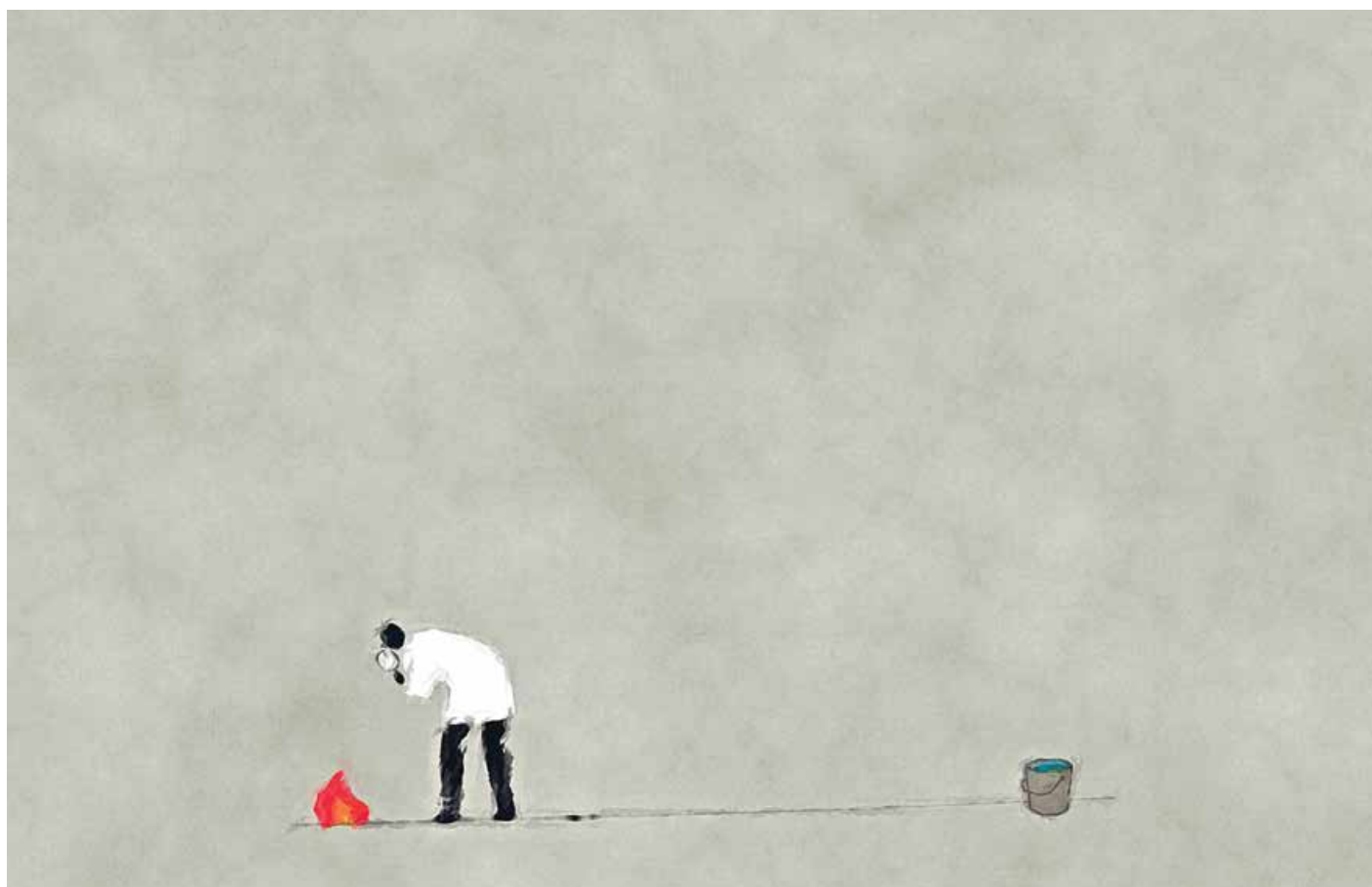


Epidemiology 2014



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letter from the chair



Colleagues,

Welcome to Epidemiology 2014, the annual report from Columbia University's Department of Epidemiology.

As I prepare for my own transition, I am filled with pride for all that our faculty, trainees, and staff have accomplished in the past five years. Our department has solidified the groundwork for epidemiologic research that not only moves the field forward but also advances our larger goal of creating healthy conditions for populations. Our faculty and trainees are investigating and constructing responses to pressing public health issues and informing and influencing the public health conversation.

Epidemiology 2014 is not a traditional annual report but rather a composite portrait of our faculty and trainees' contributions over the past year, and a reflection on the field as we see it. From gun control to Ebola to a new mayoral administration in New York City to the mental health of veterans of the wars in the Middle East, this report is both a time capsule of the state of epidemiology in 2014 and an outline of the enduring value of rigorous population health science and its relevance to the public.

With the transition to a new chair in 2015, I am confident that this department will continue to lead on epidemiologic research, education, and translation far into the future.

Warm regards,

A handwritten signature in black ink, appearing to read "Sandu". The signature is written in a cursive, flowing style.

New evidence for genetic basis of epilepsy

full article on the2x2project.org

2x2.ph/genetic-epilepsy



more on genetics

"Junk DNA" gets another look with Encode

2x2.ph/genes-encode

DNA modifications predict brain's response to stress

bit.ly/1vgodDf

Close relatives of people with epilepsy are at a greater risk of developing the disorder compared to the general population, according to a new study led by Dr. Ruth Ottman, professor of epidemiology (in Neurology and the Gertrude H. Sergievsky Center) at Columbia University, with co-author Dr. W. Allen Hauser, professor emeritus of epidemiology, and other colleagues from Columbia's department of neurology, the Mayo Clinic, and the University of Calgary.

Although this study is not the first to find that risk for epilepsy runs in families, past research had potentially serious methodological limitations according to the paper, which ran in the journal *Brain*.

For this study, the researchers analyzed data from the Rochester Epidemiology Project, a partnership of three medical centers in Minnesota, including the Mayo Clinic.

The researchers studied the families of all 660 residents of Rochester, Minnesota, who were born in 1920 or later, with new cases of epilepsy occurring during a 60 year period, from 1935-1994. Among the

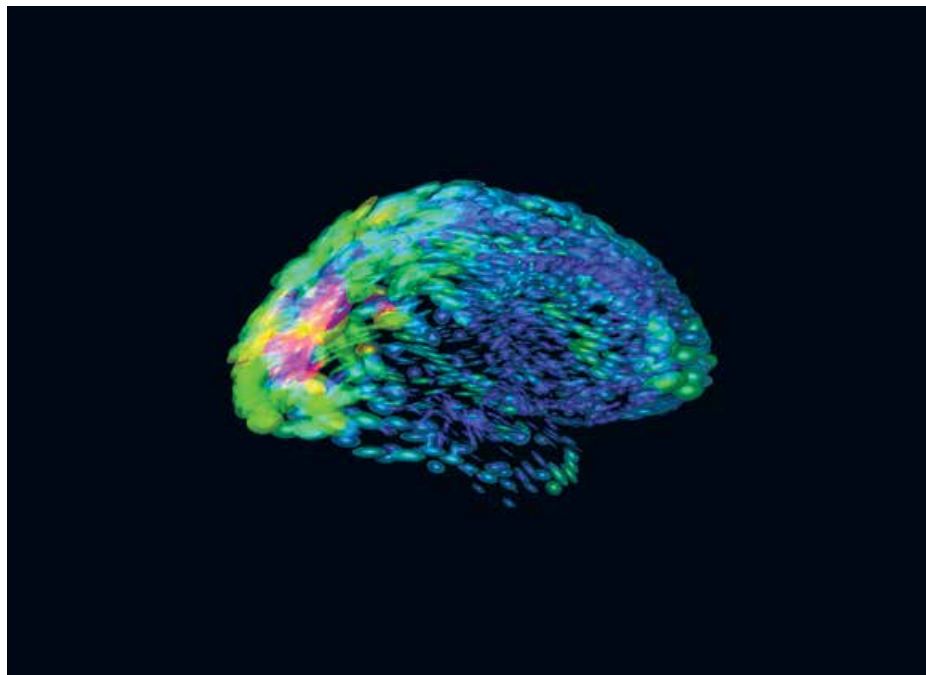


IMAGE: ARTHUR TOGA, UNIVERSITY OF CALIFORNIA AT LOS ANGELES VIA THE NATIONAL INSTITUTE OF GENERAL MEDICAL SCIENCES

nearly 2,500 parents, siblings, and children of these individuals, the risk of developing epilepsy by age 40 was 4.7 percent—three times that of the general population.

Those at highest risk were relatives of individuals with idiopathic generalized epilepsy, which is believed to have a strong genetic basis, though abnormalities in the nervous system are not apparent on imaging studies. Also at greater risk were relatives of individuals who have types of epilepsy associated with intellectual or motor disability that is likely related to prenatal or developmental problems. Epilepsies of unknown cause and prenatal and developmental cause clustered within families, suggesting shared genetic influences.

The family members of individuals whose epilepsy had a known cause occurring after birth, such as a stroke, severe traumatic brain injury, or brain tumor were not at increased risk.

"One of the most important concerns of people with epilepsy is whether the disorder is inherited—what are the risks in their family members, and especially in their offspring?" says Dr. Ottman.

Although genetic research is moving quickly, in most affected individuals the specific genes that affect risk of the disorder have not been identified.

"One thing that's important about our findings is that people with epilepsy tend to overestimate the risk in their children, and we found that risks in offspring are only about 4 percent overall, and are less than 10 percent even in the highest risk groups—so that even though risk is higher than in the general population, more than 90 percent of the offspring will remain unaffected," says Dr. Ottman.

Peljto AL, Barker-Cummings C, Vasoli VM, Leibson CL, Hauser WA, Buchhalter JR, Ottman R. Familial risk of epilepsy: a population-based study. *Brain*. 2014 Jan 26. [Epub ahead of print] PMID: 24468822

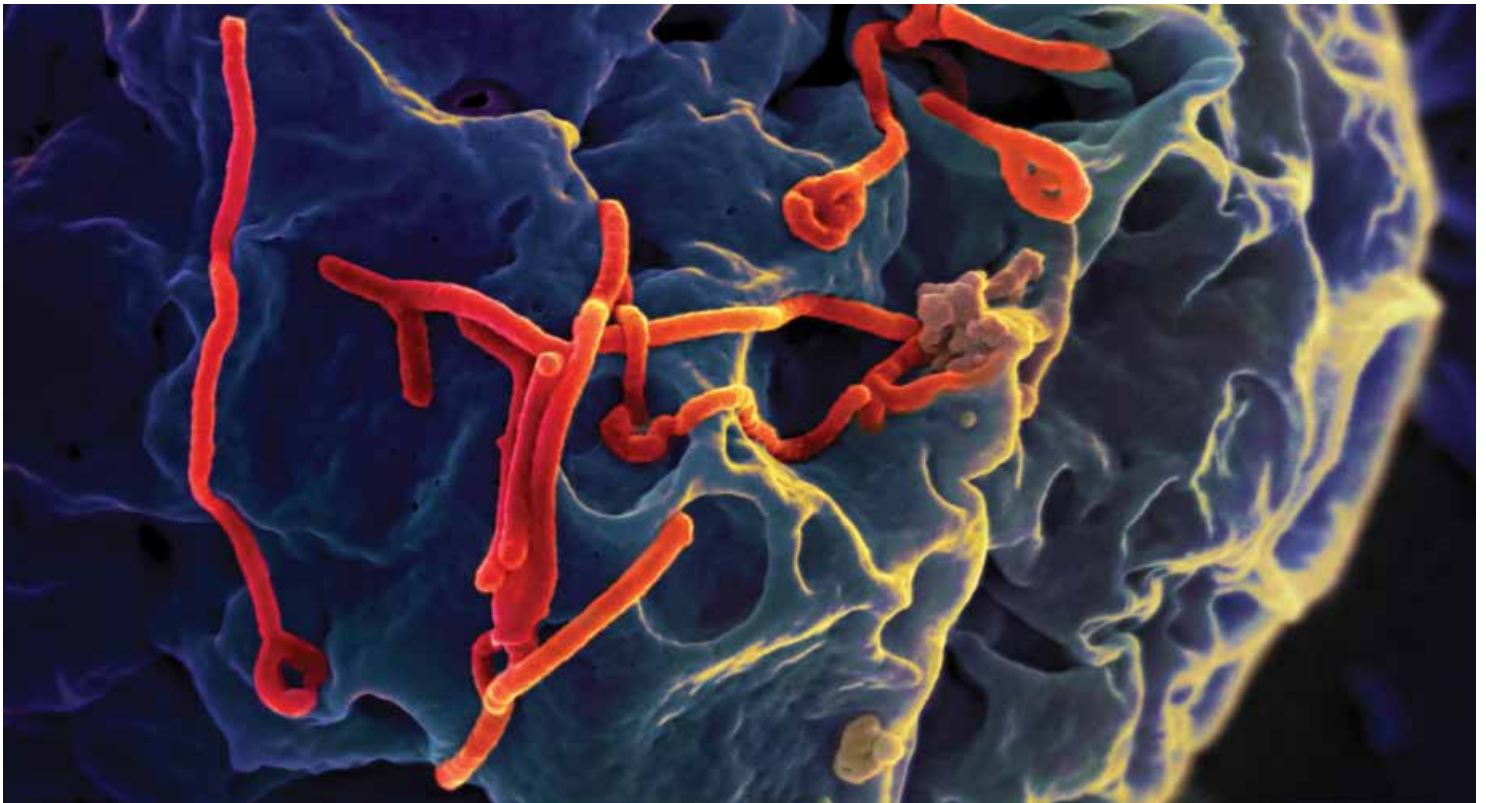


IMAGE: NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES (NIAID)

Covering the Ebola crisis

Read coverage in the2x2project

- › *Response timing in the modern age of epidemics*
2x2.ph/ebolaprob
 - › *Review of PBS's "Frontline" special on ebola*
2x2.ph/PBSebola
-

Over the past year, faculty members spoke frequently with the media about the Ebola outbreak in West Africa and several cases in the U.S. They helped us understand how Ebola is transmitted (Dr. Stephen Morse on *WNYC* › bit.ly/1pahubR), why it spread so quickly in three West African nations (Dr. Morse on *PBS* › to.pbs.org/1xpyVbO), and what can be done to fight Ebola in West Africa (Dr. Ian Lipkin in the *New Yorker* › nyr.kr/ZQRz6). At the height of public concern in the U.S., faculty members served as voices of calm (Dr. Sandro Galea and Dr. Abdul El-Sayed in *New York Magazine* › sciof.us/ZMvNrK), helping to clarify the minimal threats to Americans (Dr. Dana March in *Al Jazeera* › alj.am/1wmtWbG), the importance of protecting health workers, and questioning a quarantine that could threaten progress in West Africa (see Dr. Scott Hammer in the *New York Times* › nyti.ms/1yHYrH4, Dr. Wafaa-El-Sadr in the *New York Times* › nyti.ms/ZWmqGg, and Dr. March in the *New York Times* › nyti.ms/1wyKRp1).

