

The Influence of Being Physically Near to a Cell Phone Transmission Mast on the Incidence of Cancer

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Published in *Umwelt-Medizin-Gesellschaft* 17,4 2004, as:
'Einfluss der räumlichen Nähe von Mobilfunksendeanlagen auf die Krebsinzidenz'

Summary

Following the call by Wolfram König, President of the Bundesamt für Strahlenschutz (Federal Agency for radiation protection), to all doctors of medicine to collaborate actively in the assessment of the risk posed by cellular radiation, the aim of our study was to examine whether people living close to cellular transmitter antennas were exposed to a heightened risk of taking ill with malignant tumors.

The basis of the data used for the survey were PC files of the case histories of patients between the years 1994 and 2004. While adhering to data protection, the personal data of almost 1,000 patients were evaluated for this study, which was completed without any external financial support. It is intended to continue the project in the form of a register.

The result of the study shows that the proportion of newly developing cancer cases was significantly higher among those patients who had lived during the past ten years at a distance of up to 400 metres from the cellular transmitter site, which has been in operation since 1993, compared to those patients living further away, and that the patients fell ill on average 8 years earlier.

In the years 1999-2004, *ie* after five years' operation of the transmitting installation, the relative risk of getting cancer had trebled for the residents of the area in the proximity of the installation compared to the inhabitants of Naila outside the area.

Key words: cellular radiation, cellular transmitter antennas, malignant tumours

The rapid increase in the use of mobile telephony in the last few years has led to an increasing number of cell phone transmission masts being positioned in or near to residential areas. With this in mind, the president of the German governmental department for protection against electromagnetic radiation (Bundesamtes für Strahlenschutz) Wolfram König, has challenged all doctors to actively help in the work to estimate the risks from such cell phone masts. The goal of this investigation was therefore to prove whether or not people living near to cell phone masts have a higher risk of developing cancerous tumours.

The basic data was taken from the medical records held by the local medical authority (Krankenkasse) for the years 1994 to 2004. This material is stored on computer. In this voluntary study the records of roughly 1,000 patients from Naila (Oberfranken) were used, respecting the associated data protection laws. The results from this study show a significantly increased likelihood of developing cancer for the patients that have lived within 400 metres of the cell phone transmission mast (active since 1993) over the last ten years, in comparison to those patients that live further away. In addition, the patients that live within 400 metres tend to develop the cancers at a younger age. For the years 1999 to 2004 (*ie* after

five or more years of living with the cell phone transmission mast), the risk of developing cancer for those living within 400 metres of the mast in comparison to those living outside this area, was three times as high.

Introduction

A series of studies available before this investigation provided strong evidence of health risks and increased cancer risk associated with physical proximity to radio transmission masts. Haider *et al.* reported in 1993 in the Moosbrunn study frequent psychovegetative symptoms below the current safety limit for electromagnetic waves (1). In 1995, Abelin *et al.* in the Swiss- Schwarzenburg study found dose dependent sleep problems (5:1) and depression (4:1) at a shortwave transmitter station that has been in operation since 1939 (2).

In many studies an increased risk of developing leukaemia has been found; in children near transmitter antennas for Radio and Television in Hawaii (3); increased cancer cases and general mortality in the area of Radio and Television transmitter antennas in Australia (4); and in England, 9 times more leukaemia cases were diagnosed in people who live in a nearby

area to the Sutton Coldfield transmitter antennas (5). In a second study, concentrating on 20 transmitter antennas in England, a significant increased leukaemia risk was found (6). The Cherry study (7) indicates an association between an increase in cancer and living in proximity to a transmitter station. According to a study of the transmitter station of Radio Vatican, there were 2.2 times more leukaemia cases in children within a radius of 6 km, and adult mortality from leukaemia also increased (8).

In 1997 Goldsmith published the Lilienfeld-study that indicated 4 times more cancer cases in the staff of the American Embassy in Moscow following microwave radiation during the cold war. The dose was low and below the German limit (9).

The three studies of symptoms indicated a significant correlation between illness and physical proximity to radio transmission masts. A study by Santini *et al.* in France resulted in an association between irritability, depression, dizziness (within 100m) and tiredness within 300m of a cell phone transmitter station (10).

