Meta-analysis of studies on individual consumption of chlorinated drinking water and bladder cancer

C M Villanueva, F Fernández, N Malats, J O Grimalt, M Kogevinas

Study objective: To evaluate whether consumption of chlorinated drinking water is associated with bladder cancer.

Design: A bibliographic search was conducted and the authors selected studies evaluating individual consumption of chlorinated drinking water and bladder cancer. The authors extracted from each study risk estimates for intermediate and long term (>40 years) consumption of chlorinated water, stratified by sex when possible, and performed meta-analysis for the two exposure levels. A meta-analysis was also performed of the dose-response regression slopes.

Setting: Populations in Europe and North America.

Participants: Those included in six case-control studies (6084 incident bladder cancer cases, 10 816 controls) and two cohort studies (124 incident bladder cancer cases) fulfilling the inclusion criteria.

Main results: Ever consumption of chlorinated drinking water was associated with an increased risk of bladder cancer in men (combined OR = 1.4, 95% CI 1.1 to 1.9) and women (combined OR = 1.2, 95% CI 0.7 to 1.8). The combined OR for mid-term exposure in both genders was 1.1 (95% CI 1.0 to 1.2) and for long term exposure was 1.4 (95% CI 1.2 to 1.7). The combined estimate of the slope for a linear increase in risk was 1.13 (95% CI 1.08 to 1.20) for 20 years and 1.27 (95% CI 1.15 to 1.43) for 40 years of exposure in both sexes.

Conclusions: This meta-analysis of the best available epidemiological evidence indicates that long term consumption of chlorinated drinking water is associated with bladder cancer, particularly in men. The observed relative risk is only moderately high, but the population attributable risk could be important as the vast majority of the population of industrialised countries is potentially exposed to chlorination byproducts for long time periods.
with English abstract not available, 14 were not epidemiological studies on bladder cancer and chlorination (methodological, experimental, or clinical studies), and seven fulfilled our a priori inclusion criteria. A second search was performed using bladder cancer and tap water as search terms. From the 25 articles found, only one fulfilled the inclusion criteria. The searches were replicated in Cancerlit and Embase databases. All references retrieved from Cancerlit were included in Medline. One reference found in Embase was not included in Medline. This was a review article in Chinese. The reference lists of the papers selected and the most recent review articles were checked for undetected published studies. A certain number of studies were identified, the studies by Doyle and Freedman the only ones partially fulfilling the inclusion criteria.

### Data

We finally included in the meta-analysis six case-control studies and two cohort studies evaluating individual consumption of drinking water through personal interviews (table 1). The six case-control studies included 6084 incident bladder cancer cases and 10 000 controls. The cohort studies included 124 incident bladder cancer cases (table 1).

The study by Lynch was excluded from the analysis, because although it fulfilled the inclusion criteria, the population study was included in the study by Canter 1987. The study by Freedman is a case-control study nested in the cohort of the study by Wilkins and Comstock. The study by Freedman, however, evaluated water consumption patterns of the study population only for a limited time period, precisely at the time of the same private census used in the cohort study. We included in the main meta-analysis the cohort study. Although the number of bladder cancer cases was smaller in the cohort study, the exposure assessment was more accurate and closer to the dates in which the study was conducted. The study by Freedman was considered in an alternative analysis. Death certificate based case-control studies, although have been frequently quoted, were not included in this meta-analysis because exposure information was either ecological or based on interviews of proxies.

### Statistical analysis

For each study, odds ratios (OR) or relative risks (RR) and 95% confidence intervals (95% CI) by sex and exposure category were extracted. Two studies provided only gender specific risks and overall risk estimates were calculated by us through a meta-analysis of male and female risks. One study included only men and one only women. We used Wolf's method to combine risk estimates in all meta-analyses. This method is based on the study specific risk estimates and confidence intervals, applying the inverse of variance as the weighting factor. The exposure indices analysed were duration of chlorinated drinking water consumption in the case-control studies and water source in the cohort study. Subjects were classified as whether they ever consumed or not chlorinated drinking water. When not presented in the original papers, combined risk estimates for ever-consumers were estimated through a meta-analysis of published risk estimates for exposed subcategories. Those consuming chlorinated drinking water were further grouped according to duration of consumption. Three a priori defined exposure categories were used: no/lower exposure group (reference category) including subjects not drinking chlorinated drinking water or consuming chlorinated drinking water for short time periods; an intermediate exposure group, corresponding in most studies to a consumption of chlorinated drinking water from 1 to 40