Read more faculty in the media coverage of Ebola on our website.

› epi.is/13piXCq

Mental health is the wrong target

For preventing gun violence, mental health screening is a red herring

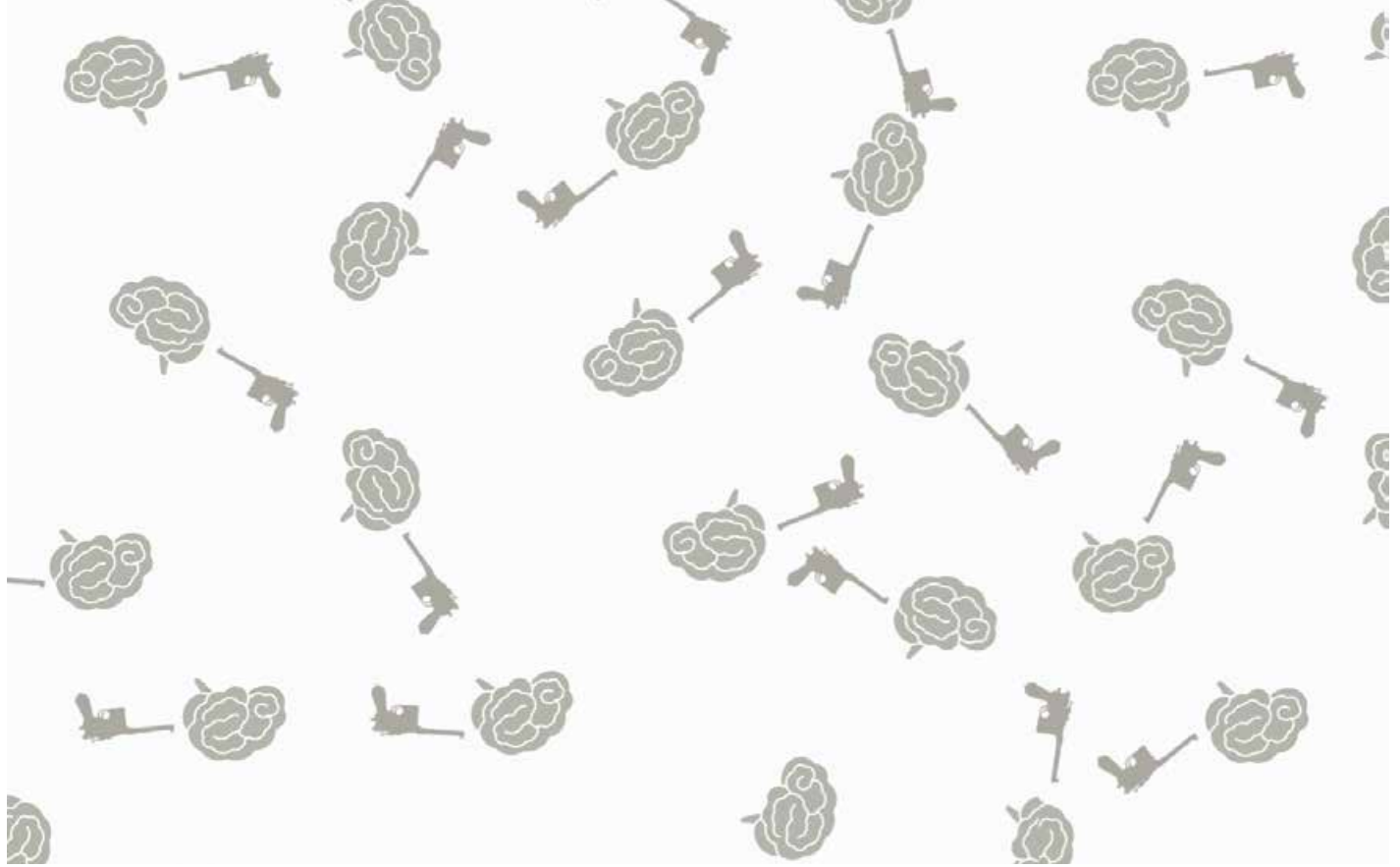
full article on the2x2project.org

2x2.ph/guns-mental-health



More on guns and health

- › *The politics of gun violence and public health*
2x2.ph/gun-violence-public-health
- › *Chicago gun violence indicates national crisis*
2x2.ph/Chicago-guns
- › *Guns and public health in the crosshairs*
2x2.ph/gunweek
- › *PopAds: Advocacy groups pack heat with ads*
2x2.ph/guns-ads
- › *Racial recoil*
2x2.ph/race-guns



Gun laws are historically difficult to pass in the U.S. Hostility toward regulating guns is worse than ever, as the Obama administration has been shut down, both in Congress and at the executive-level, from banning assault weapons and large capacity magazines and closing background check loopholes.

Only one area has received strong and perhaps surprising bipartisan support: early detection of mental illness.

Although there are many reasons to invest more resources in our mental health system, there is little evidence that focusing on mental health screening—especially at the expense of gun control—will prevent shootings.

By focusing so much on a killer's mental health, the American media, whether or not intentional, has taken a cue from the National Rifle Association, which in recent years has quickly turned the discussion after mass shootings from talk of access to guns to talk of the "bad guys" behind them. The organization has even advocated for a national registry for the mentally ill despite being staunchly opposed to any federal involvement in gun regulation. (A majority of states have background checks that draw on mental health records.) Others on the right have argued that mass shootings are caused by relaxation or repeal of laws that commit people to psychiatric institutions against their will.

Although it sounds like a sensible idea to try to keep guns out of the wrong hands, the connection between mental illness and violence is weak.

Mental health issues are widespread in the U.S. Forty-six percent of American adults meet diagnostic criteria for a mental illness such as depression or bipolar disorder over the course of their lifetime, and 9 percent meet diagnostic criteria for a personality disorder. Many people will seek help from a psychiatrist, psychologist, or other mental health professional. Most are simply struggling and if anything are at greater risk of harming themselves, not others. Only a tiny number will ever hurt someone else.

For these reasons, "mental illness is simply not a very specific predictor of violence," say Drs. Sherry Glied, dean of New York University's Robert F. Wagner Graduate School of Public Service, and Richard G. Frank, an economist at Harvard Medical School in the Department of Health Care Policy, in an article in the *American Journal of Public Health*.

CONTINUED 



MERS comes to the U.S., camels implicated as the source

Camels are the major source of Middle East Respiratory Syndrome, or MERS, a viral disease that was first detected in Saudi Arabia in 2012 and is responsible for several hundred deaths, according to a study by Dr. W. Ian Lipkin, John Snow Professor of Epidemiology, the director of the Center for Infection and Immunity; Dr. Thomas Briese, associate professor of epidemiology; and colleagues. Dr. Lipkin talked to various media outlets after 2 cases have appeared in the U.S., last month, saying he is confident that “we have [MERS] under control.”

More on MERS

- › *Watch an interview on the Wall Street Journal*
on.wsj.com/1n4tKpo
- › *Read more in the LA Times*
lat.ms/1nS6z5x
- › *Read more in the New York Times*
nyti.ms/1ncpCEp

Screening for potentially violent individuals, they say, would result in many “false positives”—instances in which people with psychiatric issues might be flagged even if they had no violent intentions—as well as wasted energy and resources. This is true even if screenings were to focus only among those with a chronic severe mental illness like schizophrenia. People in this category are much more likely to be the victims of violent crime than perpetrators, according to a 2001 study in the *Lancet* by psychiatrists at the University of Manchester in England.

In states where mental health professionals are required to notify authorities of potentially dangerous individuals, that often is not enough, according to an article by two psychiatrists who examine what the focus on mental illness and violence means for their profession. For instance, a psychiatrist who saw James Holmes notified police at his college as she was legally supposed to that he was dangerous and had homicidal thoughts. The campus police deactivated his school identification card but did nothing further. He shot and killed 12 people at the Century movie theater in Aurora, Colorado, one month later.

Not only will mental health screening likely not help, it could hurt. Linking mental illness to gun violence can do serious damage, especially if done imprecisely, as is often the case. Take a recent headline in the *Kansas City Star*: “Preserve a mental health patient’s gun rights, or protect the public?” This seems to imply that people with mental illness are ticking time bombs. Such coverage runs the danger of stigmatizing and deterring people from seeking help, for fear others perceive view them as deranged and violent.

Unlike mental health screenings, research shows a strong connection between availability of guns and gun violence. The U.S. far exceeds other rich nations both in firearm ownership and firearm homicides, according to the Council on Foreign Relations. Although we are less than 5 percent of the world’s population, an estimated 35-50 percent of the world’s

civilian owned firearms live here, according to the 2007 “Small Arms Survey” at the Graduate Institute of International and Development Studies in Geneva, Switzerland. We are also the only rich country that does not license gun owners and register weapons, according to the website GunPolicy.org.

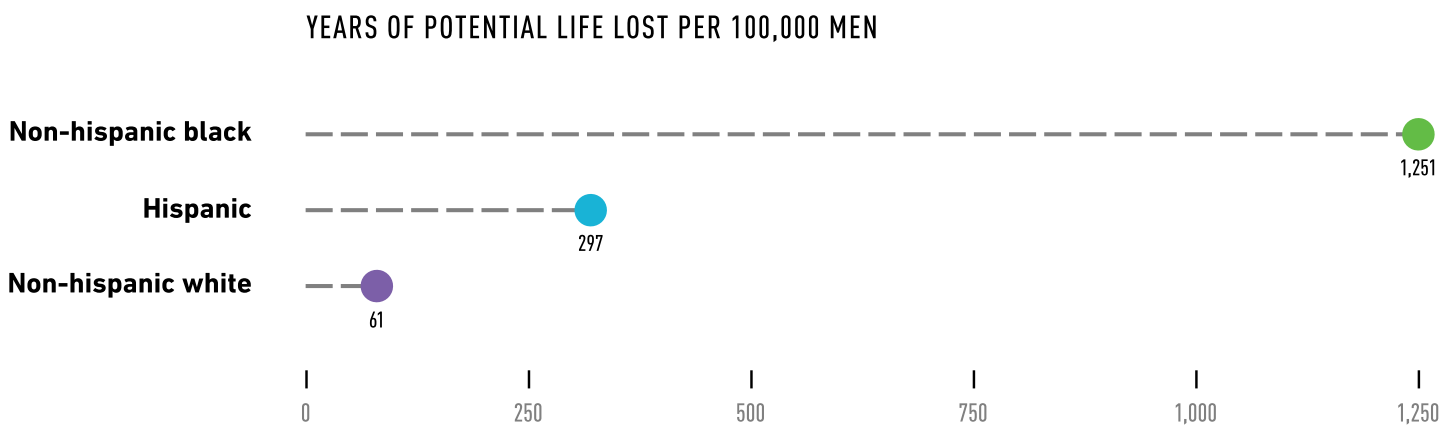
Interestingly, our overall rate of violence is comparable to Australia, Canada, and Western Europe—we just have many more gun injuries and deaths. “That’s a weapon effect. It’s not clear that guns cause violence, but it’s absolutely clear that they change the outcome,” Dr. Garen Wintemute, of the University of California, Davis, Medical Center told the *Huffington Post* in late 2012.

Lowering rates of gun violence by regulating guns should be similar to the way the health system approaches an infectious disease epidemic—by fighting the “exposure,” or cause of the disease, says Dr. Sandro Galea.

“Firearms are what we would term in epidemiology an ‘ubiquitous exposure.’ Their availability means that they are a ready recourse for the resolution of disputes, or for anyone with suicidal thoughts,” Dr. Galea says. “When exposures are ubiquitous, the fundamental approach to prevention is removal, or at least minimizing that exposure.”

