



# HealthWatch

A newsletter of the Worker Health Protection Program, a partnership between Queens College, CUNY and the following unions: United Steelworkers, Atomic Trades and Labor Council, Fernald Atomic Trades and Labor Council

Volume 5, Issue 9 Spring 2006

## Senate and House Leaders Support Continuation and Expansion of DOE Medical Screening

Ohio's congressional representatives, with support from House and Senate appropriations committees, were busy in 2005 securing over \$2 million in funds for the former worker medical screening programs in Ohio at the Portsmouth Gaseous Diffusion Plant, the Mound Closure Project and the Fernald Environmental Management Project. The Fiscal Year 2006 Energy & Water Appropriations Act (P.L. 109-103), which was signed on November 19, 2005, expands the DOE medical screening program to Fernald workers (hired after 12/31/1985) and Mound workers, and continues medical screening and local union outreach efforts at the three gaseous diffusion plants. Toward this end, the following funds have been appropriated:

- \$1.0 million for former Fernald workers;
- \$1.0 million for former Mound workers; and
- \$465,000 for Portsmouth, Paducah and K-25 workers

"Senators Mike DeWine and George Voinovich and Representative Ted Strickland made sure that the House and Senate appropriations committees inserted these projects into the legislation," noted Dan Minter, President of USW Local 5-689 in Piketon, OH.

"We are very pleased with the support from Congress and



Rep. Strickland-OH



Sen. Voinovich-OH



Sen. DeWine-OH

the DOE's Office of Environment, Safety and Health in ensuring these programs were launched as quickly as possible," added Eric Parker, President of USW Local 7-4200 at the Mound facility in Miamisburg, OH.

"The Ohio Congressional delegation stepped up to the plate to help Ohio atomic workers in 2005, and we are grateful for their support," added Ray Beatty, Financial Secretary for the Fernald Atomic Trades and Labor Council.

The Senate Appropriations Committee, working with the Tennessee delegation, supported an expansion of the Oak  
*(continued on page 4)*

## Is NIOSH's Dose Reconstruction Program Living Up to Expectations?

The National Institute for Occupational Safety and Health (NIOSH) reconstructs radiation doses under the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA). Dose reconstruction is an essential part of the claims process, as it is key for determining whether a worker's cancer is related to his or her occupational exposure to ionizing radiation. The EEOICPA prohibited the Department of Energy (DOE) from performing dose reconstructions out of concerns about conflicts of interest. Instead, NIOSH, a part of the Department of Health and Human Services, was charged with doing dose reconstructions because it had independence and credibility. Since NIOSH lacked the federal staff to carry out the job, they hired contractors -- many of whom had previously managed health physics programs at DOE sites -- to estimate radiation exposures to decide claims. NIOSH was aware of the potential for conflicts of interest, and required contractors to reveal conflicts of interest and past litigation history on the internet at [www.oraucoc.org](http://www.oraucoc.org). Despite these steps, however, conflicts

of interest have persisted.

Congress also set up a system of checks and balances through a presidentially-appointed Advisory Board on Radiation and Worker Health (ABRWH), which is tasked to audit the quality of radiation dose reconstructions and to recommend whether to add classes of workers to the Special Exposure Cohort (SEC). The Advisory Board, which must have a balance of scientific, medical and worker perspectives, hired a techni-  
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Rep. Hostettler-IN, led efforts to protect EEOICPA benefits at recent House Judiciary Committee oversight hearings.



## Message from Dr. Markowitz, WHPP Project Director

### When is a disease occupational? The new DOE compensation program

Sometimes it is perfectly clear when an illness is caused by a workplace exposure. Sudden and catastrophic inhalation of chlorine or ammonia may cause throat swelling, fluid in the lungs, or new onset asthma in a previously healthy person. Even long-term diseases such as asbestosis or mesothelioma (cancer of lining of lung or abdomen) are almost always caused by workplace exposure to asbestos. Insurance companies may fight such claims, but they are more often fighting about who is responsible for the exposure rather than whether the exposure caused the illness.

