CORRESPONDENCE

Exposure to asphalt or bitumen fume and renal disease

Editor,—The correspondence from Dittmer and Armitage provide further support for a causal association between exposure to various hydrocarbons and the development of renal disease. Since 1912, some case reports, case-control studies, and cross-sectional studies together with animal experiments have provided compelling evidence for a causative role for hydrocarbon exposure in the development of both tubular and glomerular lesions.

We now report the case of a road worker exposed to asphalt and bitumen fumes who presented in 1990 at the age of 36 with nephrotic syndrome. He was then normotensive, had proteinuria with 24 hour urinary protein of 12.2 g, showed some clinical oedema, and his renal biopsy was consistent with a diagnosis of stage 2 membranous glomerulonephritis. Later that year he presented with an unexplained deterioration in renal function. This followed several weeks of abdominal pain, and he then had haematuria without pyuria, serum creatinine of 208 µmol/l with a previously normal value of 85 µmol/l, and a marked deterioration in his renal biopsy with 20 glomerular profiles per section and tubulointerstitial scarring occupying 40% of the biopsy.

Before developing renal disease, the patient had been employed as a road worker for more than 10 years, during which time he was repeatedly exposed to intermittent but high concentrations of asphalt or bitumen fumes. During all his years exposed to these fumes, the patient had never been provided with or worn respiratory protective equipment.

The study of renal health included 92 people regularly exposed to asphalt or bitumen fumes as road workers, 38 hard rock quarry workers not occupationally exposed to hydrocarbons, and 43 office workers also not exposed to hydrocarbons.

Each participant was given a questionnaire which included an occupational and recreational exposures and medical history including renal disease. Urine and blood samples were collected for urinary chemistry, blood biochemistry, and microscopic analyses. Any person with an abnormal finding on blood or urine analyses were retested and examined by a nephrologist to assess the presence or otherwise of renal disease.

The criteria which determined an abnormal test result were as follows: (a) persistently raised serum creatinine >120 µmol/l; (b) persistently raised serum urea >7.5 mmol/l; (c) persistent microscopic haematuria or pyuria; (d) 24 hour urinary protein >150 mg/day; or (e) corrected creatinine clearance <90 ml/min.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Age and blood pressure</th>
</tr>
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<tbody>
<tr>
<td><strong>No exposure</strong></td>
<td><strong>Quarry</strong></td>
</tr>
<tr>
<td><strong>People (n)</strong></td>
<td>43</td>
</tr>
<tr>
<td><strong>Age (mean)</strong></td>
<td>39</td>
</tr>
<tr>
<td><strong>BP (mean systolic)</strong></td>
<td>133</td>
</tr>
<tr>
<td><strong>BP (mean diastolic)</strong></td>
<td>86</td>
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<table>
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<tr>
<th>Table 2</th>
<th>Renal disease</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No exposure</strong></td>
<td><strong>Quarry</strong></td>
</tr>
<tr>
<td><strong>Number of people</strong></td>
<td>206</td>
</tr>
<tr>
<td><strong>Pre-existing renal disease (n (%)) NS</strong></td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Idiopathic renal disease (%)</strong></td>
<td>4.9</td>
</tr>
<tr>
<td><strong>p&lt;0.01.</strong></td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Table 3</th>
<th>Renal function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No exposure</strong></td>
<td><strong>Quarry</strong></td>
</tr>
<tr>
<td><strong>People (n)</strong></td>
<td>43</td>
</tr>
<tr>
<td><strong>Haematuria</strong></td>
<td>4</td>
</tr>
<tr>
<td><strong>Proteinuria</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Rapid rise of creatinine</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>At least one abnormality (n (%))</strong></td>
<td>4 (9.3)</td>
</tr>
<tr>
<td><strong>p&lt;0.01.</strong></td>
<td></td>
</tr>
</tbody>
</table>

The presence of renal disease was determined as pre-existing or idiopathic according to the following criteria. Pre-existing renal disease: (a) family history or history of renal disease; (b) abnormal renal ultrasound. Idiopathic renal disease: (a) no known cause for abnormalities; (b) abnormal creatinine, urea, and creatinine clearance; (c) abnormal proteinuria; or (d) abnormal urinalysis—haematuria or pyuria.