It is hard to imagine that the cruelty to kill is within the capability of most humans, and as a result, it may be tempting to think that violent people can be easily identified. But as a practical matter, mental health screening is little more than a red herring in a highly charged debate that has been shaped substantially by people who vehemently oppose even the most minimal regulation of guns.

Race disparity another facet of gun violence



This needle plot shows the years of potential life lost for men by racial and ethnic groups in 2010 from fire-arm-related homicide in the United States. Along the x-axis is years of potential life lost per 100,000 men.

Non-Hispanic black men lost 1,251 years of potential life per 100,000 men from firearm-related homicides, more than four times the number for Hispanic men and more than 20 times the number for non-Hispanic white men.

DATA SOURCE: CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL. WEB-BASED INJURY STATISTICS QUERY AND REPORTING SYSTEM (WISQARS). [2010 DATA EXTRACTED MARCH 2, 2014]. AVAILABLE FROM URL: WWW.CDC.GOV/NCIPC/WISQARS

Originally published on the GRAPH website, at cugraph.org

NYC pedestrian safety program saves lives, money

full article on the2x2project.org

2x2.ph/pedestrian-safety



related media coverage

HealthCanal.com

bit.ly/1kCX33I



More on transportation and safety

› *Bumps in the road for popular child pedestrian program*

2x2.ph/safe-routes

› *Why teen driving deaths have plummeted*

2x2.ph/teens-driving

› *Stopping teen distracted driving*

2x2.ph/eyesroadtxt

A federal program that put money toward making it safer for children to walk or bike to school saved money and lives in New York City, according to a study from Dr. Charles DiMaggio, associate professor of epidemiology; Dr. Guohua Li, Finster Professor of Anesthesiology and Epidemiology; and Dr. Peter Muennig, associate professor of health policy and management, who was lead author.

Between 2005 and 2012, the Safe Routes to School Program gave \$1.1 billion for states to make roadway modifications around schools. New York City transportation officials used the funds to narrow intersections by building out sidewalks, set off dedicated bike lanes, install speed bumps, and program lights so pedestrians have more time to cross the streets.

These improvements led to \$230 million in cost savings as a result of a decline in pedestrian injuries and deaths and in

money spent on busing students. The authors did not include other potential sources of savings, such as reductions in pollution, traffic congestion, and obesity rates, because they are difficult to quantify. The programs also saved an estimated 2,055 quality-adjusted years of life.

The Safe Routes program lost dedicated funding in 2012 and now falls under a larger umbrella of “Transportation Alternatives” that states can choose to fund. “That’s one reason why we think evaluation of safety programs, particularly in terms of cost effectiveness, is so important,” says Dr. DiMaggio.

Muennig PA, Epstein M, Li G, DiMaggio C. The cost-effectiveness of New York City’s Safe Routes to School Program. *Am J Public Health*. 2014 Jul;104(7):1294-9. doi: 10.2105/AJPH.2014.301868. Epub 2014 May 15.

Getting to zero

Engineering an ambitious traffic policy

full article on the2x2project.org

2x2.ph/vision-zero



Zero is not a number that gets thrown around very often in public health. Even the most ambitious efforts shy away from it. Yet the goal of Vision Zero, New York City's new, Swedish-imported traffic program is to have not a single traffic death on city streets by the year 2024.

"No level of fatality on city streets should be considered inevitable and acceptable," said former acting U.S. Surgeon General Dr. Kenneth Moritsugu, summing up the philosophy behind the program. Dr. Moritsugu spoke about the traffic policy at a Columbia University Seminar, which was sponsored by Columbia University's Center for Injury Epidemiology and Prevention and Department of Epidemiology at the Mailman School of Public Health. The event brought together representatives of some of the city agencies and organizations charged with carrying out Vision Zero

The recent deaths of several pedestrians and cyclists who were hit by cars have shined a spotlight on the danger that people feel on the city's streets. Pedestrian injuries comprise 52 percent of deaths in New York City compared to 14 percent nationally, and car crashes are the number one cause of death for children and young teens in the city.

Begun in Sweden in 1997, Vision Zero recognizes that one of the biggest causes of traffic crashes is human error. New laws passed by the de Blasio administration and the city council set more limits on drivers, such as a lowered speed limit—which went into effect in November—and higher penalties when the rules are violated.

According to Dr. Guohua Li, the same principles epidemiologists draw on to eliminate diseases from a population can be applied to traffic injuries: reducing the "exposure"—in this case the traffic, reducing the occurrence of injury when one is exposed, and reducing the likelihood an injury will result in death or serious disability.

One area of focus for Vision Zero is slowing New York City's aggressive traffic stew of impatient drivers, bikers, and pedestrians. So-called "traffic calming" measures, which aim to make the streets safer for pedestrians, include, in addition to lowering the speed limit, narrowing streets and adding speed bumps, adding new traffic and pedestrian signals, and creating high visibility crosswalks, according to Dr. Charles DiMaggio.

There is still a wide disparity in who walks to work and school in New York. Over one-third of children in three "low walkability" zip codes do not walk or bike to school, even though 40 percent of them live within five blocks from school and 70 percent live within 20, according to a study by Philip Noyes, the director of research, evaluation, and planning in the New York City Department of Health's Brooklyn District Public Health Office. Less than half of students think it is safe to walk, and only one-third think it's safe to bike.

"If we don't have that commitment to changing all neighborhoods and not just responding to those neighborhoods that are able to self-advocate," said Noyes "we'll likely see that gap maintained or possibly increase."



Mayor Bloomberg's public health legacy, by statistics

There were more than 100 public health measures enacted during Michael Bloomberg's 12 years as mayor of New York City, according to a review of government databases by Dr. Ryan Demmer and colleagues. Read more in the *Scientific American*.

More on the Bloomberg legacy

- › [What public legacy does Bloomberg leave behind?](#)
2x2.ph/Bloomberg-Legacy
- › [Bloomberg's successor and a health policy legacy?](#)
2x2.ph/NYC-Mayor-Health
- › [Passing a soda tax in Berkeley](#)
2x2.ph/berktax



Treating gum disease linked to improvements in other health markers

A new study finds an association between treating periodontal disease, lower healthcare costs, and hospitalization for fewer healthcare conditions. “What they’re really getting at here is did treating the oral infections reduce these types of outcomes or adverse events among people with particular (other diseases),” said Dr. Ryan Demmer, “and I think we need more data from clinical trials that can fundamentally answer that question.”

Read more in *Reuters*. > reut.rs/TCTJeI



Does news coverage encourage suicide outbreaks?

full article on the2x2project.org

2x2.ph/suicide-outbreak



related media coverage

USA Today

usat.ly/1iQsvqP

Live Science

bit.ly/1nR3C4M

Robin Williams' death spotlights suicide

New York Times

nyti.ms/1BWuHsR

Al Jazeera

alj.am/1t7q1xF

more on suicide

A bridge to preventing suicide

2x2.ph/suicide-prevention-bridge

Debate around involuntary psychiatric commitment

2x2.ph/psychiatric-commitment

Robin Williams' death spotlights suicide and mental health

2x2.ph/psychiatric-commitment

They have been called “suicide outbreaks,” “suicide epidemics,” or “copycat suicides”—when multiple suicides occur in a community in a short period of time, usually among teenagers and young adults. It has remained a mystery why such clusters occur in some communities but not others.

To help answer that question, a group of researchers at Columbia University, led by Dr. Madelyn Gould, a professor of epidemiology in psychiatry, decided to look at the influence of media coverage in the initiation of suicide clusters. No study had yet examined whether news coverage could influence suicide clusters.

Dr. Gould and her colleagues examined the period between 1988-1996 looking at news reporting in the aftermath of the first suicide of a cluster. They compared this to coverage in communities that saw just one suicide. There were significantly more news

stories in cluster communities than in isolated suicide communities, suggesting an association between reporting on suicides and suicide clusters. Newspapers in the cluster communities gave more prominent and detailed coverage of suicidal individuals, such as front-page placement, photography, headlines containing the word “suicide” and specifying the method used, and a more detailed description of the person and how he or she committed the act.

Guidelines on how to cover suicide, which have been published by the World Health Organization, among other sources, can be helpful for the media, say the authors.

Gould MS, Kleinman MH, Lake AM, Forman J, Basset Midle J. (2014). Newspaper coverage of suicide and initiation of suicide clusters in teenagers in the USA, 1988-96: A retrospective, population-based, case-control study. *Lancet Psychiatry*. published online May 2, 2014, 7-16.

'A hopelessly prevention-oriented guy'

Alumnus Sten Vermund honored for global health work

As a pediatrician-in-training in 1970s New York City, Sten Vermund, MPhil '87, PhD '90, became interested in a career in public health after observing that many of the medical conditions he saw in patients were preventable.

Forty years later, Dr. Vermund is a leading figure in HIV and cancer prevention for women and children. As director of Vanderbilt University's Institute of Global Health and in prior roles, he has worked nationally and abroad to build a health-care infrastructure based upon his early ideals of prevention.

"I am a hopelessly prevention-oriented guy," he says. "I'm so inspired when we can avoid illness altogether."

Dr. Vermund is this year's winner of the Mailman School of Public Health's Allan Rosenfield Alumni Award. The award is given in honor of the late Dr. Allan Rosenfield, who served as dean of the school from 1986 to 2008, to recognize the achievements and leadership of outstanding alumni in the field of public health.

"[Dr. Vermund's] work has played a vital role in steadily improving programs to prevent mother-to-infant transmission of HIV in diverse venues," the Mailman School said in a statement announcing the award.



Sten Vermund

Dr. Vermund became interested in global health while he was an undergraduate at Stanford University. His professors included renowned anthropologist Dr. Jane Goodall and biologist Dr. Colin Pittendrigh. During college, he read and became inspired by Dr. Albert Schweitzer's autobiography, *Out of My Life and Thought*, about Dr. Schweitzer's time as a missionary doctor in Gabon, one of the poorest countries in the world, and U.S. Navy physician Dr. Tom Dooley's autobiographical trilogy about going to Laos after his Southeast Asian military service to build a primary care system.

After graduating, Dr. Vermund moved across the country to New York City to attend medical school at the Albert Einstein College of Medicine in the Bronx. It was there that he met his wife, Dr. Pilar Vargas, a child psychiatrist, when they were paired in histology lab—an "alphabetical romance," he jokes.

While he did his internship and residency in pediatrics at what was then the Babies Hospital of Columbia-Presbyterian Medical Center (now the New York-Presbyterian/Morgan Stanley Children's Hospital), he became aware of the importance of geography and environment on health. He saw Dominican patients who came to him with parasites and other health conditions not commonly seen in a U.S. practice. He decided that he did not want to take a traditional career path: "I felt the impact of my workday might be greater if I were focused on global health issues and health disparity issues in my own backyard."

"He was a wonderful person to have on the staff. Everybody liked him. He was very effective, and he was wonderfully naïve—meaning that he was open to all new ideas before he formed his own judgment. It was a beautiful example of maturity," says Dr. Michael Katz, then chairman of the department of pediatrics at Columbia and director of the residency program and currently senior advisor of transdisciplinary research at the March of Dimes Foundation.

"You get a bigger bang for your buck when you're working with people who are disadvantaged. There's just more benefits to accrue in those populations whose life expectancies aren't as high."

Dr. Dickson Despommier, an expert on parasites and vertical farming, remembers Dr. Vermund as being "brilliant" and having a "photographic memory." "He was able to integrate and synthesize and hypothesize from disparate knowledge sources, stuff that would never occur to everyone else," adds Dr. Despommier, a professor of public health in environmental sciences at Mailman. "If every student was like Sten, my job would have been discontinued."

Like many of his colleagues in New York City in the 1980s, Dr. Vermund's career was rocked by the emergence of AIDS, which had hit epidemic levels in several sub-populations. There were limited therapeutic options, and he regularly saw his pediatric patients die. "I got a sense that it was a very historic moment and that because I had trained in infectious disease epidemiology, I could make a difference," he says.

In 1988, the National Institutes of Health offered Dr. Vermund a job that would take epidemiologic approaches and apply them to HIV interventions. The next six years were a time of significant advances in the understanding of the virus, including the importance of regulating the "viral load"

of HIV, the behaviors that put people at risk of contracting it, and various prevention strategies involving combination drug therapies.

In 1994, Dr. Vermund accepted a position at University of Alabama-Birmingham as head of geographic medicine in the School of Medicine and as chair of the Department of Epidemiology at the School of Public Health.

During his time there, he began focusing on how to get proper medical care for people in low-income settings. "You get a bigger bang for your buck when you're working with people who are disadvantaged. There's just more benefits to accrue in those populations whose life expectancies aren't as high—where we worry about disproportionately high infant mortality, child mortality, maternal mortality," he says. "If a patient is privileged, the health system may put a lot of resources for a little gain, whereas if your clientele is not in great shape, you can put in those same resources for a lot more gain."

Dr. Vermund built up a program that trained over 50 health professionals in

CONTINUED 



Great Recession associated with a rise in suicides

A study finding there were 10,000 more suicides in the U.S. and Europe during the recession era than in the previous years has important implications for policymakers, says Dr. Abdulrahman El-Sayed: “The social welfare aspects of economic downturns like this can’t be ignored. When our economic belts get a little too tight, we shouldn’t be cutting things that help the average Joe.”

