

Article

Estimates of cancer mortality attributable to carcinogenic infections in Italy

Pietro Ferrara ^{1*}, Sara Conti ^{1,2}, Fernando Agüero ^{3,4}, Luciana Albano ⁵, Cristina Masuet-Aumatell ^{3,4}, Josep Maria Ramon-Torrell ^{3,4} and Lorenzo Giovanni Mantovani ^{1,2}

¹ Center for Public Health Research, University of Milan – Bicocca, Monza, Italy; p_ferrara@alice.it (P.F.), sara.conti@unimib.it (S.C.), lorenzo.mantovani@unimib.it (L.G.M.)

² Value-Based Healthcare Unit, IRCCS MultiMedica, Sesto San Giovanni, Italy

³ Preventive Medicine Department, University Hospital of Bellvitge – IDIBELL, L'Hospitalet de Llobregat, Barcelona, Spain; faguero@bellvitgehospital.cat (F.A.), cmasuet@bellvitgehospital.cat (C.M.A.), jmramon@bellvitgehospital.cat (J.M.R.T.)

⁴ Clinical Science Department, University of Barcelona, Barcelona, Spain

⁵ Department of Experimental Medicine, University of Campania Luigi Vanvitelli, Naples, Italy; luciana.albano@unicampania.it

* Correspondence: Pietro Ferrara - Center for Public Health Research, University of Milan – Bicocca, Via Cadore 48, I-20900 Monza, Italy; Phone +39 (0)39-2333097/8; E-mail: p_ferrara@alice.it

Abstract: Several infectious agents are ascertained causes of cancer, but the burden of cancer mortality attributable to carcinogenic infections in Italy was still unknown. To tackle this issue, we calculated the rate and regional distribution of cancer deaths due to infections sustained by seven pathogens ranked as group-1 carcinogenic agents in humans by IARC. Population attributable fractions related to these agents were applied to annual statistics of cancer deaths coded according to 10th International Classification of Diseases. The estimated burden of cancer mortality attributable to carcinogenic infections in Italy during the period 2011-2015 was on average 8.7% of all cancer deaths registered yearly. Approximately 60% of deaths occurred in men and almost the whole burden was due to four infectious agents (*Helicobacter pylori*, HCV, HPV, and HBV). The analysis of regional distribution showed a higher number of infection-related cancer deaths in the northern regions, where the estimates reached 30 (Liguria) and 28 (Friuli Venezia Giulia) deaths *per* 100,000 inhabitants in 2015. Since one-twelfth of cancer deaths were attributable to these modifiable risk factors, the implementation of appropriate prevention and treatment interventions may help to reduce the impact of these infections on cancer mortality.

Keywords: burden of cancer mortality; cancer epidemiology; cancer etiology; cancer prevention; carcinogenic infections; modifiable risk factors

1. Introduction

Cancer is among the leading causes of death worldwide: according to global estimates of cancer burden, around 25 million new cases, almost 10 million related deaths, and 234 million cancer-attributable disability-adjusted life years were calculated for 2017 [1].

Several infectious agents are ascertained – and frequently modifiable – causes of cancer, being responsible for at least a sixth of all global cancers [2,3]. As easily predictable, the fraction of incident cases and deaths attributable to carcinogenic infections varies from one country to another, mainly due to different local factors, such as the geographical context or human development index [2,4]. In this frame, there is growing awareness on the importance of providing country-based estimates of the burden attributable to carcinogenic infections, with the aim to provide actionable metrics for the implementation of public health interventions to reduce this preventable proportion of cancers [2-6].

In Italy, 371,000 new cancers were diagnosed during 2019 and currently 3.5 million people (5.3% of the whole Italian population) live with a diagnosis of cancer. Again, around 179,000 patients died for the consequences of these diseases, which constituted the second leading cause of death in the country after cardiovascular diseases [7]. Regarding the burden of cancers of infectious origin, the International Agency for Research on Cancer (IARC) estimated an age-standardized rate of 18.8 cases *per* 100,000 individuals attributable to infections [2,8], and De Flora and coll. calculated that 27,000 yearly cancer cases were attributable to carcinogenic infectious agents in Italy in 2018 [5]. However, nothing has been published on the impact and trend of carcinogenic infections on cancer-related mortality in the country, except for a preliminary communication that requested more accurate and detailed analyses of this burden [6], which remain unjustifiably unknown.

