TOBACCO SMOKING

Tobacco smoking was considered by previous IARC Working Groups in 1986, 1987 and 2002 (IARC, 1986, 1987, 2004a). Since that time, new data have become available, these have been incorporated into the *Monograph*, and taken into consideration in the present evaluation.

1. Exposure Data

1.1 Smoked tobacco products

Smoked forms of tobacco include various kinds of cigarettes (manufactured, hand-rolled, filtered, un-filtered and flavoured), cigars and pipes. While cigarette smoking, particularly manufactured cigarettes, is by far the main form of tobacco smoked globally, in some countries other forms of smoked tobacco are dominant (IARC, 2004a). In India, for example, bidis (made of coarse and uncured tobacco) account for about 60% of smoked tobacco products whereas cigarettes account for 20% (Ray & Gupta, 2009; IIPS, 2010). Water pipes, another form of smoked tobacco known by other various names such as gaza, hookah, narghile, shisha, hubble-bubble, are commonly smoked in the Eastern Mediterranean region, in some parts of Asia including India, and in North Africa (Asma *et al.*, 2009).

1.2 Chemical composition of tobacco smoke

1.2.1 Smoke from cigarettes

One cubic cm of fresh, un-aged cigarette mainstream smoke [the smoke emerging from the mouth end of a cigarette during smoking] has about 4×10^9 particles with a mean diameter of about 0.2 µm (Borgerding & Klus, 2005). The size of the particles increases as the smoke ages. Temperatures in the burning cone of the cigarette are about 800 °C during the smoulder period between puffs and increase to 910–920 °C at the periphery of the cone during puffing (Borgerding & Klus, 2005). Hydrogen is generated in the glowing cone, resulting in an oxygen deficient reducing atmosphere (Borgerding & Klus, 2005). The approximate composition of mainstream smoke of a plain cigarette is summarized in Table 1.1 (Borgerding & Klus, 2005). The total particulate matter, after subtraction of the amounts of nicotine and water, is referred to as 'tar'.

Over 5300 compounds have been identified in tobacco smoke (Rodgman & Perfetti, 2009). Classes of compounds include but are not limited to neutral gases, carbon and nitrogen oxides, amides, imides, lactams, carboxylic acids, lactones, esters, aldehydes, ketones,

Table 1.1 Approximate chemical composition of mainstream smoke generated by a plain cigarette

Compound or class of components	Relative amount w/w (%)
Nitrogen	58
Oxygen	12
Carbon dioxide	13
Carbon monoxide	3.5
Hydrogen, argon	0.5
Water	1
Volatile organic substances	5
Particulate phase	8

From Borgerding & Klus (2005)

alcohols, phenols, amines, *N*-nitrosamines, *N*-heterocyclics, aliphatic hydrocarbons, monocyclic and polycyclic aromatic hydrocarbons (PAHs), nitriles, anhydrides, carbohydrates, ethers, nitro compounds and metals (Rodgman & Perfetti, 2009).

The addictive properties of tobacco smoke are attributed to nicotine, the principal tobacco alkaloid in smoke (Hukkanen *et al.*, 2005). Minor tobacco alkaloids include nornicotine, anatabine and anabasine (Hukkanen *et al.*, 2005). The tobacco alkaloids are not generally considered carcinogenic, but are accompanied by carcinogens in each puff of smoke.

There are over 70 carcinogens in tobacco smoke that have been evaluated by the *IARC Monographs* programme as having sufficient evidence for carcinogenicity in either laboratory animals or humans (IARC, 2004a). The different chemical classes of carcinogens and representatives of each are presented in Table 1.2 (IARC, 2004a). Sixteen of these – benzo[*a*]pyrene (BaP), 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK) and *N*′-nitrosonornicotine (NNN), 2-naphthylamine, 4-aminobiphenyl, formaldehyde, 1,3-butadiene, benzene, vinyl chloride, ethylene oxide, arsenic, beryllium, nickel compounds, chromium VI, cadmium, and polonium-210 – are classified as carcinogenic to humans (Group 1). Structures of some representative carcinogens in cigarette smoke are shown in Fig. 1.1. There are other likely carcinogens in cigarette smoke that have not been evaluated by the *IARC Monographs* programme. These include, for example, PAHs with incompletely characterized occurrence levels and carcinogenic activities; over 500 PAHs have been identified (Rodgman & Perfetti, 2006).

PAHs, tobacco-specific *N*-nitrosamines, aromatic amines, aldehydes and certain volatile organics likely contribute significantly to the carcinogenic activity of tobacco smoke (Hecht, 2003).

In the early part of the 20th century, PAHs were identified as carcinogenic constituents of coal tar (Phillips, 1983). They are products of incomplete combustion of all organic matter and occur, always as complex mixtures, in tars, soots, broiled foods, vehicle engine exhaust and tobacco smoke. PAHs are generally locally acting carcinogens, and some, such as the prototypic compound BaP, have strong carcinogenic activity on mouse skin and in rodent lung. Heterocyclic analogues of PAHs also occur in cigarette smoke. Concentrations of individual PAHs in mainstream cigarette smoke are generally in the range of 1–50 ng per cigarette (IARC, 2004a).

Among the carcinogenic *N*-nitrosamines in tobacco smoke are tobacco-specific *N*-nitrosamines, which are derived from, and structurally related to, the tobacco alkaloids. Two of the most important of these are NNK and NNN (Hecht & Hoffmann, 1988). Levels of NNK and NNN in cigarette smoke vary depending on tobacco type and other factors, but are frequently in the range of 50–200 ng per cigarette (IARC, 2004a).

Aromatic amines were first identified as human carcinogens from industrial exposures in the dye industry in the early part of the 20th century. They include the well known human bladder carcinogens 2-naphthylamine and 4-aminobiphenyl which, along with other

Table 1.2 Tobacco smoke carcinogens evaluated in the *IARC Monographs*

Chemical Class	Number of Carcinogens	Representative Carcinogens
Polycyclic aromatic hydrocarbons (PAHs) and their heterocyclic analogues	15	Benzo[*a*]pyrene (BaP) Dibenz[*a*,*h*]anthracene
N-Nitrosamines	8	4-(Methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK) *N*′-Nitrosonornicotine (NNN)
Aromatic amines	12	4-Aminobiphenyl 2-Naphthylamine
Aldehydes	2	Formaldehyde Acetaldehyde
Phenols	2	Catechol Caffeic acid
Volatile hydrocarbons	3	Benzene 1,3-Butadiene Isoprene
Other organics	12	Ethylene oxide Acrylonitrile
Inorganic compounds	8	Cadmium Polonium-210

There are many other carcinogens in cigarette smoke that have not been evaluated in an *IARC Monograph*.
From IARC (2004a)

isomers, are found in cigarette smoke, but their levels are generally quite low (1–20 ng per cigarette) (IARC, 2004a).

Aldehydes such as formaldehyde and acetaldehyde occur widely in the human environment and are also found in human blood. Concentrations of acetaldehyde and formaldehyde in cigarette smoke are far higher than those of PAHs, *N*-nitrosamines or aromatic amines but their carcinogenic activities are weak (Hecht, 2003). Cigarette mainstream smoke typically contains 10–30 µg formaldehyde/cigarette and 800–900 µg acetaldehyde/cigarette (IARC, 2004a).

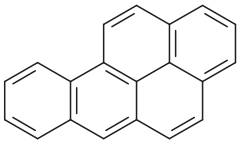
Volatile hydrocarbons in cigarette smoke include 1,3-butadiene, a powerful multi-organ carcinogen in the mouse, and benzene, a known human leukaemogen. 1,3-Butadiene (20–40 µg/cigarette) and benzene (12–50 µg/cigarette) are two of the most prevalent strong carcinogens in cigarette smoke (IARC, 2004a).

In summary, cigarette smoke is an exceedingly complex mixture which contains over 5300 compounds including multiple toxicants and carcinogens.

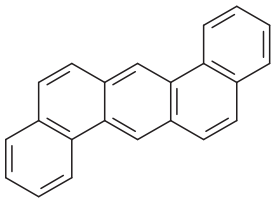
1.2.2 Smoke from other tobacco products

Some constituents have been measured in roll-your-own cigarettes, and their levels are comparable to or higher than those in commercial brands. Carcinogen and toxicant levels expressed per unit are higher in cigars than in cigarettes because of their larger size, and in some instances are also higher per litre of smoke. Levels of nicotine and tobacco-specific nitrosamines were comparable in bidis and commercial Indian cigarettes; bidis also contain high levels of eugenol, as do kreteks. Levels of NNK and NNN in chuttas were considerably higher than in standard cigarettes (IARC, 2004a).

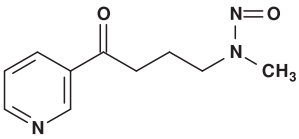
Fig. 1.1 Structures of some representative tobacco smoke carcinogens



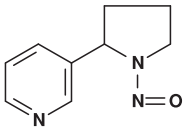
benzo[*a*]pyrene (BaP)



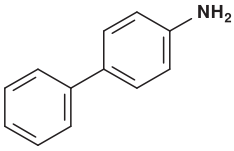
dibenz[*a,h*]anthracene



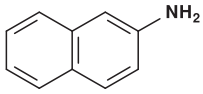
4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (NNK)



N'-nitrosonornicotine (NNN)

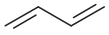


4-aminobiphenyl



2-naphtylamine

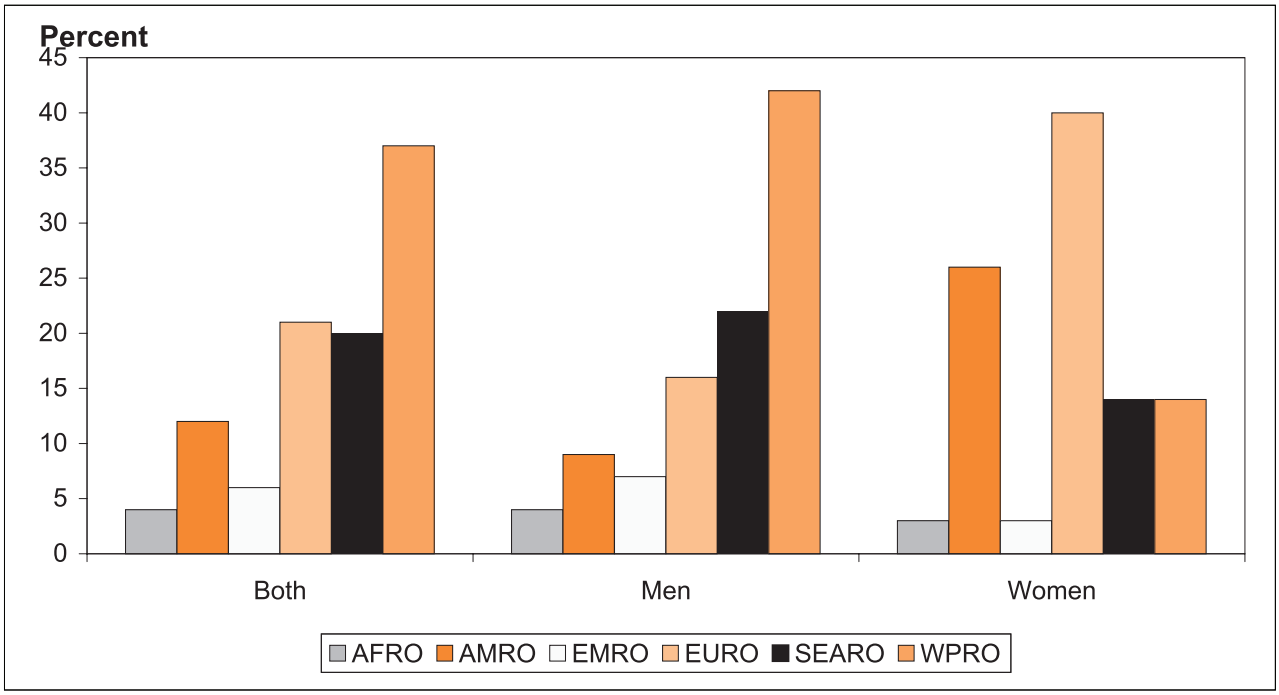
benzene



1,3-butadiene

ethylene oxide

Fig. 1.2 Proportion of adult smokers by WHO region in 2009



From WHO (2011)

1.3 Prevalence of tobacco smoking

1.3.1 Data collection and methods

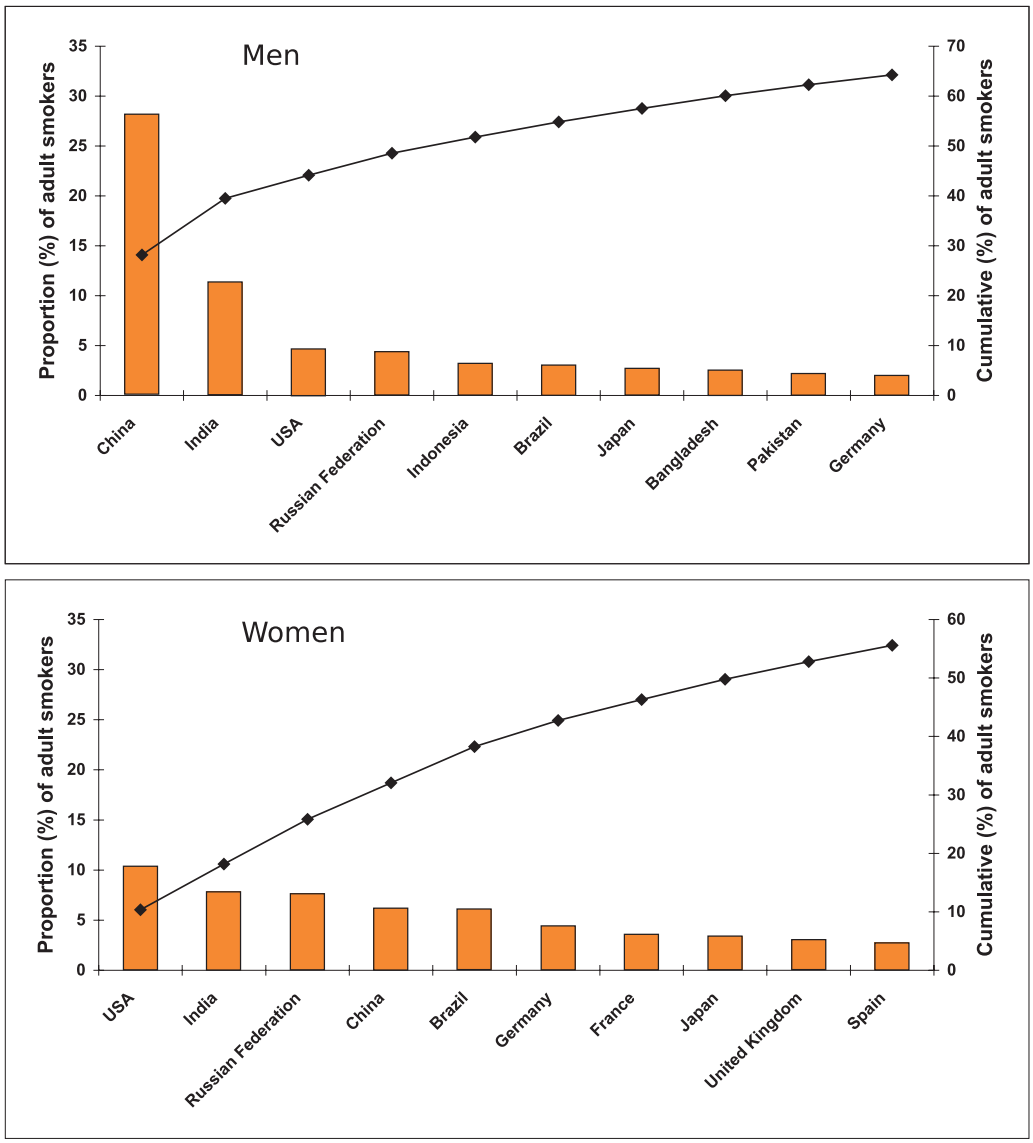
Data on smoking tobacco are available from WHO's Global Infobase (www.who.int/infobase) and the WHO Global Health Observatory (www.who.int/gho/en) – repositories of information on tobacco use and other risk factors in young people (13–15 years old) and adults (aged 15 years and over). The data span several years and are acquired from government reports, journals and unpublished sources. WHO has in the recent past used and modelled these data to produce estimates of tobacco smoking prevalence, published in the WHO Reports on the Global Tobacco Epidemic. For a complete explanation of methods used, the reader is referred to the Technical Note on Prevalence in the 3rd WHO Report on the Global Tobacco Epidemic (WHO, 2011). The six WHO regions are: EMRO, Eastern Mediterranean Region; EURO, European Region; AFRO, African Region; WPRO, Western Pacific Region; SEARO, South East Asian Region; AMRO, Region of the Americas. A listing of the countries in each region can be viewed at http://www.who.int/about/structure/en/index.html.

1.3.2 Distribution of smokers by WHO region and country

WHO estimates that in 2009, there was about 1.1 billion adult smokers worldwide, representing nearly a quarter (22%) of the global adult population (WHO, 2011). A disaggregation by the six WHO regions (Fig. 1.2) shows that over a third of smokers worldwide live in WPRO (highly influenced by the People's Republic of China), followed by SEARO, which has around a fifth of the world's smokers (influenced by India and Indonesia).

The number of smokers in any country is a function of both the prevalence of smoking and the size of the population. A further

Fig. 1.3 Proportion and cumulative percentage of smokers in high-burden countries, in men (A) and women (B) in 2009



From WHO (2011)

disaggregation of the regions by country shows that a few countries account for a large proportion of tobacco smokers. Ranked in descending order of the number of smokers, the five countries of China, India, United States of America (USA), Russian Federation and Indonesia account for about 52% of adult smokers in the world, with China and India alone accounting for 40% (Fig. 1.3). Furthermore, nearly two-thirds of the world's smokers live in only ten countries of the world.

1.3.3 Distribution of smokers by sex

With a global average smoking prevalence of 36%, men account for just over 80% of all smokers. The male adult prevalence is 4–5 times that for women, at 8%. This difference varies across WHO

regions. Smoking among men, concentrated in the five countries of China, India, Indonesia, Russian Federation and USA (Fig. 1.3), accounts for about 56% of global smoking among men. Women smokers are mostly concentrated in EURO and AMRO. These two regions account for 40% and 26% of all women smokers globally, respectively. The prevalences for women in these two regions are about half of those in men, whereas the difference is substantially greater in the other regions. Just as men smoke more than women everywhere, so too among young people, boys generally smoke more than girls. There is an increasing concern, however, that the gap may diminish, not because of a reduction in boys prevalence but because of an increase in the proportion of girls who are taking up smoking (Warren *et al.*, 2006).

1.3.4 The four stage smoking model

(a) The four stages of tobacco use

Lopez *et al.* (1994) used trend data on smoking prevalence and tobacco attributable mortality to show the evolution of tobacco use in a country. Four stages of smoking and attributable mortality have been identified to represent the growth and eventual decline of smoking among men and women (Fig. 1.4).

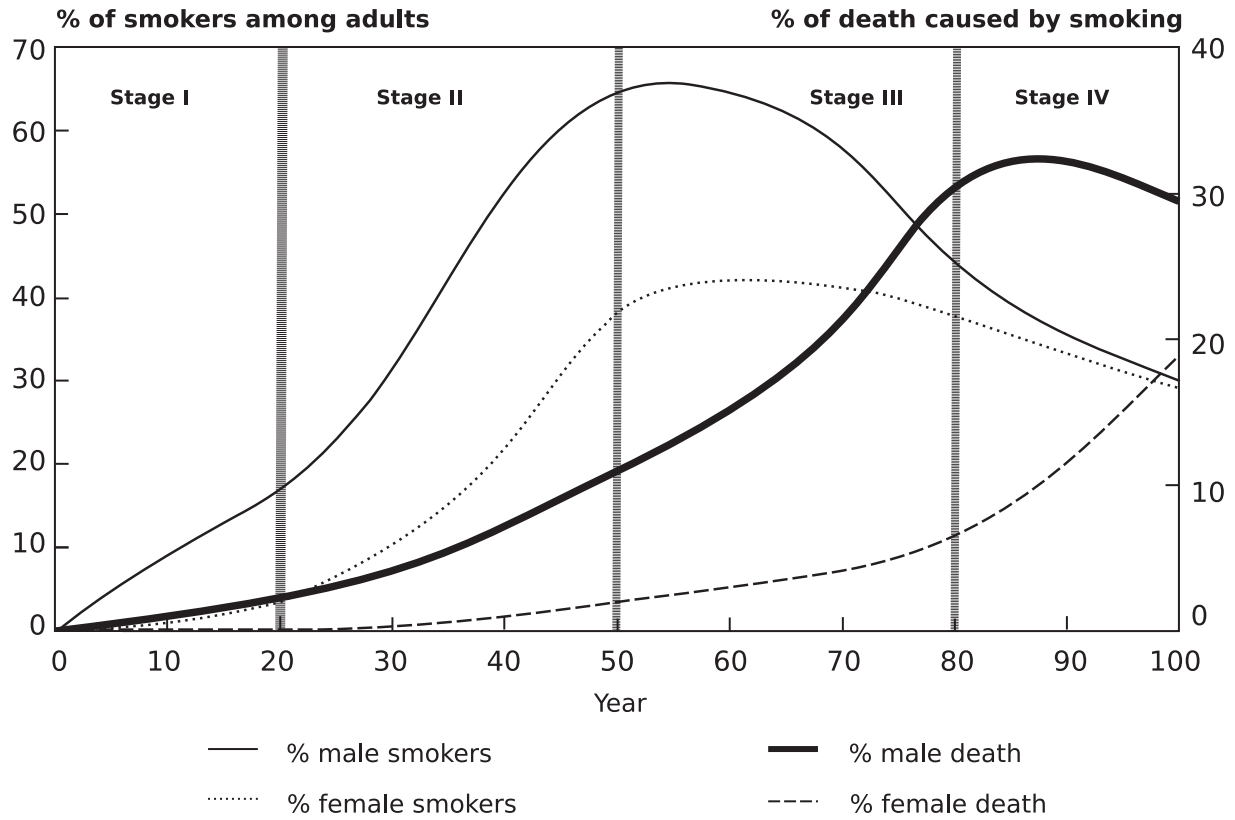
Stage 1 is characterized by low smoking prevalence in men (less than 15%) and very low in women (less than 10%). Death and disease from smoking are not apparent in this phase, as nearly all health effects from smoking are related to past smoking habits and their cumulative effects rather than current smoking. In Stage 2, smoking prevalence in men rapidly increases while it increases more slowly in women. Towards the end of this stage, smoking prevalence in men typically peaks to lie at 50–60%, with 10% of deaths in men attributable to smoking; deaths in women are comparatively fewer. After a protracted period of high smoking prevalence, Stage 3 shows a decline in smoking prevalence in men to around 40%. Smoking prevalence in women peaks and then begins to decline; towards the end of this stage the gap between men's and women's prevalence starts to narrow. However, smoking attributable deaths in men increase from around 10% to 25–30% within a span of three decades; in women the deaths are increasing but are still quite low. In the final Stage 4, smoking prevalences in both men and women continue to decline albeit relatively slowly in comparison with Stage 3, with the gap substantially narrowing to lie at around five percentage points, and as little as one percentage point in some countries. In Stage 4, smoking mortality in men peaks to between 30–35% and then declines to below 30% at the end of this period. In women, the health effects from past smoking persist, with increasing mortality, but remain lower than in men, and recently have begun to decline in some countries.

(b) Smoking prevalence worldwide

Using prevalence data for men and women collected in 2006 for 140 countries, WHO determined at which stage of the tobacco epidemic countries are in the model of Lopez *et al.* (1994). In Fig. 1.5, countries have been ranked by smoking prevalence in men in ascending order for Stages 1 and 2, and then in descending order for Stages 3 and 4. (Smoking prevalence in men is almost always higher than in women, with a few exceptions observed in the fourth stage.) While most countries fit the classification, there are a few exceptions, most of which in the last stage. Prevalence between Stage 3 and Stage 4 is discontinuous in both sexes. This is due to the classification followed, which puts countries with a relatively narrow difference in prevalence between men and women in Stage 4 even though their prevalence is largely comparable with those in Stage 3.

Most African countries fall in the first stage of the smoking model, characterized by low smoking prevalence in men and very low prevalence in women. Three of the five high burden

Fig. 1.4 The four stages of the tobacco epidemic



From Lopez *et al.* (1994)

countries fall in stage 2 (India, Indonesia and China), with the rest comprising a combination of countries from Africa, South East Asia, eastern Europe and the Middle East. At this stage smoking prevalences in women continue to remain very low, most countries having a prevalence in adult women of less than 10%.

Stage 3 includes the fourth high burden country (Russian Federation), along with countries in eastern Europe, South America and western Europe, which fall at the end of Stage 3. Stage 4 is populated entirely by the developed countries of western Europe, North America and Oceania. The USA, the fifth high burden country, fall in the last stage as a result of the relatively small difference in the smoking prevalence between men and women compared to the other intermediate stages. As mentioned before, Stage 4 includes countries where the smoking prevalence is higher in women than in men, with a small (< 8%) difference.

(c) Age-specific prevalence

Age-specific prevalence for men and women aged 15 years or older is presented for six representative countries for current smoking (Fig. 1.6). There are wide variations in age-specific prevalence between these countries. In men, prevalence varies from less than 10% to 75% in the 15–19 years age range to lie between 10% and 55% in the oldest age range. Prevalence among women varies from less than 1% to as high as 45% in young adults (15–19 years). Unlike men, prevalence in women tends to converge after age

Fig. 1.5 Prevalence of smoking in 140 countries in 2009, staged according to the model by Lopez

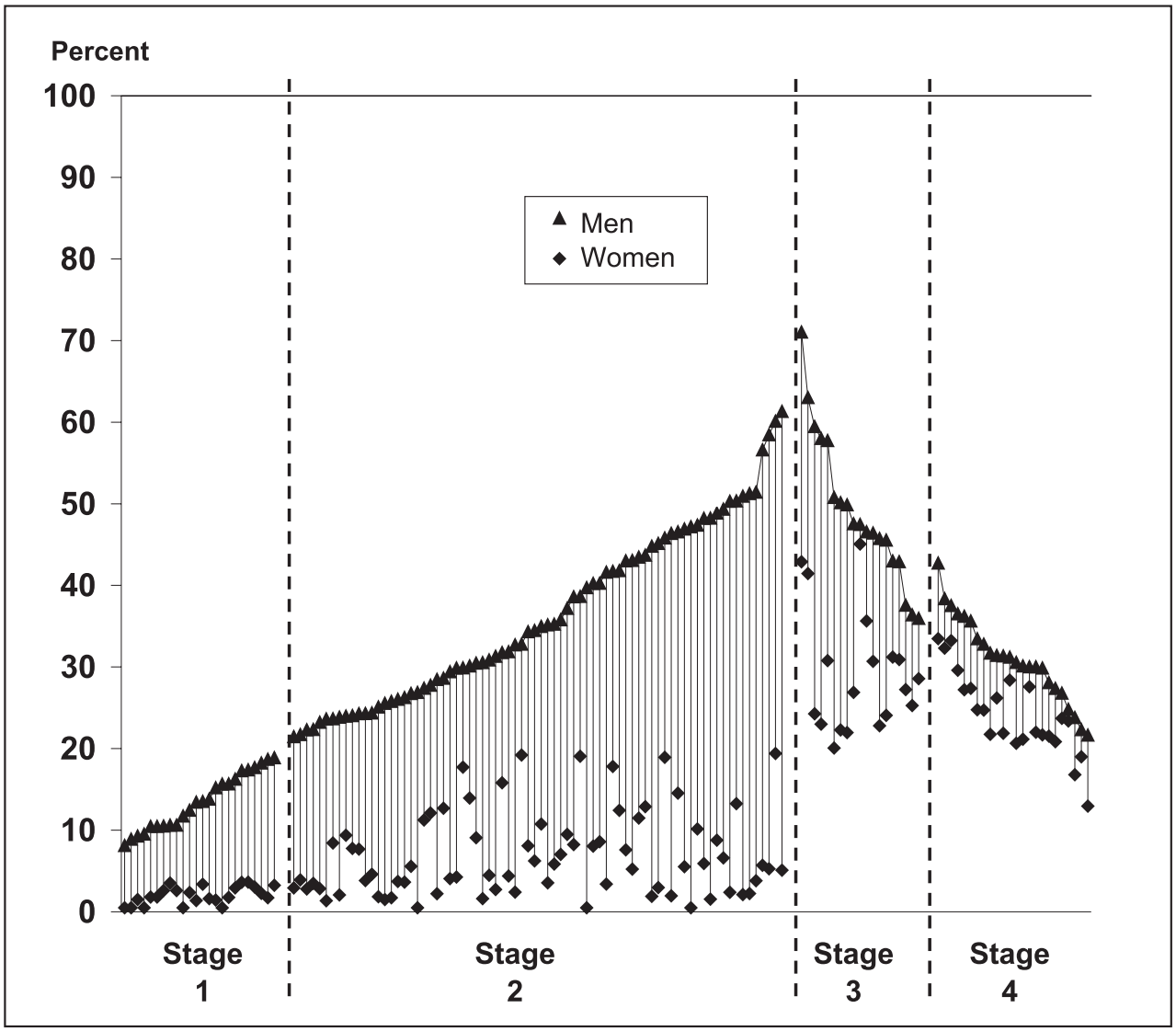
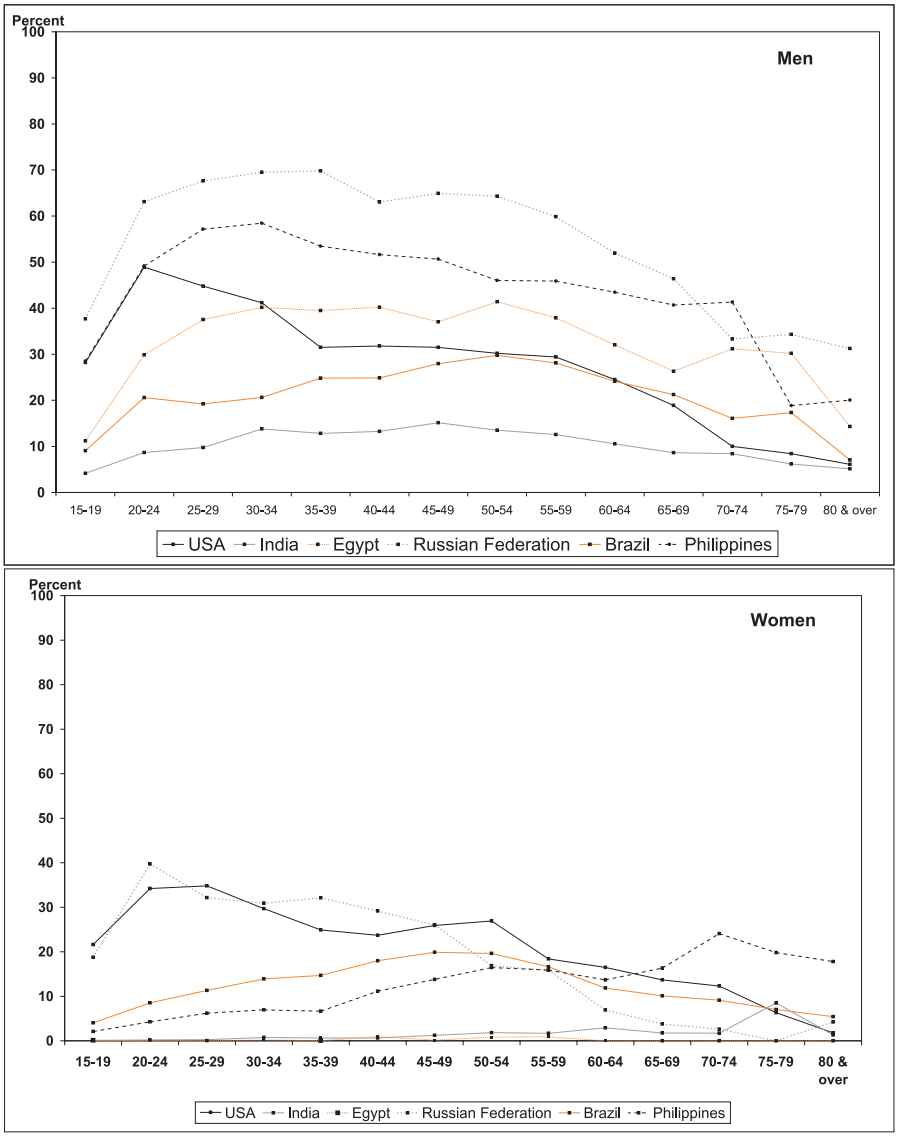


Fig. 1.6 Age-specific rates of smoking prevalence, in men and women in 2009



50, lying within 15 percentage points. Prevalence in women is almost always lower than in men in all age groups.

Initiation of smoking is shifting, and is taking place at earlier ages in both developed and developing countries. In developed countries, quitting smoking is also shifting to occur at a younger age, whereas in developing countries there is no such evidence.

(d) Smoking in youth

Information on smoking habits in youth are collected from a variety of youth surveys that include the Global Youth Tobacco Survey (GYTS), Global school-based Student Health Survey (GSHS) and Health Behaviour in School Aged Children (HBSC). Some countries have their own youth surveys, or have them as part of a general health or household survey, such as the Student Survey in Argentina, the Youth Smoking Survey in Canada, and New Zealand's Tobacco Survey.

The GYTS is a school-based survey designed to monitor tobacco use among youths aged 13 to 15 years. The GYTS uses a standard set of questions and sampling methods in over 160 countries. The survey has core questions that span seven thematic areas pertinent to tobacco. In addition to these, countries can include country-specific questions that allow assessment of tobacco use unique to the country. To assess prevalence of smoking, students are asked to report their smoking habits for both cigarettes and other tobacco products that they may have consumed over the past 30 days. Since its inception in 1999, the GYTS has covered over 2 million students. Although most GYTS are national surveys, in some countries they are limited to subnational locations. Further, countries conduct the GYTS in different years, rendering comparison for the same year difficult.

Prevalence of current tobacco use [including smokeless tobacco] in youth in 2004–09 for fourteen high burden low and middle income countries is shown in Fig. 1.7. The Russian Federation has the highest prevalence of current tobacco use among the high burden countries for which national data are available. Further, in the Americas and Europe the difference in prevalence between boys and girls is smaller than in other regions. In contrast, in Egypt, India and Thailand, prevalences in boys are significantly higher than in girls.

Fig. 1.8 shows the range of current tobacco use by WHO region for boys and for girls and for both sexes combined. There are wide variations in current tobacco use within each region. The largest variations are observed in EMRO and SEARO irrespective of sex, reflecting potentially disparate initiation rates in countries within the region. In AFRO, the range of current tobacco use between boys and girls is virtually the same. In some countries (e.g. Argentina, Peru, Sierra Leone, Bulgaria, Croatia, Cook Islands, New Zealand), tobacco use in girls exceeds that in boys; but overall boys and girls show remarkably similar propensity to take up tobacco use.

Warren *et al.* (2006) present global estimates and regional averages for current tobacco smoking in youth using GYTS data spanning 1999–2005. Their estimates show that one in five boys and one in seven girls currently smoke tobacco. Prevalence of current smoking for both boys and girls combined was highest in AMRO (22.2%) and lowest in WPRO (11.4%). AMRO have the highest average for current tobacco smoking for boys (24%) and for girls (20.4%) whereas the lowest prevalence was in WPRO among boys (15%) and in SEARO among girls (7.1%).

1.4 Regulations and policies: the WHO Framework Convention on Tobacco Control

The WHO Framework Convention on Tobacco Control (WHO FCTC) – the first multilateral evidence-based treaty on tobacco control

Fig. 1.7 Prevalence of current tobacco use in youth for selected countries, 2005–2009

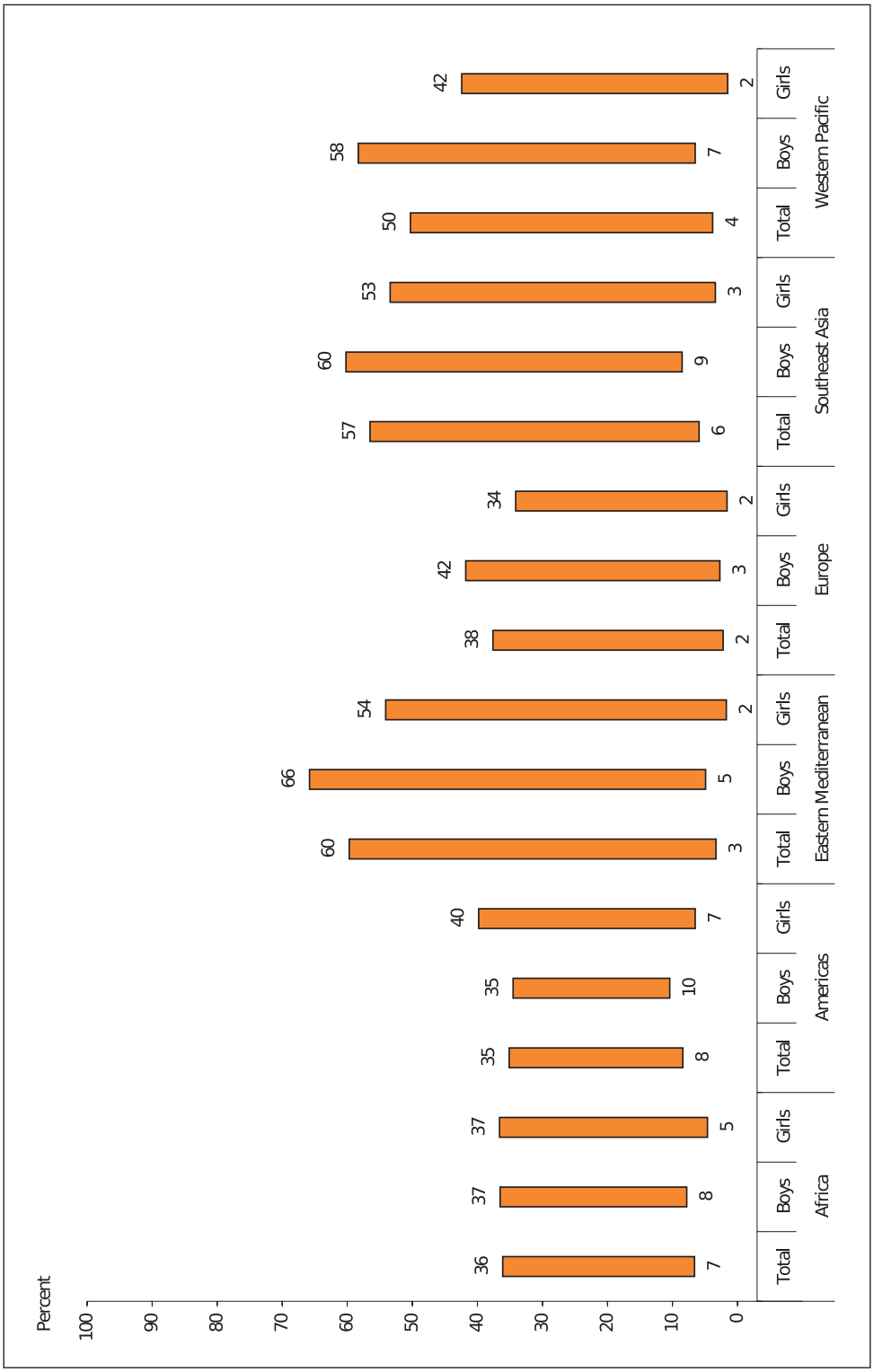
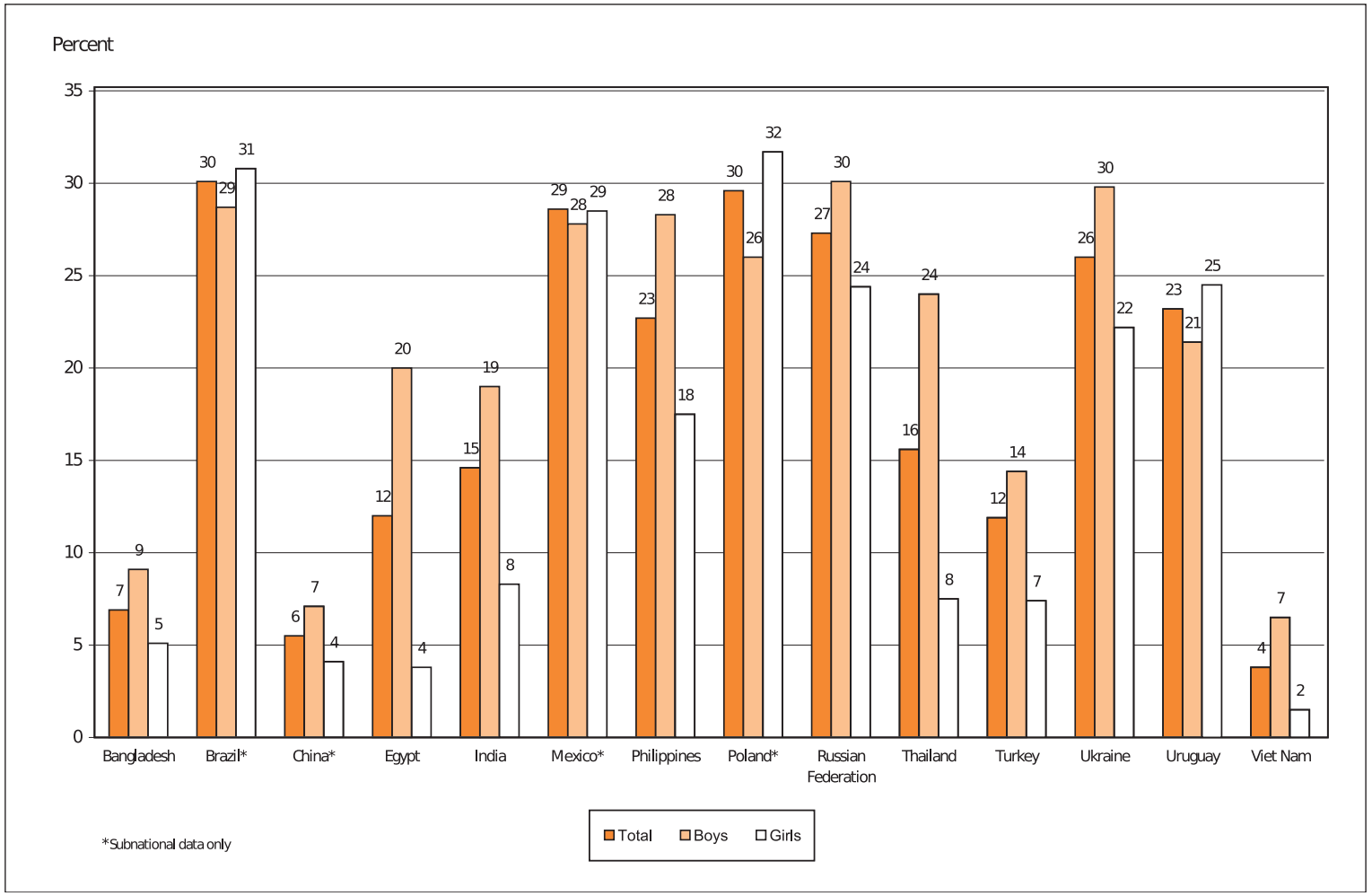


Fig. 1.8 Range of prevalence of current tobacco use in youth, 2005–2009, by WHO region



Figures have been rounded off and show prevalences in countries with national and subnational jurisdiction.

– articulates tobacco control measures available to countries to counter the growing tobacco epidemic. This treaty, which entered into force in 2005, represents one of the most universal treaties in the United Nations history. In 2008, the WHO launched MPOWER, a technical assistance package comprised of six strategies that reflects one or more of the WHO FCTC measures and helps countries meet their commitments to the WHO FCTC.

2. Cancer in Humans

2.1 Introduction

The available knowledge on the relationship between tobacco smoking and a variety of human cancers is based primarily on epidemiological evidence. An immense amount of such evidence has been obtained, and only a small proportion can be referred to here. The cancers considered to be causally related to tobacco smoking in the previous *IARC Monograph* on tobacco smoking (IARC, 2004a) included lung, oral cavity, nasal cavity and paranasal sinuses, nasopharynx, oropharynx, hypopharynx, larynx, oesophagus (adenocarcinoma and squamous cell carcinoma), upper aerodigestive tract combined, stomach, pancreas, liver, kidney (body and pelvis), ureter, urinary bladder, cervix and myeloid leukaemia. In addition, it was concluded that there was evidence suggesting lack of carcinogenicity for cancers of the breast and of the endometrium.

Since 2002, there have been additional cohort and case–control studies on the relationship of tobacco smoking in different forms to these and other cancers in many countries. A large body of evidence has been obtained from cohort studies with respect to different cancer sites and types of tobacco product. These cohort studies are described briefly in Table 2.1 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.1.pdf), listed by country. Case–control studies are described in the sections pertaining to cancer sites. More studies are now available from countries and populations that are still at an early stage of the tobacco epidemic. These studies are prone to underestimate the true strengths of the association between tobacco smoking and any specific cancer as the full effect of duration of smoking cannot be evaluated.

2.2 Cancer of the lung

2.2.1 Overview of studies

The main cause of lung cancer in humans is tobacco smoking and most information establishing this fact comes from epidemiological studies in which the assessment of exposure was based on self-reported information on personal smoking habits via self-administered questionnaire or in-person interviews. Since the previous *IARC Monograph* (IARC, 2004a), numerous studies have been published on the issues of tobacco smoking and sex and racial/ethnic susceptibility, 'tar' yields as measured by machine smoking, the relationship between histological changes and the design of cigarettes, dose–response association, genetic susceptibilities and interactions.

2.2.2 Factors affecting risk

Recent epidemiological studies incorporating measures of smoking metabolites in serum or urine are helping to refine our understanding of exposure-response relationships with tobacco smoke. Dose–response evidence has been obtained from three cohort studies (Flanders *et al.*, 2003; Boffetta *et al.*, 2006; Yuan *et al.*, 2009; Table 2.2 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.2.pdf) and four pooled analyses (Lubin & Caporaso, 2006; Lubin *et al.*, 2007a, b, 2008; Table 2.3 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.3.pdf)

since the previous *IARC Monograph* (IARC, 2004a).

The US American Cancer Society Cancer Prevention Study-II (CPS-II) is the largest cohort study on smoking and lung cancer risk using questionnaire assessment of exposure (Flanders *et al.*, 2003). In this study cigarette smoking duration is a much stronger predictor of lung cancer mortality than is cigarette smoking intensity, regardless of age in both men and women. These results are qualitatively similar to those reported by Doll & Peto (1978) and are consistent with IARC (2004a).

In a questionnaire-based assessment of the association of tobacco smoking with lung cancer risk, smokers at higher smoking intensities seem to experience a "reduced potency" per pack such that for equal total exposure, the excess odds ratio per pack–year decreases with intensity (Lubin *et al.* 2008). Below 15–20 cigarettes/day, the excess odds ratio/pack–year increases with intensity (Lubin & Caporaso, 2006; Lubin *et al.*, 2007a) while above 20 cigarettes/day, there is an 'inverse-exposure-rate' effect (Lubin *et al.*, 2007a) suggesting a greater risk for total exposure delivered at lower intensity (or a longer duration) than the equivalent exposure delivered at a higher intensity. The intensity effects were also statistically homogeneous across diverse cancer types, indicating that after accounting for risk from total pack–years, intensity patterns were comparable for cancer of the lung, bladder, oral cavity, pancreas and oesophagus. These analyses suggest that the risk of lung cancer increases with increasing tobacco exposure at all dose levels, but there is some levelling-off effect at the highest intensity of tobacco smoking.

However, when serum cotinine was used as a measure of exposure to tobacco smoking, rather than questionnaire-based data, the odds ratio of lung cancer increased linearly over the full range of exposure from ≤ 5 ng/mL through ≥ 378 ng/mL, with an odds ratio of 55.1 (95% confidence interval (CI): 35.7–85.0) in the highest exposure group. These results suggest that the decreased rate of lung cancer risk at high intensity of tobacco smoke previously described is a statistical artefact. Such an effect may be due to an inaccurate assessment of total tobacco smoke exposure from questionnaire-based studies at high exposure levels (Boffetta *et al.*, 2006). Somewhat similar results were obtained when both 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanol (NNAL) and total cotinine in urine were measured in subjects of two large cohort studies from Shanghai men and Singapore men and women (Yuan *et al.*, 2009). Among smokers with comparable smoking histories (as noted in questionnaire data) there is a 9-fold variation in subsequent risk of lung cancer between those with high and those with low levels of total urinary NNAL and cotinine. Thus measurements of urinary cotinine and total NNAL at a single point in time in a smoker could substantially improve the predictive power of a lung cancer assessment model based solely on self-reported smoking history (number of cigarettes/day, number of years of regular smoking). A positive NNAL-lung cancer association of comparable magnitude was observed in both Shanghai and Singapore subjects despite differences in the NNK content of tobacco smoked. The independent association between total urinary cotinine and lung cancer risk, after adjustment for total urinary NNAL and smoking history, suggests that tobacco smoke compounds other than NNK play a role in lung cancer development in smokers. Further, a single measurement of urinary NNAL may closely predict the average level of NNAL measured over a much longer period of time.

2.2.3 Types of tobacco or of cigarette

(a) Tar levels

In a previous *IARC Monograph* (IARC, 1986), it was concluded on the basis of the case–control, cohort studies and ecological evaluations

available at the time that prolonged use of 'high-tar' and unfiltered cigarettes is associated with greater risks than prolonged use of filter-tipped and 'low-tar' cigarettes. More recently (IARC, 2004a), it has been recognized that the actual quantitative impact of reduced 'tar' and filter-tipped cigarettes is difficult to assess because of, respectively, the concomitant increase in tobacco-specific nitrosamines that accompanies the greater use of blend tobacco and the compensatory changes in smoking behaviour by smokers attempting to maintain their accustomed level of nicotine intake. Nevertheless, it was concluded that changes in cigarette types since the 1950s have probably tended to reduce the risk for lung cancer associated with tobacco smoking.

Additional refinement in assessing the health effects associated with smoking cigarettes of various tar content has been possible since the publication of the earlier reports. Compared with smokers of medium tar (15–21 mg) filtered cigarettes risk was higher among men and women who smoked high tar (≥ 22 mg) non-filtered brands but there was no difference in risk among men and women who smoked 'very low tar' or 'low tar' brands compared with those who smoked 'medium tar' brands (Harris *et al.*, 2004). Regardless of tar content of their cigarettes, all current smokers had a far greater risk for lung cancer than people who had stopped smoking or had never smoked (Harris *et al.*, 2004).

(b) Mentholated cigarettes

In the previous *IARC Monograph* (IARC, 2004a) the conclusion was drawn that there is no additional risk associated with smoking mentholated cigarettes when total consumption (pack–years) was controlled versus non-mentholated ones. Recent evidence supports that conclusion.

Mentholated cigarettes first appeared in the 1920s, but were not widely used until the mid-1950s (Bogen, 1929; Federal Trade Commission, 2001). Since the early 1970s, menthol varieties have accounted for 25–60% of all cigarettes sold in the USA (Federal Trade Commission, 2001). There are strong ethnic differences in the use of menthol cigarettes; more than 60% of Black smokers of both sexes use menthol brands compared to fewer than 25% of White smokers (Royce *et al.*, 1993; Hymowitz *et al.*, 1995). Studies have generally not demonstrated an increased risk of lung cancer for mentholated cigarettes versus non-mentholated cigarettes (Kabat & Hebert, 1994; Carpenter *et al.*, 1999; Brooks *et al.*, 2003; Stellman *et al.*, 2003). Recent evidence also suggests that users of mentholated cigarettes smoke fewer pack–years than those of non-mentholated cigarettes.

The higher incidence of lung cancer among Blacks is an important public health concern but the causes remain unclear. Mentholated cigarette use does not appear to explain the racial disparity observed in lung cancer risk among those having the same total tobacco consumption.

2.2.4 Histology

Compiled databases from IARC and other sources indicated that squamous cell carcinoma rates [per 100000 person-years] among men declined by 30% or more in North America and some European countries between 1980–82 and 1995–97, while changing less dramatically in other areas; small cell carcinoma rates decreased less rapidly. In contrast, the proportion of adenocarcinoma cases rose among men and women in virtually all areas, with the increases among men exceeding 50% in many areas of Europe (Devesa *et al.*, 2005).

Based on a comparison of two large cohort studies initiated by the American Cancer Society (ACS) (CPS-I and CPS-II) in 1960 and 1980, respectively, a stronger association between smoking and adenocarcinoma was observed in recent compared to earlier follow-up periods (Thun & Heath, 1997). Additionally, an association between cigarette smoking and bronchioloalveolar carcinoma was also found in several

studies (Falk *et al.*, 1992; Morabia & Wynder, 1992).

A meta-analysis of 8 cohort and 14 case–control studies conducted in Japan among active smokers indicated significant excess lung cancer risks among men for both squamous cell carcinoma (relative risk (RR), 11.7) and adenocarcinoma (RR, 2.30). Among women the risks were 11.3 for squamous cell carcinoma and 1.37 for adenocarcinoma (Wakai *et al.*, 2006).

2.2.5 Population characteristics

(a) Sex

Meta-analyses on sex-specific susceptibility to lung cancer associated with tobacco smoking are presented in Table 2.4 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.4.pdf) and cohort studies in Table 2.5 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.5.pdf).

In the 1990s, two case–control studies indicated that relative risks for lung cancer associated with specific amounts and duration of cigarette smoking may be higher among women than among men (Risch *et al.*, 1993; Zang & Wynder, 1996).

In the large NIH-AARP [National Institutes of Health-American Association of Retired People] cohort (Freedman *et al.*, 2008), smoking was associated with lung cancer risk in both men and women. Age-standardized incidence rates for lung cancer tended to be higher in men than in women with comparable smoking histories (for current smokers and for quitters of less than 10 years), and in cases with squamous cell tumours. However, lung cancer risk was generally similar between men and women.

In a joint analysis, results from the Nurses' Health Study of women and the Health Professionals Follow-up Study in men (Bain *et al.*, 2004) suggest little difference in lung cancer susceptibility between men and women given equal smoking exposure. The hazard ratio in women ever smokers compared with men was 1.11 (95%CI: 0.95–1.31).

Serum cotinine levels were analysed in lung cancer cases and controls (Boffetta *et al.*, 2006). The lung cancer odds ratios (ORs) estimated for men and women were very similar for those with comparable serum cotinine levels. Other studies that have carefully quantified tobacco exposure via self-administered questionnaire or interview provide additional evidence of a comparable increase in lung cancer risk in the two sexes (Kreuzer *et al.*, 2000; Flanders *et al.*, 2003; Bain *et al.*, 2004).

In a meta-analysis of observational studies on cigarette smoking and cancer from 1961–2003 (conducted on 177 case–control studies, 75 cohort studies and two nested case–control studies), dose–response estimates were available in 44 studies: 19 with estimates for men only, 11 with estimates for women only and 14 with separate estimates for men and women (Gandini *et al.*, 2008). Overall, the risk of lung cancer for men and women increased by 7% for each additional cigarette smoked per day (RR, 1.07; 95%CI: 1.06–1.08). The increased risk appears to be slightly higher in women (RR, 1.08; 95%CI: 1.07–1.10) than in men (RR, 1.07; 95%CI: 1.05–1.08) ($P < 0.001$; adjusting for study type).

(b) Ethnicity

It has been postulated that susceptibility to lung cancer from tobacco smoking may differ by race and ethnicity (Schwartz & Swanson, 1997; Peto *et al.*, 1999; Stellman *et al.*, 2001; Kiyohara *et al.*, 2004, 2005, 2006; Pinsky, 2006; Wakai *et al.*, 2006; Vineis *et al.*, 2007; Takahashi *et al.*, 2008; Table 2.6 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.6.pdf). Lung cancer incidence rates vary considerable across racial/ethnic groups in the USA and elsewhere. Black men have higher rates than white men, while Hispanics, Asians and American Indians of both sexes have lower rates than whites (Stellman *et al.*, 2003; SEER, 2004).

