

Types of childhood cancer

The specific cancers covered in Section 8 are:

Leukaemia; liver cancer; medulloblastoma; meningioma; neuroblastoma; pituitary adenoma; primitive neuroectodermal tumours (PNETs); retinoblastoma; rhabdomyosarcoma (RMS); skin cancer; thyroid cancer

The specific cancers covered in Section 7 are:

Astrocytoma; astroglial tumour; bone cancer (including Ewing sarcoma); brain tumours; CNS tumours; ependymoma; germ cell tumours; gliomas; Hodgkin's disease; Non-Hodgkin's lymphoma; infant leukaemia; kidney tumour.

Leukaemia

General

Eden's summary of the aetiology of childhood leukaemia ([2010](#)) said *"For some leukaemias (e.g. infant MLL positive ALL) the first (genetic) event appears adequate to create a malignant clone but for the majority of ALL and AML further 'genetic' changes are required, probably postnatal. Many environmental factors have been proposed as causative for leukaemia but only ionising irradiation and certain chemicals have been confirmed and then principally for AML. It appears increasingly likely that delayed, dysregulated responses to 'common' infectious agents play a major part in the conversion of pre-leukaemic clones into overt precursor B cell ALL."* He continued *"There is little evidence to support any role of viral transformation in causation. Other environmental factors for which some evidence exists include non-ionising electromagnetic radiation and electric fields."* The recommendations were *"To date few clear preventative measures have emerged, except the complete avoidance of first trimester X-rays in pregnancy; a healthy diet with adequate oral folic acid intake both preconception and early in pregnancy; and the early exposure of children to other children outside the home to facilitate stimulation and maturation of the natural immune system."*

Rossig and Juergens' review ([2008](#)) acknowledged the necessity for the postnatal 'hits' described by Eden. They reported that the higher incidence of the most common leukaemia subtype in affluent societies, as well as the age peak between 2-5 years, suggest a contributory role of socioeconomic factors. An abnormal immune response during delayed exposure to common infections provides a plausible mechanism for malignant progression of preleukaemic clones in a subgroup of children. They concluded that a common cause for all types and subtypes of childhood leukaemia is highly unlikely. Mathonnet ([2003](#)) suggested an association between ALL susceptibility and a DNA repair problem, pointing to the effect of environmental exposure.

Ou ([2002](#)) found that the risk of pre-B-cell ALL increased with advanced paternal age, younger and advanced maternal age and high birth order, and T-cell ALL was associated with high birth weight and a history of induced abortion. The author concluded that *"the association of ALL with birth characteristics and maternal reproductive factors varies with the immunophenotype of the ALL."*

Murray ([2002](#)) found that the risk of ALL increased with high paternal age, and high birth weight, but decreased with previous miscarriage, more than 40 weeks gestation, and more crowded households, including those with 3 adults.

However, most studies have not looked at specific phenotypes, not always differentiating between ALL and AML (often because of the small numbers of children involved), and so it is difficult to gain a clear idea of what other factors may be important in the development of specific

leukaemia subtypes. Some genetic changes influence both susceptibility to ALL, and also other subtypes (Pastorczak [2011](#)).

The increase in incidence of childhood leukaemia during the 20th century suggests that changes in environmental factors, including lifestyle, are at least partly responsible. There is no single factor that is either 'necessary or sufficient' for the development of leukaemia. There are multiple pathways involved. Buffler's study ([2005](#)) estimated that the aetiology is unclear in 90% of the cases of childhood leukaemia. The authors believe that a wide range of factors, including environmental, sociological and lifestyle influences are implicated as well as genetic susceptibility.

75% of children with ALL have biologically and therapeutically relevant genetic abnormalities (Pui [1997](#)). The most consistent associations with childhood AML are parental exposures during gestation and child exposure prenatally and perinatally in the first 5 years of life (Severson [1993](#), van Duijn [1994](#), Robison & Ross 1995, Ross [1996](#), [1998](#), Shu [1996](#)). These associations probably reflect the extreme vulnerability of the foetus to leukaemogenic agents. Chang ([2011](#)) found that children with ALL may have a dysregulated immune function present at birth, as measured by the deficit of IL10.

Non-genetic causes of AML (smoking, ionising radiation and cancer chemotherapy) only explain about 20% of AML incidence, leaving 80% unexplained (Smith [2011](#)). So, although the stage for developing the illness is set in the womb, *something else is needed* for the disease to develop, the two (or more)-hit (or multi-factor) hypothesis. The risk of developing AML *increases* with increasing birth order. It may be also that more than one environmental factor has to happen at the same time, rather than sequentially (Anderson [2006](#)).