The findings of the study are summarised in tables 1–3.

We concluded from this study that: (a) workers regularly exposed to asphalt or bitumen fumes were far more likely to have evidence of early stage renal disease than those working in a quarry or office; (b) workers regularly exposed to asphalt or bitumen fumes were far more likely to have at least one abnormal renal function test than those working in a quarry or office; and (c) the renal dysfunction was non-specific, but the overall findings were consistent with previous findings—such as those from the similar study done by Yaqoob et al.

We think that chronic glomerulonephritis and chronic tubulointerstitial nephritis are renal diseases which may result from exposure to hydrocarbons—such as those experienced from asphalt or bitumen fumes generated during road making.

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Authors’ reply.—The report of Douglas and Carney of a further case of renal disease associated with hydrocarbon exposure, together with their cross sectional study of those with prolonged exposure to bitumen and asphalt further strengthens the case for an association between renal disease and hydrocarbon exposure. Yaqoob et al have also convincingly shown, that in particular, proteinuria may be associated with hydrocarbon exposure.

This highlights the need for a careful occupational and social history to be taken at the time of presentation. This case also highlights the need for performing a renal biopsy in adults presenting with unexplained proteinuria. If interstitial nephritis is found then a short course of steroids may result in a dramatic improvement in renal function as we noted in the case of our patient exposed to...
epoxy resin fumes. If there was evidence of significant renal damage then it may also be wise to counsel the patient to avoid further contact with the substance. Indeed in our case, the patient found that his general health improved dramatically when direct contact with rubber was avoided. The issues of general industrial health and possible compensation or litigation also need to be considered.

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Cancer risk in the rubber industry: a review of recent epidemiological evidence

EDITORS—Although the comprehensive review of the rubber industry reported by Kogevinas et al. only considers papers published after 1982, several of these studies relate to groups of workers from much earlier eras—for example, 1910 for the German study, 1946 for the British Rubber Manufacturers Association (BRMA) study1 and Deyes studies.2 By considering the findings of these earlier rubber workers along with studies of more recent groups of workers we are getting a picture of 80 years of cancer experience in the industry, which it is not the same as the situation that exists today.

It should also be borne in mind that the very large cohort studies—such as the 34 000 workers in the Deyes study3—have very much greater statistical power than those of the smaller studies, in which confounding factors and the role of chance are more difficult to evaluate. This does not seem to have been fully taken into account and indeed Kogevinas et al tell us that they have not “paid much attention to statistical significance”. This is disappointing as it is the omission of a full meta-analysis of the studies, which if it had been carried out, would have added considerable weight to their conclusions.

In general, the review would seem to endorse and reflect the evaluation by the International Agency for Research on Cancer (IARC) of the industry in the 1987 monograph, supplement 7 of a moderate increase in risk of cancer at several different organ sites which are not consistently found in similar studies carried out in other parts of the world. Evidence suggests that there is, perhaps, a reflection of the meta-analysis of large, case-controlled studies which compare workers in the rubber industry with non-rubber workers. And process argue against performing a meta-analysis which presumes homogeneity of studies. We agree with Straughan that this has not been documented yet in epidemiological studies.

It is to be hoped that the BRMA has been and continues to be actively involved in examining risk of cancer among workers in the rubber industry. We are aware that a new study initiated by the BRMA will do justice to the concluding sentence of our paper: “The preventive measures taken in the rubber industry in recent years may decrease risks, but this has not been documented yet in epidemiological studies”.

Yves studies4 (14 000 workers) followed up for 40 years. The findings of this domestic epidemiology enable us to conclude, with considerable confidence, that in the United Kingdom occupational leukaemia was never a factor and that the problems of bladder cancer were largely eliminated in the 1940s with the discontinued use of chemicals contaminated with β-naphthylamine. These studies also showed a small but nevertheless significant excess of stomach, lung, pharyngeal, and oesophageal cancers. With more detailed analysis, however, and consideration of confounding and socioeconomic factors, the occupational importance of these excesses seems to be less clear as time goes on. Geographical and confounding factors and a lack of a clear time-dose response also lessen the possibility of occupational causation.