More often, common diseases present more difficult problems because many factors act at the same time to cause disease. When a person with high blood pressure, diabetes, and a cigarette habit has a heart attack, there are three unquestionable causes of the heart attack. It would be incorrect to deny any of those risk factors as causing that person's heart attack. Likewise, when a worker with a long history of exposure to both workplace dusts and cigarette smoke develops chronic bronchitis, there are two causes for that person's

chronic productive cough: one occupational and one lifestyle factor.

Suppose a worker has asthma since childhood and then it gets worse when exposed to toluene diisocyanate or other agents known to cause asthma. This scenario too represents an occupational disease, even though the occupational factor was not the original cause of the asthma. The worker is hired "as is," and exposures in the workplace should not worsen the worker's health.

Fortunately, the new amendment (Subtitle E, Section 3621) of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) uses these same premises to compensate DOE workers for occupational diseases. If it is "at least as likely as not that exposure to a toxic substance was a significant factor in aggravating, contributing to, or causing the illnesses" and that exposure occurred while at a DOE facility, then the illness deserves compensation under the newly amended act. Let's make sure the Federal Government holds true to this equitable standard.

### Gaseous Diffusion Plant/INL Medical Screening Programs Extended for Two Years; National Supplemental Program Brings Screening to Workers Not Previously Served

The Gaseous Diffusion Plant (GDP) Medical Screening Program is shifting gears beginning this June. Basic medical screening will continue to be available, local WHPP offices will remain open and program participants will still be able to get help with their occupational histories and assistance with EEOICPA claims. However, early lung cancer screening is presently slated to ramp down by June 2006. The INL medical screening program will continue without change.

If the demand for the physical exams continue, and if funding is available, the GDP and INL medical screening programs will continue through 2008.

Outreach, such as newspaper ads and brochure mailings, will continue. However, everyone who reads this newsletter can help! If you know anyone who worked (or currently works) at K-25 or the Paducah or Portsmouth GDP's, who has not yet had the physical, tell him or her to call the toll-free number **today** – 1-888-241-1199.

#### National Supplemental Screening Program

The National Supplemental Screening Program (NSSP), run

by Oak Ridge Associated Universities (ORAU) and funded by the DOE's Former Worker Program, has started offering free physical examinations to eligible workers not previously served by the DOE medical screening program. For example, former workers who do not have a DOE screening program associated with their site are eligible (if it has been at least five years since they last worked at the site). Sites without a DOE former worker screening program include:

- Argonne National Lab
- Fermi Lab
- Kansas City Plant Production workers
- Pinellas Plant production workers
- Princeton Plasma Physics Lab.

The NSSP also offers medical screening to former workers who live far from the Former Worker Program clinics associated with their site, and for those former workers who prefer to see their personal physician. For more information on the ORAU program, go to [www.ORAU.gov/NSSP](http://www.ORAU.gov/NSSP) to enroll or call toll-free to ORAU at 1-866-812-6703.

# Landmark Health & Safety Rules to Protect DOE Workers

The Department of Energy (DOE) issued a worker health and safety rule in February, 2006 which, for the first time in 65 years, will make contractor violations of industrial and construction safety standards subject to fines of up to \$70,000 per day per violation.

Under a provision inserted in the FY 2003 Defense Authorization Act by Senators Jim Bunning (R-KY) and Ted Kennedy (D-MA), DOE was required to issue safety rules for DOE workers which mirrored the OSHA general and construction industry standards and to make contractors who violated the rules subject to fines and enforcement. DOE's Order 440.1A contained many of OSHA's health & safety requirements but was not enforceable.

After issuing two previous proposed rules in 2003 and 2005 that failed to protect worker safety and contained a myriad of exemptions, DOE, under the leadership of former Assistant Secretary John S. Shaw, developed a health and safety regulation that is protective of worker safety.