In Austria there was an association between field strength and cardiovascular symptoms (11) and in Spain a study indicates an association between radiation, headache, nausea, loss of appetite, unwellness, sleep disturbance, depression, lack of concentration and dizziness (12).

The human body physically absorbs microwaves. This leads to rotation of dipole molecules and to inversion transitions (13), causing a warming effect. The fact that the human body transmits microwave radiation at a very low intensity means that since every transmitter represents a receiver and transmitter at the same time, we know the human body also acts as a receiver.

In Germany, the maximum safe limit for high frequency microwave radiation is based on purely thermal effects. These limits are one thousand billion times higher than the natural radiation in these frequencies that reaches us from the sun.

The following study examines whether there is also an increased cancer risk close to cellular transmitter antennas in the frequency range 900 to 1800 MHz. Prior to this study there were no published results for long-term exposure (10 years) for this frequency range and its associated effects to be revealed. So far, no follow-up monitoring of the state of health of such a residential population has been systematically undertaken.

Materials and Methods

Study area

In June 1993, cellular transmitter antennas were permitted by the Federal Postal Administration in the Southern German city of Naila and became operational in September 1993.

The GSM transmitter antenna has a power of 15 dBW per channel in the 935MHz frequency range. The total



Fig. 1: Schematic plan of the antenna sites

transmission time for the study period is ca. 90,000 hours. In December 1997 there followed an additional installation from another company. The details are found in an unpublished report, appendix page 1-3 (14).

To compare results an 'inner' and 'outer' area were defined. The inner area covered the land that was within a distance of 400 metres from the cellular transmitter site. The outer area covered the land beyond 400 metres. The average distance of roads surveyed in the inner area (nearer than 400m) was 266m and in the outer area (further than 400m) 1,026m. Fig. 1 shows the position of the cellular transmitter sites (560m) are the highest point of the landscape, which falls away to 525m at a distance of 450m. From the height and tilt angle of the transmitter it is possible to calculate the distance where the transmitter's beam of greatest intensity strikes the ground (see Fig. 2).

The highest radiation values are in areas of the main

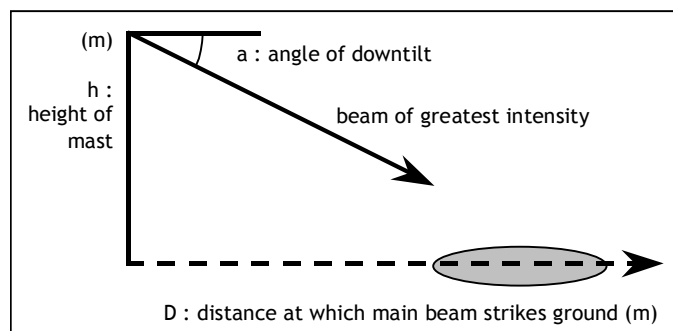


Fig. 2: From the mast height h and the downtilt angle a , the distance D at which the main beam reaches ground is given by $D = \tan(90-a) \times h$

beam where it hits the ground and from the expected associated local reflection; from this point the intensity of radiation falls off with the square of the distance from the transmitter.

In Naila the main beam hits the ground at 350m with a beam angle of 6 degrees (15). In the inner area, additional emissions are caused by the secondary lobes of the transmitter; this means in comparison that from purely mathematical calculations the outer area has significantly reduced radiation intensity.

The calculations from computer simulations and the measurements from the Bavaria agency for the environmental protection, both found that the intensity of radiation was a factor of 100 higher in the inner area as compared to the outer area. The measurements of all transmitter stations show that the intensity of radiation from the cell phone transmitter station in Naila in the inner area was higher than the other measurement shown in the previous studies of electromagnetic fields from radio, television or radar (14).

The study StSch 4314 from the ECOLOG Institute indicates an association between a vertical and horizontal distance from the transmitter station and expected radiation intensity on the local people (16). The reason for setting a distance of 400m for the differentiation point is partly due to physical considerations, and partly due to the study of Santini *et al.* who chose 300m (10).

