


# Use of Straighteners and Other Hair Products and Incident Uterine Cancer

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## Abstract

**Background:** Hair products may contain hazardous chemicals with endocrine-disrupting and carcinogenic properties. Previous studies have found hair product use to be associated with a higher risk of hormone-sensitive cancers including breast and ovarian cancer; however, to our knowledge, no previous study has investigated the relationship with uterine cancer. **Methods:** We examined associations between hair product use and incident uterine cancer among 33947 Sister Study participants aged 35-74 years who had a uterus at enrollment (2003-2009). In baseline questionnaires, participants in this large, racially and ethnically diverse prospective cohort self-reported their use of hair products in the prior 12 months, including hair dyes; straighteners, relaxers, or pressing products; and permanents or body waves. We estimated adjusted hazard ratios (HRs) and 95% confidence intervals (CIs) to quantify associations between hair product use and uterine cancer using Cox proportional hazard models. All statistical tests were 2-sided. **Results:** Over an average of 10.9 years of follow-up, 378 uterine cancer cases were identified. Ever vs never use of straightening products in the previous 12 months was associated with higher incident uterine cancer rates (HR 1.80, 95% CI 1.12 to 2.88). The association was stronger when comparing frequent use (>4 times in the past 12 months) vs never use (HR 2.55, 95% CI 1.46 to 4.45;  $P_{\text{trend}} = .002$ ). Use of other hair products, including dyes and permanents or body waves, was not associated with incident uterine cancer. **Conclusion:** These findings are the first epidemiologic evidence of association between use of straightening products and uterine cancer. More research is warranted to replicate our findings in other settings and to identify specific chemicals driving this observed association.

Uterine cancer is one of the most common gynecologic cancers. Overall, incidence and mortality rates have increased in the United States in the past 2 decades, with more than 65950 new cases and 12550 deaths expected in 2022 (1,2). Exposure to excess estrogen and a hormonal imbalance of estrogen and progesterone have been identified as key risk factors for uterine cancer (3,4).

the Sister Study, we have previously observed a higher breast cancer incidence associated with adolescent (18) and adult use (19) of hair products and a higher ovarian cancer incidence associated with adult use of straighteners (22). However, to our knowledge, no study has investigated the influence of hair product use on uterine cancer. Therefore, this study aims to examine

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Thus, it has been hypothesized that synthetic estrogenic compounds such as endocrine-disrupting chemicals (EDCs) could contribute to uterine cancer risk because of their ability to alter hormonal actions (5-11).

Hair product use, a predominant exposure pathway to various EDCs (12,13), has been associated with hormone-sensitive cancers including breast (14-19) and ovarian cancer (20-23) in previous epidemiologic studies. Hair product constituents, including formaldehyde (24-27) and formaldehyde-releasing chemicals (28-30) in some straighteners, and oxidized paraphenylenediamine and 4-aminobiphenyl in hair dyes (25,31-33), have also played a potential role in carcinogenesis, supporting an association between hair product use and cancer development.

Hair product use is common among women in the United States and Europe with more than 50% reporting ever using permanent hair dyes (19,22,34). In

associations between hair product use and the age-specific hazard of uterine cancer in a large, racially and ethnically diverse cohort in the United States.

## Methods

### Study Population

The Sister Study is a prospective cohort that enrolled 50884 women in 2003-2009. Participants were eligible if they were breast cancer-free women aged 35-74 years who had at least 1 sister diagnosed with breast cancer and if they lived in the United States, including Puerto Rico (35). At baseline, participants completed an interview and self-administered questionnaires that included questions about hair product use. Weight and height were measured during a home visit at baseline by trained examiners. Participants or next of kin for

deceased participants are contacted annually for health updates regarding new cancer diagnoses and other health-related changes, and every 2-3years for more detailed follow-up assessments. Response rates have been near 90% throughout follow-up (36). Data for the current analysis included person-time through September 2019 (Data Release 9.1). Written informed consent was obtained from all participants. This study is overseen by the institutional review boards of the National Institutes of Health.

We excluded women who withdrew from the study (n/43), who self-reported a diagnosis of uterine cancer before enrollment (n/4380), had an uncertain uterine cancer history (n/10), had an unclear timing of diagnosis relative to enrollment (n/459), had a hysterectomy before enrollment (n/15585), who did not answer any hair product use questions (n/4736), and who did not contribute any follow-up time (n/164), resulting in 33947 eligible women.

### Exposure Assessment

At baseline, participants were asked to complete a questionnaire on hair product use in the previous 12months.

Participants reported their frequency of personal use (application by themselves or others to their own hair) of 7 hair products including permanent, semipermanent, and temporary hair dyes; bleach; highlights; straighteners, relaxers, or pressing products; and hair permanents or body waves with the response options including “did not use,” “1-2 times per year,” “every 3-4months,” “every 5-8weeks,” “once per month,” and “more than once per month.” Additionally, frequency of nonprofessional application to others was collected for permanent hair dyes, semipermanent hair dyes, and straighteners, relaxers, or pressing products. Based on exposure distribution, we collapsed frequency variables as no more than 2 and more than 2 times per year for hair permanents and as no more than 4 and more than 4 times per year for the other hair product use among ever use. These exposure variables were also dichotomized to never and ever use. Color of dyes (“dark,” “light”) and lifetime duration of use (“did not use,” “less than 5years,” “5-9years,” “10 or more years”) were obtained for permanent and semipermanent hair dye use.

### Outcome and Covariate Assessment

Uterine cancer cases were defined as women who reported a diagnosis of endometrial cancer, uterine sarcoma, or other types of cancer in the uterus after enrollment (n/378). Women reporting a cancer diagnosis were asked to provide authorization to retrieve medical records. A total of 262 (69.3%) cases were confirmed using either medical records (n/247) or death certificates indicating the primary or underlying cause of death as uterine cancer (n/15). For those without medical confirmation, the information was obtained through self-report (n/109) and next of kin (n/7). The positive predictive value of self-reported uterine cancer cases in relation to medically confirmed cases is 85%.

Of 262 medically confirmed uterine cancer cases, 248 (94.7%) were classified as endometrial cancers using International Classification of Disease–10 code C54.1. Further, we used International Classification of Disease–Oncology-3 histology codes to define type I and type II endometrial cancer (37). Type I endometrial cancers are more hormone sensitive with greater estrogen receptor expression and tend to have better outcomes and survival, whereas type II cancers tend to be more clinically aggressive and have a poor prognosis (38-41).

Other covariates collected at baseline included self-reported age, race and ethnicity (African American/Black including Hispanic/Latina, Hispanic/Latina non-Black, non-Hispanic White, and all others, including Asian/Pacific Islander or American Indian), physical activity (metabolic equivalent hours per week), smoking status (never, past, or current), alcohol consumption (never or past, current <1 drink per day, current 1 drink per day), educational attainment (high school or less, some college, college and above), and occupational history working in beauty salons or barbershops. Reproductive history included age at

menarche (younger than 13 years, 13years and older), menopausal status (premenopausal and postmenopausal), parity (0, 1, 2, 3), oral contraceptive use (none, <2, 2 to <10, 10years), hormone replacement therapy use (none, estrogen alone, estrogen plus progesterone but never estrogen alone). Body mass index (BMI) was calculated by height and weight measured at baseline (35).

