

2.18 *Cancer at other sites*

2.18.1 *Testis (Table 2.87)*

(a) Parental exposure

Among two cohort (Robinette *et al.*, 1979; Jensen, 1980) and three case-control studies (Schwartz *et al.*, 1962; Brown *et al.*, 1986; Weir *et al.*, 2000) conducted in the general population, only one case-control study suggested a possible association between testicular cancer in adults and maternal drinking during pregnancy (Brown *et al.*, 1986). The association was of borderline significance for the consumption of more than one drink per week relative to no drinking (odds ratio, 2.3; 95% CI, 1.0–5.2), but no association was observed for one drink (odds ratio, 1.1; 95% CI, 0.6–2.2), and no clear trend was apparent with the amount of alcohol consumed.

Table 2.87 Case-control studies of alcoholic beverage consumption and testicular cancer

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No. of cases	Relative risk (95% CI)	Adjustment factors	Comments
Parental exposure								
Brown <i>et al.</i> (1986), USA, 1979–81	225 mothers (pre- and perinatal cancer); response rate, 88%	213 mothers; response rate, 90%	Standardized telephone questionnaire	Never drinker		1.0	Tobacco smoking	
				1 drink/week		1.1 (0.6–2.2)		
				>1 drink/week		2.3 (1.0–5.2)		
						<i>p</i> -trend=0.14		
Weir <i>et al.</i> (2000), Ontario, Canada, 1987–89	346 case mothers/502 cases, aged 16–59 years; response rate, 80.8%	522 control mothers/ 975 controls; aged 16–59 years; response rate, 67.8%	Self-administered questionnaire	<i>Drinks/ week during pregnancy</i>			Age (5-year age group)	
				0	232	1.0		
				<2	83	1.2 (0.9–1.7)		
				≥2	24	0.8 (0.5–1.3)		
Chen <i>et al.</i> (2005b), USA, 1993–2001	278 incident childhood germ-cell; response rate, 80.8%	422; response rate, 66.6%; 1:2 match	Telephone interview; self-administered questionnaire	<i>Ever drank ≥6 months</i>			Gender of children, age, maternal education, race, family income	
				Never	182	1.0		
				Yes	92	0.9 (0.7–1.2)		
				<i>Ever drank during 1 month before pregnancy to nursing</i>				
				Never	126	1.0		
Yes	148	0.9 (0.7–1.2)						

Table 2.87 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No. of cases	Relative risk (95% CI)	Adjustment factors	Comments
Adult exposure								
Swerdlow <i>et al.</i> (1989), Oxford and West Midlands, United Kingdom 1977–81	259 cases of histologically confirmed testis cancer, aged ≥ 10 years	2 sets of controls: 238 radiotherapy controls treated in the same centres as cases; 251 non-radiotherapy controls who were general surgical, orthopaedic ENT and dental in-patients	Interview	Ever drank <i>Alcohol regularly?</i> Wine No Yes	NR	1.0 1.7 (1.21–2.43)	Social class	There was no dose–response relationship between risk for the tumour in relation to mean or to maximal wine consumption
UK Testicular Cancer Study Group (1994), United Kingdom, 1984–86	794, aged 15–49 years; response rate, 92%	609; 1:2 match (case/controls); response rate, 83.1%	Face-to-face interview	<i>Alcohol (g/week)</i> None <68.8 68.8–124.6 124.6–<211.2 211.2–<364.7 ≥ 364.7	92 150 147 130 135 140	1.0 1.26 (0.86–1.83) 1.23 (0.85–1.79) 0.87 (0.60–1.28) 1.06 (0.72–1.56) 1.13 (0.97–1.66) <i>p</i> -trend=0.41	Cryptorchidism, inguinal hernia at age <15 years	No evidence of an effect of testicular temperature on cancer risk

CI, confidence interval

One additional cohort study conducted among male and female cirrhotics in Denmark found a slightly increased risk for testicular cancer of all histological types (SIR, 2.3; 95% CI, 1.0–4.5) that varied little with type of cirrhosis and disappeared after 10 years of follow-up (Sørensen *et al.*, 1998).

One case–control study investigated the association of childhood germ-cell tumours (seminoma, embryonal carcinoma, yolk-sac tumour, choriocarcinoma, immature teratoma and mixed germ-cell tumours) and parental alcohol drinking (Chen *et al.*, 2005b). Results showed no association between germ-cell cancer overall and alcoholic beverage drinking by either parent before pregnancy, or during pregnancy or nursing; odds ratios were 0.9 (95% CI, 0.7–1.2) and 1.0 (95% CI, 0.8–1.3) for ever drinking, for mothers and fathers, respectively. Additional stratified analyses by sex, histological type and anatomical site did not show any association.

(b) *Adult exposure*

Two case–control studies in the United Kingdom investigated the association between alcoholic beverage drinking and testicular cancer. Swerdlow *et al.* (1989) found no association for regular alcoholic beverage drinking, duration of drinking or consumption of beer, cider or spirits; however, a significant association was found with regular consumption of wine, with an odds ratio of 1.71 (95% CI, 1.21–2.43), but no dose–response relation. The other case–control study found no association with alcohol intake at the time of diagnosis or at age 20 years (UK Testicular Cancer Study Group, 1994).

2.18.2 *Cancer of the brain*

(a) *Parental exposure and childhood brain cancer (Table 2.88)*

Only one cohort study found an association between alcoholic beverage consumption and brain cancer (Robinette *et al.*, 1979). Three additional studies with suboptimal methodology did not provide evidence of an association between increased alcoholic beverage consumption and brain cancer (IARC, 1988). However, a descriptive study based on cancer registries and national mortality data in France (Remontet *et al.*, 2003) showed a large increase in the incidence of and mortality from brain cancer between 1980 and 2000, during which time alcohol consumption decreased markedly.