Read more in *USA Today*.

usat.ly/1zi9MI



IMAGE: JON RAWLINSON

Zambia on developing screening programs to diagnose and treat HIV and cervical cancer before the diseases spread. “It has been immensely successful,” he says. “We really focused on trying to keep things pragmatic and trying to keep things able to be implemented in low resource settings.”

He helped similar programs take root in China, India, Pakistan, and Mozambique working with professors at Vanderbilt, the University of North Carolina at Chapel Hill, and the University Teaching Hospital in Zambia. This work has inspired the “Red Ribbon, Pink Ribbon” campaign, a partnership of government, non-profits, and pharmaceutical companies to integrate cervical and breast cancer prevention into existing healthcare programs in sub-Saharan Africa, Asia, and Latin America.

For the last nine years, Dr. Vermund has directed Vanderbilt’s Institute for Global Health, which partners with Meharry Medical College, a historically black college that is a legacy of the region’s formerly segregated hospital system. The center manages development programs in resource-limited areas around the globe. In addition to treatment and

prevention programs for HIV, the Institute for Global Health focuses on building and strengthening healthcare systems, improving agricultural investment and water sanitation, and educating medical practitioners and researchers.

Dr. Vermund is honored to receive the Allan Rosenfield Alumni Award, especially because the former dean of the Mailman School was his mentor and a very good friend: “He and I shared a passion for health disparities work and international work so it’s a very personal award for me. We miss him tremendously. He had indefatigable energy. He inspired me and a whole generation of people in public health.”

More on global health

- › *Bringing surgery into global public health*
2x2.ph/surgery-agenda
- › *Winning the contest for foreign aid*
2x2.ph/aid-foreign
- › *Trade agreement threatens global health*
2x2.ph/trade-public-health

Binge drinking elevated in people who experienced events of 9/11

full article on the2x2project.org

2x2.ph/binge-drinking-911



more on disasters and mental health

Changing the landscape of mental health disaster response

2x2.ph/PTSD-veterans

The trauma signature of Hurricane Sandy

2x2.ph/sandysig

Grassroots mental health efforts after Sandy

2x2.ph/PTSD-veterans

Individuals who had significant exposure to the events of September 11, 2001, reported highly elevated levels of binge drinking five and six years after the attacks, according to a new study by researchers at Columbia University's Department of Epidemiology, Columbia's Department of Psychiatry, and the New York City Department of Health and Mental Hygiene. Among the authors are Dr. Deborah Hasin, professor of epidemiology in psychiatry, Dr. Steven Stellman, professor of clinical epidemiology and research director for the New York City Department of Health's World Trade Center Health Registry, on which the current study was based, and Dr. Katherine Keyes, assistant professor of epidemiology.

The researchers looked at the drinking habits of 41,284 individuals from the registry who were at or near the World Trade Center during and after the terrorist attacks



on September 11. This included workers and volunteers involved in rescue, recovery, and cleanup efforts and people who lived, worked, or happened to be near the site.

Rates of binge drinking were significantly elevated in people with PTSD, at 14.8 percent, over people without PTSD, at 6.3 percent. The researchers excluded all people who had been medically diagnosed with PTSD before the attacks.

"Our findings are relevant for long-term post-9/11 monitoring and treatment under existing federally funded healthcare services for survivors and responders, and more broadly for psychological and alcohol screening and counseling following a disaster," says Dr. Stellman.

Past research has found an elevated use of alcohol among populations exposed to the Oklahoma City bombing and Hurricane Katrina. "Many studies have shown a relationship between adult trauma and

drinking outcomes, but the present study contributes important new information by showing that the relationship between a major trauma and drinking persists over many years," says Dr. Hasin.

Welch AE, Caramanica K, Maslow CB, Cone JE, Farfel MR, Keyes KM, Stellman SD, Hasin DS. Drug Alcohol Depend. Frequent binge drinking five to six years after exposure to 9/11: Findings from the World Trade Center Health Registry. 2014 Apr 28. pii: S0376-8716(14)00839-4. doi: 10.1016/j.drugalcdep.2014.04.013. [Epub ahead of print]

A new, microscopic universe for public health

How the human microbiome could change our understanding of nutrition and disease

full article on the2x2project.org

2x2.ph/microbiome-health



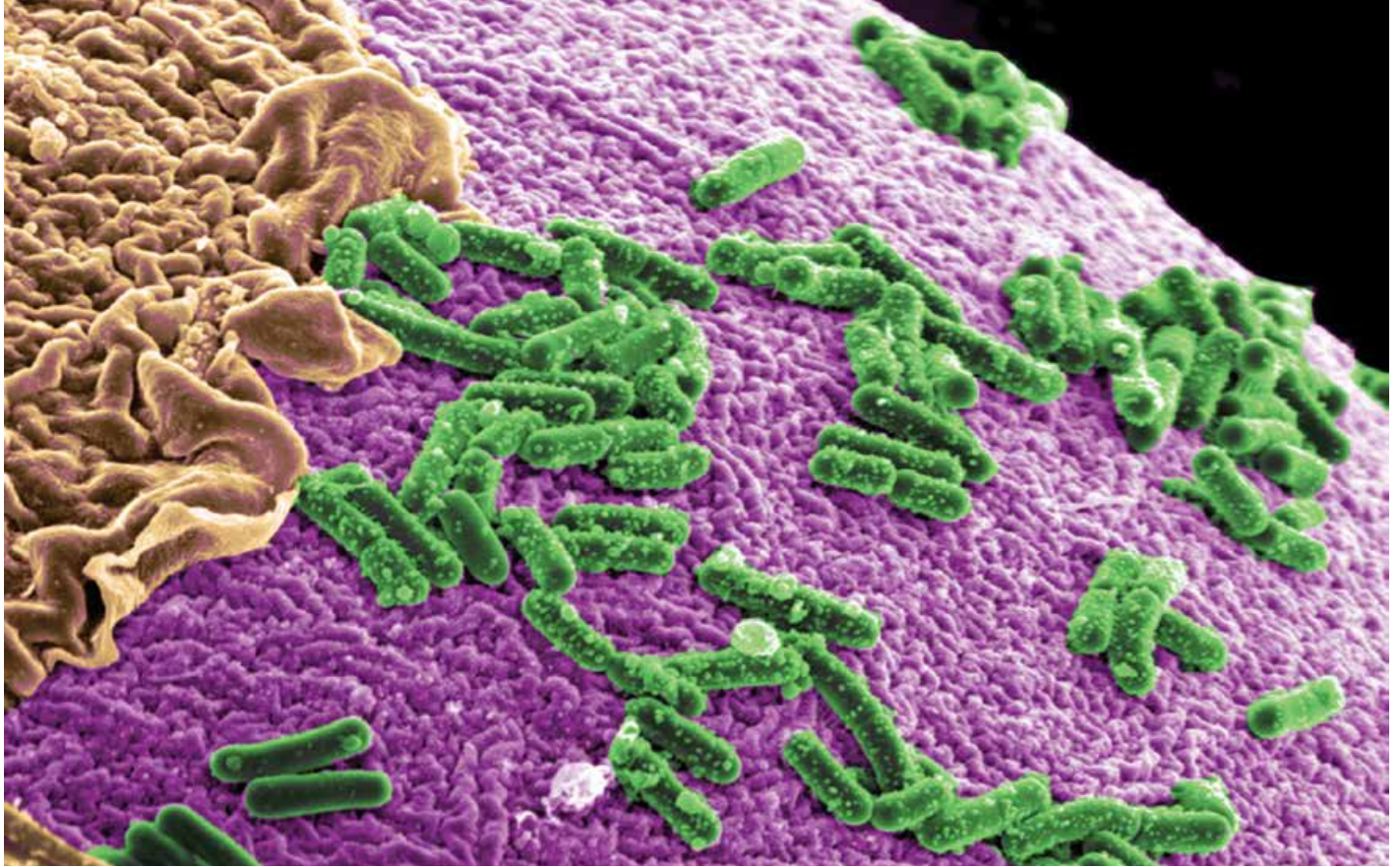
Each of us hosts hundreds of trillions of bacteria cells. These microbial ecosystems live in many places: on the surface and deep into the skin, on the tongue, and in the gastrointestinal tract. This collection is known as the human microbiome. We rely on these organisms every day for help in digesting food, synthesizing vitamins, and regulating our immune systems.

But only recently have researchers begun to uncover the importance of the microbiome for public health.

Their research could complicate how we understand public health issues such as obesity, oral health, and diabetes.

“For a long time in epidemiology and other medical research disciplines, there has been the view that most diseases are caused by interactions between genes and the environment,” says Dr. Noel Mueller, a postdoctoral research fellow in the Department of Epidemiology and the Institute of Human Nutrition. “[Microbiome] research suggests there’s a third component that interacts with the genes and the environment: the microbiota that live within us. We’re leaving out this third component by not considering how these organisms that live within us play a role in health and disease.”

Dr. Mueller’s research into this third component of health focuses on our earliest introduction to our microbiome: the bacteria we get from our mothers when we



A model of the microbial environment inside the human gut.

IMAGE: PACIFIC NORTHWEST NATIONAL LABORATORY

are born. When babies are born vaginally, they are covered in bacteria from their mothers while they pass through the birth canal. Some of these bacteria even help babies digest their first meal.

Researchers have found that babies born by caesarian section are exposed to different kinds of bacteria than babies born vaginally. One study found that babies born by C-section lacked certain bacteria that may benefit the human immune and metabolic systems. Scientists are interested in whether this difference in early gut bacteria colonization could affect our health later in life and inform treatments to promote a healthy microbiome.

One research challenge will be examining how the microbiome interacts with environmental and behavioral factors, such as diet and exercise, which affect risk for chronic diseases such as diabetes. Because gut bacteria are involved in digestion, the microbiome might influence the relationship between diet and obesity. “These differences in gut bacteria challenge the

notion in nutrition that a calorie is the same for every person, because humans metabolize nutrients differently depending on the bacteria that are living within them,” says Dr. Mueller.

Dr. Ryan Demmer, an assistant professor of epidemiology, is studying whether the oral microbiome influences our risk for developing diabetes. Previous research has shown that people with diabetes are at increased risk for periodontal disease, an infection of the gum and bone that hold the teeth in place. Changes in the oral microbiome might be a mechanism that explains this increased susceptibility, but researchers are not yet certain when and how these changes happen.

While research into the human microbiome holds promise for public health, scientists still have much to learn about the bacteria that live within us, and how to incorporate new knowledge into current public health approaches. “The human microbiome is a new and incredibly interesting dimension that could help explain

variation in disease that has been previously unexplainable,” says Dr. Demmer. “I don’t think it’s going to be a silver bullet. Nothing ever is. But there’s a lot to be learned, and I think human health will improve as a result.”

More on bacteria

- › [The trouble with antibiotics](https://www.aphis.usda.gov/antibiotics-2x2)
[2x2.ph/frontline-antibiotics](https://www.aphis.usda.gov/antibiotics-2x2)
- › [The NIH Superbug](https://www.nih.gov/antibiotics-nih)
[2x2.ph/antibiotics-NIH](https://www.nih.gov/antibiotics-nih)

Structural racism predicts worse cardiovascular health for blacks

full article on the2x2project.org

2x2.ph/racism-inequality-heart-health



more on health disparities

The public health consequences of criminal justice policy

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A mysterious disease and when epidemiology gets it wrong—and right

2x2.ph/pellagra-outbreak

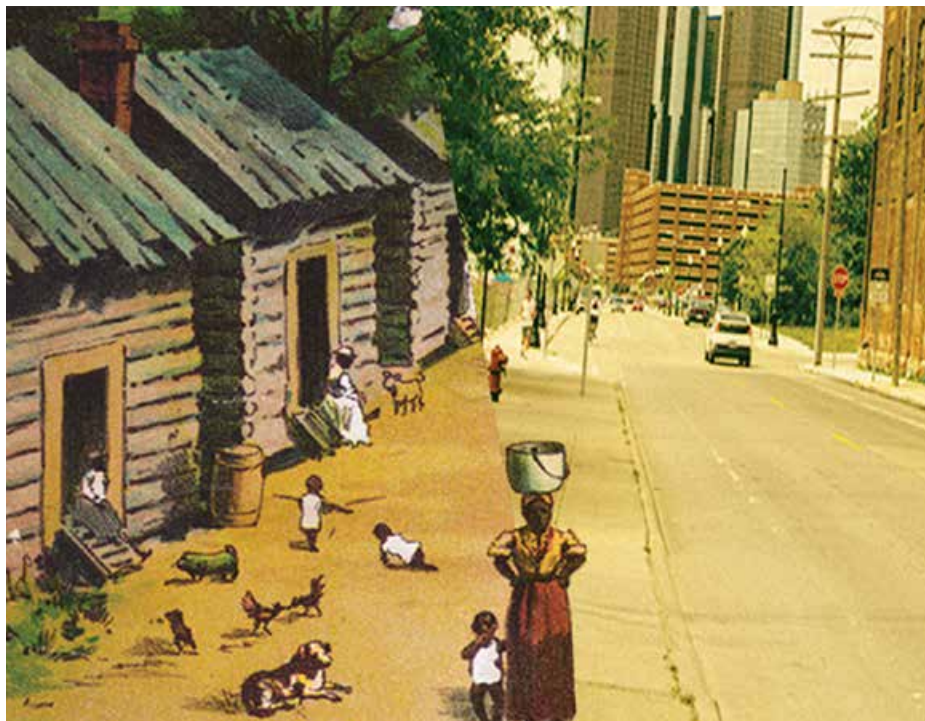
The mental health toll of stop-and-frisk

2x2.ph/stop-and-frisk

In states where they experience more systematic disadvantage than whites, blacks have worse cardiovascular health than they do in states where opportunity is more evenly distributed, according to a study published in the journal *Social Science & Medicine*.