Nutritional habits, smoking patterns, type of tobacco smoked and genetic factors may play a role in such differences between racial and ethnic groups.

The association of tobacco smoking and lung cancer does not appear to be as strong among Japanese as among populations of North America or Europe (Wakai *et al.*, 2006). In a meta-analysis of 8 cohort studies and 14 case–control studies conducted in Japan, the excess lung cancer risks observed for both men (RR, 4.39; 95%CI: 3.92–4.92) and women (RR, 2.79; 95%CI: 2.44–3.20) in both case–control and cohort studies were lower than would have been expected from studies in North America and Europe. The lower lifetime consumption of cigarettes in Japanese, due in part to a later initiation of smoking and a lower consumption per day has been suggested to explain this. Other differences that may have etiological significance include tobacco ingredients, different filters on cigarettes, lifestyle factors including diet, and possibly differences in genetic susceptibility. [The Working Group noted that North American or European populations were not directly included in any of these studies.]

Data from the Asian Pacific Cohort Studies Collaboration, 31 studies involving 480125 persons, evaluated the risk of death from lung cancer associated with smoking habits in Australia, New Zealand and Asia (Huxley *et al.*, 2007b). Among Asian men the hazard ratio was 2.48 versus 9.87 in men in Australia and New Zealand. Among women, the corresponding estimates were 2.35 and 19.33, respectively. [In these studies, Asian populations smoked fewer cigarettes for a shorter period of time compared to those in Australia and New Zealand.]

Based on data from the National Cancer Institute's Surveillance, Epidemiology, and End Results program (SEER), Chinese women residing in the USA have a fourfold increased risk of lung cancer, and Filipino women a twofold increased risk, compared to that expected based on rates in non-Hispanic whites in the USA with a similar amount of cigarettes smoked (Epplein *et al.*, 2005). Among Chinese women, the increased risk was largely restricted to adenocarcinoma and large cell undifferentiated carcinoma. Chinese females residents of the western US mainland have a much higher risk of lung cancer than would be expected from their tobacco use patterns, just as they do in Asia (Peto *et al.*, 1999; Epplein *et al.*, 2005), the reason for these difference have not been identified. [Controlling for potential confounding factors was limited using aggregate data from SEER.]

Age, sex and race-specific risks of lung cancer mortality among lifetime non-smokers were compared in the two large ACS Cancer Prevention Study cohorts (CPS-I; CPS-II). The mortality rate was higher among African American women than among white women in CPS-II (hazard ratio (HR), 1.43; 95%CI: 1.11–1.36) (Thun *et al.*, 2006). This suggests an inherent susceptibility difference between white and black women but it could also be explained by access to care, diet, or exposure to environmental carcinogens.

The risk for lung cancer associated with cigarette smoking in 183813 African-American, Japanese-American, Latino, native Hawaiian and white men and women was examined in the Multiethnic Cohort Study in the USA (Haiman *et al.*, 2006). Information on demographic factors, smoking status, cigarettes/day smoked, years of smoking, years since quitting, diet, occupations, educational level and racial and ethnic group were collected for all subjects through a self-administered questionnaire at enrolment. Information about age of smoking initiation and cessation rates were collected on a subgroup of 5090 study subjects. Incident lung cancer cases were identified by linkage to the SEER cancer registries covering California and Hawaii. Among those who smoked no more than 10 cigarettes/day and those who smoked 11–20 cigarettes/day, relative risks ranged from 0.21 to 0.39 ($P < 0.001$) among Japanese Americans and Latinos and from 0.45

to 0.57 ($P < 0.001$) among whites as compared with African Americans. However, at levels exceeding 30 cigarettes/day, differences between racial/ethnic groups were no longer significant. The differences in lung cancer risk by racial group associated with smoking were observed for both men and women and for all histological types of lung cancer. These findings could not be explained by differences between populations in other known or suspected risk factors, including diet, occupation, and education level or by age at starting smoking or cessation of smoking.

Polymorphisms in glutathione-*S*-transferase (GST), GSTM1, GSTT1 and GSTP1 genes in humans are associated with reduction of enzymatic activity towards several substrates, including those found in tobacco smoke. In a population based case–control study involving early-onset lung cancer, African Americans carrying at least one G allele at the GSTP1 locus were more likely to have lung cancer compared with African Americans without a G allele after adjustment for age, sex, pack–years of smoking and a history of lung cancer in a first degree relative (OR, 2.9; 95%CI: 1.29–6.20). African Americans with either one or two risk genotypes at the GSTM1 (i.e. null genotype) and GSTP1 loci were at increased risk of having lung cancer compared with those having fully functional GSTM1 and GSTP1 genes (one risk genotype: OR, 2.8; 95%CI: 1.1–7.2 and two risk genotypes: OR, 4.0; 95%CI: 1.3–12.2). No significant single gene associations between GSTM1, GSTT1 and GSTP1 and early-onset lung cancer were observed in Caucasians, after adjusting for age, sex, pack–years and a family history of lung cancer (Cote *et al.*, 2005).

The cytochrome P450 (CYP) superfamily of enzymes catalyses one of the first steps in the metabolism of carcinogens such as polycylic aromatic hydrocarbons, nitroaromatics and arylamines. A population-based case–control study of lung cancer in the metropolitan Detroit area found that neither CYP1A1 MspI nor CYP1A1 Ile^{462}Val was associated with lung cancer susceptibility among Caucasians or African Americans. Among Caucasians, however, CYP1B1 Leu^{432} Val was significantly associated with lung cancer susceptibility (OR for at least one Val allele, 2.87; 95%CI: 1.63–5.07). Individuals with both this polymorphism and exposure to second-hand tobacco smoke were at particularly high risk for lung cancer. Combinations of particular CYP1B1 polymorphisms appeared to increase risk, although no combination differed significantly from the risk associated with CYP1B1 Leu^{432} Val alone (Cote *et al.*, 2005; Wenzlaff *et al.*, 2005).

The hypothesis that polymorphisms in TP53 may modulate the risk for lung cancer associated with tobacco smoke was evaluated in a case–control study of lung cancer in Baltimore, Maryland. African-Americans with Pro-T-A-G-G haplotype (combining the polymorphisms TP53_01 (rs1042522), TP53_65 (rs9895829), TP53_66 (re2909430), TP53_16 (rs1625895), and TP_11 (rs12951053)) had both an increased risk for lung cancer (HR, 2.32; 95%CI: 1.38–4.10) and a worsened lung cancer prognosis (HR, 2.38; 95%CI: 0.38–4.10) compared with those having the Arg-T-A-G-T haplotype. No association of TP53 polymorphisms with lung cancer was observed in Caucasians (Mechanic *et al.*, 2007). Common genetic variation in TP53 could modulate lung cancer pathways in African Americans. Differences in lung cancer susceptibility may exist based on race, tobacco exposure and selected genetic polymorphisms (Mechanic *et al.*, 2007).

2.2.6 Interactions

(a) Diet and exercise

Antioxidant vitamins, carotenoids, isothiocyanates, total dietary vegetables and fruit, and physical exercise have been associated with a decreased risk for cancer in some studies but the overall protective effect of diet and exercise account for only a small fraction of the total risk associated with tobacco smoking.

The association of fruit and vegetable with lung cancer incidence among both smokers and non-smokers was evaluated in the European Prospective Investigation into Cancer and Nutrition (EPIC). In current smokers lung cancer risk was significantly decreased with higher vegetable consumption, the hazard ratio being 0.78 (95%CI: 0.62–0.98) per 100 g increase in daily vegetable consumption, and 0.90 (95%CI: 0.81–0.99) per 100 g fruit (Linseisen *et al.*, 2007). While overall consumption of fruits and vegetables was not found to be protective of lung cancer in the NIH-AARP Diet and Health Study, higher consumption of several botanical subgroups (i.e. rosaceae, convolvulaceae, and umbelliferae) was significantly inversely associated with risk, but only in men (Wright *et al.*, 2008).

Cruciferous vegetables (i.e. broccoli, cabbage, cauliflower, Brussels sprouts, kale) are rich in isothiocyanates and have been hypothesized to have anticancer properties that may contribute to reduced risk for lung cancer. Isothiocyanates may inhibit the bioactivation of procarcinogens found in tobacco smoke such as polycyclic aromatic hydrocarbons and 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone (Hecht, 2000). Isothiocyanates may also enhance excretion of carcinogenic metabolites before they can damage DNA (Gasper *et al.*, 2005). Furthermore, sulforaphane, a major isothiocyanate found in broccoli, can induce cell cycle arrest and apoptosis (Seow *et al.*, 2005). GSTM1 and GSTT1 encode isoenzymes that play an important role in xenobiotic metabolism (Hecht, 2000). Individuals with homozygous deletion of GSTM1 and GSTT1, or both may metabolize isothiocyanates less efficiently and may be more intensely exposed to isothiocyanates after consumption of cruciferous vegetables. Epidemiological evidence from 30 studies on the association between lung cancer and either total cruciferous vegetable consumption (6 cohort and 12 case–control studies) or specific cruciferous vegetables (1 cohort and 11 case–control studies) was recently evaluated (Lam *et al.*, 2009). The risk for lung cancer among those in the highest category of total cruciferous vegetable intake was 22% lower in case–control studies (pooled OR, 0.78; 95%CI: 0.70–0.88) and 17% lower in cohort studies (pooled RR, 0.83; 95%CI: 0.62–1.08). The strongest inverse association of total cruciferous vegetable intake with lung cancer was seen among individuals with GSTM1 and GSTT1 double null genotypes (OR, 0.41; 95%CI: 0.26–0.65; p for interaction = 0.01). The inverse association was observed in both smokers and non-smokers.

The potential role of vitamin A in the development of lung cancer attracted early research interest (Bjelke, 1975). Carotenoids were thought to have anti-cancer properties and early evidence from case–control studies tended to support an inverse association of lung cancer incidence with β-carotene intake and with serum concentrations of β-carotene. However, the case–control design is not ideal for assessing the effect of serum carotenoids as a risk factor for lung cancer risk since the disease is likely to effect serum levels. In a meta-analysis of six randomized clinical trials and 25 prospective observational studies, Gallicchio *et al.* (2008) computed a pooled relative risk for studies comparing β-carotene supplements with placebo of 1.10 (95%CI: 0.89–1.36). Among observational studies, the pooled relative risk for total carotenoid dietary intake from six studies was 0.86 (95%CI: 0.75–0.99) among current smokers. For dietary intake of β-cryptoxanthin, data from six studies gave a pooled relative risk among smokers of 0.75 (95%CI: 0.58–0.96). No other carotenoids significantly reduced the risk in current, former or never smokers.

Based on a review of the literature, antioxidant vitamins show no clear protective effect on lung cancer risk in smokers or non-smokers, although there was some, albeit inconsistent, evidence pointing to a protective role for vitamin C and E. No clear protective role was observed for vitamin A (Ruano-Ravina *et al.*, 2006).

Increased physical activity has been associated with a reduction in the incidence and mortality from all-site cancer and some site-specific cancers in studies of non-smokers, but less is known about whether physical activity is associated with similar risk reduction in smokers. Several early studies suggested that physical activity is associated with decreased risk of lung cancer in men and women after adjusting for smoking, with risk reductions estimated from 18% (Peterson *et al.*, 2001) to 62% (Kubík *et al.*, 2001). The effect of physical activity on lung cancer risk was assessed in a sample drawn from participants in the Beta-Carotene and Retinol Efficacy Trial. The results suggested that physical activity may play a small role in reducing cancer risk and mortality among those with significant tobacco exposure. The incidence of lung cancer and of all cancer sites combined seemed to be more attenuated by exercise in men than in women, while the attenuation in lung cancer mortality was greater in women than in men. These effects may be more pronounced for younger people and may differ inconsistently by pack–years of smoking (Alfano *et al.*, 2004).

(b) Radon

In a pooled analysis of data from 13 case–control studies of residential radon and lung cancer from nine European countries (7148 cases of lung cancer and 14208 controls), the dose–response relation seemed to be linear with no threshold and remained significant in analyses limited to individuals from homes with measured radon < 200 Bq/m^3. The absolute risks of lung cancer by age 75 years at radon concentrations of 0, 100, and 400 Bq/m^3 would be about 0.4%, 0.5% and 0.7%, respectively, for lifelong non-smokers, and about 25 times greater (10%, 12% and 16%) for cigarette smokers. These studies show appreciable hazards from residential radon, particularly for smokers and recent ex-smokers (Darby *et al.*, 2005). Similar risks were identified in a pooling project of North American case–control studies (Krewski *et al.*, 2005).

(c) Asbestos

Exposure to asbestos and tobacco smoking are both known causes of lung cancer in humans (Doll & Peto, 1978; de Klerk *et al.*, 1996). Some studies suggest a multiplicative effect [where the effect of asbestos exposure is a multiple of the effect of smoking] (Hammond *et al.*, 1979; Doll & Peto, 1985), and meta-analyses have suggested that the additive model [where asbestos exposure and smoking are independent of each other] is unsound (Lee, 2001; Liddell, 2001). In a recent study of 2935 asbestos miners, persons exposed to asbestos and tobacco who subsequently quit smoking remained at a 90% increased risk of lung cancer up to 20 years after smoking cessation, compared to never-smoker asbestos workers (Reid *et al.*, 2006a).

(d) Genetic polymorphisms

Lung cancer is plausibly caused by the interplay between environmental factors and several low-risk alleles. Attempts in identifying specific single nucleotide polymorphisms (SNPs) responsible for modulating lung cancer risk have yielded few conclusive results. Recent studies have focused on mechanistically plausible polymorphisms in genes coding for enzymes involved in the activation, detoxification and repair of chemical damage caused by tobacco smoke. Genetic association studies indicate that several inherited genetic polymorphisms may be associated with lung cancer risk, but the data from individual studies with low statistical power are conflicting. Evidence from pooled or meta-analyses, along with some individual studies, is briefly summarized below.

(i) Metabolic genes

Most of the 70 carcinogens in tobacco smoke are procarcinogens that must be activated by phase I enzymes and may then be deactivated by

phase II enzymes. Polymorphisms that alter the function of the genes involved in the activation or detoxification of tobacco smoke carcinogens can potentially influence an individual's risk of developing a tobacco-related cancer.

Meta and pooled analyses of 34 case–control, genotype-based studies were conducted to assess the effect of GSTT1 genotypes and smoking on lung cancer risk. No significant interaction was observed (Raimondi *et al.*, 2006). A pooled analysis of 21 case–control studies from the International Collaborative study of Genetic Susceptibility to Environmental Carcinogens showed no evidence of increased risk for lung cancer among carriers of the GSTM1 null genotype and there was no evidence of interaction between GSTM1 genotype and either smoking status or cumulative tobacco consumption (Benhamou *et al.*, 2002). Similarly, in another pooled analysis the summary OR indicated the slow acetylator genotype of N-acetyltransferase 2 (NAT2) detoxification enzyme was not associated with lung cancer risk among Caucasians (Borlak & Reamon-Buettner, 2006). In a pooled analysis to test the hypothesis of interaction among genetic variants in increasing the individual risk for cancer, the cumulative effect of variants in three metabolic genes, CYP1A1, GSTM1 and GSTT1 was assessed. The risk for lung cancer was increased with the combination of CYP1A1*2B or CYP1A1*4 alleles and the double deletion of both GSTM1 and GSTT1 up to an OR of 8.25 (95%CI: 2.29–29.77). The combination including CY1A1*4 among never smokers was associated with an OR of 16.19 (95%CI: 1.90–137). These estimates did not change after adjustment by the number of cigarettes smoked and duration of smoking. The results were consistent across ethnicities and were approximately the same for adenocarcinoma and squamous cell carcinoma (Vineis *et al.*, 2007).

Microsomal epoxide hydrolase 1 (EPHX1) plays an important role in both the activation and detoxification of tobacco-derived carcinogens. Polymorphisms at exons 3 and 4 of the EPHX1 gene have been reported to be associated with variations in EPHX1 activity. In a meta-analysis of 13 case–control studies the low-activity (variant) genotype of EPHX1 polymorphism at exon 3 was associated with decreased risk for lung cancer (OR, 0.65; 95%CI: 0.44–0.96) among whites. In white-populations, the high activity (variant) genotype of EPHX1 polymorphism at exon 4 was associated with a modest increased risk of lung cancer (OR, 1.22; 95%CI: 0.79–1.90) and the predicted low activity was associated with a modest decrease in risk (OR, 0.72; 95%CI: 0.43–1.22) (Kiyohara *et al.*, 2006).

(ii) DNA repair and cell cycle pathways

Data from 14 studies of lung cancer were used in a pooled analysis focusing on 18 sequence variants in 12 DNA repair genes, including APEX1, OGG1, XRCC1, XRCC2, XRCC3, ERCC1, XPD, XPF, XPG, XPA, MGMT and TP53 (Hung *et al.*, 2008a). None of the variants appeared to have a large effect on lung cancer risk. In a recent meta-analysis the X-ray repair cross-complementing protein group 3 (XRCC3) and the xeroderma pigmentosum group D (XPD)/excision repair cross-complementing group 2 (ERCC2) genes were evaluated (Manuguerra *et al.*, 2006). The authors found no association between these genes and the cancer sites investigated (skin, breast and lung). A significant association was identified for XPD/ERCC2 single nucleotide polymorphisms (codons 312 and 751) and lung cancer.

(iii) Nicotine acetylcholine receptor genes

A series of large genome-wide association studies for lung cancer have identified susceptibility loci for lung cancer in chromosome arms 5p, 6p and 15q (Landi *et al.*, 2009). In particular, the susceptibility locus at chromosome region 15q25 includes several genes, including three that encode nicotinic acetylcholine receptor subunits (CHRNA5, CHRNA3 and CHRNB4). Nicotinic acetylcholine receptor subunit genes

code for proteins that form receptors present in neuronal and other tissue, in particular alveolar epithelial cells, pulmonary neuroendocrine cells, and lung cancer cell lines (Wang *et al.*, 2001; Minna, 2003) and bind to nicotine and nicotine derivatives including NNN. An association of CHRNA3 and CHRNA5 variants with nicotine dependence has been reported (Saccone *et al.*, 2007; Berrettini *et al.*, 2008). These genes may act, at least partially, upon cigarette smoking. Current smokers with one or two copies of the susceptibility variant are likely to smoke between one and two cigarettes more a day (Spitz *et al.*, 2008). Evidence for an effect of the 15q25 locus among never smokers is conflicting, with an association found in one study in Europe (Hung *et al.*, 2008b) and one in Asia (Wu *et al.*, 2009a), but not in others. Whether genes in the 15q25 locus have an effect on lung cancer beyond their propensity to increase numbers of cigarettes smoked is unclear.

Three genome-wide association studies identified genetic factors that modified disease risk. The first was a genome-wide association analysis to identify genetic polymorphisms associated with lung cancer risk in 1154 lung cancer patients of European ancestry who were current or former smokers and 1137 control subjects who were frequency matched to the lung cancer patients by age, sex, race and smoking status. Two SNPs, rs105173 and rs803419, which mapped to a region of strong linkage disequilibrium within 15q25.1, were strongly associated with risk of lung cancer, with an odds ratio for rs105173 of 1.31 ($P = 9.84 \times 10^{-6}$). This finding was replicated with an additional 711 case subjects and 632 control subjects from Texas ($P = 0.00042$) and in 2013 case subjects and 3062 control subjects in the United Kingdom ($P = 2.33 \times 10^{-10}$). The region of interest encompasses the nicotinic acetylcholine receptor subunit genes CHRNA3 and CHRNA5 (as well as CHRNB4) (Spitz *et al.*, 2008). A second genome-wide association study conducted among 1989 lung cancer cases and 2625 controls from six central European countries confirm these results (Hung *et al.*, 2008a). In a third genome-wide association study of 665 Icelandic, 269 Spanish and 90 Dutch lung cancer cases and 32244 controls a common variant in the nicotinic acetylcholine receptor gene cluster [chromosome region 15q24] was significantly associated with lung cancer risk (OR, 1.31; 95%CI: 0.1.19–1.44). The variant was observed to have a significant effect on the number of cigarettes smoked per day (Thorgeirsson *et al.*, 2008). These studies have all shown a link between this variant and lung cancer risk either through a mechanism involving nicotine dependence or a direct role in downstream signalling pathways that promote carcinogens. Together these results provide compelling evidence of a locus at 15q25 and 15q24 predisposing to lung cancer.

(iv) Alpha(1)-antitrypsin

Alpha(1)-antitrypsin deficiency (α(1)ATD) is one of the most common genetic disorders, especially among European descendents. Recent results suggest that α(1)ATD carriers are at a 70–100% increased risk of lung cancer, accounting for 11% to 12% of patients with lung cancer (Yang *et al.*, 2008). [The specific effect by smoking status was not evaluated.]

(v) Other genes

Mutations in the checkpoint CHEK2 gene have been associated with increased risk of breast, prostate and colon cancer and a decreased risk of lung cancer among those with the I157T missense variant of the CHEK2 gene. In a large Polish case–control study CHEK2 mutations were protective against lung cancer (OR, 0.3; 95%CI: 0.2–0.5) (Cybulski *et al.*, 2008).

The Swedish Family-Cancer Database was used to compare the rate of lung cancers among persons without family history of lung cancer to those with a family history (Li & Hemminki, 2004). A high risk by family history in adenocarcinoma (standardized incidence ratio (SIR),

2.03) and large cell carcinoma (SIR, 2.14) was found, a slightly lower risk among patients with squamous cell carcinoma (SIR, 1.63) and small cell carcinoma (SIR, 1.55). Among siblings, an increased risk was shown for concordant adenocarcinoma and small cell carcinoma at all ages and for all histological types when cancer was diagnosed before age 50. At young age, risks between siblings were higher than those between offspring and parents. These data suggest that a large proportion of lung cancers before age 50 are heritable and due to a high-penetrant recessive gene or genes that predispose to tobacco carcinogen susceptibility.

(e) Viral infection

Data are limited regarding lung cancer risk in human immunodeficiency virus (HIV)-infected persons with modest immune suppression, before the onset of acquired immunodeficiency syndrome (AIDS). Among 57350 HIV-infected persons registered in the USA during 1991–2002 (median CD4 counts 491 cells/mm^3), 871 cancers occurred. Risk was elevated for several non-AIDS defining malignancies, including cancer of the lung (SIR, 2.6 [n = 109]) (Engels *et al.*, 2008). [Specific evaluation with smoking status was not performed.]

2.3 Cancers of the upper aerodigestive tract

Evidence relating to cancers of the upper aerodigestive tract obtained from relevant cohort and case–control studies on specific sites is described in Sections 2.3.1 to 2.3.6; studies that looked at several subsites combined are described in Section 2.3.7. The major potential confounders for the relationship between smoking and cancers of the upper aerodigestive tract are alcohol consumption and use of any form of smokeless tobacco, and for some sites infection with human papillomavirus (HPV) (especially HPV16). In general, the studies examined by the Working Group had adjusted for these two confounders when appropriate. Some studies also adjusted for dietary intake, especially of fruits and vegetables, although few reported stratified relative risks.

2.3.1 Cancer of the oral cavity

Tobacco smoking was found to be causally related to oral cancer (IARC, 1986, 2004a). New studies on the relationship between oral cancer and cigarette smoking published since the most recent *IARC Monograph* (IARC, 2004a) include four cohort studies (Table 2.7 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.7.pdf), and eight case–control studies (Tables 2.8–2.11 online; see below).

(a) Intensity and duration of smoking

Intensity of smoking was measured in almost all cohort (Table 2.7 online) and case–control studies (IARC 2004a; Table 2.8 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.8.pdf and Table 2.9 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.9.pdf). In addition to the number of cigarettes or amount of tobacco smoked daily, cumulative exposure to cigarette smoke was also measured in terms of pack–years, tobacco-years or lifetime tobacco consumption. The link between duration of cigarette consumption and oral cancer was examined in 15 case–control studies. Seven case–control studies also considered age at starting smoking.

One cohort study (McLaughlin *et al.*, 1995) and 14 case–control studies reported a dose-dependent increase in risk with increasing number of cigarettes smoked daily or increasing daily tobacco consumption (Franceschi *et al.*, 1990, 1992, 1999; Nandakumar *et al.*, 1990; Zheng *et al.*, 1990; Choi & Kahyo, 1991; Oreggia *et al.*, 1991; Bundgaard *et al.*, 1995; Zheng *et al.*, 1997; De Stefani *et al.*, 1998; Hayes *et al.*, 1999; De Stefani

et al., 2007; Subapriya *et al.*, 2007; Muwonge *et al.* 2008). Whenever analysed, the trend was always statistically significant (Franceschi *et al.*, 1990, 1992; Oreggia *et al.*, 1991; Bundgaard *et al.*, 1995; McLaughlin *et al.* 1995; Hayes *et al.*, 1999; Subapriya *et al.*, 2007), except in the study of Muwonge *et al.* (2008) which also included bidi smokers.

Bundgaard *et al.* (1995) used lifetime tobacco consumption divided into four categories and reported a positive, significant trend after adjustment for life-time consumption of alcohol and other risk factors. A positive trend was also found in all studies that have analysed consumption in pack–years or tobacco-years (Zheng *et al.*, 1990; Maier *et al.*, 1992a; Macfarlane *et al.*, 1995; Hung *et al.*, 1997; Zheng *et al.*, 1997; De Stefani *et al.*, 1998, 2007; Applebaum *et al.*, 2007; Muwonge *et al.*, 2008), except Muwonge *et al.* (2008).

Ten studies (Franceschi *et al.*, 1990, 1992; Nandakumar *et al.*, 1990; Zheng *et al.*, 1990; Choi & Kahyo, 1991; Oreggia *et al.*, 1991; Zheng *et al.*, 1997; De Stefani *et al.*, 1998, 2007; Znaor *et al.*, 2003; Subapriya *et al.*, 2007; Muwonge *et al.*, 2008) classified the duration of smoking in up to four categories, and all but one (Nandakumar *et al.*, 1990) reported increased relative risks and a positive trend.

Of six studies that considered age at start of smoking (Franceschi *et al.*, 1990, 1992; Choi & Kahyo, 1991; Oreggia *et al.*, 1991; Zheng *et al.*, 1997; Balaram *et al.*, 2002) two reported a statistically significant trend of increasing risk with decreasing age at starting (Franceschi *et al.*, 1990, 1992).

(b) *Cessation of smoking*

Three cohort studies (McLaughlin *et al.*, 1995; Freedman *et al.*, 2007a; Friborg *et al.* 2007) and nine case–control studies (Zheng *et al.*, 1990; Choi & Kahyo, 1991; Oreggia *et al.*, 1991; Franceschi *et al.*, 1992; Ko *et al.*, 1995; Zheng *et al.*, 1997; De Stefani *et al.*, 1998, 2007; Schildt *et al.*, 1998; Balaram *et al.*, 2002; Pacella-Norman *et al.*, 2002; Muwonge *et al.* 2008) estimated risks for former smokers which were always lower than those for current smokers and in five studies almost reached unity (Zheng *et al.*, 1990; Choi & Kahyo, 1991; Zheng *et al.*, 1997; Schildt *et al.*, 1998; Muwonge *et al.*, 2008). Twelve case–control studies examined the risk by years since quitting and all reported a negative trend, with relative risks compared with those in non-smokers decreasing to near unity after 10 or more years (Franceschi *et al.*, 1990, 1992; De Stefani *et al.*, 1998, 2007; Schlecht *et al.*, 1999a; Table 2.7 online; Table 2.10 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.10.pdf).

(c) *Type of cigarette*

The effect of the type of cigarette smoked was examined in several case–control studies (Table 2.11 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.11.pdf). The characteristics of the cigarettes included the presence of a filter, the type of tobacco, the tar content and whether the product was manufactured or hand-rolled. Two studies reported a statistically significantly higher risk for black than for blond tobacco (Oreggia *et al.*, 1991; De Stefani *et al.*, 1998, 2007). Similarly, a much higher risk was found for hand-rolled cigarettes than for manufactured cigarettes, and plain cigarettes had a much higher risk than filter-tipped cigarettes (De Stefani *et al.*, 1998, 2007). In one study the differences between black and blond tobacco and between hand-rolled and manufactured cigarettes persisted after stratification by duration of smoking (De Stefani *et al.*, 1998). Smoking cigarettes with a high-tar content led to higher risks than smoking cigarettes with a low-tar content (Franceschi *et al.*, 1992) and the same trend was observed for cigarettes without filter compared to cigarettes with filter (De Stefani *et al.*, 2007).

(d) Sex

Sex-specific effects were examined in two case–control studies (Zheng *et al.*, 1990; Hayes *et al.*, 1999). In both studies, the relative risks for all categories of intensity, duration of smoking and pack–years were higher for women than for men. [The Working Group noted that the background risk of oral cancer is considerably lower in women than men. Thus, the higher relative risk estimates in women than men indicate a higher proportionate contribution from smoking in women than men, rather than higher absolute risk.]

2.3.2 Cancer of the pharynx

Tobacco smoking was considered to be an important cause of oropharyngeal and hypopharyngeal cancers in the previous *IARC Monographs* on tobacco smoking (IARC, 1986, 2004a). Since then, results available from three cohort (Table 2.12 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.12.pdf) and seven case–control studies (Table 2.13 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.13.pdf and Table 2.14 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.14.pdf) provide further support for the association. Many studies, however, combine cancers of the oral cavity and pharynx (see Section 2.3.7). This section summarizes the evidence from all eight cohort and 21 case–control studies that reported results specifically on oropharyngeal and hypopharyngeal cancer, or on pharyngeal cancer in general; the latter may include data on nasopharyngeal cancer.

The risk for pharyngeal cancer was significantly increased in smokers in four cohort studies (Doll *et al.*, 2005; McLaughlin *et al.*,1995; Freedman *et al.*, 2007a; Friborg *et al.*, 2007) and all but one of the case–control studies (Rao *et al.*, 1999). The trend of increasing risk associated with increasing daily or cumulative consumption of cigarettes was evident from all these studies, particularly those from Europe (Brugere *et al.*, 1986; Tuyns *et al.*, 1988; Franceschi *et al.*, 1990, 1999; Maier *et al.*, 1994; Escribano Uzcudun *et al.*, 2002; Vlajinac *et al.*, 2006), India (Znaor *et al.*, 2003; Sapkota *et al.*, 2007), Uruguay (De Stefani *et al.*, 1998, 2007) and the USA (McLaughlin *et al.*, 1995; Applebaum *et al.*, 2007), and less strongly so in studies from Canada (Elwood *et al.*, 1984) and the Republic of Korea (Choi & Kahyo, 1991). The multicentre study in Europe, North and South America of Hashibe *et al.* (2007c) showed increased risks according to frequency (cigarettes/day) and duration (years) in never drinkers. Applebaum *et al.* (2007) found a relationship between increasing risk of pharyngeal cancer and increased pack–years of smoking in subjects with negative HPV16 serology but not in those with positive HPV16 serology (p value for interaction = 0.007).

In two case–control studies the risk increased with decreasing age at starting smoking (Franceschi *et al.*, 1990; Choi & Kahyo, 1991,), but adjustment was not made for duration and intensity of smoking. In a case–control study from Spain (Escribano Uzcudun *et al.*, 2002) the risk increased with the age of starting smoking.

Former smokers had consistently lower relative risks than did current smokers in both cohort (McLaughlin *et al.*, 1995; Freedman *et al.*, 2007a) and case–control studies (Choi & Kahyo, 1991; De Stefani *et al.*, 1998; Vlajinac *et al.*, 2006). In comparison with non-smokers, the relative risks for former smokers who had quit smoking for more than 10 years were between 2 and 4 (Franceschi *et al.*, 1990; De Stefani *et al.*, 1998; La Vecchia *et al.*, 1999), whereas the relative risks for current smokers in these studies were 10–14. In one study in Brazil (Schlecht *et al.*, 1999a), relative risks for former smokers who had stopped smoking for more than 10 years approached 1, whereas that for current smokers was just below 6. Consumption of black tobacco, hand-rolled cigarettes or plain cigarettes resulted in a higher

risk for pharyngeal cancer than consumption of blond tobacco, manufactured cigarettes or filter-tipped cigarettes (De Stefani *et al.*, 1998; 2007).

2.3.3 Cancer of the nasal cavity and accessory sinuses

In the Life Span Study in Japan (Akiba, 1994) the association of tobacco use with sinonasal cancer was examined. A total of 26 cases of sinonasal cancer were identified among 61505 adults during follow-up. Relative risk estimates, adjusted for sex, location, population group, atomic bomb exposure, year of birth and attained age, were 2.9 (95%CI: 0.5–) and 4.0 (95%CI: 1.2–) for former and current smokers, respectively, when compared with non-smokers [upper confidence limits were not reported]. The cohort of 34439 British doctors followed up to 50 years (Doll *et al.*, 2005) showed increased risk for current smokers and smokers of more than 25 cigarettes per day, but only six deaths from nasal cavity and sinuses cancers were observed (Table 2.15 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.15.pdf).

A total of nine case–control studies of nasal cavity and sinus cancers have been conducted. When histological types were combined, all studies found an increased risk associated with cigarette smoking, but only one was statistically significant (Caplan *et al.*, 2000). In seven studies, dose–response in terms of intensity of smoking (cigarettes/day), duration of smoking or pack–years was considered. A positive significant trend was found in five studies (Brinton *et al.*, 1984; Hayes *et al.*, 1987; Fukuda & Shibata, 1990; Zheng *et al.*, 1993; Caplan *et al.*, 2000) and suggested in the other two (Strader *et al.*, 1988; Zheng *et al.*, 1992c).

One study (Zheng *et al.*, 1993a) found a significant decrease in risk for sinonasal cancer associated with increasing number of years since cessation of smoking. In a previous study, the same authors had found a negative, non-significant association (Zheng *et al.*, 1992c).

Five studies analysed squamous-cell carcinomas and adenocarcinomas separately (Brinton *et al.*, 1984; Hayes *et al.*, 1987; Strader *et al.*, 1988; Zheng *et al.*, 1992c; 't Mannetje *et al.*, 1999). In all studies, there was a significantly increased risk for squamous-cell carcinomas, whereas the risk was generally not increased for adenocarcinomas.

2.3.4 Cancer of the nasopharynx

(a) Cohort studies

The risk for nasopharyngeal carcinoma has been examined in relation to tobacco use in six cohort studies, three of them reported since the last evaluation (IARC 2004a; Table 2.16 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.16.pdf). In one study, conducted in a low-risk area (Chow *et al.*, 1993a), a significant increase in risk among smokers and suggestive positive dose–response relationships by duration of smoking and age at starting smoking were found. In another study, conducted in Province of Taiwan, China, an area in which nasopharyngeal cancer area is endemic, a similarly increased risk was found, but it was not statistically significant (Liaw & Chen, 1998). Doll *et al.* (2005) identified a risk only for smokers of more than 25 cigarettes per day, however, this result was based on only four deaths. Friborg *et al.* (2007) in Singapore found statistically significant increased risk of nasopharyngeal cancer only for those smoking for 40 years or more. Hsu *et al.* (2009) in Taiwan, China observed increased statistically significant risks only for those smoking for 30 years or more and those with cumulative exposure of 30 pack–years or more.

(b) Case–control studies

The study designs and the results of the case–control studies on the association of nasopharyngeal carcinoma with cigarette smoking

reported since the previous *IARC Monograph* (IARC, 2004a) are given in Table 2.17 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.17.pdf) and Table 2.18 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.18.pdf), one being a nested case–control analysis within a cohort study (Marsh *et al.*, 2007).

In total, 14 informative case–control studies were available. In almost all of these, the risk for nasopharyngeal carcinoma was higher in smokers than in non-smokers. In Taiwan, China (Cheng *et al.*, 1999) high risks were statistically significant only for duration of smoking of 20 years or more. In the five studies conducted in the USA (Mabuchi *et al.*, 1985; Nam *et al.*, 1992; Zhu *et al.*, 1995; Vaughan *et al.*, 1996; Marsh *et al.*, 2007), where the incidence of nasopharyngeal carcinoma is low, the relative risks for current smokers ranged between 2 and 4, but were not statistically significant in the two studies (Mabuchi *et al.*, 1985; Marsh *et al.*, 2007). In a study conducted in Shanghai, an area of China in which nasopharyngeal carcinoma is not endemic (Yuan *et al.*, 2000), the relative risk was just below 2. In one study from the Philippines there was a sevenfold increase in risk after more than 30 years of smoking (West *et al.*, 1993). The four studies (Lin *et al.*, 1973; Yu *et al.*, 1990; Ye *et al.*, 1995; Cao *et al.*, 2000) conducted in areas of China in which nasopharyngeal carcinoma is endemic (Taiwan, China, Guangzhou, and Sihui) found relative risks for ever smoking ranging between 2 and 5. In the study from the North of Africa (Feng *et al.*, 2009) the only statistically significant increased risk was found for differentiated nasopharyngeal cancer in those that had smoked more than 22 cigarettes/day. [The result, based only on three cases, is very unstable (RR, 313; 95%CI: 1.94–50336).]

A statistically significant dose–response relationship was detected in seven studies that evaluated the effects of daily or cumulative exposure to tobacco smoke (Yu *et al.*, 1990; Nam *et al.*, 1992; Zhu *et al.*, 1995; Vaughan *et al.*, 1996; Cao *et al.*, 2000; Yuan *et al.*, 2000; Feng *et al.*, 2009) and was suggestive in two others (Lin *et al.*, 1973; West *et al.*, 1993). In two studies the risk of nasopharyngeal carcinoma decreased with increasing time since quitting smoking (Nam *et al.*, 1992; Vaughan *et al.*, 1996).

In the remaining studies, six from areas in which nasopharyngeal carcinoma is endemic (Ng, 1986; Yu *et al.*, 1986; Sriamporn *et al.*, 1992; Zheng *et al.*, 1994; Cheng *et al.*, 1999; Feng *et al.*, 2009; Guo *et al.*, 2009) and seven from areas in which it was not endemic (Henderson *et al.*, 1976; Lanier *et al.*, 1980; Mabuchi *et al.*, 1985; Ning *et al.*, 1990; Armstrong *et al.*, 2000, Marsh *et al.*, 2007), the relative risks for nasopharyngeal carcinoma for ever smoking were not significantly increased (Lanier *et al.*, 1980; Mabuchi *et al.*, 1985; Cheng *et al.*, 1999) or were close to 1.0 (Henderson *et al.*, 1976; Ng, 1986; Yu *et al.*, 1986; Ning *et al.*, 1990; Sriamporn *et al.*, 1992; Zheng *et al.*, 1994; Guo *et al.*, 2009).

In the two studies that distinguished between different histological types, relative risks were higher for keratinized (squamous-cell) carcinoma than for unkeratinized carcinoma (Zhu *et al.*, 1995; Vaughan *et al.*, 1996).

In the three studies in which men and women were analysed separately (Lin *et al.*, 1973; Nam *et al.*, 1992; Yuan *et al.*, 2000), the relative risks were found to increase similarly in both sexes in two studies (Nam *et al.*, 1992; Yuan *et al.*, 2000) and were higher among women in the study of Lin *et al.* (1973).

2.3.5 Cancer of the oesophagus

In the previous *IARC Monograph* (IARC, 2004a), both histological subtypes of oesophageal cancer (squamous-cell carcinoma and adenocarcinoma) were considered to be causally related to cigarette smoking. Many more epidemiological studies have since been conducted, and results of these studies further support this conclusion.

(a) *Squamous cell carcinoma and unspecified cancer of the oesophagus*

Since the previous *IARC Monograph* (IARC, 2004a), there have been reports on 9 cohort studies (Table 2.19 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.19.pdf) and 22 case–control studies (Tables 2.20–2.23; see below), making 30 cohort and 55 case–control studies in all. All showed that the risk of oesophageal squamous cell carcinoma was associated with cigarette smoking. In one study (Li *et al.*, 1989), the elevated risk was observed only in an area with a relatively low incidence of oesophageal cancer. However, two later studies in the same area, Lin County, China, found a twofold increase in risk for oesophageal cancer among smokers (Gao *et al.*, 1994; Lu *et al.*, 2000).

In most cohort studies and in most case–control studies with relatively large sample sizes (IARC, 2004a; Table 2.19 online; Table 2.20 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.20.pdf; Table 2.21 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.21.pdf), the risk for oesophageal cancer was shown to increase with increasing duration of smoking (11 cohort and 32 case–control studies) or number of cigarettes smoked daily (18 cohort and 31 case–control studies), and to decrease with increasing age at starting smoking (12 case–control studies). In comparison with pharyngeal and laryngeal cancers, relative risks for oesophageal cancer estimated by duration and by intensity of smoking were somewhat lower (see Sections 2.3.2 and 2.3.6, respectively).

Ten cohort and 20 case–control studies (IARC, 2004a; Table 2.19 online; Table 2.22 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.22.pdf) investigated the effect of smoking cessation on risk of oesophageal cancer. Although not all studies analysed the trend, all found a decreasing relative risk with increasing number of years since quitting. In some studies, the risk first started to decrease after 10 years of cessation (Brown *et al.*, 1988; Rolón *et al.*, 1995; Gammon *et al.*, 1997; Castellsagué *et al.*, 1999; Freedman *et al.*, 2007b; Bosetti *et al.*, 2008) or after 30 years of cessation (Pandeya *et al.*, 2008).

When comparing the types of tobacco smoked (Table 2.23 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.23.pdf), consumption of black tobacco resulted in a higher risk for oesophageal cancer than did consumption of blond tobacco (De Stefani *et al.*, 1990; Rolón *et al.*, 1995; Castellsagué *et al.*, 1999; Launoy *et al.*, 2000; Vioque *et al.*, 2008). Similarly, smoking untipped cigarettes generally resulted in a higher risk than smoking filter-tipped cigarettes (Vaughan *et al.*, 1995; Gammon *et al.*, 1997; Castellsagué *et al.*, 1999).

Two studies from the USA reported risks separately for blacks and whites. After adjustment for alcohol consumption, age and income, risks were very similar for former and current smokers and for the number of cigarettes smoked per day and duration of smoking (Brown *et al.*, 1994a; Brown *et al.*, 2001).

(b) *Adenocarcinoma of the oesophagus*

Two decades ago it was noted that incidence rates for adenocarcinoma of the oesophagus and gastric cardia had increased steadily in the USA, whereas the incidence rate for squamous-cell carcinoma of the oesophagus had remained relatively stable (Blot *et al.*, 1991). An increase in the incidence of adenocarcinoma of the distal oesophagus and cardia was also noted in the United Kingdom (Powell & McConkey, 1990), and in several other countries. Since 1990, several studies have focused on the risk factors for adenocarcinoma of the oesophagus. Since the last evaluation (IARC, 2004a) one cohort study (Freedman *et al.*, 2007b) and three case–control studies (Table 2.24 available at http://monographs.iarc.fr/ENG/Monographs/

vol100E/100E-01-Table2.24.pdf; Table 2.25 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.25.pdf) have been reported, totaling 13 case–control studies on the association of cigarette smoking and adenocarcinoma of the oesophagus.

(i) Intensity and duration of smoking

Ten studies, three that included only cases of adenocarcinoma of the oesophagus (Menke-Pluymers *et al.*, 1993; Gammon *et al.*, 1997; Wu *et al.*, 2001), three that included cases of adenocarcinoma of the oesophagus, gastro-oesophageal junction and gastric cardia combined (Kabat *et al.*, 1993; Brown *et al.*, 1994b; Vaughan *et al.*, 1995), and four that stratified by histology (Lindblad *et al.*, 2005; Freedman *et al.*, 2007b; Hashibe *et al.*, 2007a; Pandeya *et al.*, 2008), showed a significant positive association of adenocarcinoma of the oesophagus with cigarette smoking. The relative risks were somewhat lower than those for squamous cell carcinoma of the oesophagus. Three studies, one in China (Gao *et al.*, 1994), one in Sweden (Lagergren *et al.*, 2000), and one in the USA (Zhang *et al.*, 1996), reported similarly elevated relative risks, but some of these risks were not statistically significant, probably because of relatively small numbers of cases.

Of those studies that reported risks adjusted for alcohol consumption, a positive, significant dose–response relationship was found with intensity of smoking (Kabat *et al.*, 1993; Brown *et al.*, 1994b; Gammon *et al.*, 1997; Hashibe *et al.*, 2007a), duration of smoking (Gammon *et al.*, 1997; Pandeya *et al.*, 2008) and/or pack–years (Vaughan *et al.*, 1995; Zhang *et al.*, 1996; Gammon *et al.*, 1997; Pandeya *et al.*, 2008).

(ii) Cessation of smoking

Ten studies provided point estimates for former smokers. In eight, relative risks were lower in former smokers than in current smokers, although they remained elevated (Kabat *et al.*, 1993; Gao *et al.*, 1994; Vaughan *et al.*, 1995; Gammon *et al.*, 1997; Wu *et al.*, 2001; Lindblad *et al.*, 2005; Freedman *et al.*, 2007b; Pandeya *et al.*, 2008), and were increased in the other studies (Lagergren *et al.*, 2000; Hashibe *et al.*, 2007a). The decrease in relative risk associated with years since cessation was weak, but a significant trend was found in two out of six studies (Gammon *et al.*, 1997; Wu *et al.*, 2001).

(iii) Confounding

With the exception of two studies (Levi *et al.*, 1990; Wu *et al.*, 2001), all studies adjusted for alcohol intake as a potential confounder. Three more recent studies also adjusted for fruit and vegetables intake (Freedman *et al.*, 2007b; Hashibe *et al.*, 2007a; Pandeya *et al.*, 2008). Ten of these studies were conducted in the USA (Kabat *et al.*, 1993; Brown *et al.*, 1994b; Vaughan *et al.*, 1995; Zhang *et al.*, 1996; Gammon *et al.*, 1997; Freedman *et al.*, 2007b) the Netherlands (Menke-Pluymers *et al.*, 1993), the United Kingdom (Lindblad *et al.*, 2005), central and eastern Europe (Hashibe *et al.*, 2007a) and Australia (Pandeya *et al.*, 2008), where chewing of betel quid with tobacco or use of other forms of smokeless tobacco are not likely confounders. One study conducted in Sweden was adjusted for snuff use (Lagergren *et al.*, 2000).

(iv) Sex

Kabat *et al.* (1993) examined risks for men and women separately and observed similar patterns in both sexes, although risks among current smokers and heavy smokers were somewhat higher for women than for men. Lindblad *et al.* (2005) also found higher risks in women than in men, but they were not statistically significant.

2.3.6 Cancer of the larynx

Laryngeal cancer is one of the cancers most strongly associated with cigarette smoking (IARC, 1986, 2004a). Since the previous *IARC*

Monograph, more epidemiological evidence has become available to strengthen this conclusion.

(a) Potential confounders

Other causes of laryngeal cancer include alcohol consumption, some occupational exposures (e.g. sulphuric acid; IARC, 2012a) and possibly some dietary habits. In investigating associations between smoking and laryngeal cancer, potential confounding by alcohol consumption has been considered in most of the studies.

(b) Intensity and duration of smoking

Cohort and case–control studies have been carried out in Asia, Europe, North and South America, and South Africa. In all, the risk for laryngeal cancer was consistently higher in smokers, and a positive significant trend was observed with increasing duration and intensity of smoking (IARC, 2004a; Table 2.26 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.26.pdf; Table 2.27 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.27.pdf; Table 2.28 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.28.pdf).

In most case–control studies, the relative risks for laryngeal cancer were near to or greater than 10 for smokers who had smoked for longer than 40 years (Falk *et al.*, 1989; Zheng *et al.*, 1992b) or had smoked more than 20 cigarettes per day (Tuyns *et al.*, 1988; Falk *et al.*, 1989; Choi & Kahyo, 1991; Zatonski *et al.*, 1991; Muscat & Wynder, 1992; Zheng *et al.*, 1992b; Hedberg *et al.*, 1994; Sokić *et al.*, 1994; Talamini *et al.*, 2002). Cancer of the larynx in non-smokers is so rare that several studies used as the reference category light smokers (Herity *et al.*, 1982; Olsen *et al.*, 1985a; De Stefani *et al.*, 1987; Zatonski *et al.*, 1991; López-Abente *et al.*, 1992; Maier & Tisch, 1997), or former smokers (Hashibe *et al.*, 2007b). Consequently, relative risks were lower in these studies, although the increases were still statistically significant.

Three case–control studies reported odds ratios for cancer of the larynx that increased with decreasing age of starting smoking (Franceschi *et al.*, 1990; Zatonski *et al.*, 1991; Talamini *et al.*, 2002).

(c) Cessation of smoking

The risk for cancer of the larynx declines rather rapidly after cessation of smoking (IARC, 2004a; Table 2.29 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.29.pdf). No detectable higher risk compared with never-smokers was seen among subjects who had quit smoking for at least 10 years (Franceschi *et al.*, 1990; Ahrens *et al.*, 1991; Schlecht *et al.*, 1999a, b; Bosetti *et al.*, 2006; Hashibe *et al.*, 2007b).

(d) Types of tobacco or of cigarette

Some investigators considered the role of type of tobacco (IARC, 2004a; Table 2.30 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.30.pdf). An average 2.5-fold higher risk was observed in smokers of black tobacco compared to smokers of blond tobacco (De Stefani *et al.*, 1987; Tuyns *et al.*, 1988; López-Abente *et al.*, 1992). Smoking untipped cigarettes also led to a higher risk than smoking filter-tipped cigarettes (Wynder & Stellman, 1979; Tuyns *et al.*, 1988; Falk *et al.*, 1989). Those that smoke cigarettes only had higher risks of larynx cancer than those that smoke cigars only (Hashibe *et al.*, 2007b).

(e) Subsites

Six studies investigated the risk for glottic and supraglottic cancer separately (Olsen *et al.*, 1985a; Tuyns *et al.*, 1988; López-Abente *et al.*, 1992; Maier *et al.*, 1992b; Muscat & Wynder, 1992; Sapkota *et al.*, 2007). The cancer risk increased with increasing amount smoked per

day and with cumulative exposure for both subsites (IARC, 2004a; Table 2.28 online). In addition, the observed relative risks were higher for supraglottic cancer than for glottic cancer (Maier *et al.*, 1992b; Sapkota *et al.*, 2007).

(f) Sex

Few studies investigated sex-specific effects. In one cohort study (Raitiola & Pukander, 1997) similar risks were found for men and women, whereas in two case–control studies (Zheng *et al.*, 1992b; Tavani *et al.*, 1994), the relative risks for women were up to 10-fold higher than for the corresponding categories in men, though a small number of cases were involved. However, Freedman *et al.* (2007a) observed higher relative risks in men than women (Table 2.26 online). One study looked at women only and found higher risks of laryngeal cancer in former and current smokers relative to non-smokers, and also according to the number of cigarettes per day with a clear dose–response effect ($P < 0.001$) (Gallus *et al.*, 2003b).

2.3.7 Cancer of the upper aerodigestive tract combined

In epidemiological studies, especially in cohort studies in which there are few cases at some sites, investigators often combine cancers of the oral cavity, pharynx, larynx and oesophagus and term these 'cancer of the upper aerodigestive tract'. This section summarizes the data from 19 cohort studies (IARC, 2004a; Table 2.31 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.31.pdf), and 40 case–control studies (IARC, 2004a; Tables 2.32–2.35; see below).

(a) Intensity and duration of smoking

In all but two cohort studies from Japan (Kono *et al.*, 1987; Akiba, 1994), the risk for cancer of the upper aerodigestive tract was strongly associated with cigarette smoking. Relative risks increased with increasing daily cigarette consumption (Hammond & Horn, 1958; Doll *et al.*, 1980, 1994; Akiba & Hirayama, 1990; Kuller *et al.*, 1991; Chyou *et al.*, 1995; Engeland *et al.*, 1996; Murata *et al.*, 1996; Yuan *et al.*, 1996; Kjaerheim *et al.*, 1998; Liaw & Chen, 1998; Yun *et al.*, 2005; Freedman *et al.*, 2007a), duration of smoking (Chyou *et al.*, 1995; Yun *et al.* 2005; Friborg *et al.*, 2007) or pack–years (Liaw & Chen, 1998; Freedman *et al.*, 2007a).

The main characteristics and results of the case–control studies are presented in IARC (2004a), and in Table 2.32 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.32.pdf) and Table 2.33 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.33.pdf), respectively. Intensity of smoking was measured in most of these studies. The link between duration of smoking and cancer of the upper aerodigestive tract was examined in 20 case–control studies (Blot *et al.*, 1988; Merletti *et al.*, 1989; Barra *et al.*, 1991; De Stefani *et al.*, 1992, 2007; Franceschi *et al.*, 1992; Day *et al.*, 1993; Mashberg *et al.*, 1993; Kabat *et al.*, 1994; Lewin *et al.*, 1998; Bosetti *et al.*, 2000a; Garrote *et al.*, 2001; Gallus *et al.*, 2003a; Lissowska *et al.*, 2003; Znaor *et al.*, 2003; Castellsagué *et al.*, 2004; Menvielle *et al.*, 2004a, b; Rodriguez *et al.*, 2004; Hashibe *et al.*, 2007c; Sapkota *et al.*, 2007). Nine also considered age at starting smoking (Blot *et al.*, 1988; Merletti *et al.*, 1989; Barra *et al.*, 1991; Franceschi *et al.*, 1992; Day *et al.*, 1993; Lewin *et al.*, 1998; Garrote *et al.* 2001; Lissowska *et al.* 2003; Menvielle *et al.* 2004a).

In all but one study (Rao *et al.*, 1999) there was an increased risk for cancer of the upper aerodigestive tract associated with cigarette smoking. A clear dose–response relationship was seen with increasing daily tobacco consumption and duration of smoking as well as with decreasing age at starting smoking in most of the studies examined.

(b) Cessation of smoking

Twelve cohort studies (Doll *et al.*, 1980, 1994; Tomita *et al.*, 1991; Akiba, 1994; Chyou *et al.*, 1995; Engeland *et al.*, 1996; Nordlund *et al.*, 1997; Kjaerheim *et al.*, 1998; Yun *et al.*, 2005; Freedman *et al.*, 2007a; Friborg *et al.*, 2007; Ide *et al.*, 2008) provided point estimates for former smokers (IARC 2004a; Table 2.31 online). The relative risks for former smokers were always lower than those for current smokers.

In 16 case–control studies the relative risk by years since quitting was examined and generally a statistically significant negative trend was found (Table 2.34 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.34.pdf).

(c) Types of cigarette

The characteristics studied in several case–control studies included the use of a filter, the type of tobacco, the tar content and whether the product was manufactured or hand-rolled (IARC, 2004a; Table 2.35 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.35.pdf). Consumption of black tobacco, cigars, untipped cigarettes, hand-rolled cigarettes, or cigarettes with a high-tar yield generally resulted in a higher risk than consumption of blond tobacco (Merletti *et al.*, 1989; Castellsagué *et al.*, 2004; De Stefani *et al.*, 2007), filter-tipped cigarettes (Merletti *et al.*, 1989; Mashberg *et al.*, 1993; Kabat *et al.*, 1994; Lissowska *et al.*, 2003; De Stefani *et al.*, 2007), manufactured cigarettes (De Stefani *et al.*, 1992, 2007) or low-tar cigarettes (Franceschi *et al.*, 1992). Two studies from India (Znaor *et al.*, 2003; Sapkota *et al.* 2007) revealed higher risks of *bidi* smoking related to cigarettes smoking.

(d) Sex

Sex-specific effects were analysed in four cohort studies (IARC 2004a; Table 2.31 online). In three cohort studies (Hammond & Seidman, 1980; Akiba & Hirayama, 1990; Freedman *et al.*, 2007a) a higher relative risk was found for male smokers than for female smokers; however, Ide *et al.* (2008) detected a higher risk among women in a study with a small number of cases.