Parental

Most studies have observed an increased risk for childhood leukaemia with advanced maternal age (Schüz [1999](#), Reynolds [2002](#), Johnson [2009](#), Feller [2010](#)), advanced paternal age (Ou [2002](#)), or advanced parental age for leukaemia (Dockerty [2001](#)), especially under the age of 5 (Yip [2006](#)), although Ou ([2002](#)) reported a risk association in ALL with young maternal age.

There was an increased risk of AML in children with Down syndrome for parents who had tried for a year or more to become pregnant (Puumala [2007](#)). Hormone treatment for infertility (Schüz [1999](#)) or oral contraceptive use during the index pregnancy (Ou [2002](#)) was also found to increase the risk of acute leukaemia.

Paternal

Paternal abdominal X-ray (especially more than one) or intravenous pyelogram was associated with an increased risk of ALL if administered before the child was conceived. Maternal procedures did not seem to add to the risk (Bailey [2010b](#)).

Maternal

A maternal history of previous miscarriages is a frequently reported risk factor for development of ALL - and in some cases AML - in a subsequent child (Kaatsch [1996](#), Perrillat [2002](#), Dorak [2007](#) - especially boys, Hernández-Morales [2009](#)). Yeazel ([1995](#)) found that a previous history of foetal loss was associated with leukaemia diagnosed before the age of 4 and especially before the age of 2. One previous foetal loss increased the risk for ALL and AML by 5 times and 2 or more losses

increased the risk for ALL by 25 times and AML by 12 times. The authors concluded "*Childhood acute leukemia occurring at younger ages may be associated with an underlying genetic abnormality or chronic environmental exposure, which can be either lethal to the developing fetus or mutagenic and result in the development of acute leukemia.*" Ou (2002) found that an induced abortion prior to the index pregnancy increased the risk of a leukaemia diagnosis for children under 2.

Molar pregnancy has been associated with ALL, in the large UKCCS study though the numbers were small (Roman 2006).

Girls born to mothers with multiple sclerosis (MS) have an increased risk of ALL (Morrison 2010).

Metayer (2011) looked at the role of maternal folate with respect to risk to ALL. The researchers found that maternal folate intake modified some genetic variations, but these were variable both ethnically and individually. Some maternal genetic combinations that increase foetal iron exposure was associated with a higher ALL risk, particularly in females (Dorak 2009).

Pregnancy

Hypertension has been linked with AML in one study (Cnattingius 1995).

Ognjanovic suggested that some maternal health conditions during pregnancy may be relevant in childhood leukemogenesis, when the child also has Down syndrome. Her 2009 study reported that vaginal bleeding was associated with a reduced risk of leukaemia, whilst amniocentesis was associated with an increased risk of AML.

ALL and AML have both been associated with maternal antibiotic use (Kaatsch 2010). The authors of the study were uncertain as to whether this link may have been to the underlying infection rather than the treatment.

Diet

Increased risk of childhood leukaemia has been associated with DNA topoisomerase inhibitors. This includes some drugs used in chemotherapy, benzene metabolites (from air pollution and cigarette smoke), certain fruits, tea, coffee, wine, soy and cocoa and many other substances (Greaves 1997, Gilliland 2004). Menegaux (2005) and Milne (2011) found that maternal coffee drinking during pregnancy increased the risk of ALL, the risk increasing with increased consumption (Arab 2010). Tea-drinking may be protective, depending on the leukaemia subtype. Children with chromosomal translocations seemed to have increased risk if mothers drank high levels of coffee or tea. Topoisomerase inhibitors inhibit DNA repair and are strongly associated with one of the chromosome rearrangements common in AML (Ross 1996, Spector 2005). Petridou (2005) reported that ALL risk was higher for children born to mothers who ate more sugars and syrups, and meat and meat products. N-nitroso compounds (found in cured meats and hot dogs) have been linked with childhood leukaemia in at least one study (Peters 1994).

Birth

Birth weight

Birthweight of 3,000 grammes or more (Westergaard 1997, Ou 2002, Paltiel 2004, Podvin 2006, Johnson 2008, Spix 2009, Rangel 2010) is associated with an increased risk of ALL in children diagnosed before the age of 2 (Yeazel 1997), especially girls (Smith 2009), and AML (McLaughlin 2006, Caughey & Michels 2009). Children diagnosed under 2 years of age, weighing 4,000 g at birth increases leukaemia risk by as much as 100% (Ross 2006). Dorak (2007) found that in boys

with ALL, there was a nonlinear association with birth weight, but not for girls, suggesting possible differences in aetiology between boys and girls.