Five case–control studies have assessed the association between alcoholic beverage consumption of parents and childhood brain cancer. Two of the studies were conducted in the USA and Canada (Bunin *et al.*, 1994; Yang *et al.*, 2000), one in China (Hu *et al.*, 2000), one in Germany (Schüz *et al.*, 2001) and one in the USA (Kramer *et al.*, 1987). Three of the studies examined the association between neuroblastoma and parental alcoholic beverage consumption (Kramer *et al.*, 1987; Yang *et al.*, 2000; Schüz *et al.*, 2001). Kramer *et al.* (1987) found a weak, non-significant association for any maternal alcoholic beverage drinking during pregnancy, with a suggestive increase

Table 2.88 Case-control studies of parental alcoholic beverage consumption and childhood brain tumours

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Kramer <i>et al.</i> (1987), Great Delaware Valley, USA, 1970–79	104 incident from the Great Delaware Valley Pediatric Tumor registry and the Cancer Research Center between 1970 and 1979; response rate, 74.8%	101; selection through RDD; response rate, 57.1%	Telephone interview	<i>Maternal drinking during pregnancy</i>			Not specified	90% CI reported; 1 drink=1 serving of beer, wine or liquor
				Any drinking	36	1.44 (0.94–2.21)		
				≥1 drink/day (frequent)	9	9.0 (2.16–37.56)		
				≥3 drinks/day (binge)	6	6.0 (1.26–28.54)		
Bunin <i>et al.</i> (1994), Canada, USA, 1986–89	322 diagnosed before 6 years of age in 1986–89; identified through the Children’s Cancer Group; response rate, 65%	321; selected through RDD; 1:1 match; response rate, 74%	Telephone interview of the mother or father	≥1 drink/day or ≥3 drinks occasionally	12	12.0 (3.14–45.82)	Income	*Crude odds ratio reported
				<i>Maternal exposure to beer during pregnancy</i>				
				Astrocytoma	10	1.4 (0.5–3.7)		
				Primitive neurectoderma tumour	12	4.0 (1.1–22.1)*		

Table 2.88 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Hu <i>et al.</i> (2000), Northeast, Heilongjiang Province, China, 1991–96	82 consecutive incident (43 boys, 39 girls) intracranial primary brain tumours, ≤18 years of age; 100%; residing in Heilongjiang Province at the time of diagnosis; 100% histologically confirmed; participation rate	3 individually matched per case; participation rate, 100%	Structured questionnaire (interview) administered to parents of all study subjects; history of parental liquor drinking obtained	<i>Lifetime paternal liquor consumption (L)</i> Never ≤200 ≥201	41 20 21	1.00 3.21 (1.43–7.22) 4.43 (1.94–10.14) <i>p</i> for trend=0.0001	Family income, mother's education, father's education	Similar associations for paternal age when started to drink liquor and numbers of years of drinking liquor; only one mother in the case group and two mothers in the control group reported drinking hard liquor.

Table 2.88 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Yang <i>et al.</i> (2000), Canada, USA, 1992–94	538 children newly diagnosed with neuroblastoma in 1992–94, ≤19 years old; 100% histologically confirmed; response rate, 73%	504 mothers selected by RDD; 304 fathers directly interviewed; proxy interviews obtained for 142 (28%); 1:1 match; response rate, 72%	Structured telephone questionnaire to parents	<i>Maternal drinking</i>	253	0.9 (0.7–1.1)	Child's gender, mother's race and education, household income in the birth year	No association for paternal lifetime alcohol consumption, or before mother's pregnancy
				Lifetime	235	1.1 (0.8–1.4)		
				Around pregnancy ^a	205	1.1 (0.8–1.4)		
				1 month before conception	96	1.2 (0.9–1.7)		
				1st trimester	60	1.6 (1.0–2.4)		
				2nd trimester	58	1.4 (0.9–2.1)		
3rd trimester	54	1.0 (0.5–2.0)						
				Breastfeeding				

Table 2.88 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments	
Schüz <i>et al.</i> , (2001), Germany, 1988–94	Pooled analysis of 2 case–control studies (1988–93; 1992–94); total of 192; children; response rate, 83.1%	2537; 2:1 match by gender and date of birth within 1 year; response rate, 71%	Questionnaire and telephone interview; same exposure assessment in both studies	Maternal alcohol consumption			Socioeconomic status, degree of urbanization	Odds ratio from a matched logistic regression on age, gender, birth year	
				<i>Overall</i>	Never	140			1.0
					1–7 glasses/week	38			0.84 (0.56–1.26)
					>7 glasses/week	3			3.04 (0.75–12.2)
				<i>Stage I/II</i>	Never	73			1.0
					1–7 glasses/week	12			0.90 (0.45–1.80)
					>7 glasses/week	0			–
				<i>Stage III/VI</i>	Never	39			1.0
					1–7 glasses/week	23			0.88 (0.53–1.45)
	>7 glasses/week	3	5.23 (1.33–20.6)						

CI, confidence interval; RDD, random-digit dialling

^a Exposure category includes drinking 1 month before pregnancy, during pregnancy and during breastfeeding

in risk with amount and frequency. However, these results were based on very small numbers of controls. A case–control study based on the Children’s Cancer Group and Paediatric Oncology Group institutions in the USA and Canada (Yang *et al.*, 2000) found no associations between the risk for neuroblastoma and either maternal or paternal alcoholic beverage consumption, while the combined analysis of two case–control studies used in the German study observed no overall association between maternal alcoholic beverage consumption during pregnancy and neuroblastoma or stage I/II neuroblastoma. However, an association was observed between advanced stage (III/IV) neuroblastoma and high alcoholic beverage consumption either during lifetime or around the time of pregnancy (Schüz *et al.*, 2001).

One study conducted in the USA and Canada found that maternal beer consumption during pregnancy was associated with primitive neuroectodermata tumours, but no association was found between alcoholic beverage consumption and astrocytoma (Bunin *et al.*, 1994), while the Chinese study reported that paternal hard liquor consumption before the pregnancy was associated with brain cancer (Hu *et al.*, 2000). [The Working Group considered that there was a possibility of recall bias in this study.]

(b) *Adult brain cancers (Table 2.89)*

One cohort study (Efird *et al.*, 2004) assessed associations between cigarette smoking and other lifestyle factors, including alcohol, and the occurrence of glioma in adults. There was no association with consumption of alcoholic beverages, beer or wine in the past year, although a slight non-significant association was observed for liquor consumption in the past year.