In three case–control studies (Blot *et al.*, 1988; Kabat *et al.*, 1994; Muscat *et al.*, 1996) the relative risks were higher for women than for men in all categories of intensity of smoking (number of cigarettes per day), cumulative exposure (cumulative tar consumption, pack–years, duration of smoking) and age at starting smoking, as well as for former smokers. However, the trends in men were always in the same direction and of the same order of magnitude. An exception to the pattern was that in one study (Merletti *et al.*, 1989) the relative risk for smoking filter-tipped cigarettes was higher than that for smoking untipped cigarettes for women.

Overall, the strength of association by sex was generally similar, especially when taking into account the fact that women generally under-report levels of smoking and that most studies included many fewer women than men.

(e) Ethnicity

Relative risks were reported separately for blacks and whites in a large case–control study from the USA (Day *et al.*, 1993). Relative risks adjusted for alcohol consumption, sex and other relevant variables were very similar for the number of cigarettes smoked per day, years of cigarette smoking, age at starting smoking and number of years since stopping smoking.

2.4 Cancer of the stomach

2.4.1 Overview of studies

In the previous *IARC Monograph* (IARC, 2004a) it was concluded that there was *sufficient evidence* that tobacco smoking causes cancer of the stomach. Three meta-analyses have since examined the evidence for gastric cancer in 42

independent cohort studies published between 1958 and July 2007 (Ladeiras-Lopes *et al.*, 2008), in 46 case–control studies published between 1997 and June 2006 (La Torre *et al.*, 2009), and in 10 cohort and 16 case–control studies conducted in Japanese populations published between 1966 and March 2005 (Nishino *et al.*, 2006; Table 2.36 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.36.pdf). For current smokers compared to never smokers, the risk for stomach cancer was found to be statistically significantly increased by 53% (Ladeiras-Lopes *et al.*, 2008), 56% (Nishino *et al.*, 2006), and 57% when considering high quality case–control studies (La Torre *et al.*, 2009), with moderate to high heterogeneity.

Since the previous *IARC Monograph* (IARC, 2004a), the association between cigarette smoking and stomach cancer risk (15 studies) and mortality (4 studies) has been examined in 19 cohort studies (Table 2.37 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.37.pdf). Eleven of these were conducted in Asia (Sasazuki *et al.*, 2002; Jee *et al.*, 2004; Koizumi *et al.*, 2004; Wen *et al.*, 2004; Fujino *et al.*, 2005; Sauvaget *et al.*, 2005; Tran *et al.*, 2005; Kurosawa *et al.*, 2006; Kim *et al.*, 2007; Sung *et al.*, 2007; Shikata *et al.*, 2008), seven in Europe (Simán *et al.*, 2001; González *et al.*, 2003; Doll *et al.*, 2005; Lindblad *et al.*, 2005; Sjödahl *et al.*, 2007; Batty *et al.*, 2008; Zendehdel *et al.*, 2008) and one in the USA (Freedman *et al.*, 2007a). Only the updated British Doctors' study (Doll *et al.*, 2005) and the most recent studies (Shikata *et al.*, 2008; Zendehdel *et al.*, 2008) were not included in the meta-analysis of cohort studies (Ladeiras-Lopes *et al.*, 2008). Elevated risks in current smokers were found in all studies. The reported association of current smoking with mortality in the four cohort studies conducted in Taiwan, China (Wen *et al.*, 2004), Japan (Kurosawa *et al.*, 2006) and the United Kingdom (Doll *et al.*, 2005; Batty *et al.*, 2008) was comparable to that with incidence.

In addition, the association between smoking and stomach cancer risk has been reported in 37 case–control studies since the previous *IARC Monograph*, of which 22 are hospital-based and 15 population-based. With the exception of three studies (Campos *et al.*, 2006; García-González *et al.*, 2007; Suwanrungruang *et al.*, 2008; Table 2.38 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.38.pdf), all these studies were included in the meta-analysis conducted by (La Torre *et al.*, 2009).

2.4.2 Factors affecting risk

(a) Intensity and duration

Clear evidence has been provided by the meta-analyses as well as by the additional cohort studies that the risk for stomach cancer increases significantly with increasing daily cigarette consumption, duration or pack–years of smoking, although individual studies did not always find statistically significant dose–response relationships. In one meta-analysis based on 21 cohort studies, the risk for stomach cancer increased statistically significantly by 53% with consumption of approximately 20 cigarettes per day (Ladeiras-Lopes *et al.*, 2008). Using trend estimation analysis as proposed by Greenland & Longnecker (1992), the authors found an increase in relative risk from 1.3 for the lowest consumption to 1.7 for smoking 30 cigarettes per day.

(b) Cessation of smoking

Risk for stomach cancer has been generally found to be lower in former smokers than in current smokers. In six of the cohort studies decreasing risk with increasing years since stopping smoking was found although none found statistically significant dose–response relationships (González *et al.*, 2003; Koizumi *et al.*, 2004; Sauvaget *et al.*, 2005; Freedman *et al.*, 2007a; Kim *et al.*, 2007; Zendehdel *et al.*, 2008). Risk in former smokers was comparable to never smokers after quitting for 5 years (Kim *et al.*,

2007), 10 years (González *et al.*, 2003; Sauvaget *et al.*, 2005; Freedman *et al.*, 2007a) or 15 years (Koizumi *et al.*, 2004).

2.4.3 Subsites

The effect of current smoking on the risk for stomach cancer by subsite was assessed in ten cohort studies. Elevated risks were found for both cardia and non-cardia cancers. In six studies higher risks were found for cancer of the gastric cardia than for cancer of the distal stomach (Simán *et al.* 2001; González *et al.*, 2003; Freedman *et al.*, 2007a; Sung *et al.*, 2007; Shikata *et al.*, 2008; Zendehdel *et al.*, 2008), three studies found no difference (Sasazuki *et al.*, 2002; Lindblad *et al.*, 2005; Tran *et al.*, 2005), and in one study higher risk for cancer in the antrum rather than the body or the cardia was found (Koizumi *et al.*, 2004). A meta-analysis yielded statistically significant summary relative risks of 1.87 for cardia cancers and 1.60 for non-cardia cancers based on nine cohort studies (Ladeiras-Lopes *et al.*, 2008). However, there was substantial heterogeneity across studies for cardia cancers. For case–controls studies, the corresponding odds ratios were 2.05 (95%CI: 1.50–2.81) and 2.04 (95%CI: 1.66–2.50), respectively, with greater heterogeneity for non-cardia cancers. Criteria for the classification by subsite were not always described (Simán *et al.*, 2001; Koizumi *et al.*, 2004; Lindblad *et al.*, 2005; Tran *et al.*, 2005) and some studies included tumours located in the upper third of the stomach in the group of cardia cancer (Sasazuki *et al.*, 2002; Sung *et al.*, 2007; Shikata *et al.* 2008).

In three studies risk estimates for smoking associated stomach cancer were estimated by histological type (Sasazuki *et al.*, 2002; Koizumi *et al.*, 2004; Shikata *et al.*, 2008). The relative risks were 2.1 (95%CI: 1.2–3.6), 1.6 (95%CI: 1.1–2.3) and 2.3 (95%CI: 1.3–4.1) for the differentiated type, respectively, and 0.6 (95%CI: 0.3–1.1), 2.1 (95%CI: 1.1–4.1), and 1.3 (95%CI: 0.5–3.5) for the non-differentiated type, respectively.

2.4.4 Population characteristics

In four of the additional cohort studies risk was reported separately for men and women (González *et al.*, 2003; Jee *et al.*, 2004; Fujino *et al.*, 2005; Kim *et al.*, 2007), in three studies only for men (Koizumi *et al.*, 2004; Tran *et al.*, 2005; Sung *et al.*, 2007) and in one mortality study for men as well as for women (Wen *et al.*, 2004). Generally, the relative risks were smaller in women than in men. For all stomach cancers, risk in current smokers compared to never smokers was found to be significantly increased by 62% in men (based on 18 studies) and by 20% in women (based on nine studies) in the meta-analysis of cohort studies (Ladeiras-Lopes *et al.*, 2008). The men–women differences were independent of exposure level but could be explained by the sex difference in the distribution by histological type and other factors associated with socioeconomic status.

Ethnicity does not appear to modify the effect of smoking on stomach cancer risk. In the meta-analysis of case–control studies risk in current smokers was increased by 78% in Caucasians and by 48% in Asians (La Torre *et al.*, 2009). The summary risk based on the cohort studies increased by 46% and 47% in Caucasian and Asian studies, respectively. In a meta-regression analysis including the variables sex, population, and fruit and vegetable consumption, sex but not origin of the population showed significant differences in risk estimates (Ladeiras-Lopes *et al.*, 2008).

2.4.5 Bias and confounding

Generally, most cohort studies have relied on baseline information and did not update the exposure information, possibly leading to misclassification of smoking status. Most of

the recent cohort studies have accounted for confounding by alcohol consumption (Fujino *et al.*, 2005; Lindblad *et al.*, 2005; Sjödahl *et al.*, 2007; Sung *et al.*, 2007) as well as fruit and vegetable consumption (González *et al.*, 2003; Koizumi *et al.*, 2004; Freedman *et al.* 2007a) and still observed significantly increased risk of stomach cancer in current smokers.

2.4.6 Helicobacter pylori infection

The association between tobacco smoking and stomach cancer could be confounded or modified by the effect of *H. pylori* infection, an established risk factor for stomach cancer. In three case–control studies (Zaridze *et al.*, 2000; Brenner *et al.*, 2002; Wu *et al.* 2003), and two cohort studies (Simán *et al.*, 2001; Shikata *et al.*, 2008) the joint effects and possible interaction between *H. pylori* status and smoking in relation to risk for stomach cancer was investigated. Among subjects who had *H. pylori* infection, the risk for stomach cancer was higher in current smokers than in non-smokers by 1.6 to 2.7 fold, providing evidence for a causal effect of tobacco smoking independently of *H. pylori* infection. Smoking was associated with risk elevations of the same order of magnitude among subjects without *H. pylori* infection. Smoking and *H. pylori* therefore may act synergistically, leading to very high risks in current smokers with *H. pylori* infection compared to non-smokers without *H. pylori* infection. In one study that examined risk by subsite an effect of smoking independent of *H. pylori* infection for gastric cardia as well as distal gastric cancer was found (Wu *et al.*, 2003). In none of the studies was there statistically significant evidence for interaction.

2.5 Cancer of the pancreas

2.5.1 Overview of studies

Previous *IARC Monographs* (IARC, 1986, 2004a) concluded that exposure to tobacco smoke caused cancer of the pancreas. Additional evidence has come from a pooled analysis of eight cohort studies with almost 1500 incident cases of pancreatic cancer and an equal number of controls (Lynch *et al.*, 2009) as well as a meta-analysis of 82 independent studies (42 case–control studies, 40 cohort studies) published between 1950 and 2007 (Iodice *et al.*, 2008; Table 2.39 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.39.pdf). In the meta-analysis 74% and 20% significant increased risks for current and former smokers, respectively, were found with significant heterogeneity of effect regarding current smoking across studies. Adjustment for confounders explained some of the heterogeneity (Iodice *et al.*, 2008). A similar significant risk elevation of 77% for current smokers was found in the pooled analysis, without study heterogeneity (Lynch *et al.*, 2009). For former smokers, risk was increased non-significantly by 9%.

Since the previous *IARC Monograph* (IARC, 2004a), a total of 15 cohort studies have reported on the association between cigarette smoking and pancreatic cancer incidence (8 studies) and mortality (5 studies) or both (one study) (Table 2.40 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.40.pdf), two of which were included in the pooled analysis (Coughlin *et al.*, 2000; Vrieling *et al.*, 2009). Excluding case–control studies that did not report odds ratios for current smokers, there were three additional case–control studies (Duell *et al.*, 2002; Inoue *et al.*, 2003; Alguacil & Silverman, 2004; Table 2.41 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.41.pdf). The effect of cigar and pipe smoking on pancreatic cancer was

also examined in the ACS Cancer Prevention Study II regarding mortality (Shapiro *et al.*, 2000; Henley *et al.*, 2004) and in the Kaiser Permanente Medical Care Program regarding incidence (Iribarren *et al.*, 1999). All the additional studies showed an increased risk for pancreatic cancer associated with tobacco smoking, generally higher in current than in former smokers. The reported risk estimates were not always statistically significant, predominantly due to the small size of some studies and therefore lack of statistical precision.

2.5.2 Factors affecting risks

(a) Intensity and duration

Clear evidence has been provided by the meta-analysis, the pooled analysis as well as the additional studies that the risk for cancer of the pancreas increases significantly with increasing daily cigarette consumption, duration and pack–years of smoking (Coughlin *et al.*, 2000; Gapstur *et al.*, 2000; Nilsen & Vatten, 2000; Nilsson *et al.*, 2001; Isaksson *et al.*, 2002; Doll *et al.*, 2005; Yun *et al.*, 2005; Ansary-Moghaddam *et al.*, 2006; Gallicchio *et al.*, 2006; Vrieling *et al.*, 2009). In the meta-analysis risk of pancreatic cancer increased significantly by 62% with an increase of 20 cigarettes per day (based on 45 studies) and by 16% with a 10-year increase in smoking duration (based on 16 studies), but with significant study heterogeneity. In the pooled analysis, the excess odds ratio per pack–years generally declined with increasing smoking intensity (Lynch *et al.*, 2009).

(b) Cessation of smoking

A reduction in risk in former smokers who had stopped smoking for at least 10 years was found in the meta-analysis (Iodice *et al.*, 2008) and the pooled study (Lynch *et al.*, 2009). In some cohort studies risk was already comparable to never smokers five years after quitting (Boyle *et al.*, 1996; Fuchs *et al.*, 1996; Nilsen & Vatten, 2000; Vrieling *et al.*, 2009).

(c) Types of tobacco

In non–cigarette smokers, mortality from pancreatic cancer was increased although not statistically significantly so in cigar smokers in the CPS-II cohort study (Shapiro *et al.*, 2000) as well as a large case–control study (Alguacil & Silverman, 2004) but was less clearly elevated in the smaller Kaiser Permanente cohort study (Iribarren *et al.*, 1999). There was a significantly increased mortality for current cigar smokers who reported inhaling cigar smoke (Shapiro *et al.*, 2000). Pipe smoking was also found to be associated with an increased risk of cancer of the pancreas, which was stronger in those who reported that they inhaled the smoke (Henley *et al.*, 2004). A limitation of the cohort studies is that smoking habits were reported only at baseline, misclassification of smoking exposure is likely to underestimate the associated risks. In the meta-analysis there was a significant increase in risk of 47% associated with current cigar and/or pipe smoking (18 studies) and a non-significant risk elevation of 29% with former cigar and/or pipe smoking (5 studies) (Iodice *et al.*, 2008).

2.5.3 Population characteristics

The effect of sex on pancreatic cancer risk was investigated in two cohort studies (Nilsen & Vatten, 2000; Larsson *et al.*, 2005) and on pancreatic cancer mortality in four cohort studies (Coughlin *et al.*, 2000; Gapstur *et al.*, 2000; Nilsson *et al.*, 2001; Lin *et al.*, 2002a). The relative risks were comparable between men and women and no consistent evidence for an effect modification by sex was observed.

Ethnicity does not appear to modify the association of smoking with pancreatic cancer risk. The roughly twofold elevated risk in current smokers compared to never smokers was observed both in studies of Caucasians (Lynch *et al.*, 2009) and of Asians (Lin *et al.*, 2002a; Jee *et al.*, 2004; Yun *et al.*, 2005; Li *et al.*, 2006). In populations of the Asia-Pacific Region, there

was also no difference in the strength of association between Asia and Australia/New Zealand (Ansary-Moghaddam *et al.*, 2006).

2.5.4 Confounding factors

In two large cohort studies the risk estimates for pancreatic cancer associated with cigarette smoking were not substantially influenced by adjustment for further potential confounding factors, including diabetes, body mass index (BMI), alcohol and dietary intake (Coughlin *et al.*, 2000; Vrieling *et al.*, 2009).

2.6 Cancer of the colorectum

2.6.1 Overview of studies

In the previous *IARC Monograph* (IARC, 2004a) it was not possible to conclude that the association between tobacco smoking and colorectal cancer is casual, principally because of concern about confounding by other risk factors. That evaluation was based on a total of 60 epidemiologic studies, although only few were specifically designed to study the effects of smoking. Studies have however shown consistently that cigarette smoking is a risk factor for colorectal adenomatous polyps, which are recognized precursor lesions of colorectal cancer (Hill, 1978). To explain this discrepancy, Giovannucci *et al.* (1994) hypothesized that a long induction period is required for tobacco to play a role in colorectal carcinogenesis, which would not be captured by studies with shorter follow-up time.

Four recent meta-analyses consistently showed a strong association between cigarette smoking and colorectal cancer (Botteri *et al.*, 2008a; Liang *et al.*, 2009; Huxley *et al.*, 2009; Tsoi *et al.*, 2009).

2.6.2 Cohort studies

Since the previous *IARC Monograph* (IARC, 2004a), 22 additional cohort studies have investigated the association between tobacco smoke and colorectal cancer (Table 2.42 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.42.pdf). [Studies that did not provide point estimates of risk (Andersen *et al.*, 2009; Hansen *et al.*, 2009; Murphy *et al.*, 2009) and included prevalent colorectal cancer in patients with other diagnosis (Chan *et al.*, 2007) are excluded from this review]. Seven of the studies were conducted in Europe, nine in Asia and five in the USA. In eleven studies, risk estimates were reported solely for colorectal cancer (Tiemersma *et al.*, 2002a; Limburg *et al.*, 2003; Otani *et al.*, 2003; Colangelo *et al.*, 2004; Sanjoaquin *et al.*, 2004; Lüchtenborg *et al.*, 2005a; Kim *et al.*, 2006; Akhter *et al.*, 2007; Huxley, 2007a; Kenfield *et al.*, 2008; Hannan *et al.*, 2009), five studies separately for colon cancer and rectal cancer (Shimizu *et al.*, 2003; Wakai *et al.*, 2003; Jee *et al.*, 2004; Yun *et al.*, 2005; Batty *et al.*, 2008) and five studies both for colorectal cancer as well as for colon and rectal cancers (Terry *et al.*, 2002a; van der Hel *et al.*, 2003a; Doll *et al.*, 2005; Paskett *et al.*, 2007; Tsong *et al.*, 2007; Gram *et al.*, 2009). Six studies were restricted to women (Terry *et al.*, 2002a; Limburg *et al.*, 2003; van der Hel *et al.*, 2003a; Paskett *et al.*, 2007; Kenfield *et al.*, 2008; Gram *et al.*, 2009), and two studies to men (Doll *et al.*, 2005; Yun *et al.*, 2005; Akhter *et al.*, 2007). One study reported both colorectal incidence and mortality (Limburg *et al.*, 2003) and three studies only reported colorectal cancer mortality (Doll *et al.*, 2005; Huxley, 2007a; Batty *et al.*, 2008; Kenfield *et al.*, 2008).

(a) Smoking status

Virtually all studies reported elevated risk associated with smoking, although results were not always statistically significant. The largest meta-analysis based on 36 prospective studies

with data from a total of 3007002 subjects found that compared to never smokers, current smokers had a 15% significantly higher risk of developing colorectal cancer and 27% significantly higher risk of colorectal cancer mortality (Liang *et al.*, 2009; Table 2.43 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.43.pdf). In former smokers, colorectal cancer risk was also significantly elevated by 20% whereas colorectal cancer mortality was non-significantly increased by 20%. The risk estimates were not significantly different between colon and rectal cancer for current smokers (RR, 1.10 versus 1.19) and for former smokers (RR, 1.10 versus 1.20). There was no heterogeneity among colorectal cancer studies and no evidence for publication bias. Comparable risk elevations in current and former smokers were found in the other meta-analyses. For current smokers, the risk for colorectal cancer increased significantly by 16% when using data from 22 cohort studies (Huxley *et al.*, 2009), by 20% based on 28 cohort studies (Tsoi *et al.*, 2009), and by 7% based on data from 45 cohort and case–control studies (Botteri *et al.*, 2008a). In the latter meta-analysis a 17% significantly higher risk of colorectal cancer in former smokers was found.

(b) *Intensity of smoking*

All but three of the recent 21 cohort studies (van der Hel *et al.*, 2003a; Jee *et al.*, 2004; Sanjoaquin *et al.*, 2004) investigated dose–response relationships, using at least one of number of cigarettes smoked, duration of smoking, pack–years of smoking, age at smoking initiation, time since smoking cessation. In two further studies (Tiemersma *et al.*, 2002a; Batty *et al.*, 2008) these parameters were examined separately in current and former smokers, as by Chao *et al.* (2000). Statistically significant dose–response trends with amount smoked daily were reported for colorectal cancer (Lüchtenborg *et al.*, 2005a; Akhter *et al.*, 2007; Paskett *et al.*, 2007; Kenfield *et al.*, 2008), for colon cancer (Paskett *et al.*, 2007), and for rectal cancer (Paskett *et al.*, 2007; Tsong *et al.*, 2007). The dose–response of daily cigarette consumption and colorectal cancer was assessed in two meta-analyses (Liang *et al.*, 2009; Tsoi *et al.*, 2009) and both found statistically significant relationships. Based on eleven studies, Liang *et al.* (2009) found that risk for colorectal cancer increased significantly by 17% with an increase of 20 cigarettes/day and by 38% with an increase of 40 cigarettes/day, while colorectal cancer mortality increased by 41% and 98%, respectively (Table 2.43 online). The risk elevation associated with an increase of 20 cigarettes/day was greater for rectal than for colon cancer (13% versus 3%) but this difference was not statistically significant.

(c) *Duration of smoking*

In addition to two previously reported studies (Hsing *et al.*, 1998; Chao *et al.*, 2000), thirteen studies have examined duration of smoking and colorectal cancer risk. A statistically significant trend of increasing risk with increasing duration was found for colorectal (Limburg *et al.*, 2003; Kim *et al.*, 2006; Paskett *et al.*, 2007; Gram *et al.*, 2009), for colon cancer (Paskett *et al.*, 2007) and for rectal cancer (Terry *et al.*, 2002a; Paskett *et al.*, 2007; Tsong *et al.*, 2007). In one study, increasing duration of smoking was significantly associated with risk for colorectal cancer solely in former smokers (Tiemersma *et al.*, 2002a). Based on eight studies (Terry *et al.*, 2002a; Tiemersma *et al.*, 2002a; Limburg *et al.*, 2003; Lüchtenborg *et al.*, 2005a; Kim *et al.*, 2006; Akhter *et al.*, 2007; Paskett *et al.*, 2007; Tsong *et al.*, 2007), a meta-analysis for duration of smoking and colorectal cancer incidence yielded highly significant results (Liang *et al.*, 2009). Risk was increased by 9.4% with a 20-year increase in smoking duration and 19.7% with a 40-year increase. Smoking duration was also significantly associated with risk for rectal cancer but not for colon cancer. In another meta-analysis where dose–response relationship was modelled, a nonlinear increase in risk with

increasing duration was observed (Botteri *et al.*, 2008a). The risk started to increase after approximately 10 years of smoking and reached statistical significance after 30 years.

(d) Pack–years

Since the previous *IARC Monograph*, the association of colorectal cancer with pack–years of cigarette smoking has been evaluated in six studies (Limburg *et al.*, 2003; Otani *et al.*, 2003; Shimizu *et al.*, 2003; Wakai *et al.*, 2003; Kim *et al.*, 2006; Gram *et al.*, 2009). In addition to the previously reported significant results (Giovannucci *et al.*, 1994; Heineman *et al.*, 1994; Chao *et al.*, 2000; Stürmer *et al.*, 2000), a statistically significant trend of increasing risk with increasing pack–years was found for colorectal cancer in two studies (Limburg *et al.*, 2003; Gram *et al.*, 2009), and for colon cancer in one study (Gram *et al.*, 2009). In their dose–response analysis of pack–years and colorectal incidence, Liang *et al.* (2009) included five studies (Giovannucci *et al.*, 1994; Stürmer *et al.*, 2000; Limburg *et al.*, 2003; Otani *et al.*, 2003; Kim *et al.*, 2006) and found a statistically significant trend of increasing risk with increasing pack–years of smoking for colorectal cancer but not specifically for colon or rectal cancer. Risk for colorectal cancer increased by 27% for an increase of 35 pack–years and by 50% for an increase of 60 pack–years.

(e) Age at initiation

In nine of the cohort studies the age at smoking initiation in relation to colorectal cancer (eight studies) or colon and rectal cancer (four studies) was investigated. In four studies a statistically significant trend of increasing risk with decreasing age at initiation of smoking for colorectal cancer was found (Limburg *et al.*, 2003; Kim *et al.*, 2006; Akhter *et al.*, 2007; Gram *et al.*, 2009) and for colon cancer (Gram *et al.*, 2009) and rectal cancer (Tsong *et al.*, 2007). In one meta-analysis (Liang *et al.*, 2009), a highly significant association was found for age at smoking initiation and colorectal cancer incidence based on six studies (Limburg *et al.*, 2003; Kim *et al.*, 2006; Akhter *et al.*, 2007; Paskett *et al.*, 2007; Tsong *et al.*, 2007; Gram *et al.*, 2009). Risk for colorectal cancer was reduced by 2.2% for a 5-year delay in smoking initiation and by 4.4% for a 10-year delay.

(f) Smoking cessation

The effect of smoking cessation by years since stopping was assessed in seven studies, six for colorectal cancer (Tiemersma *et al.*, 2002a; Lüchtenborg *et al.*, 2005a, 2007; Paskett *et al.*, 2007; Kenfield *et al.*, 2008; Gram *et al.*, 2009; Hannan *et al.*, 2009) and three for colon and/or rectal cancer (Wakai *et al.*, 2003; Paskett *et al.*, 2007; Gram *et al.*, 2009). In one study a statistically significant trend in risk reduction with years since quitting was found both overall as well as separately for men and for women (Hannan *et al.*, 2009).

(g) Population characteristics

It has been suggested that the association between smoking and colorectal cancer may be stronger in men than in women. In the three recent cohort studies reporting sex–specific results (Shimizu *et al.*, 2003; Wakai *et al.*, 2003; Colangelo *et al.*, 2004), this was only observed in studies in Japan (Shimizu *et al.*, 2003; Wakai *et al.*, 2003), but could be attributed to the very low prevalence of smoking in women. The studies restricted to women have generally shown associations with cigarette smoking that were of comparable magnitude to those observed in men (Terry *et al.*, 2002a; Limburg *et al.*, 2003; van der Hel *et al.*, 2003a; Paskett *et al.*, 2007; Kenfield *et al.*, 2008; Gram *et al.*, 2009).

Recent studies have been carried out either in Europe and in USA, with predominantly Caucasian study subjects, or in Asia, mostly in Japan and in the Republic of Korea. The results from these studies suggest no differences in the association between tobacco smoking and

colorectal cancer between different ethnic groups.

(h) Subsites

Smoking and risks for colon cancer and for rectal cancer were investigated in eleven of the 21 additional studies. Risk patterns are generally consistent between colon and rectal cancer (Otani *et al.*, 2003; van der Hel *et al.*, 2003a; Wakai *et al.*, 2003; Jee *et al.*, 2004; Yun *et al.*, 2005; Batty *et al.*, 2008). In some studies, dose–response relationships were stronger for rectal cancer than for colon cancer (Terry *et al.*, 2002a; Paskett *et al.*, 2007) or were statistically significant only for rectal cancer (Shimizu *et al.*, 2003; Doll *et al.*, 2005; Tsong *et al.*, 2007). In a meta-analysis (Liang *et al.*, 2009) the association was stronger for rectal cancer than for colon cancer in the subset of cohort studies that differentiated cancer by site. Most dose–response variables were not associated with colon cancer incidence whereas associations were stronger for rectal cancer incidence and statistically significant with longer duration of smoking, albeit based only on a small number of studies. In one cohort study the increased risk associated with smoking was more apparent for proximal than for distal colon cancer (Lüchtenborg *et al.*, 2005a), which was not found in an earlier study (Heineman *et al.*, 1994).

(i) Confounding and effect modification

Smokers have been shown to be more likely than non-smokers to be physically inactive, to use alcohol, to have lower consumption of fruits and vegetables and higher consumption of fat and meat, and they are less likely to be screened for colorectal cancer (Le Marchand *et al.*, 1997; Ghadirian *et al.*, 1998; Nkondjock & Ghadirian, 2004; Reid *et al.*, 2006b; Mutch *et al.*, 2009).

Few potential confounders were considered in the cohort studies evaluated in the previous *IARC Monograph* (IARC, 2004a). Of the cohort studies published since, all except three (van der Hel *et al.*, 2003a; Jee *et al.*, 2004; Doll *et al.*, 2005) considered two or more potential confounders. In eleven of the recent studies adjustments were made for physical activity, alcohol consumption, overweight/obesity (Terry *et al.*, 2002a; Limburg *et al.*, 2003; Otani *et al.*, 2003; Wakai *et al.*, 2003; Yun *et al.*, 2005; Akhter *et al.*, 2007; Ashktorab *et al.*, 2007; Paskett *et al.*, 2007; Tsong *et al.*, 2007; Kenfield *et al.*, 2008; Hannan *et al.*, 2009), and seven also adjusted for dietary habits (e.g. intake of fruits and vegetables, dietary fibres, fat, red meat). Among the studies with the latter adjustments, eight (Giovannucci *et al.*, 1994; Chao *et al.*, 2000; Stürmer *et al.*, 2000; Limburg *et al.*, 2003; Yun *et al.*, 2005; Akhter *et al.*, 2007; Paskett *et al.*, 2007; Hannan *et al.*, 2009) found significant dose–response relationships with at least one of the smoking variables. In two studies a significant association of smoking with colorectal cancer risk was observed after accounting for history of colonoscopy (Paskett *et al.*, 2007; Hannan *et al.*, 2009). Risk factors in multivariable analyses in several studies were level of education, use of menopausal hormone therapy, family history and regular aspirin use. The association between smoking and colorectal cancer was not modified by these other characteristics, or by alcohol consumption in two studies (Otani *et al.*, 2003; Tsong *et al.*, 2007). Therefore, confounding factors do not seem to affect the observed significant increase in risk for colorectal cancer associated with tobacco smoking and the dose–response relationships with smoking variables.

When considering other types of smoking, it is generally found that cigar and pipe smoking are less associated with socioeconomic class and other life-style habits than cigarette smoking. Therefore, it is logical to assume that, for these types of smoking, risk associations derived from epidemiologic studies may be less prone to potential confounding. In all the cohort studies reviewed in the previous *IARC Monograph* (IARC, 2004a) an elevated, though not always statistically significant, risk was consistently reported for cancers of the colon and the rectum

associated with exclusive pipe and/or cigar smoking.

Infection with JC virus has been proposed as a potential risk factor for colon cancer (Rollison *et al.*, 2009) but results still need further validation.

Three cohort studies assessed possible modifying effects by genetic susceptibility. Rapid acetylator phenotype (as determined by polymorphisms of the *NAT2* gene involved in metabolism of heterocyclic aromatic amines) was found to increase the risk for colorectal cancer in smokers, in one (van der Hel *et al.*, 2003a) but not in another study (Tiemersma *et al.*, 2002a). For genes involved in the metabolism of polycyclic aromatic hydrocarbons such as *GSTM1* or *GSTT1,* no statistical contribution to the risk of colorectal cancer associated with smoking was observed (Tiemersma *et al.*, 2002a; Lüchtenborg *et al.*, 2005a).

2.6.3 Case–control studies

Thirty-one case–control studies were included in the previous *IARC Monograph* (IARC, 2004a). Although results were inconsistent with respect to risk association in ever versus former and current smokers, a dose–response relationship with smoking variables was found in some studies. Since then, seventeen case–control studies investigating the association between tobacco smoke and colorectal cancer risk have been published, seven carried out in Asia, four in Europe, five in North America and one in Hawaii (Table 2.44 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.44.pdf). Six studies reported solely for colorectal cancer (Ateş *et al.*, 2005; Chia *et al.*, 2006; Verla-Tebit *et al.*, 2006; Lüchtenborg *et al.*, 2007; Steinmetz *et al.*, 2007; Wu *et al.*, 2009b), four separately for colon and rectal cancer (Ji *et al.*, 2002; Sharpe *et al.*, 2002; Minami & Tateno, 2003; Goy *et al.*, 2008), two for colorectal cancer as well as for colon and rectal cancer (Ho *et al.*, 2004; Gao *et al.*, 2007; Wei *et al.*, 2009), three for colon cancer only (Diergaarde *et al.*, 2003; Kim *et al.*, 2003; Hu *et al.*, 2007) and one for rectal cancer only (Slattery *et al.*, 2003). Nine of the studies reported risk estimates separately for men and for women.

(a) Smoking status

Most case–control studies considered the effects of current and former smoking separately. A positive association between smoking and colorectal cancer was found in virtually all the studies, although the results were generally not statistically significant. Statistically significant increased risk was reported in current smokers for colorectal cancer (Chia *et al.*, 2006; Wu *et al.*, 2009b), for rectal cancer (Slattery *et al.*, 2003; Ho *et al.*, 2004), and in former smokers for colorectal cancer both in men and women combined (Chia *et al.*, 2006) and in women only (Lüchtenborg *et al.*, 2007). Five studies, which did not focus on the main effects of smoking, only evaluated risks for ever smoking (Diergaarde *et al.*, 2003; Kim *et al.*, 2003; Ateş *et al.*, 2005; Gao *et al.*, 2007; Hu *et al.*, 2007); none of these reported significant risk estimates.

(b) Intensity of smoking

Nine case–control studies investigated dose–response relationships considering at least one smoking variable. Number of cigarettes smoked daily was evaluated in seven studies, three for colorectal cancer (Verla-Tebit *et al.*, 2006; Lüchtenborg *et al.*, 2007; Wu *et al.*, 2009b), two for colon and rectal cancer (Ji *et al.*, 2002; Minami & Tateno, 2003), one for rectal cancer (Slattery *et al.*, 2003) and one for colorectal cancer and both subsites (Ho *et al.*, 2004). Statistically significant positive trends of increasing risk with increasing number of cigarettes smoked daily were found for colorectal cancer in only one study (Wu *et al.*, 2009b).

(c) Duration of smoking, pack–years, age at initiation, smoking cessation

Duration of smoking was examined in several studies in relation to colorectal cancer (Ho *et al.*, 2004; Chia *et al.*, 2006; Verla-Tebit *et al.*, 2006; Lüchtenborg *et al.*, 2007; Wu *et al.*, 2009b) and/or to colorectal cancer by subsite (Ji *et al.*, 2002; Minami & Tateno, 2003; Ho *et al.*, 2004). A statistically significant trend with increasing number of years smoked was found in two of the five studies of colorectal cancer (Chia *et al.*, 2006; Wu *et al.*, 2009b). In one study, increasing duration of smoking was significantly associated with risk for rectal cancer in ever smokers but not in current smokers (Ho *et al.*, 2004). In only one earlier case–control study was a significant association in ever smokers with increasing number of years of smoking for colon as well as rectal cancer found (Newcomb *et al.*, 1995).

Duration of smoking exposure was assessed by pack–years of smoking in seven studies (Ji *et al.*, 2002; Slattery *et al.*, 2003; Chia *et al.*, 2006; Verla-Tebit *et al.*, 2006; Lüchtenborg *et al.*, 2007; Goy *et al.*, 2008; Wu *et al.*, 2009b) and by age at smoking initiation in three studies (Ji *et al.*, 2002; Slattery *et al.*, 2003; Wu *et al.*, 2009b). All four studies that evaluated pack–years of smoking with respect to colorectal cancer risk found statistically significant associations. Two studies found a significant association with increasing pack–years in men and women combined; when investigated separately, the increasing trend was statistically significant only in women (Verla-Tebit *et al.*, 2006) or only in men (Wu *et al.*, 2009b). In one study a statistically significant trend with pack–years of smoking in both men and women was found only with non-filtered cigarettes (Lüchtenborg *et al.*, 2007); the relative risk was significant for colon as well as rectal cancer and was greater for rectal cancer.

In two studies a non-significant trend of decreasing risk with increasing time since stopped smoking was found (Verla-Tebit *et al.*, 2006; Lüchtenborg *et al.*, 2007).

(d) Subsites and molecular subtypes

A stronger association between tobacco smoking and rectal cancer compared with colon cancer has generally been observed in the studies that reported risk estimates by cancer site. In a recent meta-analysis including both cohort and case–control studies, higher smoking-related risk estimates for rectal cancer were found than for proximal and distal colon cancer (Botteri *et al.*, 2008a). Stronger relative risk in ever smokers, but not in current smokers, was found for proximal compared to distal tumours in one recent study (Hu *et al.*, 2007).

Colorectal cancer is a multipathway disease. A molecular approach to its classification utilizes: (1) the type of genetic instability, specifically microsatellite instability, and (2) the presence of DNA methylation or the CpG island methylator phenotype (CIMP) (Jass, 2007). Smoking has been associated with microsatellite instability in sporadic colon cancer. Higher risk for microsatellite-unstable than for microsatellite-stable tumours was found in four studies (Slattery *et al.*, 2000; Yang *et al.*, 2000; Chia *et al.*, 2006; Campbell *et al.*, 2009). The observed twofold risk elevation for colorectal cancer showing microsatellite instability is similar in order of magnitude to that found for colorectal polyps. In only one small study similar risk estimates for stable and unstable tumours were found (Diergaarde *et al.*, 2003). Microsatellite instability is characteristic of hereditary nonpolyposis colorectal cancer syndrome and smoking has been associated with colorectal cancer in patients with this syndrome (Watson *et al.*, 2004; Diergaarde *et al.*, 2007). Among sporadic colorectal tumours with microsatellite instability, about 11–28% carry somatic genetic mutations. In addition, the association of colon cancer with smoking was increased two to threefold when widespread CIMP and/or *BRAF* mutation, irrespective of microsatellite instability

status, was present (Samowitz *et al.*, 2006). These data indicate that the association with MSI-high tumours may be attributed to the association of smoking with CIMP and *BRAF* mutation.

(e) Effect modification

Effect modification by genetic polymorphisms in enzymes metabolizing tobacco smoke constituents could provide further evidence for a causal association between smoking and colorectal cancer. Most studies that have investigated modification of colorectal cancer risk associated with smoking by genetic polymorphisms of xenobiotic enzymes were too small to be informative (Inoue *et al.*, 2000; Smits *et al.*, 2003; Jin *et al.*, 2005; Tranah *et al.*, 2005; van den Donk *et al.*, 2005; Tijhuis *et al.*, 2008). Studies on the possible differential effect by acetylation status have reported stronger association of tobacco smoking (in terms of pack–years) with colorectal cancer risk in slow acetylators phenotypes (Lilla *et al.*, 2006), and with rectal cancer in rapid acetylators phenotypes (Curtin *et al.*, 2009). Furthermore, *CYP1A1* and *GSTM1* variant alleles were found to greatly affect colon cancer or rectal cancer risk in smokers (Slattery *et al.*, 2004).

2.6.4 Colorectal polyps

Colorectal adenomas and possibly some hyperplastic polyps are considered precursors of colorectal cancer. The epidemiologic evidence on the relationship between cigarette smoking and colorectal polyps has been generally consistent. Since the previous *IARC Monograph* (IARC, 2004a), twelve further independent studies have investigated this association (Table 2.45 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.45.pdf). All studies found a significantly increased risk for polyps in association with one or more smoking variables. A recent meta-analysis including 42 studies reported a statistically significant positive association between smoking and colorectal adenomas (Botteri *et al.*, 2008b). The meta-analysis, which included several studies that did not explicitly report relative risks for tobacco smoking (Cardoso *et al.*, 2002; Voskuil *et al.*, 2002; Sparks *et al.*, 2004; Gong *et al.*, 2005; Jiang *et al.*, 2005; Kim *et al.*, 2005; Mitrou *et al.*, 2006; Otani *et al.*, 2006; Skjelbred *et al.*, 2006), found a twofold risk elevation for colorectal adenomas in current smokers and a 50% increase in former smokers. The association had been previously found to be equally strong in men and women. In one of two recent studies, there was no difference in the results for men and women separately (Tranah *et al.*, 2004) but significantly greater effects in women were found in the other (Hermann *et al.*, 2009).

Significant positive trends with number of cigarettes per day were found in four (Ji *et al.*, 2006; Larsen *et al.*, 2006; Stern *et al.*, 2006; Shrubsole *et al.*, 2008) of five studies (Tiemersma *et al.*, 2004). Dose–response with duration of smoking was assessed in four studies (Ji *et al.*, 2002; Tiemersma *et al.*, 2004; Stern *et al.*, 2006; Shrubsole *et al.*, 2008) and with pack–years of smoking in five studies (Hoshiyama *et al.*, 2000; Ulrich *et al.*, 2001; Tranah *et al.*, 2004; Ji *et al.*, 2006; Shrubsole *et al.*, 2008; Omata *et al.*, 2009). All nine studies found statistically significant trends, which were consistent with those for adenomas and hyperplastic polyps when reported separately (Ulrich *et al.*, 2001; Ji *et al.*, 2006; Shrubsole *et al.*, 2008). Ever smokers were estimated to have a 13% (95%CI: 9–18%) increasing risk of presenting with adenomatous polyps for every additional 10 pack–years smoked in comparison to never smokers, based on data from 19 studies (Botteri *et al.*, 2008b).

Decreasing risks with years since quitting smoking were found in four studies (Ulrich *et al.*, 2001; Tiemersma *et al.*, 2004; Ji *et al.*, 2006; Shrubsole *et al.*, 2008), statistically significant so in the latter three studies. In comparison to never smokers, former smokers retained moderately elevated risk for colorectal polyps even 20

years after quitting smoking. One study examined both dose metrics (cigarettes per day, duration, and pack–years) and recency of tobacco use: in subjects who had quit smoking for at least 20 years, only the heaviest users of tobacco still had modest excess risks (Ji *et al.*, 2006).

It has been proposed that the association between cigarette smoking and polyps may be stronger with non-progressing adenomas, such as those that are smaller and less villous but the hypothesis is not supported in most studies (Anderson *et al.*, 2003; Toyomura *et al.*, 2004; Ji *et al.*, 2006; Skjelbred *et al.*, 2006). In one study a clearly higher risk for large and multiple adenomas in every anatomic site of the colon was found in a dose–response manner (Toyomura *et al.*, 2004). A meta-analysis found that the combined risk estimate for high-risk adenomas associated with smoking was greater than that for low-risk adenomas and that the difference was statistically significant for current smokers but not former smokers (Botteri *et al.*, 2008b). In addition, a stronger association of smoking with hyperplastic polyps than with adenomas was found in some studies (Ulrich *et al.*, 2001; Ji *et al.*, 2006; Shrubsole *et al.*, 2008) but not in another (Erhardt *et al.*, 2002). The risk associated with smoking may be even higher in subjects presenting with concurrent benign hyperplastic and adenomatous polyps (Ji *et al.*, 2006; Shrubsole *et al.*, 2008).

Relative risk estimates for tobacco smoking and polyps generally range between 2 and 3 whereas those for colorectal cancer range between 1.2 and 1.4. One possible explanation is the effect dilution due to the inclusion of a high proportion of individuals with precursor lesions in the unscreened control groups in most colorectal cancer studies (Terry & Neugut, 1998). Some indirect evidence for this hypothesis is provided by the meta-analysis of colorectal adenomas, which showed that the smoking-associated risk for adenomas was significantly higher in studies including subjects who had undergone complete colonoscopy in comparison to those in which some or all controls had undergone incomplete examination (i.e. only sigmoidoscopy) (Abrams *et al.*, 2008; Botteri *et al.*, 2008b).

It is also possible that smoking is associated with a subset of colorectal cancers so that relative risk estimates for colorectal cancer as a whole are diluted. The pattern of risk observed for colorectal cancer by microsatellite instability status and for type of colorectal polyps suggests that the traditional (non-serrated) adenoma-carcinoma sequence may proceed through a hyperplastic polyps-mixed polyps-serrated adenoma progression and that smoking may be more strongly related to the development of these subtypes (Jass *et al.*, 2000; Hawkins & Ward, 2001). More recently, a *BRAF* mutation was shown to be a specific marker for the serrated polyp neoplasia pathway originating from a hyperplastic polyp, in which the CIMP-high develops early and the microsatellite instability carcinoma develops late (O'Brien *et al.*, 2006). The findings of strong associations between smoking and colon cancer with CIMP and/or BRAF mutation, irrespective of microsatellite status, are compatible with this observation (Samowitz *et al.*, 2006).

2.7 Hepatocellular carcinoma

2.7.1 Overview of studies

In the previous *IARC Monograph* (IARC, 2004a), a causal relationship between liver cancer (hepatocellular carcinoma) and smoking was established. Two case–control and one cohort studies have been published since (Table 2.46 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.46.pdf). Overall, most cohort studies and the largest case–control studies, most notably those that included community controls, showed a moderate association between tobacco smoking and risk for hepatocellular carcinoma.

Confounding from alcohol has been addressed in the best studies. The association between alcohol drinking and hepatocellular carcinoma is strong, and alcohol intake is frequently misclassified, leading to potential residual confounding. However an association with smoking has been demonstrated also among non-drinkers.

A meta-analysis was based on 38 cohort studies and 58 case–control studies (Lee *et al.*, 2009). Compared to never smokers, the meta-relative risks adjusted for appropriate confounders were 1.51 (95%CI: 1.37–1.67) for current smokers and 1.12 (0.78–1.60) for former smokers. The increased liver cancer risk among current smokers appeared to be consistent in strata of different regions, study designs, study sample sizes, and publication periods. The association with smoking was observed in non-alcohol-drinkers (RR, 1.34; 95%CI: 0.92–1.94 in men and 1.31; 95%CI: 0.70–2.44 in women). Further supportive evidence is provided by the association between smoking and liver cancer observed among Chinese women and Japanese women, in whom alcohol drinking is extremely rare (Li *et al.*, 2011). One difficulty is that sometimes studies do not specify the histology of liver cancer (hepatocellular versus intra-hepatic biliary tract).

In the update of the Whitehall study (Batty *et al.*, 2008) (a cohort of 17363 government employees in London, followed-up for 38 years), the hazard ratio for death from liver cancer was 1.03 (0.49–2.16) in former smokers and 1.43 (0.69–2.95) in current smokers (based on 57 deaths). In the 50-year follow-up of the British doctors cohort (Doll *et al.*, 2005), there were 74 deaths from liver cancer. Death rates per 100000 per year were 4.4 in never smokers, 10.7 in smokers of 1–14 cigarettes/day, 2.6 in smokers of 15–24 cigarettes/day, and 31.3 in smokers of ≥ 25 cigarettes/day.

2.7.2 Factors affecting risks

(a) Dose–response relationship

Most studies, including the recent ones (Table 2.46 online), show a dose–response relationship with the number of cigarettes smoked and with smoking duration, with exceptions such as Franceschi *et al.* (2006) and some older studies from Asia. Relative risk estimates increased to 2.0 after 20 years of smoking.

(b) Cessation

Though former smokers tend to have lower relative risks than current smokers, there were no consistent patterns of risks after cessation, including in the recent studies (Table 2.46 online).

2.7.3 Interaction with hepatitis B or C

Infection with hepatitis B virus (HBV) is one of the major causes of liver cancer worldwide, whereas hepatis C virus (HCV) infection causes a large fraction of liver cancer in Japan, Northern Africa and southern Europe. While many studies, most notably from Asia, have found no attenuation of the association between smoking and liver cancer after adjustment/stratification for markers of HBV or HCV infection, an apparent interaction between smoking and HBV or HCV infection has been reported. The increase in risk for liver cancer associated with cigarette smoking appears to be greater among HBV carriers than among uninfected persons in some studies (Tu *et al.*, 1985), but not in others (Kuper *et al.*, 2000a). Two recent reports (Franceschi *et al.*, 2006; Hassan *et al.*, 2008a) studied possible interactions between smoking and hepatitis virus infection and both reported an apparent interaction between smoking and hepatitis C infection. Interactions between smoking and hepatitis B infection were not found among men in one study (Hassan *et al.*, 2008a) and the rarity of HBsAg prevented the evaluation of HBV and smoking in the other (Franceschi *et al.*, 2006;

Table 2.46 online). In the meta-analysis by Lee *et al.* (2009) adjustment for HBV reduced the relative risks in both men and women, while adjustment for HCV did not change the risk in women and increased it in men.

2.8 Renal cell carcinoma

2.8.1 Overview of studies

The previous *IARC Monograph* (IARC, 2004a) concluded that renal-cell carcinoma is associated with tobacco smoking in both men and women. Four case–control studies and no cohort studies have become available since then (Table 2.47 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.47.pdf). Overall these confirm the previous evidence, though with some conflicting results. In particular, both the study by Hu *et al.* (2005) in Canada and the multicentre European study by Brennan *et al.* (2008) do not show a clear effect of smoking. In contrast, the study by Theis *et al.* (2008) shows an increased risk with smoking duration (irregular, levelling-off after 40 years) and a statistically significant dose–response relationship with pack–years.

In the update of the Whitehall study (Batty *et al.*, 2008) (a cohort of 17363 government employees in London, followed for 38 years), the hazard ratio for deaths from kidney cancer was 0.64 (0.32–1.26) for former smokers, and 1.29 (0.69–2.41) for current smokers (based on 68 deaths). In the 50-year follow-up of the British doctor cohort (Doll *et al.*, 2005) there were 140 deaths from kidney cancer. Mortality rates per 100000 per year were 9.3 in never smokers, 16.4 in smokers of 1–14 cigarettes/day, 16.6 in smokers of 15–24 cigarettes/day, and 15.5 in smokers of ≥ 25 cigarettes/day (age-adjusted).

Hunt *et al.* (2005) performed a meta-analysis based on 19 case–control studies and 5 cohort studies (total 8032 cases in case–control and 1326 in cohort studies). The relative risk for smoking men was 1.54 (1.42–1.68), and for smoking women was 1.22 (1.09–1.36). A dose–response relationship was found in both men and women. The association observed was more convincing in population-based compared to hospital-based studies.

2.8.2 Confounding

Hypertension is a well established risk factor for kidney cancer but the association with smoking is only indirect. Potential confounding from hypertension was considered only by Brennan *et al.* (2008).

Other potential confounders such as BMI have been appropriately addressed in most studies.

2.8.3 Cessation

Most studies reviewed in the previous *Monograph* showed a lower risk for former smokers compared to current smokers, with a significant negative trend with increasing number of years since quitting (IARC, 2004a). In case–control study on smoking cessation and renal-cell carcinoma, the decrease in risk became significant only after 30 years of quitting (Parker *et al.*, 2003). In the meta-analysis (Hunt *et al.*, 2005), former smokers were at reduced risk after 10 years or more of quitting. A clear decline in risk after cessation was also reported by Theis *et al.* (2008). [The Working Group noted the poor quality of the study, considering the low response rate among controls.]

2.9 Cancer of the lower urinary tract (including cancer of the bladder, ureter, and renal pelvis)

2.9.1 Overview of studies

The previous *IARC Monograph* (IARC, 2004a) clearly identified a causal relationship of smoking with transitional-cell carcinomas and squamous-cell carcinomas of the bladder, ureter and renal pelvis both in men and women. Two new case–control studies (Cao *et al.*, 2005; Samanic *et al.*, 2006; Table 2.48 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.48.pdf) and two cohort studies (Bjerregaard *et al.*, 2006; Alberg *et al.*, 2007; Table 2.49 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.49.pdf) have been reported since then in addition to updates of cohort studies with longer follow-up.

In the update of the Whitehall study (Batty *et al.*, 2008) (a cohort of 17363 government employees in London, followed-up for 38 years), the hazard ratio for death from bladder cancer was 0.98 (0.62–1.54) in former smokers and 1.66 (1.06–2.59) in current smokers (based on 164 deaths). In the 50-year follow-up of the British doctors cohort (Doll *et al.*, 2005), there were 220 deaths from bladder cancer. Death rates per 100000 per year were 13.7 in never smokers, 37.7 in smokers of 1–14 cigarettes/day, 31.8 in smokers of 15–24 cigarettes/day, and 51.4 in smokers of ≥ 25 cigarettes/day. All the new studies confirm the existence of a dose–response relationship with the number of cigarettes smoked and with duration, and a decline in relative risk with time since quitting smoking, compared to non-quitters.

2.9.2 Types of tobacco

The risk of lower urinary tract cancer was more strongly associated with smoking air-cured (black) tobacco than smoking flue-cured (blond) tobacco in several studies (IARC, 2004a). The stronger association with air-cured (black) than blond tobacco among current smokers has not been clearly confirmed in a re-analysis of the Spanish multicentre case–control study (Samanic *et al.*, 2006). Relative risks in current smokers were 7.3 (4.9–10.9) in black tobacco smokers and 5.8 (3.4–10.0) in blond tobacco smokers; in former smokers, 4.2 (2.9–6.0) for black tobacco and 1.8 (1.0–3.2) for blond tobacco (Table 2.48 online). The effect of cessation was more pronounced in blond tobacco smokers than in black tobacco smokers, suggesting potentially different mechanisms of action of the two types of tobacco. Air-cured (black) tobacco is richer in arylamines.

2.9.3 Gene–environment interactions

A large number of studies have considered gene–environment interactions between tobacco smoking and genetic polymorphisms, including DNA repair genes (Vineis *et al.*, 2009) and genes involved in carcinogen metabolism (Malats, 2008; Dong *et al.*, 2008). Overall, there is evidence that the slow acetylator variant of the *NAT2* gene is involved in bladder carcinogenesis and may interact with smoking. The meta-relative risk for *NAT2* slow acetylator and bladder cancer was 1.46 (95%CI: 1.26–1.68; $P = 2.5 \times 10^{-7}$), based on 36 studies and 5747 cases (Dong *et al.*, 2008). Similar but weaker evidence has been provided for *GSTM1* (Malats, 2008).

The extent of interaction between *NAT2* variants and smoking is still unclear. In one study the *NAT2* acetylation status was found to modulate the association of bladder cancer and cigarette smoking through smoking intensity and not smoking duration (Lubin *et al.*, 2007). Studies are not consistent concerning the three-way association between smoking intensity, *NAT2* and bladder cancer. Some studies found greater effects at a lower level of exposure and others the opposite (Malats, 2008). Genome-wide

association studies have indicated 8q24 as a region that may confer high risk for bladder cancer (Kiemeney *et al.*, 2008).

2.10 Myeloid leukaemia (acute and chronic)

Myeloid leukaemia in adults was observed to be causally related to cigarette smoking in the previous *IARC Monograph* (IARC, 2004a). Risk increased with amount of tobacco smoked in a substantial number of adequate studies, with evidence of a dose–response relationship. Biological plausibility for a causal relationship of smoking with myeloid leukaemia is provided by the finding of known leukaemogens in tobacco smoke, one of which (benzene) is present in relatively large amounts. No evidence was found for an association with acute lymphocytic leukaemia.

One recently published cohort study included information on acute and chronic myeloid leukaemias (Fernberg *et al.*., 2007), based on 372 incident cases. A weak association was found between acute myeloid leukaemia and intensity of smoking, and a statistically significant association with current smoking (RR, 1.5; 95%CI: 1.06–2.11). No association was found with chronic myeloid leukaemia.

In the update of the Whitehall study (Batty *et al.*., 2008) (a cohort of 17363 government employees in London, followed-up for 38 years), the hazard ratio for mortality from myeloid leukaemias (acute plus chronic) was 5.08 (95%CI: 1.78–14.5) for current smokers, and 3.84 (95%CI: 1.35–11.0) for former smokers (based on 66 deaths). In the 50-year follow-up of the British doctors cohort (Doll *et al.*., 2005), there were 100 deaths from myeloid leukaemias. The mortality rates per 100000 per year were 6.3 in never smokers, 2.8 in smokers of 1–14 cigarettes/day, 14.0 in smokers of 15–24, and 18.3 in smokers of ≥ 25 cigarettes/day (age-adjusted).