Having expressed our confidence in the United Kingdom findings, I re-emphasise that they are largely based on results from an earlier generation of rubber workers and that their experience may not be the same as the currently employed in a modern day rubber factory.

So that we may investigate more recent experience, the BRMA initiated a further collaborative project with Birmingham University, to carry out a new study of its members’ employees. The collection of data for this study was completed last year and it includes nearly 10 000 male and female workers with at least 12 months of employment and who were first employed between 1982 and 1991. This study involves 42 rubber factories engaged in manufacturing the full range of rubber goods. This cohort study will look at both cancer incidence and mortality and make full use of all available occupational hygiene and exposure data.

Examination of the health experience generated by the study to date will take place later this year to see if there is sufficient information for a full analysis to be carried out or whether it would be appropriate to delay this until more data are available.

Kogevinas et al have given an interesting and important overview of health hazards observed in rubber workers employed during the past 80 years. I agree with them that the more relevant, modern, and comprehensive epidemiology is necessary if we are to obtain a true picture of the situation today.

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Authors’ reply—We thank Straughan for his comments. We agree that some of the studies reviewed provide a picture of 80 years of cancer experience in the industry, which is not the situation existing today (in industrialised countries). We tried to identify and report separately for studies examining work that first employed to less than the 1980s. These studies did not clearly indicate the absence of an excess risk of cancer. Unfortunately the number of subjects and cancer deaths or cases in these studies is small and does not allow definite conclusions to be drawn yet.

Considerable heterogeneity exists between and within countries in exposure circumstances in the rubber industry. What we did in our review was to give a picture of the risks in this industry. This overall picture does not apply to all countries, nor to all periods. However, an overall picture may highlight conditions that are not easily recognised at a local level. One example is the identification of an increased risk for laryngeal cancer, which had not been previously reported although it seemed consistent between centres. Another example relates to the study by Straughan (and others), that the British studies do not indicate an excess risk for bladder cancer after the discontinuation of use of β-naphthylamine. What is usually mentioned is that there was no significant excess risk, which is correct. What can be distinguished, however, looking at the overall picture (see figure 1 of our review) is a small but consistent excess risk for bladder cancer even in studies conducted in relatively late periods. There is a lack of detailed exposure information in most studies but it is probable that β-naphthylamine was not used in these late periods. We agree with Straughan that it is difficult to exclude the possibility that the observed small excess risk is due to a late effect of early exposures.

The findings of the large BRMA study are, indeed, more stable (statistically) than the results of studies in the Nordic or other countries, but they are not necessarily either more or less confounded than those of other studies. We understand Straughan’s plea for a full meta-analysis in which large studies are not given the same weight as small studies. The variability of exposures over time, geography, and process argue against performing a meta-analysis which assumes homogeneity of exposure.

It is commendable that the BRMA has been and continues to be actively involved in examining risk of cancer among workers in the rubber industry. We are aware that a new study initiated by the BRMA will do justice to the concluding sentence of our paper: “The preventive measures taken in the rubber industry in recent years may decrease risks, but this has not been documented yet in epidemiological studies”.

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PAOLO BOFFEITA
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Inhalation of ammonium nitrate fuel oil explosive (ANFO): and possible concomitant exposure

Editor,—Donoghue1 reports on respiratory symptoms and rhonchi in a miner after exposure to ammonium nitrate fuel oil explosive (ANFO). As diesel fuel is the most commonly used fuel in ANFO the vapour he refers to might be components of diesel fuel. He excludes concomitant exposure to nitrogen dioxide because the inhalation occurred before any explosion took place. Although diesel powered machines are commonly used in underground work he does not discuss possible exposure to diesel exhaust. We have measured up to 15 ppm nitrogen dioxide during construction of a tunnel where the only known source was diesel exhaust. Exposure to such high concentration may contribute to respiratory symptoms and rhonchi. Therefore nitrogen dioxide should not be excluded as a concomitant causative factor. In a study of the contribution of gases from diesel exhaust and from the blasting cloud caused by the ANFO explosive during excavation of a tunnel, diesel exhaust contributed most to the total amounts of nitrogen dioxide in the tunnel.2

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Occupational asthma due to amylase

Editor,—In a letter to you,1 Hendrick points out my inadvertently overlooked report in The Lancet on allergy to u-amylase and papain,2 and makes generous reference to my other work on enzymes.