Therefore, in order to fill this gap of knowledge, we conducted this research with the aim to estimate the burden of cancer mortality attributable to carcinogenic infections in Italy, also describing the evolution on a five-year period and regional distribution of this death toll.

2. Materials and Methods

We selected seven microorganisms ranked as group-1 carcinogenic agents in humans by IARC – *Helicobacter pylori*, hepatitis B virus (HBV), hepatitis C virus (HCV), high-risk human papillomavirus (HPV) types (such as 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, and 59), Epstein–Barr virus (EBV), human herpesvirus type 8 (HHV-8), and human T-cell lymphotropic virus type 1 (HTLV-1) – and the global, regional, or national population attributable fractions (PAF) and their 95% confidence intervals (95% CI) for the listed infectious agents on the basis of existing body of evidence [2,4,9-11]. Since the data warehouse of the Italian National Institute of Statistics (ISTAT) reported data on the causes of death according to the European Short List, without 10th International Classification of Diseases coding system (ICD-10) specification [12], we therefore selected as source the World Health Organization (WHO) CoDQL – Cause of Death Query online, a web-based system for extracting trend series detailed cause of death data submitted to the WHO by its member States on an annual basis, where deaths are recorded according to ICD-10 coding system [13]. We gathered the number of cancer-related deaths for the period 2011 to 2015 (last year available) and calculated the total number of cancer deaths by summing death cases in each sex as reported by WHO death statistics. The ICD-10 diagnosis codes considered in the analysis are listed in Table 1, alongside results.

In order to calculate the absolute number of cancer-related deaths attributable to carcinogenic infections, we applied the evidence-based PAFs of each carcinogenetic agent to the retrieved death statistics. Following a strategy reported elsewhere [4], some analysis adjustments were performed. First, the estimation of mortality attributable to liver cancer associated to HBV and HCV infections was calculated taking into account their prevalence in Italy and adjusted by the relative risk of each infection [2,10]. Second, a 5% of non-Hodgkin lymphoma due to *H. pylori* was assumed to be localized to the stomach [11]. Third, age-standardized relative risks for HPV-related vulvar carcinoma were considered for age ranges 15-54, 55-64, and ≥ 65 years [4].

In order to investigate the regional distribution of cancer deaths due to carcinogenic infections, the calculated national percentage of deaths attributable to infections with seven agents was applied to the regional cancer deaths statistics diffused on an annual basis by the Italian Ministry of Health and weighted against the resident population of each Italian region, according to ISTAT statistics for the same year [12,14]. In order to facilitate comparison, results were presented *per* 100,000 inhabitants, with 95% CIs computed based on a Poisson approximation [15].

Data for 2015 year were presented as absolute numbers, counts (percentage) with lower and upper 95% CIs (where available in literature), and mean and standard deviation (SD). Results for the previous four years were included to describe the five-year time evolution of the investigated mortality burden. Analyses were conducted with R statistical software v. 4.0.0 [16]; map was designed using QGIS v. 3.14.16 'Pi' [17].

3. Results

Over the five-year period, the annual number of cancer deaths attributable to infections with carcinogenic agents fell between 14,250 (2015) and 15,026 (2011), being on average 8.7% (± 0.2 SD) of all cancer-related deaths registered yearly. The time-series of this mortality burden is presented in Fig. 1: a slight decrease was seen from 2011 to 2015.

