CORRESPONDENCE

Defamatory article by Martin Walker

In its March/April issue of 1998, the Ecologist magazine carried an article by Martin Walker which attributed to me bizarre beliefs about the causes of cancer that I do not hold and impugned my scientific independence. At the time, I chose to ignore this inaccurate article. With hindsight, however, this may have been unwise as the article has continued to be circulated and has, I understand, been referred to as if the contents were reliable by a member of one of the Chief Medical Officer of Health’s advisory committees. It seems, therefore, necessary to put on record the incorrectness of some of the statements.

These include the following:

(1) “From 1979 to the end of his career, Sir Richard also received a very substantial yearly reward for research into cancer from General Motors.” This is untrue. In 1979, I received from President Carter one of three prizes for cancer research, which are donated annually by General Motors and given to different people each year. I have received no other money from General Motors and none of my research has been funded by General Motors.

(2) The statement that I have “always refused to accept the connection between man-made radioactivity and cancer” but have “always seen, for reasons best known to him, no evidence of a major cause of leukaemia and other cancers” is untrue. On the contrary, I have never distinguished between the effects of man-made and natural radioactivity (as, dose for dose, there are not any) and much of my research has been to assess the risk of cancer from man-made radioactivity.

(3) A question “why have Doll and his colleagues always insisted that only very high levels of man-made radioactivity were harmful?” is answered simply. They have not. On the contrary, I was one of the first (with Court Brown) to demonstrate an approximately linear relationship between (man-made) x irradiation and risk of leukaemia. It did not suggest that the relationship held down to very low doses and I have consistently held to this view ever since. With Dr Sarah Darby and others, I have published one of the few papers providing any evidence of a possible leukaemogenic effect of radioactive fallout.

(4) “Doll’s refusal to accept that any man-made chemicals can cause cancer and other serious health problems” does not accord with my tabulation of 20 chemicals as established causes of human cancer in Peto’s and my paper on the avoidable causes of cancer (Doll and Peto, 1981) most of which are man-made nor with the results of my own research demonstrating the carcinogenic effect in humans of five chemicals or groups of chemicals, three of which were man-made.

(5) “Doll does not accept that air pollution or industrial waste is regarded as a cause of lung cancer or of any other diseases of the respiratory tract” does not accord with my consistent belief that air pollution has been an important cause of chronic obstructive lung disease and my published estimate that in previous decades, it may have been responsible, in conjunction with cigarette smoking, for about 10% of lung cancers in some big towns.

(6) “For Sir Richard Doll, ... , the cancer rate is not increasing—nor indeed could it increase because lifestyles are becoming healthier” is another bizarre statement that in no way reflects anything I have ever said or could have said. Whether “the cancer rate” is increasing is a question of fact and I have repeatedly drawn attention to the recent increase in the age-standardised incidence of most of the cancers Walker lists as having increased (and, of course, to the decrease in the age-standardised incidence of several others, which he doesn’t list). I have never thought or implied that lifestyle was the only cause of cancer nor that all aspects of lifestyle were getting healthier.

(7) “He (Sir Richard Doll) tells us too, against all this evidence, that the continued, unregulated and untested introduction of chemicals into our food, can do the land, the farmers, and ultimately the consumers, nothing but good” is equally bizarre. I have never said anything like this and believe the precise opposite.

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Lung cancer mortality in an urban and industrialised area of Brazil: 1980–93

Lung cancer is the principal cause of morbidity and mortality from cancer in the developed countries, and several epidemiological studies show its relation to environmental exposure in urban industrial areas. Studies of this type are rare in regions of South America, where there are similar urban industrial areas to those in developed countries.

With the objective of contributing to this body of knowledge, we carried out an ecological study aimed at comparing the mortality from cancer among residents in a region of São Paulo State. Within this state, which is the most developed in Brazil, the region of Baixada Santista (IP) has the greatest age-standardised incidence of lung cancer and several occupational and environmental carcinogenic agents, and to smoking. Some reports from the governmental environmental institution¹ have shown an increased concentration of carcinogenic substances in the workplace, as well as in the rural and urban environment. Among them, we highlight the following: metals (chromium and nickel), aromatic hydrocarbons (benzene and styrene), polycyclic aromatic hydrocarbons (PAHs, benz(a)pyrene, antracene, naphtalene), halogenated derivatives of hydrocarbons (ter-rachloroethylene, perchloroethylene, vinyl chloride), formaldehyde, lampblack, silica, particulate material, nitrogenated compos-ites, and derivatives of sulphur. The associa-tions between lung cancer and exposure to such substances have been analyzed by several authors.² Moreover, exposure to asbestos must be great in Baixada Santista, in view of the fact that this fibre is in widespread use as thermal insulation, not only in industries, but also in cargo ships. Steeland et al³ found that the risk of lung cancer was five times greater in people exposed to asbestos. Also in the region, the concentration of PAHs seems to be intense and extensive, originating from the activities of industries and ports, and also as a result of the combustion of diesel oil by the lorries that pass along the network of roads.