Data Gathering

Similar residential streets in the inner area and outer areas were selected at random. The large old people's home in the inner area was excluded from the study because of the age of the inhabitants. Data gathering covered nearly 90% of the local residents, because all four GPs in Naila took part in this study over 10 years. Every team researched the names of the patients from the selected streets that had been ill with tumours since 1994. The condition was that all patients had been living during the entire observation time of 10 years at the same address.

The data from patients was handled according to data protection in an anonymous way. The data was evaluated for gender, age, tumour type and start of illness. All cases in the study were based on concrete results from tissue analysis. The selection of patents for the study was always done in exactly the same way. Self-selection was not allowed. Also the subjective opinion of patients that the radio mast detrimentally affected their health has not affected this study. Since patients with cancer do not keep this secret from GPs, it was possible to gain a complete data set.

Population study

In the areas where data was collected 1,045 residents were registered in 31.12.2003. The registration statistics for Naila at the beginning of the study (1.1.1994) show the number of old people in the inner and outer areas, as shown in Table 1. The average age at the beginning

	female	male	total
Inner area	41.48	38.70	40.21
Outer area	41.93	38.12	40.20
Naila total	43.55	39.13	41.45

Table 1 : Overview of average ages at the beginning of the study in 1994

1994	inner 22.4%	outer 2.8%	Naila total 24.8%
2004	inner 26.3%	outer 26.7%	

Table 2 : Proportion of patients aged over 60

of the study (1.1.1994) in both the inner and outer areas was 40.2 years. In the study period between 1994-2004, 34 new cases of cancer were documented out of 967 patients (Table 3). The study covered nearly 90% of local residents.

The average age of the residents in Naila is one year more than that of the study due to the effects of the old people's home. From the 9,472 residents who are registered in Naila, 4,979 (52.6%) are women and 4,493 (47.4%) are men. According to the register office, in 1.1.1994 in the outer area, the percentage was 45.4% male and 54.5% female, and in the inner area 45.3% male and 54.6% female. The number of people who are over 60 years old is shown in Table 2.

The social differences in Naila are small. Big social differences like in the USA do not exist here. There is also no ethnic diversity. In 1994 in Naila the percentage of foreigners was 4%. Naila has no heavy industry, and in the inner area there are neither high voltage cable nor electric trains.

Results

Results are first shown for the entire 10 year period from 1994 until 2004. Secondly, the last five-year period 1999 to 2004 is considered separately.

Period 1994 to 2004

As a null hypothesis it was checked to see if the physical distance from the mobile transmission mast had no effect on the number cancer cases in the selected population, *ie* that for both the group nearer than 400 metres and the group further than 400 metres the chance of developing cancer was the same. The relative frequencies of cancer in the form of a matrix are shown in Table 3. The statistical test method used on this data was the chi-squared test with Yates's correction. Using this method we obtained the value of 6.27, which is over the critical value of 3.84 for a

Period 1994-2004	Inner area	Outer area	total
new cases of cancers	18	16	34
with no new cancer	302	631	933
total	320	647	967

Table 3 : numbers of patients with and without cancers, 1994-2004

statistical significance of 0.05).

This means the null hypothesis that both groups within the 400-metre radius of the mast and beyond the 400 metre radius, have the same chance of developing cancer, can be rejected with a 95% level of confidence. With a statistical significance of 0.05, an even more significant difference was observed in the rate of new cancer cases between the two groups.

Calculating over the entire study period of 1994 until 2004, based on the incidence matrix (Table 3) we arrive at a relative risk factor of 2.27 (quotient of proportion for each group, eg 18/320 in the strongly exposed inner area, against 16/647 in the lower exposed comparison group). If expressed as an odds ratio, the relationship of the chance of getting cancer between strongly exposed and the less exposed is 2.35.

The following results show clearly that inhabitants who live close to transmitter antennas compared to inhabitants who live outside the 400m zone, double their risk of developing cancer. In addition, the average age of developing cancer was 64.1 years in the inner area whereas in the outer area the average age was 72.6 years, a difference of 8.5 years. That means during the 10 year study that in the inner area (within 400 metres of the radio mast) tumours appear at a younger age.

In Germany the average age of developing cancer is approximately 66.5 years, among men it is approximately 66 and among women, 67 (18).

