Authors' Response

From JOSEPH ISTVAN, ROBERT MURRAY AND HELEN VOELKER

Sir—We appreciate Dr Liu's suggestions regarding a number of factors that may account for the relationships we reported between pattern of alcohol intake and body mass index in the Lung Health Study.1 Some of these hypotheses can be addressed by supplementary analyses and others are beyond the scope of data obtained in the Lung Health Study.

First, control for the degree of lung impairment—expressed as either the forced expiratory volume in one second (FEV1) or the ratio of this measure to the forced vital capacity (FEV1/FVC)—had no effect on the strength of the relationships we reported, although as would be expected, both lung function parameters had a significant independent relationship with body mass index.

Second, collinearity between total weekly alcohol intake and drinks per drinking day is not a likely explanation for these findings. As noted in the original paper, the Lung Health Study specifically excluded heavy drinkers (>25 drinks per week). Perhaps as a consequence, the relationship between reported drinks when alcohol was consumed and total drinks per week was relatively modest. The Pearson r between these two measures for men was +0.65 and for women was +0.62, and diagnostic adjuncts to our regression analyses did not suggest that collinearity was present.

Dr Liu also mentions that these findings may be accounted for by differences in physical activity or caloric intake. As we described, the Lung Health Study did not include assessments of either one of these factors. It would obviously be reasonable to suspect that major components of energy balance may be related to these outcomes. It would also be prudent to recognize that our results may not be generalizable to heavy drinkers or nonsmokers.

REFERENCE


Aromatic Amine Exposure and Oesophageal Cancer

From PAUL A SCHULTE

Sir—In their study of aniline dye production (benzidine and 2-naphthylamine) workers, Bulbulyan et al. found excess risk due to oesophageal cancers in both male (standardized incidence ratio [SIR] = 203 [108–347]) and female (SIR = 348 [140–719]) workers.1 They indicated that studies of aniline dye workers from other countries have not reported similar excesses of oesophageal cancer. In 1985, we (Stern et al.) reported an excess (standardized mortality ratio [SMR] = 300 [110–653]) for oesophageal cancer in male workers exposed to 2-naphthylamine during its production.2 Similarly, Gu et al. studied workers exposed to another aromatic amine 4-chloro-orthotoluidine, and reported excesses of oesophageal cancer in both males (SMR= 228 [208–249]) and females (SMR= 388 [352–428]).3

As Bulbulyan et al. noted, theirs and other studies did not control for cigarette smoking and alcohol consumption, and hence in all three cited studies of oesophageal cancer excess, cigarettes and alcohol could have contributed to the excess.4 However, since these risk factors also exist in the comparison group, (e.g. in our study, the US population) only a very large difference in smoking and drinking habits could account for the excess. It is also possible that other exposures at the study plants could be responsible for the excess although the oesophageal risk in these studies does not appear to be related to occupational factors such as years of total employment and time since year first employed.

Since most aromatic amines need to be metabolized in the liver to the active carcinogen, it is not apparent why the oesophagus would be a target organ. However, there is evidence of cytochrome p450 1A2 activity

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in the nasal pharynx of some mammals, and it might be plausible that carcinogenic aromatic amines can be activated in the upper aerodigestive tract of humans. This needs confirmation. Nonetheless, it appears that most epidemiological studies of workers exposed to aromatic amines have generally not shown excess risks of oesophageal cancer. The question remains to what extent has oesophageal cancer been investigated in studies of aromatic amines or was all the attention focused on bladder cancer. It might be useful to examine thoroughly studies of aromatic amine-exposed cohorts and assess the issue further.

REFERENCES


A Census of European Health Surveys

From CAROL JAGGER AND KAREN RITCHIE

Sir—As part of the Euro-Reves project for harmonization of health expectancy calculations across Europe we are presently conducting a Census of European Mental Health studies. This covers both purely epidemiological studies and national health surveys containing mental health questions, conducted since 1980.

The census is organized by the Mental Health Sub-Committee of Euro-Reves, which aims, through consensus, and by developing and promoting calculations and instruments, to facilitate more cross-cultural comparison. The first step towards this is to find out the mental health priorities across Europe. The most common priorities for national mental health research indicated so far are dementia and depression, and although there is an enormous range of different instruments in use, certain ones such as the MMSE and CAMDEX are common all over Europe.

Details of 50 studies have been collected to date with a median size of 2500 people and range from 100 to 25 000. The age ranges covered are birth to over 100, although most of the surveys concentrate on the over-65s. Twenty surveys were locally based, 13 were regionally based and 11 were national surveys. Twenty-six were longitudinal, with 11 cross-sectional and 5 containing elements of both.

The results of this survey so far, combined with evidence from the recent Mental Health Sub-committee meeting in Leiden, Netherlands, show a good consensus of instruments in use. With this in mind we intend to produce an inventory of scales and symptoms/ADLs currently in use, compared across ICD-10 categories, as part of our aim to become a resource centre for cross-cultural comparison of mental health indicators, encouraging greater international discussion and cooperation on this topic.

We would like very much like to hear from other researchers with relevant studies, especially in Portugal, Italy, Finland, Greece and Austria. The questionnaire is two A4 sheets obtainable from us either by mail at The University of Leicester, Department of Epidemiology and Public Health, 22-28 Princess Road West, Leicester LE1 6TP, UK, by fax on (+44) (0) 116 252 3272, or by e-mail at mjhl8@le.ac.uk.