### Table 1 Description of studies included in the meta-analysis

<table>
<thead>
<tr>
<th>Study</th>
<th>Location</th>
<th>Study population</th>
<th>Exposure measurement selected for the meta-analysis</th>
<th>Exposure categories</th>
<th>Referent category</th>
<th>Mid-term exposure</th>
<th>Long term exposure</th>
<th>Confounders considered in the statistical analysis or study designs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case-control studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canter et al (1998)</td>
<td>Iowa (USA)</td>
<td>732 cases</td>
<td>Duration of exposure to chlorinated surface water</td>
<td>0 years</td>
<td>1–39 years</td>
<td>≥40 years</td>
<td>Age, sex, study period, high risk occupation, and cigarettes.</td>
<td></td>
</tr>
<tr>
<td>Kantola et al (1998)</td>
<td>Finland</td>
<td>1123 cases</td>
<td>Substantially mutagenic drinking water</td>
<td>&lt;15 years</td>
<td>15–44 years</td>
<td>≥45 years</td>
<td>Age, sex, socioeconomic status and smoking. Results stratified by sex.</td>
<td></td>
</tr>
<tr>
<td>King et al (1996)</td>
<td>Ontario (Canada)</td>
<td>696 cases</td>
<td>Chlorinated drinking water</td>
<td>≥9 years</td>
<td>10–34 years</td>
<td>≥35 years</td>
<td>Age, gender, log pack years of smoking, current smoking, education, and calorie intake.</td>
<td></td>
</tr>
<tr>
<td>McGeehin et al (1993)</td>
<td>Colorado (USA)</td>
<td>327 cases</td>
<td>Chlorinated water</td>
<td>0 years</td>
<td>1–30 years</td>
<td>&gt;30 years</td>
<td>Coffee consumption, smoking, tap water intake, family history of bladder cancer, sex, and medical history of bladder infection or kidney stones.</td>
<td></td>
</tr>
<tr>
<td>Vena et al (1993)</td>
<td>New York state (USA)</td>
<td>351 cases</td>
<td>Tap water</td>
<td>0–49 years consuming</td>
<td>0–5 glasses/day</td>
<td>0 years</td>
<td>Age, education, cigarettes (pack years), sodium, carotene, and non-tap water.</td>
<td></td>
</tr>
<tr>
<td>Cohort studies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wilkins and Comstock (1981)</td>
<td>Washington County (USA)</td>
<td>3100 study subjects, 81 bladder cancer cases</td>
<td>Drinking water source</td>
<td>Deep well users</td>
<td>Chlorinated surface water users</td>
<td>Age, marital status, education, smoking history, frequency of church attendance, adequacy of housing, and persons per room.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doyle et al (1997)</td>
<td>Iowa (USA)</td>
<td>28237 study subjects, 43 bladder cancer cases</td>
<td>Drinking water source</td>
<td>100% ground water source</td>
<td>100% surface water source</td>
<td>Age, education, smoking status, pack years of smoking, physical activity, fruit and vegetable intake, total energy intake, body mass index, and waist to hip ratio.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
years; and a high exposure group corresponding in most studies to a consumption of chlorinated drinking water of more than 40 years. In the cohort studies information was provided only on water source and data from these studies are therefore not included in the analysis by duration. When the risk estimates of the intermediate and long term exposure categories we defined did not coincide with the published data, a meta-analysis of risk estimates collapsing exposure categories within study was performed. The cut off points used to define the exposure groups were study specific and did not coincide exactly.

