-intensity occupational exposure.

This report expands the previously studied occupational cohort to include all white men hired at Libby from September 1935 through December 1981. The intent here is to describe the mortality experience of workers exposed to Libby amphibole fibers (tremolite asbestos, winchite, richterite) over the full range of exposure and employment duration. Occupational respiratory disease mortality among Libby workers is compared to that expected based on the mortality experience of the U.S. population, and standardized mortality ratios (SMRs) and standardized rate ratios (SRRs) for asbestosis, lung cancer, and all nonmalignant respiratory diseases are presented.

Materials and Methods

Study subjects. Study subjects were vermiculite miners, millers, and processors. Workers also may have been assigned jobs in the screening plant, railroad loading dock, expansion plants, or an office located in the town of Libby (several miles from the mine). The cohort was enumerated in May 1982, and study subjects were followed through December 2001. The design allowed a minimum 20 years of follow-up since first exposure, with > 65 years of follow-up for the earliest hired workers. Demographic and work history data were abstracted from company personnel and payroll records. A database created by the National Institute for Occupational Safety and Health (NIOSH) in the 1980s contained demographic data, work history, and vital status at the end of 1981 for 1,881 workers. The data were validated against company records on microfilm at NIOSH, and work history data were reabstracted. One person was removed from the cohort because company records stated that he was hired but never worked. Nine workers with Social Security numbers listed in company records were excluded because demographic and work history data were not available, leaving 1,871 potential study subjects.

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I thank A. Weston, L. Charles, M. Pickett-Harner, G. Pinheiro, M. Schubauer-Berigan, B. Yuceysoy, and R. Zumwalde for their comments on the manuscript. J. Ayersman and M. Stanton helped assemble and trace the cohort.

The findings and conclusions in this report are those of the author and do not necessarily represent the views of the National Institute for Occupational Safety and Health.

The author declares she has no competing financial interests.

Received 3 July 2006; accepted 3 January 2007.
Vital status follow-up. The NIOSH Institutional Review Board approved the research protocol; the study complied with all applicable U.S. requirements and regulations for studies involving human subjects. Vital status follow-up through 2001 used the National Death Index (NDI-Plus), the Social Security Administration, the Internet [Ancestry.com (2006), RootsWeb.com (2006), and electronic links to state death records], and a tracing service. Workers known to be alive or on after 1 January 1979 (the date NDI began tracking deaths nationwide), but not found in the NDI, were assumed to be alive at the study end date of 31 December 2001. Vital status follow-up was completed for 97.8% of the cohort (n = 1,830). Nearly 47% of these workers (n = 877) had died by 31 December 2001.

For 97% of those known to be deceased, cause of death was determined from death certificates and coded to the International Classification of Diseases (ICD) using the rubrics of the ICD revision in effect at the time of death [ICD-8 (National Center for Health Statistics 1967); ICD-9 [World Health Organization (WHO) 1977]; or ICD-10 (WHO 1992)]. Deaths before 1979 were coded by a single National Center for Health Statistics-trained nosologist; for 1979–2001, ICD codes were obtained from the NDI.

Exposure assessment. The mining, milling, and processing operations at Libby; conditions of exposure; and job-specific estimates of exposure intensity have been thoroughly described previously (Amandus and Wheeler 1987; Amandus et al. 1987, 1988; McDonald et al. 1986). Briefly, miners extracted vermiculite ore from an open-pit mine. The ore was processed in a dry mill (1935–1976) and/or two wet mills (1955–1990) that operated on Vermiculite Mountain. The resulting concentrate was shipped by railroad to processing plants where the vermiculite was expanded for use in loose-fill attic insulation. Before 1975, exposures in the mine ranged from 9–23 fibers per cubic centimeter (fibers/cc) of air for drillers; exposures in other mining jobs were estimated to be < 2 fibers/cc (Amandus et al. 1987). Early fiber exposures in the dry mill were as high as 182 fibers/cc; exposures in all work areas were < 1 fiber/cc as estimated from cumulative exposure, with likely attenuation of the effect estimators. In addition, reabstracting work histories for the current study identified several job assignments not mentioned in the earlier publications. Exposure estimates for the additional job/calendar time period combinations were extrapolated based on professional experience and review of exposure records from earlier studies of Libby workers (Amandus and Wheeler 1987; Amandus et al. 1987, 1988; McDonald et al. 1986).