Over the years of the study the time trend for new cancer cases shows a high annual constant value (Table 4). It should be noted that the number of people in the inner area is only half that of the outer area, and therefore the absolute numbers of cases is smaller.

Table 7 shows the types of tumour that have developed in the cases of the inner area.

Period 1994 to 1999

No. of cases of tumours per year of study	inner area: of the 320 people		outer area: of the 647 people	
	total cases	per 1,000	total cases	per 1,000
1994	—	—	I	1.5
1995	—	—	—	—
1996	II	6.3	I	1.5
1997	I	3.1	III	4.6
1998	II	6.3	III	4.6
1999	II	6.3	I	1.5
2000	IIII	15.6	I	1.5
2001	II	6.3	II	3.1
2002	II	6.3	II	3.1
2003-3/2004	II	6.3	II	3.1

Table 4 : Summary of the total tumours occurring per year (no. and per thousand)

Period 1994-1999	Inner area	Outer area	total
new cases of cancers	5	8	13
with no new cancer	315	639	954
total	320	647	967

Table 5 : numbers of patients with and without cancers, 1994-1999

For the first five years of the radio transmission mast operation (1994-1998) there was no significant increased risk of getting cancer within the inner area as compared to the outer area (Table 5).

Period 1999 to 2004

Under the biologically plausible assumption that cancer caused by detrimental external factors will require a time of several years before it will be diagnosed, we now concentrate on the last five years of the study between 1999 and 2004. At the start of this period the transmitter had been in operation for 5 years. The results for this period are shown in Table 6. The chi-squared test result for this data (with Yates's correction) is 6.77 and is over the critical value of 6.67 (statistical significance 0.01). This means, with 99% level of confidence, that there is a statistically proven difference between development of cancer between the inner group and outer group. The relative risk of 3.29 revealed that there was 3 times more risk of developing cancer in the inner area than the outer area during this time period.

Period 1999-2004	Inner area	Outer area	total
new cases of cancers	13	8	31
with no new cancer	307	639	946
total	320	647	967

Table 6 : numbers of patients with and without cancers, 1999-2004

The odds-ratio 3.38 (VI 95% 1.39-8.25, 99% 1.05-10.91) allows us with 99% confidence to say that the difference observed here is not due to some random statistical effect.

Discussion

Exactly the same system was used to gather data in the inner area and outer areas. The medical chip card, which has been in use for 10 years, enables the data to be processed easily. The four participating GPs examined the illness of 90% of Naila's inhabitants over the last 10 years. The basic data for this study were based on direct examination results of patients extracted from the medical chip cards, which record also the diagnosis and treatment. The study population is (in regards to age, sex and cancer risk) comparable, and therefore statistically neutral. The study deals only with people who have been living permanently at the same address for the entire study period and therefore

Type of tumour (organ)	no. of tumours found	total expected	incidence per 100,000	ratio inner: outer
breast	8	5.6	112	5:3
ovary	1	1.1	23	0:1
prostate	5	4.6	101	2:3
pancreas	m 3	0.6	14	2:1
	f 2	0.9	18	1:1
bowel	m 4	3.7	81	2:2
	f 0	4.0	81	0:0
skin melanoma	m 1	0.6	13	1:0
	f 0	0.7	14	0:0
lung	m 3	3.6	79	2:1
	f 0	1.2	24	0:0
kidney	m 2	1.0	22	1:1
	f 1	0.7	15	1:0
stomach	m 1	1.2	27	0:1
	f 1	1.1	23	0:1
bladder	m 1	2.0	44	0:1
	f 0	0.8	16	0:0
blood	m 0	0.6	14	0:0
	f 1	0.7	15	1:0

Table 7 : Summary of tumours occurring in Naila, compared with incidence expected from the Saarland cancer register

have the same duration of exposure regardless of whether they are in the inner area or outer area.

The result of the study shows that the proportion of newly developing cancer cases was significantly higher ($p < 0.05$) among those patients who had lived during the past ten years within a distance of 400 metres from the cellular transmitter site, which has been in operation since 1993, in comparison to people who live further away. Compared to those patients living further away, the patients developed cancer on average 8.5 years earlier. This means the doubled risk of cancer in the inner area cannot be explained by an average age difference between the two groups. That the transmitter has the effect that speeds up the clinical manifestations of the illness and general development of the cancer cannot be ruled out.

