



## **SECTION 17**

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# Key Scientific Evidence And Public Health Policy Recommendations

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## **Table of Contents**

### **I. Key Scientific Evidence**

**A. Weight of Evidence Assessment and Criteria for Causality**

**B. Summary of Evidence**

### **II. Fallacies and Answers in the Debate over EMF Evidence**

**A. Only a small number of children are affected.**

**B. There is insufficient evidence that adult diseases are secondary to EMF exposure.**

**C. The risk is low**

**D. There is no animal evidence**

**E. We do not know a mechanism**

**F. Vested Interests: How They Shape the Public Health Debate**

### **III. EMF Exposure and Prudent Public Health Planning**

### **IV. Recommended Actions**

### **V. Conclusions**

### **VI. References**

## I. KEY SCIENTIFIC EVIDENCE

Exposure to electromagnetic fields (EMF) has been linked to a variety of adverse health outcomes. The health endpoints that have been reported to be associated with ELF and/or RF include childhood leukemia, adult brain tumors, childhood brain tumors, genotoxic effects (DNA damage and micronucleation), neurological effects and neurodegenerative disease, immune system dysregulation, allergic and inflammatory responses, breast cancer in men and women, miscarriage and some cardiovascular effects.

Effects are not specifically segregated for ELF or RF, since many overlapping exposures occur in daily life; and because this is an artificial division based on frequencies as defined in physics that has little bearing on the biological effects. Both ELF and RF, for example have been shown to cause cells to generate stress proteins, a universal sign of distress in plant, animal and human cells.

The number of people exposed to elevated levels of EMF has been estimated in various studies, and there is general agreement among them. In the United States, few people have chronic or prolonged exposures over 4 mG (0.4  $\mu$ T) (Kheifets et al, 2005b). Section 20 has information on average residential and occupational ELF levels. The highest exposure category in most all studies is  $\geq 4$  mG ( $\geq 0.4$   $\mu$ T). Many people have daily exposures to ELF in various ways, some of them up to several hundred milligauss for short periods of time, but relatively few people with the exception of some occupational workers habitually experience ELF exposures greater than 1-2 mG (0.2 – 0.3  $\mu$ T - App. 20-A).

The exposure of children to EMF has not been studied extensively; in fact, the FCC standards for exposure to radiofrequency radiation are based on the height, weight and stature of a 6-foot tall man, not scaled to children or adults of smaller stature. They do not take into account the unique susceptibility of growing children to exposures (SCENIHR, 2007; Jarosinska and Gee, 2007), nor are there studies of particular relevance to children.

Differences in exposure patterns between infants, children and adults; 2) special susceptibilities of infants and children to the effects of EMF; and 3) interactions between chemical contaminants and EMF are lacking; as are studies on chronic exposure for both children and adults. There is

reason to believe that children may be more susceptible to the effects of EMF exposure since they are growing, their rate of cellular activity and division is more rapid, and they may be more at risk for DNA damage and subsequent cancers. Growth and development of the central nervous system is still occurring well into the teenage years so that neurological changes may be of great importance to normal development, cognition, learning, and behavior. Prenatal exposure to EMF have been identified as possible risk factor for childhood leukemia. Children are largely unable to remove themselves from exposures to harmful substances in their environments. Their exposure is involuntary.

Like second-hand smoke, EMF is a complex mixture, where different frequencies, intensities, durations of exposure(s), modulation, waveform and other factors is known to produce variable effects. Many years of scientific study has produced substantial evidence that EMF may be considered to be both carcinogenic and neurotoxic. The weight of evidence is discussed in this report, including epidemiological evidence and studies on laboratory animals.

Relative risk estimates associated with some of these endpoints are small and the disease is fairly rare (for childhood leukemia, for example), For other diseases, the risk estimates are small but the diseases are common and EMF exposures at levels associated with increased risks are widespread and chronic so the overall public health impacts may be very large.

## **A. Weight of Evidence Assessment and Criteria for Causality**

A weight-of-evidence approach has been used to describe the body of evidence between health endpoints and exposure to electromagnetic fields (ELF and RF).

The number and quality of epidemiological studies, as well as other sources of data on biological plausibility are considered in making scientific and public health policy judgments. Methodological issues that were considered in the review of the epidemiological literature include 1) quality of exposure assessment, 2) sample size of the study, which detects the power to detect an effect, 3) extent to which the analysis or design takes into account potential confounders or other risk factors, 4) selection bias, 5) the potential for bias in determining exposure. Assessment of the epidemiological literature is consistent with guidelines from Hill (1971), Rothman and Greenland (1998) and the Surgeon General's Reports on Smoking (US DHHS, 2004), and California Air Resources Board (2005). Factors that were considered in reaching conclusions about the weight of evidence overall included strength of the association, consistency of association, temporality, biological plausibility, dose-response and issues with non-linear dose-response, specificity and experimental evidence.

There is a relatively large amount of human epidemiological information with real world exposures, including data from occupational studies. There is less animal data in most cases, except for the genotoxicity studies. Human epidemiological evidence has been given the greatest weight in making judgments about weight-of-evidence, where the results across high quality studies give relatively consistent positive results. Meta-analyses of childhood leukemia, adult leukemia, adult brain tumors, childhood brain tumors, male and female breast cancer and Alzheimer's disease were relied upon in assessing the overall strength of epidemiological study results. Sections 5 – 15 provide analysis of the relevant scientific studies that are key evidence in making public health policy recommendations with respect to exposure to electromagnetic fields (both ELF and RF).

## **B. Summary of Evidence**

### **1. Childhood Leukemia**

Several meta-analyses have been conducted to assess risks of childhood leukemia from exposure to ELF. The results of these studies that combine or pool results of many individual studies (including studies that report both effects and no effects) consistently report increased risks.