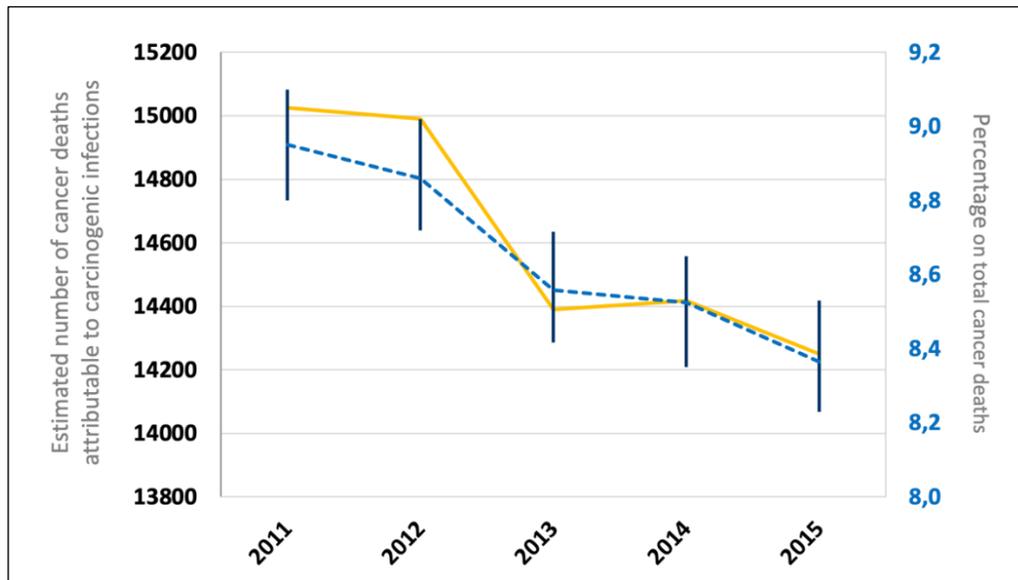


Figure 1. Time-series of cancer mortality burden attributable to carcinogenic infections over a 5-year period (2011–2015) in Italy. The yellow line represents the estimated numbers of cancer deaths attributable to carcinogenic infections; the dashed blue line identifies the percentage on the total cancer deaths, with 95% confidence intervals (vertical lines).

For each analyzed year, roughly 60% deaths occurred in men and almost the whole mortality burden (range 96.4–97.0%) was attributable, in equal proportions, to cancers due to four infectious agents (*H. pylori*, HCV, HPV, and HBV).

Limiting the analysis to the last available year, we found that of 14,250 estimated deaths (8.4% of the total cancer deaths; 95% CI: 8.2–8.5) due to carcinogenic infections in 2015, 58.4% (95% CI: 57.2–59.7) occurred in men. 8,116 deaths (57.0%; 95% CI: 55.7–58.2) were estimated to be correlated to gastric carcinoma (non-cardia and non-Hodgkin lymphoma) due to *H. pylori*, being the most frequent infection-related cause of cancer death in both men and women: respectively, 55.7% (95% CI: 54.1–57.3) and 58.7% (95% CI: 56.8–60.7). Liver cancer due to hepatitis viruses were responsible for 31.3% (95% CI: 30.2–32.3) deaths, of which 3,895 and 560 attributable to HCV and HBV infections, respectively. HCV represented the second most frequent cause of carcinogenic infection death in both sexes. In women, the third leading lethal carcinogenic infections were sustained by high-risk HPV types (13.8%, 95% CI: 12.8–14.7; $n = 816$); while in men, by HBV infection (4.6%, 95% CI: 4.1–5.0; $n = 379$). Estimated deaths associated to cancer attributable to EBV were 367, mainly due to nasopharyngeal carcinoma (55.6%, 95% CI: 48.2–63.8). Table 1 offers a complete overview of 2015 estimated numbers of cancer deaths attributable to carcinogenic infections, listed by infectious agents and diagnosis (according to ICD-10).

The analysis of regional distribution of cancer mortality attributable to infections showed higher estimates of the number of infection-related cancer deaths in the northern regions (except for Valle d'Aosta): Liguria and Friuli Venezia Giulia regions reached, respectively, 30 (95% CI, 27–33) and 28 (95% CI, 25–31) deaths *per* 100,000 inhabitants. The rate gradually decreased moving towards the southern regions. The average Italian rate was of 23.4 (95% CI, 23.1–23.8) deaths *per* 100,000 inhabitants. Fig. 2 reports regional estimates and their 95% CIs.

