

PANEL BLAMES LUNG CANCER ON CIGARETS

Committee Calls for Remedial Action

remedial health measures should be taken. He said he hoped distribution and discussion of the report will have an impact on the American public.

1. "Cigarette smoking is causally related to lung cancer in men; the magnitude of the effect of cigarette smoking far outweighs all other factors."

2. "The causal relationship of the smoking of pipes to the development of cancer of the lip appears established."

3. "Although there are suggestions of relationships between cancer or other specific sites of the oral cavity [mouth region] and the several forms of tobacco use, their causal implications cannot at present be stated."

4. "Cigarette smoking is a significant factor in the causation of laryngeal [voice-box] cancer in the male."

5. "There is evidence of a relationship between smoking and cancer of the esophagus, but there are not adequate data to determine if smoking is the cause."

6. "Data suggest an association between cigarette smoking and urinary bladder cancer in the male, but the available research is not sufficient to prove smoking is the cause."

7. "Cigarette smoking is the most important of the causes of chronic bronchitis in the United States, and increases the risk of dying from it."

8. "A relationship exists between pulmonary emphysema [a drop in lung efficiency because of tissue hardening] and cigarette smoking, but it has not been established that the relationship is causal."

9. "For the bulk of the population of the United States, the importance of cigarette smoking as a cause of chronic bronchopulmonary disease is much greater than that of atmospheric pollution or occupational exposures."

10. "Male cigarette smokers have a higher death rate from

NEWS SUMMARY AND HISTORICAL SCRAPBOOK OF THE CHICAGO TRIBUNE

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Government's medical panel links cancer to cigarette smoking and advises surgeon general "hazard calls for remedial action."

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coronary artery disease than nonsmoking males, but it is not clear that the association has causal significance.

Smoke Panel's Credentials Told

Variety of Fields Represented by 10 Members

Washington, Jan. 11—Medical researchers on the blue ribbon committee who worked 14 months on the preparation of today's report on smoking and health were praised by Surgeon General Luther L. Terry for their "unstinted devotion with which they have applied their scientific skills."

Background of Members
The members of the panel were: Dr. Stanhope Bayne-Jones, former dean of the Yale school of medicine; former president, joint administrative board, Cornell university; New York hospital medical center; former president, Society of American Bacteriologists; American Society of Pathology and Bacteriology.

History Quiz Do You Remember?

Do you have a question for this column? Send it on a postcard, with your name and address, to History Quiz, Chicago Tribune, Chicago 11, Ill.

- 1. Which President laid the cornerstone of the Washington monument? — Dorothea Kent, Miami.
2. Who was the first American citizen to receive a passport to travel abroad? — A. Witt, Chicago.
3. What is the origin of the expression, "Pig in a poke"? — Paul Oswald, Chicago.
4. Who was the only United States President born in New York City? — Conrad Fiorillo, Brooklyn.
5. What was the Window Tax war? — Mrs. B. Lelak, Calumet City.

medicine; an expert on clinical and experimental surgery and an authority on genetics. Prof. William G. Cochran, department of statistics, Harvard university; an expert on mathematical statistics, with special application to biological problems.

Dr. John B. Hickman, chairman of the department of internal medicine of the University of Indiana; an expert on internal medicine and the physiology of cardiopulmonary disease. Dr. Emmanuel Farber, chairman of the department of pathology of the University of Pittsburgh; an expert on experimental and clinical pathology.

Dr. Louis F. Fieser, Sheldon Emory professor of organic chemistry at Harvard; an expert on the chemistry of tobacco smoke. Dr. Jacob Furth, professor of pathology at Francis Delafield hospital, New York; an expert on cancer biology.

Dr. Charles LeMaistre, medical director of Woodlawn hospital and professor of medicine at Southwestern Medical college, Dallas, Tex.; an expert on internal medicine, infectious diseases, and preventive medicine.

Dr. Maurice H. SeEVERS, chairman of the department of pharmacology at the University of Michigan; an expert on the pharmacology of anesthesia and habit-forming drugs.

Terry Serves as Chairman
Dr. Leonard M. Schuman, professor of epidemiology, at the University of Minnesota

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THE CENTER FOR THE STUDY OF TOBACCO AND SOCIETY

BRITISH IGNORE WARNINGS OF CIGARET PERIL

Smoking as Much as Before 1962 Report

LONDON, Jan. 11 (AP)—Britons today apparently are smoking as many cigarettes as they did in "pre-R.C.P. days."

That is the way the tobacco industry refers to the days before March 7, 1962 when the Royal College of Physicians issued a report which said: "Habitual cigarette smoking over many years is a cause, in the ordinary sense, of lung cancer."

The report by eight British doctors headed by Sir Robert Platt, president of the college, urged government action to check the rising consumption of tobacco, especially of cigarettes.