Ross speculated that levels of insulin-like growth factor-I are positively correlated with birthweight and may be important to consider in childhood leukaemia. Circulating IGF levels are highly correlated with foetal growth, and IGFs are believed to play an important role in carcinogenesis. However, the exact mechanism by which these two factors may be linked has not been clearly established (Callan [2009](#)). Serum levels of IGF-1 and IGFBP-3 are reduced in children with ALL, but increase significantly after complete remission (Zhao [2011](#)).

McLaughlin ([2006](#)) found that high birth weight was associated with ALL only when the mother was not overweight, whilst heavier maternal weight was associated with ALL only when the infant was not high birth weight. Increased pregnancy-related weight gain was associated with ALL. For AML, birth weight under 3,000 grammes and higher pre-pregnancy weight were both associated with increased risk. These findings suggest that childhood leukaemia may be related to factors influencing abnormal foetal growth patterns.

Schüz ([1999](#)) found an increased risk of acute leukaemia with weights above 4,000 g and below 2,500g. Westergaard suggested that *“a plausible explanation may be that increasing birth weight is associated with a higher rate of cell proliferation and/or a larger number of precursor cells being at risk of malignant transformation.”* Caughey & Michels ([2009](#)) found low and high birthweight was associated with AML, suggesting that the risk is elevated at both extremes, a U-shaped association.

Hjalgrim’s meta-analysis of 18 studies ([2003](#)) concluded that for each 1 kg increase in birthweight, the risk of ALL increases by 14% and AML risk increases by 29%.

L Milne reported (2008) *“Most studies of the association between birth weight and risk of childhood ALL have reported positive associations, while results have been less consistent for AML. Few studies have taken account of gestational age in the analysis of birth weight. As birth weight is a function of both intrauterine growth and length of gestation, it is not possible to differentiate between an association with high birth weight per se and an association with accelerated intrauterine growth, without accounting for gestational age.”* It seems to be accelerated growth, rather than high birth weight (Milne [2007](#), [2009](#), Sprehe [2009](#)) that is involved in the causal pathway for ALL. This did not seem to be true of AML. Foetal growth is determined by a mixture of genetic, nutritional and hormonal factors, possibly with a role for insulin-like growth factor in the causal pathway.

Zack ([1991](#)) found associations between various factors at birth and an increased risk of leukaemia; these included exposure to nitrous oxide anaesthesia during delivery; children with a cleft lip or palate; difficult labour but unspecified complications; uncomplicated physiological jaundice; receiving supplemental oxygen, with *“other conditions of the fetus or newborn,”* and neonatal jaundice (Hernández-Morales [2009](#)).

Very little mention has been made of this as a risk factor. However, Naumberg ([2002](#)) suggested that resuscitation with 100% oxygen with a face mask and bag directly postpartum was associated with increased risk of childhood lymphatic leukaemia and Spector ([2005](#)) found a 3-fold increase in risk in childhood cancer if oxygen was administered for 3 minutes or more.

In one study that looked at potential links with leukaemia, Cnattingius ([1995](#)) found an association between caesarian section and AML.

1-minute Apgar scores of less than 7 increased risk of ALL and AML (Johnson [2008](#)).

Gender

That the incidence of ALL in boys and girls is different is well established, with boys being more likely to develop ALL than girls (Zahm & Devesa [1995](#), Pearce & Parker [2001](#), Johnson [2008](#)), although the incidence of girls is often higher among young children (Gurney [1995](#), Ross [1997](#)). Males tend to have a worse prognosis (Eden [2000](#)). Adelman ([2007](#)) found that boys (but not girls) had an elevated risk of developing ALL in areas of relatively high re-location rates.

Birth order

Behren ([2010](#)) found an increase in risk between ALL and birth order.

Being the first born child has been associated with increased risk of leukaemia (Kaye [1991](#), Kaatsch [1996](#), Dockerty [2001](#)), especially between the ages of 1 and 5, although the opposite has also been reported (Ou [2002](#)). Kaye's team had found that not just firstborns, but those with the next oldest sibling more than 5 years older had an increased risk. Jourdain-Da Silva ([2004](#)) found that having many siblings increased the risk of ALL. Westergaard ([1997](#)) found that the risk of AML went up with increasing birth order, especially for a diagnosis at 2 or 3 years of age.