The exposure index available for this and previous studies of Libby workers is based on fiber count data obtained using optical phase contrast microscopy (PCM). PCM measures fibers longer than 5 µm and wider than 0.25 µm [i.e., the fiber size regulated under the OSHA standard (U.S. Department of Labor 2006)]. Fiber count data obtained using PCM do not distinguish between the various amphiboles in the Libby vermiculite. Thus, fiber count estimates used in the exposure assessment include not only the regulated tremolite asbestos fibers but also the asbestos-form amphibole fibers not mentioned in the regulations (winchite and richterite). Recall that Meeker et al. (2003) characterized the Libby amphibole as 6% tremolite. If the observed health effects are explained by tremolite asbestos alone, then exposure has been considerably overestimated, and the effect of each fiber per cubic centimeter-year increment in exposure has been substantially underestimated (McDonald et al. 2004).

Treatment of missing values. Dates of termination were unknown for 58 of 640 workers (9%) who left employment before September 1953. These workers were assumed to have worked for 384 days, based on the mean duration of employment among all workers with known termination date before September 1953, U.S. Census Bureau data (2004) indicate that 95% of the local population identify themselves as white. Because workers at this facility were known to be primarily Caucasian, 935 workers with race unknown were assumed to be white (NIOSH 2001). Similarly, because 96% of the workforce was male, seven workers with sex unknown were assumed to be male after review of names.

Statistical analysis. Data were managed using ACCESS 2000 (Microsoft Corporation, Redmond, WA) and SAS, Version 8.0 (SAS Institute, Cary, NC). Descriptive analyses were performed using SAS, Version 9.1 (SAS Institute).

Because 95% of study subjects were white men, the analytic cohort was limited to 1,672 white males [excluding 95 men who died or were lost to follow-up before 1960, the first-year for which comparison rates for asbestosis are available in the NIOSH Life Table Analysis System (LTAS) (NIOSH 2001)]. Using LTAS software (NIOSH 2001; Steenland et al. 1990, 1998), SMRs were calculated to determine if study subjects experienced greater mortality from specific causes than was expected based on the U.S. population experience. SMRs were adjusted for age at risk and calendar year of follow-up (categorized into 5-year age and calendar time groups). SRRs evaluated exposure response across increasing categories of cumulative exposure and duration of employment, with workers in the lowest exposure group serving as the baseline for comparison. A formal test for a linear trend in the slope of the SRRs evaluated the hypothesis that β1 = 0 against the alternative hypothesis that duration or cumulative exposure predicts mortality. The 95%
The analysis presented here focuses on occupational respiratory conditions potentially related to asbestos exposure: lung cancer, asbestosis, and other nonmalignant respiratory disease. Mesothelioma was not coded as a distinct cause of death under ICD coding rubrics until 1999, so the SMR for mesothelioma is based on only 3 years of data (1999–2001).

**Results**

Demographic and exposure characteristics of study subjects by selected causes of death are presented in Table 1. Among the 752 white men with known cause of death, 13.2% died from lung cancer, 2.0% from mesothelioma, and 5.3% with asbestosis. The average age at hire among study subjects was 29.7 years (range, 15.4–69.8 years). The mean duration of employment for all 1,672 study subjects was 4.0 years and ranged from 1 day to 43.1 years. In contrast, the mean duration of employment was 7.1 years among workers who died with cancer of the lung or bronchus, 10.8 years among those with mesothelioma, and 14.6 years among those with a diagnosis of asbestosis listed on their death certificates. Similarly, median cumulative exposure was estimated at 8.7 fibers/cc-years among all workers and 21.0 fibers/cc-years among those dying through 2001, but 28.2, 145.1, and 228.4 fibers/cc-years among those dying with lung cancer, mesothelioma, or asbestosis, respectively. On average, 34.8 years passed between hire and the study end date (or death); the maximum time since hire was 66.8 years.