Nine case–control studies assessed the association between alcoholic beverage consumption and brain cancer in adults (Table 2.89). In studies conducted in Australia (Ryan *et al.*, 1992; Hurley *et al.*, 1996), Germany (Boeing *et al.*, 1993) and the USA (Preston-Martin *et al.*, 1989; Hochberg *et al.*, 1990; Lee *et al.*, 1997), no significant associations or trends were observed with the consumption of alcoholic beverages and the occurrence of glioma or meningioma. However, three studies, one conducted in Canada and two conducted in China, did find an association between the consumption of alcoholic beverages and brain cancer. The Canadian study found an elevated risk for ‘ever use’ of wine, but not of beer or spirits (Burch *et al.*, 1987) and one Chinese study (Hu *et al.*, 1998) found that consumption of liquor was associated with the occurrence of glioma in men with significant trends for the number of years of drinking, lifetime consumption and average consumption. However, no associations were seen for beer in adjusted analyses. In a separate report of the same study (Hu *et al.*, 1999), higher levels of consumption of beer, liquor and total alcohol were all associated with brain cancer, with respective adjusted odds ratios of 2.9 (95% CI, 1.1–7.6), 3.8 (95% CI, 1.6–9.2) and 3.2 (95% CI, 1.5–7.0) in the third tertile of consumption.

Table 2.89 Case-control studies of alcoholic beverage consumption and adult brain cancer

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments	
Choi <i>et al.</i> (1970), Minneapolis-St Paul Metropolitan area, USA, 1963-64	All (157) histologically proven primary tumours diagnosed in 4 hospitals between June and January 1963, and from June 1963 to June 1964; 126 histologically confirmed	157 patients admitted with conditions other than tumour of any site, neurological, psychiatric, ophthalmological or lymphatic disorders; matched on hospital of admission, sex, age, race, geographic area of residence, location of residence	Questionnaire interview	Central nervous system	<i>Verified tumours</i>			Age	Odds ratios and confidence intervals not presented; for subjects <20 years of age, his/her mother was approached for an interview; a proxy was interviewed when a subject could not provide proper responses.	
					Never	39	$p=0.008$			
					Ever	65				
					<i>Gliomas</i>					
					Never	20				
					Ever	35				
					<i>Astrocytoma</i>					
					Never	14				
					Ever	10				
					<i>Glioblastoma</i>					
Never	5									
Ever	23									
<i>Meningioma</i>										
Never	10	$p=0.007$								
Ever	14									

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Musicco <i>et al.</i> (1982); Milan, Italy, 1979–80	51 patients hospitalized with gliomas, >20 years of age; mean age, 47 years; 15 astrocytomas, grades I and II; 10 oligodendrogliomas; and 26 astrocytomas, grades III and IV, and/or glioblastoma multiforme	201 admitted to the same hospital for meningioma, intervertebral disc prolapse or radiculitis, neuraxitis or multiple sclerosis, epilepsy, cerebrovascular disease, other neurological diseases; mean age 49 years; 2:1 matched for age, sex, place of residence	Interview	Central nervous system	Drinkers	24	1.0 <i>p</i> =1.000		Analyses based on 42 case–control pairs; patients who drank alcoholic beverages daily were considered drinkers; some diseases included in the control group may be linked to alcoholic beverage consumption; CI not reported.

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Burch <i>et al.</i> (1987), southern Ontario, Canada, 1979–82	247 astrocytomas and glioblastomas (no meningiomas), aged 25–80 years; residents of metropolitan Toronto and southern Ontario; histologically confirmed through medical records; response rate, 75%	228 hospital-based, free of cancer; patients admitted to any hospital in the study area and who had a condition other than cancer at any site; response rate, 56%	Interviewer-administered questionnaire at home	Brain	<i>Beer</i>		1.0	Age, sex, proxy status, residence	Matched pair analysis
					Never		2.68 (1.18–6.07)		
					Low		0.49 (0.23–1.05)		
					Medium		1.47 (0.71–3.03)		
					High				
					<i>Spirits</i>		1.0		
					Never		1.29 (0.74–2.25)		
					Low		1.35 (0.50–3.65)		
					Medium		0.83 (0.41–1.71)		
					High				
					<i>Wine</i>		1.0		
					Never		1.06 (0.46–2.43)		
Low		2.07 (0.91–4.73)							
Medium		2.92 (1.20–7.07)							
High									
Preston-Martin <i>et al.</i> (1989), Los Angeles, USA, 1980–84	277 black and white men residing in Los Angeles County in 1980–1984, aged 25–49 years; first diagnosed with glioma or meningioma; response rate, 74%	272 neighbourhood; response rate, 98.2%	Face-to-face or telephone	Brain	<i>Glioma</i>			No adjustment specified	
					Beer at least once a month	32	0.7 (0.5–1.2)		
					Wine at least once a month	39	0.7 (0.5–1.1)		
					Liquor at least once a month	55	1.3 (0.8–1.9)		
					<i>Meningioma</i>				
					Beer at least once a month	7	0.4 (0.1–0.9)		
					Wine at least once a month	14	0.7 (0.3–1.4)		
Liquor at least once a month	15	0.7 (0.3–1.4)							

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Hochberg <i>et al.</i> (1990), USA, 1977–81	160 newly diagnosed glioblastoma or astrocytoma identified in collaborating hospitals in Boston, Providence and Baltimore	128 friends of cases, excluding blood relatives; matched for sex, age (± 5 years), place of residence	Self-administered questionnaire, with telephone follow-up	Brain	Regular consumption of beer	67	0.7 (0.4–1.1)	Age, sex, socioeconomic status	Proxy interviews for 20% of cases and 2% of controls
Ryan <i>et al.</i> (1992), Adelaide, Australia, 1987–90	190 incident gliomas or meningiomas in 1987–90, aged 25–74 years; identified through the South Australian Central Cancer Registry; response rate, 90.5%	419 selected from the Australian electoral poll; 2:1 match; response rate, 63.3%	Face-to-face questionnaire at home or at work	Brain (191, 192)	<i>Glioma</i> Non-drinkers All sources 0–6.9 g/day 7–19.9 g/day ≥ 20 g/day <i>Meningioma</i> Non-drinkers All sources 0–6.9 g/day 7–19.9 g/day ≥ 20 g/day		1.0 0.94 (0.57–1.55) 0.86 (0.47–1.60) 0.74 (0.39–1.40) 1.00 (0.53–1.91) 1.0 0.59 (0.33–1.05) 0.63 (0.31–1.30) 0.49 (0.22–1.09) 0.58 (0.22–1.49)	Sex, age	Never drinkers were subjects who never drank at least once a month for a year; similar associations for beer, wine and spirit consumption.