### Statistical Analysis

We estimated pairwise correlations using Spearman correlation coefficients among frequency metrics for hair product use. Associations between hair product use and uterine cancer were assessed using Cox proportional hazards models with age as the timescale. Women were followed from enrollment until uterine cancer diagnosis and were considered censored at the earliest event including hysterectomy, loss to follow-up, death, or end of follow-up. The 95% confidence intervals (CIs) were calculated using cluster-robust sandwich estimators to account for relations among participants (2872 women had >1 family member enrolled). Cox models were adjusted for an a priori selected list of confounders including race and ethnicity, educational attainment, BMI (restricted cubic spline with knots at the 5th, 35th, 65th, and 95th percentile, kg/m<sup>2</sup>), physical activity, menopausal status at enrollment, parity, smoking status, alcohol consumption, oral contraceptive use duration, hormone replacement therapy, and age at menarche. Proportional hazards assumptions were evaluated by Wald tests of covariate-byattained-age interaction terms.  $P_{trend}$  was assessed using Wald tests for continuous variables of hair product use frequency and duration.

We considered whether associations between hair product use and uterine cancer varied by race and ethnicity, obesity, and physical activity. Stratum specific hazard ratios (HRs) were estimated by augmenting our primary model with hair product-by-modifier interaction terms, and heterogeneity was tested using Wald tests. Hazard ratios by race and ethnicity were only estimated for African American/Black and nonHispanic White participants because of the small number of women in other racial and ethnic groups. To estimate the cumulative risk of developing uterine cancer by age 70 years, we used the Breslow method to create baseline hazard functions for uterine cancer and competing risks, and a modified AalenJohansen estimator for cumulative risk for all participants, standardized to the covariate distribution of the study population (42). From this, we calculated absolute differences and numbers needed to harm for use of straighteners.

We also evaluated the associations by different cancer subtypes, including pre- and postmenopausal uterine cancers, endometrial cancer, and types I and II endometrial cancers. Women who were premenopausal at enrollment were at risk for premenopausal uterine cancer until menopause, at which time they were considered at risk for postmenopausal uterine cancer. Women became at risk for postmenopausal uterine cancer at either age at enrollment or age at menopause, whichever was later.

Several sensitivity analyses were conducted to evaluate the robustness of our findings. First, we restricted the outcome to medically confirmed uterine cancer cases. Second, we removed physical activity from the model because physical activity may act as a confounder and/or a mediator. Costly and timeconsuming hairstyling practice may be a barrier to physical activity, whereas women engaging in intense physical activities may change their hairstyling practices (43,44). We excluded 1048 women who had worked in beauty salons or barbershops to eliminate the potential impact of occupational exposure. We considered simultaneous adjustment for other personal hair product use, including frequently used products and all products. Further, the first year of follow-up was excluded to assess the possibility of reverse causation. Finally, associations with use of straighteners or hair permanents as a combined exposure were estimated because these terms have been used interchangeably in African American and/or Black communities to describe chemical products used to change the texture of hair (45,46).

Because of sample size limitations, the frequency, stratified, and sensitivity analyses are only reported for the products more frequently used, including

personal use of permanent dyes, semipermanent dyes, straighteners, and hair permanents. Estimates with fewer than 5 cases in any stratum in the statistical model are not reported. Complete-case analyses were done with 557-1316 (1.6%-3.9%) women being excluded in the main analyses because of missingness in any variable. All analyses were conducted in R version 4.1.0.

## Results

We followed participants for a mean of 10.9 years. The study population consists of 7.4% Black/African American, 4.4% Hispanic/Latina non-Black, 85.6% non-Hispanic White, and 2.5% all other race and ethnicity. Participants had high educational attainment on average (55.8% college degree or above). Compared with the cohort overall, uterine cancer cases tended to be older with an earlier age at menarche, a higher BMI, and lower physical activity (Table 1). The participants who ever used straighteners were mostly African American/Black (59.9%) and tended to be younger with a higher BMI and lower physical activity than those never used (Supplementary Table 1, available online). The frequencies of use of different hair products were weakly correlated with each other (correlation coefficients: 0.10 to 0.39).

We observed an 80% higher adjusted hazard of uterine cancer among women with ever straightener use in the previous 12 months (HR 1.80, 95% CI 1.12 to 2.88) (Table 2). There was a monotonic exposure-response relationship with increasing frequency of use of straighteners ( $P_{\text{trend}} < .002$ ) (Table 3). Compared with no use, infrequent straightener use (4 times per year) was associated with an elevated but not statistically significantly higher rate of uterine cancer (HR 1.20, 95% CI 0.63 to 2.29), whereas for frequent use (>4 times per year), the hazard ratio was 2.55 (95% CI 1.46 to 4.45). Among women who never used straighteners in the 12 months prior to baseline, approximately 1.64% were predicted to develop uterine cancer by age 70 years. The estimated risk was 1.18% (95% CI for risk difference 0.15% to 2.54%) higher for the women with ever use, and 2.41% (95% CI for risk difference 0.52% to 4.80%) higher for those with frequent use compared with never use. The numbers needed to harm were 85 and 42 for the women with ever and frequent straightener use, respectively—that is, one additional uterine cancer case would be expected for every 85 ever users or every 42 frequent users. In contrast, use of other hair products, including permanent hair dye, was not associated with an increased rate of uterine cancer (Tables 2 and 3).

The observed higher rates of incident uterine cancer with straightener use remained evident when restricting the outcomes to postmenopausal (frequent use: HR 2.52, 95% CI 1.39 to 4.55) cases and medically confirmed uterine (frequent use: HR 2.78, 95% CI 1.39 to 5.55) and endometrial (frequent use: HR 2.68, 95% CI 1.30 to 5.53) cancer cases (Table 4). Further, we categorized endometrial cancer to type I (n=199; 80.2%) and type II (n=40; 16.1%) tumors. The association for straightener use was again similar for type I endometrial cancer (frequent use: HR 2.94, 95% CI 1.42 to 6.08). Because of the small number of premenopausal and type II endometrial cancer cases, we were unable to reliably estimate associations for some products.

We observed heterogeneity by physical activity, with stronger estimated associations of straightener use among women reporting low levels (<33rd percentile: 32.7 metabolic equivalent hours per week) compared with high levels (33rd percentile; ever use  $P_{\text{heterogeneity}} < .05$ ; frequent use  $P_{\text{heterogeneity}} < .09$ ) (Table 5). Among ever use, the hazard ratios were 2.59 (95% CI 1.46 to 4.61) and 1.30 (95% CI 0.71 to 2.38) in women with low and high physical activity, respectively. Similar patterns were also observed among women with frequent use (low physical activity: HR 3.72, 95% CI 1.91 to 7.25; high physical activity: HR 1.86, 95% CI 0.89 to 3.87). Hazard ratios of straightener use did not vary by race and ethnicity or obesity. Moreover, no hazard ratio modification by physical activity, race and ethnicity, or obesity was observed for use of permanent dyes, semipermanent dyes, or hair permanents (Supplementary Table 2, available online). Results of our sensitivity analyses did not indicate any major departure from the results of the main analysis (Supplementary Table 3, available online).

## Discussion

In this large, prospective US-based cohort, we observed novel findings of a higher incident uterine cancer rate for women who self-reported either ever or frequent hair straightener use in the 12 months prior to the baseline, relative to those who did not. Negligible associations were observed for other hair products used including permanent dyes, semipermanent dyes, temporary dyes, bleach, highlights, and hair permanents with uterine