Drops in First Weeks
In the first weeks after the report, the tobacco industry's advisory committee says, there was a 12 1/2 per cent drop in cigarette smoking. By August the net drop in smoking was 5 per cent. By January, 1963, it was 3 per cent.

The committee can't give current figures. But "Tobacco," the industry publication, estimates that today Britons are smoking as many cigarettes—and perhaps slightly more—than they did before March 7, 1962.

There has been one significant change, however. Many persons switched to filter cigarettes. The figures for 1963 haven't been released. But in 1961 the number of cigarettes smoked was 113.4 billion. The number dropped to 109.9 billion in 1962. Plain cigarettes went down 10 billion while filtered ones went up 6.5 billion.

Puts Out Posters
The ministry of health, meanwhile, had distributed 1 1/4 million posters associating smoking with lung cancer. The posters went up in schools, doctors' waiting rooms, libraries, railroads, and public buildings.

A typical poster shows a row of coffins. It says there were 5,303 deaths from lung cancer in 1940 and 26,383 in 1962. At the bottom are the words: "The more cigarettes you smoke the greater the risk."

The ministry of health regards the campaign as a success. "Nobody can say they now don't know about the danger," a spokesman said. "But this is a matter similar to drinking. You can't force people to stop smoking. Our duty simply is to guide the public to healthy habits."

Agrees on Ads
The tobacco industry agreed that its advertisement should refrain from stressing a romantic approach to cigarettes. The aim is not to encourage the young to smoke.

Five leading manufacturers agreed to remind dealers it is

U. S. May Seek Cigaret Curbs

Industry Urges Wider Study of Smoking

(Chicago Tribune Press Service)
Reaction to yesterday's report of the surgeon-general's advisory committee on smoking and health, which branded cigarettes as a cause of lung cancer and other fatal ailments, ranged from demands for more study by tobacco interests to announcement of plans for strict regulatory action.

Some sources suggested stringent controls of cigarette advertising, warning labels on cigarette packages, and campaigns for education of the public in regard to health hazards of smoking. Industry spokesmen offered to cooperate in further research but emphasized that the final chapter on smoking hazards has yet to be written.

Weigh Remedial Action
The Federal Trade Commission said in Washington that it will move promptly to determine what remedial action it should take on labeling and advertising of cigarettes. The commission has authority to ban what it considers unfair or deceptive labeling or advertising.

Reportedly under consideration are regulations requiring cigarette manufacturers to include a warning on health hazards on package labels and in advertising.

Another step within FTC authority might be removal of its ban on advertising claims about the tar and nicotine content of specific brands of cigarettes, it was reported. Such claims were halted in 1960 by the FTC, ending the so-called tar derby but preventing manufacturers from advertising efficiency results of various filter types.

Neuberger Bills Ready
Sen. Maurine Neuberger (D., Ore.), long a foe of cigarette smoking, announced in Portland, Ore., that she has two bills ready for introduction in the Senate. One would require disclosure on labels of the average yield of tar, nicotine, and other harmful agents. The other would authorize research by the department of health, education, and welfare on how to cut down smoking hazards and how to aid individuals in giving up smoking.

Rep. Kenneth A. Roberts (D., Ala.), chairman of the House public health and safety subcommittee, said he tentatively favors immediate hearings with a view toward possible legislative action and predicted Congress will act quickly. Several bills have been introduced in the House to deal with the health problem resulting from cigarette smoking.

Heart Group May Act
The American Heart association said in a statement by Dr. John J. Sampson, its president, that there is enough evidence of the harmful effects of cigarette smoking to warrant the association's chapters and affiliates joining with other health agencies in education programs to discourage cigarette smoking by the general public, especially teenagers and high risk groups.

Dr. Sampson defined "high risk" individuals as those with

high blood pressure, signs of arteriosclerosis, or a family history of heart attacks or strokes.

Dr. Leroy E. Burney, who as United States surgeon general in 1957 linked cigarette smoking to lung cancer, said a massive attack must be launched to keep young people from acquiring the habit and to help adults to break it. Dr. Burney said in an interview in Philadelphia that if one has to smoke, a pipe is preferable to a cigarette. He said he smokes three or four pipefuls a day.

Graham appeals to Clergy
Evangelist Billy Graham, who has never smoked, said in Charlotte, N. C., that clergymen of all faiths should set an example by stopping the smoking of cigarettes.

Victor Ives, general manager of radio station KWUN in Concord, Cal., announced a ban on cigarette advertising on his station, asserting he does not see how the broadcasting of cigarette advertising can be consistent with the public interest in view of the governmental report.

Dr. Wendell G. Scott of St. Louis, president of the American Cancer society, said in Los Angeles that the report of the surgeon general's advisory committee should arouse the public to the gravity of the health threat, asserting: "There is no longer room for doubt about the relationship of smoking to lung cancer."