2.11 Other leukaemias and lymphomas

2.11.1 Non-Hodgkin lymphoma

Six cohort studies have been published on the association between non-Hodgkin lymphoma and smoking, all reviewed in the previous *IARC Monograph* (IARC, 2004a). In five of these, no increased risk among smokers was evident (Doll *et al.*, 1994; McLaughlin *et al.*, 1995; Adami *et al.*, 1998; Herrinton & Friedman, 1998; Parker *et al.*, 2000). However, in one study, men who had ever smoked cigarettes had a twofold increase in risk for non-Hodgkin lymphoma, and the risk was still higher among the heaviest smokers (Linet *et al.*, 1992). Data from case–control studies generally also fail to support an effect of smoking on the incidence of non-Hodgkin lymphoma (Peach & Barnett, 2001; Stagnaro *et al.*, 2001; Schöllkopf *et al.*, 2005; Bracci & Holly, 2005; Table 2.50 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.50.pdf). Reanalysis of data of an Italian study (Stagnaro *et al.*, 2004) found a statistically significant association (OR, 1.4; 95%CI: 1.1–1.7) for blond tobacco exposure and non-Hodgkin lymphoma risk.

Three studies and a pooled analysis have examined histological subtypes of non-Hodgkin lymphoma. In one cohort study in women, smoking was associated with increased risk for follicular non-Hodgkin lymphoma (Parker *et al.*, 2000). Similarly, two other studies reported a weak positive association between smoking and risk for follicular lymphoma, but no effect for other histological types (Herrinton & Friedman, 1998; Stagnaro *et al.*, 2001). A large pooled analysis based on nine North-American and European case–control studies found an overall odds ratio of 1.07 (95%CI: 1.0–1.15) for smokers; the association was particularly strong for follicular lymphoma (OR, 1.31; 95%CI: 1.12–1.52) (Morton *et al.*, 2005).

2.11.2 Hodgkin lymphoma

In the previous *IARC Monograph* (IARC, 2004a) seven studies on the association between Hodgkin lymphoma and smoking were examined and null or weakly positive associations were noted. Among studies published since, a positive association was observed in two case–control (Willett *et al.*, 2007; Kanda *et al.*, 2009) and three cohort studies (Nieters *et al.*, 2006; Lim *et al.*, 2007; Nieters *et al.*, 2008), while one study found no clear association (Monnereau *et al.*, 2008). Several other recent studies also reported a positive association, but with some internal inconsistencies. In a European multicentre case–control study, no association was observed between tobacco and Hodgkin lymphoma for subjects below age 35 years, whereas for older subjects, ever-smokers experienced a doubled risk of Hodgkin lymphoma as compared to never smokers (Besson *et al.*, 2006). In contrast, a positive association was observed in young adults participating in the International Twin Study (Cozen *et al.*, 2009). A positive association was observed in a Scandinavian case–control study, but without a clear dose–response (Hjalgrim *et al.*, 2007). In a case–control study addressing infectious precursors, particularly Epstein-Barr virus (EBV), an increased risk for EBV-positive Hodgkin lymphoma was found among current smokers (Glaser *et al.*, 2004; Table 2.50 online).

Several of the above studies found positive associations for Hodgkin lymphoma while also demonstrating null or inverse associations with non-Hodgkin lymphoma (Nieters *et al.*, 2006; Lim *et al.*, 2007; Nieters *et al.*, 2008; Kanda *et al.*, 2009).

2.11.3 Multiple myeloma

In the previous *IARC Monograph* (IARC, 2004a), the large majority of studies on tobacco smoking and risk for multiple myeloma evaluated showed no clear association. More recently, two case–control studies found a positive association (Vlajinac *et al.*, 2003; Nieters *et al.*, 2006), whereas no clear association was observed in another case–control study (Monnereau *et al.*, 2008) or in a cohort study in Sweden (Fernberg *et al.*, 2007; Table 2.51 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.51.pdf).

2.12 Cancer of the breast

Approximately 150 epidemiological studies have been published on the relationship between breast cancer and active and passive smoking. The results from these studies have been comprehensively examined in peer-reviewed literature (Palmer & Rosenberg, 1993; Terry *et al.*, 2002a; Johnson *et al.*, 2002; Johnson, 2005; Terry & Goodman, 2006; Miller *et al.*, 2007). The previous *IARC Monograph* (IARC, 2004a) considered studies conducted through June 2002 and concluded that there is evidence suggesting lack of carcinogenicity of tobacco smoking in humans for cancers of the female breast.

Other consensus reviews have drawn different conclusions, based partly on the availability of new data, and partly on differences in interpretation:

- The 2001 US Surgeon General Report on Women and Smoking (Department of Health & Human Services, 2001) concluded that tobacco smoking does not appear to appreciably affect breast cancer risk overall. However, several issues were not entirely resolved, including whether starting to smoke at an early age increases risk, whether certain subgroups defined by genetic polymorphisms are differentially affected by smoking, and whether exposure to second-hand smoke affects risk.
- The 2004 US Surgeon General report on "The Health Consequences of Smoking" (Department of Health & Human

Services, 2004) concluded the evidence is suggestive of no causal relationship between tobacco smoking and breast cancer.

- The 2009 Canadian Expert Panel on Tobacco Smoke and Breast Cancer Risk (Collishaw *et al.*, 2009) concludes that based on the weight of evidence from epidemiological and toxicological studies and understanding of biological mechanisms, the associations between tobacco smoking and both pre- and post-menopausal breast cancer are consistent with causality.

The lack of agreement in the conclusions from these groups is not surprising, given that the observed associations are weaker and less consistent for breast cancer than for other tobacco-related cancers. Furthermore, several methodological considerations could either obscure a small increase in risk caused by tobacco smoking, or alternatively introduce a spurious association where no causal relationship exists.

2.12.1 Methodological and related issues

The principal concerns about studies of tobacco smoking and breast cancer are the following: timing of exposure, the relevant disease endpoint, the potential for confounding by factors associated with both smoking and the occurrence/detection of breast cancer, the hypothesis that tobacco smoking may have opposing effects on breast cancer risk (protective and detrimental), and the hypothesis that some women may be genetically more susceptible to develop breast cancer from smoking, and that increased risk in these subgroups may be obscured in analyses of average risk in the population.

(a) Misclassification of exposure

Self-reported information on tobacco smoking is generally considered more reliable than questionnaire information on exposure to second-hand tobacco smoke. However, studies of tobacco smoking have not uniformly considered the duration of smoking (years), the average amount smoked (cigarettes/day), or the timing of initiation in relation to first full-term pregnancy. Only one (Al-Delaimy *et al.*, 2004) of the seven available cohort studies updated the information on smoking behaviour during follow-up. Whereas some exposure variables, such as age at initiation and age at first full-term pregnancy remain constant over time, others, such as smoking status, duration and age at cessation do not. Furthermore, the average age at initiation and duration of smoking are highly correlated with birth cohort and attained age. While the number of years of smoking before first full term pregnancy has been proposed as a potentially relevant measure of exposure, the range of this variable is constrained except among women whose first pregnancy occurs at an older age, which is itself an independent risk factor for breast cancer.

(b) Specificity of disease endpoints

Breast cancer is not a single disease. Accordingly, some researchers have postulated that exposure to tobacco smoke (from tobacco smoking or second-hand tobacco smoke) could differentially affect certain clinical subtypes of breast such as pre- or post-menopausal cancers or tumours with or without hormonal receptors. It is also possible that smoking might affect the survival of women with breast cancer, whether or not it affects incidence rates. Most published studies have measured incidence rates as the endpoint, although some have measured mortality rates or effects on survival.

(c) Confounding

Alcohol consumption is positively correlated with tobacco smoking (Marshall *et al.*, 1999) and is an established cause of breast cancer (IARC, 2010a; *Monograph* on Consumption of Alcoholic Beverages in this Volume). Most epidemiologic studies attempt to control for alcohol consumption using questionnaire information on usual drinking patterns. This approach is vulnerable to residual confounding, because self-reported data on lifetime alcohol consumption leave room for misclassification. Potential confounding by alcohol consumption is of greater concern for current than for former smokers, since, on average, current smokers drink more than former smokers (Reynolds *et al.*, 2004a, b). One study by the Collaborative Group on Hormonal Factors and Breast Cancer (Hamajima *et al.*, 2002) controlled rigorously for alcohol consumption by restricting the analysis of smoking and breast cancer to women who reported drinking no alcohol.

Conversely, mammography screening can be a negative confounder in studies of tobacco smoking and breast cancer incidence. Few studies of tobacco smoking in relation to breast cancer have controlled for mammography screening. Current smokers report a lower frequency of mammographic screening than never-smokers, whereas health conscious former smokers report higher screening rates (Gross *et al.*, 2006). Mammography screening affects the detection rather than the occurrence of breast cancer; it detects some tumours that might otherwise never have been recognized and allows earlier diagnosis of others, thereby increasing breast cancer incidence in the short-term. The consequence of uncontrolled confounding by mammography screening would be to underestimate an association between current smoking and breast cancer incidence, and to overestimate the association in former smokers. Confounding by screening would be expected to have the opposite effect in studies of breast cancer mortality.

Other correlates of tobacco smoking might also confound a potential association between tobacco smoking and breast cancer, although their net effect is likely to be smaller and harder to predict than confounding by alcohol and mammography screening. Women who smoke undergo menopause about two to three years earlier than never-smokers (Baron *et al.*, 1990). The effect of this may be partly or wholly offset by the greater likelihood of girls who experience early menarche to initiate smoking in early adolescence (Jean *et al.*, 2011). There is no documentation that smokers and never-smokers differ with respect to average years of ovulation. Tobacco smoking also has a complex relationship to body mass index. Post-menopausal women who smoke are less likely to be overweight or obese than former or never smokers, but overweight adolescent girls are more likely to begin smoking for weight control (Fine *et al.*, 2004). Similarly complex relationships exist between smoking and physical activity. Current smokers report less physical activity than either former or never smokers (Kaczynski *et al.*, 2008; Trost *et al.*, 2002), but only a small proportion of the population engages in the vigorous physical activity that is needed to protect against breast cancer. The socioeconomic correlates of smoking have changed over time. Women who attended college during the 1960s and 1970s were more likely to initiate smoking than less educated women, but subsequently college-educated women have been more likely to quit. Thus, the potential for confounding by reproductive patterns and use of post-menopausal hormone treatment varies by birth cohort and differs for current and former smokers.

Most epidemiological studies have attempted to control for factors that might confound the relationship between breast cancer and tobacco smoking using questionnaire information collected on these factors. None of the published

studies have been able to control for all of the potential confounders, however. Most studies lack data on screening behaviour and have limited information on alcohol consumption, use of post-menopausal hormones, and physical activity.

(d) Potential anti-estrogenic effects of tobacco smoking

Indirect evidence suggests that tobacco smoking may have anti-estrogenic effects that might offset the adverse effects of tobacco smoke carcinogens on breast cancer risk. Baron *et al.* (1990) pointed to observations suggesting lower estrogen activity levels in women who smoke compared to those who do not. Smokers have lower risk of endometrial cancer (Department of Health & Human Services, 2004), higher risk of osteoporosis (Jensen *et al.*, 1985; Jensen & Christiansen, 1988), earlier age at natural menopause (Baron *et al.*, 1990) and lower mammography density (Roubidoux *et al.*, 2003) than women who do not smoke. Smoking also attenuates the effects of hormone replacement therapy (HRT) on lipid profiles (Jensen & Christiansen, 1988) and serum estrone (McDivit *et al.*, 2008). No difference in serum concentrations of estradiol and estrone between post-menopausal smokers and non-smokers have been reported in several studies (Cassidenti *et al.*, 1992; Khaw *et al.*, 1988; Berta *et al.*, 1991; Longcope *et al.*, 1986; Berta *et al.*, 1992; Cauley *et al.*, 1989; Friedman *et al.*, 1987; Key *et al.*, 1991). However, smokers have been observed to have higher levels of androgens (Cassidenti *et al.*, 1992) (specifically androstenedione) (Khaw *et al.*, 1988; Cauley *et al.*, 1989; Friedman *et al.*, 1987; Key *et al.*, 1991), prolactin (Berta *et al.*, 1991), and unbound serum estradiol (Cassidenti *et al.*, 1992).

(e) Genetically susceptible subgroups

Certain subgroups of women may have greater risk of breast cancer when exposed to tobacco smoke because of genetic or other factors affecting cancer susceptibility. Potential interactions between inherited polymorphisms and tobacco smoking have been studied for selected candidate genes that affect carcinogen metabolism, modulation of oxidative damage, immune responses, and DNA repair (see Sections 2.12.4b and 4.2).

2.12.2 Analytical studies

Over 130 epidemiological studies on tobacco smoking and breast cancer were reviewed.

(a) Incidence in current and former smokers

Since the previous *IARC Monograph* (IARC, 2004a), seven reports on cohort studies (Al-Delaimy *et al.*, 2004; Reynolds *et al.*, 2004a; Gram *et al.*, 2005; Hanaoka *et al.*, 2005; Olson *et al.*, 2005; Cui *et al.*, 2006; Ha *et al.*, 2007) have been published on breast cancer incidence in relation to tobacco smoking (Table 2.52 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.52.pdf). Breast cancer incidence was significantly associated with current tobacco smoking in three studies (Reynolds *et al.*, 2004a; Olson *et al.*, 2005; Cui *et al.*, 2006), with relative risk estimates among the larger studies ranging from 1.12 (95%CI: 0.92–1.37) (Al-Delaimy *et al.*, 2004) to 1.32 (95%CI:1.10–1.57) (Reynolds *et al.*, 2004a). Former smoking was significantly associated with risk in only one cohort (Al-Delaimy *et al.*, 2004), with relative risk estimates across all of the cohorts ranging from 1.00 (95%CI: 0.93–1.08) (Cui *et al.*, 2006) to 1.18 (95%CI: 1.02–1.36) (Al-Delaimy *et al.*, 2004). The association with breast cancer is stronger in current than in former smokers in four of the seven cohort studies (Reynolds *et al.*, 2004a; Hanaoka *et al.*, 2005; Olson *et al.*, 2005; Cui *et al.*, 2006), although the confidence intervals overlap widely in all but one (Cui *et al.*, 2006). [The Working group noted that three cohort studies (Gram *et al.*, 2005; Hanaoka *et al.*, 2005; Olson *et al.*, 2005) provided data on both

the age-adjusted and the multivariate-adjusted risk estimates for current and former smoking. None of these showed attenuation of the estimate associated with current smoking, and two (Hanaoka *et al.*, 2005; Olson *et al.*, 2005) reported somewhat stronger estimates when adjusted for established risk factors besides age. None of the studies adjusted for the frequency of mammography screening. Residual confounding by screening and incomplete control for other risk factors would be expected to cause underestimation of the association with current smoking, and overestimation of the association with former smoking.]

Since the previous *IARC Monograph* (IARC, 2004a), a total of 12 case–control studies on tobacco smoking and breast cancer incidence have been published (Table 2.53 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.53.pdf). Results from the case–control studies are less consistent than those from the cohort studies. Six studies (Li *et al.*, 2004; Mechanic *et al.*, 2006; Magnusson *et al.*, 2007; Prescott *et al.*, 2007; Roddam *et al.*, 2007; Slattery *et al.*, 2008) differentiated between current and former smokers, while the six other reports (Band *et al.*, 2002; Lash & Aschengrau, 2002; Gammon *et al.*, 2004; Rollison *et al.*, 2008; Ahern *et al.*, 2009; Young *et al.*, 2009) specify only ever or never smokers. Only one study (Li *et al.*, 2004) reported a borderline significant increase in risk associated with current smoking, and two studies (Band *et al.*, 2002; Rollison *et al.*, 2008) with ever smoking.

None of the six case–control studies that presented data on breast cancer incidence separately for current and former smokers found a significant difference in risk between the two smoking categories; the relative risk estimates were higher for former than for current smokers in four of the studies (Mechanic *et al.*, 2006; Prescott *et al.*, 2007; Roddam *et al.*, 2007; Slattery *et al.*, 2008) and identical in the fifth (Magnusson *et al.*, 2007).

(b) Years of cessation

When the relative risk for breast cancer incidence in former smokers is examined by years since cessation in cohort studies (Table 2.54 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.54.pdf), the point estimates do not consistently decrease with longer time since cessation. In none of the four cohort studies (London *et al.*, 1989b; Egan *et al.*, 2002; Reynolds *et al.*, 2004a; Cui *et al.*, 2006) and in only one (Li *et al.*, 2005) of the five case–control studies (Chu *et al.*, 1990; Gammon *et al.*, 1998; Johnson *et al.*, 2000; Kropp & Chang-Claude, 2002; Li *et al.*, 2005) that formally tested for trend (Table 2.55 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.55.pdf) was there a statistically significant decrease in relative risk observed with longer time since cessation. Only one study has reported data on breast cancer mortality in relation to years since quitting or age at cessation (Calle *et al.*, 1994). A statistically significant inverse trend in the relative risk estimates was reported with both years since quitting (p trend = 0.04) and younger age at cessation (p trend = 0.02). [The Working Group noted that the inverse trends in the relative risk of dying from breast cancer observed in this study are weaker than those observed with most other cancers designated as causally associated with smoking.]

(c) Duration of smoking and age at initiation

Tables 2.56–2.61 (see below for links) list the published epidemiologic studies that relate breast cancer incidence to duration of tobacco smoking, age at initiation and/or timing relative to first full term pregnancy.

Longer duration of smoking is associated with higher breast cancer incidence in five of seven cohort studies (Table 2.56 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.56.pdf). A similar trend is seen inconsistently among the 33 case–control

studies that report relative risk estimates by duration of smoking (Table 2.57 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.57.pdf). Among the 18 studies that reported a formal test of trend, eight studies (Gammon *et al.*, 1998; Johnson *et al.*, 2000; Reynolds *et al.*, 2004a; Gram *et al.*, 2005; Li *et al.*, 2005; van der Hel *et al.*, 2005; Cui *et al.*, 2006; Mechanic *et al.*, 2006) reported a statistically significant or borderline increase in the relative risk of incident breast cancer with the duration of smoking; seven studies (Ewertz, 1990; Palmer *et al.*, 1991; Egan *et al.*, 2002; Al-Delaimy *et al.*, 2004; Lissowska *et al.*, 2006; Magnusson *et al.*, 2007; Prescott *et al.*, 2007) reported no trend, and one study (Brinton *et al.*, 1986) reported an inverse relationship.

Thirty studies, including cohort (Tables 2.58 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.58.pdf) and case–control studies (Table 2.59 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.59.pdf) related breast cancer incidence to age at smoking initiation. Fifteen of these (Chu *et al.*, 1990; Ewertz, 1990; Palmer *et al.*, 1991; Nordlund *et al.*, 1997; Gammon *et al.*, 1998; Johnson *et al.*, 2000; Egan *et al.*, 2002; Kropp & Chang-Claude, 2002; Gram *et al.*, 2005; Cui *et al.*, 2006; Lissowska *et al.*, 2006; Ha *et al.*, 2007; Lissowska *et al.*, 2007; Magnusson *et al.*, 2007; Prescott *et al.*, 2007; Slattery *et al.*, 2008) reported a formal test of trend. Among these, only two (Gram *et al.*, 2005; Ha *et al.*, 2007) found a statistically significant or borderline significantly higher risk in women who began smoking at a younger ages; twelve studies (Chu *et al.*, 1990; Ewertz, 1990; Palmer *et al.*, 1991; Nordlund *et al.*, 1997; Gammon *et al.*, 1998; Johnson *et al.*, 2000; Egan *et al.*, 2002; Cui *et al.*, 2006; Lissowska *et al.*, 2006; Magnusson *et al.*, 2007; Prescott *et al.*, 2007; Slattery *et al.*, 2008) found no relationship with age at initiation, and one (Kropp & Chang-Claude, 2002) reported higher risk among women who began smoking later. [The Working Group noted that at least two studies (Cui *et al.*, 2006; Slattery *et al.*, 2008) appear to have included never-smokers in the tests of trend and that the categories that define age at initiation differ across studies.]

The relative risk of incident breast cancer according to the timing of smoking initiation relative to first full-term pregnancy was reported in 21 studies, of cohort (Table 2.60 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.60.pdf) and case–control (Table 2.61 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.61.pdf) design. For nine studies (Hunter *et al.*, 1997; Egan *et al.*, 2002; Al-Delaimy *et al.*, 2004; Reynolds *et al.*, 2004a; Li *et al.*, 2005; Cui *et al.*, 2006; Prescott *et al.*, 2007; Rollison *et al.*, 2008; Young *et al.*, 2009) categorical data on years of smoking before first pregnancy are presented, whereas for 12 (Lash & Aschengrau, 1999; Innes & Byers, 2001; Band *et al.*, 2002; Kropp & Chang-Claude, 2002; Lash & Aschengrau, 2002; Fink & Lash, 2003; Lawlor *et al.*, 2004; Gram *et al.*, 2005; Olson *et al.*, 2005; Lissowska *et al.*, 2006; Magnusson *et al.*, 2007; Slattery *et al.*, 2008) whether smoking was initiated before or after the initial pregnancy was considered. Breast cancer incidence is consistently higher when smoking began before or during first pregnancy in most (Hunter *et al.*, 1997; Lash & Aschengrau, 1999; Innes & Byers, 2001; Band *et al.*, 2002; Egan *et al.*, 2002; Al-Delaimy *et al.*, 2004; Reynolds *et al.*, 2004a; Gram *et al.*, 2005; Li *et al.*, 2005; Olson *et al.*, 2005; Cui *et al.*, 2006; Slattery *et al.*, 2008; Young *et al.*, 2009) but not all (Kropp & Chang-Claude, 2002; Lash & Aschengrau, 2002; Fink & Lash, 2003; Prescott *et al.*, 2007) studies that tested this. [The Working Group noted that the number of years of smoking before first pregnancy is highly correlated with age at first full-term pregnancy, which is itself an independent risk factor for breast cancer.]

It has been argued that some studies, and especially cohort studies, may underestimate

the true association between tobacco smoking and breast cancer risk by ignoring or underestimating lifetime exposure to second-hand tobacco smoke of those in the referent group (California Environmental Protection Agency, 2005; Johnson, 2005; Collishaw *et al.*, 2009). This criticism is based on the hypothesis that exposure to second-hand smoke may confer almost the same degree of breast cancer risk as tobacco smoking. Under this hypothesis, the inclusion of women exposed to second-hand smoke in the referent group dilutes the contrast between exposed and unexposed women in studies of tobacco smoking, and causes underestimation of the association between tobacco smoking and breast cancer. In several case–control studies the association between breast cancer and tobacco smoking strengthened when the referent group was defined as women with "never active, never-passive" exposure to tobacco smoke (Morabia *et al.*, 1996; Lash & Aschengrau, 1999; Johnson *et al.*, 2000; Kropp & Chang-Claude, 2002). In contrast, a stronger association between tobacco smoking and breast cancer risk, when women exposed only to second-hand smoke are excluded from the referent group, has not been observed in cohort studies (Egan *et al.*, 2002; Reynolds *et al.*, 2004a). Debate continues over whether the case–control studies should be considered "of highest quality" because they provide "lifetime exposure assessment" (Collishaw *et al.*, 2009) or whether the cohort studies are more credible, because prospectively-collected exposure data are not susceptible to the recall bias that can affect retrospective studies.

(d) Survival and mortality from breast cancer

The relationship between smoking and the natural history of breast cancer has been examined in several studies (Daniell, 1988; Ewertz *et al.*, 1991; Daniell *et al.*, 1993; Scanlon *et al.*, 1995; Yu *et al.*, 1997; Manjer *et al.*, 2000; Murin & Inciardi, 2001; Holmes *et al.*, 2007). In cross-sectional analyses, Daniell *et al.* (1993) found that smokers with breast cancer had more and larger lymph node metastases than non-smokers, after controlling for primary tumour size and other variables. Further, a case–control study (Murin & Inciardi, 2001) and a retrospective cohort study (Scanlon *et al.*, 1995) found smoking to be associated with an increased risk of developing pulmonary metastases from breast cancer. However, these studies could not definitively distinguish lung metastases from primary lung cancers.

Five cohort studies have focused specifically upon the association of tobacco smoking with either breast cancer survival (Ewertz *et al.*, 1991; Yu *et al.*, 1997; Manjer *et al.*, 2000; Holmes *et al.*, 2007) or breast cancer death rates (Calle *et al.*, 1994). A study of 1774 Danish women showed no association between smoking and breast cancer survival (Ewertz *et al.*, 1991), as did a study of 5056 women with breast cancer in the Nurse's Health Study (Holmes *et al.*, 2007). In contrast, follow-up of 792 women with in situ or invasive breast cancer detected in a screening study in Malmø, Sweden found a crude relative risk for smokers and ex-smokers, compared to never smokers, of 1.44 (95%CI: 1.01–2.06) and of 1.13 (95%CI: 0.66–1.94), respectively (Manjer *et al.*, 2000). The relative risk associated with smoking remained significant after adjustment for age and stage at diagnosis (RR, 2.14; 95%CI: 1.47–3.10). A study based on the ACS Cancer Prevention Study II reported an association between current smoking and increased breast cancer death rates after six years of follow-up (Table 2.56 online; Calle *et al.*, 1994). Risk of death attributed to breast cancer was positively and significantly related to the duration of current smoking reported at the time of enrolment. However, the authors acknowledge that mortality studies cannot exclude biases arising from the effect of smoking on overall death rates, which could increase the potential for prevalent breast cancer to be coded as the underlying cause of death on the death certificate (Calle *et al.*, 1994).

2.12.3 Subtypes

(a) Pre- versus post-menopausal

Since the previous *IARC Monograph* (IARC, 2004a), 19 case–control studies have published data on tobacco smoking in relation to pre- and post-menopausal breast cancer (Table 2.62 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.62.pdf). The results are inconsistent. Of the 12 studies that provide information separately for current smokers (Schechter *et al.*, 1985; Brinton *et al.*, 1986; Rohan & Baron, 1989; Ewertz, 1990; Baron *et al.*, 1996; Gammon *et al.*, 1998; Millikan *et al.*, 1998; Johnson *et al.*, 2000; Zheng *et al.*, 2002; Magnusson *et al.*, 2007; Slattery *et al.*, 2008), only five (Schechter *et al.*, 1985; Johnson *et al.*, 2000; Magnusson *et al.*, 2007; Slattery *et al.*, 2008) found a stronger association with pre- than with post-menopausal breast cancer. The other analyses show either similar associations (Brinton *et al.*, 1986; Ewertz, 1990; Baron *et al.*, 1996; Gammon *et al.*, 1998; Millikan *et al.*, 1998; Zheng *et al.*, 2002) or a stronger association with post-menopausal breast cancer (Rohan & Baron, 1989; Millikan *et al.*, 1998; Johnson *et al.*, 2000; Zheng *et al.*, 2002).

(b) Hormone receptor status

Two cohort studies (London *et al.*, 1989a; Manjer *et al.*, 2001), one case–control study (Morabia *et al.*, 1998) and a case series (Yoo *et al.*, 1997) have examined the association between quantitative measures of cigarette smoking and breast cancer risk according to estrogen receptor (ER) status. In one of the cohort studies (Manjer *et al.*, 2001), a statistically significant increased risk (RR, 1.6) of ER negative tumours associated with current smoking was found but no clear association between smoking and ER positive tumours, and no difference in the association with progestogen receptor (PR)-positive and PR-negative tumours. In the other three studies there was no clear difference in the association related to ER or PR receptor status.

2.12.4 Susceptible populations

More than 30 studies and meta-analyses (Alberg *et al.*, 2004; Terry & Goodman, 2006; Ambrosone *et al.*, 2008; Collishaw *et al.*, 2009) have evaluated whether a family history of breast cancer and/or inherited polymorphisms in various genes may confer greater susceptibility to develop breast cancer from exposure to tobacco smoke. These are described below in relation to the measure indicating potential susceptibility.

(a) Family history

In two studies, whether a family history of breast cancer modifies susceptibility to develop breast cancer from tobacco smoking has been examined. Couch *et al.* (2001) measured breast cancer incidence among female family members in a cohort of breast cancer cases diagnosed between 1944 and 1952 at the University of Minnesota. Sisters and daughters in families with at least three breast and/or ovarian cancers were at 2.4 fold higher risk for breast cancer (95%CI: 1.2–5.1) if they smoked compared to never-smokers. No dose–response was observed in relation to pack–years of smoking.

Suzuki *et al.* (2007) reported a statistically significant interaction between family history of breast cancer and smoking history in a hospital-based case–control study of 3861 breast cancer cases treated at a large cancer centre in Japan between 1988 and 2000. A family history of breast cancer in the absence of smoking was associated with a relative risk of 1.44 (95%CI: 1.21–1.71); the relative risk estimate was 1.95 (95%CI: 1.36–2.81) in women who reported < 30 pack–years of tobacco smoking, and 4.33 (95%CI: 1.65–11.40) in women who reported > 30 pack–years of smoking.

[The Working group noted that Japanese women who smoked during this time period

may have differed from never-smokers in other characteristics related to breast cancer. Besides its strong correlation with female smoking, "Westernization" might be associated with delayed childbearing, smaller families, higher body mass index, and greater use of post-menopausal hormones.]

(b) Genetic polymorphisms

Studies of breast cancer, smoking and low penetrance genetic polymorphisms are summarized in Table 2.63 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.63.pdf). The candidate genes in these studies are involved in carcinogen metabolism [*N*-acetyltransferases (*NAT1, NAT2*), cytochrome P450s (*CYP1A1, CYP1B1, CYP2E2*), GSTs], host responses to oxidative stress (superoxide dismutase) or to infectious organisms (myeloperoxidase and immunoglobulin binding protein) and DNA repair (O^6-methylguanine DNA methyltransferase, nucleotide excision repair).

The most consistent associations with breast cancer risk have been observed among long-term smokers with the *NAT2* slow acetylation genotype (Terry & Goodman, 2006). *NAT2* slow acetylation genotype is thought to confer less capability to detoxify tobacco smoke carcinogens and is associated with an increase in breast cancer risk (Ambrosone *et al.*, 1996, 2008). Approximately 50–60% of Caucasian women are reported to be slow acetylators.

Table 2.63 (online) lists 15 studies of polymorphisms in *NAT2*, of which 9 were included in a pooled analysis and 13 in a meta-analysis (Ambrosone *et al.*, 2008). [The study by Delfino *et al.* (2000) was excluded from these analyses because cases included women with benign breast disease; the study by Lilla *et al.* (2005) was not considered because it is based on the same population as that by Chang-Claude *et al.* (2002).] The meta-analysis found a statistically significant association between ever tobacco smoking and breast cancer risk among women with the *NAT2* slow acetylator genotype (meta-RR, 1.27; 95%CI: 1.16–1.40) but not in those with rapid acetylator genotype (meta-RR, 1.05; 95%CI: 0.95–1.17). Pack–years of tobacco smoking was significantly associated with increasing breast cancer risk among women with *NAT2* slow acetylator genotype (meta-RR for ever smokers, 1.44; 95%CI: 1.23–1.68, for > 20 pack–years versus never smokers), but not among rapid acetylators (Ambrosone *et al.*, 2008). No main effect was seen between *NAT2* status and breast cancer risk (meta-RR, 1.0; 95%CI: 0.93–1.07). In contrast to an earlier meta-analysis (Alberg *et al.*, 2004), this study observed no difference in risk for pre- or post-menopausal breast cancer. The pooled analysis of nine studies (Ambrosone *et al.*, 2008) reported pooled risk estimates for pre- and post-menopausal women of 1.49 (95%CI: 1.08–2.04) and 1.42 (95%CI: 1.16–1.74), respectively, among women with slow *NAT2* genotype and at least 20 pack–years of smoking compared to never-smokers. The corresponding values for women with rapid acetylator genotype were 1.29 (95%CI: 0.89–1.86) and 0.88 (95%CI: 0.69–1.13). A statistically significant interaction was observed between pack–years of smoking as a continuous variable and *NAT2* genotype (p interaction = 0.03).

A population-based case–control study published after the meta-analysis by Ambrosone *et al.* compared the prevalence of the *NAT2* genotypes and their joint effect with smoking on breast cancer risk in Hispanic and non-Hispanic white women (Baumgartner *et al.*, 2009). Non-Hispanic white women were more likely ($P < 0.001$) than Hispanics to have a slow (41.7% versus 33.5%) or very slow (19.0% versus 11.1%) *NAT2* acetylator status. Breast cancer risk was significantly increased in non-Hispanic smoking white women with a very slow acetylator genotype (RR, 2.46; 95%CI: 1.07–5.65 for current versus never).

[The Working Group noted that publication bias remains a concern in the studies of *NAT2* published to date. All of the studies included in the meta-analysis by Ambrosone *et al.* were published between 1996 and 2006; some among them (Morabia *et al.*, 2000; Sillanpää *et al.*, 2007) reported very strong associations that seem inconsistent with the rest of the data. Because genetic studies often examine multiple genes, it is plausible that studies that find no main effect with *NAT2* have not examined this association or that null results for smoking have not been published.]

Fewer studies with less consistent findings have been published on polymorphisms in other genes such as *NAT1*, *CYP1A1*, *GST*, *NOS3*, *MPO*, *MnSOD2* and various DNA repair genes (Table 2.63 online).

2.12.5 High penetrance genes & prognosis

At least seven studies have examined the hypothesis that tobacco smoking may modify breast cancer risk among women who carry *BRCA1* and *BRCA2* mutations (Brunet *et al.*, 1998; Ghadirian *et al.*, 2004; Colilla *et al.*, 2006; Gronwald *et al.*, 2006; Nkondjock *et al.*, 2006; Breast Cancer Family Registry, 2008; Ginsburg *et al.*, 2009). The results have been inconsistent. A recent case–control study of women under age 50 years who were carriers of mutations in *BRCA1* or *BRCA2* reported increased risk for breast cancer associated with as little as five pack–years of smoking. Compared to non-smokers, the risk associated with five or more pack–years of smoking was 2.3 (95%CI: 1.6–3.5) for *BRCA1* mutation carriers and 2.6 (95%CI: 1.8–3.9) for *BRCA2* mutation carriers (Breast Cancer Family Registry, 2008). In contrast, six other studies reported no increased risk among *BRCA1* or *BRCA2* carriers who smoke. The Canadian Panel review (Collishaw *et al.*, 2009) postulated that the five previous studies (Brunet *et al.*, 1998; Ghadirian *et al.*, 2004; Colilla *et al.*, 2006; Gronwald *et al.*, 2006; Nkondjock *et al.*, 2006) may have failed to observe a relationship because they included prevalent cases. However, a sixth study published since the Canadian panel review is also negative (Ginsburg *et al.*, 2009).

2.13 Cancer of the cervix

The association between smoking and cervical cancer has been examined in many epidemiological studies over the past few decades.

Since the previous *IARC Monograph* (IARC, 2004a), additional epidemiological studies have been published. Study design and results of the case–control studies restricted to HPV positive women or that adjusted for HPV status are presented in Table 2.64 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.64.pdf) and Table 2.65 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.65.pdf). Cohort studies and pooled analyses are presented in Table 2.66 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.66.pdf) and Table 2.67 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.67.pdf), respectively. Table 2.68 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.68.pdf) and Table 2.69 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.69.pdf) present additional cohort studies and pooled analyses on tobacco smoking and cervical, cervical intraepithelia neoplasia and carcinoma in situ, with our without controlling for HPV status, respectively.

2.13.1 Dose–response relationship

A positive association between smoking and incidence of cervical squamous-cell carcinoma, which account for approximately 90% of all cervical cancers, has been shown consistently over several decades in many epidemiological studies

of various designs conducted across different geographic regions. Dose–response associations with smoking intensity and duration were noted in many of the studies where such associations were examined (Berrington de González *et al.*, 2004; Appleby *et al.*, 2006). Conversely, no clear association was found among former smokers. For adenocarcinoma of the cervix, which usually account for less than 10% of the total of all types of cervical cancer, there appears to be no clear association with smoking (Berrington de González *et al.*, 2004).

2.13.2 Interaction with HPV positivity

Epidemiological studies of smoking and cervical cancer increasingly have considered the effects of HPV infection, which is recognized as the main etiological factor for invasive and pre-invasive cervical neoplasia worldwide (IARC, 1995, 2012b). HPV infection has been considered not only with respect to possible effect modification (Hellberg & Stendahl, 2005; Gunnell *et al.*, 2006), but also to confounding, as both HPV infection and smoking habits are directly associated with number of sexual partners and other indications of high-risk sexual behaviours (Sikström *et al.*, 1995; Wang *et al.* 2004; Hellberg & Stendahl, 2005; McIntyre-Seltman *et al.*, 2005; Syrjänen *et al.*, 2007). Although there have been exceptions (Syrjänen *et al.*, 2007), recent studies have generally continued to show that statistical adjustment for the potential confounding effects of HPV infection, or restricting studies to women with high risk HPV infection (Plummer *et al.*, 2003), does not appreciably alter the finding of a positive association or its magnitude (McIntyre-Seltman *et al.*, 2005; Appleby *et al.*, 2006; Tolstrup *et al.*, 2006; Tsai *et al.*, 2007; Nishino *et al.*, 2008; Kapeu *et al.*, 2009).

Statistical adjustment for the potentially confounding effect of HPV infection was usually based on the measured presence of HPV DNA in cervical cells or anti-HPV serum antibodies in multivariate analytical models; as noted above, studies have also restricted their analyses to HPV-positive cases and controls. As there is currently no reliable marker of persistent HPV infection, case–control studies based on a cross-sectional measurement of HPV cannot distinguish between transient and persistent infections (Franco *et al.*, 1999). Tobacco smoking is suspected to facilitate acquisition or persistence of an HPV infection through a reduced number of Langerhans cells and CD4 lymphocytes, which are markers of local immune response in the cervix (Vaccarella *et al.*, 2008). In addition, smoking may affect innate immunity (Ferson *et al.*, 1979). Current smokers have been shown to have a slightly higher HPV prevalence than non-smokers in a broad range of world populations after adjustment for life-time number of sexual partners (OR, 1.18; 95%CI: 1.01–1.39) (Vaccarella *et al.*, 2008). Studies have evaluated the effect of smoking on HPV persistence. One study shows lower probability of HPV clearance among ever smokers (Giuliano *et al.*, 2002) but a few others found no relationship (Molano *et al.*, 2003; Richardson *et al.*, 2005).

2.14 Cancer of the endometrium

2.14.1 Overview of studies

To date, at least 42 epidemiological studies have examined the association between smoking and endometrial cancer, 25 reviewed in the previous *IARC Monograph* (IARC, 2004a) and 17 published since then (Petridou *et al.*, 2002; Folsom *et al.*, 2003; Furberg & Thune, 2003; Newcomb & Trentham-Dietz, 2003; Beral *et al.*, 2005; Matthews *et al.*, 2005; Viswanathan *et al.*, 2005; Okamura *et al.*, 2006; Strom *et al.*, 2006; Trentham-Dietz *et al.*, 2006; Weiss *et al.*, 2006a; Al-Zoughool *et al.*, 2007; Bjørge *et al.*, 2007; Lacey *et al.*, 2007; Loerbroks *et al.*, 2007; Setiawan *et al.*, 2007; Lindemann *et al.*, 2008). Study design and results of the additional studies

are presented separately for the case–control studies (Table 2.70 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.70.pdf and Table 2.71 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.71.pdf, respectively) and for the cohort studies (Table 2.72 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.72.pdf and Table 2.73 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.73.pdf, respectively).

(a) Cohort studies

The majority of the 13 cohort studies (Engeland *et al.*, 1996; Terry *et al.*, 1999, 2002b; Folsom *et al.*, 2003; Furberg & Thune 2003; Beral *et al.*, 2005; Viswanathan *et al.*, 2005; Al-Zoughool *et al.*, 2007; Bjørge *et al.*, 2007; Lacey *et al.*, 2007; Loerbroks *et al.*, 2007; Setiawan *et al.*, 2007; Lindemann *et al.*, 2008) suggest a decreased risk among current smokers, including the largest study with over 9000 cases (Bjørge *et al.*, 2007). In five of these studies quantitative smoking measures have been examined in relation to endometrial cancer risk (Terry *et al.*, 1999, 2002b; Viswanathan *et al.*, 2005; Al-Zoughool *et al.*, 2007; Loerbroks *et al.*, 2007). Of these, one (Terry *et al.*, 1999) found a 50% reduced risk among current smokers in the highest level of intensity (11 cigarettes per day or more) compared with non-smokers, but the number of cases was low and the confidence intervals correspondingly wide. A more recent and larger cohort study (Terry *et al.*, 2002b) found a statistically significant 40% reduced risk among current smokers of more than 20 cigarettes per day, but showed somewhat weaker and statistically non-significant reductions in risk with smoking of long duration or high cumulative consumption (i.e. pack–years). In contrast, the risk among former smokers was similar to that among never smokers. The largest of these studies generally showed decreasing risk of endometrial cancer with increasing smoking intensity, duration, and pack–years of consumption (Viswanathan *et al.*, 2005). Three studies examined the association between time since smoking cessation and endometrial cancer risk. Two of these studies suggested a positive association with time since quitting (compared with non-smokers) (Viswanathan *et al.*, 2005; Loerbroks *et al.*, 2007), whereas one found no association (Terry *et al.*, 2002b).

(b) Case–control studies

The results of 17 population-based case–control studies (Smith *et al.*, 1984; Tyler *et al.*, 1985; Franks *et al.*, 1987; Elliott *et al.*, 1990; Rubin *et al.*, 1990; Brinton *et al.*, 1993; Goodman *et al.*, 1997; Shields *et al.*, 1999; Jain *et al.*, 2000; McCann *et al.*, 2000; Newcomer *et al.*, 2001; Weiderpass & Baron, 2001; Newcomb & Trentham-Dietz, 2003; Matthews *et al.*, 2005; Strom *et al.*, 2006; Trentham-Dietz *et al.*, 2006; Weiss *et al.*, 2006a), that have included between 46 and 1304 endometrial cancer cases, generally have shown reductions in risk among current smokers compared with never smokers (although the magnitude of the reduction in risk has varied somewhat); results among former smokers compared with never smokers were equally variable, albeit somewhat weaker overall. The results of eight hospital-based case–control studies (Kelsey *et al.*, 1982; Lesko *et al.*, 1985; Levi *et al.*, 1987; Stockwell & Lyman, 1987; Koumantaki *et al.*, 1989; Austin *et al.*, 1993; Petridou *et al.*, 2002; Okamura *et al.*, 2006), which included between 83 and 1374 endometrial cancer cases, are somewhat consistent with those of population-based studies. They showed moderate (e.g. 30–40%) reduction in risks among current compared with never smokers, and unaltered risks (or perhaps a small 10–20% reduction in risk) in former compared with never smokers. The largest of the hospital-based studies (Stockwell & Lyman, 1987), with 1374 cases and 3921 controls, found both former and current smokers to be at moderately (approximately 30%) reduced risk

of endometrial cancer. To date, six population-based case–control studies (Tyler *et al.*, 1985; Lawrence *et al.*, 1987, 1989; Brinton *et al.*, 1993; Newcomer *et al.*, 2001; Weiderpass & Baron, 2001) have examined quantitative measures of smoking in relation to endometrial cancer risk, generally showing inverse associations to be strongest among current smokers of high intensity or long duration.

2.14.2 Confounders

Whereas the majority of these studies adjusted their relative risk estimates for potentially confounding variables, such as BMI, HRT, parity, diabetes, and age at menopause, studies that did not adjust for these variables tended to show similar inverse associations. Within individual studies, statistical adjustment for the effects of BMI and other covariates often made little difference, although some attenuation of relative risk estimates has been noted (Weiderpass & Baron, 2001; Terry *et al.*, 2002c).

2.14.3 Effect modification

The association between smoking and endometrial cancer risk according to factors that are known determinants of endogenous hormone concentrations, and which may counteract or augment possible tobacco-related hormonal changes, have been examined in several studies. These factors include menopausal status, HRT and BMI. Effect modification can reflect true underlying differences in the association across strata (for example, if cigarette smoking acts to reduce or modify estrogen concentrations differently in one group compared with another), but can also reflect methodological factors, such as differences that occur by chance or through the varying prevalence of confounding variables.

(a) Menopausal status

Although endometrial cancer is rare among pre-menopausal women, several studies have examined the association between cigarette smoking and endometrial cancer risk according to menopausal status, because the effect of smoking (if any) might vary according to the underlying hormonal milieu. The studies have included two cohort studies (Terry *et al.*, 2002b; Al-Zoughool *et al.*, 2007), five population-based case–control studies (Smith *et al.*, 1984; Franks *et al.*, 1987; Lawrence *et al.*, 1987; Brinton *et al.*, 1993; Weiderpass & Baron, 2001), and four hospital-based case–control studies (Lesko *et al.*, 1985; Levi *et al.*, 1987; Stockwell & Lyman, 1987; Koumantaki *et al.*, 1989). In all but one of these studies, a study of early stage endometrial cancer (Lawrence *et al.*, 1987), the inverse association was (to varying degrees) stronger among post-menopausal than pre-menopausal women. Among pre-menopausal women, the relative risk estimates for cigarette smoking have been inconsistent, sometimes showing increased risks with certain measures of cigarette smoking (Smith *et al.*, 1984; Stockwell & Lyman, 1987; Koumantaki *et al.*, 1989; Brinton *et al.*, 1993; Al-Zoughool *et al.*, 2007), sometimes showing decreased risks (Lawrence *et al.*, 1987; Levi *et al.*, 1987; Brinton *et al.*, 1993; Terry *et al.*, 2002b), and sometimes showing practically no association (Lesko *et al.*, 1985; Weiderpass & Baron, 2001; Al-Zoughool *et al.*, 2007). In analyses limited to post-menopausal women, on the other hand, all showed between 10% and 80% reduced risks of endometrial cancer with the various smoking measures.

(b) Hormone replacement therapy

Given the possibility that cigarette smoking affects hormone concentrations mostly among women who are taking HRT (Jensen *et al.*, 1985; Jensen & Christiansen, 1988; Cassidenti *et al.*, 1990), the inverse association between tobacco

smoking and endometrial cancer risk might be stronger among HRT users than among non-users. However, the results of studies that have examined the association between smoking and endometrial cancer risk according to HRT use have been equivocal (Weiss *et al.*, 1980; Franks *et al.*, 1987; Lawrence *et al.*, 1987; Levi *et al.*, 1987; Terry *et al.*, 2002b; Beral *et al.*, 2005). Whereas in two studies (Franks *et al.*, 1987; Levi *et al.*, 1987) a larger reduction in risk among smokers taking HRT than among smokers not taking HRT was observed, in two other studies (Lawrence *et al.*, 1987; Terry *et al.*, 2002b) there was no difference in the association according to HRT status. A cohort study that examined associations only among women using HRT showed no clear association among users of continuous combined HRT and cyclic combined HRT, but some suggestion of increased risk among smokers who used tibolone (perhaps more clearly among former smokers) (Beral *et al.*, 2005). Thus, although effect modification by HRT status is biologically plausible, the available epidemiological evidence is equivocal.

(c) Relative body weight

Obesity is an established risk factor for endometrial cancer (IARC, 2002). Smokers tend to have a lower BMI than non-smokers, although former smokers tend to have a higher BMI than current or never smokers (Baron *et al.*, 1990). Two case–control studies have examined the association between cigarette smoking and endometrial cancer risk according to BMI, one population-based (Elliott *et al.*, 1990) and one hospital-based (Levi *et al.*, 1987). Neither of these studies found clear differences in the association between smoking and endometrial cancer risk according to BMI. In a population-based case–control study of early stage endometrial cancer (Lawrence *et al.*, 1987), the inverse association with cigarette smoking tended to become stronger with increasing absolute rather than relative body weight.

2.14.4 Gene polymorphisms

Cigarette smoking and estrogen are both thought to influence cancer risk through pathways that are under the control of specific genes, such as those involved in the formation of bulky DNA adducts by estrogen metabolites (Cavalieri *et al.*, 2000) and both bulky and non-bulky adducts formed by carcinogens in tobacco smoke (Terry & Rohan, 2002). Therefore, studies have been conducted to examine the association between smoking and endometrial cancer risk according to genes that repair these types of DNA damage. In a moderately-sized population-based case–control study no clear effect modification according to certain polymorphisms in the *XPA* and *XPC* genes, both of which are involved in the nucleotide excision repair of bulky DNA adducts and may influence endometrial cancer risk, were found (Weiss *et al.*, 2005, 2006b). A nested case–control study also showed no clear effect modification according to three polymorphisms in *CYP1A1* (McGrath *et al.*, 2007), a gene that encodes microsomal CYP1A1, which contributes to aryl hydrocarbon hydroxylase activity, catalysing the metabolism of PAHs and other carcinogens found in tobacco smoke (Masson *et al.*, 2005). In another nested case–control study some evidence was found that the association between smoking and endometrial cancer may vary according to a polymorphism (Ile^{143}Val) in O^6-methylguanine DNA methyltransferase (*MGMT*). Overall, studies that address the association between smoking and endometrial cancer risk according to genotype are scarce.

2.15 Cancer of the prostate

Many epidemiological studies have examined the association between cigarette smoking and prostate cancer risk, and most have shown no consistent association (Hickey *et al.*, 2001; Levi & La Vecchia, 2001; Batty *et al.*, 2008; Butler

et al., 2009; Huncharek *et al.*, 2010; Table 2.74 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.74.pdf; Table 2.75 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.75.pdf). However, questions remain regarding whether smoking may alter risk in various population subgroups, for example, those defined by certain genotypes, and whether any association with smoking may be stronger for, or limited to, advanced tumours or prostate cancer mortality. Regarding this latter issue, the majority of epidemiological studies, including several large, long-term cohort studies, have reported a positive association between smoking and prostate cancer mortality (Rohrmann *et al.*, 2007; Zu & Giovannucci, 2009). Several studies that examined smoking in relation to both prostate cancer incidence and mortality tend to show positive results only for the latter (Rohrmann *et al.*, 2007; Zu & Giovannucci, 2009). Given the largely null results with respect to prostate cancer incidence, the latter findings suggest that smoking is less likely to be a causal agent in prostate cancer initiation than an agent that acts on existing tumours to promote their progression (Zu & Giovannucci, 2009).

A recent review of smoking and prostate cancer that focused specifically on aggressive and fatal tumours, considered the findings from 14 cohort studies (Zu & Giovannucci, 2009). Nine of these studies showed statistically significant increased risk with at least one smoking measure, and five showed increased risks that were not statistically significant for any measure. Only one study showed no association with any measure of tobacco consumption. Seven studies of various designs examined smoking with respect to indicators of cancer aggressive behaviour at the time of diagnosis. In these studies smoking was associated positively with tumour grade, risk of regional, distant, extraprostatic or metastatic disease, Gleason score, and biochemical outcome (failure) after prostate brachytherapy and in several dose–response associations with the respective endpoint were demonstrated. In one study smoking cessation was associated with a decline in risk compared with that among current smokers.

The association between smoking and prostate cancer risk according to genotype and other potentially effect-modifying factors have been examined in several studies. For example, in a population-based case–control study tobacco use was a risk factor for prostate cancer primarily among men with high BMI (Sharpe & Siemiatycki, 2001). The results of a cohort study in Switzerland suggest that risk of prostate cancer mortality is increased in smokers, particularly those with low plasma vitamin E levels (Eichholzer *et al.*, 1999). These latter associations, as well as those regarding several genotypes that may modify the association (Mao *et al.*, 2004; Nock *et al.*, 2006; Quiñones *et al.*, 2006; Yang *et al.*, 2006; Iguchi *et al.*, 2009; Kesarwani *et al.*, 2009), have yet to be fully clarified.

[The Working Group noted that several of the studies of smoking and prostate cancer mortality did not demonstrate clear dose–response associations with risk, and noted the possibility of bias due to confounding by screening behaviour. However, in the Health Professionals Follow-up Study, screening behaviour was not found to differ appreciably between smokers and non-smokers. In an analysis limited to men with a negative digital rectal examination in the prior two years, stronger associations were found between smoking and metastatic prostate cancer risk among high intensity smokers (RR, 4.2; 95%CI: 1.6–10.9) (Zu & Giovannucci, 2009). This finding was evidence against bias from screening behaviour.]

2.16 Cancer of the ovary

2.16.1 Overview of studies

A total of over 30 epidemiological studies have investigated the association between tobacco smoking and ovarian cancer risk. Of these, 24 were case–control studies (IARC, 2004a; Table 2.76 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.76.pdf; Table 2.77 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.77.pdf) and six were cohort studies (IARC, 2004a; Table 2.78 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.78.pdf; Table 2.79 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.79.pdf). Most studies showed no statistically significant association between a measure of smoking and risk for ovarian cancer overall (Newhouse *et al.*, 1977; Smith *et al.*, 1984; Tzonou *et al.*, 1984; Baron *et al.*, 1986; Stockwell & Lyman, 1987; Whittemore *et al.*, 1988; Hartge *et al.*, 1989; Polychronopoulou *et al.*, 1993; Engeland *et al.*, 1996; Goodman *et al.*, 2001; Goodman & Tung, 2003; Pan *et al.*, 2004; Zhang *et al.*, 2004; Kurian *et al.*, 2005; Niwa *et al.*, 2005; Baker *et al.*, 2006; Huusom *et al.*, 2006; Fujita *et al.*, 2008; Lurie *et al.*, 2008; Nagle *et al.*, 2008; Tworoger *et al.*, 2008); some showed positive associations (Doll *et al.*, 1980; Tverdal *et al.*, 1993; Kuper *et al.*, 2000b; Marchbanks *et al.*, 2000; Green *et al.*, 2001; Modugno *et al.*, 2002; Gram *et al.*, 2008; Rossing *et al.*, 2008) and one (Riman *et al.*, 2004) showed an inverse association.

2.16.2 Histological subtypes

Differences in ovarian cancer risk factor profiles have been observed according to histological type, on the basis of which it has been suggested that mucinous and non-mucinous tumours are etiologically distinct diseases (Risch *et al.*, 1996). Epidemiological studies that have considered histological type tend to support a positive association primarily between cigarette smoking and mucinous ovarian tumours (Kuper *et al.*, 2000b; Marchbanks *et al.*, 2000; Green *et al.*, 2001; Modugno *et al.*, 2002; Pan *et al.*, 2004; Zhang *et al.*, 2004; Kurian *et al.*, 2005; Tworoger *et al.*, 2008). In contrast, two studies showed no clear association between smoking and risk of mucinous or non-mucinous ovarian tumours (Riman *et al.*, 2004; Baker *et al.*, 2006). In addition, one early case–control study (Newhouse *et al.*, 1977), with 300 ovarian cancer cases and with both population and hospital controls, found no clear association with "ever" compared with "never" smoking, and reported no differences according to histological type.

A pooled analysis of 10 case–control studies (Kurian *et al.*, 2005) with 254 cases of mucinous and 1580 non-mucinous tumours found an increased risk of mucinous tumours among current smokers (RR, 2.4; 95%CI: 1.5–3.8), a positive association that was not observed with other histological types. Former smokers in that analysis did not have an increased risk of any histological type of ovarian cancer. This type of dose–response, whereby current smokers have a higher risk than former smokers, was observed in most, but not all, studies of mucinous ovarian cancer (Tables 2.77 and 2.79 online). Overall, the positive association between cigarette smoking and risk of mucinous ovarian tumours is generally consistent across both case–control and cohort studies conducted among various populations. In contrast, associations with smoking have been mostly null with respect to non-mucinous ovarian tumours, suggesting that recall bias is unlikely to explain the association with mucinous tumours.

[The Working Group considered the possibility that women who smoke may come to medical attention more frequently. This raises the possibility of detection bias, because mucinous tumours, benign or malignant, tend to be quite large and could be more easily detected on routine physical exam or testing. However, the

Working Group felt that detection bias would not account for the association entirely.