### Results

We then performed a meta-analysis of the slopes and their standard errors to get a combined dose-response slope for all the studies. The exponentiation of the slope gave the OR for a unit increase of the exposure index (one year of exposure). To overcome the problem of assuming independence of dose specific OR which is incorrect as they have a common reference group, we adjusted the standard error of the within study responses to a consumption of chlorinated drinking water of more than 40 years. In the cohort studies information was provided only on water source and data from these studies are therefore not included in the analysis by duration. When the risk estimates of the intermediate and long term exposure categories we defined did not coincide with the published data, a meta-analysis of risk estimates collapsing exposure categories within study was performed. The cut off points used to define the exposure groups were study specific and did not coincide exactly.

### Table 2

<table>
<thead>
<tr>
<th>Case-control studies</th>
<th>Men</th>
<th>Women</th>
<th>Both sexes</th>
<th>Men</th>
<th>Women</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cantor 98</td>
<td>1.0</td>
<td>0.9</td>
<td>1.0</td>
<td>1.0</td>
<td>0.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Koivusalo 98</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>King 98</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Wilkins and Comstock 81</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Vena 93‡</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Doyle 97</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Wilkins and Comstock 81</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*OR for both sexes obtained from a meta-analysis of men and women risk. †OR for the quartile of exposure interval.*
cohort study or, alternatively, of the nested case-control study by Freedman et al., modified minimally the results. The combined OR for both sexes and long term exposure category was 1.5 (95% CI 1.3 to 1.7) when including the cohort study by Wilkins and Comstock, and the combined OR was 1.4 (95% CI 1.2 to 1.6) when including the nested case-control study.

Table 3  Combined risk estimates from studies on bladder cancer and consumption of chlorinated drinking water by sex and exposure category

<table>
<thead>
<tr>
<th>Exposure category</th>
<th>Meta-OR (95% CI)</th>
<th>Number of studies</th>
<th>Test for heterogeneity p value</th>
<th>Selected method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both sexes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-term</td>
<td>1.1 (1.0 to 1.2)</td>
<td>5</td>
<td>0.84</td>
<td>Fixed effects</td>
</tr>
<tr>
<td>Long term</td>
<td>1.4 (1.2 to 1.7)</td>
<td>5</td>
<td>0.55</td>
<td>Fixed effects</td>
</tr>
<tr>
<td>Ever exposed</td>
<td>1.2 (1.1 to 1.4)</td>
<td>6*</td>
<td>0.61</td>
<td>Fixed effects</td>
</tr>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-term</td>
<td>1.3 (1.0 to 1.7)</td>
<td>4</td>
<td>0.08</td>
<td>Random effects</td>
</tr>
<tr>
<td>Long term</td>
<td>1.6 (1.2 to 2.2)</td>
<td>4</td>
<td>0.11</td>
<td>Random effects</td>
</tr>
<tr>
<td>Ever exposed</td>
<td>1.4 (1.1 to 1.9)</td>
<td>5*</td>
<td>0.01</td>
<td>Random effects</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mid-term</td>
<td>1.0 (0.7 to 1.6)</td>
<td>3</td>
<td>0.09</td>
<td>Random effects</td>
</tr>
<tr>
<td>Long term</td>
<td>1.4 (0.6 to 3.6)</td>
<td>3</td>
<td>0.01</td>
<td>Random effects</td>
</tr>
<tr>
<td>Ever exposed</td>
<td>1.2 (0.7 to 1.8)</td>
<td>5*</td>
<td>0.01</td>
<td>Random effects</td>
</tr>
</tbody>
</table>

*Includes the cohort studies that do not provide risk estimates by duration of consumption.

The study specific OR for both genders and the mid-term and long term exposure categories are shown in figures 2 and 3, respectively. OR for the long term exposure category are comparable and both the test for heterogeneity and the Galbraith plot, which is a more sensitive method than the $\chi^2$ statistic, do not indicate substantial differences between studies (fig 4 and 5). Heterogeneity of results among studies is,
however, particularly evident for results in women that are based on three studies and on comparatively small numbers (table 3). In men, the main source of heterogeneity was attributable to the inclusion of the study by Vena, particularly for mid-term exposure. Excluding this study resulted to an OR for men in the mid-term exposure category of 1.2 (95% CI 1.0 to 1.4) and p value for heterogeneity of 0.82. We explored through meta-regression whether year of publication was associated with the magnitude of the OR but found no statistically significant effect attributable to the year of publication for either of the two exposure categories.