Industry Studies Report
The Tobacco Institute, Inc., a research organization representing the nation's chief tobacco manufacturers, said the government's report will receive careful study and that further research is needed.

"I endorse wholeheartedly and without any reservation

Surgeon General Terry's call, at his press conference today, not for less but for more research," said George V. Allen, president of the institute. "The tobacco industry, which is already supporting a considerable body of health research, stands ready to increase that support and also to cooperate with the government and with other groups on any project which offers possibilities for filling in the gaps of knowledge which still exist in this broad field of scientific concern."

Dr. Clarence C. Little, scientific director of the tobacco industry research committee, wired Terry offering aid in research on the relation of smoking to health.


Gov. Edward T. Breathitt of Kentucky, a state in which tobacco is the chief cash crop, said that everything possible should be done to protect the tobacco industry. He suggested a research program, centered at the University of Kentucky, to find ways of making a safer cigarette. He cautioned the public against being stampeded into believing something that may not exist.

The three major television networks announced they will re-examine their code of broadcast advertising in relation to the government's report on smoking hazards. The National Broadcasting company, the American Broadcasting company, and the Columbia Broadcasting system said they will participate next month in a television code review board study of the matter. The code now permits advertising of cigarettes and other tobacco products.

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BRITISH UNITS FAIL TO CRACK CYPRUS SIEGE

NICOSIA, Cyprus, Jan. 11 (UPI)—British troops failed today in an attempt to relieve the Turkish Cypriot town of Lefka, besieged by Greek Cypriots since bloodshed broke out at Christmas.

Patrols of the Gloucestershire regiment which tried to enter Lefka, near the island's north coast, were turned back at Turkish barricades. A Turkish Cypriot with them from Nicosia did not have sufficient authority to persuade his compatriots to open their road blocks, and he returned to the capital for further instructions.

Since the start of the crisis in which about 200 persons have been killed, 5,000 Turkish Cypriots have been besieged in Lefka, short of food, gasoline, and other supplies. Armed Greek Cypriots watch them.

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Partial Text of Panel Report on Smoking

Reviews Data on Health Effect of Tobacco

[Continued from first page]

gories that have been reported to have a relationship with tobacco use are shown in Table 1. This table presents one aspect of the size of the potential hazard; the degree of association with the use of tobacco will be discussed later.

Another cause for concern is that deaths from some of these diseases have been increasing with great rapidity over the past few decades.

Lung cancer deaths, less than 3,000 in 1930, increased to 18,000 in 1950. In the short period since 1955, deaths from lung cancer rose from less than 27,000 to the 1962 total of 41,000. This extraordinary rise has not been recorded for cancer of any other site. While part of the rising trend for lung cancer is attributable to improvements in diagnosis and the changing age-composition and size of the population, the evidence leaves little doubt that a true increase in lung cancer has taken place.

Heart Cases Increase

Deaths from arteriosclerotic, coronary, and degenerative heart disease rose from 273,000 in 1940, to 396,000 in 1950, and to 578,000 in 1962.

Reported deaths from chronic bronchitis and emphysema rose from 2,300 in 1945 to 15,000 in 1962.

The changing patterns and extent of tobacco use are a pertinent aspect of the tobacco-health problem.

Table 1—Deaths from selected disease categories, United States, 1962 (cause of death, followed by totals and breakdown male and female):

Degenerative and arteriosclerotic heart disease, including coronary disease 577,918; 348,604; 229,314.

Hypertensive heart disease 62,176; 26,654; 35,522.

Cancer of lung 41,376; 35,312; 6,064.

Cirrhosis of liver 21,824; 14,329; 7,495.

Bronchitis and emphysema 15,104; 12,937; 2,167.

Stomach and duodenal ulcers 12,228; 8,836; 3,392.

Cancer of bladder 8,081; 5,575; 2,506.

Cancer of oral cavity 6,481; 4,920; 1,561.

Cancer of esophagus 5,088; 3,973; 1,115.

Cancer of larynx 2,417; 2,172; 245.

All above causes 752,693; 463,312; 289,381.

All other causes 1,004,027; 531,477; 472,550.

All causes 1,756,720; 994,789; 761,931.

Use Has Increased

Nearly 70 million people in the United States consume to-

bacco regularly. Cigarette consumption in the United States has increased markedly since the turn of the century, when per capita consumption was less than 50 cigarettes a year. Since 1910, when cigarette consumption per person 15 years and older was 138, it rose to 1,365 in 1930, to 1,828 in 1940, to 3,322 in 1950, and to a peak of 3,986 in 1961. The 1955 current population survey showed that 68 per cent of the male population and 32.4 per cent of the female population 18 years of age and over were regular smokers of cigarettes.