"While it has taken far too long to get it right, I am pleased that DOE has finally come up with a rule that follows the intent of Congress," said Senator Bunning. "This took two mistakes, and they finally got it right the third time. I will be keeping a close eye on things as the rule goes into effect."

While DOE nuclear workers have been protected under the Price-Anderson Act since 1996, these enforceable rules were limited to nuclear safety. The current legislation will broaden the enforceable regulations to include all general construction and industry standards.



Rep. Whitfield-KY

"The third time's the charm in this case," said Congressman Ted Strickland (D-OH) who, along with Congressman Ed Whitfield (R-KY), successfully worked with the Senators to enact this legislation. "Now we need to make sure there are resources for enforcement."

Since DOE nuclear facilities are generally exempt from NRC or OSHA oversight,

DOE will enforce the rule through its Office of Enforcement within the Office of Environment, Safety and Health—the same DOE Office that currently enforces DOE's Price Anderson nuclear safety rules.

Important rights were included in the new DOE rule: workers will have the right to stop or refuse unsafe work and have the right to accompany enforcement inspectors when they

*Under the new DOE health and safety rule, workers will have the right to stop or refuse unsafe work and have the right to accompany enforcement inspectors when they tour nuclear facilities.*



Sen. Bunning-KY



Sen. Kennedy-MA

tour nuclear facilities. In some areas, the rule provides protections greater than OSHA. For example, DOE's beryllium standard (10 CFR Part 850) is ten-fold more protective than OSHA's standard, and will be enforceable for the first time under this new rule. Contractors will have one year to bring their facilities into compliance. Beginning February 7, 2007, DOE can begin bringing enforcement actions.

Senator Edward M. Kennedy praised the Department of Energy for making much-needed changes to a safety rule. Senator Kennedy said: "This rule will provide long-awaited safety protections that will benefit over 100,000 workers across the country. I applaud the critical changes that the department has made to ensure that America's energy workers have the strong protections they need and deserve."

"Next, it is important that we take steps to ensure that all USW-represented atomic workers are trained in the provisions of the new rule" commented Jim Frederick, assistant health and safety director for the United Steelworkers Union.

## WHPP Success At-A-Glance (as of 04-30-06)

<b>GDP's and INL</b>	
No. of callers	15,516
No. of exams completed	12,785
No. of workshops completed	448
No. of participants who attended workshops	3,893

<b>ATLC</b>	
No. of callers	1,662
No. of exams completed	1,172

If you haven't taken advantage of the WHPP free medical screening exam, call to make an appointment today!

**GDP's and INL: 1-888-241-1199    ATLC: 1-866-356-2852**

Or you can call the local union offices:

<b>USW:</b>	
Oak Ridge, USW Local:	865-481-3395
Paducah, USW Local:	270-442-3668
Portsmouth, USW Local:	740-289-2405
Idaho Falls, USW Local:	208-522-4748

<b>ATLC:</b>	
Oak Ridge:	865-483-8471

# Senate and House Leaders Support Continuation and Expansion of DOE Medical Screening

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Ridge ORNL/Y-12 program to include early lung cancer screening.

The need for lung cancer screening at ORNL and Y-12 was shown by the Queens College ORNL/Y-12 needs assessment that showed increased rates of lung cancer and a study of ORNL workers that showed a link between increasing rates of radiation and lung cancer.

The Atomic Trades and Labor Council (ATLC) leadership has worked diligently to get the funding approved for early lung cancer screening for both current and former Y-12 and ORNL workers. "The early lung cancer screening programs were pioneered at the three gaseous diffusion plants (K-25, Paducah and Portsmouth), and with strong bipartisan support, workers at ORNL and Y-12 will now have access to the same life-saving lung screening," noted Kenny Cook, President of ATLC.



