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.1 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 site”. The study updates and confirms an investigation 10 years earlier of the same cohorts.2 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 analyses such as the lack of specific causative factors on cancer mortality or incidence. The investigators state that they have carried out the most definitive study of the human carcinogenicity of exposure to acrylamide conducted to date.3 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 h working days). At an alveolar ventilation rate of 0.2 l/kg.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 Agency4 this would correspond to a cancer risk of 1.6×10⁻³. An estimate based on the multiplicative model5 would arrive at roughly a 3 times higher risk, 5×10⁻³. 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 workers were defined as acrylamide 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 limitations of material studied by Marsh et al.6

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 cancers. 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 1929–83 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 cancer mortality in an earlier period. 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 exposure to acrylamide. For a few mutagenic carcinogenic including acrylamide that a linear multiplicative model, P=α (β D), can be fitted to experimental cancer incidence data and, for radiation, to human data. Comparing the total and background risks of tumour at site j, D, the dose and β a relative risk coefficient that is (at least approximately) the same for all tumour sites j, βj 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 relevance, the interpretation of these findings is questionable without a loss of statistical power. For related reasons the identification of certain sites as “interesting”, with reference to response to acrylamide in animal experiments, is mostly a consequence of the pattern of background incidences Pj in the animal strain used.

The authors of the paper possess information of extreme value in further efforts to clarify the carcinogenicity 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.

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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. In each analysis, they compared 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 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 cumulative exposure groups 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, 1.8 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 95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;0.001</td>
<td>30</td>
<td>37.50</td>
<td>0.80 to 1.14</td>
</tr>
<tr>
<td>0.001–0.29</td>
<td>5</td>
<td>3.82</td>
<td>1.31 to 3.05</td>
</tr>
<tr>
<td>&gt;0.30</td>
<td>9</td>
<td>3.98</td>
<td>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, Marshall 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 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.

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

Burns et al report a significant excess of deaths due to amylotrophic lateral sclerosis (ALS) in a cohort of Dow employees potentially exposed to the herbicide 2,4-dichlorophenoxyacetic (2,4-D), but then argue against the plausibility of a causal association, concluding that the association “is not consistent with previous human or animal studies.”

This conclusion and the authors’ characterization of the available epidemiological studies seem to rely entirely upon the significance of the statistics, which downplays the importance of their finding. Firstly, the authors state that “cohort studies of people with exposure to 2,4-D (have not) reported increased rates of ALS,” citing two studies,1,2 both of which have limited power to detect the risk of ALS. One of the two studies assessed risk in a cohort that was quite young with a relatively short follow up, and would therefore be unlikely to detect an increased risk for a disease such as ALS, which has a much older median age at onset. Burns et al then go on to state that “exposure to pesticides and other agricultural chemicals have shown no significant association in several studies” (emphasis added).

In each of the three case-control studies cited, however, ALS was positively associated with pesticides or agricultural chemicals, with reported ORs of 1.4,2.0,3 and 3.0,4 although the associations do not reach significance. Finally, Burns et al refer to a case-control study,5 which found a significant association between ALS and pesticides, but, they emphasise, “did not find a significant association of exposure to herbicides.”6 The association between ALS and exposure to herbicide was increased, however, and the lack of significance reflected, at least in part, small numbers.

None of this is meant to say that the finding of a significant association between ALS and 2,4-D is conclusive. The finding is, however, consistent with several previous studies, and instead of being played down, warrants serious attention in future studies.

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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,7 the lack of 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.8 The cohort studies of 2,4-D do not consistently show increased risk of ALS.

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 appeal to 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.

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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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