For clarification, I should point out that the evidence, supported by the findings with amylase, that sensitisation and consequential symptoms may occur from proteases independently of proteolytic activity, must not obscure the fact that proteolytic mechanisms may cause other clinical and subclinical effects. As well as skin irritation, non-sensitised people may experience epistaxis or haemoptysis, whereas rhinorrhoea or asthma are more likely to be due to allergy. Proteolytic enzymes cause proteolytic effects varies between different proteases, and susceptibility to such effects varies between people.1 I think I have experienced such effects myself, and possible long term consequences have been described.

Although he concurs with the use of skin prick tests as an index of sensitisation, Kendrick expresses reservations about my evidence of causality in respect of chest symptoms from u-amylase. This is understandable if I relied solely on his condensation of an already condensed text. Although my report derived from a comprehensive ongoing investi- gation, I had hoped I had summarised sufficient information to make my point.

His reservations seem to derive from the fact that papain was also handled in the workplace, and that some of those sensitised to u-amylase were also sensitised to papain.

At this factory papain and u-amylase were handled in pure form, seldom, and at different times. I thought the association between handling one or other material and the development of symptoms was clear cut, and because of the short period of handling, with intervals of at least a month between these periods, there was time for symptoms to regress between exposures.

I had already validated a skin prick test for papain sensitivity,3 and was able to use the same test established for u-amylase and a similar one for u-amylase. Positive prick test findings seemed to confirm the specificity and likely mechanism of the typically asthmatic symp- toms from each enzyme.

Had I had any reasonable doubt as to causality I would not have published the warning. Happily, subsequent reports, including the excellent one by Aitkin et al.,4 which Hendrick is a coauthor, which included inhalation challenge tests with fungal u-amylase,6 have endorsed my conclusions and added further knowledge.

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Health of children born to medical radiographers

Editor,—There are increasing concerns that parental workplace exposure to potentially hazardous agents could affect the health of future offspring. To explore this, Roman et al have developed a questionnaire based method for collecting data on reproductive outcome and child health which has been applied to a study population comprising (predominantly female) members of the Col- lege of Radiographers. I have recently had cause to revisit their report of this work in more detail and have several comments.

The study relies on postal questionnaires for details of adverse pregnancy outcomes, major congenital abnormalities, and malignancies, but only reports of cancer were validated by reference to national registration schemes and medical records. Comparisons with national cancer registration rates for England and Wales and congenital malformation rates determined from data compiled by the Liverpool Congenital Malformation Registry showed little evidence to suggest an increased risk for cancer or for major congenital malformations. Within specific systems no excess relative risk was evident for Down’s syndrome, but two significantly increased relative risks were found—for “other musculoskeletal” malformations and for “chromosomal anomalies other than Down’s syndrome”—both dominated by adverse outcomes reported by female radiographers. My particular interest is with the group of six cases of chromosome anomalies other than Down’s syndrome.

Four cases of Turner’s syndrome were reported by female radiographers diagnosed before birth and the pregnancies terminated. The Turner phenotype, recog- nised in live born infants, is characterised by monosomy X and has a birth incidence in females of 1/2000–1/5000.5 However, the frequency of monosomy X at conception is much higher, occurring in 1%–2% of all clinically recognised pregnancies.6 Over 99% abort spontaneously,770% of these between 11 and 14 weeks gestation.8 The incidence of Turner’s syndrome will vary considerably with different stages of pregnancy and this has implications for the calculation of expected numbers of cases. When evaluating Turner’s syndrome in relation to aetiological influences it is important to have accurate information on the timing and method of diagnosis, and compari- sons must be made with appropriate registry data. In around 80% of cases the X chromo- some present is maternal in origin,9 but there- fore, by contrast with most cases of Down’s syndrome, an error in meiotic non-disjunction cannot be attributed to the mother. Of those diagnosed after birth, some are mosaics with a normal XX cell line and a mosaic cell line with one normal and one abnormal X chromosome, and it has been suggested that mosaicism increases the likelihood of survival during pregnancy.10 Such mosaics are assumed to have arisen post-zygotically. Turner’s syn- drome is, therefore, most likely to occur due to an error in non-disjunction arising either during spermatogenesis or after fertilisation, and the origin of the error can often be determined by undertaking cytogenetic and molecular studies. Consequently, it is unlikely that maternal preconceptional exposure is relevant to the occurrence of the cases of Turner’s syndrome reported to Roman et al although it is possible that events immediately after concep- tion could be implicated in the origin of any with a mosaic karyotype. It is unfortunate that Roman et al provide no karyotypic data nor information on whether the mothers were working as radiographers when they conceived as this would have assisted in the interpretation of this association.