Previous studies of this cohort included only workers employed for ≥ 1 year. Comparison of demographic characteristics between those who worked < 1 year and those who worked longer (not shown in Table 1) suggests that, initially, there was little difference between these groups, except with respect to age at hire. Perhaps because a number of students worked summers at Libby, those who left employment after < 1 year were younger at hire than those who worked longer (28.9 vs. 30.4 years; 2-sided p = 0.0016). There were, however, substantial differences between short-term and long-term workers with respect to occupational exposure. Short-term workers were employed for an average of 3 months, compared with 7.7 years among those who worked ≥ 1 year, and experienced lower cumulative exposure (median, 2.6 vs. 43.4 fibers/cc-years).

Allowing for a 15-year exposure lag, asbestos-exposed Libby vermiculite workers were 24% more likely to have died by the end of 2001 compared with white men of the same 5-year age group in the U.S. population (SMR = 1.2; 95% CI, 1.1–1.3), and were 37% more likely to have died from cancer (SMR = 1.4; 95% CI, 1.2–1.6). Libby workers also experienced significant excess mortality from cancer of the trachea, bronchus, and lung (SMR = 1.7; 95% CI, 1.4–2.1) and nonmalignant respiratory disease (SMR = 2.4; 95% CI, 2.0–2.9) after allowing for a 15-year exposure lag (Table 2).

Of the 15 mesothelioma deaths (1979–2001) identified by reviewing death certificates (Table 1), 1 worker died from peritoneal mesothelioma, and 14 died from pleural (or unspecified) mesothelioma. The SMR for mesothelioma (Table 2), based on the 2 deaths that occurred in 1999–2001, was 15.1 (95% CI, 1.8–54.4). Excess mortality was also observed for several conditions to which ICD coding rubrics assigned mesothelioma deaths before 1999. For example, there was a significant excess in mortality from cancer of the pleura (SMR = 23.3; 95% CI, 6.3–59.5) and in the LTAS minor category described as “malignancy of other and unspecified sites” (SMR = 2.4; 95% CI, 1.6–3.6). Similarly, there were 4 deaths from connective tissue cancer between 1940 and 2001, resulting in a statistically significant SMR of 4.7 (95% CI, 1.3–12.0; no lag). Lagged estimators for connective tissue cancer are not presented because small numbers likely result in unstable estimators.

Libby workers experienced significant excess mortality from asbestosis and other nonmalignant respiratory diseases (Table 2). After allowing for a 15-year exposure lag, the asbestosis SMR was 165.8 (95% CI, 103.9–251.1). Mortality ratios were elevated for chronic obstructive pulmonary disease (SMR = 2.2; 95% CI, 1.7–2.9) and the LTAS minor category described as “other respiratory diseases” (SMR = 2.7; 95% CI, 1.6–4.2).

Although this report is focused on occupational respiratory disease, an a priori goal of this study was to evaluate the cohort’s mortality.
from other potentially asbestos-related conditions, such as circulatory disease and digestive cancer. Libby workers experienced no overall excess in heart disease (SMR = 0.9; 95% CI, 0.8–1.1), but they did experience excess mortality from circulatory diseases involving the arteries, veins, and lymphatic vessels (SMR = 1.8; 95% CI, 1.2–2.6; 29 observed vs. 16 expected; ICD-9 codes 415–417, 440–459). Although not statistically significant, Libby workers employed for ≥ 1 year experienced excess mortality from cancer of the liver, gallbladder, or bile ducts (SMR = 1.6; 95% CI, 0.3–4.6; 3 observed vs. 1.89 expected; ICD-9 codes 155–156) and pancreatic cancer (SMR = 1.8; 95% CI, 0.7–3.8; 7 observed vs. 3.83 expected; ICD-9 code 157).

**Effect of cumulative exposure.** Table 3 presents the evaluation of exposure–response relationships for asbestos-related occupational respiratory disease mortality. The SMR for lung cancer rose from 1.5 (95% CI, 0.9–2.3) among workers with < 4.5 fibers/cc-years cumulative exposure to 1.9 (95% CI, 1.2–2.9) among workers exposed to at least 100 fibers/cc-years (allowing for a 15-year exposure lag).