Sen. Alexander-TN



Sen. Frist-TN



Rep. Davis-TN



Rep. Duncan-TN



Rep. Wamp-TN

## Words from Survivors

## Thanks to the Worker Health Protection Program

"In October 2003, I was diagnosed with chronic beryllium disease. By finding this early it is much easier to treat and live a normal life."

- **Kenneth Wymer, Portsmouth GDP**



"I procrastinated taking the free physical two years ago. As a result of the physical, I was diagnosed with chronic beryllium disease. I am so thankful that WHPP was there and I'll recommend their program to anyone. It could save your life."

- **Garry Sexton, Portsmouth GDP**



"I thank WHPP for providing free medical surveillance for former and current workers. I urge you to have this testing done. Your life may depend on it. MINE DID!!!"

- **John Watson, Portsmouth GDP**



I worked at the Paducah GDP from 1978 to 1981. I was in the cell change crew. This required cutting and welding many different types of metals. A WHPP representative who said my work as a foreman made me eligible for the free physical, contacted me. I had no health problems, but agreed to have the physical because it was free and I had nothing to lose. To my surprise, the physical showed that I had chronic beryllium disease. This explained my shortness of breath that I had attributed to age. Thanks to WHPP, I was able to find and stabilize my condition with medication. I am enjoying a relatively normal life.

- **David Freeze, Paducah GDP**



I would certainly encourage everyone to take advantage of this medical screening program. My beryllium sensitivity was diagnosed and I have qualified for free Federal medical monitoring. I appreciate the opportunity to be a part of this program.

- **Edgar Graham, K25 GDP**



I am very grateful for the professional service provided to me, starting with the beryllium sensitivity testing and continuing over a period of time to include my diagnosis of chronic beryllium disease. The dedication of the WHPP program staff at Oak Ridge is unsurpassed.

- **James Hackworth, K25 GDP**



I would like to thank the Worker Health Protection Program, and all the people involved. I thought I was just getting old until the testing proved I had chronic beryllium disease. I am now able to receive free medical treatment that will help me live longer. What a great program for people like me just trying to do my job and make a living.

- **Paducah GDP worker**

# Is NIOSH's Dose Reconstruction Program Living Up to Expectations?

(continued from page 1)

cal support contractor, S. Cohen & Associates, to provide technical assistance. The Board's contractor has solicited worker input and flagged many shortcomings in the dose reconstruction process. This system of checks and balances has brought a measure of credibility to the process. Furthermore, the Advisory Board's contractor has no conflicts of interest with respect to DOE.

Data to reconstruct radiation dose are spotty, and in many cases, workers simply went unmonitored. At one site, according to an audit, workers put their dose badges between lead bricks because management laid off workers if they exceeded their quarterly dose limits. In addition, historic records must often be recovered from as far back as the 1940s.

To address these complex issues and speed claims processing, NIOSH developed "site profiles" that contain each site's radiological and process history. Site profiles provide the basic data, or starting point, for estimating an individual's radiation dose. Where individual records are missing, NIOSH also may use "models" based on dose measurements of co-workers.

Initial reviews by the Advisory Board and its audit contractor, S. Cohen and Associates, revealed major shortcomings in the site profiles. One site profile, for example, excluded important production processes, and failed to list the radionuclides to which workers were exposed. NIOSH has stated that the site profiles are "living documents" and, if found to be inaccurate, will be revised accordingly.

When the site profiles were first compiled, NIOSH had little interaction with workers, but later, in response to an Advisory Board recommendation, NIOSH started outreach to DOE workers. Meetings were held in Idaho, Hanford, Oak Ridge, Paducah, Portsmouth, Mound and Fernald between April 2004 and February 2005. Whether worker comments will be incorporated in a meaningful way remains to be seen. NIOSH also conducts telephone interviews with claimants, and allows them to review dose reconstruction reports before they are sent to DOL. However, the value of these efforts is questionable as the dose reconstruction reports are difficult for many claimants, as well as most experts, to understand and WHPP coordinators report that phone interviewers are not adequately familiar with the terminology and practices at DOE sites.

