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The Accuracy of Siblings' Family History Reports of Thyroid and Other Cancers

Genetic factors may lead to a familial tendency for spontaneously occurring, nonmedullary thyroid cancers1 and radiation-induced thyroid neoplasms.2 Interest in hereditary susceptibility to cancer underscores the need to ascertain the accuracy of reported familial cancer history. We analyzed the accuracy of family history interviews in a population for which we had independent data on cancer in the interviewees' siblings.

Our cohort of 4296 subjects received childhood radiation, between 1939 and 1962, for benign head and neck conditions.3 Thyroid cancer developed in 10% to 15% of located subjects. The study cohort includes irradiated siblings from several hundred families.2 Of 770 randomly selected, previously located subjects, 590 (76.6%) completed a telephone interview. Reasons for nonparticipation were as follows: deceased (n = 3), refused (n = 24), not located (n = 97), nonresponse (n = 28), nonpublished phone number (n = 25), and other (n = 3).

Respondents were asked, "Have any members of your immediate family, that is, your biologic parents, brothers, sisters, or children, ever been diagnosed with cancer? Please include leukemia, lymphoma, Hodgkin's disease and melanoma, as well as any other cancer." For positive reports, relation to the subject, date of birth, type and location of cancer, and age at diagnosis were obtained. Of the 590 interviewees, 132 had 148 siblings who were irradiated and are members of the total cohort (Table 1). The 48 cancers, some multiple primaries, reported for the 148 siblings were confirmed from medical record information previously collected.

Analyses of the accuracy of thyroid cancer, skin cancer, and other cancer reports were performed separately (Table 2). Thyroid cancer is often underreported by siblings (64.0% sensitivity) but can also be overreported (among 34 siblings with benign thyroid nodules, four were reported as cancer). A specific question about thyroid cancer might have reduced underreporting, but it is unlikely that the cancer/benign errors would have been reduced. Skin cancer accuracy was lower (42.9%) than for thyroid cancer; for other cancer, however, the accuracy was considerably higher (87.5%).

None of the following factors were related to report accuracy: (1) difference in age between siblings, (2) sex of interviewee/reported sibling, (3) birth order, (4) geographic location, (5) clustering of inaccurate reports to the same families, (6) interviewee history of thyroid surgery, and (7) interviewee education (70.4% had 4 or more years of college).

Napier et al.4 observed "gross underreporting" (<50% correct) for eight nonneoplastic diseases in first-degree relatives, including "thyroid trouble," which was correctly reported only 5% of the time. Bondy et al.5 studied underreporting of cancer, finding it to be a problem largely confined to second-degree relatives. Other studies of family cancer reporting have focused on the validation of reported cases. Both Love et al.6 and Kuijten et al.7 reported cancer validation rates (83.3% and >88%, respectively) similar to ours (84.6%).

<table>
<thead>
<tr>
<th>TABLE 1—Selected Characteristics of the Interviewees</th>
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<tbody>
<tr>
<td>All (n = 590)</td>
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<tr>
<td>Sex, %</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Age at interview, y, mean (SD)</td>
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<tr>
<td>48.6 (5.1)</td>
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<tr>
<td>No. of familiesa</td>
</tr>
<tr>
<td>571</td>
</tr>
<tr>
<td>Median family sizeb</td>
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<tr>
<td>6</td>
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</table>

*aMore than one interviewee may be in a family.
*bIncludes interviewee, parents, siblings, and children.
These results cannot be generalized to other relatives, and they are limited because of the small number of cancer cases. However, they do emphasize the problem of underreporting and suggest caution in evaluating family history information derived from interviews for less lethal cancers. In fact, the results for thyroid cancer reporting accuracy may be an overestimate since this irradiated cohort is especially aware of thyroid cancer. □

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References
3. Schneider AB, Ron E, Lubin J, et al. Dose-response relationships for radiation-induced thyroid cancer and thyroid nodules: evidence for the prolonged effects of radia-


Magico-Religious Mercury Use and Cultural Sensitivity

In his recent commentary, “AIDS Prevention and Cultural Sensitivity: Are They Compatible?” Bayer concluded, “Homilies about cultural sensitivity must be replaced by a forthright acknowledgement that we cannot seek radical behavioral and normative change while adhering to a dictum that serves principally to protect the status quo.”4(P897)

Although Bayer specifically addresses acquired immunodeficiency syndrome (AIDS), his logic pertains to other complaints possessing culturally determined risk factors, including intoxication resulting from the magico-religious use of mercury in Hispanic and Caribbean homes.2 Although the Environmental Protection Agency (EPA) has recently initiated a public awareness campaign to deal with “the burning or sprinkling of elemental mercury in homes and cars,”3 there has been resistance on the part of numerous Hispanic “stakeholder” organizations to “regulatory action” involving the sale of illegally unlabeled mercury for magico-religious and ethnomedical use.4

Despite urging EPA “to begin its risk communication efforts quickly in order to show its concern for the affected population,”4(p7) the three national Hispanic stakeholder organizations EPA consulted felt that a more active intervention, such as enforcing the existing Federal Hazardous Substances Act labeling requirements (16 CFR §§1500–1512), “would send the message of government interference in the practicing of one’s religion.”6(p8) The stakeholder organizations agreed that “any discussion of the religious implications of [mercury use] should be omitted from the risk communication message.”4(p7)

EPA stated that “because of the cultural aspects of this problem [of magico-religious mercury use], any regulatory action would probably be very difficult to enforce.”4(p6) Similar sentiments have been voiced by the Consumer Product Safety Commission (CPSC), which has refused to exercise its subpoena powers to examine the sales records of distributors of illegally unlabeled or inadequately labeled mercury. Such records provide data on the amount of mercury sold for magico-religious purposes, as well as the geographical distribution of such sales, and would eliminate “many [of the] uncertainties . . . regarding the extent . . . of use of mercury in these practices.”4(p3)

Both EPA’s and CPSC’s actions (or inactions) illustrate Bayer’s observation that “acceding to the demands of cultural sensitivity . . . not only is not a prerequisite for effective public health practice but would be inimical to the goals of . . .