In contrast with this sharp increase in cigarette smoking, per capita use of tobacco in other forms has gone down. Per capita consumption of cigars declined from 117 in 1920 to 55 in 1962. Consumption of pipe tobacco, which reached a peak of 2½ pounds per person in 1910, fell to a little more than half a pound per person in 1962. Use of chewing tobacco has declined from about 4 pounds per person in 1900 to half a pound in 1962.

The background for the committee's study thus included much general information and findings from previous investigations which associated the increase in cigarette smoking with increased deaths in a number of major disease categories. It was in this setting that the committee began its work to assess the nature and magnitude of the health hazard attributable to smoking.

KINDS OF EVIDENCE
In order to judge whether smoking and other tobacco uses are injurious to health or related to specific diseases, the committee evaluated three main kinds of scientific evidence:

1. **Animal Experiments** — In numerous studies, animals have been exposed to tobacco smoke and tars, and to the various chemical compounds they contain. Seven of these compounds (polycyclic aromatic compounds) have been established as cancer-producing carcinogenic. Other substances in tobacco and smoke, tho not carcinogenic themselves, promote cancer production or lower the threshold to a known carcinogen. Several toxic or irritant gases contained in tobacco smoke produce experimentally the kinds of noncancerous damage seen in the tissues and cells of heavy smokers. This includes suppression of ciliary action that normally cleanses the trachea and bronchi, damage to the lung air sacs, and to mucous glands and goblet cells which produce mucus.

2. **Clinical and autopsy studies** — Observations of thousands of patients and autopsy studies of smokers and nonsmokers show that many kinds of damage to body functions and to organs, cells, and tissues occur more

frequently and severely in smokers. Three kinds of cellular changes—loss of ciliated cells, thickening (more than two layers of basal cells), and presence of atypical cells — are much more common in the lining layer [epithelium] of the trachea and bronchi of cigarette smokers than of nonsmokers. Some of the advanced lesions seen in the bronchi of cigarette smokers are probably premalignant. Cellular changes regularly found at autopsy in patients with chronic bronchitis are more often present in the bronchi of smokers than nonsmokers. Pathological changes in the air sacs and other functional tissue of the lung parenchyma have a remarkably close association with past history of cigarette smoking.

3. **Population studies** — Another kind of evidence regarding an association between smoking and disease comes from epidemiological studies.

In retrospective studies, the smoking histories of persons with a specified disease — for example, lung cancer—are compared with those of appropriate control groups without the disease. For lung cancer alone, 29 such retrospective studies have been made in recent years. Despite many variations in design and method, all but one [which dealt with females] showed that proportionately more cigarette smokers are found among the lung cancer patients than in the control populations without lung cancer.

Symptoms and Signs

Extensive retrospective studies of the prevalence of specific symptoms and signs — chronic cough, sputum production, breathlessness, chest illness, and decreased lung function — consistently show that these occur more often in cigarette smokers than in nonsmokers. Some of these signs and symptoms are the clinical expressions of chronic bronchitis, and some are associated more with emphysema; in general they increase with the amount of smoking and decrease after cessation of smoking.

Another type of epidemiological evidence on the relation of smoking and mortality comes from seven prospective studies which have been conducted since 1951. In these studies, large numbers of men answered questions about their smoking or nonsmoking habits. Death certificates have been obtained for those who died since entering the studies, permitting total death rates and death rates by cause to be computed for smokers of various types as well as for nonsmokers. The prospective studies thus add several important dimensions to information on the smoking-health problems. Their data permit direct comparisons of the death rates of smokers and nonsmokers, both over-all and for individual causes of death, and indicate the strength of the as-

sociation between smoking and specific diseases.

Each Is Considered

Each of these three lines of evidence was evaluated and then considered together in drawing conclusions. The committee was aware that the mere establishment of a statistical association between the use of tobacco and a disease is not enough. The causal significance of the use of tobacco in relation to the disease is the crucial question. For such judgments all three lines of evidence are essential. . .

In the paragraphs which follow, the committee has chosen to summarize the results of the seven prospective population studies which as noted above, constitute only one type of evidence. They illustrate the nature and potential magnitude of the smoking-health problem, and bring out a number of factors which are involved.

EVIDENCE FROM THE COMBINED RESULTS OF PROSPECTIVE STUDIES

The committee examined the seven prospective studies separately as well as their combined results. Considerable weight was attached to the consistency of findings among the several studies. However, to simplify presentation, only the combined results are highlighted here.

Of the 1,123,000 men who entered the seven prospective studies and who provided usable histories of smoking habits [and other characteristics such as age], 37,391 men died during the subsequent months or years of the studies. No analyses of data for females from prospective studies are presently available.