Even with the protections built into the compensation law, including independent

*Dose reconstruction is used for processing claims under EEOICPA to estimate an individual's radiation dose. If radiation monitoring data is unavailable, incomplete or of poor quality, NIOSH creates "co-worker" models or applies adjustment factors to estimate radiation dose. Alternatively, if it is not feasible to estimate dose with sufficient accuracy, workers can petition to be part of the Special Exposure Cohort (SEC). If approved for SEC status, it is presumed that 22 listed radiation-related cancers are related to exposures at DOE, eliminating the need to reconstruct an individual's radiation dose to decide a claim. For more information go to: <http://www.cdc.gov/niosh/ocas>*

oversight by the Advisory Board, these checks and balances are vulnerable to political interference. In January 2006, two members of the Advisory Board were removed without apparent cause, and three new members were added. As a result, the Board's balance has been upended. In addition, a recent undated OMB memo to the Labor Department outlined options to reduce the cost of compensation benefits by cutting back on NIOSH approvals of new Special Exposure Cohorts, changing the balance of the Advisory Board and imposing constraints on the Board's audit contractor. At a recent oversight hearing before the House Judiciary Subcommittee on this OMB memo, U.S. Rep. John Hostettler (R-IN) stated, "The plan to override science to meet OMB's budget priorities is inappropriate and speaks to an institutional mind set at odds with congressional intent. It does a disservice to these Cold War veterans."

The NIOSH dose reconstruction program continues to face major challenges. The Government Accounting Office (GAO) has been asked by Congress to take a hard look at conflicts of interest and a tripling of dose reconstruction administrative costs from \$70 to \$200 million dollars. Further Congressional hearings are scheduled.



## STATUS OF EEOICPA CLAIMS NEEDING DOSE RECONSTRUCTION (DR) \*

<b>Number NIOSH DR claims</b>	19,700
• Number of DR completed	12,700 (64%)
• Number awaiting DR	7,000 (36%)
<b>Number of DR completed and adjudicated to a final decision</b>	9,284
• Number of DR adjudicated and <u>denied</u>	6,806 (73%)
• Number of DR adjudicated and <u>approved</u>	2,476 (27%)
<b>Amount paid out for approved DR claims</b>	\$358 million

\*Source: [www.cdc.gov/niosh/ocas](http://www.cdc.gov/niosh/ocas), data as of 3/23/06

# Understanding Cholesterol and Heart Disease Risk

Heart disease, mainly coronary artery disease (CAD), is a leading cause of illness and death in the United States. According to the American Heart Association, CAD is responsible for about 480,000 deaths, and over one million heart attacks, each year.

## How does cholesterol contribute to heart disease?

Cholesterol is a recognized, major risk factor for developing CAD. There are many other risk factors, such as high blood pressure, cigarette smoking and uncontrolled diabetes. Age and family history can also contribute. The more risk factors you have, the more likely you are to develop CAD. Focusing on controllable risk factors, such as cholesterol, can help to prevent heart disease.

## What is cholesterol?

Cholesterol is one of several types of lipids (or fats) that are found in the bloodstream and in all of your body's cells. The body needs cholesterol for digesting dietary fats, making hormones, building cell walls, and other important processes. However, a high level of cholesterol in the blood can cause plaque (an accumulation of cholesterol and other substances in the blood vessel wall) to build up in the coronary arteries, a condition called atherosclerosis. When plaque obstructs proper blood flow to the heart, the heart muscle is impaired, and becomes deprived of oxygen, causing chest pain (angina). When one or more of the coronary arteries become significantly blocked, the result can be a heart attack (injury to the heart muscle).