2.17 Cancer of the thyroid

The previous *IARC Monograph* (IARC, 2004a) noted inconsistent associations between smoking and thyroid cancer risk. In 2003, a pooled analysis of 14 case–control studies showed that smoking was inversely associated with thyroid cancer risk (Mack *et al.*, 2003; Table 2.80 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.80.pdf; Table 2.81 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.81.pdf). The sample consisted of 2725 thyroid cancer cases (2247 women, 478 men) and 4776 controls (3699 women, 1077 men). The inverse association was stronger among current smokers (RR, 0.6; 9% CI: 0.6–0.7) than former smokers (RR, 0.9; 9% CI: 0.8–1.1) and were similar in both men and women, for both papillary and follicular thyroid cancers, as well as by age and region. An inverse association between smoking and thyroid cancer risk was also found in a subsequent case–control study (Nagano *et al.*, 2007). In contrast, two case–control studies (Zivaljevic *et al.*, 2004; Bufalo *et al.*, 2006) reported no clear association between smoking and thyroid cancer risk (no risk ratio estimates were reported; hence, data are not shown in the tables) and a cohort study with 169 incident cases of thyroid cancer, also found no clear association with any qualitative or quantitative smoking measure (Navarro Silvera *et al.*, 2005; Table 2.82 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.82.pdf; Table 2.83 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.83.pdf).

2.18 Other cancers

The cancers reviewed in this section generally have low incidence and mortality rates and are not considered to be strongly associated with cigarette smoking. This raises the possibility of preferential reporting of positive associations in epidemiological studies.

2.18.1 Cancer of the salivary gland

Studies of smoking and cancers of the salivary gland reviewed in the previous *IARC Monograph* (IARC, 2004a) were sparse and their results were inconsistent (Spitz *et al.*, 1990; Swanson & Burns, 1997; Hayes *et al.*, 1999). A few additional studies also show inconsistent results (Kotwall, 1992; Pinkston & Cole, 1996; Horn-Ross *et al.*, 1997; Vories & Ramirez, 1997; Muscat & Wynder, 1998). Studies that focused specifically on Warthin's tumour [papillary cystadenoma lymphomatosum or adenolymphoma, a benign tumour of the parotid gland] tend to show strong positive associations with smoking (Kotwall, 1992; Pinkston & Cole, 1996; Vories & Ramirez, 1997). One study (Pinkston & Cole, 1996) compared the risk for Warthin's tumour with that for other salivary gland tumours and found that smoking increased risk significantly only for Warthin's tumour.

2.18.2 Cancer of the small intestine

Epidemiological studies (all of case–control design) reviewd in the previous *IARC Monograph* (IARC, 2004a) have been inconsistent in showing a positive association between smoking and cancers of the small intestine (Chow *et al.*, 1993b; Chen *et al.*, 1994; Wu *et al.*, 1997; Negri *et al.*, 1999; Kaerlev *et al.*, 2002). A more recent study showed no clear association (Hassan *et al.*, 2008b).

2.18.3 Cancers of the gallbladder and extra-hepatic bile ducts

Epidemiological studies of smoking and risk of cancers of the gallbladder and extra-hepatic bile ducts reviewed in the previous *IARC Monograph* (IARC, 2004a) tended to show null, weak, or moderately strong positive associations. More recent studies also tend to show either no clear association with biliary tract carcinoma/extra-hepatic cholangiocarcinoma (Shaib *et al.*, 2007; Welzel *et al.*, 2007) or suggest positive associations with gallbladder/biliary cancers (Pandey & Shukla, 2003; Yagyu *et al.*, 2008; Grainge *et al.*, 2009). Attention should be paid to potential confounders, especially BMI, when considering the results of epidemiological studies of risk of cancers of the gallbladder and extra-hepatic bile ducts. Recent studies that statistically adjusted for BMI, on gallbladder disease risk (Grainge *et al.*, 2009) or on extrahepatic biliary tract carcinoma risk (Ahrens *et al.*, 2007), showed a positive and null association with smoking, respectively. To date, there are too few studies with adequate control for potentially confounding factors to determine any clear pattern.

2.18.4 Soft-tissue sarcoma

As reported in the previous *IARC Monograph* (IARC, 2004a), one cohort study found an association between cigarette smoking and mortality from soft-tissue sarcoma after 26 years of follow-up but no dose–response relationship with the number of cigarettes/day, duration of smoking or pack–years (Zahm *et al.*, 1992). No effect of cigarette smoking was detected in an Italian hospital-based case–control study (Franceschi & Serraino, 1992).

2.18.5 Cancer of the skin

(a) Melanoma

Several case–control studies found no difference in the prevalence of tobacco smoking between patients with malignant melanoma and controls, and one study found an inverse association (IARC, 2004a). An inverse association with smoking was also found in the US Radiologic Technologists cohort Study (Freedman *et al.*, 2003a). In that study, smoking for at least 30 years compared with never smoking was inversely related to melanoma risk (RR, 0.6; 95%CI: 0.3–1.3), though risk was not associated with number of cigarettes/day. An inverse association was also observed in a cohort of Swedish construction workers (Odenbro *et al.*, 2007). In this study, the risk for malignant melanoma was reduced in a dose-dependant manner for both cigarette and pipe smokers. The possibility that smoking may reduce the risk for melanoma should, therefore, be considered.

(b) Non-melanoma skin cancer

Four studies showed a positive association between smoking and non-melanoma skin cancer risk (De Stefani *et al.*, 1995; Wojno, 1999; Smith & Randle, 2001; Boyd *et al.*, 2002), and two found no clear association (van Dam *et al.*, 1999; Corona *et al.*, 2001). When distinguishing between histological subtypes, tobacco smoking was linked to the incidence of squamous-cell carcinoma of the skin in most studies, whereas the results for basal cell carcinoma remain inconsistent (Zak-Prelich *et al.*, 2004). No clear association between smoking and risk for basal cell carcinoma was found in a cohort study (Freedman *et al.*, 2003b).

2.18.6 Cancer of the penis

Case–control studies of smoking and penile cancer (Hellberg *et al.*, 1987; Daling *et al.*, 1992, 2005; Maden *et al.*, 1993; Harish & Ravi, 1995;

Table 2.84 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.84.pdf; Table 2.85 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.85.pdf) and reviews of studies of smoking and penile cancer and population surveys (Dillner *et al.*, 2000; Favorito *et al.*, 2008; Bleeker *et al.*, 2009; Table 2.86 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.86.pdf; Table 2.87 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.87.pdf) consistently showed a positive association. In most studies there was a dose–response relationship, with higher risks among those with increased smoking intensity and/or duration. A study in Brazil showed a positive correlation with penile tumour grade (Favorito *et al.*, 2008). Based on the two reviews (Dillner *et al.*, 2000; Bleeker *et al.*, 2009), relative risks were generally increased twofold to fivefold among smokers.

Most studies did not adjust for HPV infection. In one case–control study (Daling *et al.*, 2005), current smoking was associated with a 160% increased risk of HPV-positive penile cancer (n = 75), and a 180% increased risk of HPV-negative penile cancer (n = 19), suggesting no important effect modification.

2.18.7 Cancer of the testis

Studies reviewed in the previous *IARC Monograph* (IARC, 2004a) showed no association between cigarette smoking and risk for testicular cancer. More recently, two case–control studies showed positive associations with smoking, one in Canada (Srivastava & Kreiger, 2004) and one in the Czech Republic (Dusek *et al.*, 2008).

2.18.8 Cancer of the central nervous system

A recent meta-analysis was conducted on smoking in relation to glioma risk (Mandelzweig *et al.*, 2009), which included 17 epidemiological studies (6 cohort and 11 case–control). It was concluded that smoking is not associated with risk of glioma, despite a small significant increased risk seen in cohort studies. A recent cohort study found no association between smoking and carcinoma of the brain (Batty *et al.*, 2008). There have been no consistent associations of smoking with other CNS tumours (IARC, 2004a). In a population-based case–control study in the USA, smoking was associated with increased risk of intracranial meningioma in men (OR, 2.1; 95%CI: 1.1–4.2) but not in women (Phillips *et al.*, 2005).

2.18.9 Cancer of the adrenal gland

Data on risk factors for adrenal carcinoma are sparse. In the US Veterans' Study there was a fivefold increase in risk among current cigarette smokers during 26 years of follow-up, with risk being particularly high among those who smoked most intensely (Chow *et al.*, 1996). Other forms of tobacco use were associated with a statistically non-significant increase in risk. A case–control study in the USA found a twofold increase in risk for adrenal cancer among heavy smokers in men, but not in women (Hsing *et al.*, 1996).

2.19 Bidi smoking

2.19.1 Cancer of the oral cavity

(a) Overview of studies

The association between cancers of oral cavity and bidi smoking has been examined in 10 case–control studies conducted in India (Sankaranarayanan *et al.*, 1989a, b, 1990a; Rao *et al.*, 1994; Rao & Desai, 1998; Dikshit & Kanhere, 2000; Balaram *et al.*, 2002; Znaor *et al.*, 2003; Subapriya *et al.*, 2007; Muwonge *et al.*, 2008; Table 2.88 available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.88.pdf). In these studies both cases and controls were interviewed and analyses were restricted

to men, except for the studies by Balaram *et al.* (2002) and Subapriya *et al.* (2007), because very few women smoked among study subjects.

Three hospital-based case–control studies considered cancers of subsites of the oral cavity (gingiva, tongue and floor of the mouth, buccal and labial mucosa) (Sankaranarayanan *et al.*, 1989a, b, 1990a). All three studies showed a higher oral cancer risk for bidi smoking. In one early study an unadjusted relative risk of 1.6 (95%CI: 1.3–2.0) for oral cancer in bidi smokers was reported (Rao *et al.*, 1994). [The Working Group noted that the study had several deficiencies, particularly in the selection of controls that resulted in cigarette smoking apparently being protective for oral cancer.] In another early study (Rao & Desai, 1998) relative risks were estimated after stratification by age and place of residence. Bidi smoking was a significant risk factor for cancer of the base of the tongue (RR, 5.9; 95%CI: 4.2–8.2) but not significant for cancer of the anterior tongue. Relative risk for bidi smoking adjusted for alcohol drinking, illiteracy, non-vegetarian diet and tobacco chewing showed significant risk for cancer of the base of the tongue (RR, 4.7; 95%CI: 3.5–6.3) but not for cancer of the anterior tongue. In a population-based case–control study a relative risk of 1.5 (95%CI: 0.9–2.4), adjusted for age and tobacco quid chewing for smokers (bidis and/or cigarettes), was found (Dikshit & Kanhere, 2000).

Two hospital-based multi centre case–control studies on cancer of the oral cavity were conducted in southern India. One included 309 cases and 292 controls (Balaram *et al.*, 2002). The risk for oral cavity cancer among those who smoked < 20 bidis per day was 2.0 (95%CI: 1.1–3.8) and 2.5 (95%CI: 1.4–4.4) for ≥ 20 per day. The second study included 1563 cases and 3638 controls and found a risk for bidi smoking only of 2.2 (95%CI: 1.75–2.63) compared to never smokers, adjusted for age, centre, level of education, alcohol consumption and chewing (Znaor *et al.*, 2003).

In a hospital-based case–control study with 388 oral squamous cell carcinoma cases (202 men and 186 women) and an equal number of age and sex-matched controls the effect of lifestyle factors (tobacco chewing, smoking and alcohol drinking, diet and dental care) on the risk of oral cancer was evaluated (Subapriya *et al.*, 2007). Both cases and controls were interviewed using a structured questionnaire. The risk estimate for bidi smoking based on 22 cases (84 cases included in the model) and 22 controls was 4.6 (95%CI not given).

Data from a randomized control trial conducted between 1996 and 2004 in Trivandrum, southern India were used in a nested case–control analysis with 282 (163 men and 119 women) incident oral cancer cases and 1410 matched population controls aged 35 years and over (Muwonge *et al.*, 2008). Oral cancer risk among men, adjusted for education and religion, was 1.9 (95%CI: 1.1–3.2) for bidi smokers only compared to never smokers. No association was found between mixed smoking of bidi and cigarette and risk of oral cancer.

Rahman *et al.* (2003) performed a meta-analysis to investigate the relationship between bidi smoking and oral cancer. They identified 12 case–control studies published in English during 1996–2002 with quantitative information on bidi smoking and oral cancer. Of these, ten studies were conducted in India, one in Sri Lanka and one in Pakistan. All cases were confirmed histologically and exposure data were collected by direct interview. In these studies ORs were not adjusted for tobacco chewing or alcohol drinking. The OR for bidi smokers compared to never smokers based on random effects model was 3.1 (95%CI: 2.0 –5.0). The ORs ranged from 2.0 to 3.6 in different regions of India: studies conducted in Mumbai had an OR of 3.6 (95%CI: 1.6 –7.9), in central India 2.7 (95%CI: 1.6–4.6), in Kerala 2.0 (95%CI: 1.5–2.9) and in Bangalore 2.0 (95%CI: 1.1–3.7).

(b) Dose–response evidence

The trends in relative risks by intensity and duration of bidi smoking were both statistically significant in two studies (Rao *et al.*, 1994; Rao & Desai, 1998). A meta-analysis based on three studies on duration of bidi smoking and on five studies on number of bidi sticks per day, showed a dose–response relationship for duration of bidi smoking but not for number of sticks used per day (Rahman *et al.*, 2003).

In a nested case–control analysis (Muwonge *et al.*, 2008) a dose–response relationship was observed for duration of bidi smoking ($P = 0.045$). [It is not clear if the analysis was restricted to bidi smokers only (n = 40 men) and if smokers with combined smoking habits (bidi and cigarette) were excluded. Moreover, ORs for the dose–response analysis were not reported.]

2.19.2 Cancer of the pharynx

Five case–control studies, two hospital-based (Wasnik *et al.*, 1998; Rao *et al.*, 1999), one population-based (Dikshit & Kanhere, 2000) and two multicentric studies (Znaor *et al.*, 2003; Sapkota *et al.*, 2007) were conducted on cancers of oropharynx and hypopharynx in India (Table 2.88 online). In all these studies, analyses were restricted to men because very few women smoked among study subjects.

Wasnik *et al.* (1998) conducted a case–control study on oropharyngeal cancers with cases and controls were matched on age and sex. Odds ratios for tobacco smoking, predominantly in the form of bidi and/or chillum, were 2.3 (95%CI: 1.2–3.7) after adjustment for tobacco chewing and outdoor occupation. [The Working Group noted some problems with the data analysis.]

Rao *et al.* (1999) reported a relative risk for bidi smoking adjusted for alcohol, illiteracy, diet and tobacco chewing of 4.7 (3.6–6.3) for oropharyngeal cancer and of 2.8 (2.1–3.7) for cancer of the hypopharynx. Dikshit & Kanhere (2000) found an odds ratio for oropharyngeal cancer among bidi smokers only of 7.9 (95%CI: 5.1–12.4).

Znaor *et al.* (2003) reported a risk for bidi smoking only for pharyngeal cancer of 4.7 (95%CI: 3.5–6.3) and for combined bidi and cigarette smoking of 3.6 (95%CI: 2.55–4.98). Sapkota *et al.* (2007) reported an odds ratio for hypopharyngeal cancer of 6.8 (95%CI: 4.6–10.0) for bidi smokers compared to never smokers.

A dose–response relationship was observed for intensity and duration of bidi smoking for both cancers of oropharynx and hypopharynx (Rao *et al.*, 1999; Dikshit & Kanhere, 2000; Sapkota *et al.*, 2007).

2.19.3 Cancer of the lung

One cohort study (Jayalekshmy *et al.*, 2008), one population-based case–control study (Dikshit & Kanhere, 2000) and two hospital-based case–control studies (Gupta *et al.*, 2001; Gajalakshmi *et al.*, 2003) in India (Table 2.88 online) have investigated the relationship between bidi smoking and lung cancer. In all these studies both cases and controls were interviewed and analyses were restricted to men because very few women smoked among study subjects. One hospital-based case–control study in Chiang Mai, Thailand, looked at the association between lung cancer and *khii yoo,* hand-rolled cigars. The risk for lung cancer for *khii yoo* smoking was 1.2 in men and 1.5 in women, $P > 0.05$ (Simarak *et al.*, 1977).

In the population based case–control study by Dikshit & Kanhere (2000) the age-adjusted relative risk for lung cancer among bidi smokers only was 11.6 (95%CI: 6.4–21.3).

Gupta *et al.* (2001) reported an odds ratio for bidi smoking of 5.8 (95%CI: 3.4–9.7) from a hospital-based case–control study of lung cancer conducted in Chandigarh. Gajalakshmi *et al.* (2003) conducted a case–control study in two centres in which all subjects were interviewed by trained social investigators with standard

questionnaires. Odds ratios were adjusted for age, educational level, centre, chewing and alcohol habit. The odds ratios of lung cancer for former and current bidi smokers were 3.4 (95%CI: 2.1–5.4) and 5.3 (95%CI: 3.8–7.3), respectively. Odds ratios for former and current smokers of cigarette and bidi combined were 4.0 (95%CI: 2.5–6.6) and 9.1 (95%CI: 6.2–13.2), respectively.

Baseline data of a cohort of 359 619 residents in Kerala, India was collected by direct interview using standardized questionnaires during 1990–97 (Jayalekshmy *et al.*, 2008). After excluding rare earth workers, those who died, were diagnosed with cancer before 1997 or died within three years of interview, there were 65 829 bidi-smoking men aged 30–84 years old. Two hundred and twelve lung cancer cases were identified by the Karunagappally Cancer Registry between 1997 and 2004. The relative risk for lung cancer for current compared to never bidi smokers calculated by Poisson regression analysis and adjusted for age, religion and education was 3.9 (95%CI: 2.6–6.0; $P < 0.001$). The risk was lower among former than among current smokers.

(a) Dose–response evidence

Lung cancer risks increased with increasing bidi smoking intensities. The highest odds ratio was found for 9 pack–years (3.9; 95%CI: 2.1–7.1) (Gupta *et al.*, 2001). In a cohort study Jayalekshmy *et al.* (2008) found increased lung cancer incidence with increasing number of bidi sticks smoked per day ($P < 0.001$) and with increasing duration of bidi smoking ($P < 0.001$). [The number of lung cancer cases was small in each category, resulting in wide confidence intervals.] Gajalakshmi *et al.* (2003) also reported increased risk with duration and intensity of bidi smoking.

(b) Cessation of smoking

In two case–control studies (Gupta *et al.*, 2001; Gajalakshmi *et al.*, 2003) there was a clear decreasing trend in risk for years since quitting. Gajalakshmi *et al.* (2003) reported that lung cancer risk of former bidi smokers fell to 0.4 (0.1–1.2) after quitting for more than 15 years. The cohort study conducted in Kerala did not have the power to assess the risk associated with stopping bidi smoking (Jayalekshmy *et al.*, 2008).

2.19.4 Cancer of the larynx

Two hospital based case–control studies (Sankaranarayanan *et al.*, 1990b; Rao *et al.*, 1999) showed a higher risk for bidi smokers (Table 2.88 online). The relative risk was adjusted for age and religion in Sankaranarayanan *et al.* (1990b) study and for alcohol use, illiteracy, vegetarian/non-vegetarian diet and tobacco chewing in Rao *et al.* (1999) study. A multicentre case–control study on laryngeal cancer was conducted in four Indian centres using standardized questionnaires adjusting risks for centre, age, socio-economic status, alcohol consumption, tobacco snuffing and tobacco chewing (Sapkota *et al.*, 2007). Compared to never smokers bidi smokers had a higher risk for cancers of the supraglottis (OR, 7.5; 95%CI: 3.8–14.7), glottis (OR, 5.3; 95%CI: 3.2–8.9) and rest of larynx (OR, 9.6; 95%CI: 5.6–16.4).

All levels of intensity and duration of bidi smoking were associated with significant relative risk estimates and dose–response for laryngeal cancer (Sankaranarayanan *et al.*, 1990b; Rao *et al.*, 1999). A strong dose–response relationship was observed for duration and frequency of bidi smoking for cancers of supraglottis, glottis and rest of larynx (Sapkota *et al.*, 2007).

2.19.5 Cancer of the oesophagus

Three hospital-based case–control studies and one multicentre study (Sankaranarayanan *et al.*, 1991; Nandakumar *et al.*, 1996; Nayar *et al.*, 2000; Znaor *et al.* 2003) showed increased risk for oesophageal cancer among bidi smokers in India (Table 2.88 online). A significantly elevated

risk for all three segments of the oesophagus was reported (Nandakumar *et al.*, 1996). One study (Nayar *et al.*, 2000) adjusted for chewing of betel leaf with tobacco and low consumption of vegetables other than leafy vegetables. The multicentre case–control study conducted in two centres in South India found an increased risk for oesophageal cancer for bidi smoking only (OR, 3.3; 95%CI: 2.45–4.39) (Znaor *et al.*, 2003). Odds ratios were adjusted for age, centre, level of education, alcohol consumption and chewing. Only men were analysed in all the above studies.

Significant effects were noted in men for all levels of intensity and for duration of more than 20 years of bidi smoking (Sankaranarayanan *et al.*, 1991).

2.19.6 Cancer of the stomach

In a hospital-based case–control study the association between stomach cancer and bidi smoking was analysed as part of a multicentre study (Gajalakshmi & Shanta, 1996). Cases and controls were matched on age, sex, religion and mother tongue. The odds ratio for stomach cancer for current bidi smokers only was 3.2 (95%CI: 1.8–5.7) and for current smokers of any type of tobacco was 2.7 (95%CI: 1.8–4.1).

Table 2.88 (online) summarizes the studies published since the last *IARC Monograph* (IARC, 2004a). A hospital-based case–control study of stomach cancer included 170 stomach cancer cases (121 men and 49 women) and 2184 controls (1309 men and 875 women) aged 30–75 years (Rao *et al.*, 2002). The association between bidi smoking and stomach cancer was not significant (RR, 0.8; 95%CI: 0.5–1.2) in a univariate analysis. The risk increased with increase in lifetime exposure to bidi smoking and was highly significant ($P < 0.001$).

One study investigated stomach cancer risk in association with smoking of *meiziol*, a local cigarette in Mizoram, India (Phukan *et al.*, 2005). Statistically significant higher risks were seen for smokers of combined users of tobacco (cigarette and *meiziol*), with an odds ratio of 3.1 (95%CI: 2.0–11.1). Among users of a single type of tobacco, higher risks were seen for *meiziol* smokers (OR, 2.2; 95%CI: 1.3–9.3) in the multivariate model in comparison to cigarette smokers. Overall, the excess risk was limited to smokers of > 10 *meiziols* per day.

2.20 Synergistic effects of tobacco smoking and alcohol drinking

This section addresses the combined effects of smoking and alcohol consumption on cancers of oral cavity, pharynx, larynx and oesophagus, which have been examined extensively. For the purposes of this report interdependence of effects is termed *effect modification*, and *synergism* and *antagonism* are used to describe the consequences of the interdependence of disease risk when both risk factors are present (Rothman & Greenland, 1998). The studies varied in their methods and in the approaches used to assess effect modification, which ranged from descriptive to formal estimation of interaction terms in multivariate models. Study designs of the case–control and cohort studies are presented in Table 2.89 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.89.pdf) and Table 2.90 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.90.pdf), respectively; and the results for both study designs are presented in Table 2.91 (available at http://monographs.iarc.fr/ENG/Monographs/vol100E/100E-01-Table2.91.pdf).

2.20.1 Cancers of the upper aerodigestive tract

It was noted in the previous *IARC Monograph* (IARC, 2004a) with relatively large numbers of cases and controls that the pattern of increasing cancer risk with increasing alcohol consumption is strong (Mashberg *et al.*, 1993; Kabat *et al.*, 1994).

For cancers of the oral cavity, recent evidence comes from seven case–control studies and one cohort study. The pattern of odds ratios for smoking, across categories of alcohol consumption, is consistent with synergism. In four case–control studies with relatively large numbers of cases and controls (more than 200 cases and equivalent number of controls), the pattern of increasing cancer risks with increasing alcohol consumption was strong (Schlecht *et al.*, 1999b; Znaor *et al.*, 2003; Castellsagué *et al.*, 2004; Hashibe *et al.*, 2009). In the cohort study from Taiwan, China (Yen *et al.*, 2008) similar strong risks were also observed. In all four case–control studies in which the estimate of formal statistical interaction was examined, the tests were statistically significant (Schlecht *et al.*, 1999b; Znaor *et al.*, 2003; Castellsagué *et al.*, 2004; Hashibe *et al.*, 2009). In two case–control studies from India (Znaor *et al.*, 2003; Muwonge *et al.*, 2008) and in the cohort study from Taiwan, China (Yen *et al.*, 2008) the interaction of tobacco smoking, alcohol and betel quid chewing was examined. In general, the results suggested increasing risks when betel quid chewing was included in the model.

Five case–control studies and one cohort study examined the effect of interaction between tobacco and alcohol in pharyngeal cancer. The results from case–control studies were similar to those observed for oral cancer (Olsen *et al.*, 1985b; Choi & Kahyo, 1991; Schlecht *et al.*, 1999b; Znaor *et al.*, 2003; Hashibe *et al.*, 2009). In a Singapore cohort study (Friborg *et al.*, 2007) the pattern of odds ratios for smoking across categories of alcohol consumption was consistent with synergism for oropharyngeal but not for nasopharyngeal cancer.

Two cohort and fourteen case–control studies reported on joint effects of tobacco smoking and alcohol drinking on the risk for oesophageal cancer. Since multiple logistic regression models were used for analysing most of these studies, some of them tested likelihood ratio test for departure from multiplicativity of the individual effects of tobacco and alcohol. Generally, the positive results were stronger for squamous cell carcinoma. However, these tests for interaction are inadequate to assess synergy. Four studies from India and Taiwan, China, included betel quid chewing to the joint effect analysis of tobacco smoking and alcohol consumption and the results suggested increasing risks of oesophageal cancer.

Most of the twenty case–control studies of laryngeal cancer provided strong evidence for synergism of tobacco smoking and alcohol consumption. Only Zheng *et al.* (1992) did not find consistent evidence with synergism. In several studies, tests for interaction were carried out and reported to be 'non significant.' These were tests for departure from the multiplicative models, typically multiple logistic regression models, used to analyse the case–control data, and not tests for departure from additive model.

Several studies (14 case–control, 3 cohort) reported on cancer of the 'mixed upper aerodigestive tract', comprising studies on squamous cell carcinomas, regardless of specific sites. These studies also provided strong evidence for synergism.

The Working Group considers that there is strong evidence of tobacco smoking and alcohol consumption interaction on the incidence of upper aerodigestive tract cancers, as well as with regard to cancer of specific subsites of this anatomical region.

2.21 Synthesis

2.21.1 Lung

Tobacco smoking is the major cause of lung cancer, primarily from cigarettes. Duration of smoking is the strongest determinant of lung cancer in smokers. Risk also increases in proportion to the number of cigarettes smoked. The strong dose– and duration–response

relationships between lung cancer and tobacco smoking have been confirmed more recently in both questionnaire-based and biomarker-based studies. Tobacco smoking increases the risk of all histological types of lung cancer.

Differences in the intensity and/or duration of tobacco smoking may explain, in part, the lower lung cancer risks in Asian populations relative to whites. However, several studies of genetic polymorphisms among African-American and Caucasian populations provide some preliminary evidence supporting the hypothesis of a racial/ethnic disparity in susceptibility.

The results from observational studies do not provide strong support that a higher intake or a greater circulating concentration of carotenoids reduce lung cancer risk, particular in light of the elevated risk of lung cancer observed in the randomized trials of β-carotene supplementation. Residual confounding from smoking and the possibility that carotenoid measurements are serving as markers for a diet rich in total fruit and vegetables mitigate the likelihood of any protective role for total carotenoids or β-cryptoxanthins.

The specific genes that are responsible for enhanced lung cancer risk remain poorly understood, in spite of hundreds of candidate gene studies. Single-gene studies conducted to date have several limitations which contribute to inconclusive results, including small sample size and associated low power to detect moderate risks when allele frequencies are low.

2.21.2 Upper areodigestive tract

(a) Oral cavity

Tobacco smoking is causally associated with cancer of the oral cavity in both men and women. Since the previous *Monograph*, additional evidence has accumulated that further confirms the association. Risk increases with duration and intensity of smoking, and decreases after quitting.

(b) Pharynx

Tobacco smoking is an important cause of oropharyngeal and hypopharyngeal cancers. The risk increases with increasing duration and intensity of smoking and decreases with increasing time since quitting.

(c) Nasal cavity and accessory sinuses

The evidence of an association between tobacco smoking and sinonasal cancer is based on the results from case–control studies, each of which may be subject to different sources of bias. However, presence of a dose–response relationship in most studies, the decrease in risk associated with time since quitting, the consistently higher risks for squamous-cell carcinoma than for adenocarcinoma and the lack of potential confounders support the existence of a causal association.

(d) Nasopharynx

Although the interpretation of the results is complicated by small sample sizes in several studies, by different criteria used for the selection of controls and by the control groups in some studies including smoking-related diseases, the combined evidence shows an association between tobacco smoking and nasopharyngeal carcinoma in both endemic and non-endemic areas. Most studies that adjusted for known and suspected causes of nasopharyngeal carcinoma such as intake of Chinese-style salted fish, other dietary factors, alcohol drinking and family history of nasopharyngeal carcinoma, suggested only a limited confounding effect of these factors. Adjustment for infection with Epstein–Barr virus (human herpes virus 4), a major cause of nasopharyngeal carcinoma worldwide, was possible in just one of the available studies. However, it is unlikely that confounding by infection with Epstein–Barr virus would explain the observed association between tobacco smoking and risk for nasopharyngeal carcinoma.

(e) Oesophagus

Several well conducted case–control studies found a statistically significant higher risk for adenocarcinoma of the oesophagus in smokers than in nonsmokers. Positive dose–response relationships obtained using various indicators of amount smoked support a causal association, which is further corroborated by the findings of decreasing risks after smoking cessation. Several of these studies reported relative risks adjusted for alcohol consumption and other potential confounders. Further risk factors, such as chewing betel quid with tobacco or use of other forms of smokeless tobacco, have not been considered in these populations, but are not likely to be strong confounders. Studies from Australia, China and Europe also found increased risks for smokers.

(f) Larynx

Laryngeal cancer is one of the cancers most strongly associated with cigarette smoking. Recent epidemiological evidence strengthens this conclusion.

2.21.3 Stomach

The additional epidemiologic data showing a consistent association of stomach cancer with tobacco smoking in both men and women greatly strengthens the previous conclusion of a causal association. There was insufficient evidence for differential risks between cardia and non-cardia stomach cancer. Confounding and effect modification by H. pylori has not been found.

2.21.4 Pancreas

The additional data supports the previous evaluation that cancer of the pancreas is causally associated with tobacco smoking. The risk increases with increasing daily consumption levels and duration of smoking and decreases with increasing time since cessation of smoking. The risk remains elevated after accounting for potential confounding factors.

2.21.5 Colorectum

At the previous evaluation, there was already some evidence from prospective cohort and case–control studies that the risk of colorectal cancer is increased among tobacco smokers. However, inadequate adjustment for various potential confounders was considered to possibly account for some of the small increase in risk that appears to be associated with smoking. Since then, an appreciable amount of data has accumulated to support a causal association with smoking. In virtually all the cohort studies published since elevated risk associated with smoking was found, although not always statistically significant. More than half of the cohort studies that assessed dose–response relationships found statistically significant increasing risks with increasing daily cigarette consumption, duration of smoking and/or pack–years of smoking. Risk of colorectal cancer decreased with increasing delay in smoking initiation and years since cessation of smoking. A meta-analysis based on 36 cohort studies with data from a total of 3 million subjects found a significantly 15% increased risk of colorectal cancer and 27% higher risk of colorectal cancer mortality in current smokers compared to never smokers. A stronger association with smoking for rectal cancer than for colon cancer was found in the meta-analysis of the subset of cohort studies that differentiated colorectal cancer by site. Risk for colorectal cancer increased significantly by 17% and by 38% with 20 cigarettes and 40 cigarettes/day, respectively, and was elevated by 9.4% and by 19.7% with a 20-year and a 40-year duration of smoking, respectively. While these results are persuasive, this meta-analysis could not correct for the potential confounders in the individual studies. Convincing evidence has been provided by three large cohort studies that adjusted for at

least four important potential confounders (i.e. physical activity, alcohol consumption, body mass index and dietary intake of fruits and vegetables and/or meat); two studies also adjusted for history of colonoscopy. Significant dose–response relationships were found with one or more of the smoking variables, for risk of colorectal cancer and/or colon cancer and/or rectal cancer. Earlier cohort studies may not have been able to establish the association because of insufficient follow-up time and a limited number of cases. Updated results of several large cohort studies, which now show clearly significant increased risk of colorectal cancer associated with smoking, provide support for the lag-time hypothesis for smoking and colorectal risk.

Recent evidence suggests that smoking may be associated with the subtype of colorectal cancer characterized by microsatellite instability, and by CIMP status and BRAF mutation. For this subtype, the magnitude of risk associated with smoking reaches the twofold risk elevation consistently observed for colorectal adenomas and supported by a recent meta-analysis. Smoking has been associated with a stronger risk for hyperplastic polyps than for adenomas. Also, CIMP positivity and BRAF mutations have been associated with hyperplastic polyps, particularly serrated polyps. These data suggest that smoking may be associated primarily with a subtype of colorectal cancer that develops through a hyperplastic (serrated) polyp progression. The association with smoking may therefore be diluted when considering colon cancers overall.

2.21.6 Liver

Recent studies on smoking and hepatocellular carcinoma supports the established causal relationship. Supporting evidence comes from the consistency of the findings across regions (with the best evidence coming from Asian studies), and the observations of an association among non-drinkers and after controlling for hepatitis B or C virus infection.

2.21.7 Kidney

Recent evidence supports a causal association between kidney cancer and smoking. After adjustment for body mass index and hypertension, current and former smokers still had a greater risk for renal-cell cancer. A dose–response relationship with the number of cigarettes smoked has been noted in most studies, and a few also noted a reduction in risk after cessation.

2.21.8 Urinary bladder

Tobacco smoking is causally associated to bladder cancer, based on a large number of case–control and cohort studies that showed statistically significant associations not explained by confounding or bias. Risk increased with the duration of smoking and the number of cigarettes smoked. Also, stopping smoking at any age avoids the further increase in risk incurred by continued smoking. The evidence supporting a modulating role by *NAT2* polymorphisms is convincing.

2.21.9 Myeloid leukaemia

There is evidence for a causal association of tobacco smoking with myeloid leukaemia.

2.21.10 Breast

New evidence from cohort and case–control studies and from meta-analyses of genetic polymorphisms has become available since the previous *IARC Monograph* (IARC, 2004a). Results from seven new cohort studies consistently show a small overall association between current smoking and breast cancer incidence, with relative risk estimates ranging from 1.1–1.3 in studies with at least 100 exposed cases. The overall association is weaker than that observed with other cancers that have been designated as causally related to smoking, and the dose–response relationships (with years of smoking,

cigarettes smoked per day, age at initiation) are correspondingly small.

Emerging evidence from case–control studies suggests that inherited polymorphisms in the *NAT2* gene, which encode the slow acetylator phenotype, may modify (increase) the association between smoking and breast cancer. The p-value for interaction with pack–years of smoking as a continuous variable is statistically significant (P = 0.03) and another small study published since this meta-analysis supports the conclusion. The potential for publication bias remains of concern.

It is biologically plausible that tobacco smoke could be causally related to breast cancer risk. There are multiple chemicals in tobacco smoke that are known to cause mammary cancer in rodents. These substances reach the breast in humans; some are stored in adipose tissue, and some can be detected in nipple aspirate and DNA adducts.

Hypotheses have been proposed to explain why numerous well conducted epidemiological studies have generally not observed strong or consistent associations between tobacco smoking and breast cancer. Underlying all of these is the theory that tobacco smoking may have both protective and detrimental effects on breast cancer risk, which cancel each other out and which could explain the atypical dose–response relationship that has been reported between tobacco smoke and breast cancer from some studies.

2.21.11 Cervix

The largely positive findings observed in studies of cohort design, the relatively high consistency of positive associations found for squamous-cell carcinoma of the cervix (but not adenocarcinomas) across all epidemiological studies, including those with adjustment for a wide range of potentially confounding variables, and the positive associations observed in studies restricted to HPV-positive individuals, all argue against the observed positive association being due to recall or selection bias or confounding.

2.21.12 Endometrium

The results of epidemiological studies to date, including recent studies, largely show inverse associations of smoking with risk of postmenopausal endometrial cancer. However, the Working Group noted the few studies of premenopausal cancer that were less consistent, as well as indications of an increased risk among smokers in a recent multicentre European study.

2.21.13 Prostate

Many epidemiological studies have examined the association between cigarette smoking and prostate cancer risk, and most have shown no consistent association. The question remains whether smoking may alter risk in various population subgroups.

2.21.14 Ovary

A causal association between cigarette smoking and risk for mucinous ovarian tumours is indicated by 1) the consistency of the positive association across the large majority of ten pooled case–control studies and ten additional independent epidemiological studies of both case–control and cohort design, 2) the relatively strong magnitude of the association (typically greater than a doubling of risk among current smokers), 3) the tendency to show dose–response associations with risk, such that current smokers generally have higher risk than former smokers and the dose–response observed with measures of smoking intensity in some (but not all) studies, and 4) the specificity of the positive association with the mucinous histological type, which argues against recall bias as an explanation of the findings.

2.21.15 Thyroid

A pooled analysis of 14 case–control studies showed that smoking was inversely associated with thyroid cancer risk. Similar inverse associations were also observed in two subsequent case–control studies.

2.21.16 Other sites

There is inconsistent or sparse evidence for an association between tobacco smoking and other cancer sites that were considered by the Working Group.

2.21.17 Bidi smoking

Overall, bidi smoking increases the risk for cancers of the oral cavity, oropharynx, hypopharynx, larynx, lung, oesophagus and stomach.

3. Cancer in Experimental Animals

3.1 Mainstream tobacco smoke

3.1.1 Mouse

There have been multiple studies of the carcinogenic potential of tobacco smoke in mice (Table 3.1). Lifetime exposure of several mouse strains to cigarette smoke failed to result in the production of lung tumours (Harris & Negroni, 1967; Otto & Elmenhorst, 1967; Henry & Kouri, 1986). However, studies involving lifetime exposure of C57BL mice to a mixture of flue-cured or air-cured cigarette smoke or to the gas phase of flue-cured cigarette smoke led to significant increases in the number of lung tumours (adenomas) (Harris *et al.*, 1974). Similarly, lifetime exposure of Snell's mice to the gas phase of cigarette smoke led to an increased incidence of lung adenocarcinomas (Leuchtenberger & Leuchtenberger, 1970). Exposure of $B6C3F_1$ female mice to smoke for lifetime led to increased incidence of lung adenomas, bronchiolar papillomas and lung adenocarcinomas in smoke-exposed mice. In addition, the occurrence of squamous cell carcinomas of the nasal cavity in smoke-exposed mice was increased (Hutt *et al.*, 2005). In a recent study, Swiss mice were exposed whole-body to cigarette smoke for 120 days, starting within 12 hours of the birth. Smoke-exposed mice developed microscopic lung tumours beginning only 75 days after birth and reaching an overall incidence of 78.3% after 181–230 days. The mean lung tumour multiplicity was 6.1 and 13.6 tumours per mouse in males and females, respectively. In addition, malignant tumours, some of which may have had a metastatic origin, were detected in the urinary tract of smoke-exposed mice (Balansky *et al.*, 2007).

3.1.2 Rat

Several studies have evaluated the carcinogenic potential of mainstream tobacco smoke in rats (Table 3.1). Exposure of Wistar rats to cigarette smoke for lifetime did not increase the lung tumour incidence (Davis *et al.*, 1975). In contrast, exposure of Fischer 344 rats to a mixture of non-filter cigarette smoke for 128 weeks resulted in an increased incidence of nasal and lung tumours. There was also an increase in subcutaneous sarcomas at forelimb ulceration sites (Dalbey *et al.*, 1980). CDF rats were exposed to low-dose cigarette smoke (LCS) or high-dose cigarette smoke (HCS) for 126 weeks. The incidence of lung tumours was significantly higher only in female rats that received HCS (Finch *et al.*, 1995). In a recent study, Fischer 344 rats received whole body exposure to smoke containing either 100 mg (LCS) or 250 mg (HCS) total particulate matter/m^3 for 30 months. This led to significant increases in the incidence of lung and nasal cavity tumours in male rats treated with HCS but not with LCS. In female rats, there were significant increases in the incidence of lung adenomas

in animals treated with HCS and of all lung tumours in animals treated with both LCS and HCS. There was also a significant increase in the occurrence of nasal cavity tumours in female rats treated with HCS (Mauderly *et al.*, 2004).

3.1.3 Hamster

Four studies have evaluated the ability of mainstream tobacco smoke to induce tumours in hamsters (Table 3.1). Syrian golden hamsters were exposed to either a mixture of German reference cigarette smoke or of dark air-cured cigarette smoke for lifetime. There were increases in the incidence of laryngeal carcinomas in hamsters exposed to both smoke preparations (Dontenwill *et al.*, 1973). In a subsequent study, hamsters were exposed to a mixture of German reference cigarette smoke containing 1.5 mg nicotine, 0.173 mg phenol and 12.7 mL carbon monoxide/cigarette for lifetime. The incidence of laryngeal tumours in smoke-exposed hamsters was higher than in controls (Dontenwill *et al.*, 1977). BIO male hamsters exposed to a mixture of US reference smoke for 100 weeks developed laryngeal and nasopharyngeal tumours (Bernfeld *et al.*, 1974). In a subsequent study, male BIO hamsters exposed to smoke from commercial British filter cigarettes developed higher incidence of laryngeal tumours than controls (Bernfeld *et al.*, 1979).

3.2 Co-administration of tobacco smoke with known carcinogens and other agents

Study design and results of the studies on co-administration of tobacco smoke with known carcinogens and other agents are summarized in Table 3.2.

3.2.1 Rat

(a) Benzo[a]pyrene

Wistar rats received a single intratracheal instillation of 2 mg benzo[*a*]pyrene followed by lifetime exposure to cigarette smoke. This treatment led to a low incidence of lung tumours that was not significantly higher than in controls (Davis *et al.*, 1975). In another study Wistar rats were given intratracheal instillations of benzo[*a*]pyrene mixed with ferric oxide and exposed to cigarette smoke either during initiation and post-initiation or only after treatment with benzo[*a*]pyrene/ferric oxide (post-initiation). Inhalation of cigarette smoke during the initiation and post-initiation phases of carcinogenesis resulted in a higher lung tumour (squamous-cell carcinoma) multiplicity than that seen in rats exposed during the post-initiation phase only (Gupta *et al.*, 1990).

(b) Radon progeny

Sprague-Dawley rats were exposed to radon progeny at cumulative doses of 4000, 500 or 100 work-level-months (WLM), with or without concurrent exposure to cigarette smoke by inhalation for one year. Rats exposed to 4000 WLM radon progeny, without exposure to smoke, developed lung carcinomas (17/50). Thirty four carcinomas were seen in 50 rats exposed to radon and cigarette smoke. The 500 WLM radon progeny group exposed to radon only had 2/28 lung carcinomas as compared with 8/30 rats exposed to radon and cigarette smoke. No tumours were observed in rats treated with 100 WLM radon and one carcinoma was seen among 30 rats exposed to 100 WLM radon and cigarette smoke. Seventy five percent of the lung tumours were squamous-cell carcinomas, 20% were adenocarcinomas, and the remainder were undifferentiated carcinomas (Chameaud *et al.*, 1982).

Table 3.1 Carcinogenicity in response to mainstream tobacco smoke in animals

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Lung burden	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance	Comments
Mice, C57BL (M, F) Harris & Negroni (1967)	100 animals/sex/group Nose-only, mixture of fresh non-filter cigarette smoke/air (1/39, v/v), nicotine, 0.1 mg/mL; CO, 0.064% (v/v), 12 min/every other d; lifetime	Nicotine, 14–17 µg	Alveologenic adenocarcinomas: M–4/100 (alveologenic AdC) Controls–0/100 F–4/100 (alveologenic AdC) Controls–0/100	 $P = 0.06$ $P = 0.06$	
Mice, C57BL and BLH (sex, NR) Otto & Elmenhorst (1967)	126 animals/group Whole-body, gas phase of 12 cigarettes puffed 2 sec/min, concentration (NR), 90 min/d; lifetime (~27 mo)	NR	Lung (adenomas): C57BL–7/126 (5.5%) Controls–3/90 (3%) BLH–40/126 (32%) Controls–19/60 (32%)	 NS NS	
Mice, (C57BL/Cum × C3H/Anf Cum)F_1 (F) Henry & Kouri (1986)	2053, 1 014 sham Nose-only, 10% smoke from US reference cigarettes, concentration (NR), smoke 20 sec/min, 6–8 min/d, 5 d/wk for 110 wk; 116 wk	Particulate deposition, 125–200 µg	Alveolar adenocarcinomas: 19/978 (2%) Sham-exposed controls–7/651 (1%)	 $P = 0.10$	Shorter latency of tumour occurrence in smoke-exposed group suggested
Mice, C57BL (M, F) Harris *et al.* (1974)	100 animals/sex/group Nose-only, mixture of fresh flue-cured or air-cured cigarette smoke/air (1/39, v/v), concentration (NR), 12 min/d on alternate d; lifetime	NR	M: 9/162[a] (5%, flue-cured), 7/189[a] (4%, air-cured) Controls–3/160[a] (2%) F: 7/164[a] (4%, flue-cured), 0/173 (air-cured) Controls–1/159[a] (1%)	$P = 0.07$, flue-cured $P > 0.05$, air-cured $P = 0.04$, flue-cured	
	Nose-only, gas phase of flue-cured cigarette smoke, concentration (NR), 12 min/d on alternate d; lifetime	NR	M: 3/8[a] (37%) Controls–3/160[a] (2%) F: 2/88[a] (2%) Controls–1/159[a] (1%)	$P > 0.05$ $P > 0.05$	

Table 3.1 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Lung burden	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance	Comments
Mice, Snell (M, F) Leuchtenberger & Leuchtenberger (1970)	160 M, 118 F Whole-body, whole fresh cigarette smoke, concentration (NR), 2 puffs, 1 × /d, lifetime (26 mo)	Nicotine, 5 µg	M: Lung A–7/107 (6.5%) Controls–8/106 (7.5%)	NS	
			Lung AdC–11/107 (10%) Controls–5/106 (4.7%)	$P = 0.15$	
			F: Lung A–2/65 (3%) Controls–1/78 (1.2%)	$P = 0.475$	
			Lung AdC–5/65 (7.7%) Controls–3/78 (3.8%)	$P = 0.035$	
	100 M, 89 F Whole-body, gas phase of fresh cigarette smoke, concentration (NR), 2 puffs, 1 × /d, lifetime (26 mo)	NR	M: Lung A–1/44 (2%) Controls–8/106 (7%)	NS	
			Lung AdC–10/44 (23%) Controls–5/106 (5%)	$P = 0.005$	
			F: Lung A–3/44 (7%) Controls–1/78 (1%)	$P = 0.15$	
			Lung AdC–5/44 (11%) Controls–3/78 (4%)	$P = 0.15$	
Mice, B6C3F1 (F) Hutt *et al.* (2005)	330, 326 controls Whole-body, smoke from Kentucky 2R1 unfiltered reference cigarettes, 250 mg total particulate matter/m^3, 6 h/d, 5 d/wk for 30 mo; 30 mo or lifetime	NR	Lung A: 93/330 (28%) Sham-exposed controls–22/326 (7%)	$P < 0.001$ $P < 0.007$	
			Bronchiolar papillomas: 15/330 (4%) Controls–0/326	$P < 0.001$	
			Lung AdC: 67/330 (20%) Controls–9/326	$P < 0.001$	
			All lung tumours: 148/330 (45%) Controls–31/326	$P < 0.001$[b]	
			Nasal cavity tumours: 20/330 (6%) Controls–0/326	$P = 0.002$, one-tailed Fisher	
			Squamous-cell carcinomas: 9/330 (3%) Controls–0/326		

Table 3.1 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Lung burden	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance	Comments
Mice, Swiss (M, F) Balansky *et al.* (2007)	38, 36 controls (neonatal mice, 21 h of age) Whole-body, cigarette smoke/air, 818 mg total particulate matter/m^3, 65 min/d for 120 d	NR	Lung A: 15/38(19%) Sham-exposed controls–0/36	$P < 0.001$	
			Lung AdC: 7/38 (18%) Controls–0/38	$P < 0.01$	
			Kidney A: 6/16 (16%) (F only) Controls–0/21	$P < 0.01$	
			Liver carcinomas: 2/16 (5%) (F only) Controls–0/21		
Rats, Wistar (F) Davis *et al.* (1975)	408, 102 untreated, 102 sham Nose-only, mixture of cigarette smoke/air (1/5), concentration (NR), 15 sec/min, 2 × 11 min/d, 5 d/wk, lifetime	NR	4/408 (1%) (1 lung C and 3 lung neoplasms of uncertain malignancy) Controls–0/102 Sham treated controls–0/102	NS	
Rats, F344 (F) Dalbey *et al.* (1980)	80, 63 untreated, 30 sham Nose-only, mixture of non-filter cigarette smoke/air (1/10), 18.4 mg smoke particulate and 0.89 mg nicotine/cigarette, 1 cigarette/h, 7 cigarettes/d, 5 d/wk for 128 wk; 160 wk	Particulate deposition, 1.75 mg/d	10/80 (12%) (1 nasal AdC, 1 nasal C, 5 pulmonary A, 1 pulmonary C, 2 alveologenic C) Controls–3/93 (3%)	$P < 0.05$	
			Subcutaneous sarcomas at forelimb ulceration sites: 21/80 (26%) Controls–0/93	$P < 0.05$	
Rats, CDF$^{\circ}$ (F344)/CrlBR (M, F) Finch *et al.* (1995)	2165 animals Whole-body, cigarette smoke/air, 100 mg (LCS) or 250 mg (HCS) total particulate matter/m^3, 6 h/d, 5 d/wk for 30 mo; lifetime	NR	Lung tumours: M: LCS 3/173 (2%) HCS 7/78 (9%) Filtered air 3/119 (2%)	$P < 0.05$	
			F: LCS–4/145 (3%) HCS–6/83 (7%) Filtered air–0/113	$P < 0.05$	

Table 3.1 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Lung burden	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance	Comments
Rats, F344 (M, F) Mauderly *et al.* (2004)	M: 178 LCS, 82 HCS F: 175 LCS, 81 HCS Whole-body, smoke from Kentucky 1R3 unfiltered reference cigarettes, 100 mg (LCS) or 250 mg (HCS) total particulate matter/m^3, 6 h/d, 5 d/wk for 30 mo; lifetime	NR	M: Lung A– LCS 4/178 (2%) HCS 2/82 (2%) Sham-exposed controls 1/118 (1%)	NS	
			Lung AdC– LCS 1/178 (1%) HCS 5/82 (6%) Controls 3/118 (3%)	NS	
			All lung tumours– LCS 4/178 (2%) HCS 7/82 (8%) Controls 4/118	NS; trend, $P = 0.055$	
			Nasal cavity (all tumour types)– LCS 1/178 (1%) HCS 5/82 (6%) Controls 1/118 (1%)	$P = 0.032$ (HCS); trend, $P = 0.010$	
			F: Lung A– LCS 7/175 (6%) HCS 7/81 (9%) Sham-exposed controls 0/119	NS (LCS); $P < 0.001$ (HCS)	
			AdC– LCS 4/175 (2%) HCS 4/81 (5%) Controls 0/119	NS	
			All lung tumours– LCS 10/175 (6%) HCS 11/81 (13%) Controls 0/119	$P = 0.023$ (LCS); $P = 0.001$ (HCS)	
			Nasal cavity (all tumour types)– LCS 0/175 HCS 3/81 Controls 0/119	$P = 0.020$ (HCS); trend, $P = 0.003$	

Table 3.1 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Lung burden	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance	Comments
Hamsters, Syrian golden (M, F) Dontenwill *et al.* (1973)	80 animals/sex/group Whole-body, mixture of German reference cigarette smoke/air (1/15), concentration (NR), smoke of 30 cigarettes for 7–10 min; 1, 2 or 3 × /d, 5 d/wk, lifetime	NR	Laryngeal carcinomas: 1/160 (1%), 17/160 (11%) and 11/160 (7%) Controls–0/80		
	Whole-body, mixture of dark air-cured cigarette smoke/air (1/15), concentration (NR), Smoke of 30 cigarettes for 7–10 min: twice/d, 5 d/wk, lifetime	NR	Laryngeal carcinomas: 2/160 (1%) Controls–0/80		
Hamsters, Syrian golden (M, F) Dontenwill *et al.* (1977)	80 animals/group Whole-body, mixture of German reference cigarette smoke/air (1/15), 1.5 mg nicotine, 0.173 mg phenol and 12.7 mL CO/cigarette, smoke of 30 cigarettes for 7–10 min; 1, 2 or 3 × /d, 5 d/wk, lifetime	NR	M: Laryngeal C–0, 4, 6 and 11%, Controls–0% F: Laryngeal C–0, 1, 2 and 7% Controls–0%		
Rats, Inbred BIO 15.16 & Inbred BIO 87.20 (M) Bernfeld *et al.* (1974)	102 animals/group Whole-body, mixture of US reference cigarette smoke/air (1/5), concentration (NR), duration (NR)		Inbred BIO 15.16: Laryngeal tumours–9/84 (10%) Nasopharyngeal tumours–2/84 (2%) Sham-exposed controls 0/42 Controls 0/40 Inbred BIO 87.20: Laryngeal tumours–2/87 (2%) Sham-exposed controls 0/44 Controls 0/48		
Rats, Inbred BIO 15.16 (M) Bernfeld *et al.* (1979)	Number at start (NR) Whole-body, 11 or 22% smoke from commercial British filter cigarettes, concentration (NR), 2 × 12 min/d, 7 d/wk for 35–42 wk; up to 74–80 wk	NR	Laryngeal carcinomas: 11% smoke–3/44 (7%) 22% smoke–27/57 (47%) Sham-exposed controls 0/36; Controls 0/50		

[a] Most of these lung tumours are adenomas

[b] Nasal cavity tumours included 14 squamous cell carcinomas (5 in situ), 5 hemangiomas, and 1 respiratory papilloma

A, adenoma; AdC, adenocarcinoma; C, carcinoma; CO, carbon monoxide; d, day or days; F, female; h, hour or hours; HCS, high cigarette smoke; LCS, low cigarette smoke; M, male; min, minute or minutes; mo, month or months; NR, not reported; NS, not significant; sec, second or seconds; wk, week or weeks; yr, year or years

Table 3.2 Carcinogenicity in response to exposure to mainstream tobacco smoke in conjunction with exposure to known carcinogens or other agents in animals

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance
Rats, Wistar (F) Davis *et al.* (1975)	84 or 408 animals/group A single intratracheal instillation of benzo[*a*]pyrene (2 mg) + infusine + carbon black followed by British reference cigarette smoke/air (1/5); 1 cigarette, twice/d, 5 d/wk, lifetime	3/84 (4%, lung C), 1/84 (1%, lung C; benzo[*a*]pyrene alone), 4/408 (1%, 3 A + 1 malignant neoplasm; cigarette smoke only), 0/204 (controls + sham-exposed controls)	NS
Rats, Wistar (M) Gupta *et al.* (1990)	35 animals/group Cigarette smoke; 5 cigarettes/8.2 L air; 1 h/d during 2nd–24th wk or 10th–24th wk of the study Benzo[*a*]pyrene (20 mg) + Fe_2O_3; intratracheally (3 weekly doses) during 6th–8th wk of the study; 24 wk	Conventional diet: 2nd–24th wk, 2.14 lung C/animal; 10th–24th wk, 1.33 lung C/animal; benzo[*a*]pyrene control, 1.22 lung C/animal. Vitamin A-deficient diet: 2nd–24th wk, 2.86 lung C/animal; 10th–24th wk, 1.67 lung C/animal; benzo[*a*]pyrene control, 1.83 lung C/animal	
Rats, Sprague-Dawley, sex NR) Chameaud *et al.* (1982)	28–50 animals/group French reference cigarette smoke (9 cigarettes/500 L air); 10–15 min session, 4 d/wk for 1 yr Radon progeny (4 000, 500 or 100 WLM) Lifetime	4000 WLM: 34/50 (68%, lung C); 17/50 (34%, lung C; radon progeny alone) 500 WLM: 8/30 (27%, lung C); 2/28 (7%, lung C; radon progeny alone) 100 WLM: 1/30 (3%, lung C); 0/50 (radon progeny alone)	$P = 0.0015$
CDF*(F344)/CrlBR (M, F) Finch *et al.* (1995)	Number at start (NR) Cigarette smoke/air, 100 mg (LCS) or 250 mg (HCS) total particulate matter/m^3; 6 h/d, 5 d/wk for 126 wk $^{239}PuO_2$ aerosol, 1 wk (6th wk of the study); > 52 wk	49–61% (lung tumours, LCS + $^{239}PuO_2$) 72–74% (HCS + $^{239}PuO_2$) 20–33% ($^{239}PuO_2$) 2–3% (LCS) 7–8% (HCS)	
Syrian golden (M, F) Dontenwill *et al.* (1973)	80 animals/sex/group German reference cigarette smoke/air (1/15); Smoke of 30 cigarettes for 7–10 min; twice/d, 5 d/wk, lifetime DMBA (0.5 mg); intratracheally 10 d before the beginning of smoke exposure	32/160 (20%, laryngeal C), 17/160 (11%, laryngeal C; smoke only), 0/160 (DMBA alone)	

Table 3.2 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance
Syrian golden, (sex NR) Hoffmann *et al.* (1979)	20 or 40 animals/group Cigarette smoke/air (1/7); Cigarette smoke 2 × 10 min/d, 5 d/wk, 48 wk DMBA (0.24 mg); intralaryngeally	3/40 (7%, laryngeal C), 0/20 (smoke only), 0/20 (DMBA alone)	
Syrian golden (M) Takahashi *et al.* (1992)	10 or 30 animals/group Cigarette smoke/air (1/7); Smoke of 30 cigarettes for 9 min; twice/d, 5 d/wk, 12 wk NDEA (100 mg/kg bw); subcutaneously	Non-filter cigarettes (2.10 ± 1.74 P+H/animal) and filter cigarettes (1.93 ± 1.55 P + H/animal) versus sham-exposed (0.97 ± 1.03 P + H/animal)	$P < 0.01$ $P < 0.01$
Syrian golden (M) Harada *et al.* (1985)	30 animals/group Non-filter cigarette smoke/air (1/7); Smoke of 30 cigarettes for 6 min: twice/d, 5 d/wk, 58 wk NDEA (10 mg/hamster); subcutaneously (12 weekly doses)	Nasal cavity tumours 14/30 (47%, smoke + NDEA), 5/30 (17%, NDEA alone)	$P < 0.05$

A, adenoma; bw, body weight; C, carcinoma; d, day or days; DMBA, 7,12-dimethylbenz[*a*]anthracene; F, female; h, hour or hours; HCS, high cigarette smoke; LCS, low cigarette smoke; M, male; min, minute or minutes; mo, month or months; NDEA, *N*-nitrosodiethylamine; NR, not reported; NS, not significant; P + H, epithelial hyperplasias and papillomas; sec, second or seconds; wk, week or weeks; WLM, work-level-months; yr, year or years

(c) Plutonium oxide

CDF®/CrlBR rats were exposed to either filtered air or mainstream cigarette smoke at concentrations of either 100 or 250 mg total particulate matter/m^3 (LCS and HCS groups, respectively). At 12 weeks, rats were removed from smoke chambers and exposed nose-only to plutonium oxide ($^{239}PuO_2$) then returned to the smoke chambers one week later for 30 months of continuous exposure to either filtered air or cigarette smoke. The incidence and multiplicity of lung tumours (adenocarcinomas, squamous-cell carcinomas, adenosquamous carcinomas) in animals exposed to both concentrations of cigarette smoke and $^{239}PuO_2$ were higher than those in animals exposed to $^{239}PuO_2$, LCS or HCS alone (Finch *et al.*, 1995).

