



Reducing alcohol-attributable cancers in the European Union

Evaluations from the *International Agency for Research on Cancer Handbooks of Cancer Prevention* and beyond

International Agency for Research on Cancer



European Region



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Abstract

Alcohol consumption is a major cause of cancer in the European Union (EU). In 2022 one quarter of the 700 000 alcohol-attributable cancer cases worldwide occurred in Europe, where alcohol consumption remains the highest globally. The *International Agency for Research on Cancer Handbooks of Cancer Prevention* Volumes 20A and 20B provide a comprehensive review and evaluation of the evidence on the cancer-preventive potential of, respectively, reducing or ceasing alcohol consumption and of population-level alcohol policy interventions. Reduction or cessation of alcohol consumption is associated with reduced cancer risk; there is sufficient evidence of this association in the case of oral and oesophageal cancers, and also in the case of the mechanisms through which alcohol causes cancers in humans. Furthermore, there is sufficient evidence that alcohol taxes, minimum pricing, restrictions on physical availability, strong marketing bans and coordinated alcohol policy interventions lead to a reduction in alcohol consumption. A complementary modelling study estimates that implementing these policies across all 27 EU Member States could avert up to 9200 cancer cases annually, depending on the policy scenario. These findings demonstrate that population-level alcohol policies represent an underused tool for cancer prevention in the EU and should be integrated within EU and national cancer control frameworks.

Keywords

ALCOHOL DRINKING, CANCER, POLICY, PREVENTION AND CONTROL, PUBLIC HEALTH

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Contents

Acknowledgements	ii
Abbreviations	ii
Introduction	1
1. The alcohol and cancer burden in the EU in 2022	3
2. Key findings from IARC Handbook 20A: reduction or cessation of alcoholic beverage consumption	4
2.1. Impact of alcohol reduction or cessation on cancer incidence	4
2.2. Impact of alcohol reduction and cessation on carcinogenic mechanisms	5
3. Key findings from IARC Handbook 20B: alcohol policies	6
3.1. Impact of population-level alcohol policies on alcohol consumption	7
3.2. Impact of health care-based interventions on alcohol consumption	8
4. Estimated impact of alcohol policy interventions on cancer prevention in the EU	9
5. Conclusions	11
References	12

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Abbreviations

EU	European Union
IARC	International Agency for Research on Cancer

Introduction

Alcohol consumption is a major public health challenge in the European Union (EU), significantly contributing to cancer and other noncommunicable diseases. In 2022 one quarter of all alcohol-attributable cancers globally occurred in Europe (1). According to the latest WHO estimates, six of the 10 countries with the globally highest alcohol intake are in the EU, and in 2019 alone, alcohol contributed to 240 000 deaths in the EU, with cancer accounting for 30% of alcohol-attributable deaths (2).

The International Agency for Research on Cancer (IARC), the specialized WHO cancer research agency, is dedicated to research that facilitates effective cancer prevention. In 1988 the IARC Monographs Programme classified alcoholic beverages as a Group 1 carcinogen, meaning that there is sufficient evidence that they cause cancer in humans (3). The evaluation was confirmed by other large institutions (4,5). Alcohol consumption is carcinogenic to humans, and is a major cause of cancers of the oral cavity, pharynx, larynx, oesophagus, colorectum, liver and female breast (3,6); alcohol consumption can cause cancer through several pathways (Fig. 1).

Fig. 1. Overview of the mechanisms through which alcohol consumption causes cancers in humans



Acetaldehyde levels

Once consumed, the ethanol in alcoholic beverages is converted to acetaldehyde. Acetaldehyde causes cancer by damaging DNA (forming DNA adducts, DNA mutations and chromosomal aberrations) and by stopping cells from repairing this damage.



Oxidative stress

Chronic alcohol consumption induces the formation of reactive oxygen species, leading to oxidative stress and lipid peroxidation, both of which also damage DNA and affect its repair.



Microbiome dysregulation

Alcohol consumption has a strong impact on the oral and intestinal microbiome, leading to intestinal permeability, which in turn leads to microbial translocation out of the intestine into the body.



Chronic inflammation and immune deficiency

Alcohol-related chronic inflammation and perturbation of the immune system can be triggered through the oxidative stress pathway as well as through the microbiome dysregulation pathway.



Folate depletion

Alcohol consumption can cause folate deficiency and dysregulation of DNA methylation enzymes, which lead to impaired DNA methylation.



Hormonal changes

Alcohol can affect the levels of hormones such as oestrogen and insulin. Changes in sex hormone levels may be related to the risk of breast cancer.



Synergy with other carcinogens

Alcohol can interact with other carcinogens or pro-carcinogens, such as those in tobacco smoke, through several pathways including acetaldehyde levels and increasing the absorption of other carcinogens.