While past research has looked at the effects of self-reported experiences of discrimination on health at an individual level, this study is one of the first to examine how unfair treatment at an institutional level contributes to health, according to the authors, Dr. Katherine Keyes, an assistant professor of epidemiology; Dr. Mark Hatzenbuehler, assistant professor of sociomedical sciences; and Dr. Alicia Lukachko, a postdoctoral alumna of the Psychiatric Epidemiology Training Program.

To determine what the researchers call “structural racism,” which they define as “the systematic exclusion of blacks from



resources and mobility in society,” they looked at the percentage of blacks compared to the percentage of non-Hispanic whites in each of the 50 U.S. states on several measures: holding a college degree, employment, incarceration, and participation in the state’s political system.

Blacks were more likely to report having had a heart attack in the past year in states where there were a low percentage of blacks and a high percentage of whites employed, well educated, and politically represented—signifying greater inequality of opportunity. In states where blacks were more over-represented in the prison system relative to the percentage of the state that is black, they were at greater odds for a heart attack in the past year. Across the United States, blacks are jailed or put in prison from two to 14 times as much as whites.

As for whites, they reported better cardiovascular health in states where there was more structural racism.

“These results raise the provocative possibility that structural racism may not only harm the targets of stigma but also benefit those who wield the power to

enact stigma and discrimination,” write the authors of the study.

“While many recognize that disparities in civil engagement, incarceration, and employment are problematic on a social level, this is among the first of studies to show an association between these structural forms of inequality and health,” says Dr. Keyes. “Our results suggest that improving social conditions at a very macro level, which is logistically difficult but has been done many times before, may have positive health benefits for those Americans with the highest levels of many chronic adverse health events.”

Lukachko A, Hatzenbuehler ML, Keyes KM. Structural racism and myocardial infarction in the United States. *Soc Sci Med*. 2014 Feb;103:42-50. doi: 10.1016/j.socscimed.2013.07.021. PMID: 24507909 [PubMed - indexed for MEDLINE]

Preventing brain disorders globally

Symposium looks at efforts in low, middle, and high-income nations

In the public health arena, mental health has struggled to gain attention. But participants at a daylong Columbia University symposium were hopeful that with a recent focus on global conflict and post-traumatic stress disorder in veterans of the Middle East wars, this could change.

More on mental health

- › *More about the symposium*
2x2.ph/prevent-brain-disorders
- › *Mental health providers may have biases*
2x2.ph/provider-biases
- › *Antidepressant use linked to hemorrhage after pregnancy*
2x2.ph/SSRI-hemorrhage



The Columbia University Epidemiology Scientific Symposium (CUESS) series brings the best minds in epidemiology and other disciplines together for a full day of discussions on the most pressing health questions of our time.

The Columbia University Epidemiology Scientific Symposium (CUESS) on “Preventing brain disorders: Improving global mental health” took place on May 2. Jointly organized by the Department of Epidemiology, the Peter C. Alderman Foundation, and Columbia’s Global Mental Health Program (GMHP), the event brought together national and international researchers, policymakers, non-profit workers, and others to discuss how socioeconomics, violence, and war can influence mental health in high and low-income countries alike and how understanding the causes of psychiatric and other brain disorders can lead to prevention.

Today, almost half of the world’s population lives in countries with only one psychologist for every 200,000 people. Many are low-income countries dealing with other heavy disease burdens and a shortage of healthcare personnel. In the U.S., while causes of death such as stroke, AIDS, heart disease, leukemia, and homicide have declined since 1965, the suicide rate has remained unchanged for two decades, at 38,000 lives per year. Research is increasingly pointing to links between mental and physical health. For instance, the Global Burden of Disease Study by the Institute of Health Metrics and Evaluation recently found that depressive disorders are the second leading cause of years lost to physical disabilities and the leading contributor to disability adjusted life years.

At the center of the CUESS discussion was the World Health Organization’s Comprehensive Mental Health Action Plan for 2013-2020—the first of its kind—which is focused on expanding and improving mental health care around the world.

“The burden of mental disorders cannot be reduced without effective prevention,” said Dr. Shekhar Saxena, director of the department of mental health and substance abuse at WHO in opening remarks.

In order to achieve global mental health aims, prevention should be discussed in the same conversation as treatment, said Dr. Kathleen Pike, executive director of Columbia University’s Global Mental Health Program and a clinical professor of psychology in the psychiatry and epidemiology departments. She pointed out that in some cases, treatment of mental health disorders can serve as prevention. For example, treating a mother’s depression with medication and therapy reduces depression in her children, according to research.

Early childhood and adolescence is the ideal time, according to Dr. Pamela Collins, director of the office for research on disparities and global mental health at the National Institute of Mental Health, because mental disorders typically occur between age ten and early adulthood, often in conjunction with early adversities. As people grow older, the “return on investment” decreases.

Areas of global conflict and violence, such as those in African and the Middle East, contribute to a high burden of childhood adversities. Traumatic experiences in war are clearly associated with psychological disorders, said Dr. Muthoni Mathai, a psychiatrist and senior lecturer at the University of Nairobi.

CONTINUED

“Trauma is toxic,” said Dr. Adam Karpati, former executive deputy commissioner for mental hygiene at the New York City Department of Health and Mental Hygiene, comparing violence to risky environmental exposures that we should seek to mitigate.

Changing social norms around activities that are linked with mental health disorders should also be taken into account, according to Dr. Katherine Keyes, assistant professor of epidemiology at Columbia University’s Mailman School of Public Health. For instance, attitudes around binge drinking among teenagers have relaxed at the same time that rates of binge drinking have increased, according to data from the 30-plus year national Monitoring the Future survey.

Additionally, many of the interventions that wealthy countries use face challenges in post-conflict and low-resource settings, said Dr. James Okello, a psychiatrist and researcher at the Centre for Children in Vulnerable Situations.

For instance, after Sierra Leone’s civil war, there was only one hospital that provided psychiatric services for a population of 6 million, said Dr. Adeyinka M. Akinsulure-Smith, assistant professor of women’s studies at City College of New York. To help the children of Sierra Leone deal with the fallout from their war experiences, Dr. Akinsulure-Smith worked on a program that created an environment based around traditional concepts of healing, communicating, and celebrating progress.

Participants spoke of the need for more research on the prevalence and impact of mental health disorders in society, especially in middle and low-income countries, in order to understand how widespread mental health problems are. Coordination of clinicians, researchers, and programs internationally is required to strengthen surveillance and share successful methods, said Dr. Pike. She spoke about WHO’s Global Clinical Practice Network which is made up of 10,039 committed clinicians who provide data to inform the International Classification of Diseases 11th Revision (ICD-11).

On the ground, things can be difficult, however. In South Africa, 5 percent or less of the health budget is allocated for mental health, according to Dr. Solomon Rataemane, head of the department of psychiatry at the University of Limpopo. Because public ignorance about mental health is pervasive, Dr. Rataemane said most mental health professionals are stigmatized and difficult to retain.

On the other hand, the U.S. spends a lot of money on brain disorder research. But, it goes primarily to biomedical studies, said Dr. Robert Kaplan, who at the time of the symposium served as director of the office of behavioral and social sciences research at the National Institutes of Health. “Most of my colleagues believe it’s not only the best way, but the only way,” he said. Yet this approach is limited in its capacity to address the complex causes that lead to mental disorders and may not even be working well, according to Dr. Kaplan, who is now serving as the chief science officer for the Agency for Healthcare Research and Quality. “We need to redistribute some of the money we are spending on medical care and to public health services.”

Dr. Gerald Oppenheimer, professor of sociomedical sciences at Columbia University and a public health historian, offered the mental health professionals in the audience an example of the successful public health campaign in the mid-twentieth century to reduce heart disease, which had the “evangelical” and “zealot-like” commitment of members of the medical and public health establishment.

In California, the state’s 2004 Mental Health Services Act, which put \$9 million from new taxes toward prevention and early intervention in mental health disorders, has shown early success, according to Dr. Wayne Clarke, the behavioral health director for Monterey County. The initiative



focused on lowering suicides, reducing stigma, and improving student mental health. Nearly 40,000 students participated in initiative activities, and many more were reached through a social media campaign called “suicide is preventable.” Early results indicate that participants are now more likely to recognize warning signs and properly intervene when mental distress or suicidal tendencies are displayed.

Dr. Sandro Galea, chair of the Department of Epidemiology and Gelman Professor of epidemiology, acknowledged challenges of the new global mental health agenda yet pointed to the auditorium full of motivated, highly influential symposium attendees as an example of the growing recognition of global mental health.

“What struck me was that we had a synthesis of public health perspectives that are essential if we are to affect change in mental health. The challenge to all of us as a community is to capitalize on this conversation to bring to fruition the innovative ideas that we heard, such that not only is mental health a topic of conversation, but that it yields results,” he said.

Stressed men more likely to have fertility problems

related media coverage

TIME Magazine
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Stress is associated with increased likelihood of likelihood of fertility problems for men, according to a study published in the journal *Fertility and Sterility*.

“Men who feel stressed are more likely to have lower concentrations of sperm in their ejaculate, and the sperm they have are more likely to be misshapen or have impaired motility,” says senior author Dr. Pam Factor-Litvak, associate professor of epidemiology. “These deficits could be associated with fertility problems.” Epidemiology PhD graduate Dr. Teresa Janevic was a lead author on the study, and epidemiology doctoral candidate Ms. Linda Kahn was a co-author.

Although the study is not the first to look at the link between stress and fertility, the research group says this one uses the most comprehensive measure of stress to date.

The researchers looked at 193 healthy men age 38-49 enrolled in the Kaiser Foundation Health Plan in Oakland, California. To measure “subjective stress,” the men were asked to rate how often they perceived events at work and in the



rest of their life as stressful. To measure “objective stress,” they filled out a survey answering whether they had experienced various stressful events over the past year.

Men who experienced subjective and objective life stress were significantly more likely to have worse sperm quality. However, there was not an association between work stress and semen quality. Dr. Factor-Litvak hypothesizes that men may be adept at blocking out work stress, but also suggests using other measures in future studies to measure work stress. Additionally, unemployed men had lower sperm quality than employed men.

The mechanism for how stress could influence sperm quality is not clear. One possibility is through a neuroendocrine process that would impair creation of sperm.

A further possibility is that stress affects a reproductive hormone known as the follicle-stimulating hormone, or FSH, but researchers found no associations between stress measures and either FSH or total testosterone.

“Although this area of research needs further development, it suggests the importance of stress across the life course and intergenerational stress to male reproductive health,” say the authors.

Janevic T, Kahn LG, Landsbergis P, Cirillo PM, Cohn BA, Liu X, Factor-Litvak P. Effects of work and life stress on semen quality. *Fertil Steril*. 2014 May 22. pii: S0015-0282(14)00381-1. doi: 10.1016/j.fertnstert.2014.04.021.



Wave of PTSD cases coming, report predicts

“We are at the cusp of a wave of PTSD,” says Dr. Sandro Galea, who led an Institute of Medicine study on how the Defense Department and the Department of Veterans Affairs handle post-traumatic stress disorder. “We still do not have a PTSD system that is delivering high-quality care for all service members and veterans,” says Dr. Galea.

More on PTSD

› [Read more in USA Today](http://www.usatoday.com/story/news/health/2014/05/14/ptsd-report/2741117)
on.wtsp.com/1iXLh5i

› [Read more in CBS](http://www.cbsnews.com/news/ptsd-report/)
cbsn.ws/1iXLiWO

Military, VA not tracking evidence on PTSD treatments, not keeping pace with treatment demands

A report from the Institute of Medicine (IOM) finds that the U.S. Department of Defense (DOD) and U.S. Department of Veterans Affairs (VA) are not measuring the effectiveness of treatment of post-traumatic stress disorder (PTSD), calling into question millions of dollars spent to improve service members’ mental health. The report also found that neither agency has kept pace with growing demand for PTSD treatment.

“Both departments lack a coordinated, consistent, and well-developed evidence-based system of treatment for PTSD and need to do a better job tracking outcomes,” said Dr. Sandro Galea, MD, DrPH, chair of the IOM committee, of which Dr. Kar-estan Koenen, professor of epidemiology, was also a member. “Mental health is among the most important factors behind successful re-entry after military service, and we don’t know if treatments are working.”

Federal investigators determined that service members were systematically denied timely care in a network of more than 1,700 healthcare facilities that suffers from inefficiency and bureaucracy.

An estimated 8 percent of veterans who served in Iraq and Afghanistan have been diagnosed with PTSD. In 2012, more than half a million sought care for PTSD in the VA—9.2 percent of all VA users. In 2012 the DOD and VA spent \$294 million for PTSD care. If treatment demands continue to climb, the total cost for PTSD could exceed \$500 million by 2017.

The report also recommends that the DOD and VA enlist a workforce of mental health care providers to meet the growing need for PTSD treatment. While the departments have substantially increased mental health staffing, these increases do not appear to have kept pace with the demand.