3.2.2 Hamster

(a) 7,12-Dimethylbenz[a]anthracene

Groups of 160 Syrian golden hamsters received 7,12-dimethylbenz[*a*]anthracene (DMBA) intratracheally, followed by cigarette smoke for life, or treated with cigarette smoke or DMBA only. A total of 32 squamous-cell carcinomas of the larynx were observed in animals treated with both DMBA and cigarette smoke, in comparison with 17 in hamsters exposed to cigarette smoke only and none in hamsters treated with DMBA alone (Dontenwill *et al.*, 1973). Similar results were reported from other experiments in which Syrian golden hamsters were exposed to DMBA and cigarette smoke (Hoffmann *et al.*, 1979).

(b) N-Nitrosodiethylamine

Groups of hamsters received a single subcutaneous injection of *N*-nitrosodiethylamine (NDEA) and then were exposed to smoke from unfiltered cigarettes, filtered cigarettes and sham smoke. Controls were exposed to either unfiltered cigarette smoke, filtered cigarette smoke or sham smoke. In the NDEA-smoke-treated groups, epithelial hyperplasias and/or papillomas of the larynx were induced at higher frequency than in controls (Takahashi *et al.*, 1992). Hamsters exposed to cigarette smoke in air also received 12 weekly subcutaneous injections of NDEA (total dose, 10 mg/hamster). Treatment with NDEA only resulted in both benign and malignant tumours of the respiratory tract, and co-exposure to cigarette smoke potentiated the development of tumours in the nasal cavity (Harada *et al.*, 1985).

3.3 Smoke condensates

Study design and results of the studies on administration of tobacco smoke condensates are summarized in Table 3.3.

3.3.1 Skin application

(a) Mouse

Cigarette-smoke condensate produces both benign and malignant tumours on mouse skin. The carcinogenic potency of the cigarette-smoke condensate depends upon tobacco variety, composition of cigarette paper and the presence of additives (Wynder *et al.*, 1957; Gargus *et al.*, 1976; Gori, 1976).

(b) Rabbit

Cigarette-smoke condensate induced skin papillomas and carcinomas when applied to the ears of rabbits for lifetime (Graham *et al.*, 1957).

3.3.2 Intrapulmonary administration

Injection of 24 mg cigarette-smoke condensate into the lungs of female Osborne Mendel rats led to the development of squamous cell carcinomas (Stanton *et al.*, 1972). These observations were confirmed by Dagle *et al.* (1978) who observed a dose-dependent incidence of lung carcinomas when cigarette-smoke condensate prepared from two types of cigarettes were given.

Table 3.3 Carcinogenicity in response to exposure to cigarette-smoke condensate in animals

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance
Mice CAF1 (M, F) Wynder *et al.* (1953)	112, 44 controls Skin painting (dorsal) of CSC, CSC/acetone solution (40 mg CSC/ application), 3 × /wk, lifetime	36/81 (44%, skin epidermoid C), 0/30 (acetone controls)	
Mice ICR Swiss (F) Gargus *et al.* (1976)	5200 Skin painting (dorsal) of CSC, CSC/acetone solution (150 mg or 300 mg CSC/wk), 6 × /wk, 78 wk	482/5200 (9%, skin C), 3/800 (0.4%, acetone controls)[a]	
Mice ICR Swiss (F) Gori (1976)	4900 Skin painting (dorsal) of CSC, CSC/acetone solution (25 mg or 50 mg CSC/application), 6 × /wk, 78 wk	1157/4900 (24%, skin C), 0/800 (acetone controls)	
Mice, ICR/Ha Swiss (F) Hoffmann & Wynder (1971)	30 animals/group Skin painting (dorsal) with CSC active fraction with or without subsequent painting of the skin with croton oil, CSC active fraction/acetone (2.5 mg of 0.6% CSC/ application), 10 times on alternate d Croton oil (2.5%), 3 × /wk, up to 12 mo, 10 d after last CSC active fraction application; 15 mo	After 12 and 15 mo: 4/30 (13%, skin C), 0/65 (croton oil controls)	
Mice, Swiss (F) Wynder & Hoffmann (1961)	30–50 animals/group Skin painting (dorsal) of CSC with or without initiation by DMBA application; DMBA (75 µg); CSC/acetone (75 mg CSC/application, start: 1 wk after DMBA application), 2–3 × /wk, 12 mo; 15 mo	DMBA: 2/30 (7%, skin C) 2 × CSC: 1/40 (3%, skin C) DMBA + 2 × CSC: 8/30 (27%, skin C) 3 × CSC: 11/50 (22%, skin C) DMBA + 3 × CSC: 11/30 (37%, skin C)	
Mice, SENCAR (F) Meckley *et al.* (2004a)	40 animals/group Skin painting (dorsal) of CSC from Kentucky 1R4F reference cigarettes, with or without initiation by DMBA application; DMBA (75 µg) or acetone, 1x. Then starting 1 wk after DMBA or acetone: CSC in acetone, 0, 10, 20 or 40 mg/application, 3 × /wk, 29 wk; 31 wk	Mean mice with tumours/mice per group at 31 wk[e]: No DMBA: 0/40 acetone-acetone, 9/40 (22%) acetone-CSC 40 mg/treatment DMBA/CSC: 0/40, 3/40 (1.0), 16/40 (75 tumours/16 mice = 4.7), 32/40 (200 tumours/32 mice = 6.3)	
Mice, SENCAR (F) Meckley *et al.* (2004b)	40 animals/group Skin painting (dorsal) of CSC from Kentucky 1R4F reference cigarettes or ECLIPSE (non-burned) cigarettes, with or without initiation by DMBA application; DMBA (75 µg) or acetone, 1 × . Then starting 1 wk after DMBA or acetone: CSC in acetone, 0, 10, 20 or 40 mg/application, 3 × /wk, 29 wk; 31 wk	No DMBA: acetone/acetone 0/40 (0); acetone/1R4F CSC 40 mg, 9/40 (1.8); acetone/ECLIPSE CSC 40 mg, 0/40 (0) DMBA/CSC: acetone, 0/40 (0); 1R4F CSC 10 mg, 6/40 (1.8); 1R4F CSC 12 mg, 28/40 (6.6); 1R4F CSC 40 mg, 36/40 (6.8); ECLIPSE CSC, 0/40 (0); ECLIPSE CSC 10 mg, 1/40 (1); ECLIPSE CSC 20 mg, 2/40 (5.5); ECLIPSE CSC 40 mg, 12/40 (2.6)	

Table 3.3 (continued)

Species, strain (sex) Reference	Animals/group at start Dosing regimen Duration	Results Target organ Incidence and/or multiplicity of tumours (%)	Significance
Mice, SENCAR (F) Hayes *et al.* (2007)	40 or 50 animals/group Skin painting (dorsal) of CSC from heat-exchanged flue cured tobacco (HE; low TSNA) or direct-fire (DF) cured tobacco, with or without initiation by DMBA application; DMBA (75 µg) or acetone, 1 × . Then starting 1 wk after DMBA or acetone: CSC/acetone, 0, 9, 18, or 36 mg/application, 3 × /wk, 29 wk; 31 wk	No DMBA: acetone/acetone 0/40; acetone/DF CSC 36 mg, 5/50 (1.4); acetone/HE CSC 36 mg, 8/50 (1.3) DMBA/CSC: DF CSC, 0/40, DF CSC 9 mg, 15/40 (5.5); DF CSC 18 mg, 30/40 (10.0); DF CSC 36 mg, 43/50 (8.2); HE CSC, 0/40, HE CSC 9 mg, 17/40 (4.8); HE CSC 18 mg, 32/40 (7.3); HE CSC 36 mg, 42/50 (8.5)	$P < 0.05$ $P < 0.05$ $P < 0.05$
Mice, Swiss albino (M) Pakhale *et al.* (1988)	20 animals/group Oral gavage of Indian bidi smoke condensate; 1 mg bidi smoke condensate/0.1 mg DMSO, 5 d/wk, 55 wk; 90 wk	4/15 (27%, hepatic haemangiomas); 1/15 (7%, stomach papilloma); 1/15 (7%, stomach carcinoma); 1/15 (7%, oesophageal carcinoma); 0/15 (untreated or DMSO-treated controls)	
Rats, Osborne Mendel (F) Stanton *et al.* (1972)	Number/group at start (NR) Intrapulmonary administration of CSC pellet; CSC/beeswax:tricaprylin (24 mg CSC/injection), up to 107 wk after implantation	14/40[c] (35%, lung squamous-cell C), 0/63[c] (beeswax:tricaprylin controls)	
Rats, OM/NCR (F) Dagle *et al.* (1978)	120[d] Intrapulmonary administration of CSC pellet; CSC/beeswax:tricaprylin (5, 10, 20 or 67 mg CSC/injection), 120 wk after implantation	4, 10, 20 and 42% pulmonary C prevalence; 0% C prevalence for 3 control groups of about 190 rats each	
Rabbits, Albino New Zealand (M, F) Graham *et al.* (1957)	38, 7 controls Skin painting of CSC (both ears); CSC/acetone solution (100 mg CSC/application/ear), 5 × /wk, lifetime (4–6 yr)	4/38 (11%, 2 skin C + 1 skin liposarcoma + 1 skin fibrosarcoma), 0/7 (acetone controls)	

[a] Skin papillomas
[b] Mostly adenomas
[c] Incidence in animals that died 43–107 weeks after injection
[d] 4 × 10 rats/group terminated before 120 weeks
[e] Total visually identified and histologically confirmed skin tumours included mostly squamous papillomas and carcinomas [Tumour incidences and multiplicities estimated from graphs]
C, carcinoma; CSC, cigarette-smoke condensate; d, day or days; DMBA, 7,12-dimethylbenz[*a*]anthracene; DMSO, dimethyl sulfoxide; F, female; M, male; NR, not reported; TSNA, tobacco-specific *N*-nitrosamines; wk, week or weeks

3.3.3 Initiation-promotion skin painting studies

Cigarette-smoke condensate and its fractions can act as skin co-carcinogens in Swiss and SENCAR mice when tested in conjunction with croton oil (Hoffmann & Wynder, 1971) or DMBA (Wynder & Hoffmann, 1961; Meckley *et al.*, 2004a, b; Hayes *et al.*, 2007).

3.3.4 Bidi smoke

Swiss albino mice administered 1 mg bidi smoke condensate in dimethyl sulfoxide (DMSO) by oral gavage developed haemangiomas (4/15), stomach carcinoma (1/15), and esophageal carcinoma (1/15), whereas no tumours were observed in controls (Pakhale *et al.*, 1988).

3.4 Synthesis

Mainstream tobacco smoke induced lung tumours in mice, lung and nasal cavity tumours in rats and laryngeal carcinomas in hamsters.

Co-administration of tobacco smoke with benzo[*a*]pyrene, radon progeny and plutonium resulted in higher lung tumour responses in rats than administration of either agent alone. Hamsters exposed to cigarette smoke and either DMBA or NDEA had higher lung tumour responses compared to cigarette smoke, DMBA or NDEA alone.

Topical application of cigarette-smoke condensate led to the development of skin tumours in mice and rabbits; intrapulmonary administration of cigarette-smoke condensate induced squamous cell carcinomas in rat lung.

4. Other Relevant Data

4.1 Overview of the mechanistic evidence for the carcinogenicity of tobacco

4.1.1 Conceptual model of the carcinogenesis of tobacco and tobacco smoke

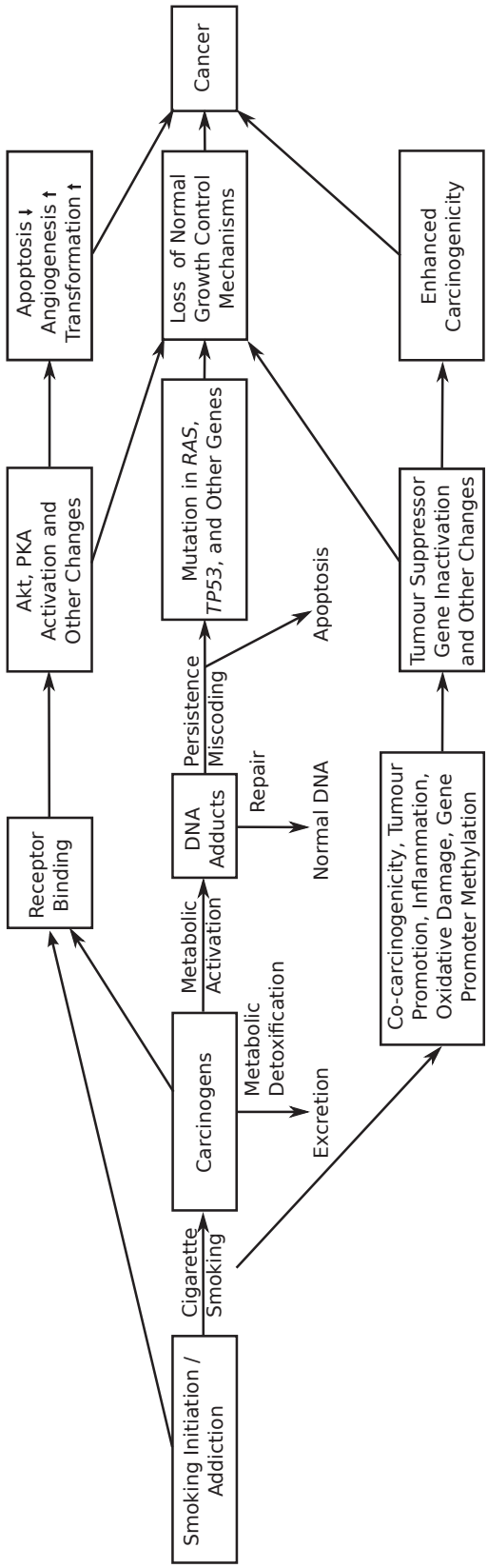
A conceptual model for understanding mechanisms by which tobacco smoke causes cancer is shown in Fig. 4.1 (Hecht, 1999, 2003). This model also applies to smokeless tobacco and other forms of smoked tobacco and, in theory, to second-hand tobacco smoke since it contains all of the same carcinogens and toxicants as mainstream cigarette smoke, although at lower doses.

The major accepted mechanistic pathway is summarized in the central track of Fig. 4.1. Smokers inhale carcinogens which, either directly or after metabolism, covalently bind to DNA, forming DNA adducts. DNA adducts are central to chemical carcinogenesis because they can cause miscoding and permanent mutations. If these mutations occur in critical regions of oncogenes and tumour suppressor genes, which are essential in growth control, the result can be loss of normal cellular proliferation mechanisms, genomic instability, and cancer. A study that sequenced 623 cancer-related genes in 188 human lung adenocarcinomas validated this premise by finding multiple somatic mutations in critical growth control genes, consistent with the chronic bombardment of cellular DNA by tobacco smoke carcinogens and their metabolically activated forms (Ding *et al.*, 2008).

Each step of this conceptual model is considered in detail below.

Most people begin smoking cigarettes when they are teenagers, and become addicted to nicotine. Nicotine is not generally considered to be a carcinogen (Schuller, 2009), but it is accompanied in each puff of each cigarette by a complex

Fig. 4.1 Conceptual model for understanding mechanisms of tobacco carcinogenesis



There may be overlap between these three tracks: e.g. mutation in *TP53* leading to tumour suppressor gene inactivation.

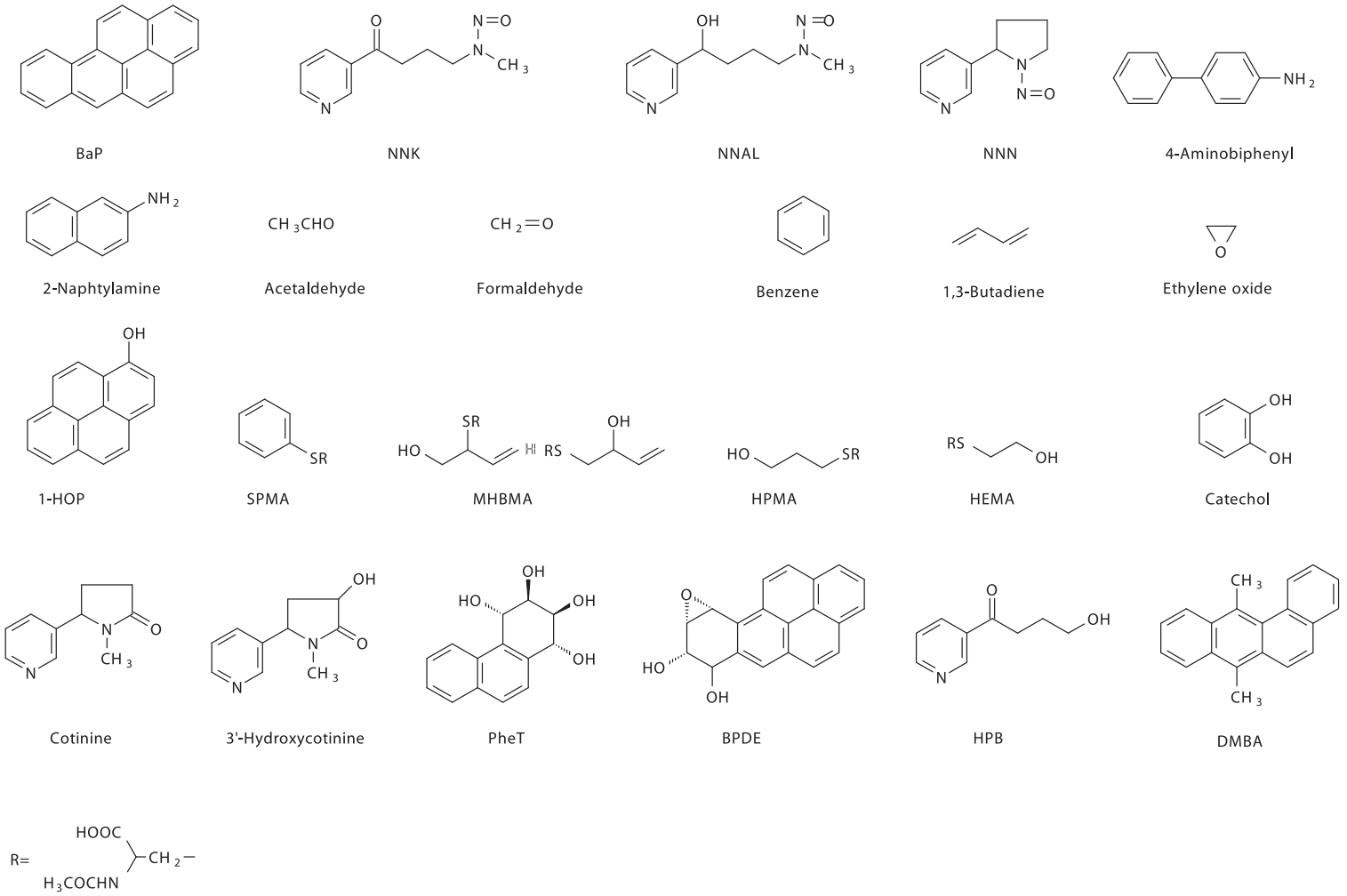
mixture of carcinogens and toxicants. There are over 60 carcinogens in cigarette smoke that have been evaluated in the previous *IARC Monograph* as having *sufficient evidence* for carcinogenicity in laboratory animals (IARC, 2004a), sixteen of which are considered to be *carcinogenic to humans (Group 1)*. There are also many other carcinogens and potential carcinogens in cigarette smoke that have not been evaluated (Rodgman & Perfetti, 2006; see Section 1.1). Structures of tobacco smoke constituents and biomarkers discussed here are presented in Fig. 4.2.

Numerous studies demonstrate the uptake of tobacco smoke carcinogens and toxicants by smokers, and showed higher levels of their metabolites in urine and blood of smokers than non-smokers (Sections 4.1.1 and 4.1.2). There are substantial differences in carcinogen exposure among people because of the number and types of cigarettes they smoke and the ways in which they smoke them. These differences can be monitored in part by biomarkers of exposure such as urinary metabolites or haemoglobin adducts (Section 4.1.2). Haemoglobin adducts of multiple aromatic amines and volatile carcinogens have been demonstrably related to tobacco (Hatsukami *et al.*, 2006a). There may also be differences in carcinogen exposure due to genetic variations (Section 4.2).

The body's response to cigarette smoke constituents is similar to its response to pharmaceutical agents and other foreign compounds. Drug metabolizing enzymes, most frequently CYPs, convert these compounds to more water soluble forms, facilitating excretion. During this natural protective attempt, some reactive intermediates are formed. These intermediates are frequently electrophilic (electron seeking, or bearing a partial or full positive charge). Electrophilic intermediates may react with water, generally resulting in detoxification, or may covalently bind to nucleophilic (electron rich) sites in DNA, forming DNA adducts (Guengerich, 2001; Jalas *et al.*, 2005), which are critical in the carcinogenic process (see Section 4.1.3c). CYP1A1 and CYP1B1, repeatedly shown to be inducible by cigarette smoke via interactions of smoke compounds with the aryl hydrocarbon receptor (AhR), are particularly important in the metabolic activation of PAHs, while CYP2A13 is critical for the metabolism of NNK (Nebert *et al.*, 2004; Jalas *et al.*, 2005). The inducibility of certain CYPs may be a critical aspect of cancer susceptibility in smokers (Nebert *et al.*, 2004). CYP1A2, CYP2A6, CYP2E1 and CYP3A4 are also important in the metabolism of cigarette smoke carcinogens to DNA binding intermediates (Jalas *et al.*, 2005), and aldo-keto reductase enzymes, also induced by tobacco smoke (Quinn *et al.*, 2008), are involved in the metabolism of NNK, BaP and other tobacco smoke carcinogens. Competing with this process of "metabolic activation" resulting in DNA binding is the intended metabolic detoxification, which leads to harmless excretion of carcinogen metabolites, and is also catalysed by CYPs and a variety of other enzymes including GSTs, uridine diphosphate-glucuronosyl transferases (UGTs), and arylsulfatases. The relative amounts of carcinogen metabolic activation and detoxification differ among individuals. It is widely hypothesized that this balance will affect cancer risk with those having higher activation and lower detoxification capacity being the most susceptible. This premise is supported in part by molecular epidemiologic studies of polymorphisms, or variants in more than 1% of the population, in certain genes coding for these enzymes (Vineis *et al.*, 2003; Carlsten *et al.*, 2008).

DNA adducts are thought to be a critical lesion in carcinogenesis. Many investigations demonstrate the presence of DNA adducts in human tissues, and some of these are summarized in Section 4.1.2c. There is massive evidence, particularly from studies which use relatively non-specific DNA adduct measurement methods, that DNA adduct levels in the lung and other tissues of smokers are higher than in non-smokers, and some epidemiologic data link

Fig. 4.2 Structures of compounds discussed in the text



BaP, Benzo[*a*]pyrene; BPDE, Benzo[*a*]pyrene diol epoxyde; DMBA, dimethylbenz[*a*]anthracene; 1-HOP, 1-hydroxypyrene; HEMA, 2-hydroxyethyl-mercapturic acid; HPMA, 3-hydroxypropyl-mercapturic acid; HPB, 4-hydroxy-1-(3-pyridyl)-1-butanone; HPMA, 3-hydroxypropyl-mercapturic acid; MHBMA, monohydroxybutyl-mercapturic acid; NNAL, 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanol; NNK, 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone; NNN, *N*'-nitrosonornicotine; PheT, phenanthrenetetrol; SPMA, S-phenyl-mercapturic acid

these higher adduct levels to increased cancer risk (IARC, 2004b; Veglia *et al.*, 2008). However, there is much more limited evidence from studies using specific carcinogen-derived DNA adducts as biomarkers (Pfeifer *et al.*, 2002). Oxidative DNA damage has also been observed, and this may result partially from exposure to metals in cigarette smoke (Stavrides, 2006).

Cellular DNA repair systems can excise DNA adducts and restore normal DNA structure (Christmann *et al.*, 2003). These complex multiple systems include direct base repair by alkyltransferases, removal of DNA damage by base and nucleotide excision repair, mismatch repair, and double strand repair. If these DNA repair systems are unsuccessful in fixing the damage, then the DNA adducts can persist, increasing the probability of a permanent mutation. There are polymorphisms in genes coding for some DNA repair enzymes. If these variants lead to deficient DNA repair, the probability of cancer development can increase (Vineis *et al.*, 2009).

DNA adducts can cause miscoding during replication when DNA polymerase enzymes misread the DNA adduct and consequently insert the wrong base opposite to it. There is some specificity in the relationship between specific DNA adducts formed from cigarette smoke carcinogens and the types of mutations which they cause. G to T and G to A mutations have often been observed (Section 4.1.3) (Hecht, 1999). Extensive studies have characterized the mutations which occur because of specific carcinogen-DNA adducts (Delaney & Essigmann, 2008). Mutations have been reported in the *KRAS* oncogene in lung cancer and in the *TP53* tumour suppressor gene in a variety of cigarette smoke-induced cancers (Ahrendt *et al.*, 2001; Pfeifer *et al.*, 2002; Ding *et al.*, 2008). The cancer causing role of these genes has been firmly established in animal studies (Lubet *et al.*, 2000; Johnson *et al.*, 2001). A selection and promotion process may also play a role in the final mutation spectrum seen in genes in smoking-associated tumours (Rodin & Rodin, 2005; Sudo *et al.*, 2008).

Urinary mutagenicity, sister chromatid exchanges, micronuclei in buccal cells, and other genetic effects have been consistently observed in smokers at higher levels than in non-smokers (IARC, 2004a; Proia *et al.*, 2006). In addition to mutations, numerous cytogenetic changes are observed in lung cancer, and chromosome damage throughout the field of the aerodigestive tract is strongly associated with cigarette smoke exposure. Mutations resulting from DNA adducts can cause loss of normal cellular growth control functions, via a complex process of signal transduction pathways, ultimately resulting in genomic instability, cellular proliferation and cancer (Ding *et al.*, 2008). Apoptosis, or programmed cell death, is a protective process, and can remove cells which have DNA damage, thus serving as a counterbalance to these mutational events. The balance between apoptotic mechanisms and those suppressing apoptosis will have a major impact on tumour growth.

While the central track of Fig. 4.1 is the major pathway by which tobacco smoke carcinogens cause cancer, other mechanisms also contribute, as indicated in the top and bottom tracks (Hecht, 2003). Nicotine, NNK, and NNN bind to nicotinic and other cellular receptors, resulting in activation of serine/threonine kinase Akt (also known as protein kinase B), protein kinase A, and other changes. Nicotine and NNK increase expression of survivin, an inhibitor of apoptosis in normal human bronchial epithelial cells, and survivin mRNA is detected in bronchial brush samples from heavy smokers (Jin *et al.*, 2008). This can cause decreased apoptosis, increased angiogenesis, and increased transformation (Heeschen *et al.*, 2001; West *et al.*, 2003). Thus, although nicotine is not carcinogenic, it may enhance carcinogenicity in various ways (Schuller, 2009). Cigarette smoke also contains well established oxidants, co-carcinogens, tumour promoting fractions, and inflammatory agents, as well as

cilia-toxic compounds such as acrolein, which impede clearance. Many studies demonstrate the co-carcinogenic and cytotoxic effects of catechol, an important constituent of cigarette smoke. An epigenetic pathway frequently observed in tobacco-induced cancers is enzymatic methylation of promoter regions of genes such as *p16* and *FHIT* [fragile histidine triad gene, a gene coding for a dinucleoside 5′, 5‴- P^1, P^3-triphosphate hydrolase, a putative tumour suppressor protein] resulting in gene silencing, which are also strongly implicated in tobacco-induced lung cancer (D'Agostini *et al.*, 2006; Bhutani *et al.*, 2008). When this occurs in tumour suppressor genes, the result can be unregulated proliferation (Belinsky, 2005). Inflammation due to smoking is associated with tumour promotion and activation of factors such as NFκB. Inflammation also plays a role in chronic obstructive pulmonary disease (COPD), which in turn is an independent risk factor for lung cancer (Smith *et al.*, 2006; Turner *et al.*, 2007; Lee *et al.*, 2008a).

This conceptual model can be applied to smokeless tobacco products. Smokeless tobacco products have much lower levels of carcinogens and toxicants that result from combustion, so the effects of these agents are not seen to a significant extent. The most prevalent strong carcinogens in smokeless tobacco are the tobacco-specific nitrosamines; other nitrosamines, PAHs, aldehydes and metals are also present, and there are large amounts of some inorganic salts that may contribute to inflammation (IARC, 2007a; Stepanov *et al.*, 2008). An additional factor in carcinogenesis by betel quid with tobacco is the basic pH resulting from addition of slaked lime to the quid, leading to oxidative damage and inflammation (IARC, 2004b).

Multiple studies demonstrate that tobacco-specific nitrosamines are absorbed and metabolised in smokeless tobacco users (IARC, 2007a).

There is evidence for DNA adduct formation in oral tissues of smokeless tobacco users, and sister chromatid exchanges, chromosomal aberrations, and micronuclei – consequences of DNA adduct formation – have been reported (Proia *et al.*, 2006; Warnakulasuriya & Ralhan, 2007). Many studies have demonstrated *RAS* and *TP53* mutations in smokeless tobacco users (Warnakulasuriya & Ralhan, 2007) consistent with the conceptual framework.

Oxidative stress and reactive oxygen species could play a significant role in cancer induction in smokeless tobacco users, particularly at high pH (Boffetta *et al.*, 2008). Chronic local inflammation and irritation induced by smokeless tobacco and its constituents could have a tumour promoting or co-carcinogenic effect (Boffetta *et al.*, 2008). Upregulation of cyclooxygenase-2, involved in prostaglandin synthesis and inflammation, has been observed in animal studies upon exposure to smokeless tobacco (Boffetta *et al.*, 2008). Smokeless tobacco products have relatively high levels of sodium chloride (NaCl), which could contribute to inflammation, tumour promotion, and co-carcinogenesis. Cancer of the oral cavity is strongly associated with tobacco smoking (IARC, 2004a) or chewing (IARC, 2007a) and alcoholic beverage drinking (IARC, 2010a) However only a fraction of exposed subjects develop tumours, which suggests that other exposures such as HPV may be independently involved or act as cofactors. HPV is known to infect the oral cavity of healthy individuals and several HPV-related lesions have been characterized (IARC, 2007b). Herpes simplex virus has also been shown to enhance the carcinogenicity of smokeless tobacco products in animal studies (Park *et al.*, 1986). These factors may contribute significantly to the local carcinogenic effects characteristic of smokeless tobacco use.

4.1.2 Absorption, distribution, metabolism and excretion

There are examples of toxicant and carcinogen metabolism and excretion for representatives of virtually every major class of compounds;

some of these are summarized in Table 4.1. Nicotine and five of its urinary metabolites – cotinine, 3′-hydroxycotinine and their glucuronides, and nicotine glucuronide – comprise about 73–96% of the nicotine dose (Hukkanen *et al.*, 2005), and are found in blood, sweat, hair and toenails (Al Delaimy, 2002; Hukkanen *et al.*, 2005; Stepanov *et al.*, 2007; Al Delaimy & Willett, 2008). Metabolites of various polycyclic aromatic hydrocarbons including pyrene, phenanthrene, fluorene, and benzo[*a*]pyrene have been quantified in human urine and are higher in smokers than in non-smokers (Hecht, 2002; Hecht *et al.*, 2005a; Jacob *et al.*, 2007; Hansen *et al.*, 2008). Metabolites of tobacco-specific nitrosamines – NNAL and its glucuronides (total NNAL) from NNK; and NNN and its glucuronides (total NNN) from NNN – are present in human urine (Hecht, 2002; Stepanov & Hecht, 2005; Hecht *et al.*, 2008a; Stepanov *et al.*, 2008). Total NNAL has also been quantified in blood and toenails (Hecht *et al.*, 2002; Stepanov *et al.*, 2007). Aromatic amine-haemoglobin adducts have been frequently measured in human blood, and their levels increase with smoking (Hecht, 2002; Hatsukami *et al.*, 2006a). Mercapturic acids of several tobacco smoke compounds such as benzene, 1,3-butadiene, acrolein, and ethylene oxide are present in human urine and are related to smoking (Carmella *et al.*, 2009). Haemoglobin adducts of acrylonitrile and related compounds are elevated in smokers' blood, and levels of metals such as Cd are increased in smokers' urine (Carmella *et al.*, 2002; IARC, 2004b).

All of the metabolites listed in Table 4.1 are elevated in cigarette smokers; in studies of second-hand smoke exposure, only nicotine metabolites and urinary total NNAL are consistently increased in exposed versus non-exposed subjects, although one very large study also observed an increase in PAH metabolites (Pirkle *et al.*, 2006; Hecht, 2008; Suwan-ampai *et al.*, 2009). Smokeless tobacco users have significantly raised levels of nicotine metabolites and tobacco-specific nitrosamine metabolites compared to non-tobacco users (Hecht *et al.*, 2007).

4.1.3 Biomarkers

Tobacco carcinogen biomarkers are quantifiable entities that can be *specifically* related to tobacco carcinogens. Specificity to a given carcinogen is critical because tobacco carcinogens vary widely in their potency and target organs.

Considering the mechanistic framework outlined in Fig. 4.1, one could visualize various types of biomarkers. Currently, biomarkers of carcinogen/toxicant dose, reflecting the second box of the central track of Fig. 4.1, are by far the most extensively used and validated. The second most common are measurements of DNA adducts (or protein adducts as their surrogates), but fewer of these have both practical utility and validation with respect to tobacco carcinogen specificity.

The use of tobacco carcinogen biomarkers bypasses many uncertainties in estimation of dose. The most commonly used estimation of dose is self-reported number of cigarettes/day, but this is not a very good marker. It may not be reported accurately and it provides no information on the way in which the cigarettes were smoked, which is critical when one considers the common phenomenon of smoker's compensation. Brand information together with machine smoking measurements of specific components is another way of obtaining a measure of dose. However, machine smoking measurements are known to have limitations and the application of a given machine smoking protocol to a given smoker requires smoking topography measurements for that smoker. A disadvantage of tobacco carcinogen biomarkers is that they are affected to some extent by individual differences in metabolism, which may complicate interpretation of dose.

Table 4.1 Examples of toxicant or carcinogen metabolites in tobacco users

Toxicant or carcinogen	Examples of metabolites in tobacco users	References
Nicotine	Cotinine, 3′-hydroxycotinine and their glucuronides in urine, blood or saliva; nicotine and cotinine in toenails	Al Delaimy (2002), Hukkanen *et al.* (2005), Al Delaimy & Willett (2008), Stepanov *et al.* (2007)
Polycyclic Aromatic Hydrocarbons (PAHs)	1-hydroxypyrene, phenanthrols, phenanthrene tetraols, fluorenols, benzo[*a*]pyrenols, benzo[*a*]pyrene tetraols in urine	Hecht (2002), Hecht *et al.* (2005a), Hansen *et al.* (2008), Jacob *et al.* (2007)
Tobacco-specific nitrosamines	NNAL and its glucuronides (total NNAL) in urine or blood, total NNN in urine; NNAL and NNN in toenails	Hecht (2002), Hecht *et al.* (2002, 2008a), Stepanov & Hecht (2005), Stepanov *et al.*, (2007, 2008)
Aromatic amines	Parent amines in urine and haemoglobin adducts in blood	Hecht (2002), Hatsukami *et al.* (2006a)
Volatile hydrocarbons		
Benzene 1,3-Butadiene	Muconic acid and S-phenyl-mercapturic acid (SPMA) in urine; Monohydroxybutyl-mercapturic acid (MHBMA) in urine	Hecht (2002), Carmella *et al.* (2009)
Acrolein	3-hydroxypropyl-mercapturic acid (HPMA) in urine	Carmella *et al.* (2009)
Ethylene oxide	2-hydroxyethyl-mercapturic acid (HEMA) in urine, haemoglobin adducts in blood	Bono *et al.* (2002), Carmella *et al.* (2009)
Acrylonitrile	Haemoglobin adducts in blood	Carmella *et al.* (2002)
Metals	Cadmium in urine	IARC (2004a)

(a) Urinary biomarkers

Probably the most practical and, to date, the most extensively applied tobacco carcinogen biomarkers are urinary metabolites of tobacco carcinogens, and these have been comprehensively reviewed (Hecht, 2002; IARC, 2004a). Advantages include the ready availability of samples, and concentrations in urine that are easily quantifiable using modern analytical chemistry methods, most frequently liquid chromatography-tandem mass spectrometry (LC-MS/MS). The urinary metabolites listed in Table 4.1 have all been used as biomarkers and all are validated with respect to exposure in cigarette smokers (Carmella *et al.*, 2009). Total nicotine equivalents (the sum of nicotine and the five metabolites in Table 4.1) is a particularly effective way of estimating nicotine dose from tobacco products.

Total NNAL, the sum of NNAL and its glucuronides, is a highly useful biomarker of NNK exposure (Hecht, 2002, 2003; Hatsukami *et al.*, 2006a). The tobacco-specificity of NNK, and therefore total NNAL, is a key feature of this biomarker because studies in which it is applied are not confounded by other environmental or dietary exposures. It also has a considerably longer half-life than cotinine and several other urinary biomarkers. Total NNAL has been used in numerous studies that estimated uptake of NNK in smokers under varying circumstances. In one example, smokers reduced their number of cigarettes smoked per day, but there was not a corresponding decrease in NNK uptake due to compensation (Hecht *et al.*, 2004). In another study, NNK and PAH uptake, estimated by total NNAL and 1-hydroxypyrene, respectively, were compared in smokers of regular, light, and ultra-light cigarettes, and found to be similar, consistent with epidemiologic studies that

demonstrate no protection against lung cancer in smokers of light compared to regular cigarettes (Hecht *et al.*, 2005b). Other studies evaluated NNK uptake in smokers who switched from their current cigarette brand to products advertised as being less hazardous, but the results generally did not support these claims (Hatsukami *et al.*, 2004). One of the most useful applications of total NNAL has been in studies of non-smokers exposed to second-hand tobacco smoke (Hecht, 2003). The sensitivity and specificity of this biomarker are ideal for such studies, and it is the most commonly elevated tobacco carcinogen biomarker in non-smokers exposed to second-hand smoke. Total NNAL has also found utility in establishing NNK uptake in smokeless tobacco users (Hecht *et al.*, 2002, 2007, 2008a, b; Hecht, 2008)

The relationship of urinary total NNAL to lung cancer was demonstrated in a study of stored urine samples collected years before diagnosis of lung cancer from smokers in Shanghai, China and Singapore (Yuan *et al.*, 2009). There was a significant relationship between total NNAL and lung cancer incidence, after correction for numbers of cigarettes smoked per day and duration of smoking. An 8.5 fold increased risk for lung cancer was observed for those smokers in the highest tertile of total NNAL and cotinine, relative to smokers with the same smoking history but in the lowest tertiles of total NNAL and cotinine. Urinary biomarkers were also used to demonstrate higher uptake of nicotine and NNK per cigarette in smokers with polymorphisms in the nicotinic acetylcholine genes associated with lung cancer in genome-wide association studies (see Section 4.2; Le Marchand *et al.*, 2008). Collectively, these results indicate that urinary total NNAL is not only a biomarker of exposure, but also a biomarker of risk for lung cancer.

(b) Serum and saliva metabolites

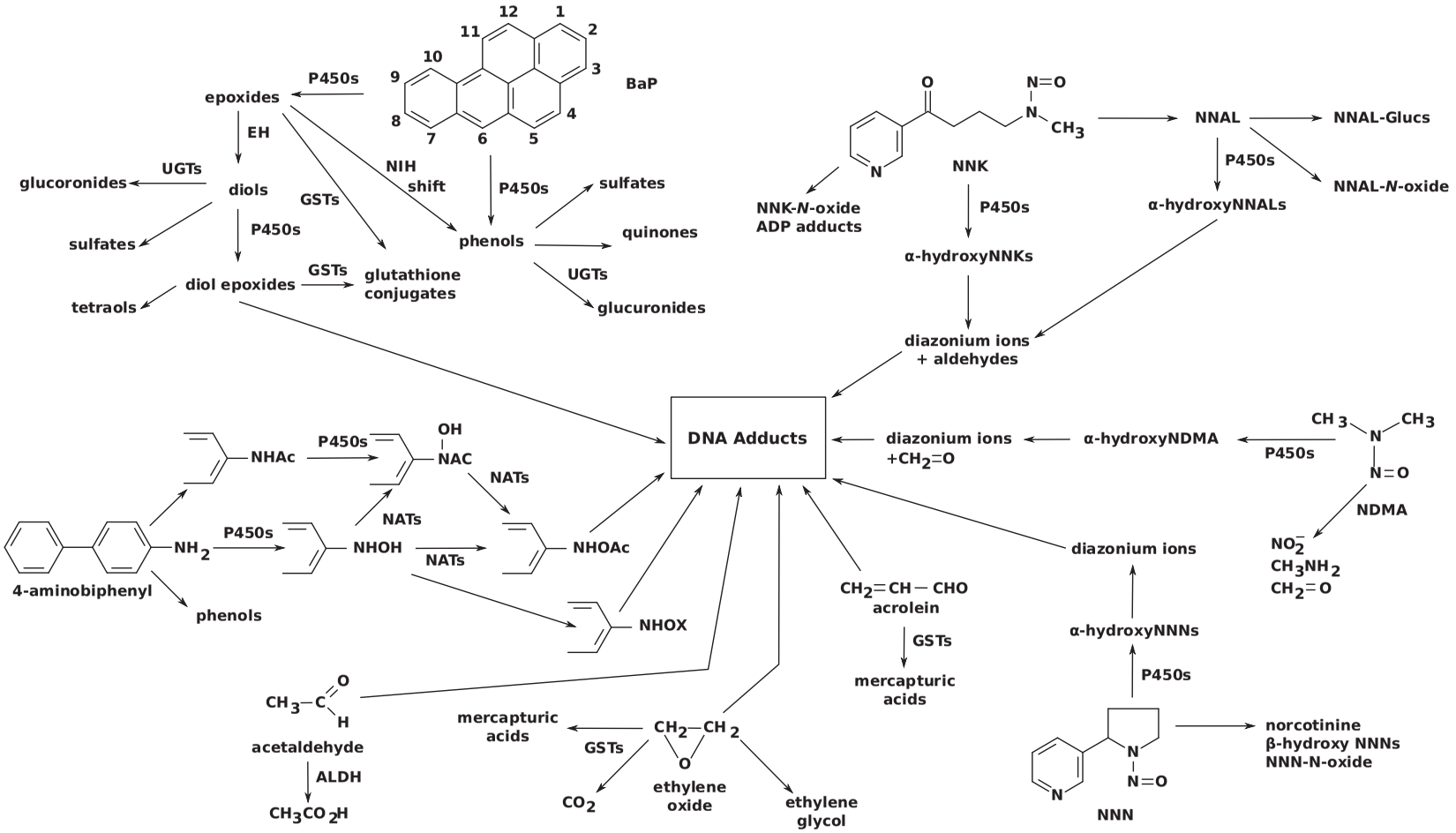
Serum and saliva metabolites have been used as biomarkers much less often than urine metabolites. The most frequently measured tobacco smoke toxicant in serum and saliva is cotinine, documented as a useful biomarker of cigarette smoking in many studies (Lee, 1999; Hukkanen *et al.*, 2005). Total NNAL can be readily quantified in serum and its levels remain relatively constant in a given smoker sampled at bimonthly intervals over a one year period. Consistent with the results described above, one study showed a significant relationship between total NNAL in prospectively collected serum samples from smokers and lung cancer risk (Church *et al.*, 2009). Other biomarkers that have been measured in serum include cadmium, benzene, styrene and *r*-1,*t*-2,3,*c*-4-tetrahydroxy-1,2,3,4-tetrahydrophenanthrene (PheT) (IARC, 2004a; Church *et al.*, 2009).

(c) DNA adducts

Fig. 4.3 presents an overview of metabolism and DNA adduct formation from eight tobacco smoke compounds (clockwise from top left): BaP, NNK, *N*-nitrosodimethylamine (NDMA), NNN, acrolein, ethylene oxide, acetaldehyde and 4-aminobiphenyl. Evidence exists for DNA adduct formation from each of these carcinogens in smokers, based on studies carried out with tissues or blood cells. DNA adduct biomarkers have been applied mainly in studies of smokers, and there is far less evidence from studies of second-hand tobacco smoke or smokeless tobacco use.

The structures of DNA adducts of tobacco smoke carcinogens have been characterized in detail, but a complete description of these structures is beyond the scope of this section. Selected DNA adduct structures are shown in Fig. 4.4. A major DNA adduct of BaP results from *trans*- addition of the benzo[*a*]pyrene diol epoxide (BPDE) to the N^2-position of dG (Szeliga

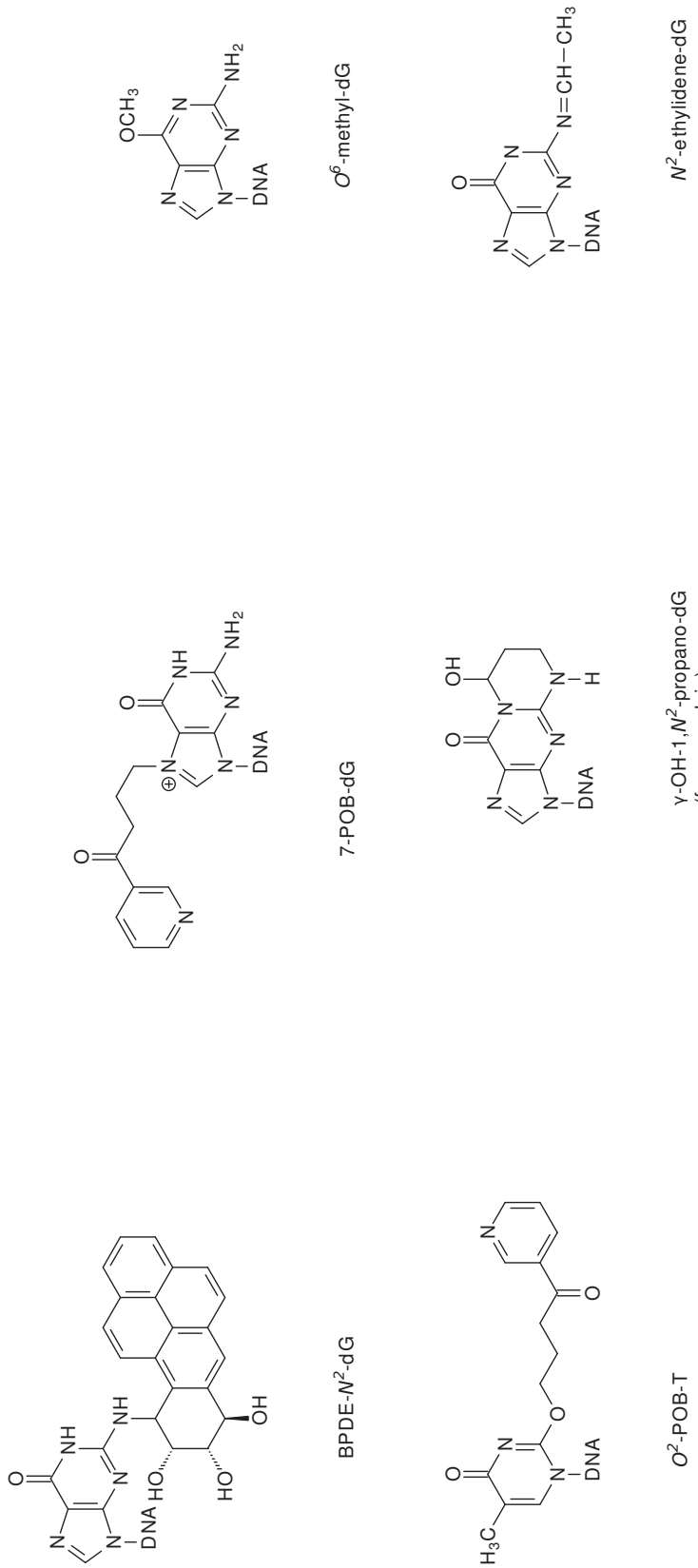
Fig. 4.3 Overview of metabolism and DNA adduct formation from eight tobacco smoke constituents



4-ABP, 4-aminobiphenyl; AC, acetyl; ADP, adenosine diphosphate; ALDH, aldehyde dehydrogenase; AKR, aldo-ketoreductase; B[*a*]P, benzo[*a*]pyrene; EH, epoxide hydrolase; Gluc, glucuronide; GSTs, glutathione *S*-transferases; NATs, *N*-acetyltransferases; NDMA, *N*-nitrosodimethylamine; NIH shift, phenomenon of hydroxylation-induced intramolecular migration; NNAL, 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanol; NNK, 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone; NNN, *N*'-nitrosonornicotine; P450s, cytochrome P450 enzymes; UGTs, uridine-5′-diphosphate-glucuronosyl transferases

Adapted from Cooper *et al.* (1983); Preussmann & Stewart (1984); Kadlubar & Beland (1985); Hecht (1998, 1999); Penning & Drury (2007); IARC (2008, 2010b).

Fig. 4.4 Structures of some DNA adducts of tobacco smoke constituents



BPDE-N^2-dG, benzo[*a*]pyrene diol epoxide-N^2-deoxyguanosine; 7-POB-dG, pyridyloxobutyl-deoxyguanosine; O^2-POB-T, O^2-pyridyloxobutyl-thymidine

& Dipple, 1998). Pyridyloxobutyl (POB)-DNA adducts of NNK and NNN are formed at the 7- and O^6-positions of deoxyguanosine dG, the O^2-position of thymidine, and the O^2-position of deoxycytidine (Hecht, 2008). They can be measured in part as 4-hydroxy-1-(3-pyridyl)-1-butanone (HPB) released upon hydrolysis. Metabolic activation of NNK also leads to 7-methyl-dG and O^6-methyl-dG, identical to the DNA adducts formed from NDMA and other DNA methylating agents (Hecht, 2008). Ethylating agents and ethylene oxide in cigarette smoke also alkylate dG (Zhao *et al.*, 1999; Singh *et al.*, 2005). Acrolein and crotonaldehyde react with DNA to produce exocyclic 1,N^2-dG adducts, while acetaldehyde forms a Schiff base adduct with the exocyclic N^2 amino group of dG. There is evidence for the presence of all these DNA adducts in tissues or blood cells of smokers, but there are also many studies in which these specific adducts have been sought but not found (Boysen & Hecht, 2003).

Measurement of these DNA adducts as biomarkers potentially can provide the most direct link between cellular exposure and cancer, because DNA adducts are so critical in carcinogenesis. However, it is challenging because their levels are extremely low, frequently ranging from 1 per 10^6 to 1 per 10^8 normal bases, and the tissue or blood samples containing them are usually available in only small quantities. Fortunately, the routine detection of amol levels [attomole, equivalent to 10 moles] of DNA adducts by conventional LC-MS/MS techniques is now feasible (Singh & Farmer, 2006). There are still relatively few examples of quantitation of *specific* DNA adducts of tobacco carcinogens in tissues of smokers using mass spectrometry, high pressure liquid chromatography (HPLC)-fluorescence, HPLC with electrochemical detection, or postlabelling techniques (Pfeifer *et al.*, 2002). A much larger body of work has used the highly sensitive, but relatively non-specific ^{32}P-postlabelling and immunoassay methods of DNA adduct detection. Although the adducts detected using ^{32}P-postlabelling are often referred to as "aromatic DNA adducts," there is strong evidence that they are not related to PAHs (Arif *et al.*, 2006). Adduct levels are generally higher in lung tissues of smokers than non-smokers while studies using blood DNA have produced varied results. Adducts have also been detected in the larynx, oral and nasal mucosa, bladder, cervix, breast, pancreas, stomach, placenta, foetal tissue, cardiovascular tissues, sputum, and sperm of smokers (IARC, 2004a). A meta-analysis of the relationship of DNA adduct levels in smokers to cancer, as determined by ^{32}P-postlabelling in the majority of studies or enzyme linked immunosorbent assay (ELISA), demonstrated a positive relationship in current smokers (Veglia *et al.*, 2003; 2008).