In the years 1999-2004, *ie* after five years and more of transmitter operation, the relative risk of getting cancer had trebled for the residents of the area in the proximity of the mast compared to the inhabitants of Naila in the outer area ($p > 0.01$). The division into inner area and outer area groups was clearly defined at the beginning of the study by the distance to the cell phone transmission mast. According to physical considerations people living close to cellular transmitter antennas were exposed to heightened transmitted radiation intensity.

Both calculated and empirical measurements revealed that the intensity of radiation is 100 times higher in the inner area compared to the outer area. According to the research StSch 4314 the horizontal and vertical position in regards to the transmitter antenna is the most important criterion in defining the radiation intensity area on inhabitants (16).

The layered epidemiological assessment method used in this study is also used in assessment of possible chemical environmental effects. In this case the layering is performed in regards to the distance from the cell phone transmitter station. Using this method it has been shown that there is a significant difference in probability of developing new cancers depending on the exposure intensity.

The number of patients examined was high enough according to statistical rules that the effects of other factors (such as use of DECT phones) should be normalised across the inner area and outer area groups. From experience the disruption caused by a statistical confounding factor is in the range between 20% and 30%. Such a factor could therefore in no way explain the 300% increase in new cancer cases. If structural factors such as smoking or excessive alcohol consumption are unevenly distributed between the different groups this should be visible from the specific type of cancers to have developed (*ie* lung, pharyngeal or oesophageal). In the study inner area there were two lung cancers (one smoker, one non-smoker), and one in the outer area (a smoker), but no oesophageal cancers. This rate of lung cancer is twice what is statistically to be expected and cannot be explained by a confounding factor alone. None of the patients who developed cancer was from a family with such a genetic propensity.

Through the many years experience of the GPs involved in this study, the social structures in Naila are well known. Through this experience we can say there was no significant social difference in the examined groups that might explain the increased risk of cancer.

The type and number of the diagnosed cancers are shown in Table 7. In the inner area the number of cancers associated with blood formation and tumour-controlling endocrine systems (pancreas), were more frequent than in the outer area (77% inner area and 69% outer area).

From Table 7, the relative risk of getting breast cancer is significantly increased to 3.4. The average age of patients that developed breast cancer in the inner area was 50.8 years. In comparison, in the outer area the average age was 69.9 years, approximately 20 years less. In Germany the average age for developing breast cancer is about 63 years. The incidence of breast cancer has increased from 80 per 100,000 in the year 1970 to 112 per 100,000 in the year 2000. A possible question for future research is whether breast cancer can be used as a 'marker cancer' for areas where there is high contamination from electromagnetic radiation. The report of Tynes *et al.* described an increased risk of breast cancer in Norwegian female radio and telegraph operators (20).

To further validate the results the data gathered were compared with the Saarland cancer register (21). In this register all newly developed cancers cases since 1970 are recorded for each Bundesland. These data are accessible via the Internet. Patients that suffer two separate tumours were registered twice, which increases the overall incidence up to 10%. In this

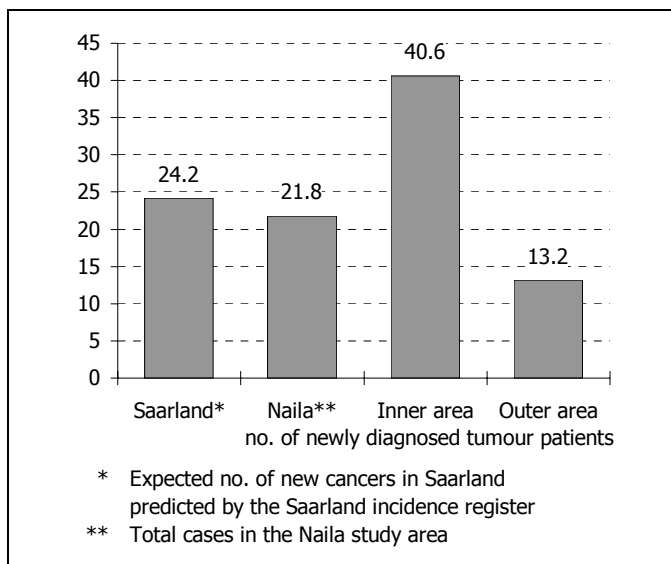


Fig. 3 : Number of new cancer cases 1999 to 2004, adjusted for age and gender, calculated for the 5,000 patient years

register there is no location-specific information, for instance proximity to cell phone transmission masts. The data in the cancer register therefore reflect no real control group but rather the effect of the average radiation on the total population.