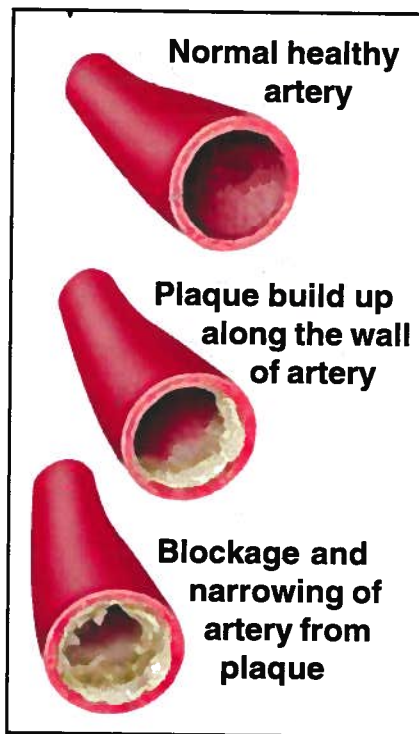
The cholesterol in a person's blood comes from two sources: from cholesterol produced naturally in the body by the liver and from cholesterol/fats in the food you eat. Dietary cholesterol comes mainly from meat, poultry, fish, and dairy products.

## What is "good" or "bad" cholesterol?

Dietary fats are digested in the small intestine and are carried from the small intestine into the blood stream by specific types of proteins. This lipid and protein complex is called a **lipoprotein**. Two of these lipoproteins — low-density lipoprotein (LDL) and high-density lipoprotein (HDL) — carry cholesterol. Once in the bloodstream, LDL transports cholesterol from the liver while HDL transports cholesterol to the liver. This is why HDL is sometimes referred to as "good" cholesterol — it can transport cholesterol from tissues, such as heart arteries, back to the liver for storage. LDL is sometimes referred to as "bad" cholesterol because it can transport cholesterol from the liver and deposit it in heart arteries.

## What are triglycerides?

Another type of lipid, called a **triglyceride**, is also carried from the small intestines into the bloodstream by lipoproteins.



Source: [www.cholesterolfocus.com](http://www.cholesterolfocus.com)

Triglycerides are made in the body from digested fats and carbohydrates eaten in foods. Recent studies have shown that elevated triglycerides are a possible independent risk factor (that is, a risk for heart disease exists even if you don't have any other risk factors).

## How do I know if my cholesterol or triglyceride level puts me at increased risk for heart disease?

The National Cholesterol Education Program (NCEP), established by the U.S. Department Health and Human Services, provides guidelines for cholesterol testing and management. The NCEP has recommended that all adults age 20 or older have a "lipid profile" (a blood test to measure the level of fats in the blood) once every 5 years. The blood sample should be drawn after an overnight fast and should include total cholesterol, LDL, HDL and triglycerides.

The NCEP has ranked the blood levels of these lipids in relationship with the risk of developing heart disease.

**See box below for the updated guidelines that should be used when interpreting your test results.**

*(continued on page 8)*

ATP III Classification of Total, LDL, and HDL Cholesterol (mg/dL) and Triglycerides	
<b>Total Cholesterol</b>	
<200	Desirable
200-239	Borderline
≥240	High
<b>LDL Cholesterol</b>	
<100	Optimal
100-129	Near optimal/above optimal
130-159	Borderline high
160-189	High
≥190	Very high
<b>HDL Cholesterol</b>	
<40	Low
≥60	High (this is desirable)
<b>Triglycerides</b>	
<150	Normal
150-199	Borderline high
200-499	High
≥500	Very high

## Paducah GDP WHPP Coordinator: James Harbison

My name is James Harbison and I retired in 1999, after 31 years as a maintenance worker at the Paducah Gaseous Diffusion Plant. Upon retirement, I was offered the opportunity to work for the Worker Health Protection Program. I have always enjoyed helping others so I was delighted to accept the position. And now I have been privileged to work for the program for the last seven years.

