Table 2.15. Cohort studies of furniture makers

Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/ deaths	Relative risk (95% CI)*	Adjustment for potential confounders	Comments
Acheson *et al*. (1982), Buckinghamshire, United Kingdom, British furniture industry cohort	Cohort of 5 371 male workers born before 1940 and employed before 1968; mortality follow-up 1945–1981; cancer incidence followup by record-linkage with Oxford Cancer Registry 1945–1981; vital status, 98.8%; case ascertainment is assumed as complete	Occupational history from plant records; workers classified by cohort of birth and length of service	Nasal cavities (160)	Birth cohorts of skilled workers: - 1890–1899 - 1900–1909 - 1910–1919 - 1920–1929	 5 23 16 4	 0.5 (0.2–1.3) 1.3 (0.8–2.0) 1.1 (0.6–1.7) 0.6 (0.2–1.6)	Age	The comparison group is the whole cohort; the study shows that even in the 1920–1929 birth cohort (mean year of entry 1940) cases continued to occur, even if with an apparent decline in incidence
Acheson *et al*. (1984), Buckinghamshire, United Kingdom, British furniture industry cohort	Cohort of 5 108 male workers born before 1940 and employed before 1968; mortality follow-up 1941–1982; vital status, 98.8%; cause of death, 100%	Occupational history from plant records; jobs classified as less dusty, dusty, and very dusty (based on industrial hygiene surveys)	Nasal cavities (160)	Overall *Occupation* Less dusty Dusty Very dusty	9 0 0 9	8.1 (3.7–15.5) - 15.8	Age	National reference
			Lung (162 163)	Overall *Occupation* Less dusty Dusty Very dusty	160 51 30 79	0.8 (0.7–0.9) 0.8 (0.6–1.1) 0.8 (0.6–1.2) 0.7 (0.6–1.0)	Age	Local reference

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Gerhardsson *et al*. (1985) Sweden, 1960 census cohort	All individuals aged 20–64 at the 1960 population census (8 141 men classified as furniture workers, 1.4 million men with other jobs), cancer incidence follow-up 1961–1979 by record linkage with the Swedish Cancer Registry; percentage of unsuccessful record linkage not given	Industry and activity declared at census	Nasal cavities (160)	Furniture workers/all other jobs (men)	All histological types: 15 Adenocarcinomas: 14	7.1 (4.4–10.9) 44.1 (26.6–68.9)	Age	90% confidence interval are given
			Lung (162)	Furniture workers/all other jobs (men)	All histological types: 57	0.9 (0.7–1.1)		
Malker *et al*. (1985) Sweden, 1960 census cohort	All individuals at the 1960 population census, cancer incidence follow-up 1961–1979 by record linkage with the Swedish Cancer Registry; percentage of unsuccessful record linkage not given	Industry and activity, and occupation declared at census	Pleura (163)	Furniture manufacturing	3	1.4 (0.3–4.1)	Sex, birth cohort, area of residence	All pleural mesothelioma cases included in the study were microscopically confirmed

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Malker *et al*. (1986) Sweden, 1960 census cohort	All individuals at the 1960 population census, cancer incidence follow-up 1961–1979 by record linkage with the Swedish Cancer Registry; percentage of unsuccessful record linkage not given	Industry and activity, and occupation declared at census	Nasal cavities (160)	Furniture industry/all other industries (men)	All histological types: 25 Adenocarcinomas: 19	4.1 ($P < 0.01$) 16.7 ($P < 0.01$)	Age, region	This study largely overlaps that by Gerhardsson *et al*. (1985)
Minder & Vader(1987), Switzerland 1980 census cohort of furniture workers	All men aged 15 and over at the 1980 population census; follow-up 1979–1985; sinonasal cancer deaths from national death register	Industry and activity declared at census	Nasal cavities (160)	Furniture workers	16	6.2 (3.6–10.2)	Age	
Minder & Vader(1988), Switzerland 1980 census cohort of furniture workers	Men aged 30–74 at the 1980 population census; no follow-up; mesothelioma deaths from national death register 1979–1985, number of deaths in the cohort estimated from occupation recorded on death certificate	Industry and activity declared at census	Pleural mesotheliom a (163)	Furniture workers	12	2.7 (2.4–4.7)	Age	No mortality follow-up; deaths occurring in the cohort estimated from death certificates reporting occupation in furniture works

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Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/ deaths	Relative risk (95% CI)*	Adjustment for potential confounders	Comments
Lynge, Thygesen (1988), Lynge et al. (1990), Denmark 1970 census cohort	All individuals aged 20–74 at the 1970 population census; cancer incidence follow-up 1970–1980 by record linkage with the National Cancer Registry; percentage of unsuccessful record linkage not given	Industry and activity declared at census	Nasal cavities (160)	Furniture makers:			Sex, age	
				Self-employed	3	14.3 (3.0–41.8)		
				Skilled workers	6	12.3 (4.5–26.7)		
Miller *et al*. (1989, 1994), US, members of United Furniture Workers of America	Cohort of 34 801 workers first employed 1946–1962; mortality follow-up 1946–1984; vital status, 90%; not specified% with known cause of death	Employment in wood furniture shops (9 163 white men), metal furniture shops (2064 white men), other workplaces	Nasal cavities (160)	Wood furniture shops	1	Not assessed	Age	SMRs for white men at least 20 years since first employed; cohort not fully at risk for nasal cancer due to relatively short follow-up and young age. Results from 1984 updated follow-up.
			Lung (162)	Wood furniture shops	116	1.0 (0.8–1.1)		
			NHL (200, 202)	Wood furniture shops	11	1.0 (0.5–1.9)		
			Myeloid leukaemia (205)	Wood furniture shops	11	1.9 (1.0–3.6)		
			Lung (162)	Metal furniture shops	33	1.1 (0.8–1.5)		
			Myeloid leukaemia (205)	Metal furniture shops	3	2.4 (0.5–7.0)		