We evaluated whether the cut off points selected could influence results, and calculated combined OR for two a priori defined “alternative” intermediate and high exposure categories. We selected as “alternative” intermediate exposure group the most comparable exposure category among studies, which corresponded to the strata including 25–26 years of consumption of chlorinated drinking water (table 2). The combined OR for this group was 1.2 (95% CI 1.0 to 1.4) with a p value for a test of heterogeneity of 0.36. The “alternative” high exposure group included the highest exposure strata in each study. The meta-OR for this group was 1.6 (95% CI 1.3 to 1.8) with a p value for a test of heterogeneity of 0.79. Similar to the overall combined OR, the gender specific combined OR calculated on the basis of these “alternative” exposure categories were slightly higher than those shown in table 3, and results for these categories were less heterogeneous.

The study by Cantor et al., 1987 reports OR by quantity of tap water consumption stratified below or above the median population level of daily water consumption (1.4 litres). Our model includes the OR of the most exposed stratum, tap water consumption above the median. We explored the effect on the combined risk estimate considering the OR from the stratum below the median. The risk estimate changed little for the overall combined risk estimate (OR=1.4, 95%CI=1.2 to 1.7; test for heterogeneity p value=0.528).

The study by Doyle reports results for three types of water source: subjects consuming 100% surface water (highest exposure), those consuming mixed surface and ground water, and those consuming 100% ground water (non-exposed). We included in our model the highest exposure category that included, however, only few subjects. We also checked for the effect on the results when using the intermediate exposure category that included the most exposed subjects. When using the intermediate category in the combined analysis, the OR increased (OR=1.4, 95%CI=0.9 to 2.2, test for heterogeneity=0.02).
Four studies applied elaborate exposure models and estimated long term level of exposure to trihalomethanes or to water mutagenicity attributable to the presence of chlorination byproducts. Risk estimates in the three studies examining both sexes were 1.4, 1.5, and 2.2 for long term exposure. The combined risk estimate for these three studies was 1.5 (95% CI 1.2 to 1.8) with a p value for the test of heterogeneity of 0.61.

The results of the dose-response analysis are shown in table 4. The combined OR for unit increase in duration of exposure is 1.006 (95%CI 1.004 to 1.009). For 20, 40, and 60 years of exposure, combined OR are respectively 1.13 (95%CI 1.08 to 1.20), 1.27 (95%CI 1.17 to 1.43), and 1.43 (95%CI 1.27 to 1.72). The comparison of “crude” and “adjusted” combined OR for the three studies that permitted the calculation of a covariance matrix, showed that adjusting for covariates led to a 20% lower combined estimate. For these three studies, the combined OR for unadjusted slopes was 1.005 per year of exposure (95%CI 1.003 to 1.008), standard error (SE)=0.000128. After adjusting for covariates, the combined OR was 1.004 (95%CI 1.001 to 1.007), SE=0.000153.

We found no evidence of publication bias. Egger’s graph showed a slight negative slope indicating that the smaller and less precise studies tended to report higher risk estimates, while the bigger and more precise studies tended to report lower risk estimates. However, the evidence of this trend is not statistically significant. We performed also the Begg’s and Egger’s tests to check for publication bias in the models stratified by sex. Because of the small number of studies, the test is not reliable as the confidence intervals very wide.

### DISCUSSION

Results of this meta-analysis indicate the presence of a moderate excess risk for bladder cancer attributable to consumption of chlorinated drinking water. A clear excess risk was observed among subjects consuming chlorinated drinking water for more than about 40 years. The risk estimate for the intermediate exposure category was only slightly increased, though it also was statistically significant. Overall, results for long term exposure to chlorinated drinking water were consistent between studies and fairly consistent exposure-response patterns were observed in all case-control studies. Previous meta-analyses or reviews had reached the same conclusions but either did not provide a quantitative summary of the effect, or did not base the analyses and conclusions on those studies with individual information.

