

Hi David,
Below is my contribution.
Lloyd

Sad to say the short sighted handling of [SB 283](#), catering to commercial and political interests, will have broad public health consequences. As a public health venue, OHA needs to begin prioritizing public health over expediency and corporate influence. We are at a tipping point environmentally that can no longer return to equilibrium from the massive exposure to microwave radiation in our environment.

First, the Hardell and Carlberg paper is of great importance.

Nevertheless. Without a **substantial changes in various nations** to pass legislation, their publication will be lost among so many science papers.

My purpose in writing this email is to have as many scientists and activists, not only to spread the word, but *also to activate a campaign in National Governments* where legislation can pass that will not allow known carcinogens to be propagated across our planet.

In the Cc list above I have included my contacts. **First**, I would hope that everyone receiving this email would forward this email onto other colleagues. **Second**, that everyone will initiate a campaign that would stop the introduction of carcinogens in general into the environment, and of even greater importance, to initiate a campaign in their Nation.

In other words, the time has come when scientists must become activists.

Best regards to all,
L. Lloyd Morgan

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IF WE DO NOT LOOK, WE CANNOT FIND

From: Joel M. Moskowitz PhD [<mailto:jmm@berkeley.edu>]
Sent: Wednesday, February 17, 2021 3:01 PM
To: CHE-EMF

Subject: New review: Lost opportunities for cancer prevention with emphasis on radiofrequency radiation (Hardell & Carlberg)

[Lost opportunities for cancer prevention: historical evidence on early warnings with emphasis on radiofrequency radiation](#)

Lennart Hardell and Michael Carlberg. Lost opportunities for cancer prevention: historical evidence on early warnings with emphasis on radiofrequency radiation. Reviews on Environmental Health. 2021. doi: <https://doi.org/10.1515/reveh-2020-0168>.

Open access paper: <https://www.degruyter.com/document/doi/10.1515/reveh-2020-0168/html> or <https://www.degruyter.com/document/doi/10.1515/reveh-2020-0168/pdf>

Abstract

Some historical aspects on late lessons from early warnings on cancer risks with lost time for prevention are discussed. One current example is the cancer-causing effect from radiofrequency (RF) radiation. Studies since decades have shown increased human cancer risk. The fifth generation, 5G, for wireless communication is about to be implemented world-wide despite no comprehensive investigations of potential risks to human health and the environment. This has created debate on this technology among concerned people in many countries. In an appeal to EU in September 2017, currently endorsed by more than 400 scientists and medical doctors, a moratorium on the 5G deployment was required until proper scientific evaluation of negative consequences has been made (www.5Gappeal.eu). That request has not been taken seriously by EU. Lack of proper unbiased risk evaluation of the 5G technology makes adverse effects impossible to be foreseen. This disregard is exemplified by the recent report from the International Commission on non-ionizing radiation protection (ICNIRP) whereby only thermal (heating) effects from RF radiation are acknowledged despite a large number of reported non-thermal effects. Thus, no health effects are acknowledged by ICNIRP for non-thermal RF electromagnetic fields in the range of 100 kHz–300 GHz. Based on results in three case-control studies on use of wireless phones we present preventable fraction for brain tumors. Numbers of brain tumors of not defined type were found to increase in Sweden, especially in the age group 20–39 years in both genders, based on the Swedish Inpatient Register. This may be caused by the high prevalence of wireless phone use among children and in adolescence taking a reasonable latency period and the higher vulnerability to RF radiation among young persons.

Radiofrequency radiation (Excerpts)

In 2011 radiofrequency electromagnetic fields (RF-EMF) in the frequency range 30 kHz–300 GHz were evaluated by IARC at WHO to be possibly carcinogenic to humans, Group 2B [62], [, 63]. This was based on evidence of increased risk for glioma and acoustic neuroma in human epidemiology studies on use of mobile and/or cordless phone (DECT) [64], [65], [66], [67], [68], [69]. The increased cancer risk was supported by laboratory studies [70], [, 71].

Extremely low frequency (ELF)-EMF was in 2001 evaluated by IARC to be a possible human carcinogen, Group 2B [72]. This was the first time that non-ionizing radiation at low intensity levels can be a possible cause of cancer. It predated the IARC finding for RF-EMF by a decade.

Since then the evidence on RF-EMF carcinogenesis has strengthened based on further human studies on use of wireless phones, as reviewed [73], [, 74]. Also animal studies show increased cancer risk, both near field RF-EMF exposure [75], [76], [77] and far field exposure [78], [, 79]. Mechanistic studies show increase of reactive oxygen species (ROS) [80] as well as DNA damage [81]. These results give support to the increased cancer risk in humans and laboratory tested animals for RF radiation. In fact, RF-EMF may now be classified as a human carcinogen, Group 1 [82], [, 83]. However, such classification can only be made by IARC.