(d) Protein adducts

Carcinogen-haemoglobin (Hb) and serum albumin adducts are regarded as surrogates for DNA adduct measurements. Although these proteins are not targets for carcinogenesis, virtually all carcinogens that react with DNA will also react with protein. Advantages of haemoglobin adducts include the ready availability of haemoglobin from blood and the relatively long lifetime of the erythrocyte in humans – 120 days –,which provides an opportunity for adducts to accumulate. Studies on protein adducts in smokers have been comprehensively reviewed (IARC, 2004a).

Haemoglobin adducts of aromatic amines are a highly informative type of carcinogen biomarker, with levels that are consistently higher in smokers than non-smokers, particularly for 3-aminobiphenyl and 4-aminobiphenyl-Hb adducts. Haemoglobin binds aromatic amines efficiently because heme accelerates the rate of nitrosoarene formation from the hydroxylamine, which is produced metabolically from the aromatic amine by CYP1A2 (Fig. 4.3; Skipper & Tannenbaum, 1990). Binding of the nitrosoarene occurs at the β-93 cysteine residue of human

haemoglobin; the adduct is hydrolysed releasing the free amine, which is quantified by GC-MS (Skipper & Tannenbaum, 1990). Adduct levels are clearly related to cigarette smoking (Skipper & Tannenbaum, 1990). Adducts that form at the terminal valine of haemoglobin are also useful biomarkers: examples include those derived from ethylene oxide, acrylonitrile and acrylamide (Bergmark, 1997; Fennell *et al.*, 2000). Ethylated N-terminal valine of haemoglobin is also higher in smokers than in non-smokers (Carmella *et al.*, 2002).

HPB-releasing Hb adducts of NNK and NNN have been quantified in studies of smokers and smokeless tobacco users (IARC, 2004a, 2007a). These adducts are thought to be tobacco-specific, but some studies report their presence in non-smokers (Falter *et al.*, 1994; Schlöbe *et al.*, 2008).

4.1.4 Genetic and related effects

(a) Mutagenicity and cytogenetic effects

Tobacco smoke and its condensates are mutagenic in a wide variety of test systems from bacteria to mammalian cells in culture to rodents and humans (DeMarini, 2004; IARC, 2004a; Husgafvel-Pursiainen, 2004). In bacterial systems, the heterocyclic amines and aromatic amines in condensates account for much of the frameshift mutagenicity, whereas the PAHs and nitrosamines may account for some of the base-substitution mutagenicity (DeMarini *et al.*, 1995). G to T is the predominant class of base-substitution mutation induced by condensates in experimental systems and found in oncogenes and tumour-suppressor genes in smoking-associated lung tumours (IARC, 2004a). The genotoxic potencies of a variety of condensates in several genotoxicity assays likely have only qualitative value with regard to health risk assessment (DeMarini *et al.*, 2008). This is consistent with findings that smokers of low- or high-tar cigarettes have similar urinary levels of lung carcinogens (Hecht *et al.*, 2005b; Hatsukami *et al.*, 2006b) and similar risks for lung cancer (Harris *et al.*, 2004).

In rodents, cigarette smoke induces sister chromatid exchange and micronuclei in bone marrow and lung cells. Human newborns of smoking mothers have increased frequencies of *HPRT* mutations, chromosomal translocations, and DNA strand breaks. Sperm of smokers has increased frequencies of aneuploidy, DNA adducts, strand breaks, and oxidative damage. Cigarette smoke also causes germ-cell mutations in mice (Yauk *et al.*, 2007). Collectively, these data suggest that smoking is likely a germ-cell mutagen in humans. Smoking produces mutagenic urine and somatic-cell mutations in humans, including *HPRT* mutations, sister chromatid exchange, microsatellite instability and DNA damage in a variety of tissues. Genotoxic effects have been found in eight organ sites at which tobacco smoke causes cancer in humans (DeMarini, 2004; IARC, 2004a).

(b) Mutations in TP53, KRAS and related genes

Gene mutation data from a variety of databases, including the IARC Cancer *TP53* Mutation Database (http://www-p53.iarc.fr/), have been collated in the Genetic Alterations in Cancer (GAC) database (http://dir-apps.niehs.nih.gov/gac/) so that mutations in a variety of genes in various cancerous tissues can be compared. An assessment of the Gene Alterations in Cancer database showed that at least three genes were mutated more frequently in lung tumours from smokers than non-smokers (Lea *et al.*, 2007): *TP53* (39 versus 26%), *K-RAS* (20 versus 3%), and loss of heterozygosity at *FHIT* (57 versus 27%). Thus, genes in the cell cycle (*TP53*), cell signalling (*KRAS*) and apoptotic (*FHIT*) pathways are mutated more frequently in smoking- rather than in nonsmoking-associated lung tumours. Genomic sequencing of lung tumours has identified other mutated genes that are associated with smoking; ten times more genes are mutated in

lung tumours from smokers compared to non-smokers (Ding *et al.*, 2008).

GC to TA transversions were the predominant class of base-substitution mutation found in *TP53* and *KRAS* genes in lung tumours from smokers, with the frequency of this mutation in *TP53* being 30% in smokers versus 22% in non-smokers. In smoking-associated oral cancers, the percentage of GC to TA mutations in *TP53* was 15% versus 2%, respectively. This mutation spectrum is consistent with that produced by a variety of known carcinogens present in tobacco smoke (IARC, 2004a). At the codon level, the most frequently mutated codons in *TP53* in lung tumours of smokers were 157, 175, 245, 248, and 273, all of which occur in the DNA-binding domain of the protein; among these codons, only 273 was mutated in lung tumours from non-smokers. Only three of these codons (157, 245 and 273) were mutated in smoking-associated larynx tumours, and only codon 157 was mutated in smoking-associated oral tumours. Thus, the mutational specificity at *TP53* is different among smoking- and nonsmoking-associated tumours and among smoking-associated tumours at various organs (Lea *et al.*, 2007). Thus, different pathways are involved in the development of different types of tumours (Le Calvez *et al.*, 2005; Mounawar *et al.*, 2007; Subramanian & Govindan, 2008).

4.1.5 Effects on gene expression profile

As indicated in a review by Sen *et al.* (2007) involving microarray analysis of 18 studies in human smokers, 7 in smoke-exposed rodents, and 3 in condensate-exposed mammalian cells, smoking generally upregulated a wide variety of genes, especially those involved in the stress response, phase I metabolism, and immune response. Genes that were consistently expressed differentially in smokers (as assessed in alveolar macrophages, lung cells or peripheral lymphocytes) included metallothioneins, heat-shock proteins, superoxide dismutase, glutathione transferase, heme oxygenase, *CYP* genes (*1A2*, *1A1* and *1B1*), interleukins and chemokines.

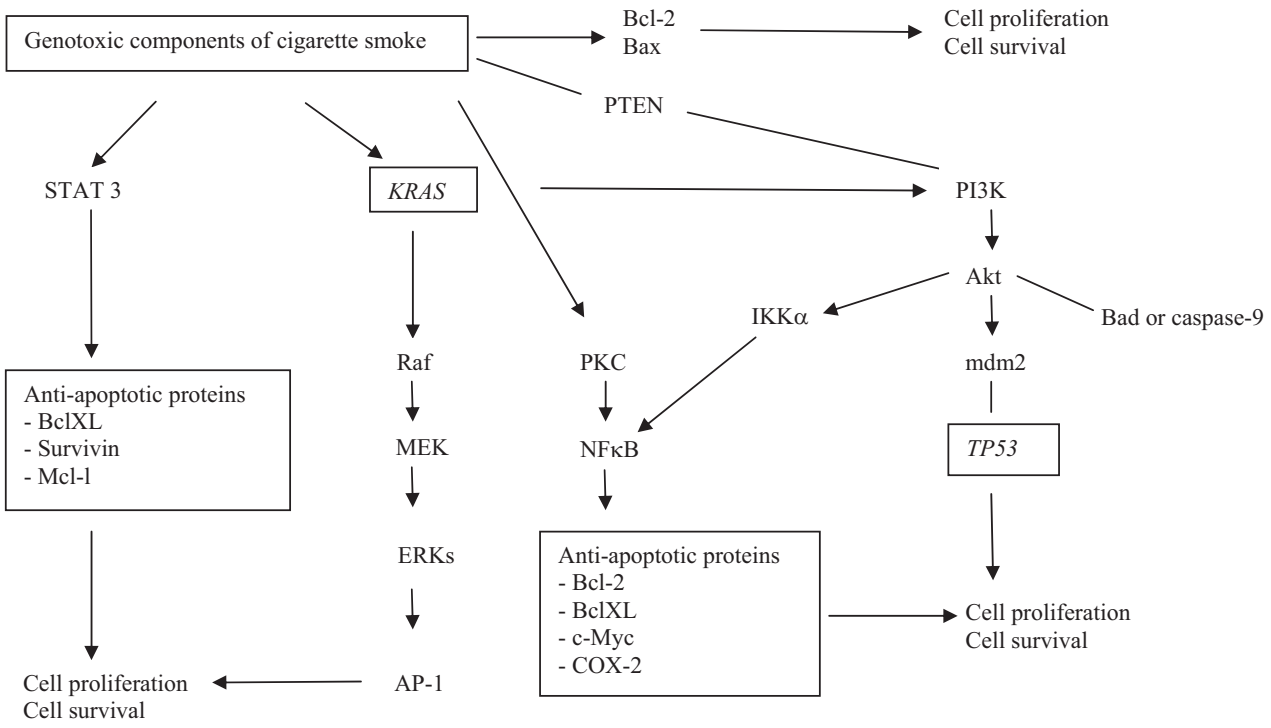
Spira *et al.* (2004) analysed global gene expression in bronchial epithelial cells and found that the expression levels of metabolizing and antioxidant genes had reverted to control levels after two years of smoking cessation. However, expression of potential oncogenes and tumour-suppressor genes never reverted to never-smoker levels even after years of smoking cessation. Consistently, expression of microRNAs is generally downregulated by cigarette smoke (Izzotti *et al.*, 2009). As discussed below, smoking also altered methylation patterns and gene expression in smoking-associated tumours.

4.1.6 Other effects associated with carcinogenesis

(a) Proliferation, differentiation, apoptosis, and inflammation

As noted above, the signal-transduction pathways in lung tumours from smokers are distinctly different from those of non-smokers (Mountzios *et al.*, 2008). Fig 4.5 shows details of signalling pathways that are deregulated by tobacco smoke. The involvement of high frequencies of mutated *K-RAS* and *TP53* genes in smoking-associated lung tumours results in altered regulation of cell proliferation, differentiation, cytoskeletal organization and protein trafficking. Cigarette smoking activates *NF-κB*, which induces pro-inflammatory cytokine expression and induces growth factors and proliferative signals (Mountzios *et al.*, 2008). This gene also influences the expression of the anti-apoptotic gene *BCL2* and pro-apoptotic gene *BAX*. Smoking produces chronic inflammation, which promotes cancer (Walser *et al.*, 2008). Smoking results in high levels of reactive oxygen species, which damage epithelial and endothelial cells and impair their function. In smoking-associated lung cancer, elevated levels of cyclooxygenase-2 (COX-2) and

Fig. 4.5 General scheme of some cell-signalling pathways that are deregulated by tobacco smoke in lung carcinogenesis



Akt, serine/threonine protein kinase; ERKs, extracellular regulated kinases; MEK, mitogen-activated protein kinase; Bad, Bcl2-associated agonist of cell death; PI3K, phosphatidylinositol 3-kinase; PKC, protein kinase C; NF-κB, nuclear factor κB; IKKα, inhibitor of nuclear factor κ-B kinase; PTEN, phosphatase and tensin homologue; STAT3, signal transducer and activator of transcription, COX-2, cyclooxygenase-2

prostaglandin (PGE_2) indicate apoptosis resistance, proliferation, immunosuppression, angiogenesis, invasion, and epithelial-mesenchymal transition (Walser *et al.*, 2008).

(b) Endogenous nitrosation

Intragastric formation of *N*-nitroso compounds, measured using urinary nitrosamino acids excreted in urine, was increased in smokers compared to non-smokers (Hoffmann & Brunnemann, 1983). Two recent studies demonstrated that NNN forms endogenously in some users of nicotine replacement therapy products (Stepanov *et al.*, 2009a, b).

(c) Hormonal changes

These are described in Section 4.3.2a.

4.2 Polymorphisms in carcinogen-metabolizing genes

4.2.1 Introduction

It has been long proposed that the known variation among individuals in their capacity to activate and detoxify carcinogens may be associated with increased susceptibility to cancer, and that polymorphisms of carcinogen-metabolising genes may play a significant role. The most intensively studied genes involved in the metabolism of carcinogens include the various *CYP* genes, the *GST* genes and the *NAT* genes. Other relevant xenobiotic-metabolising genes, such as *EPHX*, sulfotransferase (*SULT*), *UGT*, myeloperoxidase (*MPO*), and NAD(P)H quinone oxidoreductase-1 (*NQO1*) genes, have also been studied. Recently, extensive pooled studies and

reviews have been published on polymorphisms of carcinogen-metabolising genes and their role in cancer susceptibility, especially in tobacco-related lung cancer and cancers at other sites. Similarly, various biomarkers of exposure and genotoxicity that are presumed to provide a mechanistic basis for such associations have been comprehensively investigated in relation to these polymorphisms. A brief overview based largely on reviews and the meta- and pooled analyses is presented here.

4.2.2 Genetic polymorphisms of carcinogen metabolism: some central genes

(a) CYP genes

CYPs comprise the principal enzyme system catalysing various phase I oxidation reactions, including metabolic activation and detoxification of many carcinogenic substances in tobacco smoke such as PAHs. Of the various CYP enzymes expressed in humans, many of those belonging to CYP1 to CYP3 families play a role in carcinogen metabolism, producing highly reactive DNA-damaging metabolites as well as detoxified metabolites (Guengerich & Shimada, 1998; Lang & Pelkonen, 1999; Ingelman-Sundberg, 2004). CYPs have evolved into a wide superfamily with close to 60 different active genes currently identified; most of these genes exhibit polymorphism (www.cypalleles.ki.se).

(i) CYP1A1

Several allelic variants of the human *CYP1A1* gene are currently known (www.cypalleles.ki.se). The major variant forms of the *CYP1A1* gene (wildtype allele *CYP1A1*1*) mostly frequently studied for association to cancer susceptibility include the following two alleles: (i) *CYP1A1*2A* allele (m1 allele; *Msp* I) and (ii) *CYP1A1*2B* (Cascorbi *et al.*, 1996) or *CYP1A1*2C* (www.cypalleles.ki.se) allele (m2 allele; Ile^{462}Val). Importantly, the *CYP1A1* m1 allele and m2 allele are in complete linkage disequilibrium in Caucasians (Kawajiri, 1999; Bartsch *et al.*, 2000). In addition, *CYP1A1*4* allele (m4; Thr^{461}Asn) (Cascorbi *et al.*, 1996), and *CYP1A1*3* (m3) allele found in African-Americans but not in Caucasians or Asians (Crofts *et al.*, 1993) are included in some studies (Bartsch *et al.*, 2000).

In smoking-related lung cancer, the various *CYP1A1* polymorphisms as well as the differences in the frequencies of the rare variant alleles between ethnicities contribute to the differences in findings. There are collective analyses of data predominantly indicating an overall mild to moderate effect of *CYP1A1* polymorphisms on lung cancer risk (Kawajiri, 1999; Bartsch *et al.*, 2000; Houlston, 2000; Le Marchand *et al.*, 2003; Vineis *et al.*, 2003; Vineis *et al.*, 2004; Lee *et al.*, 2008a; Shi *et al.*, 2008). In many reviews and meta- or pooled analyses the increased risk associated with *CYP1A1* polymorphism has most clearly been seen in Asian populations (Kawajiri, 1999; Le Marchand *et al.*, 2003; Vineis *et al.*, 2003; Lee *et al.*, 2008a; Shi *et al.*, 2008).

Multiple studies have also analysed the gene-gene interactions between *CYP1A1*, *GSTM1* and *GSTT1* polymorphisms and lung cancer (d'Errico *et al.*, 1999; Houlston, 1999; Benhamou *et al.*, 2002; Bolt & Thier, 2006; Raimondi *et al.*, 2006; Ye *et al.*, 2006; Carlsten *et al.*, 2008). Some of the analyses have indicated that the elevated risk for lung cancer may be more pronounced for some *CYP1A1/GSTM1* null genotype combinations (Le Marchand *et al.*, 1998; Bartsch *et al.*, 2000; Vineis *et al.*, 2004, 2007; Lee *et al.*, 2008a; Shi *et al.*, 2008).

(ii) CYP1A2

CYP1A2 is highly inducible and metabolises, including deacetylation reactions, many tobacco smoke carcinogens such as aromatic and heterocyclic amines and nitro-aromatic compounds, and tobacco-specific nitrosamines such as NNK (Nebert *et al.*, 2004; Jalas *et al.*, 2005; IARC, 2007a). A few major variant alleles have been described (www.cypalleles.ki.se), some of which

may have been reported to influence inducibility (Nakajima *et al.*, 1999; Ingelman-Sundberg *et al.*, 2007). Overall, the phenotype-genotype relations have not been well established for *CYP1A2*, although current evidence points towards contribution of genetic variation (Murayama *et al.*, 2004; Ingelman-Sundberg *et al.*, 2007); data on possible associations with tobacco related cancer are sparse (Agundez, 2004; Nebert & Dalton, 2006).

(iii) CYP2A6

Several aspects of smoking behaviour are likely to be influenced by *CYP2A6* genetic variation, which influences nicotine metabolism (Malaiyandi *et al.*, 2005; Mwenifumbo & Tyndale, 2007). The most important functionally altered allele is *CYP2A6*4* (gene deletion), which confers a poor-metabolizer phenotype in homozygous individuals (Malaiyandi *et al.*, 2005; Ingelman-Sundberg *et al.*, 2007; Mwenifumbo & Tyndale, 2007). In some studies, polymorphic variants of *CYP2A6* gene have been implicated in susceptibility to smoking-related cancers (Gambier *et al.*, 2005; Malaiyandi *et al.*, 2005; Nakajima, 2007). In line with this, the accumulated data have suggested that *CYP2A6* polymorphism may affect cancer risk in smokers but not in non-smokers (Tan *et al.*, 2001; Kamataki *et al.*, 2005; Malaiyandi *et al.*, 2005; Canova *et al.*, 2009).

(iv) CYP2A13

From human CYPs, CYP2A13 is the primary form involved in the metabolic activation of the tobacco-specific nitrosamines NNK and NNN (Jalas *et al.*, 2005; IARC, 2007a). The *CYP2A13* gene exhibits polymorphism in humans (Zhang *et al.*, 2002; Jalas *et al.*, 2005), and experimental studies suggest that some of the polymorphisms may affect the hydroxylation of NNN and NNK (Jalas *et al.*, 2005; Schlicht *et al.*, 2007). However, the data on possible effects of these polymorphisms on the risk of tobacco-related cancers in humans are still limited (Wang *et al.*, 2003; Song *et al.*, 2009; Timofeeva *et al.*, 2009).

(v) CYP2D6

The *CYP2D6* gene shows high variability in expression. The enzyme is not inducible, and therefore genetic variation largely contributes to the interindividual variation in enzyme activity. Currently, more than 100 different functional CYP2D6 gene variants have been described, and these are divided into alleles causing abolished, decreased, normal, and ultrarapid enzyme activity (Ingelman-Sundberg, 2005; Ingelman-Sundberg *et al.*, 2007). The most important null alleles leading to poor-metabolizer phenotype are *CYP2D6*4* (splice defect) and *CYP2D6*5* (gene deletion) (Ingelman-Sundberg, 2005; Ingelman-Sundberg *et al.*, 2007).

A large series of studies have been carried out over the past 20 years on the association between *CYP2D6* polymorphism and susceptibility to lung cancer and to some other tobacco-related cancers (Wolf & Smith, 1999). Despite some indication of an association between CYP2D6 poor-metabolizer and decreased risk for lung cancer, no major role for CYP2D6 in carcinogen metabolism or a molecular basis for such an association have been discovered (Wolf & Smith, 1999; Ingelman-Sundberg, 2005).

(vi) Other CYP genes

CYP1B1 allelic variants that affect the catalytic activity have been described but they have been studied to a lesser extent for the association with susceptibility to smoking-related cancers (Thier *et al.*, 2003). Some positive findings have been reported on head and neck cancer (Ko *et al.*, 2001), and lung cancer (Zienolddiny *et al.*, 2008).

Several polymorphisms have been characterized in the *CYP2E1* gene and several positive associations with the risk of different cancers have been reported, in particular for cancers of the upper aerodigestive tract, lung and gastrointestinal tract (Section 2.19). *CYP2E1* may also

play an important role in the interaction of the carcinogenic effects of alcohol and tobacco (Section 4.4).

From the human *CYP3A* locus (*CYP3A4*, *CYP3A5* and *CYP3A7*), the *CYP3A4*1B* allele has been associated with lung cancer and prostate cancer in some studies but not in all (Dally *et al.*, 2003; Rodriguez-Antona & Ingelman-Sundberg, 2006). However, the role of these variants in relation to tobacco smoking is unknown.

(b) *GSTM1 and other GST genes*

Polymorphic *GST* genes have long been proposed to modify susceptibility to lung cancer (Seidegård *et al.*, 1986; Ketterer *et al.*, 1992). The polymorphic genes encoding the various classes of cytosolic GST enzymes include the *GSTM1* and *GSTM3* genes (mu class), the *GSTP1* gene (pi class), and the *GSTT1* gene (theta class). The gene deletion (null) allele of the *GSTM1* gene (*GSTM1*0*) and of the *GSTT1* gene (*GSTT1*0*) have been the most intensively studied polymorphisms in relation to increased susceptibility to cancer (Strange *et al.*, 2001; Bolt & Thier, 2006; McIlwain *et al.*, 2006). For the *GSTP1* gene, the form most abundantly present in lung tissue, genetic variation in exon 5 (*GSTP1*2*; *Ile*^{105}*Val*), in exon 6 (*Ala*^{114}*Val*), as well as a combination of these, are the variations most frequently studied for cancer susceptibility (Watson *et al.*, 1998; Cote *et al.*, 2009).

Numerous reviews, meta- and pooled analyses have been published over the past 15 years or so for the *GST* genes with systematic assessments covering altogether tens of thousands of cases and controls. For the *GSTM1* null genotype, such analyses have largely provided negative, suggestive or at most moderately positive results for an association with an increased risk for lung cancer (d'Errico *et al.*, 1999; Houlston, 1999; Benhamou *et al.*, 2002; Ye *et al.*, 2006; Carlsten *et al.*, 2008). The larger the studies, the less significant the estimates for the role of *GSTM1* emerge in systematic analysis (Ye *et al.*, 2006; Carlsten *et al.*, 2008). Also the varying allele frequencies related to ethnic background affect the findings for *GSTM1* as well as for many other genes (Garte *et al.*, 2001; Ye *et al.*, 2006; Carlsten *et al.*, 2008; Lee *et al.*, 2008a).

In a meta-analysis of the association between the *GSTT1* gene polymorphism and lung cancer no association between *GSTT1* null genotype and risk for lung cancer in Caucasians was observed, but a positive association was found for Asians (Raimondi *et al.*, 2006). A significant association for either Caucasians or Asians was also not found in a pooled analysis (Raimondi *et al.*, 2006). A meta-analysis found no significant association between lung cancer risk and the *GSTP1 Ile*^{105}*Val* polymorphism; but the pooled analysis suggested an overall statistically significant mild association between lung cancer and homozygosity or heterozygosity for the Val^{105} allele (Cote *et al.*, 2009).

A recent body of epidemiologic data suggests an inverse association between cruciferous vegetables/isothiocyanates intake and cancers of the colorectum, lung and breast; the studies also provide evidence that this protective effect is greater among individuals who possess the *GSTM1* or *T1* null genotype, who would be expected to accumulate higher levels of isothiocyanates at the target tissue level, a pre-requisite for their enzyme-inducing effects (Seow *et al.*, 2005). The association between isothiocyanates and cancer, and its modification by *GSTM1* and *GSTT1* status, is most consistent for lung cancer and appears to be strongest among current smokers who possess the combined *GSTM1* and *GSTT1* null genotypes (London *et al.*, 2000a; Spitz *et al.*, 2000; Zhao *et al.*, 2001; Brennan *et al.*, 2005; Seow *et al.*, 2005).

(c) *NAT1 and NAT2 genes*

The pooled and meta-analyses carried out on *NAT1* and *NAT2* polymorphisms and bladder cancer risk have consistently reported significantly increased risk for *NAT2* slow acetylators

(Dong *et al.*, 2008; Malats, 2008; see also Section 2.9). Data on *NAT1* fast acetylators are inconsistent, as are the studies suggesting an increased risk for *NAT2* rapid acetylator status. Additionally, genotypes for other genes, specially *GSTM1*, have also been implicated (Vineis *et al.* 2001; García-Closas *et al.*, 2005; Hein, 2006; Sanderson *et al.*, 2007; Dong *et al.*, 2008; Malats, 2008).

In a recent large study on tobacco-related lung cancer and upper aerodigestive cancers, the *NAT* genes, in particular *NAT*10* haplotype, emerged from a set of 16 genes as involved in the risk (McKay *et al.*, 2008). When more than one hundred single nucleotide polymorphisms for 31 genes involved in phase I or phase II metabolism or in antioxidant defence were investigated, only four of the previously reported polymorphisms of the *GSTP1*, *EPHX1* and superoxide dismutase *SOD2* genes and the *NAT1* fast acetylator phenotype remained significantly associated with risk of non-small cell lung cancer after correction for multiple testing (Zienolddiny *et al.*, 2008).

In breast cancer, several recent meta-analyses of epidemiological studies have suggested increased risk among smokers with the *NAT2* slow acetylator genotype; such an association has been observed especially among long-term smokers and post-menopausal women (Terry & Goodman, 2006; Ambrosone *et al.*, 2008; Ochs-Balcom *et al.*, 2007; Baumgartner *et al.*, 2009).

In all, the role of the *NAT* gene polymorphisms in tobacco-related cancers, with the exceptions of increased risk of bladder cancer and possibly breast cancer in *NAT2* slow acetylators, remains largely open due to the incomplete understanding of phenotype-genotype relationships, and the interplay between these two genes and their polymorphisms (Hein, 2002, 2006).

(d) Others

Genes coding for EPHX, UGT and SULT enzymes, mainly but not exclusively involved in detoxification reactions, exhibit polymophisms with numerous gene variants discovered (Mackenzie *et al.*, 1997; London *et al.*, 2000b; Glatt *et al.*, 2001; Burchell, 2003). Additional polymorphic genes studied for their significance in cancer susceptibility are the *NQO1* and *MPO* genes, with NQO1 playing a dual role in the detoxification and activation of procarcinogens, and MPO converting lipophilic carcinogens into hydrophilic forms (Nebert *et al.*, 2002). All these genes have been studied for their possible association with tobacco-related cancer risk to a varying extent and with variable outcomes (London *et al.*, 2000b; Bamber *et al.*, 2001; Garte, 2001; To-Figueras *et al.*, 2001; Tiemersma *et al.*, 2002b; Guillemette, 2003; Wells *et al.*, 2004; Kiyohara *et al.*, 2005; Moreno *et al.*, 2005; Nagar & Remmel, 2006; Gallagher *et al.*, 2007).

4.2.3 Biomarkers of tobacco carcinogenesis and polymorphic genes of carcinogen metabolism

A myriad of studies have investigated association between various biomarkers of tobacco-related carcinogenesis and genetic variation of genes involved in carcinogen metabolism. For involvement in increased cancer susceptibility, a large variety of intermediate biomarker have been studied, including PAH metabolites in urine, urinary mutagenicity, DNA and protein adducts, cytogenetic alterations, *HPRT* mutant lymphocytes, as well as somatic mutations of the tumour suppressor gene *TP53* and *KRAS* oncogene occurring in cancer tissue.

(a) PAH metabolites and mutagenicity in urine

(i) PAH metabolites in urine

Increased excretion of 1-hydroxypyrene in urine in association with the *GSTM1* null genotype has been reported in many studies on individuals with occupational or environmental exposure to PAHs (Yang *et al.*, 1999; Alexandrie *et al.*, 2000; Lee *et al.*, 2001; Kuljukka-Rabb *et al.*, 2002; Kato *et al.*, 2004). The associations seen between *GSTT1* polymorphism and the

PAH metabolites are somewhat more variable. Similarly, the joint effect of *GSTM1* and *GSTT1* null genotypes, as well as the effects of some other genes of xenobiotic metabolism, such as *EPHX*, *CYP1A1*, *CYP1A2* and the aryl hydrocarbon receptor (*AhR*) gene have been either positive or negative (Yang *et al.*, 1999; Alexandrie *et al.*, 2000; Lee *et al.*, 2001; Zhang *et al.*, 2001; Kuljukka-Rabb *et al.*, 2002; Yang *et al.*, 2003; Chen *et al.*, 2007; Cocco *et al.*, 2007; Bin *et al.*, 2008).

Another PAH metabolite studied in this context is phenanthrene, the simplest PAHs with a bay region, a feature closely associated with carcinogenicity. A study quantified ratios of urinary products of metabolic activation (such as PheT) and detoxification (such as phenanthrols, HOPhe) of phenanthrene in 346 smokers, who were also genotyped for 11 polymorphisms in genes involved in PAHs metabolism, including the *CYP1A1* and *GSTM1* genes. A significant association between the presence of the *CYP1A1* $Ile^{462}Val$ polymorphism and high PheT/3-HOPhe ratios was found, particularly in combination with the *GSTM1* null polymorphism (Hecht *et al.*, 2006).

Overall, the data on the influence of genetic variation in PAHs metabolism on the levels of the urinary metabolite biomarkers are variable, and currently inconclusive.

(ii) Urinary mutagenicity

One relatively early line of research investigated the relationship between urinary mutagenicity and genetic variation in activation or detoxification genes. These studies, however, have seldom been focused on smokers only but rather on other sources of exposure (Pavanello & Clonfero, 2000).

In some studies, *NAT2* slow acetylator genotype either alone or in combination with *GSTM1* null genotype has been associated with increased urinary mutagenicity in the *Salmonella* test in individuals with occupational, environmental or medicinal PAH-related exposure, or in smokers (Vineis & Malats, 1999; Pavanello & Clonfero, 2000). In another study, CYP1A2 activity, but not *NAT2*, *GSTM1* or *GSTT1* genotypes influenced urinary mutagen excretion in smokers (Pavanello *et al.*, 2002). A further study also suggested contribution of the *CYP1A2* gene variation to increased urinary mutagenicity in heavy smokers (Pavanello *et al.*, 2005). Associations with variants of other xenobiotic-metabolising genes (such as *EPHX1*) have also been reported, with somewhat complex results (Kuljukka-Rabb *et al.*, 2002).

(b) DNA adducts

The relationship between the variants of polymorphic genes of carcinogen metabolism and tobacco smoke-related DNA adduct formation has been addressed in an abundant number of studies among smokers, occupationally exposed groups, and patients with smoking-related cancer. In addition, multiple *in vitro* studies on this relationship have been carried out (Bartsch *et al.*, 2000; Pavanello & Clonfero, 2000; Alexandrov *et al.*, 2002; Wiencke, 2002).

The intensive efforts to study the relationship between *CYP1A1* and *GSTM1* gene polymorphism and the level of aromatic-hydrophobic/bulky PAH-DNA adducts in human lungs have so far provided little evidence for a role of a single metabolic genotype or their combinations on DNA adduct formation, with largely weak, non-significant or contradictory results. However, a trend of increasing adduct levels in subjects with the *CYP1A1*2-GSTM1*0* genotype combination has been observed, which was reinforced when BPDE-DNA adducts were specifically assessed. These results suggest a gene-gene interaction, supported by biological data from other studies (Bartsch *et al.*, 2000; Alexandrov *et al.*, 2002; Wiencke, 2002). Such gene-gene interaction lends support to the increased risk for lung cancer found in carriers of these genotypes in Japanese, among whom the frequency of the

variant *CYP1A1* allele is much higher (Bartsch *et al.*, 2000; Alexandrov *et al.*, 2002).

A wide selection of genes and genotypes included in the various studies have made it difficult to assess the overall role of the polymorphisms of *GSTM1* and other genes alone or in combination. Differences between the studies in the types of adducts determined, the various tissues, cell types and cancers studied, detection methods, variation in sources and types of exposure, sample size, gender differences, and sometimes poor knowledge regarding the alleles, genotypes and haplotypes under study also contribute to the large variability seen in these studies (d'Errico *et al.*, 1999; Hemminki *et al.*, 2001; Alexandrov *et al.*, 2002; Wiencke, 2002).

(c) Cytogenetic biomarkers of genotoxicity

(i) Chromosome aberrations and sister chromatid exchanges

Early studies investigating whether homozygosity for the *GSTM1* null allele affects prevalence of cytogenetic changes in lymphocytes of smokers reported positive results (Seidegård *et al.*, 1990; van Poppel *et al.*, 1992; Cheng *et al.*, 1995). Since then, studies have investigated the association between genetic polymorphisms of xenobiotic-metabolising genes and cytogenetic biomarkers in smokers and in some occupational groups (Rebbeck, 1997; Autrup, 2000; Pavanello & Clonfero, 2000; Norppa, 2003, 2004).

Collectively, the reported findings are in support of increased susceptibility of smokers to chromosomal effects in association with *GSTM1* and *GSTT1* null variants deficient in detoxification of tobacco smoke carcinogens. Exposure to genotoxicants generated from other environmental sources (e.g. polluted air, diet, endogenous sources such as reactive oxygen species) may contribute to the observed associations, and it is likely that other polymorphic metabolic genes such as *NAT2* may be involved (Pavanello & Clonfero, 2000; Norppa, 2001, 2003).

(ii) Micronucleus induction

The relationship between formation of micronuclei and genetic polymorphisms of carcinogen metabolism has been addressed in a wide range of human population studies (Norppa, 2003, 2004). Induction of micronuclei in smokers may be little, if at all, affected by *GSTM1*, *GSTT1* or *NAT2* genotypes. In contrast, the *NAT1* rapid genotype appears to show an association with increased susceptibility to smoking-related micronuclei (Norppa, 2004).

A recent review evaluated more than seventy human studies on genetic polymorphisms and micronucleus frequency detected either in peripheral blood lymphocytes or exfoliated cells in populations exposed to various genotoxic agents. There were no significant genotype effects involved in micronucleus induction in smokers (Iarmarcovai *et al.*, 2008). The relationship between genetic polymorphisms and micronucleus formation is complex, and is influenced to a variable extent by several genes of xenobiotic metabolism and DNA repair, as well as the variety of chromosomal alterations known to contribute to micronucleus formation (Iarmarcovai *et al.*, 2008).

(iii) Chromosomal damage induced in vitro

The effects of genotypes or genotype combinations *in vitro* on the induction of various cytogenetic endpoints by tobacco-smoke carcinogens and their metabolites have been studied, initially focused on the *GSTM1* and *GSTT1* null genotypes (Norppa, 2001, 2004). In a study investigating NNK *in vitro*, lymphocytes from *GSTM1* null donors were more sensitive to induction of chromosomal aberrations and sister chromatid exchanges by NNK than lymphocytes from *GSTM1* positive donors (Salama *et al.*, 1999).

(d) Gene mutations

(i) HPRT mutant lymphocytes

Associations between the frequencies of *HPRT* mutant T-lymphocytes in populations exposed to genotoxic agents, such as smokers, and the polymorphism of xenobiotic-metabolising genes have been studied. In the early studies, positive, weak, or negative associations were reported for *GSTM1* null genotype, and negative findings were published for *NAT2* slow acetylator genotype in occupationally exposed or non-exposed subjects (Rebbeck, 1997; Vineis & Malats, 1999). When healthy, non-smoking and occupationally non-exposed young adults were studied for HPRT mutant frequency and polymorphisms in *CYP1A1*, *GSTM1* and *NAT2* genes, none of these polymorphisms, analysed individually, were found to influence the *HPRT* mutant frequency (Davies *et al.*, 1999). A significant interaction between the *GSTM1* null genotype and *NAT2* slow acetylator was associated with higher mutant frequency, but no other genotype combinations (Davies *et al.*, 1999). Some later studies have reported variable associations between *HPRT* mutant frequency and polymorphisms for either individual genes (*GSTM1*, *GSTT1* or *EPHX1*) or some of the genotypes in combination among exposed (Viezzer *et al.*, 1999; Abdel-Rahman *et al.*, 2001, 2003).

(ii) Mutations of the TP53 gene and other cancer-related genes

Whether the frequency of somatic mutations detected in tumour tissue in cancer-related genes, primarily the *TP53* tumour suppressor gene and *KRAS* oncogene, may be modified by polymorphisms in carcinogen metabolizing genes was first investigated assessing the effects of the *GSTM1* genotype, alone or in combination with other genetic polymorphisms. Several, but not all, such studies showed significant association between *GSTM1* null genotype and either the frequency or type of *TP53* mutations in smoking-induced lung cancer or other cancer type (Rebbeck, 1997; Vineis & Malats, 1999; Autrup, 2000). Fewer studies examined the association between *TP53* mutations and *GSTT1* polymorphism, and some results suggested the involvement of both null genotypes (Vineis & Malats, 1999; Autrup, 2000).

In smokers with non-small cell lung cancer, the risk of mutation was found to be the highest among the homozygous carriers of the *CYP1A1* rare allele *CYP1A1 MspI* (*Ile*^{462}*Val*) who also exhibited the *GSTM1* null genotype (Kawajiri *et al.*, 1996). Similarly, positive associations between *K-RAS* mutations and homozygosity for the *CYP1A1* rare allele were observed; the risk of mutation was enhanced when the *CYP1A1* susceptible genotype was combined with *GSTM1* null genotype (Kawajiri *et al.*, 1996). In another study, also carried out in a Japanese study population, *K-RAS* mutations occurred with greater frequency in lung adenocarcinoma smoking patients and of the *GSTM1* null genotype as compared with the *GSTM1* positive genotype (Noda *et al.*, 2004).

Many of the studies that assessed *NAT2* acetylator genotypes have found non-significant associations with the frequency or type of *TP53* mutation in bladder, lung, or other cancers (Vineis & Malats, 1999; Autrup, 2000). A study on bladder cancer did not find an overall association between *TP53* mutation frequency and *GSTM1*, *GSTT1*, *GSTP1* or *NAT2* genotypes. However, among patients with *TP53* mutations, transversion mutations were more frequent in those with *GSTM1* null genotype as compared to those with GSTM1 positive genotype; no significant associations were found for the *NAT2* gene (Ryk *et al.*, 2005).

In rectal cancer, overall negative results for an association between *TP53* or *KRAS* mutations and *GSTM1* and *NAT2* polymorphisms among smokers and non-smokers exposed to tobacco smoke were found (Curtin *et al.*, 2009). An interaction of second-hand tobacco smoke and *NAT2*

was found in *TP53* mutation positive tumours but not in smokers (Curtin *et al.*, 2009). Earlier, an increased risk of *TP53* transversion mutations among *GSTM1* positive individuals who smoked cigarettes was found in colon cancer (Slattery *et al.*, 2002).

A statistically significant association was observed between the *GSTT1* null genotype and *TP53* mutation status of breast tumour in one study (Gudmundsdottir *et al.*, 2001), while in another larger study none of the genotypes for *CYP1B1*, *GSTM1*, *GSTT1* and *GSTP1* genes alone were associated with somatic *TP53* mutations (Van Emburgh *et al.*, 2008).

In summary, data from various cancer types on the association between genetic polymorphisms of carcinogen-metabolizing genes and somatic mutations of the *TP53* and *K-RAS* genes vary widely and do not permit to conclude (Rebbeck, 1997; Vineis & Malats, 1999; Autrup, 2000).

4.3 Site-specific mechanisms of carcinogenicity of tobacco smoke

4.3.1 Sites with sufficient evidence of carcinogenicity of tobacco smoking

(a) Lung

The conceptual model presented in Section 4.1 (Fig. 4.1) depicts the main mechanistic steps by which cigarette smoke causes cancer. Smokers inhale into their lungs carcinogens which, either directly or after metabolism, covalently bind to DNA, forming DNA adducts (see Section 4.1, Fig. 4.3). Tobacco smoke contains multiple strong lung carcinogens such as NNN, NNK, PAHs, 1,3-butadiene and cadmium. Levels of tobacco smoke-related DNA adducts, mainly ^{32}P-postlabelled aromatic-hydrophobic/PAH-related bulky DNA adducts, in the lung are higher in smokers than in non-smokers (Phillips, 2002; IARC, 2004a; Hecht, 2008). Higher levels of DNA adducts have further been linked to increased risk for cancer in pooled and meta-analyses (IARC, 2004a; Veglia *et al.*, 2008).

Mutations in *TP53* and *K-RAS* genes, two central genes of human carcinogenesis, are more frequently mutated in smokers' lung cancer as compared to lung cancer from non-smokers (DeMarini, 2004; IARC, 2004a; Lea *et al.*, 2007; Ding *et al.*, 2008; see Section 4.1.3). In particular, *TP53* but also to some extent *K-RAS* mutations found in smoking-associated lung tumours exhibit mutational specificity that is consistent with the pattern produced by PAH diol epoxides in experimental studies and different from that observed in non-smokers' lung cancer (Pfeifer *et al.*, 2002; DeMarini, 2004; IARC, 2004a; Le Calvez *et al.*, 2005; Section 4.1.3). Keeping with such exposure-specific mutation profile, lung cancer in non-smokers exposed to second-hand tobacco smoke shows mutational similarity to smokers' lung cancer, although less data are available (Husgafvel-Pursiainen, 2004; IARC, 2004a; Le Calvez *et al.*, 2005; Subramanian & Govindan, 2008). The different pathways of lung carcinogenesis for smokers and non-smokers are likely to involve somatic mutations and other genetic alterations in a larger set of genes that are critical in controlling normal cellular growth via signal transduction (Bode & Dong, 2005; Lea *et al.*, 2007; Ding *et al.*, 2008).

Smoking-related lung carcinogenesis also involves a multitude of other alterations influencing the complex pathogenic pathways involved in lung cancer development, such as increased inflammation, aberrant apoptosis, increased angiogenesis, tumour progression and tumour metastasis (Wolff *et al.*, 1998; Heeschen *et al.*, 2001; Schuller, 2002; West *et al.*, 2003; Smith *et al.*, 2006; Lee *et al.*, 2008b; Section 4.1.5). Continued exposure to toxicants, genotoxicants, carcinogens, co-carcinogens and tumour promoters present in tobacco smoke has major effects on biological processes at all steps of multistep tumourigenesis of human lung (Hecht,

2003, 2008; Section 4.1). For example, nicotine in tobacco smoke is currently not described as a full carcinogen, but it exerts its biological effects via binding to nicotinic and other cellular receptors and likely enhances cell transformation and carcinogenicity through mechanisms not yet defined (Heeschen *et al.*, 2001; West *et al.*, 2003).

Numerous studies have provided evidence that the human genome may contain one or several loci that confer susceptibility to lung cancer. There are low-penetrance genes involved in the metabolism of tobacco smoke carcinogens, DNA repair and cell cycle control that may influence individual susceptibility to lung cancer (Spitz *et al.*, 2006). The role of the polymorphisms of these various classes of genes in lung carcinogenesis requires a systematic evaluation of the genetic evidence with stringent criteria (Ioannidis, 2008; Risch & Plass, 2008; Vineis *et al.*, 2009; Sections 4.1 and 4.2). Recently, genome-wide association studies have identified a susceptibility locus at chromosome 15q25.1 (Amos *et al.*, 2008; Hung *et al.*, 2008; Thorgeirsson *et al.*, 2008). The identity or function of the gene is not yet known, nor is the mechanism through which it may predispose to lung cancer. It is however likely that lung cancer susceptibility is related to the nicotine receptor gene residing at 15q25.1, and there is some evidence suggesting that it may be related to increased uptake of nicotine and NNK per cigarette (Le Marchand *et al.*, 2008).

In addition to genetic alterations, a growing body of evidence shows that epigenetic mechanisms, such as aberrant DNA methylation, histone modifications and RNA-mediated gene silencing are involved in cancer development (Jones & Baylin, 2007; Cortez & Jones, 2008). In lung carcinogenesis, gene promoter-associated (CpG island-specific) hypermethylation is an early and frequent event causing transcriptional inactivation of genes involved in regulation of cellular growth and differentiation (Belinsky, 2004). For example, several studies have indicated that the tumour suppressor gene *p16* ($p16^{INK4a/CDKN2A}$), a cell cycle regulator, is among the genes most frequently inactivated by aberrant methylation in lung cancer from smokers (Belinsky, 2004), with differences seen between smokers and never-smokers (Toyooka *et al.*, 2006). Significant associations have been established between smoking and promoter hypermethylation of tumour suppressor genes in lung tumours from smokers, and in plasma, serum or sputum DNA from cancer-free smokers (Belinsky, 2004; Belinsky *et al.*, 2005, 2006; Toyooka *et al.*, 2006).

(b) Oral cavity

PAHs can be carcinogenic at the site of application, which could include the human oral cavity. DMBA, a highly carcinogenic PAH not present in tobacco or tobacco smoke, is a standard model compound for induction of oral tumours in the hamster cheek pouch; less is known about the effects on the oral cavity of PAHs that do occur in tobacco products (Shklar, 1972; Rao, 1984; Vairaktaris *et al.*, 2008). A mixture of NNN and NNK induced oral tumours in rats when applied locally (Hecht *et al.*, 1986), and DNA adduct formation from NNN, NNK and NNAL has been observed in the rat oral cavity (Zhang *et al.*, 2009a, b). HPB-releasing DNA adducts from NNK and/or NNN have been reported in exfoliated oral cells from smokers and smokeless tobacco users (Heling *et al.*, 2008) and HPB-releasing heamoglobin adducts are elevated in smokeless tobacco users (IARC, 2007a). Unidentified DNA adduct levels are consistently elevated in oral cells and tissues from smokers compared to non-smokers (IARC, 2004a). Mutations in the *TP53* gene have been observed in oral tumours from smokers and smokeless tobacco users (IARC, 2006b, 2007a; Warnakulasuriya & Ralhan, 2007). Tobacco-associated genetic mutations including micronuclei, gene mutations, DNA polymorphisms, and chromosomal abnormalities have been reported in studies of buccal cells from smokers and smokeless tobacco users (Proia *et al.*, 2006). The use of lime by betel quid chewers is associated

with enhanced oxidative damage that could play a role in inflammation or tumour promotion (IARC, 2004b).

(c) Larynx and nasopharynx

Hamsters exposed to cigarette smoke by inhalation consistently developed benign and malignant tumours of the larynx; tumours were produced by inhalation of the particulate phase, but not the gas phase of cigarette smoke (IARC, 1986). In related studies in which hamsters were treated with DMBA by intratracheal instillation followed by exposure to cigarette smoke, a significantly higher incidence of laryngeal tumours was observed than in hamsters exposed only to cigarette smoke or to DMBA (IARC, 1986). Collectively, these results indicate an initiation-promotion mechanism for the production of laryngeal tumours, and are consistent with the results of experiments in which tobacco smoke condensate is applied to mouse skin (IARC, 1986). The combined data implicate PAHs and tumour promoters in tobacco smoke as potential etiologic agents for cancer of the larynx in hamsters. Levels of DNA adducts measured by non-specific methods were higher in larynx tissue from smokers than from non-smokers (IARC, 2004a). Analyses of mutations in the *TP53* gene from tumours of the larynx in smokers show a pattern similar to that observed in lung tumours, and both are consistent with the pattern produced by PAH diol epoxides (IARC, 2006b). The available data are consistent with the conceptual framework illustrated in Fig. 4.1 (Szyfter *et al.*, 1999).

Formaldehyde, a constituent of cigarette smoke, causes nasopharyngeal cancer in humans (IARC, 2006a). A recent study demonstrates a 10-fold higher level of the formaldehyde-DNA adduct N^6-hydroxymethyldeoxyadenosine in leukocytes of smokers compared to non-smokers, suggesting its possible involvement in nasopharyngeal cancer in smokers (Wang *et al.*, 2009). Acetaldehyde, another carcinogenic constituent of tobacco smoke, which also forms genotoxic adducts (Section 4.1), may also contribute to the development of these forms of head and neck cancer.

(d) Oesophagus

Nitrosamines are probably the most effective oesophageal carcinogens known, with particularly strong activity in the rat (Lijinsky, 1992). NNN and NDEA are both present in cigarette smoke, and levels of NNN greatly exceed those of NDEA (IARC, 2004a). NNN is also present in considerable quantities in smokeless tobacco and betel quid containing tobacco (IARC, 2004a, 2007a). Thus, NNN is a likely candidate as a causative agent for esophageal cancer in smokers, smokeless tobacco users, and chewers of betel-quid with tobacco. While considerable mechanistic data are available from studies of NNN in laboratory animals (Hecht, 1998; Wong *et al.*, 2005; Lao *et al.*, 2007; Zhang *et al.*, 2009a), there are little comparable data in humans.

Increased acetaldehyde production derived both from tobacco smoke and from microbial alcohol oxidation may play a role in the synergistic carcinogenic action of alcohol and smoking on oesophagus, as well as on other upper aerodigestive locations (Homann *et al.*, 2000; Salaspuro & Salaspuro, 2004; Lee *et al.*, 2007a).

(e) Stomach

Hypermethylation of the E-cadherin 1 gene (*CDH1*) was observed preferentially in gastric tumours from smokers rather than non-smokers (Poplawski *et al.*, 2008). *CDH1* can act as a tumour-suppressor gene, preventing cells from growing and dividing in an uncontrolled way to form a cancerous tumour. Because the protein encoded by this gene helps cells stick together, altered regulation may lead to metastasis.

Boccia *et al.* (2007) found an increased risk for stomach cancer among smokers who had the *SULT1A1 His* genotype, and Lee *et al.* (2006) found an increased risk for those who had the *m2* allelic variant of *CYP1A1*. A nested case–control

study found that smokers had an increased risk of gastric cancer if they carried at least one variant allele A in Ex7+129 C > A (*Thr*^{461}*Asn*, *m4*) of *CYP1A1* (Agudo *et al.*, 2006). Stomach cancer tissue from smokers had higher levels of stable DNA adducts than did those from non-smokers; however, the number of non-smokers was quite small (Dyke *et al.*, 1992).

(f) Pancreas

NNK and its metabolite NNAL are the only pancreatic carcinogens known to be present in tobacco and tobacco smoke. NNK was detected in the pancreatic juice of 15 of 18 samples from smokers, at levels significantly higher than in non-smokers; NNAL and NNN were also detected in some samples (Prokopczyk *et al.*, 2002). DNA adducts of NNK and NNAL were present in pancreatic tissue of rats treated with these nitrosamines (Zhang *et al.*, 2009b), but were not detected in most human pancreatic tissue samples (Prokopczyk *et al.*, 2005).

(g) Colorectum

Tobacco smoke contains heterocyclic amines, such as 2-amino-1-methyl-6-phenylimidazo[4,5,6]pyridine (PhIP), which are intestinal carcinogens in rats and mutate the adenomatous polyposis coli (*Apc*) gene in mice (Møllersen *et al.*, 2004). The *APC* gene is frequently mutated and has altered expression in human colon cancer (Samowitz *et al.*, 2007; Samowitz, 2008). A recent model of colon cancer by Sweeney *et al.* (2009) suggests that this disease can develop via at least three independent mechanistic pathways. One pathway is initiated by methylation of *MINT* (methylation in tumour) markers that proceeds down a pathway predisposing to microsatellite instability, followed by methylation of the mismatch repair gene mutL homologue 1 (*MHL1*) and the tumour-suppressor gene *TP16*, followed by mutation in *BRAF* (a homologue of a viral raf oncogen). A second independent pathway is initiated with a mutation in the *APC* gene, followed by a mutation in the *TP53* gene. A third independent pathway involves only *KRAS2* mutations. One study found BPDE-DNA adducts at a higher frequency in colon DNA from smokers than from non-smokers (Alexandrov *et al.*, 1996). Mutations or epigenetic changes in some or all of these genes have been found in smoking-associated colon or colorectal tumours.

Microsatellite instability, which is the expansion or contraction of short nucleotide repeats, occurs in approximately 10–15% of sporadic colorectal cancer, and is usually associated with smoking and hypermethylation of the promoter of the mismatch repair gene *MLH1* (Samowitz, 2008). Smoking-associated colorectal tumours also have high frequencies of methylation at CpG islands (Samowitz, 2008).

In a case–control study of colorectal cancer, Kasahara *et al.* (2008) found that the genetic polymorphism *APEX1/APE1* (apurinic/apyrimidinic endonuclease-1) Asp^{148}Glu, which is a gene involved in DNA repair, was associated with risk for colorectal cancer among smokers but not non-smokers. Other studies have also found associations between polymorphisms in the DNA repair genes *XRCC1* and smoking and risk for colorectal cancer (Stern *et al.*, 2007; Campbell *et al.*, 2009).

(h) Liver

Tobacco smoke contains liver carcinogens such as furan and certain nitrosamines. Liver tumours exhibit increased expression of *C-MYC*, *P16*^{INK4A}, epidermal growth factor receptor (*EGFR*), telomerase, transforming growth factor-α (*TGF-α*), insulin-like growth factor-2 (*IGF-2*) and *RAF* oncogene (Abou-Alfa, 2006). Smokers show altered expression of some of these genes or of genes in the same or similar pathways (Sen *et al.*, 2007). A genome-wide association study found that SNP rs1447295 in the 8q24 chromosome was positively associated with liver cancer among ever-smokers (Park *et al.*, 2008). Thus, tobacco smoke appears to have epigenetic

effects on the liver that may contribute to hepatocellular carcinoma.

(i) Urinary bladder

Tobacco smoke contains aromatic amines such as 4-aminobiphenyl and 2-naphthylamine, which are human bladder carcinogens (see IARC, 2012a). In bladder tumours, smoking was associated with a more than twofold increase risk of methylation of the promoter region of the *P16*^{INK4A} gene and of the soluble Frizzled receptor protein (*SFRP*) gene (Marsit *et al.*, 2006). In addition, Tang *et al.* (2009) suggested that epigenetic silencing of *Wnt* antagonists through hypermethylation may play a role in smoking-related invasive bladder cancer (Tang *et al.*, 2009). SNP rs6983267 of the 8q24 chromosome was inversely associated with bladder cancer among ever-smokers (Park *et al.*, 2008). Smokers generally have mutagenic urine and smoking is associated with specific cytogenetic changes and DNA breaks in bladder tumours (DeMarini, 2004). Smoking-associated stable DNA adducts have been found in bladder tissue or exfoliated urothelial cells, supporting a role for DNA damage in smoking-associated bladder cancer (Phillips, 2002).

(j) Cervix

The cervical mucus of smokers is more mutagenic than that of non-smokers, and cervical epithelia of smokers have higher frequencies of micronuclei than those of non-smokers (DeMarini, 2004). Several studies have found increased levels of DNA adducts in cervical tissue from smokers relative to non-smokers, suggesting a role for smoking-associated DNA damage in cervical cancer (Phillips, 2002).

(k) Ovary

It has been observed that the inverse associations reported for serous and endometrioid tumours with respect to parity and oral contraceptives did not hold for the mucinous tumours. Based on these observations, Risch *et al.* (1996) suggested that mucinous ovarian tumours may be etiologically unrelated to the other types of epithelial tumours. Whereas mucinous elements such as gastric or intestinal type glands may be seen in mature teratomas, a form of germ cell neoplasia, overall mucinous tumours are classified as surface epithelial tumours because transitions among the subtypes may be observed. The major difference between mucinous and serous tumours is their biologic behaviour. Mucinous carcinomas of the ovary are slow growing tumours that appear to develop from their benign counterparts. The fact that the transitions between the benign, borderline, and malignant form of the disease can be seen in the same tumour suggests that over time, there is a progression from benign to malignant (Riopel *et al.*, 1999). *K-ras* mutational analysis, for example, demonstrates a heterogeneous distribution of the mutation within different parts of the same neoplasm, suggesting that acquisition of the *K-ras* mutation occurs in malignant transformation (Mandai *et al.*, 1998). Serous carcinomas seem to develop de novo rather than from a benign pre-existing lesion; alternatively, the rate of progression is rapid and the precursor lesion is obliterated before the detection of the tumour. In some data, current smoking is associated with a shorter interval to detection of mucinous than non-mucinous tumours. Because the mucinous tumour is slow growing, smoking could contribute to the malignant progression of the adenoma-carcinoma sequence, as the benign form of the tumour may have been present for some time.