Characteristics <sup>a</sup>	Incident uterine cancer cases (n=378)	Full eligible cohort <sup>b</sup> (n=33947)
Mean age (SD), y	58.0 (8.07)	54.2 (8.94)
Mean follow-up time (SD), y	6.45 (3.61)	10.9 (3.08)
Mean age at menarche (SD), y	12.4 (1.40)	12.7 (1.51)
< 13 years old, No. (%)	196 (51.9)	15570 (45.9)
Race and ethnicity, No. (%)		
African American/Black including Hispanic/Latina Black	29 (7.7)	2523 (7.4)
Hispanic/Latina non-Black	14 (3.7)	1508 (4.4)
Non-Hispanic White	326 (86.2)	29060 (85.6)
Other	9 (2.4)	854 (2.5)
Education, No. (%) High school or less	47 (12.4)	4523 (13.3)
Some college	119 (31.5)	10482 (30.9)
College or above	212 (56.1)	18937 (55.8)
Mean body mass index (SD), kg/m <sup>2</sup>	30.4 (7.2)	27.3 (6.1)
Normal or underweight, No. (%)	91 (24.1)	14408 (42.4)
Overweight, No. (%)	109 (28.8)	10453 (30.8)
Obese, No. (%)	178 (47.1)	9075 (26.7)
Mean physical activity (SD), metabolic equivalent (MET) hours per week	47.7 (32.7)	50.8 (31.3)
Low (<33rd percentile 32.7 MET hours per week), No. (%)	146 (38.6)	11114 (32.7)
Premenopausal, No. (%)	103 (27.2)	14108 (41.6)
Parity, No. (%)		
Nulliparous	82 (21.7)	6769 (19.9)
1 birth	51 (13.5)	5033 (14.8)
2 births	145 (38.4)	12472 (36.7)
3 births	99 (26.2)	9650 (28.4)
Smoking status, No. (%)		
Never	195 (51.6)	19370 (57.1)
Past	166 (43.9)	11931 (35.1)
Current	17 (4.5)	2638 (7.8)
Alcohol consumption, No. (%)		
Never or past	73 (19.3)	5591 (16.5)
Current <1 drink/day	257 (68.0)	23382 (68.9)
Current 1 drinks/day	48 (12.7)	4918 (14.5)
Duration of oral contraceptive use, No. (%)		
None	87 (23.0)	5171 (15.2)
<2 years	78 (20.6)	5007 (14.7)
2 to <10 years	152 (40.2)	14476 (42.6)
10 years	60 (15.9)	9262 (27.3)
Hormone replacement therapy use, No. (%) <sup>c</sup>		
None	238 (63.0)	22799 (67.2)
Estrogen alone	34 (9.0)	2329 (6.9)
Estrogen plus progestin	104 (27.5)	8736 (25.7)
Had worked in beauty salon or barbershop, No. (%)	11 (2.9)	1048 (3.1)

<sup>a</sup> Missing: age at menarche (29 overall), race and ethnicity (2 overall), education (5 overall), body mass index (11 overall), physical activity (3 cases, 269 overall), menopausal status at baseline (7 overall), parity (1 case, 23 overall), smoking status (8 overall), alcohol consumption (56 overall), oral contraceptive use (1 case, 31 overall), hormone replacement therapy (2 cases, 83 overall), and had worked in beauty salon or barbershop (1 case, 51 overall).

<sup>b</sup> Excluded women who withdrew (n=3), were diagnosed with uterine cancer before baseline (n=380), had an uncertain uterine cancer history (n=10), had an unclear timing of diagnosis relative to enrollment (n=59), had a hysterectomy prior to enrollment (n=15585), did not respond to all questions about hair product use (n=736), or did not contribute any follow-up time (n=164).

<sup>c</sup> The women who ever reported using estrogen-alone hormone replacement therapy were categorized as estrogen alone.

These findings are consistent with prior studies supporting a role of straighteners in increased risk of other female, hormone-related cancers (14,15,17-19,22).

To our knowledge, this is the first epidemiologic study investigating the relationship between straightener use and uterine cancer. Previous studies have demonstrated that exposure to straighteners was associated with lower sex steroid hormone levels (47,48), elevated risk of uterine leiomyomata (49), early

age at menarche (50), and incident breast (14,15,17,19) and ovarian cancer (22), supporting a potential role of straighteners in the etiology of hormone-sensitive health outcomes.

Several chemicals often identified as constituents in straighteners (6,26,51,52) could contribute to the increased incident uterine cancer rates observed here. Concentrations of parabens in endometrium tissues and phthalates in urine samples were higher in participants with endometrial cancer

Table 1. Characteristics of the study participants in the Sister Study at enrollment by incident uterine cancer cases, 2003-2009

than those who are endometrial cancer-free (53,54). Chronic exposure to low-dose bisphenol A has been associated with altered estrous

with higher physical activity might be less susceptible to other risk factors for uterine cancer. However, more studies are warranted to understand the

Table 2. Associations between ever use of hair product in the 12months prior to enrollment and uterine cancer in the Sister Study

Hair product use <sup>a</sup>	Person-years	Full cohort No. (%) <sup>b</sup>	Case No. (%) <sup>b</sup>	Age-adjusted HR (95% CI) <sup>c</sup>	Fully adjusted HR (95% CI) <sup>c,d</sup>
<b>Permanent dyes</b>					
Never	162425	14795 (44.4)	184 (49.9)	Referent	Referent
Ever	200450	18531 (55.6)	185 (50.1)	0.88 (0.71 to 1.08)	0.90 (0.74 to 1.11)
Never to others	337846	30935 (92.7)	352 (95.4)	Referent	Referent
Ever to others	25530	2436 (7.3)	17 (4.6)	0.76 (0.47 to 1.23)	0.69 (0.42 to 1.14)
<b>Semipermanent dyes</b>					
Never	293148	26829 (80.5)	307 (82.7)	Referent	Referent
Ever	69590	6484 (19.5)	64 (17.3)	0.94 (0.71 to 1.23)	0.94 (0.72 to 1.24)
Never to others	350705	32169 (96.5)	362 (97.6)	Referent	Referent
Ever to others	12246	1162 (3.5)	9 (2.4)	0.85 (0.44 to 1.64)	0.78 (0.4 to 1.51)
<b>Temporary dyes</b>					
Never	334730	30666 (92.1)	333 (90.2)	Referent	Referent
Ever	27967	2644 (7.9)	36 (9.8)	1.29 (0.91 to 1.81)	1.25 (0.88 to 1.78)
<b>Bleach Never</b>					
	321325	29464 (88.5)	340 (91.6)	Referent	Referent
Ever	41196	3832 (11.5)	31 (8.4)	0.73 (0.50 to 1.05)	0.77 (0.53 to 1.11)
<b>Highlights</b>					
Never	245613	22598 (67.7)	279 (75.8)	Referent	Referent
Ever	117912	10792 (32.3)	89 (24.2)	0.77 (0.6 to 0.97)	0.86 (0.68 to 1.1)
<b>Straighteners, relaxers, or pressing products</b>					
Never	333535	30329 (90.9)	332 (89.7)	Referent	Referent
Ever	29733	3036 (9.1)	38 (10.3)	1.63 (1.17 to 2.29)	1.80 (1.12 to 2.88)
Never to others	354618	32465 (97.3)	358 (97.0)	Referent	Referent
Ever to others	8775	914 (2.7)	11 (3.0)	1.76 (0.96 to 3.22)	1.42 (0.72 to 2.79)
<b>Hair permanents or body waves</b>					
Never	323483	29689 (89.0)	316 (85.6)	Referent	Referent
Ever	39779	3681 (11.0)	53 (14.4)	1.13 (0.84 to 1.53)	1.01 (0.75 to 1.37)

<sup>a</sup> Missing: permanent dyes (2 cases, 137 overall); permanent dyes to others (2 cases, 92 overall); semipermanent dyes (150 overall); semipermanent dyes to others (132 overall); temporary dyes (2 cases, 153 overall); bleach (167 overall); highlights (3 cases, 73 overall); straighteners, relaxers, or pressing products (1 case, 98 overall); straighteners, relaxers, or pressing products to others (2 cases, 84 overall); hair permanents or body waves (2 cases, 93 overall). CI ¼ confidence interval; HR ¼ hazard ratio. <sup>b</sup> Participants with complete confounder information.

<sup>c</sup> Accounted for age by using age as the timescale, where the participants were followed from age at baseline until age at end of follow-up.