The complexity of the exposure to these multiple carcinogenic agents makes imperative the need to take into account three factors that can be contributing greatly to the increase in concentrations in workplaces, air, soil, and water of this area of Baixada Santista: (a) the transfer, to some industries, of obsolete technology from other countries; (b) the barrier formed by the mountain range (Serra do Mar), making the dispersal of industrial pollutants difficult; (c) the lack of effective measures of industrial hygiene up to 1983. Only after this date were governmental programs of control of local emissions implemented. It is assumed that the lower ratios of the significant excess in mortality in the area of IP could have been due in the second part of the study (1987–93) to the implementation of this programme of control.

These results reinforce the need for epidemiological case-control studies that could better characterise the relation between lung cancer and several occupational and environmental carcinogenic agents, which are
present in the region, possible synergism among them, and other risk factors—in particular, tobacco smoke.

Furthermore, such analyses could put the interactions of these factors into perspective, alongside genetic susceptibility—an important factor in the induction of cancer. Knowledge of this type is fundamental so that preventive measures can be taken.

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There remains the question whether these data once obtained and should be, available for others to use in other protocols for other purposes. Certainly in the nuclear industry, we have taken the view that it should not, without revisiting the consent of the workforce. Perhaps this too is an area that COPE might consider in the future.

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BOOK REVIEW

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It is difficult to think that it is 30 years since the first edition of Respiratory medicine by Crofton and Douglas was published. It was the first comprehensive textbook of respiratory medicine in the United Kingdom and every respiratory physician had a well thumbed copy. The editorship moved to the present editors and the fifth edition has just been published in two volumes. The editors for the first time have invited some of their colleagues to write specific chapters.

Crofton and Douglas has always been characterised by beautiful, lucid writing and this continues to be an outstanding feature, supported by many attractively presented figures, radiographs, and line drawings. Reading this book is a real pleasure. A second major strength is the very balanced perspective it provides. The authors are skilled at separating the genuinely important from more transient fashionable fads and the writing is proportional to the requirements of the reader and the importance of the topic. The book is clearly focused on the needs of patients and the need to prevent disease when possible. It includes some hard hitting comments on political matters such as the tobacco industry and the way in which complacency in the treatment of tuberculosis has led to multidrug resistance.

As with any good textbook there is something for everyone. Simple but important facts such as how to measure and interpret the response to a Heaf test are explained clearly and not assumed. On the other hand the book is an invaluable reference source. If you want to look up, as I did, the evidence for benefit from pneumococcal vaccination, there is an excellent state of the art review. Subjects such as air pollution that are particular interests of the authors are covered superbly as expected.

Are there any deficiencies? Very few as far as I can see. As readers are particularly likely to turn to a textbook when faced with a patient with a rare disease I looked up two in particular and these were perhaps covered less well than the more common diseases. The section on Langerhans’ cell histiocytosis made little of its very close association with smoking—an important point both for diagnosis and management, and the reader may well be confused, as I was, by the headings relating to lymphangioleiomyomatosis (and lymphangioleiomyoma). A new, long chapter on lung diseases could be a useful resource, particularly for drugs that are used relatively infrequently. It may not, however, do justice to complicated problems such as the long term effects of inhaled corticosteroids. These are very small criticisms in a book which is masterly by any standard.

To edit a comprehensive textbook that is also a pleasure to read requires knowledge, skill, experience, and wisdom. Respiratory medicine is extremely fortunate to have such an excellent book and our patients will be the beneficiaries. This book is an absolutely necessary for anyone working in the area of respiratory medicine. Sadly, Leitch is not alive to enjoy the success of this edition.

A E Tattersfield

Guidelines on good publication practice

I was interested to read the excellent COPE Report paper and note the intention of Occupational and Environmental Medicine to follow these guidelines.

In particular, from the occupational health point of view, I welcome the inclusion of involvement of the study participants in consideration and agreement of the research protocol, although I am a little sad that the COPE Group have restricted their consideration of publication information of the results to “patients, especially if there are clinical implications”.

As you are aware, the professional guidance on ethics for occupational physicians now includes a specific section on occupational health research which highlights the need to consider publication of results, including publication briefings to workforces who are the subjects of such research. I know that the BMJ Group have long been in support of this sort of ethical stance, and would hope that in the future the COPE might expand their consideration of publication information beyond patients and clinical medicine into workers in the occupational setting.

Another area of ethics of research relevant to occupational health not considered by COPE is the field of data access and shared data. Research in the workplace can be consented to by the workforce for a specific purpose, specific protocol, and even on occasions for the use of a specific researcher.

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Medichem—the international scientific association for occupational and environmental health in the chemical industry in cooperation with The Czech Society of Occupational Medicine of the Czech Medical Association of J E Purkyne and the Section of Toxicology of the Czech Society of Experimental and Clinical Pharmacology and Toxicology of the Czech Medical Association of J E Purkyne are pleased to invite you to take part in the Medichem 2001 Congress.

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