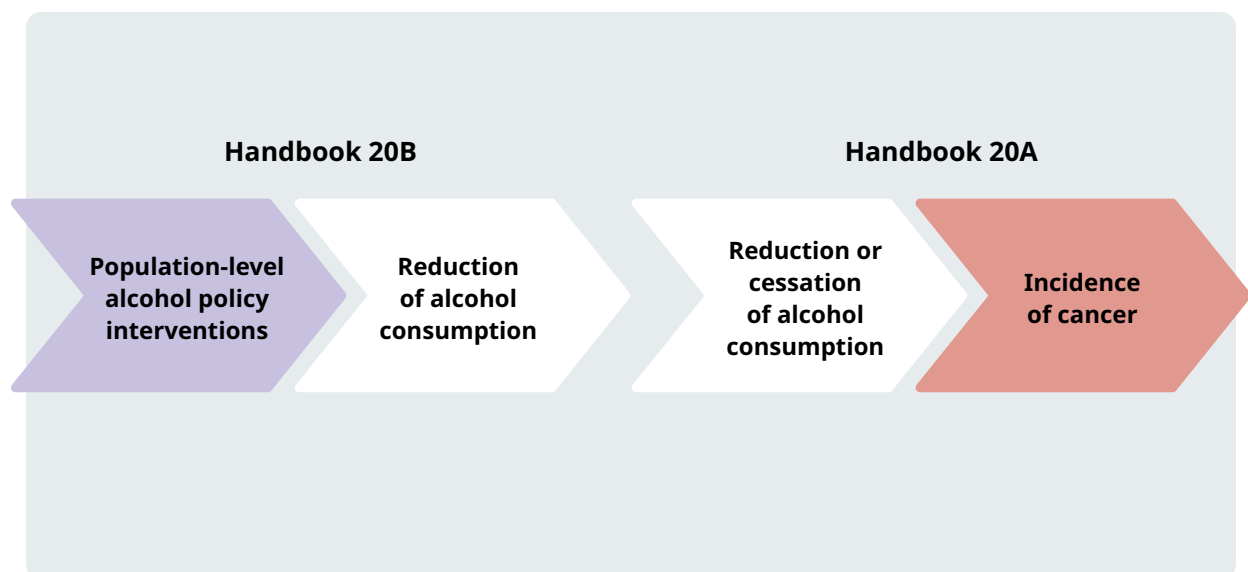
Source: adapted from (7).

There is a dose–response relationship between alcohol consumption and cancer risk – the more alcohol consumed, the higher the risk – and there is no threshold for the carcinogenicity of alcohol (8). Even light or moderate drinking increases the risk of several cancers, including breast cancer (9). In fact, over half of all alcohol-related cancers in the EU occur in individuals who do not drink heavily, and nearly one third of breast cancer cases linked to alcohol result from moderate drinking of the equivalent of up to two drinks per day (10). As a result, the European Code Against Cancer advises avoiding alcoholic drinks (11,12). Despite this, public awareness of alcohol as a cancer risk factor remains low, in particular for breast cancer (13).

The IARC Handbooks of Cancer Prevention provide comprehensive reviews and consensus evaluations of the evidence on the effectiveness of preventive interventions that may reduce cancer incidence and mortality (14). In developing these handbooks, IARC convenes independent, interdisciplinary working groups of international experts who transparently synthesize different streams of evidence and translate them into an overall evaluations based on established criteria.

Because of the paucity of data on population-level alcohol policies in relation to cancer incidence, the analytical framework for the IARC Handbook evaluations uses an intermediate outcome – namely, reduction or cessation of alcohol consumption (Fig. 2). Handbook 20A reviewed the evidence on the link between the intermediate outcome and cancer (7), while Handbook 20B reviewed the evidence on the link between population-level alcohol policy interventions and alcohol consumption (15). This policy brief highlights the key findings from the two handbooks and provides a short overview of the preventive potential of the evaluated alcohol policies for the EU.