Two further pregnancies with chromosomal abnormalities were described—a 45X0 chromo- somal anomaly reported by a female radiographer and a trisomy 17 reported by a male radiographer—both of which were termi- nated. Referral to results of chromosomal studies would have provided useful information on whether the infants were mosaic, and the possibility of the gross chromosomal anomaly being the result of a familial rearrangement could then have been explored. Trisomy 17 is rather a surprise as this is considered incompatible with embryo development11 and has not, to my knowledge, been detected by antenatal diagnosis. There must be a possibility that this information is incorrect.

Aetiological mechanisms must be consid- ered when assessing the biological plausibility
of epidemiological associations, and reliance on personal memory will not provide the detailed data which allow chromosomal abnormalities to be grouped in a meaningful way when exploring possible environmental influences. The study of Roman et al. illustrates the need to confirm diagnoses reported in questionnaires with objective data, and to obtain any additional information that may assist in the scientific evaluation of epidemiological results.

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3 Howald T, Petry D, et al. Molecular- 

Book reviews

As indicated by the title, this book is an edited series of proceedings of symposia on inhaleed particles. These international symposia, held in 1960, 1965, 1970, 1975, 1980, 1985, 1991, and 1996 at various venues in the United Kingdom, were all sponsored by the British Occupational Hygiene Society (BOHS). Since the 1975 meeting, the proceedings were also issued simultaneously as special issues of the BOHS journal Annals of Occupational Hygiene. These symposia and their proceedings have served as landmarks documenting the state of the art in knowledge and techniques concerning human exposures to airborne particles, their deposition and clearance within the respiratory tract, and their health effects.

The broadening depth and scope of the symposia to now include radioactive, outdoor and indoor particulate matter have put a great strain on the organisers and especially on the editors. Additional pressure was resulted from the fact that the two previous proceedings did not appear until three years after the meetings. Thus, the publication of this volume only one year after the symposium is a significant accomplishment and a tribute to the dedication of its new editors. A price for this accomplishment was the restriction of the 127 papers to four pages each, and the elimination of external peer reviews. The reviews and editing were done by the editors alone. Also, for the first time, there were no abstracts included in the papers and the questions from the audience, and authors’ responses, that were notable features of the earlier volumes, were not included.

The quality of the papers and editing remain at a high level, and this volume should be a valuable addition to the bookshelf of all scientists, health professionals, and public health authorities who are seriously inter-


Airborne fibre concentrations have been evaluated by the membrane filter method for over 30 years. The original method, which was developed for use in asbestos factories, has been adapted for use with many different types of fibre in both occupational and non-occupational situations. By the 1970s it was clear that there were substantial differ-


The section entitled "Statistical methods: cross sectional study" (page 687) should read:

The quality of the papers and editing remain at a high level, and this volume should be a valuable addition to the bookshelf of all scientists, health professionals, and public health authorities who are seriously interested in the health effects of airborne particles. It is clear that the price is high enough to limit its readership.

MORTON LIPPMANN

Book review editor: R L Maynard

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This book is aimed at managers and others who wish to obtain an understanding of the principles of occupational safety and health in the United Kingdom. It is published by the Institution of Occupational Safety and Health (IOSH) and it is the recommend text for their safety appreciation course, Managing Safety.