To permit ready comparison of the mortality experience of smokers and nonsmokers, two concepts are widely used in the studies—excess deaths of smokers compared with nonsmokers, and mortality ratio. After adjustments for differences in age and the number of cigarette smokers and nonsmokers, an expected number of deaths of smokers is derived on the basis of deaths among nonsmokers. Excess deaths are thus the number of actual observed deaths among smokers in excess of the number expected. The mortality ratio . . . measures the relative death rates of smokers and nonsmokers. If the age-adjustment death rates are the same, the mortality ratio will be 1.0; if the death rates of smokers are double those of nonsmokers, the mortality ratio will be 2.0. Expressed as a percentage, the example would be equivalent to a 100 per cent increase.

Shows Combined Data

Table 2 presents the accumulated and combined data on 14 disease categories for which the mortality ratio of cigarette

[Cont. on following page]

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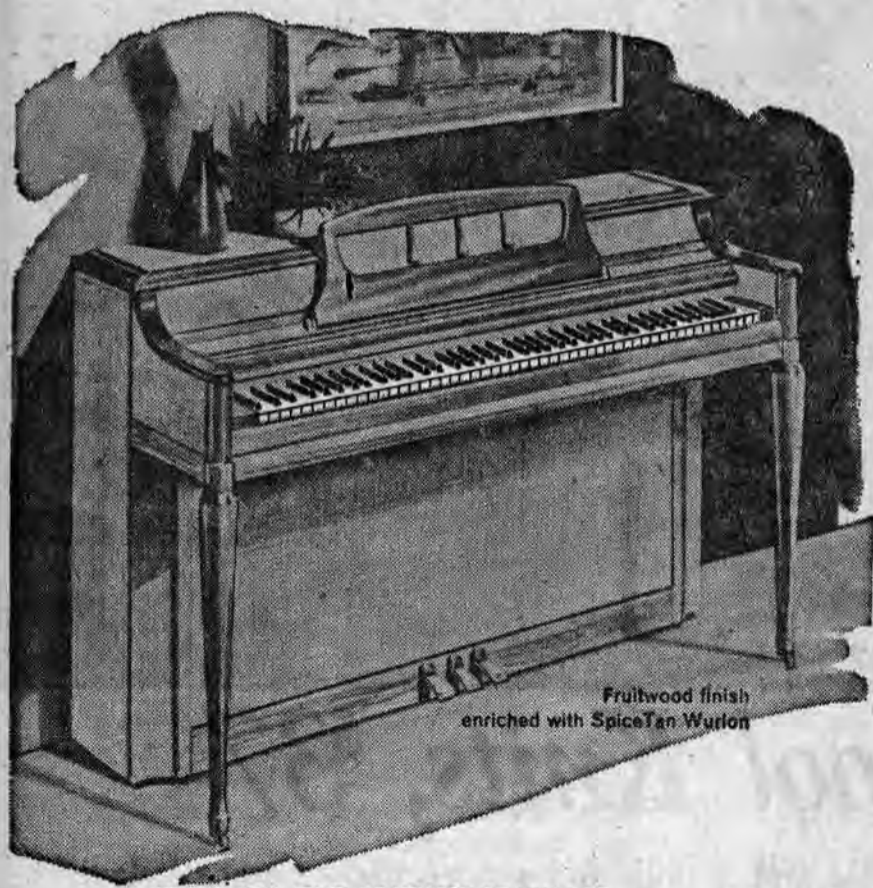
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WURLITZER

Smoking Report: Partial Text

[Cont. from preceding page]

smokers to nonsmokers was 1.5 or greater.

The mortality ratio for male cigaret smokers compared with nonsmokers, for all causes of death taken together, is 1.68, representing a total death rate nearly 70 per cent higher than for nonsmokers. This ratio includes death rates for diseases not listed in the table as well as for the 14 disease categories shown.

In the combined results from the seven studies, the mortality ratio of cigaret smokers over nonsmokers was particularly high for a number of diseases: cancer of the lung [10.8], bronchitis and emphysema [6.1], cancer of the larynx [5.4], oral cancer [4.1], cancer of the esophagus [3.4], peptic ulcer [2.8], and the group of other circulatory diseases [2.6]. For coronary artery disease the mortality ratio was 1.7.

Expressed in percentage form, this is equivalent to a statement that for coronary artery disease, the leading cause of death in this country, the death rate is 70 per cent higher for cigaret smokers. For chronic bronchitis and emphysema, which are among the leading causes of severe disability, the death rate for cigaret smokers is 500 per cent higher than for nonsmokers. For lung cancer, the most frequent site of cancer in men, the death rate is nearly 1,000 per cent higher.

Totals in Table II
TABLE II — Expected and observed deaths for smokers of cigarettes only and mortality rates in seven prospective studies; underlying cause of death, followed by totals of expected deaths, observed deaths and mortality ratio:

- Cancer of lung 170.3; 1,833; 10.8.
- Bronchitis and emphysema 89.5; 546; 6.1.
- Cancer of larynx 14.0; 75; 5.4.
- Oral cancer 37.0; 152; 4.2.
- Cancer of esophagus 33.7; 113; 3.4.
- Stomach and duodenal ulcers 105.1; 294; 2.8.
- Other circulatory diseases 254.0; 649; 2.6.
- Cirrhosis of liver 168.2; 379; 2.2.
- Cancer of bladder 111.6; 216; 1.9.
- Coronary artery disease 6,430.7; 11,177; 1.7.
- Other heart diseases 526.0; 868; 1.7.
- Hypertensive heart 409.2; 631; 1.5.