<sup>d</sup> Adjusted for race and ethnicity (African American/Black, Hispanic/Latina non-Black, non-Hispanic White, other), education (high school or less, some college, college and above), body mass index (restricted cubic spline, continuous, kg/m<sup>2</sup>), physical activity (metabolic equivalent [MET] hours per week, continuous), menopausal status at enrollment (premenopausal, postmenopausal), parity (0, 1, 2, 3), smoking (never, past, or current), alcohol (never or past, current <1 drink, current 1 drinks), oral contraceptive use duration (none, <2years, 2 to <10years, 10years), hormone replacement therapy (none, estrogen alone, estrogen plus progestin but never estrogen alone), age at menarche (<13 years, 13years old).

cycle and uterine pathology in rats, which has been associated with endometrial cancer development and progression (7,9). Moreover, cyclosiloxanes have been associated with neoplastic responses in the uterus of rats (55-57), and diethanolamine, metals, and formaldehyde have been considered carcinogenic (9,25,27,58,59).

Notably, chemical exposure through the pathway of hair product use, especially straighteners, could be more concerning than other personal care products. Higher percutaneous absorption of chemicals has been observed in scalp compared with other skin such as on the forearm, palm, and abdomen (60). Straightener use may cause scalp lesions and burns, which facilitates the permeability of chemicals through the scalp (61,62). Heating processes such as flat ironing or blow drying during straightening treatments could release or thermally decompose chemicals from the products, leading to potential higher exposures to hazardous chemicals among the users (63,64).

We observed stronger associations with straightener use among women with low physical activity. Because physical activity has been associated with decreased sex steroid hormones and less chronic inflammation (65), women

interrelationship between physical activity, hair product use, and uterine cancer.

Obesity has previously been shown to modify associations between the exposures related to hormonal activity and uterine cancers (66-69); however, we did not observe heterogeneity by obesity. Although more estrogen and progesterone receptor–positive tumors have been observed in premenopausal than postmenopausal endometrial cancers (41,70), we did not observe a stronger effect of hair product use on premenopausal cases possibly because of a small number of exposed cases (n¼5). However, when we limited the outcome to hormonesensitive (type I) cancer subtype, the effect estimates remained similar, supporting a potential hormonal mechanism linking hair product use to uterine cancer.

Although no differences in the hazard ratios between racial and ethnic groups were observed, the adverse health effects associated with straightener use could be more consequential for African American and/or Black women because of the higher prevalence and frequency of hair product use, younger age of initiating use, and harsher chemical formulations (ie, higher

Hair product use <sup>a</sup>	Person-years	Full cohort No. (%) <sup>b</sup>	Case No. (%) <sup>b</sup>	Age-adjusted HR (95% CI) <sup>c</sup>	Fully adjusted HR (95% CI) <sup>c,d</sup>
<b>Permanent dyes</b>					
Frequency in the past 12months prior to baseline					
Never	162425	14795 (44.4)	184 (49.9)	Referent	Referent
4 times	83284	7740 (23.2)	64 (17.3)	0.80 (0.60 to 1.06)	0.79 (0.59 to 1.05)
>4 times	117166	10791 (32.4)	121 (32.8)	0.92 (0.73 to 1.16)	0.98 (0.78 to 1.24)
P <sub>trende</sub>				.44	.77
Color used in the past 12months prior to baseline					
Never	162425	14795 (44.4)	184 (49.9)	Referent	Referent
Light color <sup>f</sup>	107507	9895 (29.6)	98 (26.5)	0.87 (0.69 to 1.10)	0.93 (0.73 to 1.18)
Dark color <sup>f</sup>	111846	10401 (31.2)	101 (27.4)	0.92 (0.72 to 1.16)	0.91 (0.72 to 1.16)
Duration of use, lifetime					
Never	128528	11660 (35.4)	151 (41.8)	Referent	Referent
<5years	61572	5688 (17.3)	48 (13.3)	0.76 (0.55 to 1.06)	0.75 (0.54 to 1.04)
5 to <10years	55141	5064 (15.4)	50 (13.9)	0.83 (0.60 to 1.14)	0.84 (0.61 to 1.15)
10years	113108	10494 (31.9)	112 (31.0)	0.80 (0.63 to 1.03)	0.82 (0.64 to 1.05)
P <sub>trende</sub>				.10	.14
<b>Semipermanent dyes</b>					
Frequency in the past 12months prior to baseline					
Never	293148	26829 (80.5)	307 (82.7)	Referent	Referent
4 times	41738	3903 (11.7)	35 (9.4)	0.92 (0.65 to 1.31)	0.91 (0.63 to 1.29)
>4 times	27852	2581 (7.7)	29 (7.8)	0.96 (0.65 to 1.40)	0.98 (0.67 to 1.44)
P <sub>trende</sub>				.69	.77
Color used in the past 12months prior to baseline					
Never	293148	26829 (80.5)	307 (82.7)	Referent	Referent
Light color <sup>f</sup>	25324	2339 (7.0)	19 (5.1)	0.72 (0.45 to 1.14)	0.73 (0.46 to 1.17)
Dark color <sup>f</sup>	46522	4364 (13.1)	44 (11.9)	1.02 (0.74 to 1.40)	1.03 (0.74 to 1.42)
Duration of use, lifetime					
Never	249458	22877 (70.1)	254 (71.1)	Referent	Referent
<5years	54979	5014 (15.4)	49 (13.7)	0.94 (0.69 to 1.27)	0.93 (0.69 to 1.27)
5 to <10years	25424	2326 (7.1)	28 (7.8)	1.08 (0.73 to 1.60)	1.15 (0.78 to 1.70)
10years	25570	2414 (7.4)	26 (7.3)	0.91 (0.61 to 1.36)	0.90 (0.60 to 1.35)
P <sub>trende</sub>				.78	.85
<b>Straighteners, relaxers, or pressing products</b>					
Frequency in the past 12months prior to baseline					
Never	333535	30329 (90.9)	332 (89.7)	Referent	Referent
4 times	14268	1464 (4.4)	12 (3.2)	1.06 (0.59 to 1.88)	1.20 (0.63 to 2.29)
>4 times	15464	1572 (4.7)	26 (7.0)	2.19 (1.47 to 3.26)	2.55 (1.46 to 4.45)
P <sub>trende</sub>				<.001	.002
<b>Hair permanents or body waves</b>					
Frequency in the past 12months prior to baseline					
Never	323483	29689 (89.0)	316 (85.6)	Referent	Referent
2 times	21293	1951 (5.8)	23 (6.2)	0.99 (0.65 to 1.52)	0.92 (0.60 to 1.41)
>2 times	18486	1730 (5.2)	30 (8.1)	1.28 (0.87 to 1.89)	1.11 (0.75 to 1.63)
P <sub>trende</sub>				.24	.71

<sup>a</sup>Missing: permanent dyes (2 cases, 137 overall); color of permanent dyes (4 cases, 168 overall); duration of permanent dye uses (10 cases, 557 overall); semipermanent dyes (150 overall); color of semipermanent dyes (2 cases, 172 overall); duration of semipermanent dyes use (14 cases, 832 overall); straighteners, relaxers, or pressing products (1 case, 98 overall); hair permanents or body waves (2 cases, 93 overall). CI ¼ confidence interval; HR ¼ hazard ratio.

<sup>b</sup>Participants with complete confounder information.

<sup>c</sup>Accounted for age by using age as the timescale, where the participants were followed from age at baseline until age at end of follow-up.

<sup>d</sup>Adjusted for race and ethnicity (African American/Black, Hispanic/Latina non-Black, non-Hispanic White, other), education (high school or less, some college, college and above), body mass index (restricted cubic spline, continuous, kg/m<sup>2</sup>), physical activity (metabolic equivalent [MET] hours per week, continuous), menopausal status at enrollment (premenopausal, postmenopausal), parity (0, 1, 2, 3), smoking (never, past, or current), alcohol (never or past, current <1 drink, current 1 drinks), oral contraceptive use duration (none, <2years, 2 to <10years, 10years), hormone replacement therapy (none, estrogen alone, estrogen plus progestin but never estrogen alone), age at menarche (<13 years, 13years old).