Fig. 2. The two-step framework used in IARC Handbooks 20A and 20B



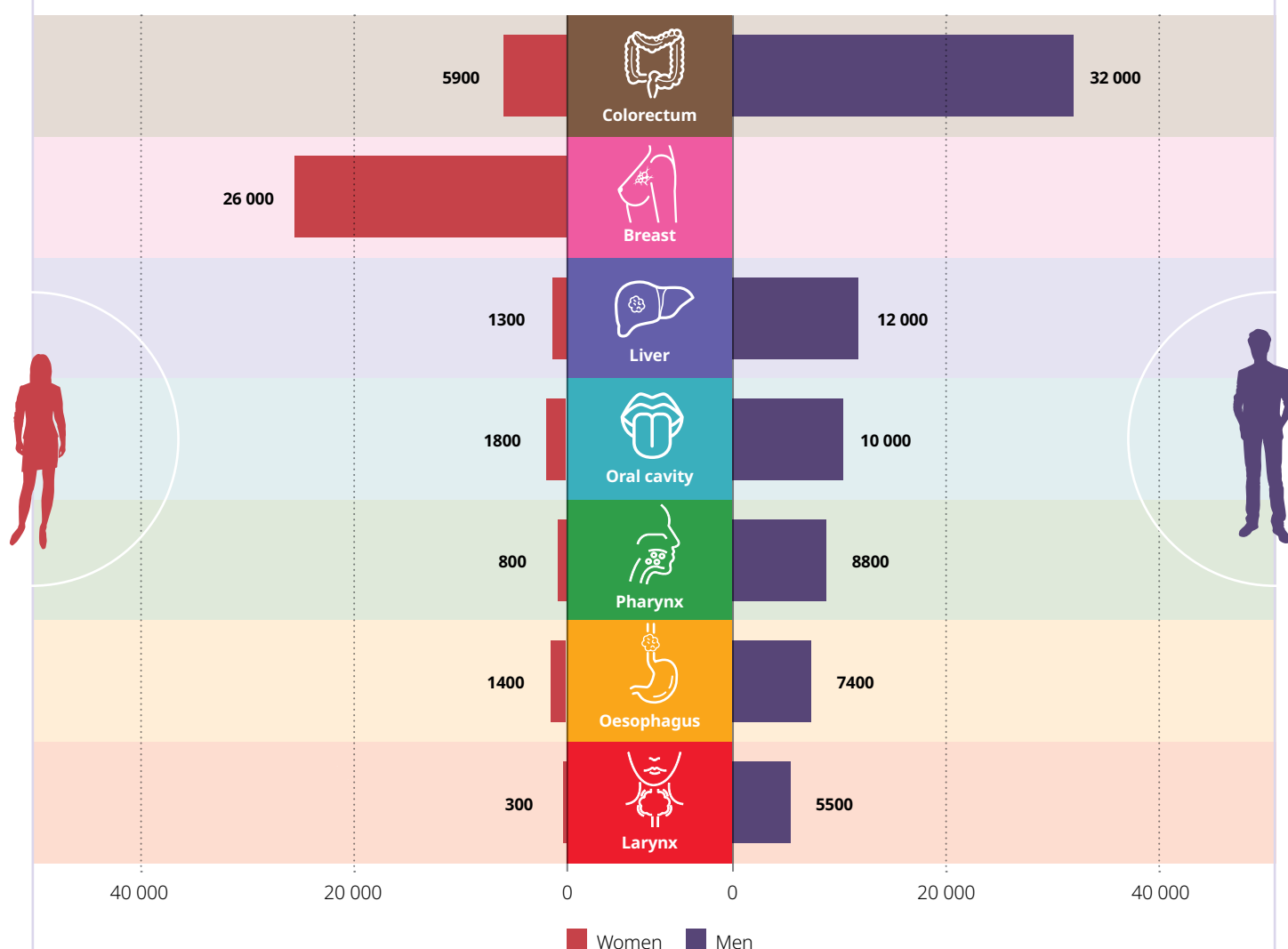
Source: (7,15).

1. The alcohol and cancer burden in the EU in 2022

The EU has the highest levels of alcohol consumption in the world. In 2024 six of the 10 countries with the greatest alcohol intake were in the EU (2). In 2019 alone, alcohol contributed to approximately 240 000 deaths in the region, with around three in 10 alcohol-attributable deaths caused by cancer (16).

In 2022 alcohol consumption represented 4% of all newly diagnosed cancers in the EU (1). Two thirds (67%) of these cases occurred in men, partly reflecting higher levels of alcohol consumption among men. The most common alcohol-attributable cancers in the EU in 2022 were colorectal cancer (38 000 cases), breast cancer (26 000 cases) and liver cancer (13 000 cases) (Fig. 3).

Fig. 3. Cancer cases and deaths caused by alcohol in the EU, by sex and cancer site, 2022



Note: The graph shows incident cancer cases in 2022 that were attributable to alcohol consumption in the European Union 27. Data were obtained from IARC. *Source:* (9).

From an economic perspective, the cost of premature deaths from cancer in 2018 was estimated at €52.9 billion in productivity losses across the EU. Of this, €4.58 billion were linked specifically to alcohol-related cancers, accounting for approximately 9% of the overall cost (17).