Exposure assessment has been identified as one of the main problems when evaluating results of epidemiological studies on chlorination by products and recent studies have made considerable efforts in characterising lifetime exposure. All studies included in this meta-analysis recorded individual information on water consumption. Heterogeneity of the results by duration of exposure, combined OR are respectively 1.13 (95%CI 1.08 to 1.20), 1.27 (95%CI 1.17 to 1.43), and 1.43 (95%CI 1.27 to 1.72). The comparison of “crude” and “adjusted” combined OR for the three studies that permitted the calculation of a covariance matrix, showed that adjusting for covariates led to a 20% lower combined estimate. For these three studies, the combined OR for unadjusted slopes was 1.005 per year of exposure (95%CI 1.003 to 1.008), standard error (SE)=0.000128. After adjusting for covariates, the combined OR was 1.004 (95%CI 1.001 to 1.007), SE=0.000153.

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Exposure assessment has been identified as one of the main problems when evaluating results of epidemiological studies on chlorination by products and recent studies have made considerable efforts in characterising lifetime exposure. All studies included in this meta-analysis recorded individual information on water consumption. Heterogeneity of the methods used in different studies and different background levels of chlorination byproducts remains, however, a main concern. Statistical heterogeneity of the results was present for the intermediate exposure category and particularly for results stratified by gender. Small numbers, especially in women, and differences in exposure assessment are probably the most important sources of heterogeneity of results between studies. The study by Vena et al was the main source of statistical heterogeneity observed particularly in the mid-term category. In this study, OR were generally higher than in other studies, and is the least comparable to the other studies concerning various aspects of assessment of exposure including the exposure categories used.

The exposure categories used in the meta-analysis could correspond to different levels of exposure to chlorination byproducts between studies. The exposure strata used were not directly comparable between studies and also, levels of chlorination byproducts would be expected to differ between the geographical areas examined in these studies. Despite our effort to select the most comparable exposure categories identifying subjects with intermediate and long term consumption of chlorinated drinking water, exposure categories between studies differed. Even though the highly exposed group included in all studies subjects with long term consumption of chlorinated water the cut off points differed between studies. In one study the minimum was 30 years, in another 35 years, in two studies 40, in one study 45, and in two 50 years. More importantly, the groups considered as non-exposed in two studies had consumed chlorinated drinking water for a few years, which would have led to an underestimation of the risk. In an alternative analysis we examined the extent to which the definition of the cut off points could affect results. This analysis indicated that observed results are robust. Even though different estimates can be derived if the data are categorised in alternative ways, these differences are small and results tend to support a positive association between consumption of chlorination drinking water and bladder cancer.

Levels of trihalomethanes were measured and modelled only in three studies while a fourth study used a matrix of water mutagenicity that corresponds well with levels of chlorination byproducts. In the two studies measuring trihalomethanes and evaluated both sexes, risks for specific contaminant levels were comparable. The extent to which this finding can be extrapolated to the other studies included in this analysis is unknown and, in principle, one should not expect that risks by duration of exposure should be directly comparable as levels of contaminants and type of contaminants differ between areas and time periods. It should be
noted that trihalomethanes have been traditionally used as markers of the whole mixture of chlorination byproducts because they are the most prevalent byproducts. Other chlorination byproducts such as haloacetic acids and MX, have also been shown to have mutagenic or carcinogenic properties.10–15

In one study the excess risk identified was present only among ever smokers.7 All studies adjusted for important confounding factors like age, sex, and smoking and some studies also for occupation and socioeconomic status. Residual confounding attributable to smoking could still be present but, overall, confounding seems to be an unlikely explanation for the findings of individual studies and the results of the meta-analysis.