From the Saarland cancer register for the year 2000 the incidence of new cancer cases was 498 per 100,000 for men and 462 per 100,000 for women. When adjusted for age and sex one would expect a rate of between 480 and 500 per 100,000 in Naila. For the years 1999 to 2004 there were 21 new cases of cancer among 967 patients. The expected number was 24 cases per 1,000 patients.

The results of the study are shown graphically in Fig. 3. The bars of the chart represent the number of new cancer cases per 1,000 patients in the separate areas, over the five years (bars 2 to 4). The first bar represents the expected number from the Saarland cancer register.

In spite of a possible underestimation, the number of newly developed cancer cases in the inner area is more than the expected number taken from the cancer register, which represents the total population being irradiated. The group who had lived during the past five years within a distance of 400 m from the cellular transmitter have a two times higher risk of developing cancer than that of the average population. The relative risk of getting cancer in the inner area compared with the Saarland cancer register is 1.7 (see to Table 7).

Conclusion

The result of this retrospective study in Naila shows that the risk of newly developing cancer was three times higher among those patients who had lived during past ten years (1994-2004), within a distance of 400m from the cellular transmitter, in comparison to those who had lived further away.

Cross-sectional studies can be used to provide the decisive empirical information to identify real problems. In the 1960s just three observations of birth deformities were enough to uncover what is today an academically indisputable Thalidomide problem.

This study, which was completed without any external financial support is a pilot project. Measurements of individual exposure as well as the focused search for further side effects would provide a useful extension to this work, however such research would need the appropriate financial support.

The concept of this study is simple and can be used everywhere, where there it a long-term electromagnetic radiation from a transmitting station.

The results presented are a first concrete epidemiological sign of a temporal and spatial connection between exposure to GSM base station radiation and cancer disease.

These results are, according to the literature relating to high frequency electromagnetic fields, not only plausible and possible, but also likely.

From both an ethical and legal standpoint it is necessary to immediately start to monitor the health of the residents living in areas of high radio frequency emissions from mobile telephone base stations with epidemiological studies. This is necessary because this study has shown that it is no longer safely possible to assume that there is no causal link between radio frequency transmissions and increased cancer rates.

Acknowledgements

Our thanks go to all those involved in developing this study, in particular, Herrn Professor Frentzel-Beyme for his advice on all the epidemiological questions.

(Received 14.09.2004; Accepted 08.10.2004)

Footnotes

(1) HAIDER, M., KUNDI, M., KNASMÜLLER, S., HAIDER, T., GROLL KNAPP, E. & G. OBERMEIER (1993): Medizinisch-hygienische Untersuchungen und Beurteilungen der Kurzwellensendeanlage Moosbrunn, Institut für Umwelthygiene, Universität Wien.

(2) ABELIN, T., ALTPETER, E.S., PFLUGER, D.H., KREBS, T., KÄNEL, J.V., STÄRK, K. & C. GRIOT (1995): Gesundheitliche Auswirkungen des Kurzwellensenders Schwarzenburg, BEW Schriftenreihe Studie Nr. 56 (BEW: Bundesamt für Energiewirtschaft).

(3) MASKARINEC, G., COOPER, J. & L. SWYGERT (1994): Investigation of increased incidence in childhood leukemia near radio towers in Hawaii: Preliminary observations, J. Environ. Pathol. Toxicol. and Oncol. 13: 33-37.

(4) HOCKING, B., GORDON, IR., GRAIN HL. et al. (1996): Cancer Incidence and Mortality and Proximity to TV-Towers. Med. J. Australia 165, 11-12: 601-605.

