

## Renaming the NCDs

**Editor** – It was with interest and pleasure — but concern — that I read Vol. 79, No.10 of the *Bulletin of the World Health Organization* devoted to noncommunicable diseases. As a resident of the “South”, I am delighted that this subject receives attention that highlights not only the valuable lessons but also the harmful influences that can emanate from the North.

My concern arises from the continued use of terminology that dulls the senses to the urgency of the problems involved. I note that the occurrence of keywords such as “pandemic” and “epidemiological transition” in the editorial, “epidemic” in reference to cardiovascular disease, and “lifestyle” in many contributions has become commonplace.

In my country and in various forums such as the WHO Regional and Global Advisory Committees on Health Research, I have long argued that there are new pathways conveying pathogenic influences to the mind and body and turning them into harmful behaviours and hence disease, on a par with the insect vectors of communicable diseases. These are electronic “vectors” (radio, television, and the Internet) and print media, and peer pressure across nations. There are now more subtle and sophisticated methods of using communication with high-pressure presentation and advertising techniques to force compliant behaviour by readers — whether the general public, children, or potential consumers of the products and services being promoted. Yet at the same time there is widespread acceptance of the dangers of noncommunicable diseases and the effects of lifestyle on them (and also on other causes of ill-health such as diabetes, most malignancy, accidental and non-accidental trauma, and family breakdown).

The urgency that ought to pervade this subject is lacking. I think the term “noncommunicable diseases” is so dull that it deadens our perception, and I suggest that the words are consigned to history or a very small bit of the present, and that the name *neocommunicable* is used for the bulk of the conditions under consideration. This does not even involve a change in the acronym:

NCD could still be used though NeoCD would be better, but the new nomenclature would subconsciously instill a sense of urgency. I hope my suggestion will instigate debate on this matter and help to stimulate action. ■

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## Arsenic and hypertension in Bangladesh

**Editor** – The prevalence, awareness, treatment and control of hypertension among the elderly in Bangladesh and India were discussed recently in the *Bulletin* (1). I should like to draw attention to the role of arsenic poisoning in this respect. My colleagues and I previously reported in the *Bulletin* that the contamination of groundwater by arsenic in Bangladesh can be described as “the largest poisoning of a population in history, with millions of people exposed” (2). Tube-wells were installed to provide safe drinking-water and prevent diarrhoeal diseases, but were not tested for arsenic.

We have recently described a link between arsenic in drinking-water and the occurrence of diabetes mellitus and hypertension in Bangladesh (3). From a public health point of view, arsenic exposure has attracted great interest in the past few decades, especially regarding the risk of lung cancer among copper-smelting workers, but also the risk of skin and bladder cancer seen in connection with exposure through drinking-water. Studies in other countries with long-term exposure indicate that 1 in 10 persons who drink water containing 500 µg of arsenic per litre may ultimately die from arsenic-related cancers of the lung, bladder and skin.

Epidemiological data (4) indicate the dose–effect relationship between levels of arsenic in drinking-water and the prevalence of hypertension. For a 50 µg/l concentration, the risk of hypertension was doubled compared with non-exposure. These results confirm findings reported from Taiwan, China (5). Considering time-weighted mean arsenic

exposure (500 µg/l, 500–1000 µg/l, and >1000 µg/l), the adjusted prevalence ratios for hypertension among the subjects without skin lesions were 0.8 (95% confidence interval (CI) = 0.4–1.8), 1.7 (95% CI = 0.8–3.3), and 2.2 (95% CI = 1.1–4.3), respectively (4). With the same reference and exposure categories, subjects with skin lesions had adjusted prevalence ratios of 1.4 (95% CI = 0.6–3.2), 2.5 (95% CI = 1.2–5.1), and 2.9 (95% CI = 1.3–6.1), respectively (4). The dose–response trend was significant both for subjects with and without skin lesions ( $P < 0.001$ ). Currently, at least 20 out of 120 million population in Bangladesh are exposed to arsenic in drinking-water at concentrations of >50 µg/l (6). Given this frequency of exposure and the indicated excess risk for hypertension, a non-negligible proportion of the future hypertension burden in Bangladesh could be attributed to arsenic poisoning.

The epidemiological evidence supporting a causal association between well water containing inorganic arsenic and occurrence of hypertension points to the need to take arsenic exposure into account in further studies on hypertension. ■

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