

**Summary of Investigation into the Occurrence of Cancer
Zip Code 77879, Somerville
Burlison County Texas
1995-2003
July 24, 2006**

Background:

Concern about a possible excess of cancer prompted the Texas Cancer Registry (TCR) Branch of the Texas Department of State Health Services to re-examine the occurrence of cancer in zip code 77879, Somerville, Texas. Local residents were concerned that a local creosote plant may be causing cancer among residents. A previous cancer cluster investigation (#05008) had found no significant elevations for cancers of the female breast, prostate, lung and bronchus, colon and rectum, bladder, corpus and uterus, kidney and renal pelvis, non-Hodgkin's lymphoma, oral cavity and pharynx, esophagus, stomach, larynx, total leukemia, and selected leukemia subtypes. The TCR evaluated 1995-2003 incidence data for cancers of the female breast, prostate, lung and bronchus, colon and rectum, bladder, corpus and uterus, renal cell carcinoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, oral cavity and pharynx, esophagus, stomach, larynx, gliomas (brain/CNS), childhood brain/CNS, childhood neuroblastoma, total leukemia, and selected leukemia subtypes. According to the scientific literature, creosote has shown a possible association with cancers of the oral cavity, larynx, esophagus, stomach, bladder, renal cell carcinoma, leukemia, Hodgkin's lymphoma, non-Hodgkin's lymphoma, gliomas, childhood brain/CNS, and childhood neuroblastoma. Incidence data are the best indicator of the occurrence of cancer in an area because they more accurately show the number and types of cancer diagnosed each year than mortality data. Compared with previous investigations that included mortality data as a supplemental measure, the TCR now solely uses incidence data for assessment of possible cancer clusters. This is due to the improved timeliness, quality, and availability of incidence data which now also meet national standards for high data quality. The rest of this report examines the investigative methods the TCR used, the results of the investigation, recommendations, and general information on cancer risk factors.

Methodology:

According to the National Cancer Institute, a cancer cluster is a greater than expected number of cancers among people who live or work in the same area and who develop or die from the same cancer within a short time of each other. The cancer cluster investigation is the primary tool used by the TCR to investigate the possibility of excess cancer in a community. The cancer cluster investigation is not used to prove that cancer was caused by environmental or other risk factors because it is extremely difficult to determine exactly what causes a particular cancer in a particular individual. Individuals are often exposed to many cancer-causing agents over their lifetime and not everyone who is exposed will get cancer. Instead, the cancer cluster investigation is specifically intended to answer the question "Is there an excess of cancer in the area or population of concern?" Two other questions that must be answered before an environmental hazard can be possibly associated with the cancer are: 1) Is there evidence of exposure to hazardous substances, and 2) Can the exposure and the cancer type be linked by a statistical association? To answer these questions, the TCR often works with the Environmental &

Injury Epidemiology and Toxicology Branch, the Spatial Approaches to Health Outcomes program within the Texas Department of State Health Services, and other state and federal agencies.

The TCR follows guidelines recommended by the Centers for Disease Control and Prevention for investigating cancer clusters.¹ To determine if a true excess of cancer is occurring and if further study is warranted at the time of the initial investigation, biologic and epidemiologic evidence is considered.

Such evidence may include documented exposures; the toxicity of the exposures; plausible routes by which exposures can reach people (ingesting, touching, breathing); the actual amount of exposure to the people which can lead to absorption in the body; the time from exposure to development of cancer; the statistical significance of the findings; the magnitude of the effect observed; risk factors; and the consistency of the findings over time. The occurrence of rare cancers or unlikely cancers in certain age groups may indicate a cluster needing further study. Because excesses of cancer may occur by chance alone, the role of chance is also considered in the statistical analysis.

If further study is indicated, the TCR will determine the feasibility of conducting an epidemiologic study examining the cancer and the exposure. If the epidemiologic study is feasible, the final step is to perform an etiologic investigation to see if the cancer can be related to the exposure. Very few cancer cluster investigations in the United States proceed to this stage.

To determine whether a statistically significant excess of cancer existed in the geographic areas of concern, the number of observed cases was compared to what would be "expected" based on the state cancer rates. Calculating the expected number(s) of cancer cases takes into consideration the race, sex, and ages of people who are diagnosed or die from cancer. This is important because peoples' race, sex, and age all impact cancer rates. If we are trying to determine if there is more or less cancer in a community compared to the rest of the state, we must make sure that the difference in cancer rates is not simply due to one of these factors.

