Cancer risk from exposure to occupational acrylamide

Recently the results of a comprehensive epidemiological follow up study of cancer mortality in cohorts with occupational exposure to acrylamide was published. With the exception of a weak significance for a raised incidence of pancreatic cancer the study arrived at and strongly at the conclusion that there is “little evidence for a causal relation between exposure to acrylamide and mortality from any cancer sites”. The study updates and confirms an investigation 10 years earlier of the same cohorts. The analysis was based on standardised mortality ratios (SMRs) in comparison with United States national or relevant county mortality statistics. It exemplifies the shortcomings of epidemiological studies of this kind to determine moderate influences of specific causative factors on cancer mortality or incidence. The investigators state that they have carried out the most definitive study of the human carcinogenic potential of exposure to acrylamide conducted to date. The results, however, pose questions. Could unacceptable risks be detected? Which risks would have been expected?

For the workers in the United States the average cumulative exposure is given as 0.25 mg/m³·y. (We assume this to correspond to exposure of the whole factory staff to 0.25 mg/m³ for 365 8 hour working days). At an alveolar ventilation rate of 0.2 l/kg.min this exposure would mean a cumulative uptake of about 9 μg acrylamide per kg body weight. This dose corresponds to a lifetime (70 years) uptake of 0.35 μg/kg.d. According to the estimate of the United States Environmental Protection Agency this would correspond to a cancer risk of $1.6 \times 10^{-4}$. An estimate based on the multiplicative model would arrive at roughly a 3 times higher risk, $5 \times 10^{-4}$. With a cancer mortality in the western world countries of 0.18, these figures correspond to a 1%–3% increase of the cancer mortality risk (RR) — that is, an RR of 1.01–1.03. As about one fifth of the five workers were defined as exposed (at≥10–3 mg/m³·y) the relative risk in the exposed group due to inhalation of acrylamide may have been about 1.05–1.15.

Although it is doubtful that these risk increments could be considered negligible, they would not be detectable in a study of the present kind. As uptake through the skin often occurs in addition to inhalation of acrylamide it is possible that the true risk increments are considerably higher. If we assume the total relative risk (from inhalation plus dermal uptake) to be in the range of 1.1–1.2, it is a pertinent question whether this risk increment is detectable within the large body of material studied by Marsh et al. Like many other materials of similar kinds the data are far from ideal for epidemiological analyses. The main reasons for this are the skewed distribution of duration of employment, the incompleteness of data for smoking, and the healthy worker effect. The healthy worker effect leads to a deficit in death rates from all causes, in the present study by about 20% for all causes except cancer. Deficits in SMR for all malignant neoplasms and for certain tumour types are also often significant, although with a disturbing influence of a significantly increased SMR for lung cancer in an earlier period. (The significant decrease in deaths from lung cancer as well as deaths from diseases of the circulatory system from 1925–83 to 1984–94 would be compatible with a drastic reduction in smoking, before 1984.) It is expected that the healthy worker effect comprises cancer, at least to some extent, as well as other causes of death.

A straightforward way of overcoming the healthy worker effect is a within cohort analysis of the regression of mortalities or incidences on the estimated dose. Marsh et al. have done this for each of a few selected tumour sites. Due to too few observed deaths in each dose interval the statistical power of this material is, however, too small to show anything.

This analysis of individual sites, avoiding a pooling of data that would increase the statistical power, illustrates the widespread dogma that different cancer types are affected specifically by acrylamide. It has often been shown for a few mutagenic carcinogens including acrylamide that a linear multiplicative model, $P_j = P_j^{(0)} \times (1 + \beta D)$, can be fitted to experimental cancer incidence data and, for radiation, to human data. With this type of pooling of data that would increase the statistical power of this material is, however, too small to show anything. This practice does not preclude, however, the exploratory investigation of other non-implicated sites as long as the related findings are interpreted in the light of their hypothesis generating nature.

We agree that for many of the initial cancer sites examined in our study, the statistical power to detect a moderate excess in mortality (1.5 to twofold or greater) was low, a point considered in the discussion section of our paper. However, the primary reason for detecting a twofold or greater excess in lung cancer, the end point of primary concern, at the one sided 5% significance level was in the excellent range (0.87), as would be the power to detect a similar excess of pancreatic cancer in a future update of this cohort.