Of course, these well documented health hazards from RF-EMF are not well accepted by the telecom industry and its allied experts. Several methods are used to create doubt. Studies are discredited, only partly cited, or even not cited at all [84], [85], [86]. Thereby the uniformed reader gets the wrong information on actual risks. This includes also regulatory agencies and policy makers. Even agencies

aimed at setting exposure guidelines may include pro-industry and biased scientists that obscure the true risks [87], [, 88].

ICNIRP

The International Commission on Non-Ionizing Radiation Protection (ICNIRP) is a private non-governmental (NGO) organization registered in Munich, Germany. ICNIRP appoints its own members and is closed to transparency. It was started in 1992 with the biophysicist Michael Repacholi as the first chairman, now emeritus member. ICNIRP has published three articles with guidelines on RF-EMF exposure [86], [89], [90]. Only thermal (heating) effects from RF radiation are recognized, thereby excluding all studies showing harmful effects at lower non-thermal intensities. In contrast to ICNIRP, some other expert panels such as European Academy of Environmental Medicine [91], the Bioinitiative group [92], and the Russian Commission for Protection from Non-Ionizing Radiation [93], take into account non-thermal RF effects and suggest much lower guidelines for RF exposure.

ICNIRP has managed to get collaborative status with WHO, as discussed previously [88]. The aim is to harmonize the RF-radiation guidelines all over the world. For that purpose ICNIRP has been successful. The guidelines are set to allow very high exposure levels so that the deployment of this technology is not hampered, in favor of industry but at disadvantage to human health and environment. In fact, the ICNIRP guidelines have never been challenged by industry in peer-reviewed articles, which must be taken as a green card for acceptance by industry.

Attributable fraction

The attributable fraction (AF), sometimes also called the etiologic fraction, is the number of cases in which exposure played an etiologic role. This is the preventable fraction if exposure would not be present. In Belpomme et al. [73] we published meta-analyses for longest cumulative use of mobile phones with odds ratio (OR) and 95 % confidence interval (CI), both for total and for ipsilateral wireless phone use. Note that only the Hardell group assessed also use of cordless phones (DECT). We present here AF based on statistically significant increased risks in the meta-analyses. AF is the proportion of cases that can be attributed to the particular exposure. This is calculated as the exposed case fraction multiplied by $[(OR - 1)/OR]$.

As displayed in Table 1 the AF for glioma was calculated to 4.88%, 95% CI = 2.44–6.57%, corresponding to 211 preventable cases, 95% CI = 105–284 cases in the longest time for all cumulative use of wireless phones. Regarding ipsilateral use of the wireless phone AF was 6.03%, 95% CI = 4.51–7.12%, yielding 150 cases; 95% CI 112–177 to be preventable.

Rates of brain tumors in the Swedish National Inpatient Register ICD-code D43

Rates of brain tumors of unknown type, D43, were studied using the Swedish Inpatient Register (IPR) without any personal identification information [94]. It was established in 1964 and has complete national coverage since 1987 [95]. Register data on D43 are available from 1998. Currently more than 99% of hospital discharges are registered. For outpatients the data are less reliable due to missing information. The reporting of outpatients has increased during more recent years so these time trends may give spurious results, thus we omitted outpatients from the analysis.

Data were analyzed for the time period 1998–2019. Age-standardized rates are not available in the register. Instead numbers of patients per 100,000 inhabitants are reported. The Joinpoint Regression Analysis program version 4.1.1.1 was used to examine numbers of patients per 100,000 in inpatient care and incidence per 100,000 person-years in the Swedish Inpatient Register, by fitting a model of 0–3 joinpoints using permutation tests with Bonferroni correction for multiple testing to calculate the number of joinpoints that best fits the material [96]. When joinpoints were detected annual percentage changes (APC) and 95% CIs were calculated for each linear segment. Average annual percentage changes (AAPC) were also calculated for the whole time period using the average of the APCs weighted by the length of the segment. To be able to calculate APC and AAPC the data was log-transformed prior to

analysis. Thus, it was not possible to perform joinpoint regression analysis when there were years with no cases during that time period. Since the data do not include any personal identification no ethical approval was needed.

In men AAPC increased during 1998–2019 with +1.77%, 95% confidence interval (CI) –0.02, +3.58%, Table 2; Figure 1. The increase was highest in the age group 20–39 years, +2.90%, 95% CI +1.66, +4.16%, Figure 2. AAPC increased statistically significant in all age groups, except 0–19 years.

Similar results were found in women with AAPC +1.70%, 95% CI +0.38, +3.05% during 1998–2019, Table 3; Figure 3. Also in women the highest increase of AAPC was found in the age group 20–39 years, +2.89%, 95% CI + 1.54, +4.27%, Figure 4. AAPC increased statistically significant in all age groups except 0–19 years and 80+ years. Especially high increase of APC was seen in women aged 60–79 years during 2005–2019, and women aged 80+ years during 2010–2019.