The attached Tables 1–2 present the number of observed cases for males and females, the number of "expected" cases, the standardized incidence ratio (SIR), and the corresponding 99% confidence interval. The standardized incidence ratio (SIR) is simply the number of observed cases compared to the number of "expected" cases. When the SIR of a selected cancer is equal to 1.00, then the number of observed cases is equal to the expected number of cases, based on the incidence in the rest of the state. When the SIR is less than 1.00, fewer people developed cancer than we would have expected. Conversely, an SIR greater than 1.00 indicates that more people developed cancer than we would have expected. To determine if an SIR greater than 1.00 or less than 1.00 is statistically significant or outside the variation likely to be due to chance, confidence intervals are also calculated.

A 99% confidence interval is used for statistical significance and takes the likelihood that the result occurred by chance into account. It also indicates the range in which we would expect the SIR to fall 99% of the time. If the confidence interval contains a range that includes 1.00, no statistically significant excess of cancer is indicated. The confidence intervals are particularly important when trying to interpret small numbers of cases. If only one or two cases are expected for a particular cancer, then the report of three or four observed cases will result in a very large SIR. As long as the

99% confidence interval contains 1.00, this indicates that the SIR is still within the range one might expect and, therefore, not statistically significant.

Results:

The analysis of incidence data for zip code 77879, Somerville, Texas, from January 1, 1995–December 31, 2003 found cancers of the female breast, prostate, lung, colon and rectum, bladder, corpus and uterus, renal cell carcinoma, Hodgkin's lymphoma, non-Hodgkin's lymphoma, oral cavity and pharynx, esophagus, stomach, larynx, gliomas, childhood brain/CNS, childhood neuroblastoma, total leukemia, and selected leukemia subtypes to be within expected ranges in both males and females. Analysis summaries are presented in Tables 1–2.

Discussion:

Like other studies, this cancer cluster investigation had limitations. The incidence data did not include data for the most recent years. Also, cancer incidence data are based on residence at the time of diagnosis. It is possible that some residents who may have been exposed and developed cancer no longer lived in the area at the time of diagnosis so were not included in the data. However, it is also possible that people with no exposure may have moved into the area and then developed cancer because of other factors. These cases are included in the investigation.

Recommendations:

Based on the findings and the information discussed above, it is not recommended at this time to further examine the cancers in zip code 77879, Somerville, Texas. As new data or additional information become available, consideration will be given to updating or re-evaluating this investigation.

Information on Cancer and Cancer Risk Factors:

Overall, the occurrence of cancer is common, with approximately two out of every five persons alive today predicted to develop some type of cancer in their lifetime.² In Texas, as in the United States, cancer is the leading cause of death for people under the age of 85.³ Also, cancer is not one disease, but many different diseases. Different types of cancer are generally thought to have different causes. If a person develops cancer, it is probably not due to one factor but to a combination of factors such as heredity; diet, tobacco use, and other lifestyle factors; infectious agents; chemical exposures; and radiation exposures. Although cancer may impact individuals of all ages, it primarily is a disease of older persons with over one-half of cancer cases and two-thirds of cancer deaths occurring in persons 65 and older. Finally, it takes time for cancer to develop, between 10–40 years can go by between the exposure to a carcinogen and a diagnosis of cancer.⁴

The chances of a person developing cancer as a result of exposure to an environmental contaminant are slight. Most experts agree that exposure to pollution, occupational, and industrial hazards account for fewer than 10% of cancer cases.⁵ The Harvard Center for Cancer Prevention estimates 5% of cancer deaths are due to occupational factors, 2% to environmental pollution and 2% to ionizing/ultraviolet radiation.⁶ In contrast, the National Cancer Institute estimates that lifestyle factors such as tobacco use and diet cause 50 to 75 percent of cancer deaths.⁷ Eating a healthy diet and refraining from tobacco are

the best ways to prevent many kinds of cancer. It is estimated that one-third of all cancer deaths in this country could be prevented by eliminating the use of tobacco products. Additionally, about 25 to 30 percent of the cases of several major cancers are thought to be associated with obesity and physical inactivity.⁸

Known Risk Factors for Cancers Examined in This Investigation:

The following is a brief discussion summarized from the American Cancer Society and the National Cancer Institute about cancer risk factors for the specific cancers studied in this investigation.^{9,10}

The occurrence of cancer may vary by race/ethnicity, gender, type of cancer, geographic location, population group, and a variety of other factors. Scientific studies have identified a number of factors for various cancers that may increase an individual's risk of developing a specific type of cancer. These factors are known as risk factors. Some risk factors we can do nothing about, but many are a matter of choice.

