

New Evidence on Fluoridation

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Abstract

A review of recent scientific literature reveals a consistent pattern of evidence - on hip fractures, skeletal fluorosis, the effect of fluoride on bone structure, fluoride levels in bones and osteosarcomas - together pointing to the existence of causal mechanisms by which fluoride damages bones. In addition, there is evidence, accepted by some eminent dental researchers and at least one leading US proponent of fluoridation, that there is negligible benefit from ingesting fluoride, and that any (small) benefit from fluoridation comes from the action of fluoride at the surface of the teeth before fluoridated water is swallowed. Public health authorities in Australia and New Zealand have appeared reluctant to consider openly and frankly the implications of this and earlier scientific evidence which is unfavourable to the continuation of the fluoridation of drinking water supplies.

Introduction

In recent years, new scientific evidence has emerged which suggests that there are significant risks and negligible benefits from ingesting low levels of fluoride (F). In this short paper, we outline the evidence that fluoridation of water supplies is harmful to bone, while providing negligible benefits when swallowed.

In focussing on the new evidence (mostly post-1989) in just two areas, it is not intended to diminish the importance of earlier evidence for concern about the health hazards of fluoridation: notably dental fluorosis, allergies and intolerance reactions, and genetic damage. These are reviewed elsewhere.¹⁻³

Fluoride damages bones

Since 1990, five major epidemiological studies from three countries - USA, UK and France - have been reported in leading peer-reviewed journals showing a higher rate of hip fractures in fluoridated regions than unfluoridated regions.⁴⁻⁸ Although two of these reports were published as letters, the first was a correction to a refereed publication⁹ and the second was a supplement to a refereed publication about a prospective study which took account of major individual risk factors¹⁰. In addition, a prospective study from USA shows a higher rate of hip fractures in a naturally fluoridated region with 4 ppm F in drinking water than in a comparison region with 1 ppm.¹¹ Although there are a few studies which find no difference between fluoridated and unfluoridated regions, they are either limited to small samples or the women were not exposed to F during the time of their lives when F would be expected to affect bone most, i.e. before menopause.¹²

The main weight of the recent evidence on hip fractures is consistent with earlier evidence from naturally fluoridated areas that low levels of fluoride ingested for several decades can cause the disease of bones and joints known as osteofluorosis or skeletal fluorosis. Evidence of skeletal fluorosis has been reported in at least 9 studies from 5 countries with F concentrations in drinking water of 0.7-2.5 ppm. These studies, and the inadequacies of studies which are used to claim that there is no skeletal fluorosis in the USA at F concentrations below 4 ppm, have been reviewed elsewhere.²

In 3-4 decades, when people in artificially fluoridated areas have accumulated F in their bones from birth to old age, the increased rates of hip fractures and skeletal fluorosis will be larger.

Fluoride has been used in high doses (20-32 mg/day) for short periods of time (1-2 years) to treat osteoporosis. It is now recognised widely that, while this therapy adds mass to bones, it also damages the bone structure and leads to an increased risk of hip fracture.¹³⁻¹⁸ Bone analyses have shown that elderly women who had lived for at least a decade in the town of Kuopio, Finland, with 1 ppm F in its water supply, had high levels of F in bone (typically 1600 ± 700 ppm, but, in the case of subjects with impaired kidney function, as high as 3890 ppm).^{19,20} These levels are as high as have been reported in patients who have undergone F therapy for osteoporosis.²¹

Furthermore, in the US National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program, an increase of 79% was found in the incidence of osteosarcomas in young men living in fluoridated areas of Iowa and Seattle, but not in the unfluoridated areas where the incidence decreased by 4%.²² In fluoridated regions of the State of New Jersey, the incidence of osteosarcoma was 3 to 7 times higher among males aged 10-19 years than in unfluoridated regions.²³ Osteosarcoma is a rare disease and so more evidence is required before any conclusions are drawn. But there is already a strong basis for concern, because the human data are supported by an animal experiment: the US National Toxicology Program has recorded a statistically significant, dose-related increase in the incidence of osteosarcoma in male rats ingesting fluoride.^{24,25}

Thus, there is a consistent pattern of evidence - on hip fractures, skeletal fluorosis, the effect of F on bone structure, F levels in bones and osteosarcomas - together pointing to the existence of causal mechanisms by which F damages bones.