Infante-Rivard ([2000](#)) found that having a school age sibling at the time of diagnosis significantly increased the risk in all children, but most markedly in those diagnosed before 4 years of age.

Birth order is used as a proxy for infection as it is assumed that children in larger families – especially those lower down the birth order – are exposed to more infections in early childhood. A number of studies have reported results but there is little consensus. Of 13 recent case-control studies, five showed an increased risk of childhood leukaemia in larger families, seven found no effect and two showed a protective effect. The different results of the studies may reflect some impact of changing social conditions in the countries studied, and over time.

Ethnicity

Incidence of ALL is significantly lower among black children in the US (Gurney [1995](#), Reynolds [2002](#), Adelman [2007](#), Johnson [2008](#)) and Africa, and mixed race children in South Africa and Chile (Greaves [1993](#)). During the first few years of life, the incidence rate of AML among African American children is approximately $\frac{1}{3}$ the rate of Caucasian children; however, African American children ≥ 3 years of age have higher rates than Caucasians. Hispanics had a higher incidence of ALL, particularly in childhood, in a study by Yamamoto ([2008](#)), but there were differences in incidence, depending on the subtype (Aldrich [2006](#)).

However, for many adult cancers, ethnicity seems less important than the country you are living in and the adopted lifestyle, as the incidence levels in immigrants generally begins to resemble that of the indigenous population in the country they are living in – certainly in subsequent generations. A study by Spallek ([2008](#)) found that children born in Germany into a family of Turkish descent (as determined by name) had no increased risk of developing leukaemia compared with children of German descent.

Seasonal variation

Higgins ([2001](#)) found significant links between leukaemia and month of birth, for those born before 1960, and month of diagnosis for those diagnosed before 1962. Seasonal variations at diagnosis have also been found (Westerbeek [1998](#), Ross [1999](#), Karimi & Yarmohammadi [2003](#)). Feltbower ([2001](#)) found variations according to birth area; and HT Sørensen ([2001](#)) found an April birth peak for leukaemia diagnosis in the under 4s. Other studies found no variation (Kajtár

2003). The variations may be proxies for infections which can have seasonal peaks of occurrence. Yaniv (2010) found that children who develop ALL and AML have a different month of birth pattern from the general population, which depended on the leukaemia subtype.

Childhood

Diet

Hamburgers eaten once a week or more doubled the risk of ALL (Sarasua & Savitz 1994), and was greater if the child did not take vitamin supplements. The author believed “*there was a possible adverse effect of dietary nitrites and nitrosamines*”.

It has been suggested (Lachenmeier 2010) that infant carrot juice contains substances that may act as precursors for benzene formation during food processing. Benzene exposure has been linked to childhood leukaemia. The authors concluded that the risk was very low, though care should be taken to reduce contaminants to as low levels as reasonably achievable.

Residential status

The Petridou study (1997) found differences in spatial clustering as to urban, semi-urban or rural places where children live. Children younger than 10 years old, living in an urban environment had an increased risk of developing leukaemia, and Petridou concluded that localised environmental exposures could contribute to the aetiology of childhood leukaemia. This may have relevance to a theory of infection, and there may be other factors at work as well.

Socioeconomic status

Incidence of ALL is higher in areas of high social class (Alexander 1991, Stiller & Parkin 1996, Dockerty 1999, Borugian 2005, Draper 2005), though A. Smith (2006), analysing the large UKCCS study found no effect, and neither did Swensen (1997). Adam (2008), in a literature study, suggests any such link is likely to be weak, possibly more significant at the birth of the child, than later. Smith suggested that previous studies varied because of the statistics used to analyse the result. This is always a problem with the small number of children concerned. A review of the literature by Poole (2006) found a consistent inverse association between incidence of childhood leukaemia and family income, mother's and father's education.

However, evidence from developing countries suggests that incidence of ALL in children aged 1-4 years is rising with improved socioeconomic conditions (Hrusák 2002).

Chemicals

An increased risk of ALL was found for professional pest control treatments done during the index pregnancy and possibly the child's early years (Bailey 2011).

Water

Cocco (1996) found that having a well in the backyard increased the risk of ALL. This was in one town in Sardinia, so there may have been something specific to the local water.