Breast Cancer: Simply being a woman is the main risk factor for developing breast cancer. Breast cancer can affect men, but this disease is about 100 times more common among women than men. White women are slightly more likely to develop breast cancer than are African-American women, but African Americans are more likely to die of this cancer because they are often diagnosed at an advanced stage when breast cancer is harder to treat and cure. Other risk factors for breast cancer include aging, presence of genetic markers such as the BRCA1 and BRCA2 genes, personal and family history of breast cancer, previous breast biopsies, previous breast irradiation, diethylstilbestrol therapy, oral contraceptive use, not having children, hormone replacement therapy, alcohol, and obesity. Currently, research does not show a link between breast cancer risk and environmental pollutants such as the pesticide DDE (chemically related to DDT) and PCBs (polychlorinated biphenyls).

Stomach Cancer: Stomach cancer is about twice as common in men as it is in women. Other risk factors for stomach cancer include *Helicobacter pylori* infection, diets high in smoked and salted foods, tobacco and alcohol abuse, previous stomach surgery, pernicious anemia, type A blood, familial cancer syndromes, aging, and stomach polyps. Japanese have a very high rate of stomach cancer when they live in Japan. If they move to the United States, the rate goes down after a number of years, but still remains higher than that of people born in the U.S.

Prostate Cancer: Prostate cancer is the most common type of malignant cancer (other than skin) diagnosed in men, affecting an estimated one in five American men. Risk factors for prostate cancer include aging, a high fat diet, physical inactivity, and a family history of prostate cancer. African American men are at higher risk of acquiring prostate cancer and dying from it. Prostate cancer is most common in North America and northwestern Europe. It is less common in Asia, Africa, Central America, and South America.

Lung Cancer: The greatest single risk factor for lung cancer is smoking. The American Cancer Society estimates that 87% of lung cancer is due to smoking. Several studies have shown that the lung cells of women have a genetic predisposition to develop cancer when they are exposed to tobacco

smoke. Other risk factors include secondhand smoke, asbestos exposure, radon exposure, other carcinogenic agents in the workplace such as arsenic or vinyl chloride, marijuana smoking, recurring inflammation of the lungs, exposure to industrial grade talc, people with silicosis and berylliosis, personal and family history of lung cancer, and diet. In some cities, air pollution may slightly increase the risk of lung cancer. This risk is far less than that caused by smoking.

Colon and Rectum Cancer: Researchers have identified several risk factors that increase a person's chance of developing colon cancer: family and personal history of colon cancer, hereditary conditions such as familial adenomatous polyposis, personal history of intestinal polyps and chronic inflammatory bowel disease, aging, a diet mostly from animal sources, physical inactivity, obesity, smoking, and heavy use of alcohol. People with diabetes have a 30%-40% increased chance of developing colon cancer. Recent research has found a genetic mutation leading to colorectal cancer in Jews of Eastern European descent (Ashkenazi Jews).

Bladder Cancer: The greatest risk factor for bladder cancer is smoking. Men get bladder cancer at a rate four times that of women. Smokers are more than twice as likely to get bladder cancer as nonsmokers. Whites are two times more likely to develop bladder cancer than are African Americans. Other risk factors for bladder cancer include occupational exposure to aromatic amines such as benzidine and beta-naphthylamine, aging, chronic bladder inflammation, personal history of urothelial carcinomas, birth defects involving the bladder and umbilicus, infection with a certain parasite, high doses of certain chemotherapy drugs, and arsenic in your drinking water.

Corpus and Uterus Cancer: Corpus and uterus cancer include cancer of the endometrium (lining of the uterus). Risk factors for endometrial cancer include menstrual periods before age 12, menopause after age 52, infertility, obesity, treatment with the drug Tamoxifen, estrogen replacement therapy, certain ovarian diseases, a diet high in animal fat, diabetes, aging, family history of endometrial cancer, and early pelvic radiation therapy. Women who have had breast or ovarian cancer may have increased risk of getting endometrial cancer.

Esophageal Cancer: Compared with women, men have a three-fold higher rate of esophageal cancer. African Americans are two times more likely to have esophageal cancer than whites. Other risk factors for esophageal cancer include aging, use of tobacco products, alcohol, obesity, gastric reflux, diets low in fruits and vegetables, lye ingestion, frequent drinking of very hot liquids, achalasia, tylosis, and esophageal webs.

Oral Cavity and Pharynx Cancer: Risk factors for cancers of the oral cavity and pharynx include tobacco use, alcohol consumption, ultraviolet light, long-term denture irritation, poor nutrition, Plummer-Vinson syndrome, use of high-alcohol content mouthwash, human papillomavirus infection, immune suppression, aging, and being male.