The most surprising outcome over four years of deliberation, according to Dr. Galea, is the dissonance between the intention of senior leadership and how a PTSD management system is implemented. “There is generally good will and spikes of excellence in both departments. Substantial effort has been made toward providing service members excellent PTSD care. However, there is tremendous variability in how care is implemented and an absence of data that tell us if programs are working or not,” Dr. Galea said.

“In many respects our findings that neither the DOD nor the VA has a system that documents patients’ progress and uses standardized instruments to chart long-term treatment are not surprising,” he added. “We are hopeful that the report will provide a blueprint for where we need to get to.”

Alcohol problems in National Guard linked to stress upon returning home

full article on the2x2project.org

2x2.ph/alcohol-national-guard



more on veterans' health

Treating the mental wounds of war

2x2.ph/PTSD-veterans

Is resilience too much to expect from veterans?

2x2.ph/resilience-veterans-war

How conscientious objectors contributed to nutrition knowledge

2x2.ph/WWII/nutrition

Using MDMA to treat PTSD

2x2.ph/mdmaptsd

Infographic on genetic risk and PTSD

2x2.ph/PTSD-infographic



Problems faced by National Guard soldiers upon coming home to the U.S., such as unemployment, financial and legal troubles, and divorce, better predict whether they developed an alcohol use disorder than the traumatic experiences of combat, according to a new study published in the *American Journal of Preventive Medicine*. The study was authored by Drs. Magdalena Cerdá, assistant professor of epidemiology; Dr. Karestan Koenen, professor of epidemiology; Dr. Sandro Galea; Dr. Catherine Richards, associate research scientist in epidemiology (now at University of Washington); and predoctoral candidate in epidemiology Mr. Greg Cohen; along with faculty at Case Western Reserve University, the University of Michigan, and the University of Toledo.

Alcohol problems are of particular concern among reservists. Fourteen percent abuse or are dependent on alcohol, compared to about 7 percent of the general American population, according to a 2012 survey from the Substance Abuse and Mental Health Service Administration.

The study spotlights the significant challenges of transitioning back into civilian life for reservists. “Exposure to the traumatic event itself has an important effect on mental health in the short-term, but what defines long-term mental health problems is having to deal with a lot of daily life difficulties that arise in the aftermath—when soldiers come home,” says Dr. Cerdá.

Additionally, members of the National Guard do not have the same access to services as regular military personnel when they return home. “Guardsmen who return home need help finding jobs, rebuilding their marriages and families, and reintegrating into their communities. Too many of our warriors fall through the cracks in our system when they return home,” says Dr. Koenen.

Cerdá M, Richards C, Cohen G, Calabrese JR, Liberson I, Tamburrino M, Galea S, Karestan Koenen KC. Civilian Stressors Associated with Alcohol Use Disorders in the National Guard. *American Journal of Preventive Medicine*. Epub 30 July 2014. <http://dx.doi.org/10.1016/j.amepre.2014.06.015>.

Does your brain really do better off grain?

Experts question the science behind gluten-free diet recommendations

full article on the2x2project.org

2x2.ph/gf-brain



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Americans are increasingly adopting a gluten-free diet, spurred by claims that avoiding this protein, found in wheat and other grains, might cure various ailments or even prevent diseases such as Alzheimer's and dementia.

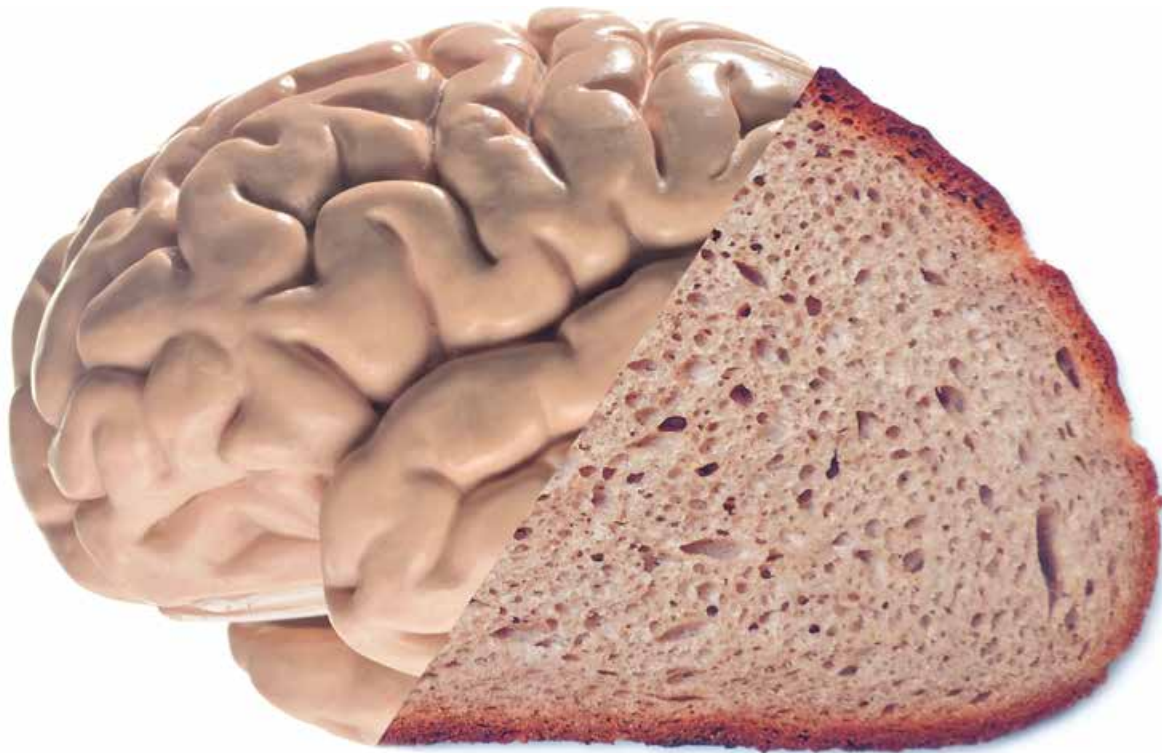
Eliminating gluten is typically recommended for people with celiac disease, a condition in which the small intestine's ability to absorb nutrients is inhibited by the gluten protein. Incidences of celiac disease are rising in the U.S.—a 2012 study from the Mayo Clinic found that the number of U.S. adults with the disease has increased four-fold over the last 50 years, with about 1

percent of adults currently affected.

However, most Americans on a gluten-free diet do not have celiac disease. In a 2013 survey conducted by the Food Marketing Institute, only 2 percent of shopper respondents said they bought gluten-free foods because they had a celiac sensitivity; 59 percent said they simply believed gluten-free foods to be healthier.

The reasons for the increase are not entirely understood, but one unintended consequence is clear to anyone who has walked down the aisles of a grocery store recently, where there is a "gluten-free" label on everything from boxes of crackers to milk cartons. The idea that gluten-free is healthy has spread rapidly, championed by a few celebrity doctors.

Researchers who study gluten and celiac disease caution that if you don't have the condition, it would be wise to steer clear of this fad, which bans everything from beer to bagels.



“We don’t take the decision to start a gluten-free diet lightly,” says Dr. Benjamin Lebwohl, Herbert Irving Assistant Professor of Epidemiology at Columbia, who focuses on outcomes in celiac disease. “It’s a difficult and expensive and socially isolating diet,” and when it comes to using it as a preventative measure for diseases other than celiac, the science just isn’t there, he says.

Experts further warn that questionable claims are being made by people who stand to benefit lucratively.

One of the most controversial of gluten-free proponents is Dr. David Perlmutter, whose *Grain Brain: The Surprising Truth about Wheat, Carbs and Sugar—Your Brain’s Silent Killers* which has made the *New York Times* bestseller list and has been published in 15 countries. The book argues that eating foods with high glycemic indexes, which happen to be some of the most gluten-rich foods, increases the chances of developing neurological

disorders like Alzheimer’s and dementia.

The book’s prescription of a gluten-free diet relies in part on recent studies showing that some people without celiac disease have neurological responses to gluten, including migraines, “brain fog,” and trouble controlling their muscles, and that high glucose levels, which may be caused by a number of things from diabetes to stress to diet, may be correlated with dementia.

“In those who have celiac disease, the management decision is clear: they need to go on a gluten-free diet. In those who don’t have the disease, it’s still very tempting, and I often agree with going on a strict gluten-free diet to see what happens to neurological symptoms,” Dr. Lebwohl says. But “on the other side of things, the more common neurological symptoms a lot of people report...the reason for that is completely unknown at this point.”

For instance, a study by Dr. Lebwohl and others of migraine headaches in people

with gluten intolerance found no meaningful correlation between the severity of migraines and the duration of a gluten-free diet.

Ultimately, experts agree that not enough is known about the way gluten impacts the brain—or even whether restricting gluten may negatively impact people without celiac disease—to support a gluten-free diet as a preventative measure for any disease, let alone dementia.

“Even though it makes for a great story, it doesn’t make for great science,” Dr. Alaedini said.

Bringing consequentialism back to epidemiology

In a challenging funding environment,
epidemiologists urge more action

full article on the2x2project.org

2x2.ph/consequential-epidemiology





A field that is devoted to scientifically studying the distribution, causes, and effects of disease, injuries, and general well-being, epidemiologic research has driven public health campaigns and policy changes that have led to longer life spans across the globe, such as anti-smoking regulations, seatbelt laws and speed limits, water treatment, vaccines against infectious diseases, sex education, and folate supplementation in flour to prevent birth defects.

Despite those “big wins” of the past, some epidemiologists are concerned that their field has not achieved comparable public health improvements in the last decade and will have difficulty weathering the current financial climate.

“Implicit in pressures [from large funders] is a growing dissatisfaction outside the field of epidemiology with epidemiologic description and correlation and a sense that our current approaches are not leading to ‘wins,’ to practical solutions to diseases and challenges to health, or to science that is more saliently useful to decision makers with a responsibility to the health of the public,” says Dr. Sandro Galea.

On top of this, a few critics have contended that the observational cohort studies commonly used in epidemiology are “lead[ing] the public astray,” as Drs. Paul Sorlie and Gina S. Wei, of the National Institutes of Health’s Heart, Lung, and Blood Institute epidemiology branch, put it in a 2011 article that itself is sympathetic to the use of such studies. These critics compare observational research of risk factors unfavorably to the methods of the

randomized controlled trials that are commonly used in drug studies.

“While the tools of epidemiology—comparisons of populations with and without a disease—have proven effective over the centuries in establishing that a disease like cholera is caused by contaminated water, as the British physician John Snow demonstrated in the 1850s, it is a much more complicated endeavor when those same tools are employed to elucidate the more subtle causes of chronic disease,” writes one of the most vocal critics, science journalist Gary Taubes, in the *New York Times* in 2007.

While this is a controversial view among epidemiologists, some still believe their field needs to re-assert its relevance. “I think over time, a lot of epidemiology has become data analysis and data dredging and highly sophisticated statistical modeling but without any emphasis on the application of epidemiology on public health and preventive medicine,” says Dr. Kuller, a professor of epidemiology at the University of Pittsburgh Graduate School of Public Health.

CONTINUED 



Dr. John Snow's map of cholera cases in London. The map has been colorized to enhance the mapping of deaths depicted by bars running perpendicular to streets. After mapping the area's 13 public wells, Dr. Snow noted the spatial clustering of cases around one particular water pump on the southwest corner of the intersection of Broad (now Broadwick) Street and Cambridge (now Lexington) Street.

Consequentialist epidemiology

In June of 2013, Dr. Galea stood before a hotel ballroom filled with his peers to give the annual outgoing president's speech at the Society for Epidemiologic Research (SER) annual meeting in Boston.

"We are seeing a gross failure in our improving the health of populations," he said. Epidemiology risks being shunted aside if its practitioners do not use it for "consequentialist" purposes, he says.

"Academic epidemiology now spends most of its time concerned with identifying the causes and distributions of disease in human population, and far less of its time and imagination asking how we might improve health," Dr. Galea wrote in a follow-up article published in September in the American Journal of Epidemiology.

Reviewing articles in the four leading epidemiology journals, Dr. Galea and his colleagues found that over 85 percent

focused on causality or etiology of a disease "with little particular attention to how that etiology may be relevant to intervention." The 14 leading epidemiology textbooks "devote[d] the overwhelming majority of their content to educating the reader about how we may identify causes and distribution of disease."

"Our focus on causal thinking at the expense of pragmatic thinking is not cost free, and runs the risk of marginalizing us as a discipline," he says.

Dr. Galea is not the first to express these concerns.

In 1967, the president of the American Public Health Association (APHA), Dr. Milton Terris told attendees at the organization's annual meeting: "Public health problems, whether new or old, are essentially social in character and can only be solved in terms of social policy.

"The task of public health workers is to convince society to undertake the

“Our focus on causal thinking at the expense of pragmatic thinking is not cost free, and runs the risk of marginalizing us as a discipline.”

specific social measures, governmental or other, which are required to solve specific health problems, and to participate in the implementation of these policies,” said Dr. Terris, who was known as an outspoken advocate for a progressive public health policy.

At another APHA annual meeting, in 1983, Dr. William Foege made his own call for a consequential epidemiology. In his talk, he said that epidemiologists should not shy away from political involvement.

“[Epidemiology] is a tool to change the world, not merely to study the world,” said Dr. Foege, whose consequentialist resumé included working on the 1970s campaign that eradicated small pox and directing the U.S. Centers for Disease Control and Prevention.