Granath et al. overlook a fundamental point — occupational cohort studies of the type we used to evaluate cancer mortality risks among workers exposed to acrylamide are neither designed nor necessarily well suited for quantitative risk assessment. Occupational cohort studies are purposely not designed to detect small excesses in the range of 5%–15% deemed by Granath et al. unacceptable. The primary reason for this is that excesses of this magnitude could easily be due, at least in part, to one or more confounding factors. Observational epidemiological studies usually cannot discriminate among such small mixed effects, and are generally most useful for detecting increases in risk that exceed 50%–100% as these are unlikely to be due to uncontrolled confounding. Considerations of statistical power notwithstanding, the fact remains that our study is the largest and most recent cohort study of exposure to acrylamide conducted to date,
and will continue to provide useful epidemiological information through future updates and analysis.

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Dose-response relation between acrylamide and pancreatic cancer

In their 1999 study of workers exposed to acrylamide, Marsh et al conducted an SMR analysis, and fitted several relative risk regression models to the data. 1 In each analysis, they found that the risk of pancreatic cancer increased by about twofold for workers in the highest cumulative exposure group, but risk of pancreatic cancer did not increase monotonicly with cumulative exposure in any of their analyses. Duration of exposure was monotonically related and mean intensity showed a nearly monotonically relation with risk of pancreatic cancer.

The cut off points Marsh et al chose for the exposure categories are based on multiples of current and proposed regulated levels of exposure intensity. 1 Because these cut off points resulted in small numbers of expected deaths in the low and intermediate exposure groups, 1.08 and 2.74 respectively, we have regrouped the data to attempt to obtain more stable standardised mortality ratios (SMRs). These results are presented in table 1 and indicate a monotonic dose-response pattern with the SMRs increasing from 0.80 to 1.31 to 2.26.

Table 1 Observed deaths, expected deaths, and SMRs for cancer of the pancreas, all United States workers, 1950–94, local county comparisons, two lowest exposure groups combined

<table>
<thead>
<tr>
<th>Cumulative exposure (mg/m³.y)</th>
<th>Obs</th>
<th>Exp</th>
<th>SMR %5 CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.001</td>
<td>30</td>
<td>37.50</td>
<td>0.80 0.54 to 1.14</td>
</tr>
<tr>
<td>0.001–0.29</td>
<td>5</td>
<td>3.82</td>
<td>1.31 0.35 to 3.05</td>
</tr>
<tr>
<td>&gt;0.30</td>
<td>9</td>
<td>3.98</td>
<td>2.26 1.03 to 4.29</td>
</tr>
</tbody>
</table>

In part based on the absence of a pattern of monotonically increasing risk with increased cumulative exposure, Marsh et al argue that “our findings for cancer of the pancreas should be interpreted with caution, in the context of an exploratory analysis to generate hypotheses.” Nevertheless, given the sufficient evidence in experimental animals for the carcinogenicity of acrylamide, 7 this study plays an important part in the evaluation of safety for occupational exposures to acrylamide.

When data are sparse, it is not always clear how best to choose cut off points; the grouping we have shown results in a finding that is more compatible with the findings for duration and for intensity of exposure. It would be interesting to see if a regrouping of the exposure categories alters the results of the analyses based on internal comparisons.
Bullying in hospitals

As victims of bullying and proponents of emotional intelligence in the health profession we read with interest the article on workplace bullying. Kivimaki et al did not mention whether the responses were anonymous. Identified responses may underestimate the incidence of bullying in the cohort. Given that previous studies (mentioned by the authors in the discussion) have shown a considerable percentage of victims deciding to resign as a result of bullying, it is a pity that the article by Kivimaki et al did not contain similar data. The other two issues that should have been included were the duration of the bullying, and how many bullies are actually aware that they are bullies. These can be answered by asking the question: Have you subjected your colleagues to such bullying behaviour?

With doctors and nurses constituting 58% of the victims, we wonder whether the authors could reanalyse their data to see whether there is a higher incidence of bullying in the high stress specialties—such as adult intensive care and neonatal intensive care. We would also like to know whether the victims in their study were offered any counselling by their institutions, and if so, the nature and impact of the counselling.

Emotional intelligence is defined by the five emotional quotients of self awareness of feelings, emotional self regulation, self monitoring and goal setting, empathy, social skills, and communication skills. According to Goleman, “The rules for work are changing, we’re being judged by a new yardstick: not just how smart we are, or our expertise, but also how well we handle ourselves and each other.” Emotional intelligence is considered more important than intelligence quotient (IQ) in enabling people to function well in society. We suggest that emotional intelligence, which can be taught, can be an important solution in reducing the incidence of bullying in the workplace.

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