I started my work as a member of the Paducah Worker Health Protection Program Ground Team by calling retirees and setting up their physicals and CT scans. This was a pleasure because I was able to see and talk to many of the men that had mentored me during my early years at the plant. With the help of these older workers, the program began to have a better understanding of where the chemicals and other hazards were located. In addition to such radiation hazards as uranium, technetium-99 and neptunium-237, chemical exposures included PCB's, mercury, nickel, chromic acid, HF and asbestos. I've helped participants who have trouble remembering, or did not know what hazards existed in the various buildings and departments, to fill out the occupational history questionnaires, so that the program doctors can better evaluate their health conditions.

It has been rewarding to help my fellow workers get treatment through their personal physicians when they have suffered physical problems from exposures at the plant and to help them receive the monetary compensation they are entitled to, through the Energy Employees Occupational Illness Compensation Program.

My main concern now is to reach workers who have not been contacted and do not know about the free medical screening. We are trying to do this through mailings, advertisements in the newspaper, at public events, on television and with our continued word of mouth.

I would like thank all who have been responsible for starting and continuing this program, including DOE Secretary Bodman, Acting Assistant Secretary Russell Shearer, former Assistant Secretary Shaw and our Congressional delegation (Senators McConnell and Bunning and Congressman Whitfield). **It has touched my life and many others in a most positive way.**



James Harbison

## GDP Early Lung Cancer Screening Program Winds Down Summer 2006; Starts Up at X-10 & Y-12

As the WHPP Early Lung Cancer Detection Program for gaseous diffusion plant workers nears its end, we would like to note the tremendous accomplishments of the last five and a half years. Since October 2000, over 6,200 participants received a screening CT on the mobile unit. In addition, over 10,000 nodule follow-up and repeat screening CT scans have been completed, bringing the total scans to over 16,000! At the time of press, the mobile unit had traveled 47,500 miles between the three GDP union halls and made over 130 trips.

All of this hard work has allowed us to reach the goal that we set out to achieve five years ago – to detect early lung cancer in the GDP workers at highest risk for this deadly disease. To date, the Program has detected 44 cancers, the majority of which were in the early stages (80%). The number of cancers is likely to increase, as we continue to follow the health status of those currently undergoing work-up or being observed by their personal physicians. Each year over 160,000 people in the U.S. die of lung cancer, largely because the cancers were detected too late for intervention to change the outcome of the disease. The long-term survival of patients with symptomatic lung cancer is extremely low and has not improved much in the past 30 years. The WHPP Early Lung Cancer Detection Program is pleased to be part of the effort to change this unfortunate reality, through early detection with low-dose screening **before** symptoms appear.

Though all involved are sad to see the program winding down, at the same time, we are thankful to have been able to offer such a large number of GDP workers the opportunity to get screened. We are proud to be part of one of the largest national lung screening programs in the United States and the only one specifically designed to address occupational risk factors.

As a reminder, screening needs to be done on an ongoing basis. Anyone at high risk for lung cancer, even those who have already been through the program, needs to talk with their personal physician and discuss monitoring their lungs for lung cancer.

In the summer of 2006, we will be offering the lung cancer screening to a new population – current and former workers at the X-10 and Y-12 DOE facilities in Oak Ridge. The lung cancer program CT scanner will be set up outside the ATLC union hall. Further details will be provided in future HealthWatch issues. Any questions about the ATLC lung cancer screening program, please call Linda Parker at 865-483-8471.



Special thanks to our CT technicians, Lori Brannon and Christy Robertson, our mobile unit drivers Mike Church and Gerold Wilkin, the three GDP Ground Teams, and the Queens College ELCD staff for their contributions to the success of the WHPP Early Lung Cancer Detection Program.