Discussion

RF radiation is a current controversy regarding cancer risks. The 2011 IARC evaluation on carcinogenesis [62], [63] has been downplayed and detracted by industry and captured agencies from the very beginning in spite of increasing evidence on harmful effects. However, IARC has decided that a new evaluation of cancer risks is top priority within a few years [100].

In this article we give some further data on the RF carcinogenesis. The attributable fraction gives the number of cases that could have been prevented if no risk exists for a specific exposure. Based on results in case-control studies from three study groups that have shown statistically significant increased risk for glioma and acoustic neuroma 211 glioma cases (all exposure) and 42 acoustic neuroma cases (ipsilateral exposure) would have been preventable in the longest cumulative exposure group. The preventable fraction was 4.88 and 4.63%, respectively. Highest preventable fraction was found for glioma with ipsilateral wireless phone use, 6.03% corresponding to 150 cases. Lower AF was calculated for meningioma, 1.75%, yielding 39 preventable cases (ipsilateral exposure). As displayed in Belpomme et al. [73] these results were based on Interphone [67], Coureau et al. [101], and Carlberg, Hardell [102], each without statistically significant increased risk. However, meta-analysis of these studies yielded, OR = 1.49, 95% CI = 1.08–2.06.

We have previously published results on increasing rates of tumors of unknown type in the brain or CNS both in the Swedish Inpatient Register and Causes of Death Register during 1998–2013 [103]. There was a clear increasing trend in both genders during that time period, especially during more recent years with AAPC +1.78%, 95% CI + 0.76, 2.81% for both genders combined. A joinpoint was found in men in 2007; time period 2007–2013 APC +4.95%, 95% CI +1.59, +8.42%. Similarly, in women a joinpoint was detected in 2008; time period 2008–2013 APC +4.08%, 95% CI +1.80, +6.41%.

We have now extended the time period up to 2019. Thus, we report increasing AAPC in both genders during 1998–2019 of similar magnitude as previously. In men the result was of borderline significance although the AAPC overlapped previous findings. Lower APC was found during more recent years in both men and women, see Figures 1 and 3. This may reflect a better diagnostic procedure and thus decreasing numbers of unknown brain tumor type. A delay in reporting to the register during recent years may also have an impact on the results.

It is noteworthy that we found highest AAPC in the age group 20–39 years in both men and women, Tables 2 and 3. We found in our case-control study on glioma a median latency period for use of mobile phone of 9.0 years (mean 10.1 years). The corresponding results for cordless phones (DECT) were 7.0 and 8.0 years, respectively [104]. In a population-based study during 2005–2006 on use of mobile and cordless phones among Swedish children aged 7–14 years 79.1% reported access to mobile phone and use of cordless phone was reported by 83.8% [105]. Thus, our current findings with increasing numbers of brain tumors in the age group 20–39 years may be consistent with use of wireless phones taking a reasonable latency period. Moreover, our previous results showed highest risk for subjects that started the use of mobile or cordless phone before 20 years of age [104]. That age groups would also be more vulnerable to RF radiation [106]. In legends to Figures 1 and 3 we report the history for wireless phone use in Sweden. Figure 5 displays the number of out-going mobile phone minutes in millions during 2000–

2019 in Sweden. The major increase is since early 21st century and may be associated with our findings of increasing numbers of brain tumors of unknown type considering a reasonable latency time.

As we have discussed elsewhere the Swedish Cancer Register is not reliable to study the incidence of brain tumors [103], [, 107]. The register is mainly based on reporting of cases with histopathological diagnosis. Now diagnosis may be based on CT and/or MRI without further investigations especially of patients with poor outcome. Biopsy or operation may be difficult to perform due to tumor location, age and co-morbidity. In the Swedish Cancer Register about 90% of the cases are diagnosed with cytology or histology, a number that has increased somewhat during recent years [107]. This fact indicates that brain tumors of unknown type are under-reported to the Cancer Register.

This review gives insight into missed opportunities for cancer prevention exemplified by asbestos, tobacco, certain pesticides and now RF radiation. No doubt economic considerations are favored instead of cancer prevention. The cancer victim is the loser in terms of suffering, life quality and shorter life expectancy. Also the life for the next-of-kin is affected. A strategy to sow doubt on cancer risks was established decades ago and is now adopted and implemented in a more sophisticated way by the telecom industry regarding RF-EMF risks to human beings and the environment. Industry has the economic power, access to politicians and media whereas concerned people are unheard.

Open access paper: <https://www.degruyter.com/document/doi/10.1515/reveh-2020-0168/html> or <https://www.degruyter.com/document/doi/10.1515/reveh-2020-0168/pdf>

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