The alternative dose-response methods we used confirmed the existence of an excess risk, though they led to combined risk estimates of slightly different magnitude. According to the dose-response analysis described by Berlin16 and Greenland,17 we reached combined risk estimates slightly lower than according our intermediate term and long term exposure approach. The combined risk estimates obtained from both methods are comparable for the intermediate duration of exposure (about 20 years), and the difference seems to be larger for long term exposures. Both methodologies have their limitations. The dose-response slope approach is based on the assumption of a linear dose-response, which may be a simplification of the real dose-response trend. The mid-term, long term approach implies the combination of risk estimates from exposure categories that are not fully comparable among studies. These results obtained from different methodologies indicate the presence of an excess bladder cancer risk associated with exposure to disinfection byproducts, and also indicate that the limitations of each method are probably not producing a spurious association.

Publication bias is a concern for all meta-analyses. Our bibliographic search was limited to databases including published studies. There may exist other not published studies, for example, doctoral theses and congress communications. It is extremely difficult to identify such studies. Furthermore, their inclusion could be questioned as quality criteria are difficult to apply. A simple observation of the graphics presented (figs 1–3) indicates that there is no trend along the years. If publication bias did exist, reported risks would tend to be higher in the first published studies, and lower risks in more recent studies. We additionally examined with publication bias through statistical and graphical methods, showing no evidence of such bias.

To conclude whether disinfection byproducts (DBP) or chlorinated drinking water exposure is a risk factor for a certain cancer, evaluations could be based on an evaluation of single compounds but should also be based on the effect of the total DBP mixture, as humans are exposed to complex mixtures of DBP and it is impossible to evaluate the effect of one single compound through epidemiological studies. Results of this meta-analysis of case-control studies of bladder cancer and chlorinated drinking water exposure provide an objective summary risk for one of the cancers most consistently associated with DBP exposure.

In industrialised countries disinfection and chemical protection of drinking waters should not be considered as antagonistic. The recommendations of a recent report by the WHO similar to previous reports although applicable at a global level, do not correspond to the current situation of most industrialised societies where contamination of the water by microorganisms has been drastically, although not entirely,18 reduced. Traditional drinking water treatment is highly chlorine and chemical based. There exist reasonable alternatives that keep the disinfection power and produce fewer byproducts. In the long term, the most efficient approach is the protection of source waters aimed at reducing the presence of natural organic matter.19 Exposure to chlorination byproducts occurs through ingestion, inhalation, and dermal absorption.20–23 Epidemiological studies have only evaluated ingestion. Changing drinking water practices, for example consuming bottled water, would reduce exposure to trihalomethanes by only about one third.24

In conclusion, on the basis of epidemiological evidence, chronic exposure to chlorinated drinking water is associated with a moderate increased risk for bladder cancer, particularly among men. The estimated relative risks are not high, but the population attributable risk could be important, as the vast majority of the population of industrialised countries is potentially exposed for long time periods.

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Multivariate regression analysis of associations between general practitioner prescribing rates for coronary heart disease drugs and healthcare needs indicators

A recent paper in the journal by the authors presented the results of bivariate correlations between prescribing rates for coronary heart disease (CHD) drugs and healthcare needs indicators (HCNIs). This paper added further weight to the suggestion that GP practice prescribing rates for statins are inequitable, although we also provided evidence for a range of other CHD drugs.

One of the letters to the journal suggested that a multivariate analysis would have helped to determine the independent associations between prescribing rates and HCNIs. We have undertaken multivariate regression analysis to determine the amount of variation in prescribing rates that can be explained by a combination of HCNIs and also to understand the strength and direction of independent associations with individual HCNIs. The main results are provided in this letter.

Between 22% to 25% of the variation in prescribing rates for statins, β blockers, and benzoflazide was explained in the multiple regression models. Slightly more variation was explained for ACE inhibitors (31.6%) and considerably more for aspirin (51.2%). Prescribing rates for all drug groups (except ACE inhibitors) were positively associated with CHD hospital diagnoses and procedures. Prescribing rates for statins and ACE inhibitors were negatively associated with the percentage of patients aged over 75 years in addition to the proportion of patients from minority ethnic groups. Prescribing rates for aspirin, benzoflavazide, and all CHD drugs combined were negatively associated with deprivation.