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Boeing <i>et al.</i> (1993), Southwest Germany, 1987–88	115 gliomas, 81 meningiomas and 30 acoustic neuromas, aged 25–75 years; 100% histopathologically confirmed; participation rate, 97.8%	418 randomly selected from the residential registries of the study area; participation rate, 72%	Standardized interview	Brain (191.0, 192.0, 192.1)	Consumption of alcoholic beverages assessed by lifelong history				No numerical data on alcohol presented; alcohol consumption was assessed by lifelong history; no significant association of risk for glioma or meningioma with lifelong consumption of a single alcoholic beverage or total alcohol.

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Hurley <i>et al.</i> (1996), Australia (state of Victoria), 1987–91	416 incident (250 men, 166 women) primary gliomas, aged 20–70 years; identified through medical records from 14 Melbourne hospitals; 100% histologically confirmed; participation rate, 66% of eligible and 86% of the contacted cases	Selected from the electoral roll; 422 interviewed (252 men, 170 women); participation rate, 43.5% of those identified as eligible and 64.7% of the contacted controls	Structured questionnaire (interview); subjects sent a section of the questionnaire on details of some other variables	Brain (ICD-0 938–946)	Drank any alcoholic beverages	318	1.00 0.96 (0.67–1.37)	Age, gender, reference date	No increase in risk when average daily alcohol consumption considered
					<i>All</i>				
					Never				
					Ever				
Lee <i>et al.</i> (1997), California, USA 1991–1994	494 incident gliomas from 1991 to 1994, aged ≥20 years; identified through hospital records in the San Francisco Bay area; response rate, 82%	462 (random-digit dialling telephone number); frequency matched by age, gender, race/ethnicity; response rate, 63%	Structured questionnaire face-to-face	Brain (glioma) (ICD-0-2 9380–9481)	Mean consumption levels	No levels presented	Age, education, income	Only mean consumption levels of cases and controls presented; no significant differences noted	
					Never				
					Ever				
					Never				

Table 2.89 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Hu <i>et al.</i> (1998), China (Northeast, Heilongjiang Province), 1989–95	218 incident primary gliomas (139 astrocytomas and 79 other brain gliomas) identified from the Department of Neurosurgery of 6 major hospitals, aged 20–74 years; 100% histologically confirmed; participation rate, 100%	436 subjects with non-neoplastic, non-neurological diseases; 2:1 matched for sex, age, area of residence; participation rate, 100%.	Structured questionnaire (interview)	Brain	Liquor			Income, education, occupational exposure, consumption of vegetables and fruit; liquor also controlled for number of years of beer drinking, and beer controlled for number of years of liquor consumption	Only subjects directly interviewed included; associations for liquor similar for numbers of years drinking and lifetime liquor consumption; no associations noted for similar measures of beer consumption in the Hu <i>et al.</i> (1998) analysis, but were seen in an expanded analysis (Hu <i>et al.</i> , 1999, see text).
					<i>Age started to drink</i>				
					Never	55	1.00		
					≤20	54	1.98 (1.05–3.72)		
					≥21	31	1.40 (0.70–2.78)		
							<i>p</i> for trend=0.28		
<i>Average oz/day</i>									
Never	55	1.00							
≤2	38	1.54 (0.77–3.06)							
>2	47	1.87 (0.98–3.58)							

CI, confidence interval; ICD, International Classification of Diseases

2.18.3 *Cancer of the thyroid*

The association of alcoholic beverage consumption and thyroid cancer was examined in four cohort (Table 2.90) and six case–control (Tables 2.91) studies.

One cohort study among alcoholics in Sweden reported no significant excess risk for thyroid cancer compared with the general population (Adami *et al.*, 1992a). Two cohort studies conducted in the general population also reported no significant association of increasing alcohol consumption with risk for thyroid cancer (Iribarren *et al.*, 2001; Navarro Silvera *et al.*, 2005).

A pooled analysis of the case–control studies (Table 2.91), based on 1732 cases, found no association with increasing intake of beer and wine (relative risk, 0.9 (95% CI, 0.7–1.1) for more than 14 drinks per week) (Mack *et al.*, 2003). No difference was found for wine or beer separately or between men or women.

No data were available on the effect of duration of alcoholic beverage drinking or cessation of drinking on the risk for thyroid cancer.

2.18.4 *Melanoma*

(a) *Cohort studies (Table 2.92)*

Two cohort studies, one in a group of radiological technologists exposed to ionizing radiation in the USA (Freedman *et al.*, 2003) and one in alcoholic women in Sweden (Sigvardsson *et al.*, 1996), found no significant associations between the risk for melanoma and alcoholic beverage intake.

(b) *Case–control studies (Table 2.93)*

Six of nine case–control studies reported no significant association between alcoholic beverage intake and the risk for melanoma (Østerlind *et al.*, 1988; Bain *et al.*, 1993; Kirkpatrick *et al.*, 1994; Westerdahl *et al.*, 1996; Naldi *et al.*, 2004; Vinceti *et al.*, 2005). These studies were conducted in Australia, Italy, Denmark, Sweden and the USA.

Three case–control studies in the USA reported some increase in risk for melanoma associated with alcoholic beverage intake (Stryker *et al.*, 1990; Millen *et al.*, 2004; Le Marchand *et al.*, 2006). None of these were adjusted for exposure to ultraviolet light and thus the possibility of confounding can not be excluded.

2.18.5 *Other female cancers (vulva and vagina)*

(a) *Cohort studies (Table 2.94)*

Two cohort studies have examined the association between alcoholic beverage intake and risk for other female cancers. These studies were carried out in special populations, namely women being treated for alcohol abuse or alcoholism in Sweden (Sigvardsson *et al.*, 1996; Weiderpass *et al.*, 2001b). One study indicated an elevated

Table 2.90 Cohort studies of alcoholic beverage consumption and thyroid cancer

Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/deaths	Relative risk (95% CI)*	Adjustment factors	Comments
Special populations								
Hakulinen <i>et al.</i> (1974), Finland	Chronic alcoholic men (mean annual number in registry, 4370), aged >30 years, registered in 1967–70 when under custody of alcohol-misuse supervision, or when sent to a labour institute because of the vagrant law		Thyroid	Alcoholics	1 death observed/0.4 expected			No information regarding alcohol consumption, relative risk or CI was reported

Table 2.90 (continued)

Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/deaths	Relative risk (95% CI)*	Adjustment factors	Comments
Adami <i>et al.</i> (1992a), Uppsala, Sweden	9353 patients (8340 men; mean age at entry, 49.8 years; at diagnosis, 68.1 years; 1013 women; mean age at entry, 49.4 years; at diagnosis, 60.0 years) with a hospital discharge diagnosis of alcoholism in 1965–83	Follow-up through to 1984 (average follow-up, 7.7 years; maximum, 19 years)	Thyroid	No data on individual alcohol or tobacco use	Men: 3 Women: 0	SIR <i>Men</i> 1.7 (0.3–4.9) <i>Women</i> 0.0 (0.0–8.0)	Sex	

Table 2.90 (continued)

Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/deaths	Relative risk (95% CI)*	Adjustment factors	Comments
General population								
Iribarren <i>et al.</i> (2001), California, USA, Kaiser-Permanente Medical Care Program Cohort	94 549 men and women, aged 10–89 years, subscribers to the Kaiser Permanente Medical Care Program, northern California, who underwent regular health check-ups in 1964–73; follow-up based on the Cancer Incidence File (San Francisco Bay Area) through to 1997; median follow-up, 19.9 years	Self-administered questionnaire	Thyroid	<i>Alcohol consumption (drinks/day)</i> 0 1–2 3–5 ≥6		0.9 (0.6–1.3) 1.0 1.0 (0.5–1.8) 1.0 (0.3–3.0)	Age, sex, race, education, goitre, treatment to neck with X-rays, family history	Alcohol intake of 1–2 drinks/day = referent category; 73 cases of thyroid cancer in men and 123 cases in women; relative risk by gender not given

Table 2.90 (continued)

Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/deaths	Relative risk (95% CI)*	Adjustment factors	Comments
Navarro Silvera <i>et al.</i> (2005), Canada, Canadian National Breast Screening Study Cohort	49 613 women, aged 40–59 years, from the general Canadian population, recruited into the cohort between 1980 and 1985; average follow-up, 15.9 years	Self-administered questionnaire	Thyroid	<i>Alcohol intake (g/day)</i> None Any 1–3 3–10 ≥10	103 total	<i>Hazard ratio</i> 1.0 1.2 (0.7–1.8) 1.2 (0.7–2.0) 0.7 (0.4–1.2) 0.8 (0.5–1.4) <i>p</i> -trend=0.56	Age, education, pack–years of smoking, body mass index	No association for papillary or follicular subtype

CI, confidence interval; ICD, International Classification of Diseases

Table 2.91 Case-control studies of alcoholic beverage consumption and thyroid cancer

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Ron <i>et al.</i> (1987), Connecticut, USA, 1978–80	159 identified via Connecticut Tumor Registry; 100% histologically confirmed; response rate, 80%	285 population (random-digit dialling, Medicare records); 2:1 frequency-matched by sex, age; response rate, 65%	Interviewer-administered questionnaire	<i>Alcohol use</i> Non-user Any beer Any wine Any hard liquor	87 37 56 59	1.0 0.7 (0.4–1.3) 0.8 (0.5–1.3) 0.9 (0.6–1.5)	Age, sex, prior radiotherapy to the head and neck, thyroid nodules, goitre	Non-user: consumer of <1 drink per week
Kolonel <i>et al.</i> (1990), Hawaii, USA, 1980–97	191 (140 women, 51 men), identified through Hawaii Tumor registry, aged ≥ 18 years; 100% histologically confirmed; response rate, 79%	441 from Health Surveillance of the Department of Health; matched by age, sex; response rate, 74%	Self-administered questionnaire plus diet history	Regular alcohol use <i>Men</i> Never Ever <i>Women</i> Never Ever		1.0 0.6 (0.3–1.4) 1.0 1.0 (0.6–1.6)	Age, ethnicity	Number of cases not reported

Table 2.91 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Galanti <i>et al.</i> (1997), Norway/Sweden, 1993–94	Norway: 87 identified through Norwegian Cancer Register, born in Norway and living in the Tromsø Health Care Region, aged 18–75 years; response rate, 75% Sweden: 165 identified through registry, aged 18–75 years; response rate, 86%	Norway: 192 from population register; matched by age, sex; response rate, 56% Sweden: 248 from population register; matched by age, sex, county of residence; response rate, 69%.	Self-administered questionnaire	No. of drinks/month		Odds ratio (univariate analysis)		Not adjusted; results not changed after adjustment for smoking status, education
				<i>Wine (1.5 dL)</i>				
				<1	107	1.0		
				1–3	54	1.1 (0.7–1.7)		
				>3	52	0.7 (0.4–1.1)		
				<i>Light beer (2–5 dL)</i>				
				<1	113	1.0		
				1–4	61	1.0 (0.7–1.6)		
				>4	49	0.8 (0.5–1.2)		
				<i>Strong beer (2–5 dL)</i>				
				<1	181	1.0		
				>1	35	0.9 (0.5–1.6)		
				<i>Mild liquor (0.4 dL)</i>				
				<1	184	1.0		
>1	34	0.8 (0.5–1.2)						
<i>Hard liquor (0.4 dL)</i>								
<1	147	1.0						
>1	71	0.8 (0.5–1.1)						
<i>Ethanol (g/day)</i>								
<1	89	1.0						
1–3.95	80	0.8 (0.6–1.2)						
>3.95	67	0.7 (0.5–1.1)						

Table 2.91 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Chatenoud <i>et al.</i> (1999), Italy, 1983–93	428, aged <75 years; 100% histologically confirmed; refusal rate for interview, <3%	3526 hospital patients (non-malignant); excluded alcohol and tobacco- or dietary-related diseases	Interviewer-administered questionnaire	<i>Alcohol intake 2 years before</i> Lowest Highest		Odds ratio 1.0 1.7 (1.3–2.3)	Age, sex	The main focus of this study was on refined-cereal intake and risk for cancer; the quantity of alcohol consumed was not specified.

