UNITED STATES DEPARTMENT OF LABOR

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ADVISORY BOARD ON TOXIC SUBSTANCES AND WORKER HEALTH

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WORKING GROUP ON PRESUMPTIONS

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SUMMARY MINUTES

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WEDNESDAY,
JUNE 21, 2017

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The Advisory Board met telephonically at 1:00 p.m. Eastern Time, Steven Markowitz, Chair, presiding.

MEMBERS

SCIENTIFIC COMMUNITY:

KENNETH Z. SILVER
LESLIE I. BODEN

MEDICAL COMMUNITY:

STEVEN MARKOWITZ, Chair
VICTORIA A. CASSANO

CLAIMANT COMMUNITY:

KIRK D. DOMINA
GARRY M. WHITLEY
FAYE VLIEGER

BOARD MEMBERS ALSO PRESENT:

KIRK DOMINA

DESIGNATED FEDERAL OFFICIAL:

CARRIE RHOADS

Call to order and roll call

Carrie Rhoads, the DFO for the work group, called the meeting to order at 1:05 p.m. The board members in attendance introduced themselves.

Use of presumptions for asbestos-related diseases

Chair Markowitz presented a slideshow summarizing what the board has already done regarding presumptions and proposed a path forward. So far the board has focused on exposure presumptions rather than helping DOL make determinations about how to recognize a diagnosis of disease. At the last meeting someone suggested that the board look at the medical side and see if there are some suggestions that the board can make to DOL about asbestos-related diseases.

EEOICP recognizes non-malignant asbestos-related diseases, like asbestosis, pleural plaques, pleural thickening, and benign asbestos-related pleural effusion. EEOICP also recognizes malignant asbestos-related diseases, such as malignant mesothelioma, lung cancer, cancer of the ovary, and cancer of the larynx.

For a claim of asbestosis, the claims examiner (CE) is asked to look at several sources of evidence: 1) Opinion of qualified MD based on CXR, CT, MRI, PFT, or lung biopsy, 2) DOE FWP physician findings, 3) Death certificates.

Opinion of qualified MD:

CXR - pulmonary interstitial fibrosis + heart enlargement

CT/MRI - lung scarring, pleural thickening, heart enlargement

PFT - restriction; requires MD interpretation

Lung biopsy - “sputum cytology or bronchial lavage often show asbestos bodies” but “not definitive”

DOE FWP

Physician assessment of asbestosis or asbestos-related lung disease

Death certificate (DC)

Cites “asbestosis” as cause or contributing factor. If DC cites diagnosis other than “asbestosis,” need evidence to support the diagnosis of asbestosis.

The question of how much discretion the claims examiners have is one that the DOL will need to struggle with. Perhaps there needs to be guidance for pulmonologists who are treating people. The board will need to get clarification from DOL on how the CEs use diagnoses.

The procedure manual requires that the CE find confirmation of the diagnosis of mesothelioma of the pleura. With regard to pleural plaques (PP) and pleural effusions (PE), the supportive medical evidence includes the following: 1) MD diagnosis, 2) CXR, CT, or other imaging evidence of PP or pleural thickening (PT) not due to surgery or trauma, 3) Rounded atelectasis, and 4) Bilateral pleural effusions.

The CE is to consult with a treating MD or contract medical consultant (CMC) if 1) Evidence is inconclusive, 2) PT is in an area of surgery or trauma, and 3) Evidence for other causes of PE is present.

The Former Worker Medical Screening Program surveillance case definitions for asbestosis are 1) A reported history of exposure to asbestos or job title with a reasonable likelihood of asbestos exposure, or 2) A B-reading of standard PA chest film demonstrating bilateral irregular parenchymal opacities (shape and size: s,t,u) with profusion score of 1/0 or greater. Member Boden suggested that these criteria are rather restrictive.

For asbestos-related pleural disease, the case definitions are 1) A reported history of exposure to asbestos or job title with a reasonable likelihood of asbestos exposure, and 2) A B-reader notation of findings of unilateral or bilateral pleural thickening consistent with pneumoconiosis.

Proposed diagnostic criteria for asbestosis

1) History of asbestos-related exposure and radiography (CXR or CT): bilateral diffuse interstitial fibrosis affecting any combination of mid- and lower lung zones. If ILO scoring is used, scores of greater than or equal to 1/0 s, t, or u opacities are required. 2) DOE FWP physician finding (see above for details). 3) History of asbestos exposure and pathology (“pathology” being histologic evidence of diffuse interstitial fibrosis of the lung).

Also, as an alternative to a history of asbestos exposure, asbestos exposure can be documented if lung tissue burden finds concentrations of asbestos fibers or asbestos bodies compatible with asbestosis by the examining laboratory.

Proposed diagnostic criteria for asbestos-related pleural disease

1) History of asbestos exposure or 2) Radiography (CXR or CT) showing a unilateral or bilateral pleural thickening or plaques that is not readily explained by another cause.

Member Boden said that the board should consider what precisely "history of exposure" means. Member Whitley said that the CE is going to go to the SEM database to get their information. Following a comment by Member Cassano, Chair Markowitz said that if a person isn't in an expected or typical job title but has pleural plaques and interstitial fibrosis, then he would lean toward that person having asbestosis.
Member Silver and Chair Markowitz suggested that the rationales be accessible to the treating physicians and CMCs.

Proposed diagnostic criteria for asbestos-related pleural effusion

This is a rare condition. 1) History of asbestos exposure or 2) Diagnosis of unilateral or bilateral pleural effusions that are not readily explained by another cause.

Proposed diagnostic criteria for mesothelioma (pleural), cancer of the lung, ovary, and larynx

1) Documented by pathology, 2) Clinical and radiological presentation that favors malignant mesothelioma of pleura or cancer of lung, ovary, and larynx, or 3) Death certificate: cause, underlying, or primary or contributing factor.

The claims process does not take into consideration smoking, and treating physicians need to be made aware in the rationale that smoking does not contribute to mesothelioma, but it does to lung cancer, and it amplifies risk due to asbestos exposure.

Member Vlieger said that no doctor is going to make any asbestos-related diagnosis on a death certificate without an autopsy. Developing consensus guidelines will provide a basis for the making of more uniform decisions. Member Cassano will be drafting some helpful language on the topic of the death certificate and sending it back to the work group.

Additional candidate issues for EEOICP presumptions

Some potential issues include Parkinsonism, neurologic diseases, and kidney diseases. Organic solvents are also on the radar. Member Vlieger said that she would send a list of the most-denied conditions by DOL to the board compiled by DIAB. Two of the things that were more routinely denied were peripheral neuropathy and chronic encephalopathy. The claims process does not recognize certain aspects of these diseases. The board will need to figure out what the

particular issues are with these diseases before trying to elaborate presumptions.

Member Whitley said DOL won't pay neuropathy claims if there is any sign of diabetes in the family and that the DOL won't "touch" pancreatic cancer.

Member Silver said that there is evidence of synergistic effects of chemicals in kidney disease.

Member Boden said that sometimes certain conditions are denied for good reasons. Chair Markowitz suggested asking DOL for a list of frequently denied conditions.

Adjournment

Chair Markowitz closed the meeting at 3:00 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are on accurate summary of the meeting.

Submitted by:

Steven Markowitz, MD, DrPh.
Chair, Working Group on Presumptions
Advisory Board on Toxic Substances and Worker Health
Date: 9/21/2017