
In this Journal, Evens et al. provide the first report of Hodgkin lymphoma (HL) incidence in US Hispanics and Asians/Pacific Islanders (A/PIs) by nativity using National Cancer Institute SEER data [1]. Racial/ethnic variation in HL incidence is well described, but the underlying contributions of socioeconomic and genetic influences remain unclear [2]. Thus, a large migrant study similar to that of Evens et al. could productively inform this important aspect of HL etiology.

Unfortunately, the nativity findings in this paper could be misleading. (i) Birthplace information is missing for a substantial proportion of SEER cases—in this study, one-third of Hispanics and A/PIs (Table 4 [1]). We previously showed that SEER Hispanic and A/PI cases without registry birthplace data are younger, better educated, and more likely to be US-born than cases with recorded birthplace; and that rates may be biased by excluding cases with missing birthplace, or assigning them as US- or foreign-born using a simple proportional distribution of cases [3, 4]. As HL incidence is elevated for young persons, particularly in higher economic settings [2], either of these methodologic strategies for addressing missing birthplace will lead to rate underestimation, particularly for the US-born, and thus attenuate differences in rates by nativity. (ii) As annual population estimates by nativity are not easily available, the authors’ effort to derive them is laudable. However, their use of population estimates for 2000 to calculate rates for 1992–2007 is problematic considering likely population changes of interest. (iii) Comparisons using crude relative frequencies are vulnerable to confounding by intergroup differences. Given the highly complex and interdependent variation in HL incidence by age, sex, race/ethnicity, and histologic subtype, demographic differences between US- and foreign-born populations may bias comparisons of HL cases for certain strata; thus, some nativity differences in Evens’ Table 4 [1] may reflect demographic, rather than disease, effects.

Further, there are flaws in the authors’ defense of their methodologic choices. They justify the use of incomplete nativity data by citing both our observations that nativity, where available, is accurate [3, 4], and the previous use of incomplete data. However, accuracy of recorded birthplace does not resolve rate biases due to non-random exclusion of cases from numerators. Nor does the use of compromised data by others justify the practice. Among papers cited as examples of this practice is ours on lymphoid malignancies in Asians [5]; in fact, nativity classifications in our paper did not exclude cases with missing birthplace but rather relied on a validated imputation methodology designed to reduce bias from missing data. Our work cited as support for linking SEER data to population estimates overlooks that paper’s main purpose, which was to illustrate application of statistical and demographic methods for more accurate estimation of cancer rates by nativity [3].

Finally, Evens et al. highlight the broader scope of their SEER-based study than of a previous statewide (California) analysis [6]. For Hispanics, California data may be more interpretable than SEER-wide data due to greater ethnic homogeneity of this state’s population (predominantly of Mexican origin).

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References

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