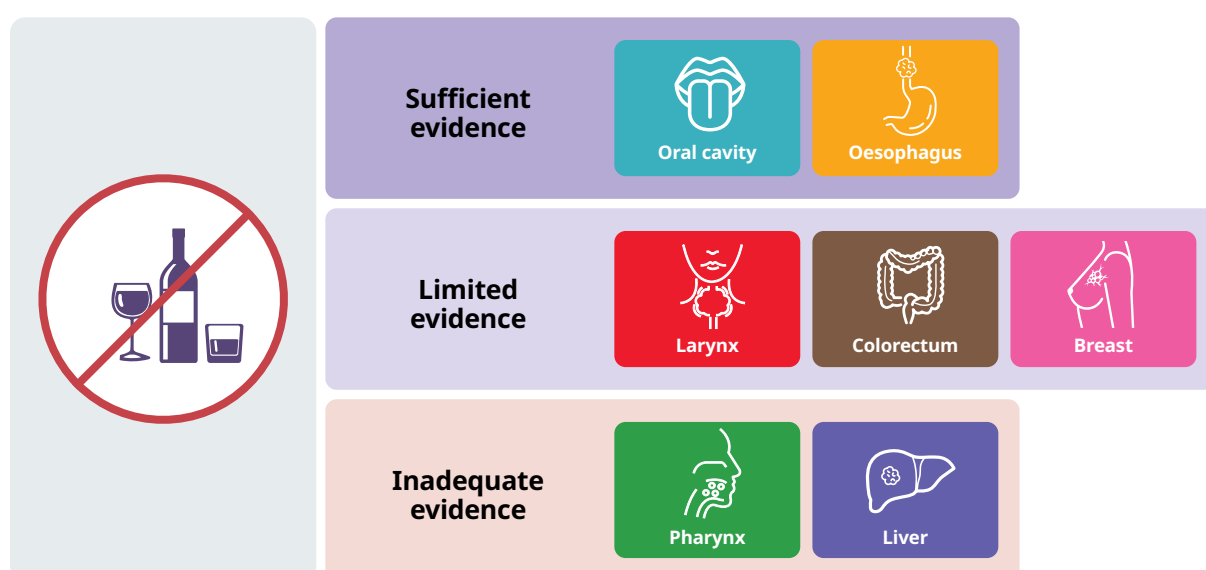
2. Key findings from IARC Handbook 20A: reduction or cessation of alcoholic beverage consumption

2.1. Impact of alcohol reduction or cessation on cancer incidence

The evidence for alcohol reduction or cessation in relation to specific cancers is presented below (Fig. 4).

- **Oral cavity cancer.** The risk decreases with longer duration of alcohol cessation, even after adjustment for smoking.
- **Oesophageal cancer.** Several studies show decreasing risk after years of cessation, even after adjustment for smoking.
- **Laryngeal cancer.** Some studies suggest lower risk after long-term cessation, but results are less consistent and may be affected by smoking-related confounding.
- **Colorectal cancer.** Findings across studies are inconsistent. Some studies suggest reduced risk with alcohol reduction, but evidence for cessation is limited.
- **Breast cancer.** Meta-analyses show modest but imprecise reductions in risk. Possible benefits may be limited to hormone receptor-positive tumours.
- **Pharyngeal cancer.** Few studies exist and results are inconsistent.
- **Liver cancer.** Evidence is inconclusive and may be influenced by reverse causation or underlying liver disease.

Fig. 4. Summary of evidence for the effect of alcohol reduction or cessation on cancer risk, by cancer site



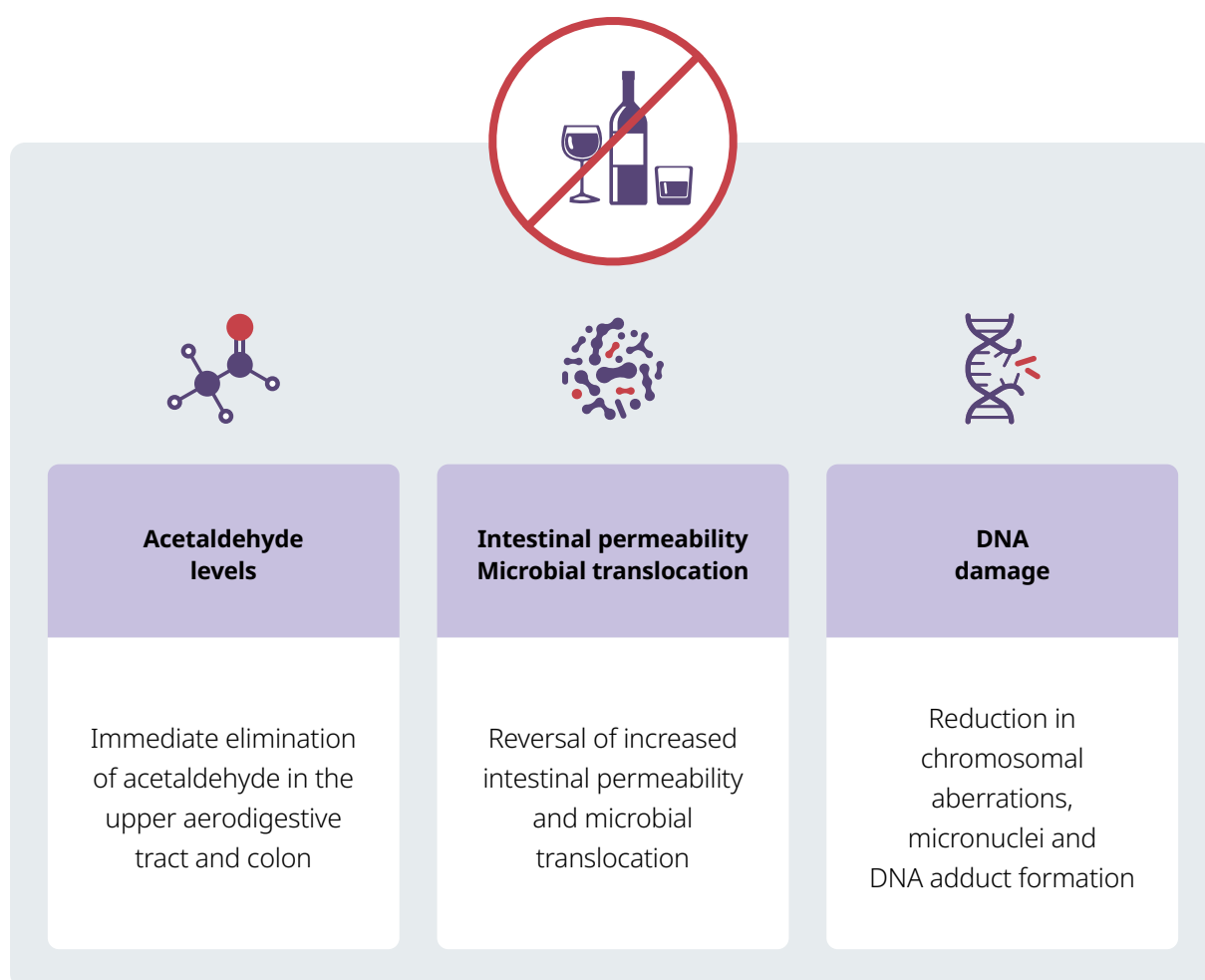
Source: based on the evaluations by the Working Group for IARC Handbook 20A (7).