General arteriosclerosis 210.7; 310; 1.5.

Cancer of kidney 79.0; 120; 1.5.

All causes 15,653.9; 23,223; 1.68.

Other findings of the prospective studies:

In general, the greater the number of cigarettes smoked daily, the higher the death rate. For men who smoke fewer than 10 cigarettes a day, according to the seven prospective studies, the death rate from all causes is about 40 per cent higher than for nonsmokers. For those who smoke 40 or more, it is 120 per cent higher.

Duration of Smoking

Cigaret smokers who stopped smoking before enrolling in the seven studies have a death rate about 40 per cent higher than nonsmokers, as against 70 per cent higher for current cigaret smokers, men who began smoking before age 20 have a substantially higher death rate than those who began after age 25. Compared with nonsmokers, the mortality risk of cigaret smokers, after adjustments for difference in age, increases with duration of smoking [number of years], and is higher in those who stopped after age 55 than for those who stopped at an earlier age.

In two studies which recorded the degree of inhalation, the amount of smoking was greater for inhalers than for noninhalers.

The ratio of the death rates of smokers to that of nonsmokers is highest at the earlier ages [40 to 50] represented in these studies, and declines with increasing age.

Possible relationships of death rates and other forms of tobacco use were also investigated in the seven studies. The death rates for men smoking less than 5 cigars daily, death rates are slightly higher. There is some indication that these higher death rates occur primarily in men who have been smoking more than 30 years and who inhale the smoke to some degree. The death rates for pipe smokers are little if at all higher than for nonsmokers, even for men who smoke 10 or more pipefuls a day and for men who have smoked pipes more than 30 years.

Excess Mortality

Several of the reports previously published on the prospective studies included a table showing the distribution of the excess number of deaths of cigaret smokers among the princi-

pal causes of death. The hazard must be measured not only by the mortality ratio of deaths in smokers and nonsmokers but also by the importance of a particular disease as a cause of death.

In all seven studies, coronary artery disease is the chief contributor to the excess number of deaths of cigaret smokers over nonsmokers, with lung cancer uniformly in second place. For all seven studies combined, coronary artery disease [with a mortality ratio of 1.7] accounts for 45 per cent of the excess deaths among cigaret smokers, whereas lung cancer [with a ratio of 10.8] accounts for 16 per cent.

Some of the other categories of diseases that contribute to the higher death rates for cigaret smokers over nonsmokers are disease of the heart and blood vessels, other than coronary artery disease, 14 per cent; cancer sites other than lung, 8 per cent; and bronchitis and emphysema, 4 per cent.

Since these diseases as a group are responsible for more than 85 per cent of the higher death rate among cigaret smokers, they are of particular interest to public health authorities and the medical profession.

ASSOCIATIONS AND CAUSALITY

The array of information from the prospective and retrospective studies of smokers and nonsmokers clearly establishes an association between cigaret smoking and substantially higher death rates. The mortality ratios in Table 2 provide an approximate index of the relative strength of this association, for all causes of death and for 14 disease categories.

In this inquiry the epidemiologic method was used extensively in the assessment of causal factors in the relationship of smoking to health among human beings upon whom direct experimentation could not be imposed. Clinical, pathological, and experimental evidence was thoroughly considered and often served to suggest an hypothesis or confirm or contradict other findings. When coupled with the other data, results from the epidemiologic studies can provide the basis upon which judgments of causality may be made.

It is recognized that no simple cause-and-effect relationship is likely to exist between a

[Cont. on following page]

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Here Is Partial Text of U. S. Panel Report on Smoking, Health

Reviews Data on Cigaret Link to Disease

[Cont. from preceding page] complex product like tobacco smoke and a specific disease in the variable human organism. It is also recognized that often the coexistence of several factors is required for the occurrence of a disease, and that one of the factors may play a determinant role; that is, without it, the other factors [such as genetic susceptibility] seldom lead to the occurrence of the disease.