Table 2.91 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments	
Rossing <i>et al.</i> (2000), Washington State, USA, 1988–94	410 papillary tumours identified via the Washington State Cancer Surveillance System, aged 18–64 years; response rate, 84%	574 population (random-digit dialling); matched by age, county of residence; response rate, 74%	Interviewer-administered questionnaire	Alcohol intake			Odds ratio	Age	* Never drank ≥ 12 alcoholic drinks within 1 year; cases and controls were only women
				Never*	126	1.0			
				>10 years ago	28	1.0 (0.5–1.7)			
				6–10 years ago	23	0.8 (0.5–1.5)			
				≤ 5 years ago	33	1.0 (0.6–1.8)			
				Amount (drinks/week)					
				Current drinkers					
				Never*	128	1.0			
				≤ 1	59	0.7 (0.4–1.0)			
				2–3	55	0.6 (0.4–0.9)			
				4–7	44	0.6 (0.4–0.9)			
				>7	42	0.9 (0.5–1.4)			
				Former drinkers					
				Never*	128	1.0			
≤ 1	42	1.2 (0.7–1.9)							
2–3	16	0.9 (0.5–1.9)							
4–7	6	0.3 (0.1–0.8)							
>7	18	1.2 (0.6–2.4)							
Pooled analyses									
Franceschi <i>et al.</i> (1991), 4 hospital-based case-control studies	385, aged <75 years; 100% histologically confirmed; response rate, ~97%	798 hospital patients (non-malignant)	Interviewer-administered questionnaire	Alcohol intake			Odds ratio	Age, sex, education, study centre	CI not reported
Low	103	1.0							
Intermediate	122	1.1							
High	160	1.3							
						χ^2 (trend), 2.72			

Table 2.91 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	No of cases	Relative risk (95% CI)	Adjustment factors	Comments
Mack <i>et al.</i> (2003), 10 case-control studies	370 men, 1296 women; six studies provided information on wine and beer combined	702 men, 2106 women	Pooled analysis	<i>Weekly drinks of wine and beer</i> None ≤2 >2–7 7–14 >14	787 263 321 146 149	<i>Men</i> 1.0 0.8 (0.6–1.0) 0.8 (0.7–1.0) 1.0 (0.8–1.3) 0.9 (0.7–1.1) <i>p</i> for trend 0.12	Stratification on study, age, sex, ethnicity, current smoking	No difference in cancer risk between men and women

CI, confidence interval

Table 2.92 Cohort studies of alcoholic beverage consumption and melanoma

Reference, location, name of study	Cohort description	Exposure assesment	Exposure categories	No. of cases/deaths	Relative risk (95% CI)	Adjustment factors	Comments
Sigvardsson <i>et al.</i> (1996), Sweden, Swedish Cancer Registry Study	15 508 alcoholic women individually matched for region and age with one non-alcoholic women; incidence data from the Swedish Cancer Registry	Alcoholic women from the records of the Temperance boards in Sweden	Reference Alcoholic women	28 14	1.0 0.5 (0.3–1.0)		[May be confounded by differences in smoking, dietary habits and/or other factors.]

Table 2.92 (continued)

Reference, location, name of study	Cohort description	Exposure assessment	Exposure categories	No. of cases/deaths	Relative risk (95% CI)	Adjustment factors	Comments
Freedman <i>et al.</i> (2003), USA, 1926–98 Radiologic Technologists Study	68 588 white cancer-free radiological technologists (54 045 women, 14 543 men); follow-up, 698 028 person-years; cases identified through SEER	Baseline questionnaire 1983–89 on height, weight, smoking, alcohol use, female hormonal factors, work history, other factors; participation rate, 86%; Second questionnaire 1994–98 updated information on risk factors, skin pigmentation, hair and eye colour, family medical history; participation rate, 83%	Alcohol (drinks/week)			Gender, years smoked, skin pigmentation, hair colour, personal history of non-melanoma skin cancer, decade of starting work as a technologist, education, proxy measures for residential childhood and adult exposure to sunlight	
			<i>Women</i>	159			
			Never	23	1.0		
			Ever	136	1.2 (0.8–1.9)		
			<1–6	114	1.2 (0.7–1.9)		
			7–14	19	1.7 (0.9–3.1)		
			>14	3	2.1 (0.6–7.0)		
					<i>p</i> for trend		0.05
			<i>Men</i>	48			
			Never	8	1.0		
			Ever	40	1.5 (0.7–3.3)		
			<1–6	32	1.5 (0.7–3.4)		
			7–14	4	0.9 (0.2–3.0)		
			>14	4	2.4 (0.7–8.2)		
<i>All</i>	207						
Never	31	1.0					
Ever	176	1.3 (0.9–1.9)					
<1–6	146	1.2 (0.8–1.8)					
7–14	23	1.4 (0.8–2.5)					
>14	7	2.1 (0.9–4.8)					
		<i>p</i> for trend	0.08				

CI, confidence interval, SEER, Surveillance, Epidemiology and End Result

Table 2.93 Case-control studies of alcoholic beverage consumption and melanoma

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors
Østerlind <i>et al.</i> (1988), East Denmark	474 incident, identified in the Danish Cancer Registry, aged 20–79 years; response rate, 92%	926 selected from National Population Register; response rate, 82%	Face-to-face structured questionnaire at home	<i>Alcoholic beverage</i>			Sunbathing, socioeconomic status
				Beer	0.7 (0.5–1.1)		
				Wine	0.7 (0.5–1.1)		
				Fortified wine	0.8 (0.5–1.2)		
				Distilled liquor	0.7 (0.5–1.1)		
				<i>Alcohol (kg/year)</i>			
0–1.1	1.0						
1.2–3.3	0.8 (0.6–1.1)						
3.4–8.4	0.8 (0.5–1.1)						
≥8.5	0.6 (0.4–0.9)						
Stryker <i>et al.</i> (1990), Massachusetts, USA, 1982–85	196 Caucasians; biopsy-confirmed cases older than 18 years; response rate, 92%	232 Caucasians; response rate, 92%	Face-to-face food-frequency questionnaire	Alcoholic bev.			Age, sex, hair colour, ability to tan
				<i>Beer</i>			
				None	1.0		
				<10 g/day	1.1		
				≥10 g/day	1.6		
					<i>p</i> trend=0.2		
				<i>Red wine</i>			
				None	1.0		
				<10 g/day	0.9		
				≥10 g/day	1.1		
	<i>p</i> trend=0.9						
<i>White wine</i>							
None	1.0						
<10 g/day	0.9						
≥10 g/day	0.8						
	<i>p</i> trend=0.9						