Liver cancer (PHM – pediatric hepatic malignancies)

The main constitutional risk factors for PHMs are 1) Beckwith-Wiedemann (BW) syndrome; 2) isolated hemihyperplasia syndrome (IHS); 3) adenomatous polyps of the colon 4) hemochromatosis 5) Hereditary Tyrosinemia Type 1; 6) α -1-antitrypsin deficiency; 7) porphyrias 8) cirrhosis 9) nonalcoholic steatosis; and 10) primary sclerosing cholangitis. The main environmental risk factors are a) hepatitis B virus (HBV) and C virus (HCV); b) B1 aflatoxin (B1AF); c) ionizing radiation; d) alcohol; e) hormonal treatments; f) occupational exposure to pesticides, solvents, vinyl chloride and metals; g) smoking; h) arsenic; I) prematurity and very low birth weight; and j) trematodes.

HBV universal vaccination of newborns provides the biggest opportunity to prevent a substantial proportion of PHMs (Ferris i Tortajada [2008](#)).

Medulloblastoma

Family and genetic factors

A 5-year-old boy diagnosed with medulloblastoma was found to have 12 times the amount of L-2-hydroxyglutaric aciduria in his urine. There were other inherited characteristics that suggested a potential aetiological factor (Yazici [2009](#)). The incidence of medulloblastoma in males is higher than in females.

The most common chromosomal abnormality in medulloblastoma is the location of the tumour suppression gene p53 (Philipova [2011](#)).

Pre-conceptual, pregnancy and birth factors

The peak month of birth for a risk of developing medulloblastoma is October, according to findings by Hoffman ([2007](#)), especially females aged 5-19. The authors suggest an environmental exposure may be responsible. Harder ([2008](#)) found that medulloblastoma was associated with high birth weight.

Maternal use of a sauna close to conception or in the first trimester, and paternal use in the 3 months before the pregnancy, use of an electric blanket, or any heat source have been linked to an increased risk of medulloblastoma. Heat and magnetic field exposure would both have been involved (Bunin [2006](#)), and both may have contributed.

Cured meats combined with low vitamin C intake Bunin ([2006](#)), or oil products (Pogoda [2009](#)), or french fries, chilli peppers and non-chocolate candy (Bunin [2005](#)) consumed in pregnancy have been associated with an increased risk of medulloblastoma.

An increased risk of medulloblastoma was associated with paternal lawn care using pesticides and a weak association with stripping paint, both during pregnancy and after the birth of the index child (Rosso [2008](#)).

Infections

Harding ([2009](#)) concluded that an early exposure to infections is not strongly implicated in the aetiology of CNS tumours, but the effect for social contact outside the home, particularly for medulloblastoma warrants further investigation.

Meningioma

Neurofibromatosis type 2 and ionising radiation (including cranial radiotherapy) are two known risk factors. There have been associations made with Rubinstein-Taybi and with Golin syndromes.

Neuroblastoma

Family and genetic factors

The anaplastic lymphoma kinase (ALK) gene increases the risk for familial neuroblastoma (Mossé [2008](#), Devoto [2011](#)).

Menegaux ([2005](#)) found an association between neuroblastoma and congenital, especially urogenital, and cardiac, anomalies. Munzer ([2008](#)) found a strong link between neuroblastoma and congenital malformations in children aged less than 1 year, but not those older.

Pre-conceptual, pregnancy and birth factors

A history of infertility and the use of infertility medication, specifically, the use of clomiphene, has been associated with an increased risk of neuroblastoma, especially in male children (Olshan [1999](#)). Brassesco ([2009](#)) found a genetic abnormality in a 13-month-old boy with neuroblastoma, born after infertility treatment. The authors were unsure whether the abnormality may have been associated with the assisted reproductive technologies and felt further investigation should be carried out.

Children of women who suffered from pre-eclampsia during pregnancy were at a higher risk of developing neuroblastoma (Bjørge [2008](#)). Hamrick ([2001](#)) found associations between neuroblastoma in the child and a large number of prior pregnancies, a history of previous miscarriages, induced abortions, hypertension during pregnancy, threatened miscarriage, anaesthetic during labour (specifically epidural), and Caesarean and premature delivery.

Maternal anaemia has been associated with an increased risk of neuroblastoma diagnosed within the first year (Bluhm [2008](#)).

Use of any hair dye, especially temporary hair dye, in the month before and/or during pregnancy has been associated with an increased risk of neuroblastoma (McCall [2005](#)). The authors felt that more investigation was needed with respect to application methods, colour, and chemical composition.