2.2. Impact of alcohol reduction and cessation on carcinogenic mechanisms

Based on results for three specific mechanisms, there is sufficient evidence that alcohol cessation reduces alcohol-related carcinogenesis (Fig. 5).

- **Reduced acetaldehyde exposure.** Stopping alcohol consumption rapidly reduces local exposure to acetaldehyde in the mouth, throat and digestive tract.
- **Improved gut barrier function.** Alcohol cessation reverts the intestinal permeability and microbial translocation provoked by alcohol consumption, leading to recovery of the gut barrier.
- **Reduced DNA damage.** Alcohol cessation reduces the formation of harmful chemical bonds between acetaldehyde and DNA strands.

Fig. 5. Summary of evidence for the effect of alcohol cessation on alcohol-related carcinogenic mechanisms

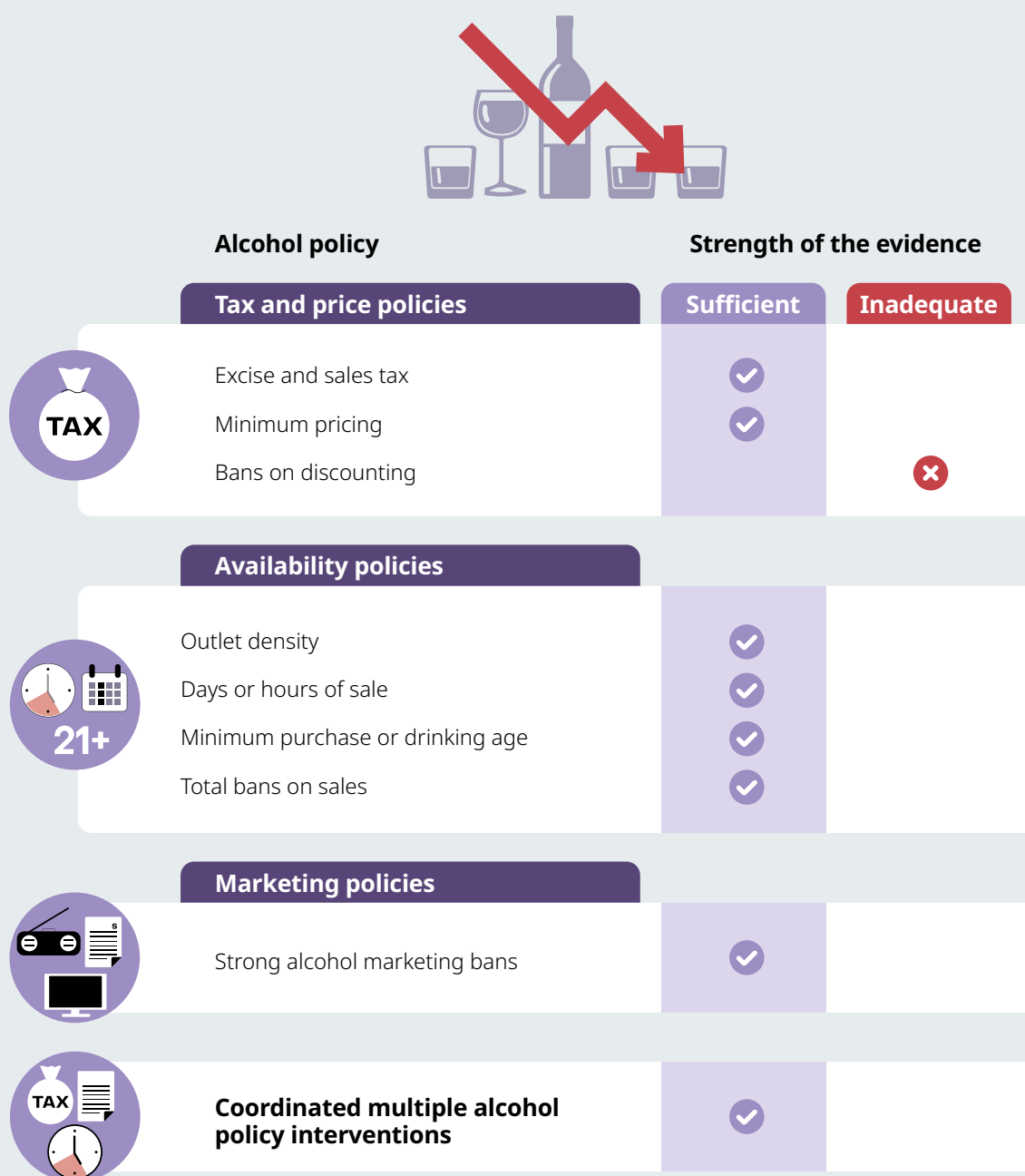


Source: based on the evaluations by the Working Group for IARC Handbook 20A (7).

3. Key findings from IARC Handbook 20B: alcohol policies

Population-level alcohol policies that target availability, affordability and marketing of alcohol lead to a reduction in alcohol consumption (Fig. 6).

Fig. 6. Summary of evidence for the effect of alcohol policy interventions on alcohol consumption, by policy category and specific measure



Source: based on the evaluations by the Working Group for IARC Handbook 20B (15).

3.1. Impact of population-level alcohol policies on alcohol consumption

3.1.1. Tax and price policies

Policies that increase the price of alcohol consistently reduce consumption. Tax increases were inversely associated with alcohol consumption in all studies across multiple countries, with evidence further supported by consistent findings that tax increases are passed through to consumer prices.

Similarly, minimum pricing policies consistently reduced alcohol sales and household purchases across different study designs and populations.

In contrast, the evidence concerning bans on alcohol discounts was highly inconsistent across studies and no conclusion could be drawn.

3.1.2. Availability policies

Policies regulating the physical availability of alcohol can also reduce consumption:

- › Restrictions on the density of alcohol outlets were consistently associated with reductions in alcohol consumption and proxy outcomes such as alcohol-related hospital admissions.
- › Restricting the days or hours of alcohol sales reduced consumption in all studies reviewed, while extensions of sales hours had the opposite effect.