Table 1. Number of cancer deaths attributable to carcinogenic infections, by infectious agents, diagnosis (ICD-10), and sex - Italy, 2015.

	<i>Total deaths</i>	<i>PAF (95% CI) *</i>	<i>Total (N, 95% CI) §</i>	<i>Men (N, 95% CI) §</i>	<i>Women (N, 95% CI) §</i>
Helicobacter pylori					
Non-cardia malignant neoplasm of stomach (C16.1-9)	8.915	89% (79-94)	7934 (7043-8380)	4538 (4028-4793)	3396 (3015-3587)
Gastric non-Hodgkin lymphoma (C82-85, C96)	245	74% (43-86)	182 (106-211)	99 (57-115)	83 (48-96)
Hepatitis C virus					
Liver cancer (C22)	4064	94% (92-96)	3812 (3718-3881)	2583 (2520-2630)	1229 (1199-1251)
Non-Hodgkin's lymphoma (C82-85, C96)	4908	1.7% (1.5-2.1)	83 (74-103)	45 (40-56)	38 (34-47)
Hepatitis B virus					
Liver cancer (C22)	801	70% (63-76)	560 (502-610)	379 (340-413)	181 (162-197)
Human papillomavirus (high-risk HPV types)					
<i>Carcinomas of the oropharynx</i>					
Neoplasm of base of tongue (C01)	92	24% (17-30)	22 (16-28)	17 (12-21)	5 (4-7)
Neoplasm of tonsil (C09)	186		45 (32-56)	32 (23-41)	12 (9-15)
Neoplasm of oropharynx (C10)	321		77 (55-96)	57 (40-71)	20 (14-25)
<i>Cancers of the oral cavity</i>					
Neoplasm of other and unspecified parts of tongue (C02)	1233	4.3% (3.2-5.7)	53 (39-70)	30 (22-39)	23 (17-31)
Neoplasm of gum (C03)	522		22 (15-30)	13 (9-17)	10 (7-13)
Neoplasm of floor of mouth (C04)	35		2 (1-2)	1 (1-1)	1 (1-1)
Neoplasm of palate (C05)	38		2 (1-2)	1 (1-1)	1 (1-1)
Neoplasm of other and unspecified parts of mouth (C06)	72		3 (2-4)	2 (1-2)	1 (1-2)
Anal carcinoma (C21)	566		24 (18-32)	14 (10-18)	11 (8-14)
Laryngeal cancer (C32)	278	88% (85-91)	245 (236-253)	93 (90-96)	151 (146-157)
Vulvar carcinoma (C51)	1480	4.6% (3.3-6.1)	68 (49-90)	61 (44-80)	7 (5-10)
Vaginal carcinoma (C52)	497	16.6% (12.5-19.8)	82 (62-98)	-	82 (62-98)
Cervix uteri carcinoma (C53)	93	78% (68-86)	73 (63-80)	-	73 (63-80)
Penile carcinoma (C60)	442	100%	442	-	442
Epstein-Barr virus					
Nasopharyngeal carcinoma (C11)	121	51% (47-55)	62 (57-67)	62 (57-67)	-
Hodgkin's lymphoma (C81)	211	96.7%	204	149	55
Burkitt's lymphoma (C83.7)	424	36% (32-39)	153 (136-165)	91 (81-99)	61 (54-66)
Human herpesvirus type 8					
Kaposi's sarcoma (C46)	51	20%	10	7	3
Human T-cell lymphotropic virus type 1					
Adult T-cell leukemia/lymphoma (C91.5)	137	100%	137	76	61
Human T-cell lymphotropic virus type 1					
Adult T-cell leukemia/lymphoma (C91.5)	7	100%	7	3	4

* 95% CIs were not available in literature for all the population attributable fractions considered; § Estimates for the two sexes may not add up to total estimated number of each cancer type; ICD-10, 10th International Classification of Diseases code; PAF, population attributable fraction; 95% CI, 95% confidence interval.

