CORRESPONDENCE

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 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 cancer attributable to 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. (We assume this to correspond to exposure of the whole factory staff to 0.25 mg/m³ for 365 hours working days). At an alveolar ventilation rate of 0.27 litres/min this exposure would mean a cumulative uptake of about 9 mg 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 1.6×10⁻¹⁰. An estimate based on the multiplicative model would arrive at roughly a 3 times higher risk, 5×10⁻⁹. 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 of about one fifth of the fifth cohort were defined as exposed (at≥ 10 mg/m³) 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 limits of the 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 uptake. 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 any indication of increased cancer risks.

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 the same risk. It has been shown for a few mutagenic carcinogens including acrylamide that a linear multiplicative model, \( P = P_0 \times (1 + \beta d) \), can be fitted to experimental cancer incidence data and, for radiation, to human data. For comparison the total and background risks of tumour at site j, D the dose and \( \beta \) a relative risk coefficient that is (at least approximately) the same for all tumour sites j, is thus applicable to pooled data for groups of sites or for all (responding) sites. Although analysis of death risks associated with specific tumours has its indisputable specific findings from experimental animal studies is mostly a consequence of the pattern of background incidences in the animal strain used.

The authors of the paper possess information of extreme value in further efforts to clarify the carcinogenic potency of acrylamide. In view of the importance of this question we urge the authors of the paper to continue their work, particularly with analyses of regression on pooled data, primarily for all cancers, with and without exclusion of sites related to smoking.

F GRANATH
Department of Medical Epidemiology, Karolinska Institute, Stockholm, Sweden

L EHRENBERG
Department of Genetic and Cellular Toxicology, Stockholm University, Sweden

B PAULSSON
M TÖRNQVIST
Department of Environmental Chemistry, Stockholm University, Sweden

Correspondence to: Dr M Törnqvist
Margareta.Tornqvist@mlk.su.se

Dose-response between relation 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. In each analysis they found no risk of pancreatic cancer increased by about twofold for workers in the highest cumulative exposure group, but risk of pancreatic cancer did not increase monotonically with cumulative exposure in any of their analyses. Duration of exposure was monotonically related and mean intensity showed a nearly monotonic relation with risk of pancreatic cancer.

The cut off points Marsh et al chose for the exposure groups are based on multiples of current and proposed regulated levels of exposure intensity. 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 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.

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, this study plays an important part in the evaluation of safety for occupational exposure to acrylamide.

When data are sparse, it is not always clear how best to choose cut off points; the groupings 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.

# Correspondence

E VAN WINGAARDEN
J HERNANDEZ
Department of Epidemiology, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7400, USA

L M BALL
Department of Environmental Sciences and Engineering

Correspondence to: Dr M R Schulz
mrs6388@email.unc.edu


Amotrophic lateral sclerosis and occupational exposure to 2,4-dichlorophenoxyacetic acid

Burns et al report a significant excess of deaths potentially due to amyotrophic lateral sclerosis (ALS) in a cohort of Dow employees compared with the weight placed upon the non-significant increase of non-specific exposures found in human studies of amytrophic lateral sclerosis compared with the weight placed upon controlled animal studies specific to the herbicide 2,4-dichlorophenoxyacetic acid (2,4-D).

In some with Freedman the threshold for undetected significance is ill advised. He is correct that the case-control studies cited in our paper showed increased odds ratios, but there is no evidence that any subjects were actually exposed to 2,4-D. The exposures were limited to pesticides, agricultural chemicals, and herbicides. The cohort studies examined workers who were definitely exposed to 2,4-D and thus provide a more valid assessment of risk even though they are less powerful than the case-control studies.

The associations found in the case-control studies are clearly unsupported by the experimental studies that have been conducted on 2,4-D. Environmental causes of ALS remain unknown. If future epidemiological studies investigate the neurotoxicity of herbicides such as 2,4-D, the researchers must improve upon the status quo of surrogate exposure information used in case-control studies or perform further studies of the 2,4-D workers. Epidemiologists must make a commitment to quality exposure assessment of individual pesticides, perhaps coupled with biomonitoring, to assess the putative health concerns associated with pesticides.

C J BURNS
The Dow Chemical Company, 1803 Building, Midland, MI 48674, USA

Correspondence to: Dr C J Burns cburns@dow.com


Burns replies

We appreciate the interest taken in our study by Freedman. At the heart of the discussion are the interpretation of the significance of the statistics in our study, the lack of significance in others. A critical point in valuing causation is the weight of the evidence to be placed upon the non-significant increase of non-specific exposures found in human studies of amytrophic lateral sclerosis compared with the weight placed upon controlled animal studies specific to the herbicide 2,4-dichlorophenoxyacetic acid (2,4-D).

None of this is meant to say that the findings for cancer of the pancreas are conclusive. The finding is, however, consistent with several previous studies, and instead of being played down, warrants serious attention in future studies.

M FREEDMAN
Division of Cancer Epidemiology and Genetics, National Cancer Institute, USA

Correspondence to: Dr M Freedman mf1016@nih.gov


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.1

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.2 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.3 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.”4 Emotional intelligence is considered more important than intelligence quotient (IQ) in enabling people to function well in society.5 We suggest that emotional intelligence, which can be taught, can be an important solution in reducing the incidence of bullying in the workplace.6

T S KOH
T H H G KOH
EQ-InSight and Kirwan Hospital, QLD 4814, Australia

Correspondence to: Dr T H H G Koh
guan_koh@health.qld.gov.au

Dose-response relation between acrylamide and pancreatic cancer

M R SCHULZ, I HERTZ-PICCIOTTO, E VAN WIJNGAARDEN, J C HERNANDEZ and L M BALL

Occup Environ Med 2001 58: 609
doi: 10.1136/oem.58.9.609

Updated information and services can be found at:
http://oem.bmj.com/content/58/9/609.1

These include:

References
This article cites 2 articles, 1 of which you can access for free at:
http://oem.bmj.com/content/58/9/609.1#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/