<sup>e</sup>Assessed using Wald tests for continuous variables of hair product use frequency and duration.

<sup>f</sup>Hair color is nonexclusive: participants could be both light and dark users. Both colors were included in the models simultaneously.

Table 3.  
Association of hair product use frequency, color of dyes, and duration of use with uterine cancer in the Sister Study

concentrations of EDCs and chemicals being regulated or banned) than other races and ethnicities (6,71).

Strengths of this study include the prospective cohort design and access to medical records for most cases, which reduced the possibility of recall bias and allowed investigation by different uterine cancer subtypes. Brands or ingredients of hair products were not collected; thus, the specific chemicals contributing to incident uterine cancer were not identified. However, because some products may be regularly applied, our approach has the benefit of capturing chronic exposures to chemicals

with short biological half-lives, which would be challenging to assess using biomarkers in relation to an outcome like cancer with a long latent period. Further, self-reported hair product use reflects exposure to chemical mixtures including chemicals that have not been previously identified (47). We evaluated exposure in the 12months before the baseline; however, product use behaviors and product formulations may vary over time. In the questionnaire, straightening product use was inclusive of use of pressing products. Because pressing hair is a treatment using heated combs and/or flatirons, which requires less harsh products than chemical straighteners

Table 4. Association between hair product use in the 12months prior to enrollment and uterine cancer by subtypes

Hair product use <sup>a</sup>	Ever		Frequent <sup>b</sup>		P <sub>trend</sub> <sup>c</sup>
	Case No. (%) <sup>c</sup>	HR (95% CI) <sup>d</sup>	Case No. (%) <sup>c</sup>	HR (95% CI) <sup>d</sup>	
<b>Permanent dyes</b>					
Premenopausal cases <sup>f</sup>	12 (50.0)	0.66 (0.29 to 1.48)	7 (29.2)	0.82 (0.32 to 2.13)	.61
Postmenopausal cases <sup>f</sup>	173 (50.1)	0.95 (0.76 to 1.18)	114 (33.0)	1.00 (0.79 to 1.28)	.96
<b>Medically confirmed cases<sup>g</sup></b>					
All uterine cancer	123 (47.9)	0.80 (0.63 to 1.03)	86 (33.5)	0.92 (0.70 to 1.21)	.44
Endometrial cancer <sup>h</sup>	119 (49.0)	0.83 (0.64 to 1.06)	83 (34.2)	0.94 (0.71 to 1.24)	.56
Type I endometrial cancer <sup>i</sup>	97 (49.7)	0.83 (0.62 to 1.10)	72 (36.9)	1.01 (0.74 to 1.37)	.92
Type II endometrial cancer <sup>j</sup>	19 (48.7)	0.90 (0.48 to 1.70)	11 (28.2)	0.80 (0.38 to 1.69)	.58
<b>Semipermanent dyes</b>					
Premenopausal cases <sup>f</sup>	5 (20.8)	0.89 (0.33 to 2.41)	1 (4.2)	— <sup>k</sup>	— <sup>k</sup>
Postmenopausal cases <sup>f</sup>	59 (17.0)	0.98 (0.73 to 1.31)	28 (8.1)	1.05 (0.71 to 1.55)	.97
<b>Medically confirmed cases<sup>g</sup></b>					
All uterine cancer	44 (17.1)	0.98 (0.70 to 1.36)	20 (7.8)	1.02 (0.65 to 1.62)	.98
Endometrial cancer <sup>h</sup>	39 (16.0)	0.92 (0.65 to 1.30)	17 (7.0)	0.93 (0.56 to 1.52)	.67
Type I endometrial cancer <sup>i</sup>	33 (16.8)	0.98 (0.67 to 1.43)	15 (7.7)	1.05 (0.62 to 1.79)	.98
Type II endometrial cancer <sup>j</sup>	5 (12.8)	0.73 (0.28 to 1.88)	2 (5.1)	— <sup>k</sup>	— <sup>k</sup>
<b>Straighteners, relaxers, or pressing products</b>					
Premenopausal cases <sup>f</sup>	5 (20.8)	1.56 (0.26 to 9.29)	5 (2.08)	1.56 (0.26 to 9.29)	— <sup>k</sup>
Postmenopausal cases <sup>f</sup>	33 (9.5)	1.90 (1.16 to 3.13)	21 (6.1)	2.52 (1.39 to 4.55)	.003
<b>Medically confirmed cases<sup>g</sup></b>					
All uterine cancer	21 (8.2)	1.94 (1.10 to 3.42)	14 (5.4)	2.78 (1.39 to 5.55)	.005
Endometrial cancer <sup>h</sup>	17 (7.0)	1.89 (1.04 to 3.43)	11 (4.5)	2.68 (1.30 to 5.53)	.005
Type I endometrial cancer <sup>i</sup>	13 (6.7)	1.89 (1.01 to 3.54)	9 (4.6)	2.94 (1.42 to 6.08)	.009
Type II endometrial cancer <sup>j</sup>	2 (5.1)	— <sup>k</sup>	2 (5.1)	— <sup>k</sup>	— <sup>k</sup>
<b>Hair permanents or body waves</b>					
Premenopausal cases <sup>f</sup>	4 (15.7)	— <sup>k</sup>	3 (12.5)	— <sup>k</sup>	— <sup>k</sup>
Postmenopausal cases <sup>f</sup>	49 (14.2)	0.96 (0.69 to 1.32)	27 (7.8)	0.96 (0.63 to 1.46)	.80
<b>Medically confirmed cases<sup>g</sup></b>					
All uterine cancer	33 (12.8)	0.93 (0.64 to 1.36)	19 (7.4)	1.07 (0.66 to 1.74)	.95
Endometrial cancer <sup>h</sup>	31 (12.8)	0.94 (0.64 to 1.39)	19 (7.8)	1.18 (0.72 to 1.92)	.87
Type I endometrial cancer <sup>i</sup>	26 (13.3)	1.04 (0.68 to 1.59)	16 (8.2)	1.36 (0.80 to 2.32)	.51
Type II endometrial cancer <sup>j</sup>	5 (12.8)	0.82 (0.31 to 2.16)	3 (7.7)	— <sup>k</sup>	— <sup>k</sup>

<sup>a</sup> Missing: permanent dyes (2 cases, 137 overall); semipermanent dyes (150 overall); straighteners, relaxers, or pressing products (1 case, 98 overall); hair permanents or body waves (2 cases, 93 overall). CI % confidence interval; HR % hazard ratio.

<sup>b</sup> Definition of frequent use: >4 times in the past 12months (permanent dyes; semipermanent dyes; straighteners, relaxers, or pressing products); >2 times in the past 12months (hair permanents or body waves).

<sup>c</sup> Participants with complete confounder information. Percentage of ever or frequent users among cases.

<sup>d</sup> Compared with never users. Adjusted for race and ethnicity (African American and/or Black, Hispanic and/or Latina non-Black, non-Hispanic White, other), education (high school or less, some college, college and above), body mass index (restricted cubic spline, continuous, kg/m<sup>2</sup>), physical activity (metabolic equivalent [MET] hours per week, continuous), menopausal status at enrollment (premenopausal, postmenopausal), parity (0, 1, 2, 3), smoking (never, past, or current), alcohol (never or past, current <1 drink, current 1 drinks), oral contraceptive use duration (none, <2years, 2 to <10years, 10years), hormone replacement therapy (none, estrogen alone, estrogen plus progestin but never estrogen alone), age at menarche (<13 years, 13years old).

<sup>e</sup> Assessed using Wald tests for continuous variables of hair product use frequency (never, infrequent, frequent use).