Overall, this study found that prescribing rates were generally positively related to the rates of CHD hospital procedures and diagnoses, although they were also negatively associated with proxies of deprivation and ethnicity. These findings present further evidence of inequities of GP practice prescribing rates and the continued relevance of the inverse care law in prescribing. However, this ecological study cannot be used to infer inequitable prescribing by GPs, as the lower prescribing rates in GP practice populations with higher proportions of elderly, ethnic minority, and deprived patients may be attributable to lower utilisation of primary healthcare services because of social, psychological, economic, or cultural barriers. Therefore, further work needs to be undertaken in identified GP practice populations to understand the reasons for the low prescribing rates and ultimately to make CHD prescribing commensurate with healthcare need.

Acknowledgements
Paul Ward received a Health Services Research Training Fellowship from the North West NHS Executive to carry out the study on which this paper is based. We thank all health authority, PCT and Local Authority staff who provided access to PACT data, GP practice list data, hospital episode statistics and a variety of other data sources.

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References


BOOK REVIEWS

Health


This book offers a revision of health concept and discusses different meanings of health and illness. It propels work needs to be undertaken in identified GP practice populations to understand the reasons for the low prescribing rates and ultimately to make CHD prescribing commensurate with healthcare need.

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References

Global public goods for health; health economic public perspectives

This volume explores the applicability of the concept of global public goods to health and related issues as well as the question of the added value—for example, in terms of new analytical insights or a better understanding of various policy approaches and issues. The authors, looking at challenges through the lens of global public goods. As the stage setting chapter 1 by Woodward and Smith notes, “as globalization progresses… matters which were once confined to national policy are now issues of global impact and concern; yet no one nation necessarily has the ability, or the incentive, to address these problems” (page 3). So cross border cooperation is important in order for a global public good, let us say, polio eradication, to emerge and to be available for the consumption—or enjoyment—of local communities or countries.

The volume’s chapter analyses are written by a multi-disciplinary team of authors and address three main sets of issues: (1) the global public goods properties of the control or eradication of select communicable conditions (including polio, tuberculosis, antimalarial drug resistance), and the health consequences of a number of global environmental “bads” (such as the global climate change or the depletion of the ozone layer); (2) the importance of knowledge (including medical knowledge, genomics knowledge, and public health infrastructure and knowledge) as a critical input to people’s improved health status and enhanced public health conditions; and (3) how to enable global public goods for health, such as international law and health regulations. However, running through the individual chapter analyses also are common themes. Among them are such issues as the prioritisation of global public goods and the policies of their provision, their “production”, and financing.

The discussions on these themes are analytically rigorous yet clear and focused, leading to practical and pragmatic—yet in part, also innovative—policy conclusions and recommendations. Thus, the book should be of interest to researchers and students as well as policymakers and practitioners alike.

Inge Kaul

Health inequalities: life course approaches

This weighty and impressive collection describes and critically assesses the development of life course approaches to understanding health inequalities over the past two decades. In part, these approaches reflect the revival of interest in early years’ influences on adult health and mortality. However, this book goes much further, showcasing several important studies that demonstrate how the social and the physical are mutually constitutive throughout the life course and that trajectories and processes of influence vary with different illness conditions. Life course approaches, made possible partly because of the development of longitudinal datasets, have resulted in a questioning of theories about how health inequalities develop and persist. Some of these papers show a simple cumulative life course effect of exposure to health risks and insults; others examine critical time windows of exposure and influences of particular inheritances or life and lifestyle experiences. Frustations that, as products of their academic and political times, these datasets have inherent limitations, are evident in several papers. Nevertheless, this collection (39 papers, all co-authored by David Davey Smith) shows yet again that social structural factors are crucially important in generating health inequalities and includes many challenges to policy makers to tackle poverty. There are weaknesses. Although acknowledged by the editor, the gender blindness of much of this collection must still be seen as a deficit. Another is that explicit attention to culture, beliefs, and behaviour seems only to occur in the section on ethnic inequalities in health, (although the idiosyncratic “Diversions” section perhaps shows the editors’ inherent racial and sociological talents!). However, by highlighting the part played by social and cultural processes and clearly discussing the exceptions to notions of straightforward linear causality or general susceptibility theory, this collection should convince even the sceptical of the heuristic benefits of taking a life course approach, the photographs are good too.

