

why else would identical twins so rarely have the same kind of cancer?²⁵ In 1940, Bauer argued that there were other reasons cancers should be regarded as exogenous in origins. For one thing, there was the fact that heritability was obvious in only a very few cancers. Xeroderma pigmentosum, neuroblastomas of the retina, and polyposis of the colon were well-known examples, but these were all quite rare. There was also the fact that men and women could have very different cancer rates. Cancer of the larynx, for example, was twenty times more common in men than in women, and lung cancer was five or ten times as likely to strike a man as a woman. Could male and female lungs really be so different—or were environmental influences involved? Lip and stomach cancers were also found more than twice as often among males, though with gallbladder cancer the ratios were reversed (women were six or seven times more likely to suffer the disease). It was hard to see how heredity could explain such differences. Male and female lungs and lips and stomachs were not obviously different in any relevant aspect; the more satisfactory explanation, Bauer suggested—correctly, as it turned out—was that something in the environments of the two sexes—smoking or drinking habits, for example—must be responsible for the differences. He also pointed out that cancer might well “run in families” for no other reason than that people in those families may be exposed to a common environment, as in the families of Schneeberg’s uranium miners, longtime sufferers from lung cancer.²⁶

“Lifestyle” theories of carcinogenesis were actually quite popular in the Nazi era—even among committed Nazis. In 1939, in a long review of world cancer trends, Arthur Hintze, a leading Berlin radiologist and professor of surgery, argued that dietary habits and religious practices were important in explaining cancer rates on different parts of the planet. Stomach cancer, for example, was the most common cause of cancer death in both Europe and Japan, but the same disease was rare in Calcutta, accounting for less than 1 percent of all malignancies. The difference in the Indian case seemed to have little to do with race; rather, it appeared to stem from economic constraints and religious practices that led local populations to consume very little alcohol and almost no meat.

Lifestyle factors also seemed to be at work in the rarity of stomach cancer among the Malays living in Java and Sumatra: one large autopsy study of 3,885 Malays in Batavia found only a single gastric malignancy, a fairly common disease among the Europeans and Chinese living in that part of the world. Hintze pointed out that most of the Malays were Muslims and therefore avoided alcohol and meat—habits which led to low stomach cancer rates also among the predominantly Buddhist Sinhalese of Ceylon. Lifestyle factors were similarly responsible for the high rates of genital and bladder cancers among Arabs in the Middle East, a situation that, he explained, following Sigismund Peller (a Jew whose books had been banned, interestingly), was most likely a consequence of infection by pathogens such as bilharzia and the syphilis spirochete.

Hintze did not deny that different individuals and perhaps even different races were unequally susceptible to the influence of carcinogens (he mentions the fact that light-skinned peoples are more vulnerable to sun-induced skin cancer); he simply claimed that environmental and lifestyle factors played a stronger role than was sometimes acknowledged. The upshot: we should not be fatalistic in thinking of cancer as an unavoidable accompaniment of civilization. Hintze also noted that demographic variables were the root cause of many “racial” variations: Africans, for example, were often observed to have high sarcoma rates—though part of the reason, he explained, was that these were cancers which most often struck at an early age. Africans did not live as long as some other peoples, giving rise to the (false) impression that sarcomas were a particular weakness of the Negro race. He also suggested that the idea that Africans were particularly vulnerable to benign tumors might have something to do with non-Africans’ failure to appreciate the widespread cosmetic practice of ritual scarring.²⁷

I don’t want to leave the impression that Hintze was a flaming Boasian—he was not. He was a dedicated Nazi who profited directly from the expulsion of Jews at the Rudolf Virchow Hospital. Cancer was common among the young in certain populations, he speculated, because those populations were “closer to the youth of humanity”—meaning humans’ evolutionary ancestors. He also