Eleven years later, as president of SER, Dr. Willard Cates reinvigorated the call for a consequential epidemiology, telling his peers to “seize the day of impending healthcare reform.”

Dr. Cates saw in the field the same problems as Dr. Galea describes today.

“The bulk of our research efforts identified risk factors but rarely affected public health actions. We were told that epidemiologists tended to ‘torture’ our data until some—frequently obscured—associations were found,” recalls Dr. Cates, who is currently president of Family Health International and an adjunct professor at the University of North Carolina-Chapel Hill, Emory University, and the University of Michigan School of Public Health, in a response to Dr. Galea’s article.

Those who talk about a consequential epidemiology don’t see it as a departure but rather as a return to the field’s roots. These roots are embodied by the story of Dr. John Snow.

An anesthesiologist living in nineteenth century London, Dr. Snow began monitoring cases of a deadly cholera outbreak in 1854. He found that nearly everyone who had died lived near a water pump on Broad Street in the city’s Soho neighborhood.

Based on the deaths and a water sample from the Broad Street source, he became convinced that cholera was transmitted not through the atmosphere—the popular theory of the time—but through contaminated water. He took this theory to the local government parish, prevailing on authorities to remove the Broad Street pump handle so it could no longer be used as a water source. Although Dr. Snow did not have complete information to prove his theory, cholera stopped spreading soon after. (It would take many more years for health authorities to embrace water and sewage treatment.)

Dr. Snow’s decision to act for the public good based on the imperfect information he had is what epidemiology of the best kind looks like, say consequentialists.

“It is unlikely that John Snow would be revered in public health if he had merely studied cholera,” says senior vice president of the Robert Wood Johnson Foundation Dr. James S. Marks in a 2009 article. “Our heroes have been tied to action.”

More on consequentialism in population health

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Gambling with America's health?

The public health costs of legal gambling

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More on behavior addiction

- > *What Internet addiction treatment looks like*
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-



To gamble legally 40 years ago, one had to travel to Nevada, go to a racetrack, or live in one of the handful of states that offered lotteries. In most towns, the closest one came to a betting game was playing charitable Bingo at church. Now popular video slot machines had not yet come to market.

For most Americans today, a casino is just a car ride away. There are about 1,400 of them in 39 states, and 43 states sponsor lotteries with games that are recognizable even to non-gamblers, like Mega Millions, Powerball, Pick 10, and instant scratch off tickets. In advertising to citizens, states use slogans like, "Hey you never know," "Give your dreams a chance," and "Believe in something bigger." Hawaii and Utah are the only states that offer no forms of legal gambling.

Casinos represent a substantial part of the nation's economy and enjoy support from members of both political parties. In 2012, the industry took in \$37 billion in gross revenue, employed 332,075 people, paid \$13 billion in wages, and contributed \$8.6 billion in taxes, according to the American Gaming Association. Many casinos are not just places to play blackjack and slots but to eat or take in live music and comedy acts.

In this environment, gambling addiction is often considered a small cost, one brought upon by the individual unwise gambler. "They think that it's an easy painless way to raise revenue but they don't see the other side of it," says Arnie Wexler. Wexler quit gambling over 45 years ago after a nearly three-decade addiction and has since served as executive director of New Jersey's Council on Compulsive Gambling. He also runs counseling services for compulsive gamblers with his wife, Sheila.

The idea that gambling lends itself to addiction like drugs or alcohol has taken some time to be acknowledged. Until the 2013 publication of the fifth edition of the Diagnostic Statistics Manual, or DSM-5, problem gambling was classified as an "impulse control disorder" in the same category as pyromania and kleptomania, even though most clinicians who treated

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problem gamblers recognized it as an addiction, says Dr. Silvia Martins, an associate professor of epidemiology at the Columbia University Mailman School of Public Health.

According to a conservative interpretation of the available research by the National Center for Problem Gambling, 1.1 percent or 3.4 million Americans have a pathological gambling disorder and 2 percent or 6.2 million engage in problem gambling, a less severe form of gambling addiction. (The term problem gambling is often used to refer to both problem and pathological gambling). Internationally, prevalence is as low as .5 percent of the population in Denmark and the Netherlands and as high as 7.6 percent in Hong Kong, according to a 2012 review for the province of Ontario. Though problem gamblers are a minority of visitors to casinos, their spending accounts for anywhere from 35 to 50 percent of the revenues, according to

several studies summed up in a paper by the Institute for American Values.

Problem gamblers exhibit many of the same problems as other addicts. "Everything you see with substance abuse you can make an analogy to gambling problems," Dr. Martins says, citing family strife, financial hardship, and struggles with depression or anxiety.

Betting on science

Compared to other nations, there has been relatively little epidemiologic research on rates of problem gambling in the U.S. The existing studies find that problem gambling increases with proximity to casinos. The federal government's 1999 National Gambling Impact Study found that areas within 50 miles of a casino had twice as high a rate of problem gambling as those within 250 miles. The presence of a casino within 10 miles of a survey respondent's home was positively related to problem

or pathological gambling, according to a 2004 study by the University of Buffalo's Research Institute on Addictions published in the *Journal of Gambling Studies*.

"Basically what we've learned is that as with many other kinds of environmental exposures, there typically is an increase in the prevalence rate of problem gambling in the wake of major introductions of new forms of gambling, whether it's lotteries back in the 1980s and 1990s or casinos in the 1990s and 2000s," says Dr. Rachel Volberg, a research associate professor of epidemiology at University of Massachusetts, Amherst and a researcher for the Massachusetts Gaming Commission.

Yet she says problem gambling rates seem to level off after awhile. A study by the Research Institute on Addictions that has not been published yet found that rates of problem gambling did not continue to rise between 2010-2012 despite greater opportunity to gamble. Principal

The commercialization of a dangerous product that threatens both individual and public health has been called an “industrial epidemic.”

investigator Dr. John Welte, senior research scientist in psychology at the University of Buffalo, says it is not clear why, but he says it could be a result of the economic crisis.

The National Center for Responsible Gambling, or NCRG, is the charitable arm of the gambling industry’s trade association, called the American Gaming Association. NCRG cites a few studies that it says show problem gambling has not risen since the 1970s. After a casino moves in, problem gambling may become more widespread initially, but after a while, people “adapt”—they become more aware of the risks, seek treatment, or simply lose interest, says Christine Reilly, the senior research director of NCRG. This is called an “adaption effect.”

But prevalence studies do not tell the full story, says Dr. Stephen Q. Shafer, the chairman of the Coalition Against Gambling in New York. “One of the fallacies is that, let’s say you assume that your prevalence statistics are absolutely correct and you show that the prevalence of pathological gambling has not risen. It was, say, five years ago 1.1 percent. Last year it was 1.2 percent. What that forgets is that the prevalence is a pool out of which people move and into which people come, and looking at prevalence compared to time one and time two, you have to account for the people

who have recovered, died, moved away.”

For this reason, there need to be studies that use more rigorous epidemiologic methods, says Dr. Shafer, who is also a retired professor of medicine and epidemiology at Columbia’s College of Physicians & Surgeons and the Mailman School. He has pushed to get New York State to commission such a study, but the state’s health department, the legislature, and the gambling commission has shown no interest.

Following in the footsteps of tobacco?

In a court case over a casino deal in Massachusetts, an organization called the Public Health Advocacy Institute filed a friend-of-the-court brief that made a public health argument against the gambling industry. “Legalized casino gambling causes devastating effects on the public’s health, including not only the gambler but also their families, neighbors, communities and others with whom they interact,” the brief says. Electronic gambling machines “are designed to addict their customers in a way that is similar to how the tobacco industry formulates its cigarettes to be addictive by manipulating their nicotine levels and other ingredients.”

“The commercialization of a dangerous product that threatens both individual and public health has been called an ‘industrial epidemic,’” the brief continues, citing a 2007

paper published in the journal *Addiction* by Drs. René I. Jahiel and Thomas F. Babor. This is an epidemic “driven at least in part by corporations and their allies who promote a product that is also a disease agent.”

The brief argues that the citizens of Massachusetts have an interest in regulating gambling the way they have regulated cigarettes.

That may be a pipe dream given the power of the gambling industry and the dependence of states on gambling revenues. However, other countries employ harm reduction strategies in casinos to intervene on potential problem gambling, according to a 2011 report from the Cleveland Plain Dealer. In Holland, computers identify anyone who visits a casino more than 15 times a month as having a gambling problem. In the United Kingdom, casinos have to display the odds of winning on slot machines. And in Australia, there are limits on playing speeds and betting amounts.

The underlying principle behind this is articulated by Dr. Williams: “If provincial governments are going to make gambling available to their citizens, then concerted efforts are needed to prevent problem gambling, to effectively treat gambling addiction, and to minimize the amount of gambling revenue that comes from problem gamblers.”

Encouraging urban health has multiple benefits

Retrofitting cities to encourage healthy behavior

full article on the2x2project.org

2x2.ph/urban-health-benefits



More on urban health

- > Read more about the symposium
2x2.ph/breaking-ground-urban-health
- > Watch the video courtesy of GSAPP
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- > How cities impact health
2x2.ph/cities-health

A pedestrian walkway and plaza that used to be street space near the Flatiron Building in New York, NY.



When it comes to urban planning, we tend to look at competing interests: environmentalism versus economic development or affordability versus gentrification. But a building and design approach that prioritizes health can act as an entry point for promoting many interests at the same time, said speakers at a daylong symposium of the Mailman School of Public Health's Urban+Health program, co-organized with the Graduate School of Architecture, Planning, and Preservation (GSAPP), which took place on April 22 at the GSAPP Studio-X NYC space downtown.

"When you look at the political context—politicians, communities, societies—often health is a very important value, but it is not the only value. People also care about issues like economic development, the environment, equity issues," said Dr. Karen Lee, senior adviser on the built environment and healthy housing at the New York City Department of Health and Mental Hygiene. "Finding synergies and co-benefits has been a critical part in terms of advancement of these issues in communities."

She pointed to the multiple benefits of New York City's "pedestrianization" of Times Square, Herald Square, and Union Square where the city converted automobile lanes to plazas with more walking space and seating. In addition to reducing traffic injuries and encouraging more physical activity, the urban makeovers have conferred economic benefits. Union Square has seen a 49 percent drop in vacant storefronts, and Times Square has for the first time become one of the top ten retail areas in the world. The city's FRESH (Food Retail Expansion to Support Health) program has incentivized the building of grocery stores in parts of the city that were formerly food deserts, creating both new jobs and proximity to healthy food for residents.

In China, alarm over the economic effects of heavy air pollution has fueled concern from a government historically lax on environmental regulation. "Businesses are paying a premium to send people to China because of air pollution concerns," said Dr. Carlos Dora, coordinator of the interventions for healthy environments unit, part of the department of public health and environment at the World Health Organization.

Cities also promote "public joy," said Vishaan Chakrabarti, the Marc Holliday Associate Professor of Real Estate Development at GSAPP, and a partner at SHoP Architects. People are seeking a walkable lifestyle free of long office commutes, affording them "something that's critical for health and joy, which is more time," he said. "Most young people today are looking at that 20th century technology of that suburban house and that office park and trying to find a different way."

As Dr. Gina Lovasi, an assistant professor of epidemiology at the Columbia Mailman School of Public Health, said: "Cities that support health are going to be supporting other social and economic goals and the kinds of lives we want to live."

The global burden of lung disease

Smoking, pollution major factors

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related coverage

Q&A with Neil Schluger

2x2.ph/q-and-a-schluger

Why banning cigarettes is good policy

2x2.ph/cigarette-ban-tasmania



Beijing, China

IMAGE: CHRIS ASTON

In rural Kentucky, a middle-aged female, ex-smoker visits her doctor complaining of shortness of breath. In Beijing a young man walks to work in a haze of smog with a splitting headache. In Nairobi, Kenya, a young woman hunches over a stove, breathing in toxic fumes and coughing as she cooks her family's dinner over charcoal.

These experiences represent the global scope of lung diseases, which are a heavy burden in low, middle, and high-income countries alike and are among the leading causes of death in the world, according to a recently released report by the Forum of International Respiratory Societies. Yet because they often manifest in initially less dramatic symptoms like a cough or headache, and because they are associated with cigarettes, lung diseases often are ignored or written off as a smoker's problem.

"Some of these things seem like background noise. I think that's part of the problem," says Dr. Neil Schluger, a professor of medicine, epidemiology, and environmental health sciences and chief of the pulmonary, allergy and critical care medicine division at Columbia University.

According to Dr. R. Graham Barr, a professor of medicine and epidemiology at Columbia, "The bottom line is that the amount we spend on research diagnosis and treatment in lung disease is miniscule compared to cardiovascular disease or nonsmoking related cancer."

Diseases of the lung have existed since Greek and Roman times, but they have

increased dramatically with industrialization, the development and marketing of cigarettes, and the drop in deaths from other diseases.

A delicate and complex system, the lungs are the only internal organs that are constantly exposed to the environment. When people regularly breathe in toxins, their lungs over time can experience inflammation, scarring, and infection. Because the damage accumulates gradually, people do not always make the connection between hazardous air exposures and diseases like lung cancer, chronic obstructive pulmonary illness or COPD, acute respiratory tract infection, and tuberculosis—four of the leading causes of death in the world.

Since becoming chief scientific officer of the World Lung Foundation, Dr. Schluger has been working to draw attention to lung diseases and the central role that is played by the air we breathe. "Although molecularly lung diseases are different from each other, they are all exacerbated by pollution and tobacco," he says.