#### **Meta-Analysis: Studies of Childhood Leukemia and EMF**

Greenland et al., (2000) reported a significantly elevated risk of 1.68 [95% CI 1.23-2.31] based on pooled results from 12 studies using a time-weighted average of exposure greater than 3 mG (0.3  $\mu$ T). This is a 68% increased risk of childhood leukemia.

Ahlbom et al., (2000) reported a doubling of risk based on a meta-analysis of nine (9) studies. The results reported an elevated risk of 2.0 [95% CI 1.27-3.13] for EMF exposures equal to or greater than 4 mG (0.4  $\mu$ T) as compared to less than 1 mG (0.1  $\mu$ T)

#### **Other Relevant Evidence**

In 2002, the International Agency for Cancer Research (IARC) designated EMF as a “possible human carcinogen” or Group 2B Carcinogen based on consistent epidemiological evidence. The exposure levels at which increased risks of childhood leukemia are reported in individual studies range from above 1.4 mG or 0.14  $\mu$ T (Green et al., 1999) for younger children to age six (6) to 4 mG (0.4  $\mu$ T). Many individual studies with cutpoints of 2 mG or 3 mG (0.2-0.3  $\mu$ T) report increased risks. Plausible biological mechanisms exist that may reasonably account for a causal relationship between EMF exposure and childhood leukemia.

#### **Recurrence of Childhood Leukemia and Poorer Survival Rates with Continued EMF Exposure**

Foliart reported more than a four-fold (450% increased risk) of adverse outcome (poorer survival rate) for children with acute lymphoblastic leukemia (ALL) who were recovering in EMF environments of 3 mG (0.3  $\mu$ T) and above (OR 4.5, CI 1.5-13.8). Svendsen reported a poorer survival rate of children with acute lymphoblastic leukemia (ALL) in children exposed to 2 mG (0.2  $\mu$ T) and above. These children were three times more likely (300% increased risk) to die than children recovering in fields of less than 1 mG (OR 3.0, CI 0.9-8). Children recovering in EMF environments between 1- 2 mG (0.1-0.2  $\mu$ T) also had poorer survival rates, where the increased risk was 280% (OR 2.8, CI 1.2-6.2).

#### **Higher Lifetime Cancer Risks with Childhood EMF Exposure**

Lowenthal (2007) reported that children raised for the first five years in home environments exposed to EMF within 300 meters of a high voltage power line have a five-fold (a 500 percent increased risk of developing some kinds of cancers sometime in later life. For children from newborn to 15 years of age; it is a three-fold risk of developing cancer later in life (Lowenthal et al., 2007). There is suggestive evidence for a link between adult leukemia and EMF exposure.

### **Attributable Risk**

Wartenberg estimates that 8% to 11% of childhood leukemia cases may be related to ELF exposure. This translates into an additional 175 to 240 cases of childhood leukemia based on 2200 US cases per year. The worldwide total of annual childhood leukemias is estimated to be 49,000, giving an estimate of nearly 4000 to 5400 cases per year. Other researchers have estimated higher numbers that could reach to 80% of all cases (Milham, 2001).

## **2. Childhood Brain Tumors**

### **Childhood Brain Tumors**

There is suggestive evidence that other childhood cancers may be related to EMF exposure. The meta-analysis by Wartenberg et al., (1998) reported increased risks for childhood brain tumors. Risks are quite similar whether based on calculated EMF fields (OR = 1.4, 95% CI = 0.8 – 2.3] or based on measured EMF fields (OR = 1.4, 95% CI = 0.8 – 2.4).

## **3. Adult Brain Tumors**

### **Brain Tumors in Electrical Workers and in Electrical Occupations (Meta-analysis)**

A significant excess risk for adult brain tumors in electrical workers and those adults with occupational EMF exposure was reported (Kheifets et al., 1995). This is about the same size risk for lung cancer and second hand smoke (US DHHS, 2006). A total of 29 studies with populations from 12 countries were included in this meta-analysis. The relative risk was reported as 1.16 (CI = 1.08 – 1.24) or a 16% increased risk for all brain tumors. For gliomas, the risk estimate was reported to be 1.39 (1.07 – 1.82) or a 39% increased risk for those in electrical occupations. A second meta-analysis published by Kheifets et al., ((2001) added results of 9 new studies published after 1995. It reported a new pooled estimate (OR = 1.16, 1.08 – 1.01) that showed little change in the risk estimate overall from 1995.

## **4. Brain Tumors and Acoustic Neuromas in Cell Phone and Cordless Phone Users (Meta-Analysis)**

### **Glioma and Acoustic Neuroma**

Hardell et al., (2007) reported in a meta-analysis statistically significant increased risk for glioma with exposure of 10 years or greater in persons using cell phones. Risks were estimated to be 1.2 (0.8 – 1.9) for all use; but when ipsilateral use was assessed (mainly on same side of head) it increased the risk of glioma to 2.0 (1.2 – 3.4) for 10 years and greater use.

For acoustic neuromas, Hardell et al., (2007) reported the increased risk with 10 years or more of exposure to a cell phone at 1.3 (0.6 – 2.8) but this risk increased to 2.4 (1.1 – 5.3) with ipsilateral use (mainly on the same side of the head). There is a consistent pattern of increased risk for brain tumors (glioma) and acoustic neuromas at 10 years and greater exposure to cell phones.

The meta-analysis by Lakhola et al., (2006) reported that brain tumor risk was 1.3 (0.99 – 1.9) for ipsilateral use of a cell phone, but no data was given for exposures at 10 years or greater (all exposures were of shorter duration).

The meta-analysis by Kan et al., (2007) reported “no overall risk” but found elevated risk of brain tumors (RR = 1.25, CI 1.01 – 1.54)  $\geq$  10 years, reinforcing the findings of other pooled estimates of risk. No estimates of increased risk with ipsilateral use were provided, which would have likely increased reported risks.