Table 2.93 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors
Stryker <i>et al.</i> (1990) (contd)				<i>Liquor</i>			
				None		1.0	
				<10 g/day		1.3	
				≥10 g/day		1.2	
						<i>p</i> trend=0.7	
				<i>All types</i>			
None		1.0					
<10 g/day		1.2					
≥10 g/day		1.8 (1.0–3.3)					
		<i>p</i> trend=0.03					
Bain <i>et al.</i> (1993), Brisbane, Queensland, Australia, 1983–85	41 women, aged <80 years; histologically confirmed; [response rate, 63%]	297, aged <80 years; response rate not given	Mailed food-frequency questionnaire plus home interview	<i>Alcohol drinking (g/day)</i>			Age, hair colour, number of painful sunburns, total energy intake, number of years of schooling
			None		1.0		
			0.1–9.9		0.78 (0.32–1.94)		
			10.0–19.9		1.40 (0.46–4.30)		
			≥20.0		2.50 (0.87–7.40)		
Kirkpatrick <i>et al.</i> (1994), Washington State, USA, 1984–87	256 white, aged 25–65 years, identified from SEER cancer registry; response rate, 80%	234 identified by random-digit dialling to approximate age, sex, county of cases; response rate, 73%	Mailed food-frequency questionnaire plus telephone interview	<i>Drinks/month</i>			
				≤1	103	1.0	
				2–10	69	1.55	
				>10	62	1.18 (0.52–2.62)	
				≤1	103	1.0	
				2–10	69	1.31	
		>10	62	1.16 (0.53–2.59)			

Table 2.93 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors
Westerdahl <i>et al.</i> (1996), southern Sweden, 1988–90	400 men and women, aged 15–75 years, from Regional Tumour Registry; histopathological diagnosis; response rate, 88.1%	640 population-based, selected by random sampling, matched 2:1 by sex, age, parish; response rate, 70.1%	Mailed comprehensive questionnaire	Any versus none		1.0 (0.7–1.4)	History of sunburn, hair colour, number of raised naevi
				Distilled alcohol >1/month		1.4 (1.0–1.9)	
				<i>Total alcohol intake (g/day)</i>			
				0	84	1.0	
				1–9	160	0.8 (0.6–1.1)	
10–19	37	0.9 (0.5–1.5)					
≥20	25	0.9 (0.5–1.8)	<i>p</i> trend>0.05				
Millen <i>et al.</i> (2004), Philadelphia, California, USA, 1991–92	497 newly diagnosed invasive cutaneous melanoma in two clinics, aged 20–79 years; 100% histologically confirmed; response rate, 84%	561 hospital-based; dermatological or psychiatric problems for clinic visit excluded; response rate, 66%	Food-frequency questionnaire	<i>Alcohol (times/week)</i>			Education, skin response after repeated sun exposure, age, sex, study site, presence of dysplastic nevi
				0	154	1.0	
				0.7	77	1.04 (0.69–1.57)	
				1.4–7.0	160	1.55 (1.09–2.20)	
				7.7–59	106	1.53 (1.03–2.29)	
				<i>p</i> for trend		0.04	

Table 2.93 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors
Naldi <i>et al.</i> (2004), 27 centres in Italy, 1992–94	542 (226 men, 316 women), aged 15–87 years; 100% histologically confirmed; participation rate 99%	538 hospital-based (230 men, 308 women), aged 15–92 years; participation rate, 99%	Structured questionnaire, standardized examination	<i>Alcohol (drinks/week)</i> Never <1 1–13 14–27 ≥28	131 89 132 132 58	1.0 0.81 (0.53–1.22) 0.91 (0.62–1.33) 1.26 (0.83–1.91) 0.83 (0.49–1.40)	Age, sex, education, body mass index, history of sunburns, propensity to sunburn, number of naevi, number of freckles, skin, hair and eye colour, tobacco smoking

Table 2.93 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors
Vinceti <i>et al.</i> (2005), Modena, Italy, 3 years	59 (28 men, 31 women newly diagnosed cutaneous melanomas attending the Dermatologic Clinic of Modena University Hospital (only centre for diagnosis, therapy and follow-up); 100% histologically confirmed; participation rate, 72%)	59 randomly selected residents of Modena; matched on sex, age	Self-administered questionnaire on diet and lifestyle habits	<i>Alcohol (g)</i> <1.6 ≥1.6–23.3 >23.3		1.0 1.86 (0.64–5.42) 0.97 (0.17–5.50)	Dietary factors, energy intake

Table 2.93 (continued)

Reference, location, period	Characteristics of cases	Characteristics of controls	Exposure assessment	Exposure categories	Number of exposed cases	Odds ratio (95% CI)	Adjustment factors	
Le Marchand <i>et al.</i> (2006), Hawaii, USA, 1986–92	278 prevalent and incident (167 men, 111 women) invasive or in situ identified through Hawaii Tumor Registry with four grandparents of pure Caucasian origin; aged 18–79 years 100% histopathologically confirmed; participation rate, 67.5%	278 Caucasians randomly selected from local residential; registries matched to each case on sex, age; participation rate, 60.6%	Standardized interview by trained interviewers, including demographics, sun exposure, vacations, lifetime smoking, alcohol use, quantitative food-frequency questionnaire, skin colour, naevi, hair colour	Alcohol drinking status			Height, education, hair and eye colour, number of blistering sunburns at ages 10–17 years, ability to tan, family history	
				<i>Men</i>	Never	22		1.0
				Former	35	1.6 (0.8–3.4)		
				Current	110	1.9 (1.0–3.4)		
				<i>Women</i>	Never	35		1.0
				Former	30	1.3 (0.6–2.6)		
				Current	46	1.5 (0.7–2.9)		
				Lifetime ethanol intake (kg)				
				<i>Men</i>	≤45	47		1.0
				>45–265	52	1.2 (0.6–2.2)		
>265	68	2.3 (1.2–4.4)						
<i>Women</i>	≥0	35	1.0					
1–48.6	36	1.1 (0.5–2.4)						
>48.6	40	1.7 (0.7–3.8)						

CI, confidence interval; SEER, Surveillance, Epidemiology and End Result

Table 2.94 Cohort studies of alcoholic beverage consumption and other female cancers