(l) Leukaemia

Tobacco smoke contains known leukaemogens such as benzene, 1,3-butadiene and formaldehyde (IARC, 2012a). The mechanisms of leukaemogenesis are currently not well understood. Data indicate that leukaemogenic agents, such as benzene, cause toxicity to the

haemotopoietic system, as well as genotoxicity at low levels, and that genetic polymorphisms may be involved in these processes (Aksoy, 1989; Lan *et al.*, 2004; Garte *et al.*, 2008; Hosgood *et al.*, 2009; Lau *et al.*, 2009; Rappaport *et al.*, 2009). Recent studies suggest the importance in carcinogen-related leukaemogenesis of damage to haematopoietic stem/progenitor cells circulating in the peripheral blood, or, alternatively, damage to primitive pluripotent progenitor cells present in other tissues (Zhang *et al.*, 2009c). In these two models, damaged stem/progenitor cells would then travel to the bone marrow and become initiated leukaemic stem cells. Mechanisms considered central in these models are: disruption of bone marrow DNA, through e.g. formation of DNA adducts, DNA–protein crosslinks, the action of free radicals or active states of oxygen; intercalation of metals within the DNA structure; or inhibition of enzymes involved in cell division (Zhang *et al.*, 2007, 2009c).

4.3.2 Sites with limited evidence of carcinogenicity or evidence suggesting lack of carcinogenicity

(a) Breast

(i) Carcinogenic pathway

Carcinogens found in tobacco smoke pass through the alveolar membrane and into the blood stream, by means of which they can be transported to the breast via plasma lipoproteins (Yamasaki & Ames, 1977; Shu & Bymun, 1983; Plant *et al.*, 1985). Tobacco smoke contains known rodent mammary carcinogens, including PAHs and aromatic amines (IARC, 1986, 2004a; el-Bayoumy, 1992; Ambrosone & Shields, 1999; Ambrosone, 2001; Hoffmann *et al.*, 2001) which, due to their lipophilicity, can be stored in breast adipose tissue (Obana *et al.*, 1981; Morris & Seifter, 1992) and then metabolized and activated by human mammary epithelial cells (MacNicoll *et al.*, 1980). Tobacco smoke constituents reach the breast as demonstrated by the detection of cotinine in breast fluid (Petrakis *et al.*, 1978). There is evidence suggesting the presence of mutagenic arylamines (Thompson *et al.*, 2002) and PAHs (Zanieri *et al.*, 2007) in human breast milk. Cigarette smoke condensate has been shown to transform normal human breast epithelial cells *in vitro* (Narayan *et al.*, 2004), perhaps by blocking long-patch base excision repair (Kundu *et al.*, 2007). Transformation and cytogenetic effects have been observed in human mammary epithelial cells after exposure to chemical carcinogens such as PAHs or arylamine (Mane *et al.*, 1990; Eldridge *et al.*, 1992; Calaf & Russo, 1993).

The formation of specific adducts from PAHs and aromatic amines has been observed in human breast epithelial cells *in vitro*, and unspecified-DNA adducts have been found in exfoliated ductal epithelial cells in human breast milk (Gorlewska-Roberts *et al.*, 2002; Thompson *et al.*, 2002).

Mutations in the *TP53* tumour suppressor gene have been found in 15–30% of breast cancers (Goldman & Shields, 1998; Olivier & Hainaut, 2001). An increased prevalence and altered spectrum of *TP53* mutations in breast tumours have been observed among current smokers compared with never smokers (Conway *et al.*, 2002). The breast tumours with the most pronounced smoking-related mutational pattern (for example, a greater number of G:C→T:A transversions) were from women who had smoked for more than 20 years, although total *TP53* mutations were not associated with smoking duration (Conway *et al.*, 2002). This increased frequency of G to T transversions in smokers versus non-smokers is also observed in the IARC TP53 database (IARC, 2006b; Van Emburgh *et al.*, 2008).

Recent meta-analyses of epidemiological studies tend to show positive associations of breast cancer with long-term smoking among *NAT2* slow acetylators, especially among post-menopausal women (who are more likely than pre-menopausal women to be very long-term

smokers). Firozi *et al.* (2002) showed that breast tissue from *NAT2* slow acetylators had significantly higher levels of the diagonal radioactive zone (smoking-related) DNA adduct pattern than that from fast acetylators.

High rates of breast cancer in women exposed to ionizing radiation during adolescence (aged 10–19 years at exposure) (Tokunaga *et al.*, 1987) suggested that the adolescent breast may also be sensitive to the DNA-damaging effects of other exposures. This might also be true for the genotoxic compounds contained in tobacco smoke. Although some studies have supported such association, the results have been sparse and mixed. In addition, it is difficult to separate the effects of early life exposure to tobacco and smoking duration (Terry & Rohan, 2002).

Early age at first full-term pregnancy has been associated with reduced breast cancer risk (Kelsey *et al.*, 1993), hypothetically due to terminal differentiation of the breast epithelium that occurs late in the first trimester. It has been suggested that in the early stages of pregnancy, when growth-promoting hormone levels are high, but before terminal differentiation (Montelongo *et al.*, 1992), the breast may be particularly susceptible to the cancer-promoting chemicals in tobacco smoke. Several epidemiological studies compared measures of smoking before and after a first full-term pregnancy. Although suggestive, the data did not consistently show an increased risk for breast cancer among women who smoked before a first full-term pregnancy (Adami *et al.*, 1988; Hunter *et al.*, 1997; Band *et al.*, 2002; Egan *et al.*, 2003; Gram *et al.*, 2005; Li *et al.*, 2005; Olson *et al.*, 2005; Cui *et al.*, 2006). Smoking was associated with a 50% increased risk among women with slow *NAT2* acetylation genotype (Egan *et al.*, 2003). Overall, studies of risk in association with the timing of smoking relative to a first pregnancy are inconclusive; nevertheless, the breast tissue appears to have a greater susceptibility to the carcinogenic chemicals in tobacco smoke before compared to after terminal differentiation of breast epithelium.

(ii) Estrogenic pathway

The "anti-estrogenic" mechanism through which tobacco smoking may inhibit breast cancer progression is unclear. Estrogen is a known risk factor for breast cancer and several hypotheses have been proposed: earlier age at menopause among smokers, a reduction in the gastrointestinal absorption or distribution of estrogen, enhanced metabolism of estradiol to inactive catechol estrogens, increased binding of estrogens by serum sex hormone-binding globulin, lowered levels of estrogen derived from adipose tissue (Baron, 1984; Baron *et al.*, 1990; Terry & Rohan, 2002). Several studies of cigarette smoking and mammographically-defined breast density showed lower measures of breast density in current smokers than in non-smokers (Sala *et al.*, 2000; Vachon *et al.*, 2000; Warwick *et al.*, 2003; Jeffreys *et al.*, 2004; Modugno *et al.*, 2006; Bremnes *et al.*, 2007; Butler *et al.*, 2008). Since exposure to estrogen has been associated positively with breast density, a strong risk factor for breast cancer (McCormack & dos Santos Silva, 2006), the results of these studies are consistent with an anti-estrogenic effect of cigarette smoking. Although smokers and non-smokers may have the same concentrations of estrogens overall, it may be the type rather than the absolute levels of circulating estrogens that is important. Smokers might have a lower concentration of more biologically active estrogens, primarily 16-α-hydroxyestrone (16α-OHE1) (Michnovicz *et al.*, 1986, 1988; Berta *et al.*, 1992; Berstein *et al.*, 2000; Terry *et al.*, 2002b). Estrogen can be metabolized along three pathways, to 16α-OHE1 or to 2-OHE1 or to 4-OHE1. 16α-OHE1 and 4-OHE1 have been observed to increase mammary epithelial cell proliferation rates in experimental studies (Schütze *et al.*, 1993, 1994; IARC, 2007c). In contrast, 2-OHE1 might decrease epithelial cell proliferation rates (Bradlow *et al.*, 1996;

Muti *et al.*, 2000). If cigarette smoking increases estradiol 2-hydroxylation, as has been suggested (Michnovicz *et al.*, 1986), thereby increasing the ratio of 2-OHE1:16-α-OHE1, an inverse association between smoking and breast cancer risk might be observed. However, only one study has directly examined 2-hydroxylation in relation to cigarette smoking (Michnovicz *et al.*, 1986). Using injected radiolabelled estradiol, a 50% increased estradiol 2-hydroxylation was found in premenopausal women who smoked at least 15 cigarettes/day compared with non-smokers. Two studies of urinary estrogens found increased excretion of 2-OHE1 and decreased excretion of estriol among smokers (Michnovicz *et al.*, 1988; Berstein *et al.*, 2000), which may also support the hypothesis that smoking decreases the formation of active estrogen metabolites along the 16α-hydroxylation pathway. However, the ratio of urinary 2-OHE1:16α-OHE1 was not related to breast cancer risk in the one case–control study that examined the association (Ursin *et al.*, 1999). The 4-hydroxylation of estrogens is catalysed by CYP1B1, which is induced by tobacco smoke (Nebert *et al.*, 2004). This has been postulated as an additional pathway that could lead to formation of DNA adducts via catechol estrogen-quinones (Gaikwad *et al.*, 2008) and oxidative/DNA damage via redox-cycling (Zhu & Conney, 1998). The ratio of 2-OHE1:4-OHE1 has been studied in relation to breast cancer risk and smoking in one study (Berstein *et al.*, 2000). Smokers carrying the *CYP1B1 Val* allele [associated with high hydroxylation activity] had a significantly higher risk for breast cancer compared to never smokers with the *Leu/Leu* [wildtype] genotype (Saintot *et al.*, 2003).

(b) Endometrium

Exogenous estrogens unopposed by progesterone have been shown to increase the risk for endometrial cancer through increased mitotic activity of endometrial cells, increased number of DNA replication errors, and somatic mutations resulting in the malignant phenotype (IARC, 2007c, 2012c). Hence, factors associated with estrogen absorption or metabolism may alter the risk of this malignancy. Several investigators have hypothesized that cigarette smoking might be have anti-estrogenic effects, and through this mechanism reduce the risk of endometrial cancer (Baron, 1984; Baron *et al.*, 1990; Terry *et al.*, 2002b, 2004a).

Whether mediated through changes in the amount of adipose tissue, altered age at menopause, or anti-estrogenic effects, blood hormone concentrations might be an important link between smoking and the reduced risk of endometrial cancer observed in most epidemiological studies. The estrogens that have typically been studied in relation to cigarette smoking include estrone, sex hormone binding globulin (SHBG)-bound estradiol, and estriol. Blood concentrations of androgens, typically androstenedione and dehydroepiandrosterone sulfate (DHEAS), have also been studied, because these are biological precursors of estrone. Studies that have examined blood concentrations of SHBG are less common, and studies of unbound (free) estradiol are scarce.

Studies of cigarette smoking and blood hormone concentrations have been conducted mostly among post-menopausal women who were not taking HRT. Of these studies, nine examined serum (Friedman *et al.*, 1987; Cauley *et al.*, 1989; Slemenda *et al.*, 1989; Schlemmer *et al.*, 1990; Cassidenti *et al.*, 1992; Austin *et al.*, 1993; Law *et al.*, 1997) or plasma (Khaw *et al.*, 1988; Longcope & Johnston, 1988) estrone, ten examined serum (Friedman *et al.*, 1987; Cauley *et al.*, 1989; Slemenda *et al.*, 1989; Schlemmer *et al.*, 1990; Key *et al.*, 1991; Cassidenti *et al.*, 1992; Austin *et al.*, 1993; Law *et al.*, 1997) or plasma (Khaw *et al.*, 1988; Longcope & Johnston, 1988) estradiol, and two examined serum (Cassidenti *et al.*, 1992) or plasma (Longcope & Johnston, 1988) free estradiol. These studies consistently showed little or no association between smoking

and blood estrogen concentrations among post-menopausal women who were not taking hormone replacement therapy. Among pre-menopausal women, three studies (Longcope & Johnston, 1988; Key *et al.*, 1991; Berta *et al.*, 1992) found no clear association between cigarette smoking and estrogen concentrations. Studies that adjusted hormone measurements for the effects of BMI (and other covariates) showed similar results to those that did not, suggesting that BMI is not a strong confounder of this association.

In two studies the association between cigarette smoking and blood estrogen concentrations after randomization of women to groups receiving either estradiol or placebo were examined (Jensen & Christiansen, 1988; Cassidenti *et al.*, 1990). In a small study of 25 post-menopausal women, unbound estradiol was significantly lower among smokers than non-smokers both at baseline and shortly after taking micronized estradiol orally (Cassidenti *et al.*, 1990). No important differences were observed between smokers and non-smokers in serum concentrations of either estrone or bound estradiol. In contrast, in a study in which 110 post-menopausal women were randomized to take hormones (either orally or percutaneously) or a placebo (Jensen & Christiansen, 1988), smokers had lower concentrations of both estrone and bound estradiol than non-smokers after oral (but not percutaneous) hormone treatment for at least one year (concentrations of free estrogens were not examined). These results indicate that smoking might affect the absorption or metabolism of hormones used in replacement therapy.

Of the five studies that have examined the association between cigarette smoking and serum (Lapidus *et al.*, 1986; Cassidenti *et al.*, 1992; Law *et al.*, 1997) or plasma (Khaw *et al.*, 1988; Longcope & Johnston, 1988) SHBG, none found any clear association. However, one of these studies (Khaw *et al.*, 1988) found an inverse association between smoking and the ratio of bound estradiol to SHBG, a measure of estrogen activity. In this context, Cassidenti *et al.* (1990) found unbound (but not SHBG-bound) estradiol was significantly lower among smokers than non-smokers both at baseline and after taking oral estradiol, suggesting an increased SHBG-binding capacity in the women who smoked.

In post-menopausal women, androgens are the major source of estrone, converted through aromatization in fat deposits. Thus, adiposity is positively correlated with estrogen concentrations in post-menopausal women. Of the nine studies in which blood concentrations of androstenedione were examined in smokers (Friedman *et al.*, 1987; Khaw *et al.*, 1988; Longcope & Johnston, 1988; Cauley *et al.*, 1989; Slemenda *et al.*, 1989; Schlemmer *et al.*, 1990; Cassidenti *et al.*, 1992; Austin *et al.*, 1993; Law *et al.*, 1997), higher circulating concentrations were found among current than among never or former smokers in all studies. However, there was no clear variation in blood estrone concentrations by smoking status, suggesting a reduced conversion of androstenedione to estrone among smokers. Of the five studies where cigarette smoking and DHEAS concentrations were examined, three (Khaw *et al.*, 1988; Cassidenti *et al.*, 1992; Law *et al.*, 1997) found increased blood concentrations among current smokers, one (Friedman *et al.*, 1987) found also an increase that was not statistically significant, whereas another (Key *et al.*, 1991) found no clear differences according to smoking status.

Cigarette smoking and urinary estrogen concentrations have been examined in seven studies (MacMahon *et al.*, 1982; Michnovicz *et al.*, 1986; Trichopoulos *et al.*, 1987; Michnovicz *et al.*, 1988; Berta *et al.*, 1992; Key *et al.*, 1996; Berstein *et al.*, 2000). Of these, three found no major differences according to smoking status (Trichopoulos *et al.*, 1987; Michnovicz *et al.*, 1988; Berta *et al.*, 1992). The remaining four studies all showed lower urinary estriol concentrations among smokers than among non-smokers, but mixed results for urinary estrone and estradiol.

Two of these studies (Michnovicz *et al.*, 1988; Berstein *et al.*, 2000) showed higher concentrations of 2-hydroxyestrone among smokers, than non-smokers but only after estrogen treatment in Berstein *et al.* (2000).

Age at natural menopause varies substantially under the influence of genetic and environmental factors (McKinlay, 1996). A relatively early age at menopause has been associated with reduced risk of endometrial cancer (Kelsey *et al.*, 1982; Baron, 1984; Baron *et al.*, 1990; Akhmedkhanov *et al.*, 2001). A one year decrease in age at menopause has been associated approximately with a 7% decrease in risk (Kelsey *et al.*, 1982). It has been proposed that cigarette smoking decreases the age at natural menopause (Baron *et al.*, 1990), more clearly with qualitative than quantitative smoking measures (Parente *et al.*, 2008), and thus might reduce endometrial cancer risk through reduced exposure to endogenous estrogens. On average, smokers have menopause approximately 1 to 1.5 years earlier than non-smokers (Terry *et al.*, 2002b, 2004a). Adjustment for obesity and other covariates did not alter the results (Terry *et al.*, 2002b).

4.4 Mechanistic considerations of the interaction of ethanol and tobacco carcinogens

The combined effects of alcoholic beverages and tobacco on the risk for cancer incidence and mortality have been widely studied in human populations. When tested for multiplicative and additive interactions, synergistic effects of alcoholic beverages and tobacco have been found, especially for oropharyngeal and oesophageal cancers (Homann *et al.*, 2000; Castellsagué *et al.*, 2004; Salaspuro & Salaspuro, 2004; Lee *et al.*, 2005a; Lee *et al.*, 2007b).

Data support at least four possible mechanisms for the modifying effects of alcoholic beverages on cancer risk due to tobacco.

1. Alcohol may have a local permeabilizing effect on penetration of the oral mucosa by tobacco carcinogens (Du *et al.*, 2000), particularly important in the case of oropharyngeal and oesophageal cancer.
2. CYP2E1 and other CYPs may both activate and detoxify carcinogens present in tobacco smoke, including NDMA, NDEA, NNK, benzene and other tobacco-derived carcinogens in two ways: CYP induction increases metabolic activation of tobacco carcinogens leading to enhanced formation of proximate reactive chemical species at target sites; and alteration of phase II conjugation/detoxification enzymes by ethanol may also occur, changing the effective dose at the target site.
3. Competitive inhibition of CYP metabolism leads to reduced central hepatic and gastrointestinal clearance thus increasing dose delivery of carcinogens to peripheral target tissues (reviewed in Meskar *et al.*, 2001).
4. Effects of acetaldehyde derived by microbial alcohol oxidation and from the tobacco smoke (Homann *et al.*, 2000; Salaspuro & Salaspuro, 2004).

Supportive evidence for ii) and iii) is briefly presented below.

4.4.1 Effects of induction of CYPs by ethanol

(a) CYP2E1

Ethanol induces CYP2E1 in the human liver and in all species tested. Over 70 substrates of CYP2E1 have been compiled (Raucy & Carpenter, 1993; Guengerich *et al.*, 1994; Djordjević *et al.*, 1998; Klotz & Ammon, 1998; Cederbaum, 2006). Among those are tobacco carcinogens such as benzene, vinyl chloride, NDMA, NDEA and *N*-nitrosopyrrolidine, as well as many low-molecular-weight compounds. Induction of CYP2E1 by ethanol generated increased levels of toxic metabolites from the metabolism of many of these chemicals (Novak & Woodcroft, 2000). Pyridine, a constituent of tobacco smoke and

substrate of CYP2E1, generates DNA damaging products by redox-cycling (Kim & Novak, 1990).

In humans, in addition to the prominent CYP2E1 expression in the centrilobular regions of the liver, the enzyme is also detectable in the kidney cortex and, at lower levels, in organs such as the oropharynx, nasal mucosa, ovary, testis, small intestine, colon and pancreas (Ingelman-Sundberg *et al.*, 1994; Lieber, 1999, 2004).

In rats, ethanol induced CYP2E1 in epithelia of the cheek, tongue and oesophagus (Shimizu *et al.*, 1990). As a result of CYP2E1 induction by ethanol in the upper respiratory tract and possibly of inhibition of carcinogen clearance, hamsters had a significant increase of nasal cavity and tracheal tumours after intraperitoneal injection of *N*-nitrosopyrrolidine (McCoy *et al.*, 1981). Thus, induction of CYP2E1 by ethanol may participate in the genesis of cancers at several sites via metabolic activation of tobacco carcinogens into reactive species in target tissues.

(b) Other xenobiotic-activating CYPs

In addition to CYP2E1, several CYPs, including CYP3A4 and probably CYP1A2 in humans, and CYP1A1, 2B1 and 3A in rat liver, may be induced by ethanol. Of particular interest are members of the CYP3A family, which have wide substrate specificity and have been implicated in the activation of several known or suspected human carcinogens, including those derived from tobacco (Wojnowski & Kamdem, 2006). Both CYP3A4 and CYP1A2 metabolize NNK (Jalas *et al.*, 2005). Based on the Michaelis constant (Km) data (IARC, 2007a), the relative efficiencies in NNK metabolism by human CYP are (from greatest catalyst to least): 2A13 > 2B6 > 2A6 > 1A2 ~1A1 > 2D6 ~2E1 ~3A4. As the amount of CYP enzymes with overlapping substrate specificity that participate in nitrosamine metabolism varies according to organ and species, it is difficult to determine their individual contribution at target sites.

4.4.2 Effects of inhibition of CYPs by ethanol

Ethanol is a competitive inhibitor of CYP2E1 (reviewed in Anderson, 1992). It also inhibits the activities of CYP1A1, 2B6 and 2C19 but not those of CYP1A2.

Direct inhibition of CYPs by ethanol in target tissues may reduce metabolic activation of xenobiotics and hence local toxic and tumorigenic effects. Thus CYP inhibition in the liver could increase extrahepatic exposure to genotoxic metabolites from tobacco carcinogens that are substrates for these CYP enzymes. This mechanism is supported by several studies.

Ethanol caused a fivefold increase in oesophageal DNA adducts in rats induced by NDEA (Swann, 1984). In monkeys, O^6-methylguanine-DNA adducts after an oral dose of NDMA with or without ethanol were increased by co-exposure to ethanol in all tissues except the liver (Anderson *et al.*, 1996). Effects were seen in the oesophagus (17-fold increase), colonic mucosa (12-fold), pancreas (sixfold), urinary bladder (11-fold), ovary (ninefold), uterus (eightfold), brain (ninefold), spleen (13-fold) and nasal mucosa (fivefold). In these studies, ethanol treatment was acute, so that enzyme induction was improbable, and the oesophagus was not directly exposed to either ethanol or carcinogen. This indicates that a systemic interaction, most likely inhibition of hepatic carcinogen clearance, was responsible for the observed effects in the oesophagus and other extrahepatic tissues. The 17-fold increase in DNA adducts in the monkey oesophagus is similar to the 18-fold increased risk for human oesophageal cancers in tobacco smokers combined with heavy alcohol drinking (Tuyns *et al.*, 1977).

The relevance of increased genotoxic effects in extrahepatic target sites by ethanol is confirmed by many rodent experiments. Oral dosing of mice with NDMA in ethanol resulted in nasal cavity tumours (olfactory neuroblastoma) that were not seen with NDMA or ethanol alone (Griciute

et al., 1981). Ethanol in the drinking-water led to a ninefold increase in oesophageal tumours in rats induced by NDEA (Aze *et al.*, 1993). Ethanol given by gavage to nursing dams together with NDMA or NNK (Chhabra *et al.*, 2000) increased O^6-methylguanine-DNA adducts in maternal mammary glands, by 10-fold with NDMA and to a lesser extent with NNK. In the suckling infants, DNA adducts were detected in the lungs and kidneys after maternal exposure to NDMA and increased about fourfold after maternal co-treatment with ethanol. In mice, ethanol given with NDMA in the drinking-water resulted in a fourfold increase in lung tumours, but had no significant effect when NDMA was given intragastrically, intraperitoneally, subcutaneously or intravenously (Anderson, 1992). These negative findings support that direct inhibition of hepatic carcinogen clearance by ethanol is the main operative mechanism.

There is indirect evidence that ethanol can inhibit the *in vivo* clearance of the carcinogen NDMA in humans: individuals with chronic renal failure showed detectable blood and urine levels of NDMA, which were increased by consumption of ethanol (Dunn *et al.*, 1990). Other studies that involved sources of NDMA from tobacco smoke, diet or pharmaceuticals are consistent with ethanol reducing its clearance rate in humans (Anderson, 1992).

Other possible modifying effects of ethanol in tobacco-related tumorigenesis are presented in Section 4 of the *Monograph* on Consumption of Alcoholic Beverages in this Volume.

4.5 Synthesis

4.5.1 Mechanisms of tobacco-related carcinogenesis

The pathways by which tobacco products cause cancer essentially recapitulate established mechanisms of carcinogenesis by individual compounds, which were elaborated by landmark studies during the second half of the 20th century. These studies demonstrate that most carcinogens, either directly or after metabolism catalyzed by multiple cytochrome P450 enzymes, react with nucleophilic sites in DNA to form covalent binding products called adducts (a contraction for "addition products"). These DNA adducts, if left unrepaired by cellular DNA repair enzymes, persist and cause mistakes during DNA replication leading to incorporation of the wrong base in a DNA strand and consequent permanent mutations. If these permanent mutations occur in important regions of critical growth control genes such as the oncogene *KRAS* or the tumor suppressor gene *p53*, cellular growth processes can become severely unregulated and cancer can result. Multiple studies of mutations in *KRAS*, *p53*, and other growth control genes in lung tumours from smokers, some of which report thousands of mutations, are fully consistent with this overall concept.

It is the complexity of tobacco carcinogenesis which challenges investigators to identify specific mechanisms that fully explain the ways in which tobacco products cause each type of cancer. There are over 70 established carcinogens in cigarette smoke, and analyses of smokers' urine and blood clearly demonstrate higher uptake of these compounds in smokers than in non-smokers. The urine of smokers is consistently mutagenic. Similar considerations apply to smokeless tobacco users, although there are fewer identified carcinogens. Multiple DNA adducts are present in the lungs and other tissues of smokers, and sister chromatid exchanges as well as other genetic effects are consistently observed. But much less is known about the specifics of the process. Only relatively few DNA adducts in smokers' lungs have been structurally characterized and the relationship between specific adducts and the consequent mutations in critical genes is still somewhat unsettled.

There are other processes which contribute to cancer induction by tobacco products, based on

multiple studies in both laboratory animals and humans. These include inflammation, tumor promotion, oxidative damage, co-carcinogenesis, and direct activation of cellular growth pathways by constituents of smoke. Many studies demonstrate the involvement of these processes in tobacco carcinogenesis but the details by which they interact with the DNA damage pathways and their roles in specific cancers caused by tobacco products are still not fully understood.

4.5.2 Genetic polymorphisms

Multiple studies have been carried out on the role of genetic polymorphisms of xenobiotic metabolism in smoking-related carcinogenesis in humans. These studies have covered various cancer types, with lung cancer representing one of the most intensively studied. The polymorphic genes, their variant forms, and the genotype combinations investigated in these studies have similarly been numerous. In addition to the associations with increased risk of cancer, much data have accumulated on relationships between the polymorphisms and the various biomarkers of tobacco carcinogenesis in non-cancer control populations, whether smokers or non-smokers, in subjects with work-related exposure or in patients with other cancers.

Despite the massive body of research, many observations remain ambiguous. Some associations between genetic polymorphism and increased risk for cancer, such as for the *GSTM1* null genotype, alone or in combination with *CYP1A1* polymorphism, in lung cancer, or the *NAT2* slow acetylator genotype in bladder cancer and breast cancer appear stronger and more consistent, but not without controversies. Similarly, the data on the various biomarkers of tobacco-related carcinogenesis exhibit inconsistencies.

The variability in the data is at least partially likely due to differences between the studies in the genes and gene variants included (many of which are still of unknown functional or regulatory consequence), in the types of cancer studied, in levels and sources of exposure, in ethnic backgrounds, in sex, in histological types and in the features of the genome such as haplotype blocks and copy number variation resulting in linkage disequilibrium. In addition, gene-gene interactions and gene-environment interactions are likely to contribute to the discrepancies in current data. Mechanisms of tobacco-related carcinogenesis also involve genes from numerous other classes, such as those encoding for DNA repair proteins and many other regulators of cell cycle and growth. In addition; there are well described mechanistic pathways of carcinogenesis mediated via epigenetic alterations and genetic instability, to mention a few.

4.5.3 Site-specific mechanisms

The Working Group reviewed the mechanistic evidence relative to specific target sites for which there is sufficient evidence of carcinogenicity in humans, i.e. lung, oral cavity, oesophagus, larynx and nasopharynx, pancreas, stomach, liver, urinary bladder, leukaemia, cervix and ovary. Genotoxic effects have been found in eight organ sites at which tobacco smoke causes cancer in humans (DeMarini, 2004).

Sites with limited evidence of carcinogenicity or evidence suggesting lack of carcinogenicity in humans include the breast and the endothelium and relevant mechanisms are presented below.

Breast — There are several plausible mechanisms by which smoking may increase breast cancer risk, and some data support such an effect, including the increased risk among long-term smokers with *NAT2* slow genotype. Despite the overall lack of clear association in epidemiological studies, and the potential anti-estrogenic effects of smoking, the possibility that smoking increases breast cancer risk is biologically plausible.

Endothelium — The mechanisms by which cigarette smoking reduces the risk for endometrial cancer among current smokers, mainly among postmenopausal, remain unclear.

4.5.4 Interaction of ethanol and tobacco carcinogens

Data in rodents and non-human primates on the relationships between a) inhibition of hepatic clearance of nitrosamines by ethanol, b) the formation of promutagenic DNA adducts and c) tumours in extra-hepatic targets, likely also pertain in humans.

5. Evaluation

There is *sufficient evidence* in humans for the carcinogenicity of tobacco smoking.

Tobacco smoking causes cancers of the lung, oral cavity, naso-, oro- and hypopharynx, nasal cavity and accesory sinuses, larynx, oesophagus, stomach, pancreas, colorectum, liver, kidney (body and pelvis), ureter, urinary bladder, uterine cervix and ovary (mucinous), and myeloid leukaemia. Also, a positive association has been observed between tobacco smoking and cancer of the female breast. For cancers of the endometrium (post-menopausal) and of the thyroid, there is *evidence suggesting lack of carcinogenicity*.

There is *sufficient evidence* in humans for the carcinogenicity of parental smoking. Parental smoking causes hepatoblastoma in children. Also, a positive association has been observed between parental smoking and childhood leukaemia (particularly acute lymphocytic leukaemia).

There is *sufficient evidence* in experimental animals for the carcinogenicity of tobacco smoke and of tobacco smoke condensates.

Tobacco smoking is *carcinogenic to humans (Group 1)*.

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Ingredients and Emissions

Rodgman and Perfetti, The chemical components of tobacco and tobacco smoke, CRC Press, 2009

ISBN 978-1-4200-7883-1

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THE CHEMICAL COMPONENTS OF TOBACCO AND TOBACCO SMOKE

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CRC Press
Taylor & Francis Group
Boca Raton London New York
CRC Press is an imprint of the
Taylor & Francis Group, an **informa** business

CRC Press
Taylor & Francis Group
6000 Broken Sound Parkway NW, Suite 300
Boca Raton, FL 33487-2742

© 2009 by Taylor & Francis Group, LLC
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Printed in the United States of America on acid-free paper
10 9 8 7 6 5 4 3 2 1

International Standard Book Number-13: 978-1-4200-7883-1 (Hardcover)

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Library of Congress Cataloging-in-Publication Data

Rodgman, Alan.
The chemical components of tobacco and tobacco smoke / Alan Rodgman and Thomas A. Perfetti.
p. ; cm.
"A CRC title."
Includes bibliographical references and index.
ISBN 978-1-4200-7883-1 (hardcover : alk. paper) 1. Tobacco--Composition. 2. Tobacco smoke--Composition. I. Perfetti, Thomas Albert, 1952 II. Title.
[DNLM: 1. Smoke--adverse effects. 2. Tobacco--chemistry. 3. Smoking--adverse effects. 4. Tobacco--adverse effects. WA 754 R691c 2009]

SB275.R63 2009
613.85--dc22 2008018913

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Public Health England

Nickel

Toxicological Overview

Key Points

Kinetics and metabolism

- Nickel is absorbed by inhalation and ingestion
- The absorption of nickel is related to the solubility of the nickel compound
- Absorbed nickel is primarily excreted via the urine

Health effects of acute exposure

- Nickel carbonyl is the most toxic nickel compound following acute inhalation exposure
- The immediate effects of nickel carbonyl exposure are respiratory tract irritation and neurological effects
- Delayed effects of nickel carbonyl exposure include pulmonary oedema, pneumonitis and in severe cases death
- Acute ingestion of nickel compounds can cause nausea, vomiting, diarrhoea and headache
- Dermal contact with nickel or nickel compounds can lead to sensitisation and the development of contact dermatitis

Health effects of chronic exposure

- Chronic inhalation of nickel or nickel compounds can cause rhinitis, sinusitis, anosmia and in extreme cases perforation of the nasal septum
- The International Agency for Research on Cancer (IARC) classified nickel compounds as carcinogenic to humans (Group 1)
- The IARC classified elemental nickel as possibly carcinogenic to humans (Group 2B)
- Nickel carbonyl and soluble nickel salts are considered to be reproductive toxicants

Prepared by the Toxicology Department
CRCE, PHE
2009
Version 1

Toxicological Overview

Summary of Health Effects

Nickel carbonyl is the most toxic nickel compound following acute inhalation exposure in humans. The effects of nickel carbonyl inhalation occur in two phases, immediate and delayed. The immediate effects include respiratory tract irritation and neurological effects such as dizziness and headache, following which there is often an asymptomatic period before the onset of the delayed pulmonary symptoms, including chest pain, cough and dyspnoea. In severe cases pulmonary oedema, pneumonitis and death may occur. Patients who survive a severe exposure to nickel carbonyl may develop weakness and neurasthenic syndrome.

Data from occupationally exposed groups indicate that inhalation of nickel compounds may produce rhinitis, sinusitis and anosmia, and after a prolonged exposure, perforation of the nasal septum.

Acute ingestion of nickel compounds may cause nausea, vomiting, diarrhoea, headache, cough and shortness of breath. In severe cases, ingestion of large amounts of a nickel compound may cause death. Chronic oral exposure to nickel or nickel compounds has not been characterised in humans.

Dermal exposure to nickel salts can cause skin irritation. Nickel and its water soluble salts are potent skin sensitisers. Once sensitisation has occurred dermal exposure to even small amounts of nickel or nickel compounds can lead to an outbreak of contact dermatitis. In the past, prolonged dermal exposure of the public to nickel occurred widely from certain jewellery, earrings, watch straps etc. This was a major cause of skin sensitisation. Widespread exposure has now been largely eliminated by the Nickel Directive which places an upper limit (0.5 µg cm^{-2} $week^{-1}$) on the amount of nickel released from such products. This was implemented in the UK in 2000.

The International Agency for the Research on Cancer (IARC) concluded that nickel compounds are human carcinogens (Group 1). IARC also concluded that elemental nickel is a possible human carcinogen (Group 2B). No classification was given for nickel alloys.

Nickel carbonyl is classified in the EU as a reproductive toxicant (Risk Phrase R61 – ‘may cause harm to the unborn child’). Several animal studies have reported malformations in the offspring of animals exposed to nickel carbonyl. Soluble salts such as the sulphate and the chloride are also similarly classified.

Kinetics and Metabolism

Nickel can be absorbed via inhalation, ingestion and to a very limited extent following dermal exposure. The absorption of nickel is related to the solubility of the compound, the general order of absorption being: nickel carbonyl > soluble nickel compounds > insoluble nickel compounds.

The extent of absorption following inhalation depends on particle size and the solubility of the compound. Smaller particles penetrate deeper into the respiratory tract than larger ones and therefore the relative absorption is greater. Smaller compounds are absorbed more quickly making them less available for mucociliary clearance and then being swallowed [1].

The presence of food in the stomach reduces the bioavailability of nickel. In an absorption study 27% of nickel sulphate given to humans in drinking water was systemically absorbed compared with 1% when it was given in food [1, 2].

Percutaneous absorption is minimal, but is clinically important in the development of contact dermatitis [1].

Human autopsy studies on individuals non-occupationally exposed to nickel found the highest concentrations of nickel in the lungs, thyroid and adrenal glands. Lower levels of nickel have been detected in the kidneys, heart, liver, brain, spleen and pancreas [2, 3]. Nickel crosses the placenta and has been found in breast milk [1].

The elimination of absorbed nickel predominately occurs via the urine, although some may be excreted in saliva, sweat, milk and tears. Nickel that is not absorbed from the gastrointestinal tract is excreted in the faeces [1]. A urinary elimination half life (for absorbed nickel) of 17 – 48 hours has been reported in a human oral exposure study [3].

Sources and Route of Human Exposure

Nickel occurs naturally in the earths crust and is ubiquitous in air, water, soil and the biosphere. The average concentration of nickel in the earth's crust is 0.008% [1, 2].

Nickel also exists as a number of compounds. Nickel compounds that are soluble in water include nickel chloride and nickel sulphate; insoluble nickel compounds include nickel oxide, nickel sulphide and nickel subsulphide [1]. Nickel carbonyl is a highly toxic, volatile liquid that has specialised industrial uses [4].

Nickel is emitted to the atmosphere from natural sources including windblown dust, volcanoes, vegetation, forest fires and meteoric dust [2]. The principle anthropogenic sources of nickel emissions to the atmosphere include the combustion of coal and oil, municipal incineration, steel and other nickel alloy production and electroplating [1, 2]. In urban areas, nickel levels in the ambient air range from 1-10 ng m^{-3}. In industrialised areas and large cities levels in the range of 110-180 ng m^{-3} have been recorded [3]. In polluted air, the main nickel compounds appear to be nickel sulphate, nickel oxides, nickel sulphides, and to a smaller extent, elemental nickel [1].

Food and cigarette smoke are the main sources of nickel exposure in the general public [3, 5]. Approximately 0.04-0.58 µg nickel is released with the mainstream smoke of one cigarette. Smoking 40 cigarettes a day may therefore lead to inhalation of 2-23 µg nickel [1]. The average daily intake of nickel from foodstuffs for an adult has been estimated to be

approximately 152 µg [5]. The general public may also be exposed to low levels of nickel by inhaling ambient air or by drinking water contaminated with nickel [2].
In the past, items such as less expensive jewellery, earrings, wristwatches etc were a common source of exposure to nickel (resulting in a high incidence of nickel sensitization). This exposure route has largely been eliminated by the 'Nickel Directive' which was implemented in the UK in 2000. A requirement of the Directive was that the upper limit for nickel release in articles which have direct or prolonged contact with the skin was 0.5 µg cm^{-2} $week^{-1}$ [6].

Exposure to nickel in the workplace may occur by dermal contact, by inhalation of aerosols, fumes, dusts or mists containing nickel or by inhalation of gaseous nickel carbonyl [7]. Occupational exposure to nickel is considered to be highest for individuals involved in production, processing and use of nickel [2]. Workplace exposure limits (WELs) for nickel and its inorganic compounds have been derived in the UK. The long-term exposure limit (LTEL) for water soluble nickel compounds is 0.1 mg m^{-3} (8 hour time weighted exposure (TWA) reference period) and the LTEL for nickel and water-insoluble nickel compounds is 0.5 mg m^{-3}. The short-term exposure limit (STEL) for nickel carbonyl is 0.24 mg m^{-3} (15 minute reference period) [8].

Health Effects of Acute / Single Exposure

Human Data

Inhalation

Nickel carbonyl is the most toxic nickel compound following acute exposure. The symptoms of acute exposure to nickel carbonyl occur in two stages, immediate and delayed [1, 9]. The immediate toxic effects of nickel carbonyl exposure are respiratory tract irritation and neurological symptoms. Initial symptoms include dizziness, frontal headache, nausea, vomiting, irritability and upper airway irritation [4, 5]. Following the immediate symptoms there is an asymptomatic period before the onset of the delayed pulmonary symptoms; similar to those of a viral pneumonia [1, 9]. Symptoms include chest pain, cough, dyspnoea, tachycardia, weakness and fever with leukocytosis. Pulmonary haemorrhage, cerebral oedema, toxic myocarditis, pulmonary oedema and pneumonitis may occur in severe cases [1, 4]. Neurasthenic syndrome and weakness may develop following a severe exposure to nickel carbonyl, and may persist for up 6 months [4].

There are limited data available on the acute effects of elemental nickel inhalation in humans. Death due to adult respiratory distress syndrome was reported in an individual who was exposed to elemental nickel at a concentration of 382 mg m^{-3} for 90 minutes [2, 5].

Ingestion

Only limited data are available on the effects of acute ingestion of nickel salts in humans.

Thirty-two industrial workers accidently ingested water contaminated with nickel sulphate and nickel chloride (1.63 g L^{-1}). Twenty of the workers rapidly developed symptoms including nausea, vomiting, diarrhoea, headache, cough and shortness of breath; all were asymptomatic within three days. Temporary elevated levels of blood reticulocytes (7 workers), urine-albumin (3 workers) and serum bilirubin (2 workers) were also reported. The nickel doses in the symptomatic workers were estimated to range from 7-36 mg kg^{-1} bw [1, 2].

A 2 year old child ingested approximately 570 mg kg^{-1} bw of nickel sulphate crystals and on admission to hospital she was somnolent with wide and unresponsive pupils, high pulse rate and pulmonary rhonchi. Cardiac arrest occurred 4 hours after ingestion. Gastrointestinal distress and muscular pain were also reported [1, 5].

Ingestion of a single dose of nickel salts has been reported to exacerbate vesicular hand eczema in nickel-allergic patients [1, 2, 5].

Dermal/ocular exposure

Primary skin irritation was observed when human skin was patch tested with a solution of nickel salts. A 10% aqueous solution of nickel chloride caused irritation when applied to the back. Irritation was observed when a 20% aqueous solution of nickel sulphate was applied to human forearm skin once a day for 3 days [1].

Animal and In-Vitro Data

General toxicity

The main target organ for nickel induced toxicity in animals is the respiratory tract [3]. The toxicity of nickel compounds appears to be related to the solubility of the compound. Several acute animal studies have reported soluble nickel sulphate as being the most toxic and insoluble nickel oxide the least toxic [2].

Inhalation

The 30 minute LC_{50} values for nickel carbonyl inhalation in cats, rats and mice were 0.19 mg L^{-1}, 0.24 mg L^{-1} and 0.067 mg L^{-1}, respectively. The pulmonary effects and lesions are comparable to those seen in cases of human nickel carbonyl poisoning. Pulmonary effects include oedema, intra-alveolar haemorrhage and fibrosis. Other lesions including congestion, oedema, focal haemorrhage, vacuolisation and mild inflammation in the brain, liver, kidney, adrenals, spleen and pancreas have been reported in laboratory animals acutely exposed to nickel carbonyl [1].

In an acute inhalation study, chronic inflammation was observed in rats exposed to nickel sulphate (0.7 mg m^{-3}) or nickel subsulphide (0.44 mg m^{-3}) 6 hours day^{-1} for 12 days in a 16 day period. Alveolitis was reported in rats exposed to 0.22 mg m^{-3} as nickel subsulphide 6 hours day^{-1} for 7 days. Acute lung inflammation was observed in rats exposed to nickel oxide at 7.9 mg m^{-3}. In mice, the lowest observed adverse effect levels (LOAELs) of 0.7, 1.83 and > 23.6 mg m^{-3} as nickel sulphate, nickel subsulphide and nickel oxide, respectively, were identified for chronic inflammation. These results suggest that mice are less sensitive than rats to the acute toxicity of nickel [2].

Atrophy of the nasal olfactory epithelium has been reported in rats exposed to nickel sulphate or nickel subsulphide [2]. Inhalation exposure to nickel chloride has resulted in immunological effects including alveolar macrophage alterations in laboratory animals [2].

Ingestion

Acute oral lethality studies suggest that soluble nickel compounds are more toxic than the less-soluble nickel compounds. Acute oral LD_{50} values of 46 and 39 mg kg^{-1} nickel sulphate were reported in male and female rats, respectively. In rats the oral LD_{50} values for the less soluble nickel compounds nickel oxide and subsulphide were >3,930 and >3,665 mg kg^{-1}, respectively [2].

The oral LD_{50} for nickel acetate has been reported as 350 mg kg^{-1}in the rat and 410 mg kg^{-1} in the mouse. Diarrhoea, distress and lethargy were noted 2 – 3 hours after exposure in animals which died [1].

Health Effects of Chronic / Repeated Exposure

Human Data

Inhalation

The respiratory tract is the primary site of toxicity following inhalation of nickel and its compounds. Rhinitis, sinusitis, asthma, chronic bronchitis, emphysema and nasal septal perforations have frequently been reported in individuals occupationally exposed to nickel or nickel compounds. Hyposmia or anosmia was also noted in many of the workers with sinusitis. Pulmonary changes with fibrosis were also observed in workers exposed to nickel dust or fumes[1, 5].

Ingestion

There are currently no data available on the effects of chronic ingestion to nickel or nickel compounds in humans.

Dermal / ocular exposure

Nickel and water soluble nickel salts are powerful skin sensitisers. Following sensitisation, dermal exposure to even small amounts of nickel or water soluble nickel salts can cause outbreaks of dermatitis [1].

Contact dermatitis is the predominant effect of nickel in the general population due, in the past, to prolonged dermal exposure from products such as jewellery, buttons and zips. The incidence of nickel sensitivity is higher in females (around 10% of the population) compared with males and has been associated particularly with ear piercing. Occupational induced contact dermatitis occurs in individuals who work in refining and electroplating industries [10].

Genotoxicity

Cytogenetic studies in workers involved in nickel crushing/roasting/smelting processes (mainly exposed to nickel oxide and nickel sulphide) and electrolysis (mainly exposed to nickel chloride and nickel sulphate) reported elevated levels of chromosome aberrations, mainly gaps). Chromosome aberrations, including elevated levels of gaps and breaks, were also seen in retired nickel workers from the same plant who had plasma nickel levels of 2 µg L^{-1} [1, 7].

Elevated levels of sister chromatid exchange and chromosome aberrations were reported in electroplating workers. No exposure or chemical data were provided [1]. In contrast, no effects were observed in workers in a nickel carbonyl production plant, although authors proposed this was due to low exposure due to adequate protective measures [1, 7].

Carcinogenicity

Increased risks of cancer of the lungs and nasal passages have been reported in workers exposed to nickel compounds (oxidic and sulphidic nickel) during roasting, sintering and calcining processes, in refineries in the UK, Norway and Canada. These processes have involved substantial exposure to insoluble nickel compounds such as nickel subsulphide and oxide, and also possibly to soluble salts such as nickel sulphate.

Soluble nickel is also associated with an increased risk of cancer to the lungs and nasal passages in, for example, electrolysis workers with estimated exposures of 1-2 mg m^{-3}. There is evidence to suggest it may enhance risks associated with exposure to less soluble nickel compounds [1, 7, 11].

The IARC concluded that there is sufficient evidence in humans for the carcinogenicity of nickel sulphate, and of the combinations of nickel sulphides and oxides encountered in the nickel refining industry. Nickel compounds are classified as carcinogenic to humans (Group 1) [7].

No significant increase in respiratory tract cancer was reported in users of elemental nickel powder or in workers involved in high-nickel alloy manufacture. IARC concluded that there is inadequate evidence in humans for the carcinogenicity of elemental nickel and nickel alloys. There was sufficient evidence in experimental animals for the carcinogenicity of elemental nickel hence it was classified as possibly carcinogenic to humans (Group 2B). There was limited evidence for carcinogenicity of nickel alloys in animals. IARC did not give any overall classification for nickel alloys [7].

Reproductive and developmental toxicity

There are no data available on the reproductive and developmental effects of nickel and its compounds in humans.

Animal and In-Vitro Data

Inhalation

A number of studies have investigated the effect of chronic inhalation exposure to nickel or nickel compounds in laboratory animals. The target organ for nickel toxicity is the lung.

Lung irritation was observed in rats, mice and guinea pigs exposed to elemental nickel dust at 15 mg m^{-3}. In rats, nasal sinus inflammation and ulcers were also observed [1].

Rats and mice exposed to 0.06 mg m^{-3} nickel sulphate, 0.11 mg m^{-3} nickel subsulphide and 0.4 mg m^{-3} nickel oxide six hours per day, five days per week for 16 or 90 days resulted in inflammation of the lungs, fibrosis and increased lung weight. Toxicity was directly related to the compounds solubility [5].

The toxicity of nickel oxide, nickel sulphate and nickel subsulphide was also investigated in a two year inhalation study in rats and mice. Chronic lung inflammation was observed in rats and mice at the lowest administered dose of nickel oxide (0.5 mg m^{-3}) and nickel subsulphide (0.11 mg m^{-3}) in both species. Nickel sulphate produced lung effects in both species at doses of 0.06 mg m^{-3} and above [5].

Inflammatory changes in the nasal mucous membranes and the trachea, bronchitis and slight fibrosis in the lung were reported in rabbits exposed to 100 mg m^{-3} nickel graphite dust for 3 hours a day, 5 days a week for 6 months [1].

Rats exposed to nickel oxide (53 mg m^{-3} nickel oxide) for the life span developed emphysema and pneumoconiosis. Abscesses and metaplastic changes were observed in rats exposed to nickel subsulphide for 78 weeks [1].

Other effects reported in laboratory animals exposed to nickel or its compounds include atrophy of the nasal epithelium, reduction in body weight gain and immunological and lymphoreticular effects [1, 2].

Ingestion

The main toxic effects observed following long-term oral exposure of laboratory animals to nickel compounds are on the lungs and kidneys.

Mice exposed to ≥108 mg kg^{-1} bw day^{-1} as nickel sulphate in drinking water for 180 days developed minor renal tubular damage. Significant decreases in urinary glucose and urine volume were reported in rats exposed to 14.4 or 28.8 mg bw kg^{-1} day as nickel sulphate in drinking water for 13 days. Increases in blood urea were also observed in rats exposed to 28.8 mg bw kg^{-1} [2].

In a two year dietary study rats were given 0, 5, 50 or 125 mg kg^{-1} bw day^{-1} nickel sulphate. A significant reduction in body weight gain was noted in rats given ≥ 50 mg kg^{-1} day^{-1}. No histopathological changes were observed; therefore the NOAEL was taken to be 5 mg kg^{-1} bw day^{-1} [5].

In a 90 day gavage study in rats administered nickel chloride the NOAEL was found to be 5 mg kg^{-1} bw day^{-1}. Effects on body weight, on organ weight and on the nervous system were reported at doses of 35 and 100 mg kg^{1} bw day^{-1} [5].

Pneumonitis was reported in rats administered 8.6 mg kg^{-1} bw day^{-1} as nickel chloride by gavage for 91 days. Significant increases in absolute and relative lung weights were reported in rats exposed to 28.8 mg kg^{-1} bw day^{-1} in drinking water for 13 weeks. Dogs exposed to 22.5 mg kg^{-1} bw day^{-1} as nickel sulphate in the diet for 2 years developed emphysema, bronchiolectasis and cholesterol granulomas [2].

A reduction in body weight gain has also been reported in laboratory animals following chronic oral exposure to nickel compounds [2].

Dermal/ocular exposure

Skin atrophy, acanthosis, and hyperkeratinisation were observed in rats following repeated skin application of 40 – 100 mg kg^{-1} as nickel sulphate [1].

Experimental sensitisation has been observed in laboratory animals, but only under special conditions rather than using more routine methods [1].

Genotoxicity

Chromosomal aberrations were induced in the bone marrow cells of Chinese hamsters and Swiss mice administered nickel chloride by intraperitoneal injection [1, 7].

Nickel compounds produced negative results in the majority of bacterial mutation assays reported [1, 7].

In one study, elemental nickel did not induce chromosomal aberrations in cultured human peripheral lymphocytes [7].

Nickel subsulphide induced cell transformation and increased the frequency of sister chromatid exchange but did not cause gene mutation in cultured human cells. In animal cells *in-vitro* nickel subsulphide and nickel sulphide induced cell transformation, gene mutation

and DNA damage; nickel sulphide also induced sister chromatid exchange and chromosome aberrations [7].

Soluble nickel compounds have generally given positive results in human and animal *in-vitro* assays. In human cells *in-vitro,* nickel sulphate induced cell transformation and chromosome aberrations, nickel sulphate and nickel chloride increased the frequency of sister chromatid exchange Nickel sulphate and nickel chloride have been reported to cause cell transformation, chromosome aberrations, sister chromatid exchange and gene mutations in cultured animal cells. Nickel chloride has also been reported to induce DNA damage in animal cells [1, 7].

In summary nickel compounds are generally inactive in bacterial assays but positive results were obtained in mammalian cell assays. There is a lack of information from published *in-vivo* assays.

Carcinogenicity

A number of studies have investigated the carcinogenicity of nickel and its compounds in experimental animals [7].

Several studies reported that tumours were induced at the site of injection or implantation of a nickel compound. In these studies nickel subsulphide was the most potent carcinogen [7].

An inhalation study reported an increased incidence of lung tumours (adenomas, adenocarcinomas, squamous cell carcinomas and fibrosarcoma) in rats exposed to nickel subsulphide [2, 7]. In a 2 year NTP inhalation bioassay in mice and rats exposed to nickel subsulphide, nickel oxide or nickel sulphate no increased incidences of tumours were reported in mice exposed to any of the compounds or rats exposed to nickel sulphate. However, significant increases in lung adenomas and carcinomas were observed in rats exposed to the less-soluble nickel compounds (nickel oxide and nickel subsulphide). Exposure to nickel oxide or subsulphide also caused significant increases in the incidence of adrenal pheochromocytomas in rats [2, 3].

In 1990, IARC concluded that there is sufficient evidence in experimental animals for the carcinogenicity of elemental nickel, nickel monoxides, nickel hydroxides and crystalline nickel sulphides. IARC also concluded that there is insufficient evidence in experimental animals for the carcinogenicity of nickel alloys, nickelocene, nickel carbonyl, nickel salts, nickel arsenides, nickel antimonide, nickel selenides and nickel telluride. The evidence in experimental animals for the carcinogenicity of nickel trioxide, amorphous nickel sulphide and nickel titanate was considered to be inadequate [7].

Reproductive and developmental toxicity

A number of multigeneration reproductive studies have been carried out in rats, administered soluble nickel salts in water. The main effect noted was increased neonatal mortality at exposures producing maternal toxicity. In some studies there was also some evidence for effects at levels that did not produce maternal toxicity [5].

In a two generation study using nickel chloride in drinking water, reduced numbers of viable pups and increased mortality was seen at doses above 30.8 mg kg^{-1} bw day^{-1}, which were also associated with maternal toxicity. There was equivocal evidence at lower dose levels. In another two generation study in rats, however, increased perinatal mortality was seen in the second litter at the lowest dose investigated (1.3 mg kg^{-1} bw day^{-1}), but there was no clear dose response in this study. In a three generation study in rats, increased neonatal mortality was seen at doses estimated to be approximately 0.5 mg kg^{-1} bw day^{-1} [5].

In a more recent gavage study, an increased post-implantation loss and pup mortality were seen in rats given nickel sulphate at 2.2 mg kg^{-1} bw day^{-1} [5].

A series of studies reported malformations in the offspring of rats and hamsters exposed to nickel carbonyl by inhalation or injection before, or a few days after implantation. Malformations reported include anophthalmia, microphthalmia, cystic lungs, fused rib, cleft palate, exencephaly and hydronephrosis [1, 7].

Both nickel carbonyl and a number of soluble nickel salts (sulphate, chloride, nitrate and carbonate) are classified in the EU as toxic to reproduction Category 2 on the basis of their developmental toxicity (and are required to be labelled ‘may cause harm to the unborn child’) [12].

There are limited data from investigating nickel compounds specifically in developmental toxicant studies.

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