- (5) DOLK, H., SHADDICK, G., WALLS, P., GRUNDY, C., THAKRAR, B., KLEINSCHMIDT, I. & P. ELLIOT (1997a): Cancer Incidence Near Radio and Television Transmitters in Great Britain, Part 1. Sutton Coldfield Transmitter, Am. J. Epidemiol. 145: 1-9.
- (6) DOLK, H., ELLIOT, G., SHADDICK, G., WALLS, P. & B. THAKRAR (1997b): Cancer Incidence Near Radio and Television Transmitters in Great Britain, Part 2. All High Tower Transmitters, Am. J. Epidemiol. 145: 10-17.
- (7) CHERRY, N. (1999): Criticism of the proposal to adopt the ICNIRP guidelines for cellsites in New Zealand, ICNIRP Guideline Critique, Lincoln University, Environmental Management and Design Division, Canterbury, NZ.
- (8) MICHELOZZI, P., CAPON, A., KIRCHMAYER, U., FORASTIERE, F., BIGGERI, A., BARCA, A. & C.A. PERUCCI (2001): Department of Epidemiology. Local Health Authority RME Rom, Italy.
- (9) GOLDSMITH, JR. (1997): European EpiMarker 2(4): 4-7; Lilienfeld 1978 Final report US Dept. of State, NTIS PB-288163, 1978.
- (10) SANTINI, R., SANTINI, P., DANZE, J. M., LE RUZ, P. & SEIGNE, M. (2002): Symptoms experienced by people living in vicinity of cell phone base stations: I. Incidences of distance and sex, Pathol. Biol. 50: 369-373.
- (11) KUNDI, M. (2002): Erste Ergebnisse der Studie über Auswirkungen von Mobilfunk-Basisstationen auf Gesundheit und Wohlbefinden. Bericht des Instituts für Umwelthygiene der Universität Wien.
- (12) NAVARRO EA., SEGURA J., PORTOLES M., GOMEZ-PERRETTA de MATEO C. (2003): Das Mikrowellensyndrom: Eine vorläufige Studie in Spanien. Electromagnetic Biology and Medicine (früher: Electro- and Magnetobiology) 22(2): 161-169, www.grn.es/electropolucio/TheMicrowaveSyndrome.doc.
- (13) BROCKHAUS (1973): abc Physik, VEB F.A. Brockhaus Verlag, Leipzig: 991 ff.
- (14) EGER, H., HAGEN, K.U., LUCAS, B., VOGEL, P. & H. VOIT (2004): Einfluss der räumlichen Nähe von Mobilfunk-sendeanlagen auf die Krebsinzidenz, Tabellarischer Teil, unveröffentlicht, Naila
- (15) Regulierungsbehörde für Post und Telekom (oJ): Standortbescheinigungen,
- (16) ECOLOG-INSTITUT (2003): Bestimmung der Exposition von Personengruppen, die im Rahmen des Projektes "Querschnittsstudie zur Erfassung und Bewertung möglicher gesundheitlicher Beeinträchtigungen durch die Felder von Mobilfunkbasisstationen" untersucht werden, Berichtszeitraum: 1.2.2003 bis 31.5.2003, Förderkennzeichen: StSch 4314, ECOLOG-Institut für sozial-ökologische Forschung und Bildung gGmbH, Hannover.
- (17) KLEINBAUM, D.G., KLEIN, M. (2002): Logistic Regression - A. Self - learning text, Springer Verlag
- (18) AG BEVÖLKERUNGSBEZOGENER KREBSREGISTER IN DEUTSCHLAND (Hrsg.) (2004): Krebs in Deutschland, 4. überarb., akt. Ausgabe, Arbeitsgemeinschaft bevölkerungsbezogener Krebsregister in Deutschland in Zusammenarbeit mit dem Robert Koch-Institut, Saarbrücken.
- (19) LEGATOR, M.S. & B. STRAWN (1998): Umwelt-Risiko: Chemie, Haug-Verlag.
- (20) TYNES, I., HANNEVIK, M., ANDERSEN, A., VISTNES, AI. & HALDORSEN T. (1996): Incidence of breast cancer in Norwegian female radio and telegraph operators. Cancer Causes Control 7: 197-204.
- (21) www.krebsregister.saarland.de

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