<sup>f</sup> Person-time is stratified by menopausal status.

<sup>g</sup> Confirmed diagnosis with medical records or death certificates from National Death Index (NDI). <sup>h</sup> International Classification of Disease (ICD)-10 code of C54.1% malignant neoplasm of endometrium.

<sup>i</sup> ICD-Oncology-3 histology codes: 8140, 8262, 8380, 8382, 8480, 8560, and 8570.

<sup>j</sup> ICD-Oncology-3 histology codes: 8310, 8323, 8441, 8460, 8950, and 8980.

<sup>k</sup> Data not presented as small number of cases (<5) within any stratum in the model.

<sup>l</sup> Unable to assess P<sub>trend</sub> because all cases are frequent users.

and relaxers, the estimated associations might underestimate the true relationship between the use of chemical straighteners and relaxers and uterine cancer.

In this large, prospective cohort study, we observed that straightening product use was positively associated with uterine cancer. More research is

warranted to confirm our novel findings in different populations, particularly in African American and/or Black women because of the high prevalence of straightener use, and to evaluate the potential contribution

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Table 5. Associations between straightener, relaxer, or pressing products use in the 12months prior to enrollment and uterine cancer in the Sister Study stratified by participant characteristics

Potential modifier <sup>a</sup>	Ever		Frequent <sup>b</sup>		P <sub>trend</sub> <sup>c</sup>
	Case No. (%) <sup>c</sup>	HR (95% CI) <sup>d</sup>	Case No. (%) <sup>c</sup>	HR (95% CI) <sup>d</sup>	
<b>Race and ethnicity<sup>f</sup></b>					
African American/Black <sup>g</sup>	23 (79.3)	1.66 (0.67 to 4.09)	17 (58.6)	2.12 (0.83 to 5.39)	.09
Non-Hispanic White	12 (3.8)	1.94 (1.09 to 3.47)	7 (2.2)	2.66 (1.25 to 5.67)	.011
<i>P</i> <sub>heterogeneity</sub> <sup>h</sup>		.77		.71	
<b>BMI</b>					
Nonobese (<30kg/m <sup>2</sup> )	16 (7.7)	1.81 (1.04 to 3.17)	10 (5.1)	2.48 (1.22 to 5.03)	.010
Obese (30kg/m <sup>2</sup> )	22 (12.6)	1.68 (0.90 to 3.14)	16 (9.2)	2.40 (1.19 to 4.85)	.022
<i>P</i> <sub>heterogeneity</sub> <sup>h</sup> Physical activity <sup>i</sup>		.83		.94	
Low	22 (15.3)	2.59 (1.46 to 4.61)	15 (10.4)	3.72 (1.91 to 7.25)	<.001
High	16 (7.1)	1.30 (0.71 to 2.38)	11 (4.9)	1.86 (0.89 to 3.87)	.16
<i>P</i> <sub>heterogeneity</sub> <sup>h</sup>		.05		.09	

<sup>a</sup> Missing: straighteners, relaxers, or pressing products (1 case, 98 overall). BMI ¼ body mass index; CI ¼ confidence interval; HR ¼ hazard ratio.

<sup>b</sup> Definition of frequent use: >4 times in the past 12months (permanent dyes; semipermanent dyes; and straighteners, relaxers, or pressing products).

<sup>c</sup> Participants with complete confounder information. Percentage of ever or frequent users among cases in each stratum.

<sup>d</sup> Compared with never users. Accounted for age by using age as the timescale, where the participants were followed from age at baseline until age at end of follow-up. Adjusted for race and ethnicity (African American/Black, Hispanic/Latina non-Black, non-Hispanic White, other), education (high school or less, some college, college and above), BMI (restricted cubic spline, continuous, kg/m<sup>2</sup>), physical activity (metabolic equivalent [MET] hours per week, continuous), menopausal status at enrollment (premenopausal, postmenopausal), parity (0, 1, 2, 3), smoking (never, past, or current), alcohol (never or past, current <1 drink, current 1 drinks), oral contraceptive use duration (none, <2years, 2 to <10years, 10years), hormone replacement therapy (none, estrogen alone, estrogen plus progestin but never estrogen alone), age at menarche (<13 years, 13years old).

<sup>e</sup> Assessed using Wald tests for continuous variables of hair product use frequency (never, infrequent, frequent use).

<sup>f</sup> Non-Black Hispanic or other race and ethnicity were excluded because of small sample size and limited power.

<sup>g</sup> Including Hispanic and Latina Black. <sup>h</sup> Assessed using Wald tests for hair product-by-modifier interaction terms.

<sup>i</sup> Low and high physical activities were categorized by 33rd percentile 32.7 MET hours per week. of hair products to health disparities in uterine cancer. Future efforts are also needed to identify the chemical ingredients, which might result in the elevated rates. Given the widespread use of hair products and the rising incidence of uterine cancer (2), our findings which identify hair straightener use as a potential target for intervention are particularly relevant for public health approaches to reduce uterine cancer incidence.

study.

## Data Availability

All data necessary to reproduce the current analysis are publicly available following procedures described on the Sister Study website

(<https://sisterstudy.niehs.nih.gov/English/datarequests.htm>).

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## References

1. National Cancer Institute. Cancer stat facts: uterine cancer. <https://seer.cancer.gov/statfacts/html/corp.html>. Published November 10, 2021. Accessed May 20, 2022.
2. Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer Statistics, 2022. *CA Cancer J Clin*. 2022;72(1):7-33. doi:10.3322/caac.21708.
3. Liang J, Shang Y. Estrogen and cancer. *Annu Rev Physiol*. 2013;75(1):225-240. doi:10.1146/annurev-physiol-030212-183708.
4. Rodriguez AC, Blanchard Z, Maurer KA, Gertz J. Estrogen signaling in endometrial cancer: a key oncogenic pathway with several open questions. *Horm Cancer*. 2019;10(2-3):51-63. doi:10.1007/s12672-019-0358-9.
5. Crews D, McLachlan JA. Epigenetics, evolution, endocrine disruption, health, and disease. *Endocrinology*. 2006;147(suppl 6):s4-s10. doi:10.1210/en.2005-1122.
6. Helm JS, Nishioka M, Brody JG, Rudel RA, Dodson RE. Measurement of endocrine disrupting and asthma-associated chemicals in hair products used by Black women. *Environ Res*. 2018;165:448-458. doi:10.1016/j.envres.2018.03.030.
7. Leung YK, Biesiada J, Govindarajah V, et al. Low-dose bisphenol a in a rat model of endometrial cancer: a CLARITY-BPA study. *Environ Health Perspect*. 2020;128(12):127005. doi:10.1289/EHP6875.
8. Li Y, Luh CJ, Burns KA, et al. Endocrine-disrupting chemicals (EDCs): in vitro mechanism of estrogenic activation and differential effects on ER target genes. *Environ Health Perspect*. 2013;121(4):459-466. doi:10.1289/ehp.1205951.