## 5. Neurodegenerative Diseases

### Alzheimer’s Disease and ALS

Evidence for a relationship between exposure and the neurodegenerative diseases, Alzheimer’s and amyotrophic lateral sclerosis (ALS), is strong and relatively consistent. While not every publication shows a statistically significant relationship between exposure and disease, ORs of 2.3 (95% CI = 1.0-5.1 in Qio et al., 2004), of 2.3 (95% CI = 1.6-3.3 in Feychting et al., 2003) and of 4.0 (95% CI = 1.4-11.7 in Hakansson et al., 2003) for Alzheimer’s Disease.

Hakansson et al., report more than a doubling of risk for ALS 2.2 (95% CI = 1.0-4.7).

Savitz et al., (1998) reports more than a tripling of risk for ALS (3.1, CI = 1.0 – 9.8).

## 6. Breast Cancer (Men and Women)

A meta-analysis by Erren (2001) on EMF and breast cancer reported pooled relative risks based on studies of both men and women. A total of 38 publications were reviewed; there were 23 studies on men; 25 studies on women; and 10 studies on both men and women. The pooled relative risk for women exposed to EMF was 1.12 (CI 1.09 – 1.15) or a 12% increased risk, Erren observed that variations between the contributing results are not easily attributable to



chance ( $P = 0.0365$ ). For men and breast cancer, he reported a fairly homogeneous increased risk (a pooled relative risk of 1.37 [CI 1.11 – 1.71]).

This analysis is well conducted. The results were stratified according to measured or assumed intensity of exposure to EMF; and the estimate of risk for the most heavily exposed group was extracted. Independent estimates of RRs were grouped according to gender, type of study (case-control and cohort), country where the study was conducted and method used to assess exposure. Pooled estimates of RRs and their 95% confidence intervals (CI) referring to various combinations of these factors were calculated according to appropriate statistical methods (Greenland, 1987). Misclassification possibilities were thoroughly assessed, and whether the results were sole endpoints or there were multiple endpoints in each study did not affect the RRs.

Erren qualifies his findings by discussing that latencies for cancers can be 20 to 30 years. Further, he notes that studies of total EMF exposures from both home, travel and workplace are rarely available, and these EMF sources are ubiquitous. Both could result in underestimation of risks. Another way in which risks might be masked is by variations in age of study participants. Forssen and colleagues (2000) reported no increased RRs for breast cancer in women of all ages when they combined residential and occupational EMF exposures (RR = 0.9, CI 0.3 – 2.7). However, when risks for the women younger than 50 years of age were separated out and calculated, the RR increased to 7.3 (CI 0.7 – 78.3) although with wide confidence intervals based on only four cases. Erren notes

*“When possibly relevant exposures to EMF in the whole environment are assessed only partially, errors in the categorization of exposure status are likely to occur. If such misclassification is random and thus similar in subgroups being compared (nondifferential), then the error will tend to introduce bias towards the null. Substantial random misclassification of exposures would then tend to generate spurious reports of ‘little or no effect’. Note for example that estimates of smoking-associated lung cancer risks in the early 1950’s could have been seriously distorted if exposure assessment had not considered smoking either at work or at home.”*

*“Collectively, the data are consistent with the idea that exposures to EMF, as defined, are associated with some increase in breast cancer risks, albeit the excess risk is small.”* Erren (2001)

## **7. Combined Effects of Toxic Agents and ELF**

### **ELF and Toxic Chemical Exposures**

There is also the issue of what weight to give the evidence for synergistic effects of toxic chemical exposure and EMF exposure. Juuilainen et al., (2006) reported that the combined effects of toxic agents and ELF magnetic fields together enhances damage as compared to the toxic exposure alone. In a meta-analysis of 65 studies; overall results showed 91% of the *in vivo*

studies and 68% of the *in vitro* studies had worse outcomes (were positive for changes indicating synergistic damage) with ELF exposure in combination with toxic agents. The percentage of the 65 studies with positive effects was highest when the EMF exposure preceded the other exposure. The radical pair mechanism (oxidative damage due to free radicals) is cited as a good candidate to explain these results. Reconsideration of exposure limits for ELF is warranted based on this evidence.

## II. FALLACIES AND ANSWERS IN THE DEBATE OVER EMF EVIDENCE

There are several arguments (false, in our view) that have been presented by those who minimize the strength of the relationship between exposure to both 50-60Hz ELF and RF EMFs. These are as follows:

### A. “Only a small number of children are affected.”

This argument is not correct because we do not know precisely how many children are affected. In 1988 Carpenter and Ahlbom attempted to answer this question based on the results of the New York State Powerlines Project and the results of the study of Savitz et al. (1988), and concluded that if the magnetic fields homes in the US were similar to those in Denver, Colorado fully 10 to 15% of US childhood leukemia (about 1,000 cases) could be associated with residential magnetic field exposure. They then concluded that exposure to magnetic fields from non-residential sources (particularly appliances) must be at least equal in magnitude, and that if so these two sources of exposure would account for 20-35% of childhood leukemia.

There have been several meta-analyses of the childhood leukemia data (Wartenberg, 1998; Greenland et al., 2000; Ahlbom et al., 2000). All have concluded that there is a significant association between residential exposure to magnetic fields and elevated risk of leukemia in children. Greenland et al. (2000) performed a meta-analysis of 15 studies of magnetic field or wire code investigations of childhood leukemia, and calculated the attributable fraction of cases of childhood leukemia from residential magnetic field exposure in the US was 3%. Ahlbom et al. (2000) conducted a different meta-analysis that concluded there was a significant 2-fold elevation of risk at exposure levels of 4 mG (0.4  $\mu$ T) or greater. Kheifets et al. (2006) attempted to calculate the attributable fraction of worldwide childhood leukemia due to EMFs, based on the meta-analyses of Ahlbom et al. (2000) and Greenland et al., (2000). They concluded that the attributable fraction of leukemia was between <1% to 4%. The recent WHO Environmental Health Criteria ELF Monograph #238 (2007) states “(A)ssuming that the association is causal, the number of cases of childhood leukaemia worldwide that might be attributable to exposure can be estimated to range from 100 to 2,400 cases per year. However this

represents 0.2 to 4.9% of the total annual incidence of leukaemia cases, estimated to be 49,000 worldwide in 2000. Thus, in a global context, the impact on public health, if any, would be limited and uncertain.”

