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Dear Ms. Pierce,

Thank you for taking the time to review the *Housatonic River Area Cancer Incidence Evaluation* and for sharing your thoughtful questions. We understand the importance of this issue for residents and want to respond directly to the concerns you raised.

This project was designed as a **cancer incidence evaluation**, not a full epidemiologic study. The scope, developed in collaboration with and approved by the Pittsfield City Council's Subcommittee on Public Health and Safety, was to determine whether rates of certain cancer types in the region were elevated or show an unusual pattern—particularly for cancer types associated with PCB exposure. The evaluation is considered a screening-level review of health data. It provides important baseline information to determine whether further studies or interventions should be considered.

Below are responses to the key points you highlighted:

1. **Project Timeline**
   To clarify the timeline of the project: the scope of work for the evaluation was finalized in April 2023, following multiple meetings with the Pittsfield City Council Subcommittee to understand community concerns and complete a comprehensive review of the scientific literature to select cancer types most associated with PCB exposure. The Massachusetts Cancer Registry provided data in April 2024, and the evaluation was released in September 2025.

2. **Melanoma**
   Including melanoma in the evaluation would have introduced substantial bias likely to underestimate rates in the evaluation area. Melanoma is diagnosed in both hospital and non-hospital settings, but reporting from non-hospital providers was incomplete during the years of the evaluation. This limitation is particularly important in the Housatonic River Area, where a larger share of melanoma diagnoses occur outside hospitals compared with other parts of Massachusetts. As a result, relying only on hospital-reporting would have missed a significant number of local diagnoses and underestimated melanoma rates. At the same time, statewide comparison rates include more complete reporting, especially from urban areas where hospital diagnoses are the norm. This imbalance would have biased the standardized incidence ratios downward for the Housatonic River Area. For this reason, melanoma was excluded—not to avoid potential findings, but to prevent presenting misleading results that would underestimate risk.

Importantly, if PCB exposure were influencing cancer risk in the region, we would expect to see increases in other cancers most strongly associated with PCB exposure—liver cancer, breast cancer, and non-Hodgkin lymphoma. These cancers were found to be within expected ranges.

3. **Residential history**
   You are correct that cancer registry data do not contain full residential histories. This is a limitation faced by all cancer registries in the U.S. and Canada, which follow uniform data standards set by the North American Association of Central Cancer Registries (NAACCR). Reconstruction of historical residence is not part of a standard cancer incidence evaluation. Epidemiologic studies, such as case–control or cohort designs, sometimes embark on this effort depending on study design. This evaluation was a **cancer incidence evaluation**, not a full epidemiologic study.

4. **Exposure data**
   As a screening-level review of health data, the evaluation was not designed to collect individual exposure measurements or assess individual exposure. Instead, it addressed the specific question of whether cancer incidence rates are elevated in the region, especially for cancers potentially associated with PCB exposure.

5. **Statistical methods and small numbers**
   Standardized incidence ratios (SIRs) are the standard method for evaluating cancer incidence in a small area (such as a community or census tract) in comparison to a large, stable population (such as the state as a whole).

   To address the challenge of small numbers, we conducted additional analyses, including combining data over longer time periods, to increase statistical stability. For less common cancer types (i.e., biliary, childhood ALL, gallbladder, liver and IBD, NHL, and stomach), SIRs were also calculated for 10-year time periods. These results are included in the Supplemental Tables. Additionally, DPH also evaluated geographic and temporal patterns, histologies (cell types), and cancer-specific risk factors (e.g., age at diagnosis, sex, occupation, tobacco use history).

6. **Smoking and lifestyle factors**
   DPH takes the elevated rates of bladder and colorectal cancer very seriously, and it is important to consider the most likely causes. Tobacco use is the most significant risk factor for bladder cancer, with about half of all diagnoses attributable to smoking, and it is also a major risk factor for colorectal cancer. Occupational exposures (such as to certain dyes, paints, rubber, or diesel exhaust) can also play a role in the development of bladder cancer.

   Evaluating lung cancer rates—which are strongly linked to smoking—is a standard public health approach to assess whether higher-than-average smoking rates may be contributing to cancer risk in the region. Although smoking is often described as a lifestyle behavior, DPH emphasizes that it is also shaped by systemic factors and broader social determinants of health. Prevention and cessation programs remain among the most effective tools to reduce the burden of tobacco-associated cancers.

   We recognize the sensitivity of this topic. However, the data point to a likely role of smoking on cancer rates in the area and avoiding discussion of this factor would be a disservice to the

community. Strengthening efforts to reduce tobacco use and increase colorectal cancer screening are evidence-based ways to help lower cancer rates.

7. **Spatial analysis**
   In addition to qualitative mapping, we evaluated incidence at the census tract level in Pittsfield. This analysis did not identify patterns of elevation in tracts closest to the GE site that would suggest a common environmental cause. More complex spatial modeling was beyond the scope of this project. The methods used were chosen to balance rigor, interpretability, and data constraints.

Next steps

The methods used to conduct this evaluation were consistent with epidemiologic standards, and it is important to emphasize again that this effort was designed as a **cancer incidence evaluation**, not a full epidemiologic study. The results of this evaluation with respect to PCB-associated cancer types were generally reassuring, as most cancer types known to be associated with PCB exposure, including those most strongly associated with PCBs, were not elevated. Where increases were observed, notably bladder and colorectal cancer, DPH is committed to working with local and state partners as well as health professionals to assess potential causes and to consider whether additional studies or public health actions are warranted.

We appreciate your engagement and share your commitment to ensuring that scientific evaluations reflect the best interests of the community. Your feedback will be part of our ongoing discussions about how to build on this work.

Sincerely,

Massachusetts Department of Public Health