THE EFFECTS OF SMOKING; PRINCIPAL FINDINGS

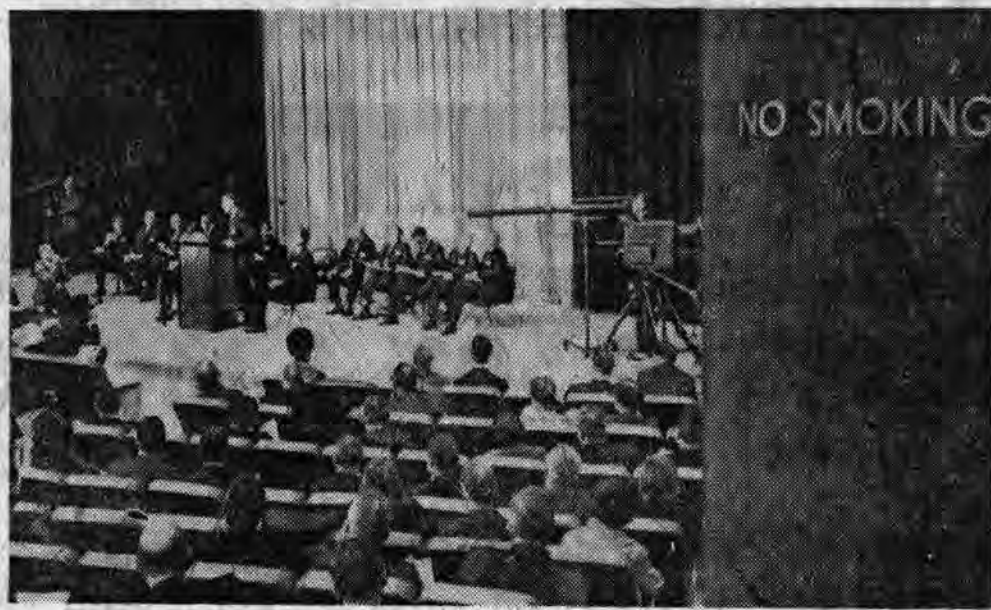
Cigaret smoking is associated with a 70 per cent increase in the age-specific death rates of males, and to a lesser extent with increased death rates of females. The total number of excess deaths causally related to cigarette smoking in the United States population cannot be accurately estimated. In view of the continuing and mounting evidence from many sources, it is the judgment of the committee that cigarette smoking contributes substantially to mortality from certain specific diseases and to the over-all death rate.

LUNG CANCER

Cigaret smoking is causally related to lung cancer in men; the magnitude of the effect of cigarette smoking far outweighs all other factors. The data for women, though less extensive, point in the same direction.

The risk of developing lung cancer increases with duration of smoking and the number of cigarettes smoked per day, and is diminished by discontinuing smoking. In comparison with nonsmokers, average male smokers of cigarettes have approximately a 9- to 10-fold risk of developing lung cancer and heavy smokers at least a 20-fold risk.

The risk of developing cancer of the lung for the combined group of pipe smokers, cigar smokers, and pipe and cigar



Prominent No Smoking sign is even more so as a report is given in state department auditorium on the dangers of smoking. Luther Terry, surgeon general, is at rostrum.

smokers is greater than for nonsmokers, but much less than for cigarette smokers.

Cigaret smoking is much more important than occupational exposures in the causation of lung cancer in the general population.

CHRONIC BRONCHITIS AND EMPHYSEMA

Cigaret smoking is the most important of the causes of chronic bronchitis in the United States, and increases the risk of dying from chronic bronchitis and emphysema. A relationship exists between cigarette smoking and emphysema but it has not been established that the relationship is causal. Studies demonstrate that fatalities from this disease are infrequent among nonsmokers.

For the bulk of the population of the United States, the relative importance of cigarette smoking as a cause of chronic broncho-pulmonary disease is much greater than atmospheric pollution or occupational exposures.

CARDIOVASCULAR DISEASES

It is established that male cigarette smokers have a higher death rate from coronary artery disease than nonsmoking males. Although the causative role of cigarette smoking in

deaths from coronary disease is not proven, the committee considers it more prudent from the public health viewpoint to assume that the established association has causative meaning than to suspend judgment until no uncertainty remains.

Although a causal relationship has not been established, higher mortality of cigarette smokers is associated with many other cardiovascular diseases, including miscellaneous circulatory diseases, other heart diseases, hypertensive heart disease, and general arteriosclerosis.

OTHER CANCER SITES

Pipe smoking appears to be causally related to lip cancer. Cigarette smoking is a significant factor in the causation of cancer of the larynx. The evidence supports the belief that an association exists between tobacco use and cancer of the esophagus, and between cigarette smoking and cancer of the urinary bladder in men, but the data are not adequate to decide whether these relationships are causal. Data on an association between smoking and cancer of the stomach are contradictory and incomplete. The Tobacco Habit and Nicotine The habitual use of tobacco is related primarily to psychological and social drives, rein-

forced and perpetuated by the pharmacological actions of nicotine.

Social stimulation appears to play a major role in a young person's early and first experiments with smoking. No scientific evidence supports the popular hypothesis that smoking among adolescents is an expression of rebellion against authority. Individual stress appears to be associated more with fluctuations in the amount of smoking than with the prevalence of smoking. The overwhelming evidence indicates that smoking — its beginning, habituation, and occasional discontinuation — is to a very large extent psychologically and socially determined.