These reports are important, in that they show consistency in there being a clearly elevated risk of leukemia in children with EMF exposure from power line fields in homes. These meta-analyses lead to the conclusion, reflected in the WHO report, that there is an association between childhood cancer and exposure to elevated magnetic fields in homes. We strongly disagree, however, with the overall conclusion that these calculations indicate that the fraction of childhood leukemia attributable to EMFs is so small as to not have serious public health implications.

There are several reasons why the WHO ELF Environmental Health Criteria Monograph conclusion is not justified. These studies all considered either only measured magnetic fields in homes or wire codes from power lines, ignoring exposure from appliances, wireless devices and all exposures outside of the home. Thus these metrics do not come close to accounting for any individual’s cumulative exposure to EMFs. If residential magnetic fields cause cancer, then those from other sources will add to the risk. The failure to measure total EMF exposure would tend to obscure the relationship and lead to gross underestimation of the true relationship between exposure and disease. While the evidence for a relationship between exposure and childhood leukemia may be considered to be definitive at exposure levels of 3 or 4 mG (0.3 or 0.4  $\mu$ T) or higher; there is evidence from some (but not all) of the other studies for an elevated risk at levels not greater than 2 mG (0.2  $\mu$ T) (Savitz et al., 1988; Green, 1999). There is absolutely no evidence that exposures at lower levels are “safe”, since persons with these exposures are usually the “control” group. Therefore this WHO statement fails to acknowledge the true magnitude of the problem, even when considering only childhood leukemia. The global attributable risk of childhood leukemia as a result of exposure to EMFs must be significantly greater than that calculated from consideration of only residential 50/60 Hz magnetic fields in studies where there is no unexposed control.

As detailed in other chapters in this report (Chapter 10), there is some evidence for a relationship between EMF exposure and brain cancers in children. We have almost no understanding of the mechanisms behind the development of brain cancers, and any cancer in a child is a tragedy. While evidence for a relationship between EMF exposure and childhood brain cancer is not as strong as for leukemia, it is of concern and deserves more study. Of even greater concern, given the clear evidence for elevated risk of childhood leukemia upon exposure to 50/60 Hz EMFs, is the relative lack of a comparable body of information on the effects of radiofrequency EMFs on the health of children. A recent study of South Korean children (1,928 with leukemia, 956 with brain cancer and 3,082 controls) living near to AM radio transmitters reports an OR of 2.15 (95% CI = 1.19-2.11) for risk of leukemia in children living within 2 km of the nearest AM transmitter as compared to those living more than 20 km from it (Ha et al., 2007). No relation was found for brain cancer. This study is consistent with the hypothesis that radiofrequency EMFs have similar effects to 50/60 Hz EMFs, but more study is needed. Since radiofrequency EMFs have higher energy than do power line frequencies, one

might expect that they would be even more likely to cause disease. The enormous and very recent increase in use of cell phones by children is particularly worrisome. However there is little information at present on the long-term consequences of cell phone use, especially by children.

**B. “There is insufficient evidence that adult diseases are secondary to EMF exposure.”**

It is correct that the level of evidence definitively proving an association between exposure to EMFs and various adult diseases is less strong than the relationship with childhood leukemia. However there are multiple studies which show statistically significant relationships between occupational exposure and leukemia in adults (see Chapter 11), in spite of major limitations in the exposure assessment. A very recent study by Lowenthal et al. (2007) investigated leukemia in adults in relation to residence near to high-voltage power lines. While they found elevated risk in all adults living near to the high voltage power lines, they found an OR of 3.23 (95% CI = 1.26-8.29) for individuals who spent the first 15 years of life within 300 m of the power line. This study provides support for two important conclusions: adult leukemia is also associated with EMF exposure, and exposure during childhood increases risk of adult disease. Thus protecting children from exposure should be a priority.

The evidence for a relationship between exposure and breast cancer is relatively strong in men (Erren, 2001), and some (by no means all) studies show female breast cancer also to be elevated with increased exposure (see Chapter 12). Brain tumors and acoustic neuromas are more common in exposed persons (see Chapter 10). There is less published evidence on other cancers, but Charles et al. (2003) report that workers in the highest 10% category for EMF exposure were twice as likely to die of prostate cancer as those exposed at lower levels (OR 2.02, 95% CI = 1.34-3.04). Villeneuve et al. (2000) report statistically significant elevations of non-Hodgkin’s lymphoma in electric utility workers in relation to EMF exposure, while Tynes et al. (2003) report elevated rates of malignant melanoma in persons living near to high voltage power lines. While these observations need replication, they suggest a relationship between exposure and cancer in adults beyond leukemia.

Evidence for a relationship between exposure and the neurodegenerative diseases, Alzheimer’s and amyotrophic lateral sclerosis (ALS), is strong and relatively consistent (see Chapter 12). While not every publication shows a statistically significant relationship between exposure and disease, ORs of 2.3 (95% CI = 1.0-5.1 in Qio et al., 2004), of 2.3 (95% CI = 1.6-3.3 in Feychting et al., 2003) and of 4.0 (95% CI = 1.4-11.7 in Hakansson et al., 2003) for Alzheimer’s Disease, and of 3.1 (95% CI = 1.0-9.8 in Savitz et al., 1998) and 2.2 (95% CI = 1.0-4.7 in Hakansson et al., 2003) for ALS cannot be simply ignored.

In total the scientific evidence for adult disease associated with EMF exposure, given all of the difficulties in exposure assessment, is sufficiently strong that preventive steps are appropriate, even if not all reports have shown exactly the same positive relationship.