CONTINUED 



IMAGE: KEVIN SCHOENMAKERS

In March, he and Dr. Ram Koppaka, a senior advisor at the Centers for Disease Control and Prevention published a think piece in the *Annals of the American Thoracic Society*, articulating the problem: “The lung diseases that account for the greatest global morbidity and mortality are preventable to a very significant degree.

“A new approach is required that goes beyond simply developing new treatments for each of the major respiratory disorders.”

Outdoor air pollution

According to WHO, one in eight of total global deaths in 2012—7 million people—were linked to air pollution. With the global trend toward urbanization, the problem will likely get worse.

In their paper, Drs. Schluger and Koppaka say that “Governments must be held accountable...for protecting the lives of their citizens at least as much as they protect the commercial interests of large industries.” They cite ways that high-income countries have reduced pollution at its source, such as mandating lead-free gasoline, encouraging fuel-efficient

vehicles, traffic planning, and air filtering methods at factories.

Government air quality standards have made a difference, as the U.S. has shown with the Clean Air Act, passed in 1963. By the 1990s, air pollution in most American cities had declined or plateaued. “Those of us who live in high income cities, we breathe much cleaner air than our grandparents and our parents did,” says Dr. Darby Jack, assistant professor of environmental health sciences at Columbia’s Mailman School of Public Health.

Household air pollution

Around 3 billion people, especially in nations in sub-Saharan Africa, South and East Asia, the Middle East, and Latin America, heat their homes with open fires and cook using leaky stoves that burn dirty fuels like coal, animal dung, straw, and agricultural waste. Soot from these sources penetrates deeply into the lungs and can lead to pneumonia in children and COPD in adults. An estimated 4.3 million people die each year as a result of exposure to household air pollution, a big part of which is

from cooking on these kinds of stoves, according to WHO.

Several initiatives have sprung up to promote the design of more efficient, cleaner burning stoves, but it has proven difficult because of limited budgets.

Dr. Jack is currently conducting an intervention study in Ghana that compares giving people “the latest and greatest biomass stoves” with giving them liquefied petroleum gas, which is cleaner than the fuels they usually use. “Those are sort of the two options: clean fuels or clean combustion. Our study is designed to look at both of those side by side. Most of those studies have just looked at the clean cook stoves,” he says.

Based on disappointing results from previous studies of stoves, he believes the solution will likely come from clean fuels but acknowledges that money is a big obstacle. “It’s much more expensive,” he says.

Smoking

While high-income countries began snuffing out cigarette advertising many decades ago, cigarette companies redirected their efforts toward nations with growing middle classes and fewer anti-tobacco regulations.

According to WHO, one in eight of total global deaths in 2012—7 million people—were linked to air pollution.

In China, which has nearly one-third of the world's smokers, the state-run tobacco company China National Tobacco Corporation has not set cigarette taxes at any meaningful level. As a result, smoking runs cheap in cost—74 cents a pack—but costly in health—an estimated 1 million people die of tobacco-related causes each year, a number that is expected to triple by 2050.

In Africa, smoking rates are rising amidst dedicated marketing efforts by cigarette companies to target a continent that has been called “Big Tobacco’s last frontier.” Tobacco companies employ locals in their factories and deploy marketing strategies, such as selling cigarettes individually-wrapped to increase affordability for those who do not have much spending money—such as children.

Dr. Schluger says that tobacco companies, not individuals, should primarily be held responsible for smoking rate spikes: “By no means should we treat people who use tobacco and have lung disease as if it’s their fault. The tobacco industry says this all the time: ‘people choose to do it.’ Let’s face it: it’s not a fair fight. The tobacco industry is spending billions of dollars on advertising, which is extremely effective.”

In the U.S., New York City has been a leader, with a hefty increase on cigarette taxes and bans on smoking at indoor and outdoor public spaces. Since the ban was

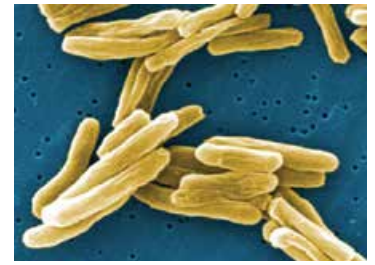
enacted in 2003, the percent of active smokers has decreased in New York City from 21 to 14, and the city now has the lowest rate of lung cancer deaths in the New York state, according to the American Cancer Society of New York and New Jersey.

“Mayor Bloomberg saved more lives from lung disease than any physician in New York or any hospital because of what he did to decrease tobacco use in the city,” says Dr. Schluger. “Individuals can say, ‘I’m not going to smoke,’ but they need help from the government,” he adds.

That help is more forthcoming in some countries than others. In 2013, the WHO ratified the Framework Convention on Tobacco Control, which sets a universal standard for regulating tobacco production, sales, advertising, distribution, and taxes. “Almost every country in the world has signed it, almost no country has adopted all of its measures,” says Dr. Schluger.

Promoting global public health

Despite the challenges implementing the tobacco treaty, the centrality of public health interventions cannot be underestimated. Dr. Schluger says: “When I think of the global burden of lung disease, these public health and population approaches could be so much more effective than waiting for people to get sick and treating them.”



Tuberculosis requires more attention, investment

Drug companies, governments, and other sources under-invest in tuberculosis compared to other global diseases, especially given the emerging threat of new strains of multi-drug resistant tuberculosis, says Dr. Neil Schluger in the Financial Times: “The biggest challenge is for people to realize how much TB is out there. The rate is going down 2 percent a year but that is too slow for eradication to happen for decades to come.”

More on tuberculosis

› *Big pharma balks at investment in TB*
on.ft.com/1dOsIho

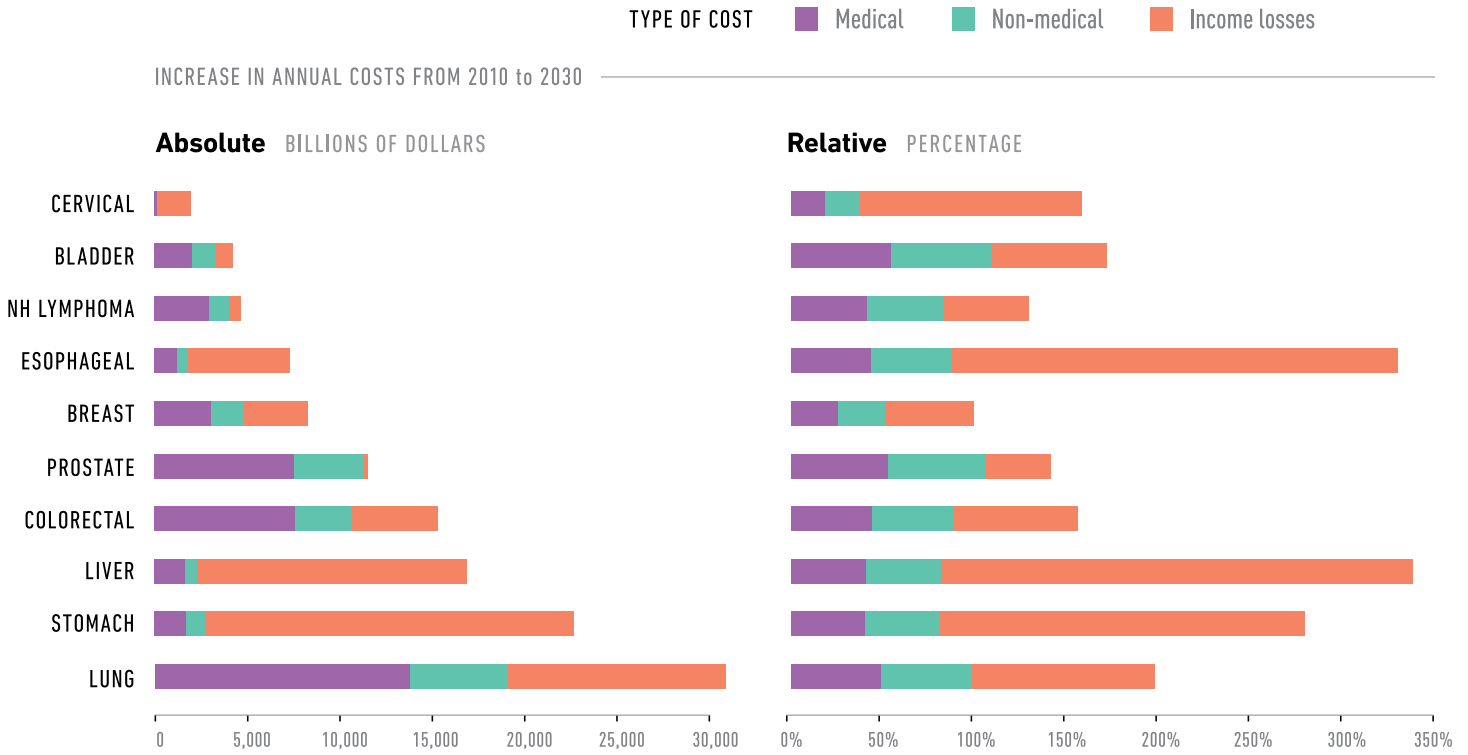
› *Stubborn new TB strain threatens to reverse progress*
on.ft.com/ObAA0i

› *TB, disease of the poor, now threatens rich*
on.ft.com/1dOsW81

“The [U.S.] president’s budget proposal, with stunning short-sightedness, calls for a \$45 million cut for USAID’s TB program,” writes Dr. Gerald Friedland, adjunct professor of epidemiology at Columbia’s Mailman School of Public Health. Read more in the Hill. > bit.ly/1fEOsNA

IMAGE: DR. RAY BUTLER, CDC

Projected global increase in cancer-related costs per year



These two stacked bar graphs depict the projected increase in cancer-related costs in 2030 compared with 2010 for the top 10 most prevalent cancers. The graph on the left shows the absolute increase in cancer-related costs along the x-axis. The graph on the right shows the relative, or percent, increase in cancer-related costs along the x-axis. Along the y-axis for both graphs is a list of the top 10 most prevalent cancers, ordered from top to bottom in ascending order according to the cancer associated with the lowest projected absolute annual increase in related costs. **The largest absolute increase in cancer-related costs is projected to occur with lung cancer,** with a large proportion of the increase occurring due to medical costs and income losses.

DATA SOURCE: INSTITUTE FOR HEALTH METRICS AND EVALUATION. GBD CAUSE PATTERNS. GBD 2010, RELEASED 3/2013. [HTTP://WWW.HEALTHMETRICSANDEVALUATION.ORG/GBD/VISUALIZATIONS/GBD-CAUSE-PATTERNS](http://www.healthmetricsandevaluation.org/gbd/visualizations/gbd-cause-patterns)

Originally published on the GRAPH website, at cugraph.org



IMAGE: HELENE KRENISKE

Mervyn Susser, who passed away this year at 92, remembered in New York Times

“Dr. Susser, something of a self-taught epidemiologist, is widely credited with helping the field establish proven methods for studying and treating disease. He and his wife, Dr. Zena Stein, promoted some of the earliest educational and treatment programs for AIDS in South Africa. Dr. Susser sought to improve public health from the ground up by gathering data on who was affected by diseases and why, and by trying to understand what their distinctive social and economic circumstances were. Social medicine, it was sometimes called.”

Read the full obituary in the *New York Times*. > nyti.ms/1C6ruqL

Read memoriam articles about Dr. Mervyn Susser’s contribution to community health, AIDS, and other areas of public health, by Dr. Ezra Susser > 1.usa.gov/1uNgFYe, Dr. Salim Abdool Karim > 1.usa.gov/1p3zlBW, Dr. Alfredo Morabia > 1.usa.gov/1zJCjfS, and Dr. Ezra Susser and Dr. Sandro Galea > bit.ly/1uNgL25.

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- Neuroscience Institute, Sacramento, CA; St John's Mercy Medical Center, St Louis, MO; Canada, 2 sites (n=52); Charles LeMoyné Hospital, Greenfield Park, QC; McGill University Montreal General, Montreal, QC; Chile, 2 sites (n=90); Hospital Clínico Universidad Católica de Chile, Santiago; Universidad Católica, Santiago, and Hospital Naval, Viña del Mar; Ecuador, 1 site (n=171); Hospital-Clinica-Kennedy, Guayaquil; Mexico, 2 sites (n=18); Hospital Civil/México, Guadalajara, Jalisco; Instituto Nacional de Neurología y Neurocirugía, México City; Peru, 1 site (n=151); Hospital Sabogal, Lima, Perú; Spain, 6 sites (n=137); Hospital de Girona Dr Josep Trueta, Girona; Hospital Del Sagrat Cor, Barcelona; Hospital del Bellvitge, Barcelona; Hospital Universitario German Trias i Pujol, Barcelona; Hospital del Mar, Barcelona; Hospital Clínico Universitario de Santiago de Compostela, Santiago de Compostela; Statistical and Data Management Center; University of Alabama at Birmingham, AL; SPS3 Coordinating Center; University of British Columbia, Vancouver, BC, Canada, and University of Texas Health Science Center at San Antonio, TX; Neuroradiology Core; Neuropsychology Core; LIMITS Coordinating Center; Columbia University, NY. C-Reactive Protein as a Prognostic Marker After Lacunar Stroke: Levels of Inflammatory Markers in the Treatment of Stroke Study. Stroke. 2014 Feb 12. [Epub ahead of print]
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