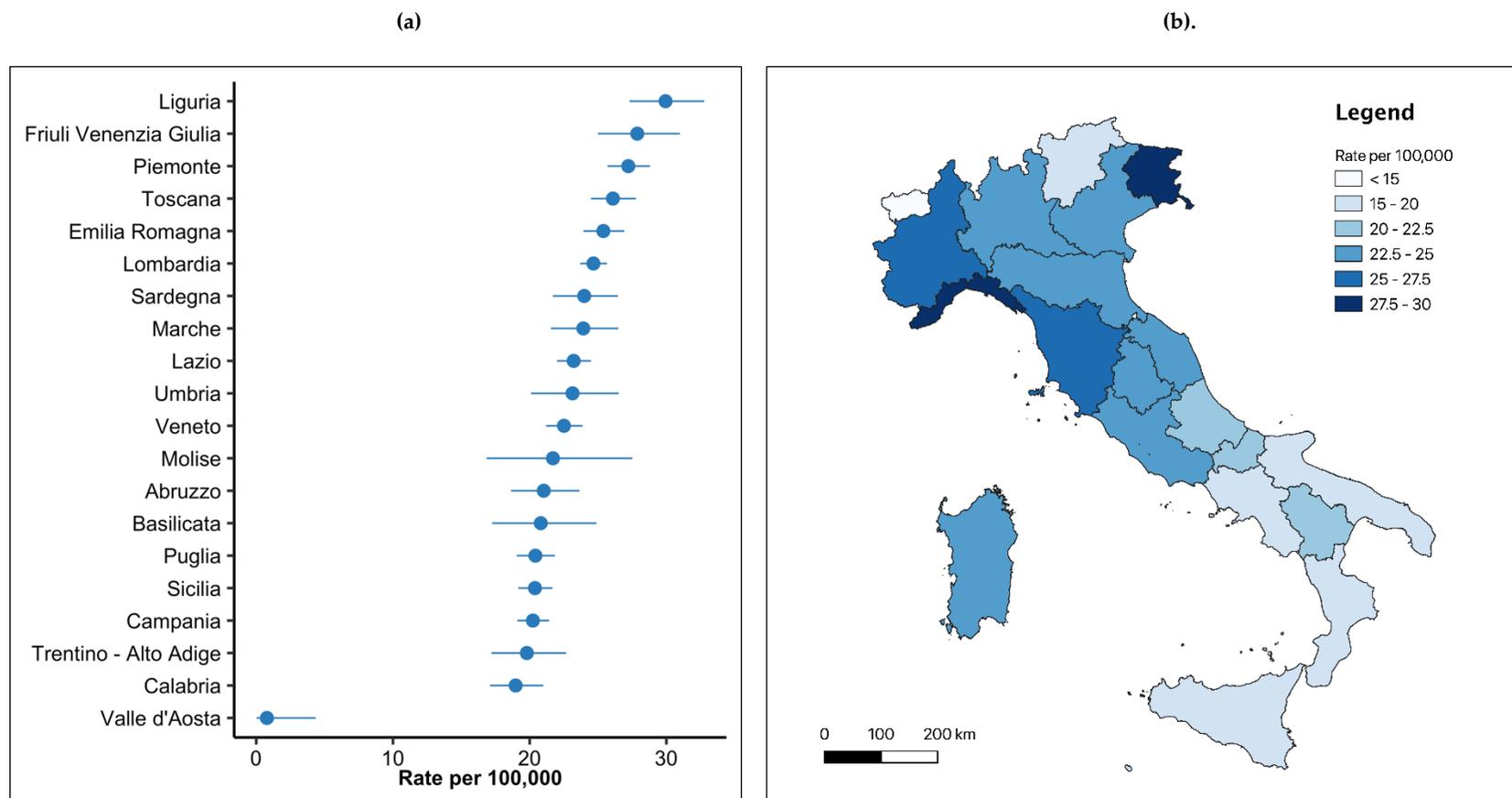


Figure 2. Regional estimates of cancer deaths due to carcinogenic infections *per* 100,000 inhabitants, Italy, 2015. (a) Death rates (dots) and 95% confidence intervals (lines); (b) Geographical distribution of death rates.