- › Increasing the minimum legal purchasing age consistently reduced alcohol consumption among the affected age groups across all better-quality studies.
- › Total bans on alcohol sales were associated with large reductions in consumption and alcohol-related harms across a range of settings in both high-income and low- and middle-income countries.

3.1.3. Marketing policies

Exposure to alcohol marketing increases alcohol consumption, particularly among young people. No studies have assessed comprehensive bans on alcohol marketing. Nevertheless, strong marketing restrictions, covering at least one major media type and all three major types of beverages (beer, wine and spirits), consistently lead to lower alcohol consumption. It is worth noting that the available evidence pre-dates highly personalized digital marketing, which represents a growing and largely unregulated channel for alcohol promotion.

3.1.4. Coordinated multiple alcohol policy interventions

Regulatory frameworks that combine several policy measures can also reduce alcohol consumption.

- › Government alcohol monopolies include pricing controls, restrictions on availability and limits on marketing. Their weakening or privatization has led to increases in alcohol consumption and heavy drinking.
- › Evidence from other national action plans that combine multiple alcohol policies also suggest reductions in alcohol consumption.

3.2. Impact of health care-based interventions on alcohol consumption

Health care-based approaches can also play an important role in lowering alcohol consumption and related harms, although their overall impact depends heavily on access, implementation and broader health system support. In Handbook 20B, health care-based interventions to reduce alcohol consumption are summarized but not evaluated, because these interventions target individual persons, and their potential population-level effects on consumption are not usually measured.

Screening tools are effective for identifying individuals with hazardous or harmful drinking, and brief interventions, particularly those delivered by trained practitioners in health-care settings, lead to modest but consistent reductions in alcohol consumption and in heavy drinking episodes. Digitally delivered interventions also show beneficial effects, although these are generally smaller and less consistent.

The effectiveness of screening and brief interventions varies across populations and contexts. Small but positive effects are observed among adolescents and young adults as well as a higher likelihood of abstinence among pregnant women.