9. Mallozzi M, Leone C, Manurita F, Bellati F, Caserta D. Endocrine disrupting chemicals and endometrial cancer: an overview of recent laboratory evidence and epidemiological studies. *Int J Environ Res Public Health*. 2017;14(3):334-340. doi:10.3390/ijerph14030334.
10. Nowak K, Ratajczak-Wrona W, Gorska M, Jablonska E. Parabens and their effects on the endocrine system. *Mol Cell Endocrinol*. 2018;474:238-251. doi:10.1016/j.mce.2018.03.014.
11. Zacharewski TR, Meek MD, Clemons JH, Wu ZF, Fielden MR, Matthews JB. Examination of the in vitro and in vitro estrogenic activities of eight commercial phthalate esters I. *Toxicol Sci*. 1998;46(2):282-293. doi:10.1093/toxsci/46.2.282.
12. Braun JM, Just AC, Williams PL, Smith KW, Calafat AM, Hauser R. Personal care product use and urinary phthalate metabolite and paraben concentrations during pregnancy among women from a fertility clinic. *J Expo Sci Environ Epidemiol*. 2014;24(5):459-466. doi:10.1038/jes.2013.69.
13. Hsieh CJ, Chang YH, Hu A, et al.; for the TMICS study group. Personal care products use and phthalate exposure levels among pregnant women. *Sci Total Environ*. 2019;648:135-143. doi:10.1016/j.scitotenv.2018.08.149.
14. Brinton LA, Figueroa JD, Ansong D, et al. Skin lighteners and hair relaxers as risk factors for breast cancer: results from the Ghana Breast Health Study. *Carcinogenesis*. 2018;39(4):571-579. doi:10.1093/carcin/bgy002.
15. Coogan PF, Rosenberg L, Palmer JR, Cozier YC, Lenzy YM, Bertrand KA. Hair product use and breast cancer incidence in the Black Women's Health Study. *Carcinogenesis*. 2021;42(7):924-930. doi:10.1093/carcin/bgab041.
16. Heikkinen S, Pitkanieni J, Sarkeala T, Malila N, Koskenvuo M. Does hair dye use increase the risk of breast cancer? A population-based case-control study of Finnish women. *PLoS One*. 2015;10(8):e0135190. doi:10.1371/journal.pone.0135190.
17. Llanos AAM, Rabkin A, Bandera EV, et al. Hair product use and breast cancer risk among African American and White women. *Carcinogenesis*. 2017;38(9):883-892. doi:10.1093/carcin/bgx060.
18. White AJ, Gregoire AM, Taylor KW, et al. Adolescent use of hair dyes, straighteners and perms in relation to breast cancer risk. *Int J Cancer*. 2021;148(9):2255-2263. doi:10.1002/ijc.33413.
19. Eberle CE, Sandler DP, Taylor KW, White AJ. Hair dye and chemical straightener use and breast cancer risk in a large US population of Black and White women. *Int J Cancer*. 2020;147(2):383-391. doi:10.1002/ijc.32738.
20. Stavray KM, Clarke EA, Donner A. A case-control study of hair-dye use and cancers of various sites. *Br J Cancer*. 1981;43(2):236-239.
21. Tzonou A, Polychronopoulou A, Hsieh CC, Trichopoulos D, Rebelakos A, Karakatsani A. Hair dyes, analgesics, tranquilizers and perineal talc application as risk factors for ovarian cancer. *Int J Cancer*. 1993;55(3):408-410. doi:10.1002/ijc.2910550313.
22. White AJ, Sandler DP, Gaston SA, Jackson CL, O'Brien KM. Use of hair products in relation to ovarian cancer risk. *Carcinogenesis*. 2021;42(9):1189-1195. doi:10.1093/carcin/bgab056.
23. Zhang Y, Birman BM, Han J, et al. Personal use of permanent hair dyes and cancer risk and mortality in US women: prospective cohort study. *BMJ*. 2020;370:m2942. doi:10.1136/bmj.m2942.
24. Baan R, Grosse Y, Straif K, et al.; for the WHO International Agency for Research on Cancer Monograph Working Group. A review of human carcinogens—part F: chemical agents and related occupations. *Lancet Oncol*. 2009;10(12):1143-1144. doi:10.1016/s1473-0245(09)70358-4.
25. International Agency for Research on Cancer (IARC). Chemical Agents and Related Occupations. Vol 100F. Lyon, France: IARC Monographs on the Evaluation of Carcinogenic Risks to Humans; 2012.
26. Weathersby C, McMichael A. Brazilian keratin hair treatment: a review. *J Cosmet Dermatol*. 2013;12(2):144-148. doi:10.1111/jocd.12030.
27. Aglan MA, Mansour GN. Hair straightening products and the risk of occupational formaldehyde exposure in hairstylists. *Drug Chem Toxicol*. 2020;43(5):488-495. doi:10.1080/01480545.2018.1508215.
28. Flyvholm MA, Andersen P. Identification of formaldehyde releasers and occurrence of formaldehyde and formaldehyde releasers in registered chemical products. *Am J Ind Med*. 1993;24(5):533-552. doi:10.1002/ajim.4700240505.
29. Flyvholm MA. Formaldehyde and formaldehyde releasers. In: Kanerva L, Wahlberg JE, Elsnér P, Maibach HI, eds. *Handbook of Occupational Dermatology*. Berlin, Heidelberg: Springer; 2000:474-478. doi:10.1007/978-3-662-07677-4\_60.
30. Malinauskienė L, Blaziene A, Chomiciene A, Isaksson M. Formaldehyde may be found in cosmetic products even when unlabelled. *Open Med (Wars)*. 2015;10(1):323-328. doi:10.1515/med-2015-0047.
31. Rojanapo W, Kupradinun P, Tepsuwan A, Chutimataewin S, Tanyakaset M. Carcinogenicity of an oxidation product of p-phenylenediamine. *Carcinogenesis*. 1986;7(12):1997-2002. doi:10.1093/carcin/7.12.1997.
32. Schieferstein GJ, Littlefield NA, Gaylor DW, Sheldon WG, Burger GT. Carcinogenesis of 4-aminobiphenyl in BALB/c3H1/1Ncr mice. *Eur J Cancer Clin Oncol*. 1985;21(7):865-873. doi:10.1016/0277-5379(85)90227-5.
33. Turesky RJ, Freeman JP, Holland RD, et al. Identification of aminobiphenyl derivatives in commercial hair dyes. *Chem Res Toxicol*. 2003;16(9):1162-1173. doi:10.1021/tx030029r.
34. International Agency for Research on Cancer (IARC). Some Aromatic Amines, Organic Dyes, and Related Exposures. Vol 99. Lyon, France: IARC Monographs Working Group on the Evaluation of Carcinogenic Risks to Humans; 2010.
35. Sandler DP, Hodgson ME, Deming-Halverson SL, et al.; for the Sister Study Research Team. The Sister Study Cohort: baseline methods and participant characteristics. *Environ Health Perspect*. 2017;125(12):217003. doi:10.1289/EHP1923.
36. Sister Study questionnaire response rates. 2020. <https://sisterstudy.niehs.nih.gov/English/images/SIS-FU-TimelineDR6-FURR-508.pdf>. Published March 30, 2020. Accessed May 20, 2022.
37. Clarke MA, Devessa SS, Harvey SV, Wentzensen N. Hysterectomy-corrected uterine corpus cancer incidence trends and differences in relative survival reveal racial disparities and rising rates of nonendometrioid cancers. *J Clin Oncol*. 2019;37(22):1895-1908. doi:10.1200/JCO.2019.00151.
38. Bokhman JV. Two pathogenetic types of endometrial carcinoma. *Gynecol Oncol*. 1983;15(1):10-17. doi:10.1016/0090-8258(83)90111-7.
39. Emons G, Fleckenstein G, Hinney B, Huschmand A, Heyl W. Hormonal interactions in endometrial cancer. *Endocr Relat Cancer*. 2000;7(4):227-242.
40. Morice P, Leary A, Creutzberg C, Abu-Rustum N, Darai E. Endometrial cancer. *Lancet*. 2016;387(10023):1094-1108. doi:10.1016/S0140-6736(15)00130-0.
41. Shen F, Gao Y, Ding J, Chen Q. Is the positivity of estrogen receptor or progesterone receptor different between type 1 and type 2 endometrial cancer? *Oncotarget*. 2017;8(1):506-511. doi:10.18632/oncotarget.13471.
42. Breslow NE. Discussion on Professor Cox's paper. *J R Stat Soc Ser B Methodol*. 1972;34(2):216-217. doi:10.1111/j.2517-6161.1972.tb00900.x.
43. Hall RR, Francis S, Whitt-Glover M, Loftin-Bell K, Swett K, McMichael AJ. Hair care practices as a barrier to physical activity in African American women. *JAMA Dermatol*. 2013;149(3):310-314. doi:10.1001/jamadermatol.2013.1946.
44. Gaston SA, James-Todd T, Riley NM, et al. Hair maintenance and chemical hair product usage as barriers to physical activity in childhood and adulthood among African American women. *Int J Environ Res Public Health*. 2020;17(24):9254. doi:10.3390/ijerph17249254.
45. James-Todd T, Senie R, Terry MB. Racial/ethnic differences in hormonally active hair product use: a plausible risk factor for health disparities. *J Immigrant Minority Health*. 2012;14(3):506-511. doi:10.1007/s10903-011-9482-5.
46. Gaston SA, James-Todd T, Harmon Q, Taylor KW, Baird D, Jackson CL. Chemical straightening and other hair product usage during childhood, adolescence, and adulthood among African-American women: potential implications for health. *J Expo Sci Environ Epidemiol*. 2020;30(1):86-96. doi:10.1038/s41370-019-0186-6.
47. Rivera-Nunez Z, Ashrap P, Barrett ES, et al. Personal care products: demographic characteristics and maternal hormones in pregnant women from Puerto Rico. *Environ Res*. 2021;206:112376. doi:10.1016/j.envres.2021.112376.
48. Gezick AM, Falk RT, Xu X, et al. Relation of circulating estrogens with hair relaxer and skin lightener use among postmenopausal women in Ghana. *J Expo Sci Environ Epidemiol*. 2022;1-10. doi:10.1038/s41370-021-00407-4.
49. Wise LA, Palmer JR, Reich D, Cozier YC, Rosenberg L. Hair relaxer use and risk of uterine leiomyomata in African-American women. *Am J Epidemiol*. 2012;175(5):432-440. doi:10.1093/aje/kwr351.
50. McDonald JA, Tehranifar P, Flom JD, Terry MB, James-Todd T. Hair product use, age at menarche and mammographic breast density in multiethnic urban women. *Environ Health*. 2018;17(1):1. doi:10.1186/s12940-017-0345-y.
51. Chemicals in hair straightening products background document. *Dep Toxic Subst Control Safer Consum Prod Program*. 2021. <https://dtsc.ca.gov/wp-content/uploads/sites/31/2021/05/Chemicals-in-Hair-Straightening-Products-Background-Documents.pdf>. Published May 24, 2021. Accessed May 20, 2022.
52. Iwegbue CMA, Emakunu OS, Obi G, Nwajei GE, Martincich BS. Evaluation of human exposure to metals from some commonly used hair care products in Nigeria. *Toxicol Rep*. 2016;3:796-803. doi:10.1016/j.toxrep.2016.10.001.
53. Sarink D, Franke AA, White KK, et al. BPA, parabens, and phthalates in relation to endometrial cancer risk: a case-control study nested in the multiethnic cohort. *Environ Health Perspect*. 2021;129(5):57702. doi:10.1289/EHP8998.
54. Dogan S, Tongur T, Erkamayaz T, et al. Traces of intact paraben molecules in endometrial carcinoma. *Environ Sci Pollut Res Int*. 2019;26(30):31158-31165. doi:10.1007/s11356-019-06228-1.
55. Dekant W, Scialli AR, Plotzke K, Klauinig JE. Biological relevance of effects following chronic administration of octamethylcyclotetrasiloxane (D4) in Fischer 344 rats. *Toxicol Lett*. 2017;279:42-53. doi:10.1016/j.toxlet.2017.01.010.
56. Jean PA, Plotzke KP, Scialli AR. Chronic toxicity and oncogenicity of decamethylcyclopentasiloxane in the Fischer 344 Rat. *Regul Toxicol Pharmacol*. 2016;74:S57-S66. doi:10.1016/j.yrtph.2015.06.014.
57. Jean PA, Plotzke KP. Chronic toxicity and oncogenicity of octamethylcyclotetrasiloxane (D4) in the Fischer 344 rat. *Toxicol Lett*. 2017;279:75-97. doi:10.1016/j.toxlet.2017.06.003.
58. International Agency for Research on Cancer (IARC). Arsenic, Metals, Fibres and Dusts. Vol 100 C. Lyon, France: IARC Working Group on the Evaluation of Carcinogenic Risks to Humans; 2012.
59. International Agency for Research on Cancer (IARC). Some Chemicals Present in Industrial and Consumer Products, Food and Drinking-Water. Vol 101. Lyon, France: IARC Monographs on the Evaluation of Carcinogenic Risks to Humans; 2013.
60. Bronaugh RL, Maibach HI, eds. *Percutaneous Absorption: Drugs, Cosmetics, Mechanisms, Methodology*. 4th ed. New York: Informa Healthcare; 2010.
61. Scott DA. Disorders of the hair and scalp in blacks. *Dermatol Clin*. 1988;6(3):387-395. doi:10.1016/S0733-8635(18)30650-8.
62. Khalil EN. Cosmetic and hair treatments for the Black consumer. *Cosmet Hair Treat Black Consum*. 1986;101(10):51-58.
63. Chang CJ, Cheng SF, Chang PT, Tsai SW. Indoor air quality in hairdressing salons in Taipei. *Indoor Air*. 2018;28(1):173-180. doi:10.1111/ina.12412.
64. Pierce JS, Abelmann A, Spicer LJ, et al. Characterization of formaldehyde exposure resulting from the use of four professional hair straightening products. *J Occup Environ Hyg*. 2011;8(11):686-699. doi:10.1080/15459624.2011.626259.