4. Discussion

To the best of our knowledge, this research is the first that assessed the burden, trend and regional distribution of cancer mortality attributable to carcinogenic infections in Italy. Overall, we estimated that more than the eight percent – one out of twelve – cancer deaths was attributable to an infection sustained by microorganisms classified as group 1 carcinogenic agents in human beings by IARC. Three cancer types, i.e. gastric, liver, and cervical cancers, represented the most frequent diagnoses, attributable to four infectious agents, namely *H. pylori*, HCV, HPV, and HBV. These results are noticeably lower than the proportion of cancer cases attributable to infections according to the last global estimates, assessed at 13% of all cancer cases [2]. However, they mirror the findings of a nation-wide study conducted in Spain in 2018, which similarly analyzed the impact of infections on cancer mortality [4].

It should be remarked that most of these carcinogenic agents are risk factors that can be modified through prevention measures and successful treatments, thereby avoiding a consistent number of incident cancers and deaths [2,4,6,9].

Our estimates revealed that 57.0% of all cancer deaths attributable to carcinogenic infections were related to gastric cancers attributable to *H. pylori*, which is responsible for a number of gastric diseases, including chronic inflammation and ulcers [18]. Yet, screen-and-treat strategies for *H. pylori* represent a valuable and cost-effective tool for the prevention of gastric cancer at a population level [18,19]. In Italy, local surveys estimated a 56.5% prevalence of *H. pylori* infection in the general population, and even though a regional declining has been registered, the growing antibiotic resistances are posing an important challenge for its eradication [18,20,21].

Almost one-third of the cancer mortality burden attributable to carcinogenic infections was due to HCV. A recently published survey modeled prevalence data of HCV-positive patients in the country, resulting in 443,491 cured and HCV-positive living patients and 240,043 ill patients who have yet to be treated as of 2015, with 0.18 new cases of HCV *per* 100,000 inhabitants [22]. Moreover, the analysis of ITA.LI.CA (Italian Liver Cancer) register documented a 4% drop per quinquennium of HCV-related hepatocellular carcinoma (HCC) from 2000 to 2014 [10]. The recent introduction of direct-acting antivirals favorably contributed to HCV infection eradication, with valuable evidence of lower rate of HCC development in patients who achieved sustained virologic response at 12 weeks post-treatment [23]. In this frame, it is worth highlighting that access to hepatitis C treatment was expressly recommended by the WHO Thirteenth General Programme of Work (GPW13) as an indicator of country-based universal health coverage (UHC) [24].

Other 560 liver cancer deaths were attributed to HBV infection. The ITA.LI.CA register estimated a decreasing prevalence of HBV infections over the last decade. The epidemiology of acute viral HBV hepatitis in Italy changed alongside the implementation of universal HBV vaccination in 1991, mandatory for all infants and for 12-year-olds [25]. The highly effective drugs for the suppression of HBV are further contributing to reduce the cases of HBV-related liver cancers [4].

To the high-risk HPV types could be attributed more than 1,000 cancer-deaths yearly. As known, this risk factor may be modified by prevention measures, such as vaccination and screening programs for cervical cancer. The former has proven to have protective benefits and to reduce cervical cancer incidence and mortality [26]. The HPV vaccination – together with cervical cancer treatment – is another index of effective UHC according to GPW13 [24], being a valuable and effective tool for the reduction of HPV infections and anogenital warts at population level, also protecting against cervical precancer lesions [27]. In Italy, HPV vaccine was firstly recommended to all young girls aged 11 years in 2008 and then extended to boys in the twelfth year of life, men who have sex with men, and immunocompromised subjects in 2017 [28]. Longer follow-up periods are needed to show the potential effect of HPV vaccination on cancers associated with the pathogen.

We estimated that a total of 204 deaths were due to nasopharyngeal carcinoma, based on the PAF for EBV. In Italy, a hospital-based study of 150 histologically-confirmed cases found a high prevalence of EBV nuclear antigen in undifferentiated nasopharyngeal carcinoma for which EBV status was known [29].