# Understanding Cholesterol and Heart Disease Risk

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It is important to note that even if the total cholesterol is less than 200 (desirable), the results should always be interpreted with the other lipid levels, especially the LDL-cholesterol. In other words, your total cholesterol can be within acceptable limits but, if one of the other lipid levels in the chart is not, you are still at increased risk of heart disease. In fact, much research has demonstrated that elevated LDL cholesterol alone is a major cause of heart disease.

## What can be done to reduce my cholesterol and triglyceride levels?

If your doctor has determined that you have high cholesterol or triglycerides, **you should be advised to improve your diet and increase physical activity as the first step toward lowering your risk of heart disease.**

Dietary modification should include reducing or eliminating foods high in cholesterol and meat products high in fat (such as bacon, sausage and hamburger), removing the skin from poultry and using leaner cuts of meat.

An exercise program does not have to involve painstaking routines. Even moderate aerobic activity, such as walking at a comfortable pace three or four times a week, can help bring blood lipid levels to a desirable level.

By making changes in your lifestyle, you *can* reduce your risk of heart disease. Many resources are available to get information about preventing heart disease. For example, the American Heart Association, can be reached toll-free at 1-800-242-8721 or at their website ([www.americanheart.org](http://www.americanheart.org)). Additional information about the updated NCEP guidelines can be obtained at the website of the National Heart, Lung and Blood Institute ([www.nhlbi.nih.gov](http://www.nhlbi.nih.gov)).

# Proposed Reduction of Recommended Occupational Exposure Level for Beryllium

In January of 2006, the American Conference of Governmental Industrial Hygienists (ACGIH) published a new proposed Threshold Limit Value (TLV) for occupational exposure to beryllium. A TLV is defined as the eight-hour average airborne concentration "to which it is believed that nearly all workers may be repeatedly exposed, day after day, for a working lifetime without adverse effect". The current proposal includes changing the TLV from 2 micrograms of beryllium per cubic meter of air ( $\mu\text{g}/\text{m}^3$ ) to  $0.05 \mu\text{g}/\text{m}^3$ . This is a 40-fold reduction in recommended exposure levels.

The proposal makes the beryllium TLV one of the lowest recommended exposure levels of the 677 chemicals with adopted TLVs. In addition, the new proposal specifies a different method for sampling the air in a workplace to measure exposure levels as compared to previous beryllium TLVs.

ACGIH explicitly states that TLVs are not intended to be used as regulatory standards, rather they are intended to be used by trained industrial hygienists as guidelines for making decisions on safe levels of exposure to chemicals in the workplace. The new beryllium TLV is intended to establish an acceptable level of exposure at which workers will not become sensitized to beryllium. Many beryllium-using industries including the U.S. Department of Energy have already adopted their own internal exposure levels, which range from  $0.1$  to  $0.2 \mu\text{g}/\text{m}^3$ . Typical airborne beryllium exposure levels observed in well controlled machining operations range from  $0.08$  to  $0.12 \mu\text{g}/\text{m}^3$ . In order to reduce exposures to the  $0.05 \mu\text{g}/\text{m}^3$  level, it is likely that most ongoing beryllium processes would have to be performed in well designed, heavily ventilated enclosures. National Jewish Medical Center is currently studying whether the proposed  $0.05 \mu\text{g}/\text{m}^3$  could be an appropriate exposure guideline from both the medical and industrial hygiene perspectives.

For ACGIH, the proposed beryllium TLV will remain on the "Notice of Intended Change" list as a trial value for a period of at least one year (until February 2007). During this one-year period, ACGIH will accept public comments and additional data. Review of the comments and new data will determine whether the TLV will be adopted as an official value, or revised.

*Excerpt from the Beryllium Voice, a publication of the National Jewish Medical and Research Center. This article was written by: Mike Van Dyke, a Certified Industrial Hygienist working with National Jewish Medical and Research Center. He has participated in several beryllium studies conducted by National Jewish and has consulted with many companies regarding the use and manufacturing of beryllium products.*

## WHPP Health Watch

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