Longer-term treatment interventions can include pharmacotherapy and psychosocial approaches (for example, motivational therapies, couples-based interventions and 12-step facilitation). Psychosocial approaches improve abstinence and reduce drinking, with no single approach being clearly superior across outcomes. The combination of psychosocial treatments with pharmacotherapy provides additional benefits. However, important limitations remain, including reliance on self-reported outcomes, challenges in scaling interventions in real-world settings, and variability in access to trained providers and medications.



4. Estimated impact of alcohol policy interventions on cancer prevention in the EU

To quantify the potential of effective alcohol policies for cancer prevention in the EU, a multicountry modelling study was conducted across all 27 EU Member States (18). The study estimated how four population-level alcohol policy interventions, had they been implemented in 2012, would have reduced alcohol-attributable cancer incidence by 2022, taking account of a 10-year latency period between changes in alcohol consumption and cancer incidence. Cancer incidence was estimated for the seven cancer sites causally linked to alcohol consumption, by country, sex and age group.

The four policy scenarios, selected on the basis of real-world evidence from high-income countries reviewed in IARC Handbook 20B (15), each had sufficient evidence of an established effect on alcohol consumption. All four policy scenarios would have reduced cancer incidence across the EU.



Increased alcohol excise taxation.

This scenario would have averted approximately **8400 cancer cases**, or 5.9% of alcohol-attributable cases.



Ban on Sunday alcohol sales.

This scenario would have averted approximately **5500 cancer cases**, or 3.8% of alcohol-attributable cases.



National ban on alcohol marketing.

This scenario would have averted approximately **6400 cancer cases**, or 4.5% of alcohol-attributable cases.



Integrated alcohol policy. This scenario would have averted approximately **9200 cancer cases**, or 6.5% of all alcohol-attributable cases in the EU – the largest reduction among the four scenarios.

Across all scenarios, the largest absolute reductions were estimated for female breast cancer and oesophageal cancer (Fig. 7). Alcohol-attributable female breast cancer incidence would have been reduced by up to 10.4%. The estimated reductions in oesophageal cancer corresponded to approximately one in every 14 oesophageal cancer cases in the EU being averted. Under the integrated policy, these two cancer sites together accounted for over half of all cases averted (Fig. 8). The reductions for cancers of the oral cavity, pharynx and larynx would be smaller than those for breast and oesophageal cancer but larger than those for colorectal and liver cancer. Across all scenarios, colorectal and liver cancer showed the smallest reductions, generally below 4% across all scenarios.

Fig. 7. Cancer cases averted under each policy scenario in the EU for the seven alcohol-related cancer sites, by cancer site