Reference, location, name of study	Cohort description	Organ site (ICD code)	Exposure categories	No. of cases/deaths	Relative risk (95% CI)	Adjustment factors	Comments
Sigvardsson <i>et al.</i> (1996), Sweden, Temperance Boards Study	Nested case–control study; 15 508 alcoholic women born in 1870–1961 obtained from Temperance Boards; controls matched for region and day of birth; case ascertainment, Swedish Cancer Registry	Vulva, vagina and other female genital (ICD-7 176)	Alcohol abusers	16	4.0 (1.3–12)	Age, region	Estimate not adjusted for smoking
Weiderpass <i>et al.</i> (2001b), Sweden, National Board of Health and Welfare/Study of Alcoholic Women	36 856 women registered and hospitalized with alcoholism between 1965 and 1994; data from Inpatients Register; linkages to nationwide Registers of Causes of Death and Emigration and national Register of Cancer; mean age, 42.7 years; average follow-up time, 9.4 years	Vulva (ICD-7 176.0) Vagina (ICD-7 176.1)	Total <i>Age at cancer diagnosis</i> <50 years ≥50 years	8 0 8	SIR 1.0 (0.4–2.0) – 1.2 (0.5–2.4)		Using expected rates specifically for squamous-cell carcinoma of the vulva, the overall SIR was 1.1 (0.5–2.2)
			Total <i>Age at cancer diagnosis</i> <50 years ≥50 years	10 1 9	4.6 (2.2–8.5) 2.5 (0.1–14.1) 5.1 (2.3–9.7)		

CI, confidence interval; ICD, International Classification of Diseases; SIR, standardized incidence ratio

risk for vaginal cancer but not for vulvar cancer (Weiderpass *et al.*, 2001b). The other study presented high relative risk estimates for both vulvar and vaginal cancers combined. The cohort studies could not adjust risk estimates for factors that may have confounded the association between alcoholic beverage and vulvar and vaginal cancers, such as HPV infections, number of sexual partners and tobacco smoking. It is possible that women who abuse alcohol have other behavioural patterns that may affect risks for vulvar and vaginal cancer.

(b) *Case-control studies (Table 2.95)*

Three case-control studies investigated the association between alcoholic beverage consumption and risk for vulvar cancer in Italy (Parazzini *et al.*, 1995b) and in the USA (Mabuchi *et al.*, 1985b; Sturgeon *et al.*, 1991). Two of these were hospital-based (Mabuchi *et al.*, 1985b; Parazzini *et al.*, 1995b) and one was population-based (Sturgeon *et al.*, 1991).

Confounding factors were considered in two studies (Sturgeon *et al.*, 1991; Parazzini *et al.*, 1995b), but only one provided risk estimates adjusted for smoking and sexual behaviour (Sturgeon *et al.*, 1991), which are potential confounders.

The three case-control studies reported no association between alcoholic beverage consumption and risk for vulva cancer.

(c) *Evidence of a dose-response*

One case-control study (Parazzini *et al.*, 1995b) and the cross-sectional study (Williams & Horm, 1977) presented information on dose-response for alcoholic beverage consumption and vulvar cancer. Neither study found evidence of a dose-response.

(d) *Types of alcoholic beverage*

Three studies (Williams & Horm, 1977; Mabuchi *et al.*, 1985b; Sturgeon *et al.*, 1991) investigated differences in risk according to the type of beverage and found no evidence of an effect.

Table 2.95 Case-control studies of alcoholic beverage consumption and other female cancers

Reference, study location and period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	Relative risk (95% CI)	Adjustment for potential confounders	Comments
Williams & Horm (1977), The Third National Cancer Survey (cross-sectional study), USA, 1967-71	3856 cancer patients (all sites); age range not given; response rate, 57%	Randomly selected patients with cancers thought to be unrelated to tobacco and alcohol use	Personal interview	Vulva	Wine	0.63	Age, race, smoking	None of the values were significantly increased ($p > 0.05$) *less/more than one drink per week during a year
					$\leq 51^*$	-		
					>51			
					Beer			
					≤ 51	1.61		
					>51	0.84		
					Hard liquor			
≤ 51	1.67							
>51	0.43							
Total alcohol								
≤ 51	1.20							
>51	0.39							

Table 2.95 (continued)

Reference, study location and period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	Relative risk (95% CI)	Adjustment for potential confounders	Comments
Mabuchi <i>et al.</i> (1985b), New York, Michigan, Florida, Minnesota, USA, 1972–75	149 patients with vulvar carcinoma from 155 hospitals; patient identification abstracted from hospital records; 100% histologically confirmed; participation rate, 79.7%	149 patients, admitted to the hospital for circulatory, digestive, nervous system, musculoskeletal, respiratory, genitourinary, endocrine, orthopaedic diseases, accidents and others; free of any cancer; matched to cases on hospital, sex, race, age (in 3-year range), marital status	Interview by blinded interviewers, mostly at hospital	Vulva	No association between alcohol consumption or specific alcoholic beverages and risk for vulvar cancer			

Table 2.95 (continued)

Reference, study location and period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	Relative risk (95% CI)	Adjustment for potential confounders	Comments
Sturgeon <i>et al.</i> (1991), Chicago and Upstate New York, USA, 1985–87	201 incident cancer obtained from 34 hospitals in Chicago and Upstate New York, aged 53.9 years; 100% pathologically confirmed; participation rate, 61%	342 randomly selected using digit dialling techniques for controls <65 years and Health Care Financing Administration for women ≥65 years; mean age, 52.6 years; matched to cases by age in 5-year groups, race, residence; participation rate, 51%	Structured interview and food-frequency questionnaire at home	Vulva	No association between overall ethanol consumption and vulvar cancer; specific types of alcoholic beverage showed no appreciably increased risk with increasing intake.		Age, sexual behaviour, cigarette smoking	

Table 2.95 (continued)

Reference, study location and period	Characteristics of cases	Characteristics of controls	Exposure assessment	Organ site (ICD code)	Exposure categories	Relative risk (95% CI)	Adjustment for potential confounders	Comments
Parazzini <i>et al.</i> (1995b), Milan, Italy, 1987–93	125 admitted to general and teaching hospitals in the greater Milan area, aged 30–80 years; invasive vulvar cancer histologically confirmed	541 patients randomly selected, admitted to the same hospitals for acute conditions, not hormonal, gynaecological or neoplastic, aged 27–79 years; matched by age, interview year	Standard questionnaire; interview during hospital stay	Vulva	<i>Alcohol drinking</i> Never Occasional Regular	1.0 0.7 (0.4–1.2) 1.1 (0.7–1.7) χ^2 trend=0.17 $p=0.68$	Age, education, body mass index	Limited statistical power due to small study sample size; possible information bias

CI, confidence interval; ICD, International Classification of Diseases

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