The text is divided into four sections: safety technology, occupational health and hygiene, safety management techniques, and law. There are 68 short chapters which cover the essential factual information required by someone responsible for managing health and safety. Each chapter includes several self assessment questions and a bullet point sum-

CORRECTION

...
mmary of the key points which could be used for our course. The breadth of the book is enormous and includes machinery guarding, chemical safety, fires, electrical hazards, manual handling, and accident investigation. There are over 100 pages out of about 270 devoted to summarising the main pieces of health and safety legislation. This edition of the book has been revised to include new legislation, especially that referring to construction health and safety.

The book is clearly designed to support taught courses covering the basics of health and safety. Used in this way I am sure that it would be a valuable resource, with the section dealing with the law being particularly helpful. I would also think it would be useful to be used as a textbook in other situations. There are extensive commendations for further reading, although these are almost exclusively publications from the United Kingdom Health and Safety Executive or British Standards.

The index is particularly poor and seems to have been naively compiled with some completely random entries unhelpful—for example, 45 entries referring to employees—or irrelevant—for example, an entry for yawning in respect of someone who has received an electric shock. However, I found it a useful resource for managers and others in the United Kingdom who plan to attend a basic course in health and safety. The sections on legislation give a good overview of the relevant acts and regulations, although they are probably insufficient to act as a reference for those trying to comply with the law.

JOHN W CHERRIE


Although the harmfulness to health of asbestos was originally described at the end of the 19th century, it was only in the 1960s after the publication of the seminal paper on mesothelioma in South African crocidolite workers by Wagner et al that general attention was drawn to these problems. The possibility that hazards from asbestos might extend to the general population rather than simply to workers in the asbestos industry gradually gained currency through the 1970s until in the 1980s the educated and reading public were being informed by their newspapers that inhalation of as little as one fibre of the mineral could prove fatal. The debate on the risks associated with exposure to asbestos became extremely polarised in the United States, resulting in widespread and inappropriate action to remove asbestos from buildings where it was found, thus putting at risk a large and relatively unprotected workforce of asbestos removal men.

As asbestos has proved to be an exceptionally useful material, industry naturally has required substitutes and various other fibrous minerals have been produced, increasingly since the 1930s. Of these the most common are used in insulation as rockwool and glasswool. As these new fibres are longer and have greater strength than asbestos, namely fibre size and resistance to degradation are also those that make asbestos dangerous, it is essential that industrial use of these materials is well understood so that, in the case of any resulting exposure, the health risks are minimised.

This book, one of a series of reviews produced by the World Health Organisation and Health, provides a useful summary of the current understanding of the risks associated with both asbestos and more importantly, and less well-known, man-made mineral fibres. It provides useful background information on the many types of fibre produced and used in industry and documents comprehensively the amount and types of fibre to be found in materials and in buildings in the United Kingdom. After reviewing the difficulties of measuring tiny respirable fibres, it summarises the scientific literature on fibre concentrations to be found in the general and domestic environment and makes estimates of the exposure of the United Kingdom population.

The book summarises the known health effects of asbestos and the, as yet, incomplete but reassuring literature on the epidemiology of workers exposed to other fibres. It then discusses the experimental animal and in vitro evidence with respect to man-made fibres. There is useful discussion of fibre deposition, clearance, and solubility leading to conclusions which in my view are wholly sensible. For asbestos, the authors argue against a general policy of removal and for management in situ unless the material is releasing unacceptable amounts of dust. For man-made mineral fibres, the authors express caution about the production of fine diameter fibres but point out that almost all the material used commercially is not respirable and that there is no reason to suppose that current levels of exposure pose any risk to the public. All in all it is a remarkably informative book containing much information on mineral fibres that is not readily available elsewhere.

The debate about the harmfulness of fibres needs to shift back to the protection of exposed workers and away from theoretical risks to the general population.

ANTHONY SEATON

Tobacco Or Health: A Global Status Report.