Laryngeal Cancer: Risk factors for laryngeal and hypopharynx cancer include tobacco use, alcohol abuse, poor nutrition, infection with human papillomavirus, a weakened immune system, occupational exposure, gastroesophageal reflux disease, aging, and being male. Cancers of the larynx are about 50% more common among African Americans than among whites.

Renal Cell Carcinoma: Kidney cancer risk factors include smoking, obesity, a sedentary lifestyle, occupational exposure to heavy metals or organic solvents, advanced kidney disease, family history, high blood pressure, certain medications, and aging. Men have higher rates of kidney cancer.

Childhood Brain/CNS Cancer: The vast majority of brain cancers happen for no apparent reason and are not associated with anything which the child or parent did or didn't do, or anything that the child was exposed to in the environment. The only established risk factors for brain cancer are ionizing radiation and family history.

Childhood Neuroblastoma: The only established risk factor for neuroblastoma is heredity.

Gliomas: The large majority of gliomas are not associated with any risk factors. Most gliomas simply happen for no apparent reason. A few risk factors associated with gliomas are known and include radiation treatment, occupational exposure to vinyl chloride, immune system disorders, and family history of brain and spinal cord cancers.

Hodgkin's Lymphoma: Some people who have reduced immune systems, for example, those with AIDS, and organ transplant patients, are at a higher risk of Hodgkin's lymphoma. Possible risk factors include being in young or late adulthood, being male, being infected with the Epstein-Barr virus, or having a first-degree relative with Hodgkin's lymphoma.

Non-Hodgkin's Lymphoma: Risk factors for non-Hodgkin's lymphoma include infection with *Helicobacter pylori*, human immunodeficiency virus (HIV), human T-cell leukemia/lymphoma virus (HTVL-1), or the Epstein-Barr virus and malaria. Other possible risk factors include obesity, aging, certain genetic diseases, radiation exposure, immuno-suppressant drugs after organ transplantation, benzene exposure, the drug Dilantin, exposure to certain pesticides, a diet high in meats or fat, or certain chemotherapy drugs.

Acute Lymphocytic Leukemia (ALL): Possible risk factors for ALL include the following: being male, being white, being older than 70 years of age, past treatment with chemotherapy or radiation therapy, exposure to atomic bomb radiation, or having a certain genetic disorder such as Down syndrome.

Chronic Lymphocytic Leukemia (CLL): Possible risk factors for CLL include the following: being

middle-aged or older, male, or white; a family history of CLL or cancer of the lymph system; having relatives who are Russian Jews or Eastern European Jews; or having exposure to herbicides or insecticides including Agent Orange, an herbicide used during the Vietnam War.

Acute Myeloid Leukemia (AML): Possible risk factors for AML include the following: being male; smoking, especially after age 60; having had treatment with chemotherapy or radiation therapy in the past; having had treatment for childhood ALL in the past; being exposed to atomic bomb radiation or the chemical benzene; or having a history of a blood disorder such as myelodysplastic syndrome.

Chronic Myeloid Leukemia (CML): Most people with CML have a gene mutation (change) called the Philadelphia chromosome. The Philadelphia chromosome is not passed from parent to child.

For additional information about cancer, visit the "Resources" link on our web site at <http://www.dshs.state.tx.us/tcr/>.

Questions or comments regarding this investigation may be directed to Ms. Brenda Mokry, Texas Cancer Registry, at 1-800-252-8059 or brenda.mokry@dshs.state.tx.us.

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Table 1

Number of Observed and Expected Male Cancer Cases and Race Adjusted Standardized Incidence Ratios, Selected Sites, Zip Code 77879, Somerville, TX, 1995–2003