While there are many possible sources of false positive results in epidemiological studies, there are even more possible reasons for false negative results, depending on sample size, exposure assessment and a variety of other confounders. It is inappropriate to discount the positive studies just because not every investigation shows a positive result. While further research is needed, with better exposure assessment and control of confounders; the evidence for a relationship between EMF exposure and adult cancers and neurodegenerative diseases is sufficiently strong at present to merit preventive actions to reduce EMF exposure.

### **C. “The risk is low.”**

This argument is incorrect because at present it is not possible to determine the magnitude of the risk. Clearly as far as EMFs are concerned there is no unexposed population. Therefore one can only compare groups with different levels of exposure. We can perhaps say with confidence that the elevated risk of leukemia from residential exposure of children to magnetic fields is “low” (meaning ORs in the range of 2-4), but this does not consider the child’s exposure to appliances, exposure in automobiles and at daycare or school, exposures in playgrounds and at all of the other places that a child spends time. Even if the risk to one individual is low, the societal impact when everyone is exposed may be very significant.

In addition the exposure assessment is grossly inadequate, even in the best of studies. Most reports deal only with either characterization of the fields within residences or with job titles in occupational settings. Some studies attempt to quantitate other sources of exposure, such as frequency of cell phone usage or use of other appliances, but these studies almost always do not consider residential exposure from power lines. In no investigation has it been possible to follow the exposures of a large number of people over a number of years with accurate monitoring of total exposure to EMFs. This would of course be almost impossible to do for the very good reason that as a person moves through his or her environment the exposures vary from place to place and from moment to moment. However to truly and objectively determine the risk of exposure to EMFs it is essential to consider residential, occupational (or school) and recreational exposures to the full range of the electromagnetic spectrum, including appliances and wireless devices. This has not been accomplished in any study, and without such information it is not possible to determine the overall magnitude of the risk. It is possible, indeed likely, that upon consideration of both childhood and adult diseases that the risk is not low.

### **D. “There is no animal evidence”.**

It is correct that there is no adequate animal model system that reproducibly demonstrates the development of cancer in response to exposure to EMFs at the various frequencies of concern. McCann et al. (1997) reviewed the animal studies, and while they found most to be negative there were several that showed suggestive positive results. They also clearly identified issues that need to be improved in further animal carcinogenesis

investigations. However Kheifets et al. (2005a) in a policy review noted that “even consistent negative toxicological data cannot completely overcome consistent epidemiological studies. First, a good animal model for childhood leukemia has been lacking. Second, particularly for ELF, the complex exposures that humans encounter on a daily basis and a lack of understanding of the biologically relevant exposure calls into question the relevance of exposures applied in toxicology. Another limitation of toxicologic studies is that animals cannot be exposed to fields that are orders of magnitude more powerful than those encountered by humans, decreasing their power to detect small risks.” Further, they conclude that “(A)lthough the body of evidence is always considered as a whole, based on the weight of evidence approach and incorporating different lines of scientific enquiry, epidemiologic evidence, as most relevant, is given the greatest weight.”

One positive animal study is that by Rapacholi et al. (1997), who demonstrated that lymphoma-prone transgenic mice developed significantly more lymphoma after exposure to 900 MHz fields (lymphoma being the animal equivalent of human leukemia) than did unexposed animals. More striking is the report from Denver, Colorado using the wire-code characterization originally developed by Wertheimer and Leeper (1979) showing that pet dogs living in homes characterized as having high or very high wire codes, as compared to those with low or very low wire codes or buried power lines, showed a OR of 1.8 (95% CI = 0.9-3.4) for development of lymphoma after adjustment for potential confounders, whereas dogs that lived in homes with very high wire codes had an OR of 6.8 (95% CI = 1.6-28.5) (Reif et al., 1995). This study is impressive because the exposure of the dogs reflects the environment in which exposure has been associated with elevated risk of human cancer in two independent investigations (Wertheimer and Leeper, 1979; Savitz et al., 1988).

It is curious that in many legal situations the courts are reluctant to accept only evidence that substance X causes cancer in animals without corresponding evidence in humans. In the case of EMFs we have strong evidence that EMFs cause cancer in human, but much less evidence from animal models. The US Supreme Court, in the case of *Daubert vs. Merrell Dow Pharmaceuticals*, effectively ruled that animal studies were not relevant to human health, and that the only admissible evidence must be from human epidemiological studies! While this is certainly not a justifiable conclusion, the situation with regards to EMF health effects is that we have strong evidence for human cancer from epidemiological studies, but do not have good evidence for cancer in experimental animals. But it is humans that we should be concerned about, not the laboratory rats.

#### **E. “We do not know a mechanism.”**

We do not know the mechanism of cancer in general, although we know a lot about cancer. It came as a major surprise to most scientists when Lichtenstein et al., (2000) reported that genetic factors play a minor role in causing most types of cancer, since it was commonly assumed that genetics was the major cause. However Lichtenstein et al. concluded from their study of identical twins that environmental factors were the initiating event in the great majority of cancers. This does not, of course, mean that

genetic susceptibility to environmental contaminants is unimportant, but only that genetic factors alone do not result in cancer. We know mechanisms of action for some carcinogenic substances, but for most cancers we know neither the environmental trigger nor the mechanism of action. So there is no reason to negate the evidence that EMFs cause cancer just because we do not know a single mechanism to explain its mode of action.

We do not know the mechanism or cause for development of Alzheimer's Disease or ALS. We do know that both are more common in individuals in certain occupations, and that exposure to certain metals appears to be associated with increased risk (Kamel et al., 2002; Shcherbatykh and Carpenter, 2007). In the case of Alzheimer's Disease there are abnormalities of amyloid  $\beta$  and tau protein (Goedert and Spillantini, 2006), but very limited understanding of why or how they form. Neither the association with metals nor the presence of abnormal proteins constitutes a mechanism for cause of disease. So rather than discounting the relationship between EMF exposure and neurodegenerative diseases we should be using this information as a tool to better understand the etiology of these diseases.