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Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/ deaths	Relative risk (95% CI)*	Adjustment for potential confounders	Comments
Demers *et al*. (1995a), United Kingdom and US, pooled analysis of the British furniture industry cohort and the United Furniture Workers of America cohort	a) British furniture industry cohort: 5 106 male workers born before 1940 and employed before 1968; mortality follow-up 1941–1992; vital status, 96%; not specified% with known cause of death b) United Furniture Workers of America cohort: 12 158 workers in wood furniture shops; mortality follow-up 1946–1992; vital status, 93%; not specified% with known cause of death	Jobs less dusty, dusty, and very dusty (see Acheson *et al*. 1984) classified as possibly, probably and definitely exposed Jobs placed in the same categories used for the British study	Nasal cavities (160) Nasopharynx (147) Lung (162) NHL (200, 202) Leukaemia (204–208)	Furniture workers Furniture workers Definitely exposed Furniture workers Furniture workers Furniture workers	11 7 5 408 37 31	4.3 (2.2–7.8) 2.9 (1.2–5.9) 7.3 (2.4–16.9) 0.8 (0.7–0.9) 1.1 (0.8–1.5) 0.7 (0.5–1.0)	Age	The pooled analysis included also two cohort studies of plywood workers and one of wood model makers, whose results are not reported here. This study is based on an extended follow-up compared with Acheson *et al.* (1984) and Miller *at al.* (1994), but the metal furniture workers in Miller *et al.* (1994) were not included

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Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/ deaths	Relative risk (95% CI)*	Adjustment for potential confounders	Comments
Innos *et al*. (2000), Estonia workers of two furniture factories	All workers employed for at least 6 months between 1946 and 1988, living in Estonia on January 1, 1968: 3 723 men, 3 063 women; cancer incidence follow-up 1968–1995; mortality follow-up 1946–1995; vital status 98%	Based on industrial hygiene surveys 1973–1985 (area samples) and on full personal work histories: high, medium, and low exposure groups	Esophagous (150)	Men and women	11	1.7 (0.8–3.0)	Sex, age	Formaldehyde-based glues were used in both plants since 1960. No trend in incidence according to exposure level to wood dust was present for any cancer site, except for nasal cavities and sinuses. For colon cancer, a clear trend with increasing duration of employment was present.
			Stomach (151)	Men and women	86	1.1 (0.9–1.3)		
			Colon (153)	Men and women	50	1.7 (1.2–2.2)		
			Rectum (154)	Men and women	33	1.3 (0.9–1.9)		
			Nasal cavities (160)	Men and women	3	1.9 (0.4–5.5)		
			Lung (162)	Men and women	105	1.1 (0.9–1.3)		
			Pleura (163)	Men and women	3	4.1 (0.8–11.9)		
			Bone (170)	Men and women	4	2.5 (0.7–6.3)		
			Pharynx (146–149)	Men and women	9	1.8 (0.8–3.5)		

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Reference, location, name of study	Cohort description	Exposure assessment	Organ site (ICD code)	Exposure categories	No. of cases/ deaths	Relative risk (95% CI)*	Adjustment for potential confounders	Comments
Veglia *et al*. (2007), selected EPIC centres in Spain, Greece, Denmark, Germany, Italy, United Kingdom 2 776 individuals engaged in furniture production at enrollment in EPIC	Volunteers enrolled in the EPIC study in centres where the baseline questionnaire included information on employment in 52 occupations at high risk of cancer, among which furniture production. EPIC volounteers were rectuited from 1992 to 1998, when aged 35–74	Employment in any occupation in a list of 52	Lung (162)	Furniture production	18	1.5 (0.9–2.4)	Sex, age, country, educational level, smoking, fruit and vegetable consumption, body-mass index, physical activity	Cancer incidence follow-up through cancer registries

* specify *p*-value if no confidence interval indicated

• Include preferably the most informative/up-to-date study. Previous publications may be briefly mentioned in the corresponding text, where more details on cohort description and exposure assessment can be given.

• Cohort characteristics: size (men, women) – inclusion criteria, employment period if occupational cohort– age range – mortality/incidence, duration and completeness of follow-up.

• Exposure assessment: mailed questionnaire – structured interview – job–exposure matrix – biomarker.

• ICD codes to be given only for some cancers, incl. upper aerodigestive tract, colorectal, uro-genitary, leukaemia, lymphoma. ICD-9, unless otherwise specified.

• RR: consider the most valid point estimate (e.g. adjusted)

• Comments, if relevant for the interpretation of the study, such as: type of reference used for SMR calculation (national/local rates) – stratified results/interaction