| Males | | | | |
|--|-----------------|-----------------|------------|---------------|
| Site | Observed | Expected | SIR | 99% CI |
| Lung and Bronchus | 31 | 25.96 | 1.19 | 0.71 – 1.87 |
| Prostate | 36 | 40.60 | 0.89 | 0.55 – 1.34 |
| Colon and Rectum | 21 | 14.85 | 1.41 | 0.75 – 2.42 |
| Renal Cell Carcinoma | 6 | 3.25 | 1.85 | 0.47 – 4.82 |
| Bladder | 7 | 7.34 | 0.95 | 0.28 – 2.34 |
| Esophagus | 2 | 1.96 | 1.02 | 0.05 – 4.72 |
| Oral Cavity and Pharynx | 7 | 4.22 | 1.66 | 0.48 – 4.06 |
| Larynx | 1 | 2.29 | 0.44 | 0.00 – 3.25 |
| Stomach | 2 | 2.45 | 0.82 | 0.04 – 3.79 |
| Childhood Brain/CNS (0-19) | 0 | 0.24 | 0.00 | 0.00 – 22.27 |
| Childhood Neuroblastoma (0-19) | 0 | 0.05 | 0.00 | 0.00 – 103.93 |
| Gliomas | 0 | 1.56 | 0.00 | 0.00 – 3.41 |
| Hodgkin's Lymphoma | 0 | 0.60 | 0.00 | 0.00 – 8.89 |
| Non-Hodgkin's Lymphoma | 5 | 4.96 | 1.01 | 0.22 – 2.85 |
| Total Leukemia | 4 | 3.70 | 1.08 | 0.18 – 3.40 |
| Acute Lymphocytic Leukemia | 1 | 0.32 | 3.08 | 0.02 – 22.91 |
| Chronic Lymphocytic Leukemia | 1 | 1.27 | 0.79 | 0.00 – 5.86 |
| Acute Myeloid Leukemia | 1 | 1.00 | 1.00 | 0.01 – 7.43 |
| Chronic Myeloid Leukemia | 1 | 0.49 | 2.05 | 0.01 – 15.25 |
| Aleukemic, Subleukemic, and NOS | 0 | 0.23 | 0.00 | 0.00 – 22.87 |

Note: The SIR (standardized incidence ratio) is defined as the number of observed cases divided by the number of expected cases. The latter is based on race-, sex-, and age-specific cancer incidence rates for Texas during the period 1995–2003. The SIR has been rounded to the second decimal place.

*Significantly higher than expected at the $p < 0.01$ level.

**Significantly lower than expected at the $p < 0.01$ level.

Table 2

Number of Observed and Expected Female Cancer Cases and Race Adjusted Standardized Incidence Ratios, Selected Sites, Zip Code 77879, Somerville, TX, 1995–2003

| Females | | | | |
|--|-----------------|-----------------|------------|---------------|
| Site | Observed | Expected | SIR | 99% CI |
| Breast | 27 | 35.07 | 0.77 | 0.44 – 1.24 |
| Lung and Bronchus | 17 | 17.56 | 0.97 | 0.47 – 1.75 |
| Colon and Rectum | 8 | 13.75 | 0.58 | 0.19 – 1.35 |
| Renal Cell Carcinoma | 2 | 1.96 | 1.02 | 0.05 – 4.74 |
| Bladder | 0 | 2.44 | 0.00 | 0.00 – 2.17 |
| Corpus and Uterus | 4 | 5.74 | 0.70 | 0.12 – 2.20 |
| Esophagus | 0 | 0.61 | 0.00 | 0.00 – 8.69 |
| Oral Cavity and Pharynx | 2 | 1.80 | 1.11 | 0.06 – 5.16 |
| Larynx | 0 | 0.53 | 0.00 | 0.00 – 9.96 |
| Stomach | 2 | 1.58 | 1.27 | 0.07 – 5.89 |
| Childhood Brain/CNS (0-19) | 1 | 0.20 | 5.09 | 0.03 – 37.85 |
| Childhood Neuroblastoma (0-19) | 0 | 0.04 | 0.00 | 0.00 – 132.57 |
| Gliomas | 0 | 1.26 | 0.00 | 0.00 – 4.19 |
| Hodgkin's Lymphoma | 1 | 0.47 | 2.11 | 0.01 – 15.70 |
| Non-Hodgkin's Lymphoma | 1 | 4.54 | 0.22 | 0.00 – 1.64 |
| Total Leukemia | 4 | 2.78 | 1.43 | 0.24 – 4.52 |
| Acute Lymphocytic Leukemia | 0 | 0.25 | 0.00 | 0.00 – 21.12 |
| Chronic Lymphocytic Leukemia | 1 | 0.89 | 1.13 | 0.01 – 8.36 |
| Acute Myeloid Leukemia | 1 | 0.81 | 1.24 | 0.01 – 9.20 |
| Chronic Myeloid Leukemia | 1 | 0.36 | 2.75 | 0.01 – 20.41 |
| Aleukemic, Subleukemic, and NOS | 0 | 0.23 | 0.00 | 0.00 – 23.17 |

Note: The SIR (standardized incidence ratio) is defined as the number of observed cases divided by the number of expected cases. The latter is based on race-, sex-, and age-specific cancer incidence rates for Texas during the period 1995–2003. The SIR has been rounded to the second decimal place.

*Significantly higher than expected at the $p < 0.01$ level.

**Significantly lower than expected at the $p < 0.01$ level.