65. McTiernan A. Mechanisms linking physical activity with cancer. *Nat Rev Cancer*. 2008;8(3):205-211. doi:[10.1038/nrc2325](https://doi.org/10.1038/nrc2325).
66. Beral V, Bull D, Reeves G; for the Million Women Study Collaborators. Endometrial cancer and hormone-replacement therapy in the Million Women Study. *Lancet*. 2005;365(9470):1543-1551. doi:[10.1016/S0140-6736\(05\)66455-0](https://doi.org/10.1016/S0140-6736(05)66455-0).
67. Bernstein L, Deapen D, Cerhan JR, et al. Tamoxifen therapy for breast cancer and endometrial cancer risk. *J Natl Cancer Inst*. 1999;91(19):1654-1662. doi: [10.1093/jnci/91.19.1654](https://doi.org/10.1093/jnci/91.19.1654).
68. Michels KA, Pfeiffer RM, Brinton LA, Trabert B. Modification of the associations between duration of oral contraceptive use and ovarian, endometrial, breast, and colorectal cancers. *JAMA Oncol*. 2018;4(4):516-521. doi: [10.1001/jamaoncol.2017.4942](https://doi.org/10.1001/jamaoncol.2017.4942).
69. Eriksen KT, Halkjær J, Sørensen M, et al. Dietary cadmium intake and risk of breast, endometrial and ovarian cancer in Danish postmenopausal women: a prospective cohort study. *PLoS One*. 2014;9(6):e100815. doi: [10.1371/journal.pone.0100815](https://doi.org/10.1371/journal.pone.0100815).
70. Koshiyama M, Konishi I, Wang D. P, et al. Immunohistochemical analysis of p53 protein over-expression in endometrial carcinomas: inverse correlation with sex steroid receptor status. *Vichows Archiv A Pathol Anat*. 1993;423(4): 265-271. doi:[10.1007/BF01606889](https://doi.org/10.1007/BF01606889).
71. Zota AR, Shamasunder B. The environmental injustice of beauty: framing chemical exposures from beauty products as a health disparities concern. *Am J Obstet Gynecol*. 2017;217(4):418.e1-418.e6. doi: [10.1016/j.ajog.2017.07.020](https://doi.org/10.1016/j.ajog.2017.07.020).