There is clear evidence from animal and cell culture studies that ELF and RFR have biological effects. Furthermore, these effects occur at intensities commonly experienced by humans. We know a number of ways in which EMFs alter cell physiology and function, as detailed in various chapters in this report. EMFs affect gene transcription (Chapter 5 and 6), cause the synthesis of stress proteins (Chapter 7) and cause breakage of DNA, probably through generation of reactive oxygen species (Chapter 6 and 9 - Lai and Singh, 2004). Any one of these actions might be responsible for the carcinogenic and neurodegenerative actions of EMFs. However, as with many environmental agents, it would be a mistake to assume that there is only one target or mechanism of action. It is unlikely, for example, that the effects on the nervous system and behavior are secondary to exactly the same cellular targets and actions that lead to cancer. It is likely that there are multiple mechanisms of action leading to disease. But the lack of complete understanding of basic mechanisms does not alter the importance of the relationships.

## **F. Vested Interests: How They Shape the Public Health Debate**

There is no question but that global implementation of the safety standards proposed in this report has the potential to not only be very expensive but also could be disruptive of life and economy as we know it if implemented abruptly and without careful planning. Action must be a balance of risk to cost to benefit. However, "deny and deploy" strategies by industry should not be rewarded in future risk assessment calculations. For example, if significant economic investments in the roll-out of risky technologies persist beyond the time that there is reasonable suspicion of risk available to all who look, then such costs should not be borne by ratepayers (in the case of new powerlines) or by compensating industry for bad corporate choices. Such investments in the deployment of new sources of exposure for ELF and RF should not count toward the balance sheet when

regulatory agencies perform risk assessments. Mistakes may be made, but industry should make mid-course corrections to inform and protect the public, rather than deny effects pending “proof”. Whether the costs of remedial action are worth the societal benefits is a formula that should reward precautionary behavior. Prudent corporate policies should be expected to address and avoid future risks and liabilities. Otherwise, there is no market incentive to produce safe (and safer) products.

The deployment of new technologies is running ahead of any reasonable estimation of possible health impacts and estimates of probabilities, let alone a solid assessment of risk. However what has been missing with regard to EMF has been an acknowledgement of the risk that is demonstrated by the scientific studies. As discussed in earlier sections, in this case there is clear evidence of risk, although the magnitude of the risk is uncertain, and the magnitude of doing nothing on the health effects cost to society is similarly uncertain. This situation is very similar to our history of dealing with the hazards of smoking decades ago, where the power of the industry to influence governments and even conflicts of interest within the public health community delayed action for more than a generation, with consequent loss of life and enormous extra health care costs to society.

Just because a problem is difficult to solve is not a reason to deny that a problem exists. In fact solutions to difficult issues usually can’t be expected until the issues are known and creative thinking is brought to bear to find a solution.

The most contentious issue regarding public and occupational exposures to ELF and RF involves the resolute adherence to existing ICNIRP and IEEE standards by many countries, in the face of growing scientific evidence of health risks at far lower levels. Furthermore there is widespread belief that governments are ignoring this evidence. There are two obvious factors that work against governments taking action to set exposure guidelines based on current scientific evidence of risk. These are: 1) contemporary societies are very dependent upon electricity usage and RF communications, and anything that restricts current and future usage potentially has serious economic consequences and 2) the electric power and communications industries have enormous political clout and even provide support for a significant fraction of what research is done on EMF. This results in legislation that protects the status quo and scientific publications whose conclusions are not always based on only the observations of the research. It hinders wise public health policy actions and implementation of prevention strategies because of the huge financial investments already made in these technologies.

In 1989, in an editorial for Science Magazine, Philip H. Abelson called for more research into low-frequency electromagnetic fields. At that time, he confirmed that a US Office of Technology Assessment (OTA) study had determined that “*(o)verall, the evidence is too weak to allow firm conclusions either way*” but a policy of prudent avoidance strategy was suggested, Abelson defined this as “*to systematically look for strategies which can keep people out of 60 Hz fields*”. Both policy actions were developed in the midst of scientific uncertainty, but rising concern for possible health impacts to the public. At that time, with



high level of unknowns, the appropriate level of policy action was prudent avoidance or precautionary action. Nearly two decades later, the level of action warranted is higher – based on many new scientific publications confirming risks may exist – and justifying prevention or preventative action.

### **III. EMF EXPOSURE AND PRUDENT PUBLIC HEALTH PLANNING**

- *The scientific evidence is sufficient to warrant regulatory action for ELF; and it is substantial enough to warrant preventative actions for RF.*
- *The standard of evidence for judging the emerging scientific evidence necessary to take action should be proportionate to the impacts on health and well-being*
- *The exposures are widespread.*
- *Widely accepted standards for judging the science are used in this assessment.*

Public exposure to electromagnetic radiation (power-line frequencies, radiofrequency and microwave) is growing exponentially worldwide. There is a rapid increase in electrification in developing countries, even in rural areas. Most members of society now have and use cordless phones, cellular phones, and pagers. In addition, most populations are also exposed to antennas in communities designed to transmit wireless RF signals. Some developing countries have even given up running land lines because of expense and the easy access to cell phones. Long-term and cumulative exposure to such massively increased RF has no precedent in human history. Furthermore, the most pronounced change is for children, who now routinely spend hours each day on the cell phone. Everyone is exposed to a greater or lesser extent. No one can avoid exposure, since even if they live on a mountain-top without electricity there will likely be exposure to communication-frequency RF exposure. Vulnerable populations (pregnant women, very young children, elderly persons, the poor) are exposed to the same degree as the general population. Therefore it is imperative to consider ways in which to evaluate risk and reduce exposure. Good public health policy requires preventative action proportionate to the potential risk of harm and the public health consequence of taking no action.