There was significant excess mortality from nonmalignant respiratory disease even among workers with < 4.5 fibers/cc-years cumulative exposure (SMR = 1.8, 95% CI, 1.1–2.8). The SMR for nonmalignant respiratory disease rose to 4.8 (95% CI, 3.1–7.3) among workers exposed to ≥ 300 fibers/cc-years (Table 3).

Cumulative exposure was a significant predictor of nonmalignant respiratory disease mortality even among those who worked < 1 year, with the SMR rising from 1.9 (95% CI, 1.1–3.2) among those with < 3.5 fibers/cc-years exposure to 2.6 (95% CI, 1.5–4.3) among short-term workers exposed to ≥ 15 fibers/cc-years (not shown). The test for a linear trend in the SRRs was statistically significant with p < 0.001.

Although 40 white male workers died with asbestosis listed on their death certificates (Table 1), SMR analysis is based on the 22 workers with asbestosis listed as the underlying cause of death (currently, the LTAS software does not include multiple cause comparison rates for asbestosis). SMRs for asbestosis increased with increasing cumulative exposure (Table 3). The SMR rose from 37.3 (approximate 95% CI, 7.5–122.3) among workers with < 50 fibers/cc-years exposure, to 749.1 (95% CI, 373.0–1367.8) among those with ≥ 250 fibers/cc-years cumulative exposure, after allowing for a 15-year exposure lag.

Table 3 also provides SRRs for lung cancer, nonmalignant respiratory disease, and asbestosis over increasing categories of cumulative exposure. For each outcome, linear trend tests were statistically significant at the p < 0.01 level.

**Effect of exposure duration.** Those working < 1 year experienced a significant excess in lung cancer (SMR = 1.6; 95% CI, 1.1–2.1), with the SMR rising to 2.5 (95% CI, 1.4–4.3) among those working for ≥ 10 years (Table 4). The SMR for nonmalignant respiratory disease was 2.1 (95% CI, 1.6–2.8) among those who worked < 1 year, and rose to 3.6 (95% CI, 2.2–5.7) among those employed ≥ 10 years. As there was only one death attributed to asbestosis among those working < 1 year, 15 months was used as the cut point for the lowest category of exposure duration (providing a more stable estimator for comparison in the SRR analysis). Those working < 15 months were 38.2 (approximate 95% CI, 7.7–125.1) times more likely than expected to die from asbestosis; among those employed ≥ 10 years, the SMR was 628.6 (95% CI, 301.1–1185.1). The SRRs for lung cancer, nonmalignant respiratory disease, and asbestosis increased across increasing categories of exposure duration, and for each outcome, the test for a linear trend in the slope of the SRRs was statistically significant at the p < 0.05 level (Table 4).

**Discussion**

Libby vermiculite workers experienced significant excess deaths from all causes, all cancers, lung cancer, cancer of the pleura, and asbestosis. Mortality from asbestosis and lung cancer increased with increasing exposure to airborne asbestos and other amphibole fibers.
Results of the present study are consistent with findings of previous mortality studies of workers from this cohort (Amandus and Wheeler 1987; McDonald et al. 1986, 2004). Amandus and Wheeler (1987) studied the mortality experience through 1981 of 575 white men with mean exposure estimated at 200 fibers/cc-years, who were hired at Libby before 1970 and worked at least 1 year. These researchers reported (Table 5) an overall SMR of 2.2 (95% CI, 1.4–3.4) for lung cancer (ICD-8 codes 162–163), with an SMR of 6.7 observed among those with ≥ 400 fiber-years cumulative exposure (not shown). However, the study did not have sufficient power to adequately assess lung cancer risk at lower exposure levels. The overall SMR for nonmalignant respiratory disease (ICD-8 codes 460–519) was 2.4 (95% CI, 1.5–3.8), but the small number of deaths through 1981 did not support clear conclusions about the exposure–response relationship.