“Every 10 seconds, another person dies as a result of tobacco use”. This is the stark introductory sentence to this reference book compiled by the World Health Organisation as a source of standardised baseline information on tobacco production, trade, consumption, health effects, and control in WHO member states. The book is divided into two parts: the first, comprising 60 pages, attempts to summarise the global situation in the late 1980s and early 1990s. The second and larger part provides a series of "country profiles" for each of the member states, typically of one or two pages. These list the latest available information on demographic and general health indicators, tobacco production, trade and industry, tobacco consumption and smoking prevalence by age and sex, and national tobacco control policies and programmes.

This volume provides a powerful reminder, if such is needed, that tobacco use is a global phenomenon, with one third of adults now smoking, and two thirds of these residing in developing countries. The premise underpinning the report is that widespread tobacco consumption and public health are mutually incompatible, but readers seeking a comprehensive collation and consideration of the epidemiological evidence linking the effects of tobacco use on health in many countries, particularly in the developing world, will be disappointed. It is apparent that the WHO intends these data to be a baseline for a global programme of surveillance of smoking habits and tobacco control. Evidently much needed and desirable, the WHO has compiled a similarly comprehensive account of the effects of tobacco use on health in many countries, particularly in the developing world. A valuable addition to future editions would be evidence from countries with well developed tobacco control policies of the extent to which lowering smoking prevalence reduces death and disability. This might encourage much needed policy initiatives in many other countries where tobacco control has yet to achieve prominence on the public health agenda.
exposures to ionising irradiation before con-
ception. This study has also been published
as a paper in the BMJ, but this volume goes
into far greater details than is available
elsewhere. This is very much a book for the
concerned specialist reader who wants the
technical background to the BMJ article.

This study is essentially a record linkage
exercise. The exposed fathers (and mothers)
defined as having records with the
National Registry for Radiation Workers
(NRRW) held by the NRPB. This is a
database of over 120 000 people and it was
linked with the national register of childhood
tumours, a database of over 50 000 children
with all types of cancers. Two other data
sources on childhood cancers were also
included.

For the three sources of data on childhood
tumours, controls were found in various ways
to ascertain if these children had a father in
the NRRW. The parental estimated doses
were created from the NRRW. In all a total of
200 fathers and mothers were linked to chil-
dren with cancer. Eighty two children with
leukaemia or lymphoma were linked to
fathers’ records at the NRRW, as were 79
control fathers. The corresponding numbers
for mothers were 15 and three.

The cases in the original Gardner paper
were excluded and the results for fathers
showed that case fathers had a 1.77 signifi-
cant excess risk over control fathers for
having a child with leukaemia or lymphoma.
However, the risk was associated with the
lowest dosages and there were no dose
responses in any of the comparisons. In this
sense the Gardner hypothesis is refuted!

Furthermore, the risk in mothers was also
significantly and greater in magnitude than
the fathers. However, the small numbers
make this result unreliable and difficult to use
extrapolate risk.

The explanation of the association found in
these NRRW members exposed to low doses
is not known. It could be chance, it could also
be due to misuse of film badges by those in
high risk industries. This explanation is
unlikely in that the cancers were distributed
widely across industries in the United King-
dom and were not confined, by any means, to
the nuclear reprocessing or related industries.
It may be due to other exposures associated
with the wider radiation industries where
many other hazardous substances exist as
well as ionising irradiation. Finally, it could
be some other, more subtle aspect, of wearing
a film badge. The authors speculate that this
might be associated with the mobility of the
parents, thereby linking these results with the
Kinlen hypothesis which is based on ideas of
infectivity associated with population mixing.
They do not produce evidence to suggest that
film badge wearers are more mobile than
other professions but the differences in
behaviour may be more complex.

Further light might be shed on this associ-
ation when the nuclear industry family study
(NIFS) is analysed shortly. This study will
answer some criticisms of the present study.
For example, it is known that there are differ-
ences in behaviour of people within the
nuclear industry and those outside it. The
NIFS uses internal comparisons and so such
differences can be accounted for.

Despite the lack of any explanation of this
observation attention is now bound to be
focused on other preconceptional and peri-
conceptual exposures in both sexes and their
possible links with childhood malignancies.

R A CARTWRIGHT

1 Draper G, Little MP, Sorahan T, et al. Cancer in
the offspring of radiation workers: a record