Skin telangiectases and ischaemic disorders in primary aluminium production workers

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Skin telangiectases in primary aluminium production workers were first described in 1976 among Polish workers. The lesions displayed unique clinical features. They were round non-pruritic red macules whitening on pressure, with sharp edges and ranging in size from 1 to 30 mm. The upper part of the body was chiefly affected: chest, back, shoulders, forearms, neck, and face in order of frequency. Microscopically, they resulted from elastoid degenerescence of connective tissue surrounding the arteriolar, venular, and capillary portion of the peripheric vessels, accompanied by a mononuclear infiltrate. The capillaries were distended and oedematous.

A Russian study showed that the attack rate was significantly higher in electrolysis workers. In a later study carried out in Quebec the group at risk was narrowed down to workers in the Soderberg electrolysis process, which releases more complex aromatic hydrocarbons in the environment than the newer process (prebake). After four years of seniority in the Soderberg process, 40% of the workers had more than 10 skin lesions and after 20 years nearly all were affected.

Skin telangiectases were found to be associated with an excess of ECG abnormalities. No other association with life style habits or other disease could be identified. The present study, conducted in a large aluminium reduction plant in Quebec, Canada, employing over 6000 men, is an attempt to confirm the association between skin telangiectases and ischaemic heart disease. Stroke and arterial insufficiency of the lower extremities (AILE) were also included as ischaemic outcomes.

Method

The study population consisted of a cohort of men working at a primary aluminium production plant in Quebec who were alive (actively employed or retired) on 11 January 1978 and were free from any of the three ischaemic diseases studied. In Quebec skin telangiectases are compensated as an occupational disease, on the basis of aesthetic prejudice. Compensated workers were individually matched to three non-compensated workers for date of birth, date of hiring, and seniority at the plant (five year caliper), using the company computerised files.

All men were followed up from 1 January 1978 to 31 December 1983 for the occurrence of an ischaemic event: the company medical records were reviewed for a history of ischaemic heart disease (IHD) (ICD-9 410–414), stroke (ICD-9 430–438), and AILE (ICD-9 440–448). Only the most severe diagnosis reached by an individual in each of the three diagnostic categories was retained in the analysis. Medical information also included the following covariables: weight and height, blood pressure, cholesterolama, glycaemia, smoking and alcohol intake history, and a medical history of lung, thyroid, liver, or kidney diseases or rheumatic fever. The records were of good and equal quality for all men. Death certificates were reviewed for all deaths.

A detailed occupational history was available from the company computerised files. A list of each division, department, and job to which the men had been assigned since the beginning of their employment was obtained for all workers included in the study.

A conditional (to the matched ensembles) logistic regression analysis was used to control for potential confounders. Odds ratios and confidence intervals were calculated from the regression coefficients using the method described by Schlesselman.

Results

The study included 126 men compensated for telangiectases (100% of eligible compensated men) and 335 non-compensated matched individuals on a predicted total of 378 (89%). The comparison between the two groups shows a great similarity for the covariables (table 1), except for the seniority in the
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Table 1  Comparison of the two study groups for potential confounding variables

<table>
<thead>
<tr>
<th></th>
<th>Workers with telangiectases (n = 126)</th>
<th>Workers without telangiectases (n = 335)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median (range)</td>
<td>Median (range)</td>
</tr>
<tr>
<td>Date of birth</td>
<td>1923 (1906-50)</td>
<td>1923 (1906-50)</td>
</tr>
<tr>
<td>Year of hiring at plant</td>
<td>1943 (1933-70)</td>
<td>1943 (1934-70)</td>
</tr>
<tr>
<td>Seniority at plant (years)*</td>
<td>35.4 (13.0-46.3)</td>
<td>35.3 (12.6-47.9)</td>
</tr>
<tr>
<td>Senility in Soderberg electrolysis (years)*</td>
<td>32.8 (0.0-44.8)</td>
<td>0.6 (0.0-38.2)</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>65 (53-3)</td>
<td>141 (45-1)</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>70 (41-0)</td>
<td>144 (46-0)</td>
</tr>
<tr>
<td>Never smoker</td>
<td>7 (5-7)</td>
<td>28 (8-9)</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diastolic &lt; 95</td>
<td>103 (81-7)</td>
<td>279 (83-3)</td>
</tr>
<tr>
<td>Diastolic ≥ 95 or systolic ≥ 160</td>
<td>23 (18-3)</td>
<td>56 (16-7)</td>
</tr>
<tr>
<td>Cholesterolasma:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;250 mg/dl</td>
<td>99 (79-8)</td>
<td>256 (77-3)</td>
</tr>
<tr>
<td>≥250 mg/dl</td>
<td>25 (20-2)</td>
<td>75 (22-7)</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

*Seniority calculated to 31 December 1983 or date of retirement or death.

The previous findings of a possible association between skin telangiectases and IHD created a great deal of concern among workers, occupational health professionals and industry. The possibility having been raised, this study was designed to provide convincing evidence, either to support or reject the hypothesis. As it turned out to be the latter, the power of the study was sufficient in that regard.

The largest relative risk observed in this study was due to an excess of AILE in workers with telangiectases (OR = 2.3). That result was not statistically significant, perhaps because of the small number of events in this diagnostic category (13 cases were found overall). On the other hand, the association between skin telangiectases, a condition that affects predominantly the upper part of the body, and arterial ischaemic disorders of the lower extremities, without any other vascular finding, would be rather puzzling from a pathophysiological point of view.

The finding of no significant association between skin telangiectases and IHD goes against previous observations. This suggests that skin telangiectases is only a dermatological problem. A bias resulting in a selection of healthier men in the Soderberg process (developing the telangiectases) could explain the seemingly protective effect (not statistically significant) of telangiectases on IHD. This possibility cannot be excluded but would be unlikely to mask an association of clinical significance. The matching for date of birth, date of hiring, and seniority at the plant was intended to minimise such bias by giving men in both groups an equal chance of developing IHD.

As for the aetiology of skin telangiectases, the main
clue is their characteristic distribution, mainly the upper chest and back. The hypothesis has been raised that these are areas of heavy perspiration and that inhaled environmental contaminant excreted in sweat would be causative. The Soderberg process is associated with the development of skin telangiecstases and also with more air pollution, mainly complex aromatic hydrocarbons. The higher degree of air pollution is consistent with the sweat excretion hypothesis.

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References


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