Under contract with the company that operated the mine and mill from 1963–1990, McDonald et al. (1986) evaluated the mortality experience through mid-1983 of 406 white men with a mean cumulative exposure of 144.6 fibers/cc-years; these men had at least 1 year of tenure and were hired before 1963. McDonald et al. (2004) later independently reevaluated the mortality experience of these workers with follow-up through 1998. Overall SMRs of 2.4 (95% CI, 1.7–3.2) for respiratory cancer (44 deaths; ICD-9 codes 160–165) and 3.1 (95% CI, 2.3–4.1) for nonmalignant respiratory disease (51 deaths; ICD-9 codes 100–108 and 460–519) were reported (Table 5). Using Poisson regression, McDonald et al. (2004) found an exposure–response relationship between cumulative fiber exposure and respiratory cancer [highest quartile of cumulative exposure relative risk (RR) = 3.2; 95% CI, 1.2–8.8], nonmalignant respiratory disease (highest quartile RR = 3.1; 95% CI, 1.2–8.4), and mesothelioma (highest quartile RR = 3.4; 95% CI, 0.4–33.2). Asbestosis mortality per se was not described.

The summary SMRs for lung cancer and nonmalignant respiratory disease reported here are somewhat lower than those reported by McDonald et al. (2004), partially because my analysis used no tenure exclusion. More importantly, previous studies of Libby workers excluded those hired after the 1960s; the present study includes workers hired through 1981—that is, workers whose employment began after exposure intensity had been significantly reduced (Amandus et al. 1987). To assist in comparison between studies, summary SMRs for the subcohort of 864 white men (hired 1935–1981) who worked at least 1 year are included in Table 5.

However, the present analysis reveals substantial disease even among workers employed < 1 year. Short-term workers were 1.6 (95% CI, 1.1–2.1) times more likely to die from lung cancer and 2.1 (95% CI, 1.6–2.8) times more likely to die from nonmalignant respiratory disease than the comparable U.S. population (Table 4). Further, even among workers employed < 1 year, increasing cumulative fiber exposure was observed to predict nonmalignant respiratory disease mortality (not shown). Thus, including the mortality experience of workers employed < 1 year provides a more realistic picture of the true effect of working at Libby.

SMRs observed here for asbestos-exposed vermiculite workers are similar to those reported in other studies of asbestos-exposed workers. Goodman et al. (1999) conducted a meta-analysis of 69 asbestos-exposed cohorts (including a subset of the Libby cohort), and found a meta-SMR for lung cancer of 1.6 (95% CI, 1.6–1.7) after allowing for 10 years cancer latency. Honda et al. (2002) evaluated mortality among tremolite-exposed talc miners and millers, reporting an SMR of 2.2 (95% CI, 1.5–3.2) for nonmalignant respiratory disease, similar to the SMR of 2.4 (95% CI, 2.0–2.9) reported here among tremolite-exposed vermiculite workers.

The literature does not provide SMRs for asbestosis mortality among other tremolite asbestos–exposed cohorts. Among Libby workers, the SMRs for asbestosis were substantially higher than expected based on the U.S. population experience. The SMRs reported here may be inflated; that is, the small number of expected deaths from asbestosis (< 0.13) may have resulted in unstable estimators (Checkoway et al. 2004). On the other hand, the extremely high tremolite asbestos exposure (Amandus et al. 1987) these workers experienced (generally without respiratory protection), or concomitant exposure to other fibrous amphiboles, may have caused more disease than usually observed with less intense fiber exposure.

Clearance of asbestos fibers (and fiber toxicity) is believed to be a function of fiber size. Phagocytosis is limited by the size of human macrophages (generally 14–21 µm) (ATSDR 2003). Using standard asbestos fiber-counting methods (i.e., optical PCM considering only fibers ≥ 5 µm in length), 36% of fibers from Vermiculite Mountain had lengths > 20 µm, and 10% were > 40 µm (Amandus et al. 1987). Fibers longer than 20 µm have been associated with asbestosis. These long fibers, longer than the human macrophage, result in incomplete phagocytosis, perhaps partially explaining the unusually high mortality from asbestosis observed among the Libby workers.