## IV. RECOMMENDED ACTIONS

### A. Defining new exposure standards for ELF

This chapter concludes that new ELF limits are warranted based on a public health analysis of the overall existing scientific evidence. The public health view is that new ELF limits are needed now. They should reflect environmental levels of ELF that have been demonstrated to increase risk for childhood leukemia, and possibly other cancers and neurological diseases. ELF limits should be set below those exposure levels that have been linked in childhood leukemia studies to increased risk of disease, plus an additional safety factor. It is no longer acceptable to build new power lines and electrical facilities that place people in ELF environments that have been determined to be risky. These levels are in the 2 to 4 milligauss\* (mG) range (0.2 – 0.4  $\mu\text{T}$ ), not in the 10s of mG or 100s of mG. The existing ICNIRP limit is 1000 mG (100  $\mu\text{T}$ ) and 904 mG (90.4  $\mu\text{T}$ ) in the US for ELF is outdated and based on faulty assumptions. These limits are can no longer be said to be protective of public health and they should be replaced. A safety buffer or safety factor should also be applied to a new, biologically-based ELF limit, and the conventional approach is to add a safety factor lower than the risk level.

While new ELF limits are being developed and implemented, a reasonable approach would be a 1 mG (0.1  $\mu\text{T}$ ) planning limit for habitable space adjacent to all new or upgraded power lines and a 2 mG (0.2  $\mu\text{T}$ ) limit for all other new construction. It is also recommended for that a 1 mG (0.1  $\mu\text{T}$ ) limit be established for existing habitable space for children and/or women who are pregnant (because of the possible link between childhood leukemia and *in utero* exposure to ELF). This recommendation is based on the assumption that a higher burden of protection is required for children who cannot protect themselves, and who are at risk for childhood leukemia at rates that are traditionally high enough to trigger regulatory action. This situation in particular warrants extending the 1 mG (0.1  $\mu\text{T}$ ) limit to existing occupied space. "Establish" in this case probably means formal public advisories from relevant health agencies. While it is not realistic to reconstruct all existing electrical distribution systems, in the short term; steps to reduce exposure from these existing systems need to be initiated, especially in places where children spend time, and should be encouraged. These limits should reflect the exposures that are commonly associated with increased risk of child hood leukemia (in the 2 to 5 mG (0.2 to 0.5  $\mu\text{T}$ ) range for all children, and over 1.4 mG (0.14  $\mu\text{T}$ ) for children age 6 and younger). Nearly all of the occupational studies for adult cancers and neurological diseases report their highest exposure category is 4 mG (0.4  $\mu\text{T}$ ) and above, so that new ELF limits should target the exposure ranges of interest, and not necessarily higher ranges.

Avoiding chronic ELF exposure in schools, homes and the workplace above levels associated with increased risk of disease will also avoid most of the possible bioactive parameters of ELF discussed in the relevant literature.

It is not prudent public health policy to wait any longer to adopt new public safety limits for ELF. These limits should reflect the exposures that are commonly associated with increased risk of childhood leukemia (in the 2 to 5 mG (0.2-0.5  $\mu$ T) range for all children, and over 1.4 mG (0.14  $\mu$ T) for children age 6 and younger). Avoiding chronic ELF exposure in schools, homes and the workplace above levels associated with increased risk of disease will also avoid most of the possible bioactive parameters of ELF discussed in the relevant literature.

### **B. Defining preventative actions for reduction in RF exposures**

Given the scientific evidence at hand, the rapid deployment of new wireless technologies that chronically expose people to pulsed RF at levels reported to cause bioeffects, which in turn, could reasonably be presumed to lead to serious health impacts, is a public health concern. A public health action level that implements preventative action now is warranted, based on the collective evidence. There is suggestive to strongly suggestive evidence that RF exposures may cause changes in cell membrane function, cell communication, metabolism, activation of proto-oncogenes and can trigger the production of stress proteins at exposure levels below current regulatory limits. Resulting effects can include DNA breaks and chromosome aberrations, cell death including death of brain neurons, increased free radical production, activation of the endogenous opioid system, cell stress and premature aging, changes in brain function including memory loss, retarded learning, performance impairment in children, headaches and fatigue, sleep disorders, neurodegenerative conditions, reduction in melatonin secretion and cancers (Chapters 5, 6, 7, 8, 9, 10, and 12).

As early as 2000, some experts in bioelectromagnetics promoted a 0.1  $\mu$ W/cm<sup>2</sup> limit (which is 0.614 Volts per meter) for ambient outdoor exposure to pulsed RF, so generally in cities, the public would have adequate protection against involuntary exposure to pulsed radiofrequency

(e.g., from cell towers, and other wireless technologies). The Salzburg Resolution of 2000 set a target of  $0.1 \mu\text{W}/\text{cm}^2$  (or  $0.614 \text{ V}/\text{m}$ ) for public exposure to pulsed radiofrequency. Since then, there are many credible anecdotal reports of unwellness and illness in the vicinity of wireless transmitters (wireless voice and data communication antennas) at lower levels. Effects include sleep disruption, impairment of memory and concentration, fatigue, headache, skin disorders, visual symptoms (floaters), nausea, loss of appetite, tinnitus, and cardiac problems (racing heartbeat). There are some credible articles from researchers reporting that cell tower -level RF exposures (estimated to be between  $0.01$  and  $0.5 \mu\text{W}/\text{cm}^2$ ) produce ill-effects in populations living up to several hundred meters from wireless antenna sites,

This information now argues for thresholds or guidelines that are substantially below current FCC and ICNIPR standards for whole body exposure. Uncertainty about how low such standards might have to go to be prudent from a public health standpoint should not prevent reasonable efforts to respond to the information at hand. No lower limit for bioeffects and adverse health effects from RF has been established, so the possible health risks of wireless WLAN and WI-FI systems, for example, will require further research and no assertion of safety at any level of wireless exposure (chronic exposure) can be made at this time. The lower limit for reported human health effects has dropped 100-fold below the safety standard (for mobile phones and PDAs); 1000- to 10,000-fold for other wireless (cell towers at distance; WI-FI and WLAN devices). The entire basis for safety standards is called into question, and it is not unreasonable to question the safety of RF at any level.