Kaposi's sarcoma associated with HHV-8 follows the epidemiology of this herpesvirus. It is the most frequent cancer in HIV-seropositive individuals, especially those untreated [30]. Furthermore, in Italy, Kaposi's sarcoma is highly prevalent in areas where HHV-8 is widespread, such as southern regions and Sardinia island (especially in the province of Sassari), suggesting possible predisposing conditions in populations leaving in those areas and a lifelong latency of HHV-8 of infection acquired during childhood, as with other herpesviruses [31-32].

HTLV-I infection in Italy appears to be rare and essentially found in migrants from endemic areas and in their sexual partners [33]. The low prevalence explains the scarce estimated number of deaths due to adult T-cell leukemia/lymphoma attributable to HTLV-I. Nevertheless, since one tenth of the Italian population is constituted by migrants and refugees, potential screening interventions might be performed in case of blood testing or donation, likewise to those performed for HBV and HCV infections, in order to limit virus circulation [33].

Observing the regional distribution of the rate of cancer mortality attributable to carcinogenic infections, we found interesting disparities from north to south. One main source of these differences might be regional patterns in cancer incidence [5,7,14]. For instance, it has been recognized that gastric cancer – the major contributor to the investigated mortality burden – had higher incidence and mortality in northern Italy than in other areas of the country, probably for a multifactorial nature (i.e., dietary pattern, *H. pylori*, alcohol and smoking habits, etc.) [34]. Again, the viral hepatitis surveillance system of the Italian National Institute of Health registers more incident cases of HCV infections in northern than in southern regions [35]. Similar patterns could likely influence the epidemiology and course of carcinogenic infections in the Italy. Regional differences on cancer mortality warrant further study, also taking into account the age distribution of the population (i.e., proportion of elders), the access to and compliance towards prevention strategies, and other possible local factors that could have a synergistic effect on mortality in combination with infections, such as metabolic, dietary or behavioral risk factors.

Briefly, by combining global, regional, and national PAFs for *H. pylori*, HBV, HCV, high-risk HPV types, EBV, HHV-8, HTLV-1 with death statistics, we could estimate the burden of cancer mortality attributable to carcinogenic infections in Italy. One out of 12 cancer deaths was potentially caused by a carcinogenic agent: this class of risk factors may be preventable or treatable, and a great proportion of these deaths could be avoided with specific public health measures. Yet, it should be stressed the importance of focusing on the implementation of further preventive and treatment strategies – particularly including vaccination and the promotion of healthy sexual behaviors to prevent sexually transmitted diseases – in order to reduce this mortality burden. Moreover, since many of the infections sustained by HTLV-1, HCV, and HBV occur in immigrants, they constitute one of the target population that calls for specific strategies for addressing this challenge [33,36].

The reduction of these infections concerns not only the possibility of avoiding a significant number of deaths, but their whole impact on health and health systems, adverting disease cases and direct and social costs associated to cancer. Therefore, our findings might help primary care professionals and policy makers providing actionable metrics to adjust national and regional health care policies and enhance community health promotion for cancer prevention, screening and care [37,38].

Some limitations of our research must be acknowledged. First, data were gathered in an aggregated form from publicly accessible databases, and this prevents from evaluating and adjusting for potential predictors of death, such as disease history and course, tumor lethality, and survival rate. Second, the nature of data source did not allow to appreciate and address possible biases due to missing or error in recording, as well as uncertainty sources. Third, IARC group-1 of carcinogenic agents to humans include three more infectious pathogens – namely the parasites *Schistosoma haematobium* (associated with bladder cancer) and *Opisthorchis viverrine* and *Clonorchis sinensis* (associated both with cholangiocarcinoma); however, cancers attributable to these infections are predominantly seen in those geographical areas where the parasites have an endemic distribution, without cases seen in Italy [8,39-41].

5. Conclusions

In Italy, one-twelfth of cancer deaths are potentially attributable to infections due to carcinogenic agents. Many of these risk factors are both preventable and treatable through existing interventions. Data from this study may help clinicians, public health specialists, and policy makers to enhance initiatives to reduce the impact of these infections, the related mortality burden and the associated healthcare costs.

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