Mothers who took opioid agonists, such as medication containing codeine while pregnant or nursing (Cook [2004](#)), or used diuretics (Schüz [2007](#), Heck [2009](#)) or hypertensives, and vitamin, folate or iron supplements Schüz ([2007](#)) had an increased risk of neuroblastoma in the child. Maternal use of any illicit or recreational drug, especially the use of marijuana was associated with an increased risk of neuroblastoma (Bluhm [2006](#)) in their offspring. Bluhm found that the effect was strongest in children diagnosed before the age of one.

Respiratory distress at birth has been associated with neuroblastoma (Bluhm [2008](#)).

Parental occupational factors

De Roos ([2001](#)) concluded that maternal exposure to most chemicals was not associated with neuroblastoma; however, paternal exposure to hydrocarbons, such as diesel fuel, lacquer thinner,

and turpentine, or pesticides (Van Wijngaarden [2003](#)), wood dust and solders were associated with an increased incidence of neuroblastoma.

In a large study (2920 cases of neuroblastoma) paternal occupational exposure to leather was the only exposure out of the 32 looked at, that was associated with an increased risk of neuroblastoma. Inferred exposure rather than actual exposure was used and the range of time 1962 to 1999, may mean that the results may be more difficult to interpret (Maccarthy [2010](#)). Van Wijngaarden ([2003](#)) showed neuroblastoma was linked to paternal occupational exposure to herbicides.

Parental lifestyle factors

Some papers have linked brain tumours (including neuroblastoma) with parental alcohol consumption (Heck [2009](#)).

An increase in risk of neuroblastoma was found with pesticide use in the home and garden Daniels ([2001](#)), and stronger links when the diagnosis was later than 1 year of age.

Pituitary adenoma

Inherited mutations in the ARYL hydrocarbon receptor interacting protein (AIP) gene may be involved in the predisposition to pituitary adenoma formation, as this was discovered in one patient, and 5 relatives who did not have tumours (Naves [2010](#)).

Primitive Neuroectodermal Tumours (PNETs)

Family and genetic factors

Kuijten ([1993](#)) found cancers were significantly more common in relatives of children with PNET, especially those aged 0-4 years at the age of diagnosis.

Pre-conceptual, pregnancy and birth factors

Stålberg ([2007](#)) found an increased risk of PNET with prenatal abdominal X-ray exposure.

Beer consumption during pregnancy has been associated with a four-fold increase in PNETs (Bunin [1994](#)). French fries, chilli peppers and non-chocolate candy eaten in pregnancy were associated with an increased risk of PNET (Bunin [2005](#)).

Parental occupational and lifestyle factors

Paternal exposure to polycyclic aromatic hydrocarbons (PAHs) increased the risk for PNETs (Cordier [2004](#)) and maternal exposure to solvents or kerosene at a high level increased the risk (Bunin [1994](#), Cordier [1997](#)). An increased risk of PNET was associated with paternal lawn care using pesticides and a weak association with stripping paint, both during pregnancy and after the birth of the index child (Rosso [2008](#)).

PNETs (Bunin [1994](#), Yeni-Komshian & Holly [2000](#)) have been associated with both maternal and child exposure to pigs, poultry, dogs and cats. Children who were on a farm for more than a year and were first on a farm when they were less than 6 months of age (Holly [1998](#)) had an increased risk for PNETs, as did the children of mothers who ever had worked on livestock farms (Efird [2003](#)).

Infections

Harding (2009) concluded that an early exposure to infections is not strongly implicated in the aetiology of CNS tumours, but the effect for social contact outside the home, particularly for PNET warrants further investigation.

Retinoblastoma (Rb)

Spector (2009) suggested there may be an association with very low birth weight (1500-1999 g).

Paternal occupational exposure to oil mists in metal working at the birth of the child concerned is associated with a higher risk of retinoblastoma, both the heritable and non-heritable form (MacCarthy 2009).

Maternal smoking in pregnancy has been associated with an increased risk of retinoblastoma (Stavrou 2009).

Rhabdomyosarcoma (RMS)

Ognjanovic (2010) found a positive association between accelerated *in utero* growth and embryonal RMS (the more common form of RMS), but not alveolar RMS

Skin cancer

Melanoma

Paediatric melanoma is rare, but increasing in incidence. Some risk factors for melanoma include xeroderma pigmentosum, giant congenital melanocytic nevi, dysplastic nevus syndrome, atypical nevi, many acquired melanocytic nevi, family history of melanoma and immunosuppression (Jen 2009).

Thyroid cancer

Living in an area of relative iodine deficiency, having one or both parents from a similar region, with a family history of thyroid disease, older age and higher body weight are all risk factors for thyroid cancer in children (Bandurska-Stankiewicz 2010).