Negligible benefit from F ingestion

Recent research on the mechanism of action of F in reducing the prevalence of dental caries (tooth decay) in humans shows that F acts topically (i.e. at the surface of the teeth) and that there is negligible benefit in actually ingesting it.²⁶⁻²⁸ This is supported by experiments on laboratory rats: a slow-release source of F fixed in the mouth reduced dental caries, but when the mouth was bypassed by placing the source under the skin, there was no detectable reduction.²⁹ The lack of observed systemic benefit from ingesting fluoridated water at concentration 1 ppm is not surprising, since the resulting level of F in the saliva is only around 0.01 ppm.³⁰

The evidence that there is negligible systemic benefit from fluoridation is accepted by eminent dental researchers²⁶⁻²⁸ and at least one leading US proponent of fluoridation, Professor Brian Burt.³¹ Therefore proponents must come to grips with a serious ethical question: Is it right to put F in *drinking* water and to mislead the community that F must be ingested, when any small benefit is due to the topical action of F on teeth.³²

Alleged benefit from fluoride

We say 'any small benefit', because the results of recent large-scale studies in at least three countries show that, when similar communities are compared and the traditional DMFT index of dental caries is used, there is no detectable difference in caries prevalence. This has been demonstrated for schoolchildren in the major cities of New Zealand, Australia, the USA and elsewhere.³³⁻³⁸ (When the newer DMFS index was used, a 25% reduction was reported for USA,³⁹ but, in absolute terms, this is only a fraction of a cavity per child.)

Of the many studies used by proponents of fluoridation to claim that there are enormous benefits from fluoridation, not one is a randomised controlled trial. Those which have been re-examined have been found to have serious design flaws.^{38,40-44} Indeed, hardly any of the many small-scale studies by enthusiasts of fluoridation are ‘blind’ and, in the rare cases when they are, the so-called ‘control’ was selected from a known high-caries area.⁴³ Many studies also fail to take into account that unfluoridated towns tend to be rural, while fluoridated towns tend to be large cities, and that there is generally more dental caries in rural areas irrespective of fluoridation status. In general, diet tends to be better in urban areas.

Many other studies had no controls. Their authors ‘justified’ their pro-fluoridation conclusions on the basis of large temporal declines in tooth decay. But, it is now known that equally large declines in caries have taken place in unfluoridated areas,⁴⁵⁻⁴⁸ and that in several cases this decline commenced before F in any form was used to a significant degree.^{47,48}

However, there is now abundant evidence that topical uses of fluoride, extensively practised in Europe instead of water fluoridation, are effective in controlling tooth decay.⁴⁹ We agree that their cautious uses in dentistry are justified and provide an alternative to fluoridation which satisfies ethical concerns.³² However, in the past they have been promoted and practised rather irresponsibly - for example, the provision of highly concentrated fluoride toothpastes and mouth rinses to young children who inevitably ingest much of the fluoride. Too often overlooked is the evidence that tooth decay is associated with deteriorated diets,⁵⁰ and that dietary control of caries, without the use of fluoride, is possible.⁵¹

Bias of health authorities

In our view, the above evidence indicates that fluoridation entails real health risks and at best very small benefits. Therefore the fluoridation of water supplies should be terminated forthwith. Yet, both in Australia and New Zealand, health authorities appear to be redoubling their efforts to fluoridate the remaining towns which have so far managed to hold fluoridation at bay.

The 1991 report on fluoridation by the National Health and Medical Research Council (NH&MRC)⁵² was published just as the first papers reporting the link between fluoridation and hip fractures were being published. It acknowledged in its section 6.4 some of the evidence that skeletal fluorosis is a potential health hazard, but created the false impression in its executive summary that there are no health risks. It is the executive summary which is read by decision-makers and the media. The report’s pro-fluoridation bias was further demonstrated by its failure to cite any of the studies published in refereed journals which present the evidence against fluoridation.

The 1995 Report to the Minister by the New Zealand Public Health Commission⁵³ (PHC) demonstrated similar bias by failing even to cite any of the published papers on hip fractures, skeletal fluorosis or osteosarcomas. However, the 1994 New Zealand PHC report⁵⁴ did include some of these references and did acknowledge that:

“It is possible that there is a small increased risk of hip fracture associated with water fluoridation, though the evidence for this is very inconclusive. More research is required to clarify this issue. A large amount of research has failed to provide evidence that exposure to fluoride causes cancer. However, the possibility of a small increased risk of osteosarcoma (a rare type of bone cancer) in young men cannot be ruled out at this stage. Here again, more research is needed.”

But this information, and the references supporting it, was not forwarded officially to the Minister.

One of the undersigned (D.E.), while Federal Minister for Health in Australia from 1972 to 1975, could not get frank answers from his own department on the risks and benefits of fluoridation. Another of the undersigned (J.C), while convenor of the New Zealand Fluoridation *Promotion* Committee, observed at first hand how his then fellow proponents of fluoridation kept from the public and decision-makers the evidence that fluoridation is less effective than claimed by proponents and is harmful, and then represented the evidence in a misleading way when it was eventually released. All of us have observed attempts by the medical and dental establishment in pro-fluoridation countries to evade the evidence of concern and to suppress and misrepresent scientists, medical practitioners and dentists who attempt to publish evidence against fluoridation.⁵⁵⁻⁵⁷

For these and other reasons, we have no confidence in the impartiality of those institutions of government and the professions which have endorsed fluoridation for decades. Those who have built their careers and professional status on fluoridation cannot credibly assess the evidence against it. We have submitted this short paper for publication in the hope that at least some kind of scholarly debate will ensue.

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