A cautionary target level for pulsed RF exposures for ambient wireless that could be applied to RF sources from cell tower antennas, WI-FI, WI-MAX and other similar sources is proposed. The recommended cautionary target level is  $0.1 \text{ microwatts per centimeter squared } (\mu\text{W}/\text{cm}^2)**$  (or  $0.614 \text{ Volts per meter or V}/\text{m})**$  for pulsed RF where these exposures affect the general public; this advisory is proportionate to the evidence and in accord with prudent public health policy. A precautionary limit of  $0.1 \mu\text{W}/\text{cm}^2$  should be adopted for outdoor, cumulative RF exposure. This reflects the current RF science and prudent public health response that would reasonably be set for pulsed RF (ambient) exposures where people live, work and go to school. This level of RF is experienced as whole-body exposure, and can be a chronic exposure where there is wireless coverage present for voice and data transmission for cell phones, pagers and PDAs and other sources of radiofrequency radiation. An outdoor precautionary limit of  $0.1$

$\mu\text{W}/\text{cm}^2$  would mean an even lower exposure level inside buildings, perhaps as low as  $0.01 \mu\text{W}/\text{cm}^2$ . Some studies and many anecdotal reports on ill health have been reported at lower levels than this; however, for the present time, it could prevent some of the most disproportionate burdens placed on the public nearest to such installations. Although this RF target level does not preclude further rollout of WI-FI technologies, we also recommend that wired alternatives to WI-FI be implemented, particularly in schools and libraries so that children are not subjected to elevated RF levels until more is understood about possible health impacts. This recommendation should be seen as an interim precautionary limit that is intended to guide preventative actions; and more conservative limits may be needed in the future.

Broadcast facilities that chronically expose nearby residents to elevated RF levels from AM, FM and television antenna transmission are also of public health concern given the potential for very high RF exposures near these facilities (antenna farms). RF levels can be in the 10s to several 100's of  $\mu\text{W}/\text{cm}^2$  in residential areas within half a mile of some broadcast sites (for example, Lookout Mountain, Colorado and Awbrey Butte, Bend, Oregon). Like wireless communication facilities, RF emissions from broadcast facilities that are located in, or expose residential populations and schools to elevated levels of RF will very likely need to be re-evaluated for safety.

For emissions from wireless devices (cell phones, personal digital assistant or PDA devices, etc) there is enough evidence for increased risk of brain tumors and acoustic neuromas now to warrant intervention with respect to their use. Redesign of cell phones and PDAs could prevent direct head and eye exposure, for example, by designing new units so that they work only with a wired headset or on speakerphone mode.

These effects can reasonably be presumed to result in adverse health effects and disease with chronic and uncontrolled exposures, and children may be particularly vulnerable. The young are also largely unable to remove themselves from such environments. Second-hand radiation, like second-hand smoke is an issue of public health concern based on the evidence at hand.

## V. CONCLUSIONS

- We cannot afford “business as usual” any longer. It is time that planning for new power lines and for new homes, schools and other habitable spaces around them is done with routine provision for low-ELF environments . The business-as-usual deployment of new wireless technologies is likely to be risky and harder to change if society does not make some educated decisions about limits soon. Research must continue to define what levels of RF related to new wireless technologies are acceptable; but more research should not prevent or delay substantive changes today that might save money, lives and societal disruption tomorrow.

- New regulatory limits for ELF based on biologically relevant levels of ELF are warranted. ELF limits should be set below those exposure levels that have been linked in childhood leukemia studies to increased risk of disease, plus an additional safety factor. It is no longer acceptable to build new power lines and electrical facilities that place people in ELF environments that have been determined to be risky (at levels generally at 2 mG (0.2  $\mu$ T) and above).

- While new ELF limits are being developed and implemented, a reasonable approach would be a 1 mG (0.1  $\mu$ T) planning limit for habitable space adjacent to all new or upgraded power lines and a 2 mG (0.2  $\mu$ T) limit for all other new construction, It is also recommended for that a 1 mG (0.1  $\mu$ T) limit be established for existing habitable space for children and/or women who are pregnant . This recommendation is based on the assumption that a higher burden of protection is required for children who cannot protect themselves, and who are at risk for childhood leukemia at rates that are traditionally high enough to trigger regulatory action. This situation in particular warrants extending the 1 mG (0.1  $\mu$ T) limit to existing occupied space. "Establish" in this case probably means formal public advisories from relevant health agencies.

- While it is not realistic to reconstruct all existing electrical distributions systems, in the short term; steps to reduce exposure from these existing systems need to be initiated, especially in places where children spend time, and should be encouraged.

- A precautionary limit of 0.1 ( $\mu\text{W}/\text{cm}^2$  (which is also 0.614 Volts per meter) should be adopted for outdoor, cumulative RF exposure. This reflects the current RF science and prudent public health response that would reasonably be set for pulsed RF (ambient) exposures where people live, work and go to school. This level of RF is experienced as whole-body exposure, and can be a chronic exposure where there is wireless coverage present for voice and data transmission for cell phones, pagers and PDAs and other sources of radiofrequency radiation. Some studies and many anecdotal reports on ill health have been reported at lower levels than this; however, for the present time, it could prevent some of the most disproportionate burdens placed on the public nearest to such installations. Although this RF target level does not preclude further rollout of WI-FI technologies, we also recommend that wired alternatives to WI-FI be implemented, particularly in schools and libraries so that children are not subjected to elevated RF levels until more is understood about possible health impacts. This recommendation should be seen as an interim precautionary limit that is intended to guide preventative actions; and more conservative limits may be needed in the future.

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