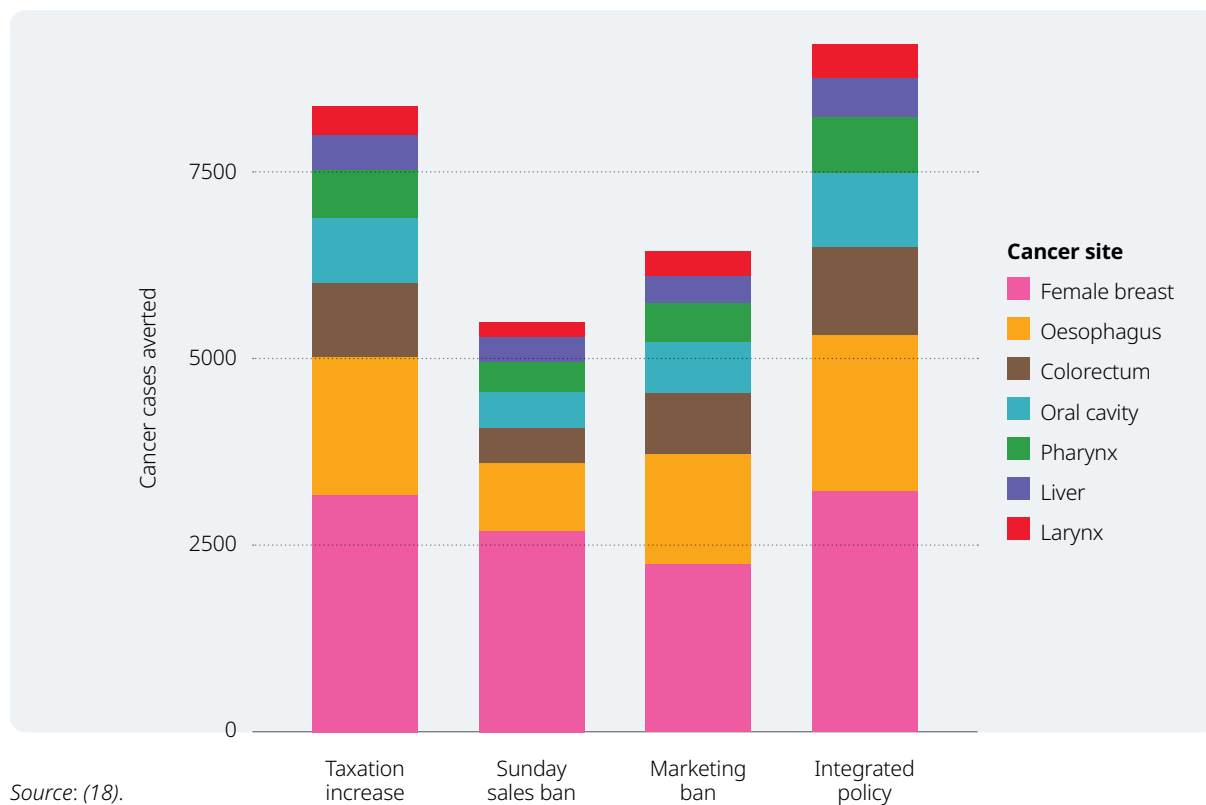
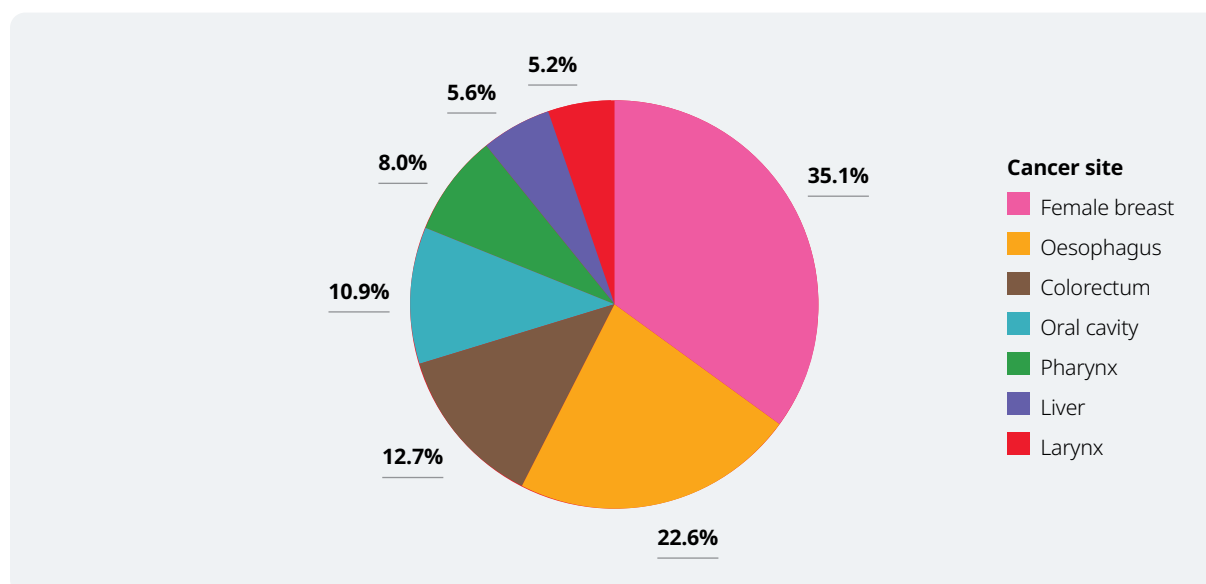


Fig. 8. Relative contribution of each cancer site to total cancer cases averted under the integrated policy scenario in the EU



These findings demonstrate that population-level alcohol policies represent an underused tool for cancer prevention. Implementation of WHO-recommended alcohol policies could prevent thousands of cancer cases annually across the EU and should be integrated within European and national cancer control frameworks.

5. Conclusions

Bringing together evidence from policy-level interventions to reduce alcohol consumption and evidence on cancer outcomes demonstrates the pertinence of population-level alcohol control strategies for reducing the burden of cancer. The value of coordinated approaches that bring together regulatory, fiscal and public health measures within broader alcohol policy frameworks is highlighted. Relevant actions include policies targeting availability, affordability and marketing of alcohol. Health care-based interventions may complement these population-level strategies by supporting early identification and risk reduction.

The outlined policy directions are consistent with the recommendations of the WHO global alcohol action plan (19) and the WHO European framework for action on alcohol 2022–2025 (20), which encourage countries to strengthen comprehensive and proportionate responses to alcohol-related harm.

The impact of alcohol policies evaluated and discussed in Handbook 20B can be reinforced by improving public awareness of the health risks associated with alcohol consumption. This may involve measures such as warning labels on alcoholic beverages, targeted public health campaigns, and expanded screening and brief interventions for alcohol-related disorders and other conditions influenced by alcohol use. Integrating evidence on the links between alcohol and cancer into brief intervention guidance can also support health-care providers in helping individuals make informed decisions.

Together, these complementary approaches can contribute to reducing the burden of alcohol-attributable cancers while also addressing wider public health and social harms.



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