Further, using transmission electron microscopy, around 65% of airborne fibers collected at Libby were found to be < 5 µm (ATSDR 2003). Animal and in vitro studies suggest that fibers < 5 µm may also play a role in fibrosis, particularly under conditions of overload. Intense exposures in early years and some jobs (mill sweeper, railroad car cleaner) may have resulted in overload, limiting clearance even of small fibers (ATSDR 2003). Thus, the high SMRs for asbestosis observed among Libby workers may be a function of fiber length and/or biopersistence.

Table 5. Cohort characteristics and SMRs from several studies of Libby, Montana, vermiculite workers.

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>SMR with at least 1 year</th>
<th>SMR with at least 1 year</th>
<th>Present study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deaths to mid-1983</td>
<td>Deaths through 1998</td>
<td>SMR with at least 1 year</td>
</tr>
<tr>
<td></td>
<td>(SMR)</td>
<td>(SMR)</td>
<td>1981</td>
</tr>
<tr>
<td></td>
<td>(95% CI)</td>
<td>(95% CI)</td>
<td>(95% CI)</td>
</tr>
<tr>
<td>All causes</td>
<td>1.2&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.1 (0.9–1.3)</td>
<td>1.2 (1.1–1.3)</td>
</tr>
<tr>
<td>All cancer</td>
<td>1.2</td>
<td>1.3 (0.9–1.8)</td>
<td>1.4 (1.2–1.6)</td>
</tr>
<tr>
<td>Respiratory cancer</td>
<td>2.5</td>
<td>2.4 (1.7–3.2)</td>
<td>2.0 (1.5–2.5)</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>2.2</td>
<td>2.1 (1.4–3.4)</td>
<td>1.9 (1.4–2.5)</td>
</tr>
<tr>
<td>NMRD</td>
<td>2.6</td>
<td>2.4 (1.5–3.8)</td>
<td>2.6 (2.0–3.4)</td>
</tr>
<tr>
<td>Asbestosis</td>
<td>2.6</td>
<td>2.5 (1.3–5.1)</td>
<td>2.5 (1.2–5.0)</td>
</tr>
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</table>

SMR, standardized mortality ratio; CI, confidence interval.

<sup>a</sup>Study of 406 white men who were hired before 1963 (mean duration of employment = 8.7 years; mean cumulative exposure estimate = 144.6 fibers/cc-years; total person-years not provided in the publications).

<sup>b</sup>Study of 575 white men who were hired before 1970 (mean duration of employment = 8.3 years; mean cumulative exposure estimate = 200 fibers/cc-years; 13,502 person-years of follow-up.

<sup>c</sup>Excluded those hired after the 1960s; the present study includes workers hired through 1981—that is, workers whose employment began after exposure intensity had been significantly reduced (Amandus et al. 1987). To assist in comparison between studies, summary SMRs for the subcohort of 864 white men (hired 1935–1981) who worked at least 1 year are included in Table 5.

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The long-term biopersistence of the Libby fibers is supported by the work of Lockey and colleagues (Lockey et al. 1984; Rohs et al. 2005). In 1980, 4.4% of a cohort of 513 Ohio manufacturing workers exposed to expanded vermiculite and/or concentrate from Libby was found to have pleural changes documented on chest radiograph (Lockey et al. 1984). Rohs et al. (2005) reevaluated 236 of these workers > 20 years after the plant stopped using the asbestos-contaminated Libby vermiculite, and documented that 26% had pleural changes on chest radiograph. Further, an exposure–response effect was observed, with the proportion of workers with pleural changes rising from 5% among those in the lowest exposure group to 44% among workers with the heaviest exposure.