Kathryn Backett-Milburn

Violence against women: the health sector responds

Gender based violence (GBV) is an important public health problem with far reaching physical and mental health outcomes. Although non-governmental organisations and women’s advocacy groups have been at the forefront of the efforts to stop this epidemic, the response from the health sector has lagged behind. This book is a succinct synopsis of the Pan American Health Organisation’s (PAHO) efforts to eliminate gender based violence in Latin America. While the reader is provided with a brief overview of the scope of GBV, a significant portion of the book is devoted to a description of the needs assessment for their project called “Critical Path”, the implementation of the multi-level PAHO Latin America Community/sector/Regional/national) in 10 Latin American countries and the lessons learned from this project. As the healthcare sector was only one of the many levels at which this plan was implemented, the book describes more than just the health sector response to GBV; the book also describes the change effected in national policies and laws as a result of the PAHO project, as well as the effect on the women affected by GBV. Even though the specific strategies described in this book had been tailored to the local milieu, it should be possible to use the same process in other settings; the last chapter provides a global perspective on the lessons learned. The book has a comprehensive section on GBV resources; the bibliography contains selected references, and includes references to regional GBV projects. This book is a quick read; and although the tables, figures, and boxes look attractive, in contrast, they do summarise relevant information for the reader and are worth paying attention to. In sum, this book provides an excellent summary of PAHO’s interdisciplinary efforts towards eliminating GBV and is likely to be useful to other field efforts to curb GBV.

Anuradha Paranjape

MONICA monograph and multimedia sourcebook
Edited by Hugh Tunstall-Pedoe. Geneva: WHO, Swiss Fr 45, pp 224. ISBN 92-4-156223-4 (available with two CD ROMs provided)

There can be little doubt that the MONICA project represents the most significant study of the epidemiology of coronary heart disease (CHD) that the world has seen thus far. Inspired in the late 1970s by the 1950s and 1960s CHD epidemic in developed countries and by the seven countries study among (among) others, it was established in the early 1980s to measure trends in CHD and stroke mortality, and to relate these to changes in risk factors, lifestyle, health care, and major socioeconomic factors in defined communities in different countries. Much of our current level of understanding of cardiovascular disease is derived from the numerous reports and publications resulting from this project.

This monograph is a “must” for all those hoping to obtain an understanding of how MONICA was planned and set up, aimed to achieve, and of all the various studies, carried out under its umbrella, which contributed to its findings. However, it does not discuss these findings in the text, which is very largely descriptive, and the text describes important aspects of the project only in very general terms; it would, for example, be useful to obtain rapid access to the precise protocol for measurement of blood pressure, or collection of blood or serum cholesterol. Such details are not provided in the text itself, perhaps because such matters varied somewhat between different MONICA collaborating centres; however, two CD ROMs are provided with the book and these provide massive quantities of background information (including on protocols), links to results, published papers, etc. Overall, this book provides a splendid read; it is written by the leading partners in MONICA and edited by Hugh Tunstall-Pedoe, probably the single individual who, over 23 years, has held MONICA together more than any other single person. It provides a superb overview of what MONICA was all about, and of why it remains so important to us all.

Christopher A Birt

An author’s error occurred in this review by Drs Villanueva and others (2003;57:166–73). In figure 1 the odds ratio corresponding to the study by King et al “ever consumption” of chlorinated drinking water should be 1.2 (95%CI 1.1 to 1.3) not 1.4 (95%CI 1.1 to 1.8). The correct combined odds ratio should be 1.2 (95%CI 1.1 to 1.3) not 1.2 (95%CI 1.1 to 1.4).