There has been no published human or animal (and very little in vitro) research on the potential health effects of winchite and richterite (Cleveland 1984; Collan et al. 1986; Holopainen et al. 1986), two unregulated amphibole minerals in the same mineralogic series as tremolite. However, another unregulated amphibole with similar elemental composition and structure has been linked with asbestos-related mortality—mesothelioma in a community exposed to fluorodiezenite (Comba et al. 2003). Although speculative, it is possible that Libby workers experienced effects from two or more of the amphibole minerals at Vermiculite Mountain (tremolite, winchite, richterite), or from an amphibole and quartz or mica, and that these joint effects may have contributed to the extreme asbestos-related SMRs. Quartz is known to cause silicosis (another pneumoconiosis), although only one worker in this cohort died from silicosis. Vermiculite belongs to the mica family; mica has previously been linked with pneumoconiosis (Skulberg et al. 1985; Venter et al. 2004; Zinnman et al. 2002).

It is also possible that pneumoconiosis resulting from exposure to these other minerals may have been misclassified as asbestosis on death certificates. Local physicians were aware that Libby vermiculite workers were exposed to asbestos, and this exposure was sometimes mentioned on death certificates. Alternatively, these elevated SMRs may reflect the joint effect of lifelong ambient exposure to asbestos fibers from living in the nearby town combined with high intensity fiber exposure at work. In any case, a clear relationship between increasing cumulative fiber exposure and increasing asbestosis mortality was observed.

Limitations. Retrospective exposure estimates were developed using a combination of government inspection reports, company compliance-monitoring data (available from 1974), and professional judgment (Amandus et al. 1987; McDonald et al. 1986). These methods likely resulted in some measurement error. Assuming that any misclassification of exposure was not systematic, the most likely effect is bias toward the null (Checkoway et al. 2004; Mannetje et al. 2002). Further, there is insufficient sampling data to develop reliable exposure estimates for potential confounders for lung cancer such as workplace exposure to diesel particulate generated by mine machinery, or exposure to respirable crystalline silica dust.

Work history data were missing for 9% of workers who terminated before 1954. These workers were assumed to have worked about 1 year, based on the average employment duration among other workers who terminated between 1935 and 1953. Without the missing data, it is not possible to determine with certainty the impact of this approach, although the most likely effect is bias toward the null. Analysis deleting the 55 workers with missing termination dates did not result in appreciably different effect estimates than are reported here.

No minimum employment duration restriction was imposed in the present analysis. Thus, overall effect estimates are somewhat lower than those reported in previous studies of this cohort (Table 5). Elevated SMRs were observed for the occupational respiratory diseases of interest and among those employed < 1 year. The assumption that biologically significant exposures occurred immediately at hire is realistic in this workplace (particularly in early years), where new hires were frequently assigned to the labor pool and often rotated through the most heavily exposed jobs. Evaluation of job-assignment patterns suggests that some job tasks (i.e., “bin mucker”) were systematically assigned to transitory workers. Alternatively, these jobs may have been so onerous that newly hired workers quit after only a day or two.

Strengths. Strengths of this study include the long period of vital status follow-up—> 65 years from 1935–2001. A minimum of 20 years since first exposure to the end of follow-up allowed sufficient latency for most cancers. Previously published analyses of data from this occupational cohort reported SMRs for nonmalignant respiratory disease (Amandus and Wheeler 1987; McDonald et al. 1986, 2004). In the analysis reported here I made use of comparison rates for asbestosis that have become widely available within the last 10 years. The resulting effect estimates for asbestosis provide a more accurate description of the magnitude of asbestos-related disease among this cohort of workers.

Conclusions

Significant elevations in SMRs for asbestosis, lung cancer, and cancer of the pleura were observed among Libby vermiculite workers. Exposure–response relationships were noted for asbestosis and lung cancer. Significant excess mortality from nonmalignant respiratory disease was observed even among workers with cumulative exposure < 4.5 fibers/cc-years [i.e., a worker’s cumulative lifetime exposure, if exposed to asbestos fibers at the current OSHA standard of 0.1 fibers/cc (National work- ing life (U.S. Department of Labor 2006)]. Since vermiculite from the Libby mine was used to make loose-fill attic insulation that remains in millions of homes, these findings highlight the need for better understanding and control of exposures that currently occur when homeowners or construction renovation workers (including plumbers, cable installers, electricians, telephone repair personnel, and insulators) disturb loose-fill attic insulation made with asbestos-contaminated vermiculite from Libby, Montana.

REFERENCES

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