Nicotine is rapidly changed in the body to relatively inactive substances with low toxic-

ity. The chronic toxicity of small doses of nicotine is low in experimental animals. These two facts, when taken in conjunction with the low mortality ratios of pipe and cigar smokers, indicate that the chronic toxicity of nicotine in quantities absorbed from smoking and other methods of tobacco use is very low and probably does not represent an important health hazard.

The significant beneficial effects of smoking occur primarily in the area of mental health, and the habit originates in a search for contentment. Since no means of measuring the quantity of these benefits is apparent, the committee finds no basis for a judgment which would weigh benefits against hazards of smoking as it may apply to the general population. Committee's Judgment in Brief

On the basis of prolonged study and evaluation of many lines of converging evidence, the committee makes the following judgment:

Cigaret smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action.

B. Comments and Detailed Conclusions

All conclusions formally adopted by the committee are presented at the end of this section. For convenience of reference, in the interest of conciseness, the documentation and most of the discussion are omitted from this condensation.

CHARACTERIZATION OF THE TOBACCO HABIT

The habitual use of tobacco is related primarily to psychological and social drives, reinforced and perpetuated by the pharmacological actions of nicotine on the central nervous

system. Nicotine-free tobacco or other plant materials do not satisfy the needs of those who acquire the tobacco habit.

The tobacco habit should be characterized as an habituation rather than an addiction. Discontinuation of smoking, although possessing the difficulties attendant upon extinction of any conditioned reflex, is accomplished best by reinforcing factors which interrupt the psychogenic drives. Nicotine substitutes or supplementary medications have not been proven to be of major benefit in breaking the habit.

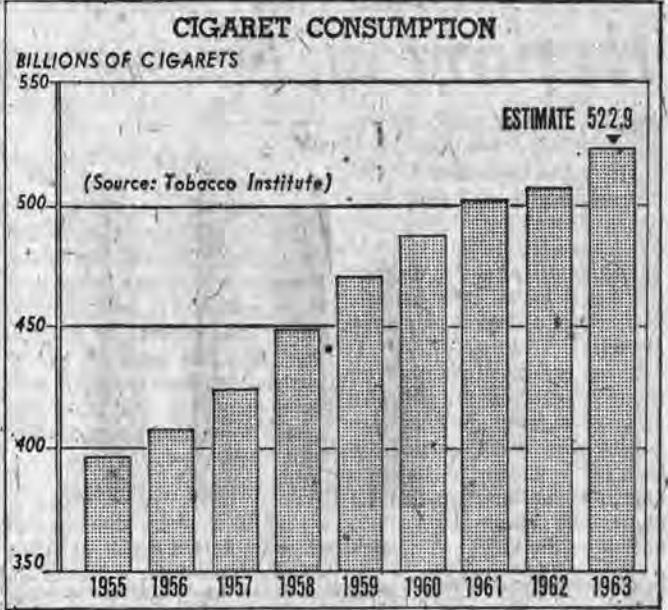
PATHOLOGY AND MORPHOLOGY

Several types of epithelial changes are much more common in the trachea and bronchi of cigarette smokers, with or without lung cancer, than of nonsmokers and of patients without lung cancer.

Extensive atypical changes have been seen most frequently in men who smoked two or more packs of cigarettes a day.

Women cigarette smokers, in general, have the same epithelial changes as men smokers. However, at given levels of cigarette use, women appear to show fewer atypical cells than do men. Older men smokers have more atypical cells than younger men smokers. Men who smoke either pipes or cigars have more epithelial changes than nonsmokers, but have fewer changes than cigarette smokers consuming approximately the same amount of tobacco. Male ex-cigarette smokers have less hyperplasia and fewer atypical cells than current cigarette smokers.

It may be concluded, on the basis of human and experimental evidence, that some of



Yearly increase in cigarette consumption in the United States is shown in chart.

the advanced epithelial hyperplastic lesions with many atypical cells, as seen in the bronchi of cigarette smokers, are probably pre-malignant.

MORTALITY

The death rate for smokers of cigarettes only, who were smoking at the time of entry into the particular prospective study, is about 70 per cent higher than that for nonsmokers. The death rates increase with the amount smoked. For groups of men smoking less than 10, 10 to 19, 20 to 39, and 40+ cigarettes and over per day, respectively, the death rates are about 40 per cent, 70 per cent, 90 per cent, and 120 per cent higher than for nonsmokers.

The ratio of the death rates of smokers to nonsmokers is highest at the earlier ages 40 to 50 represented in these stud-

ies, and declines with increasing age. The same effect appears to hold for the ratio of the death rate of heavy smokers to that of light smokers. In the studies that provided this information, the mortality ratio of cigarette smokers to nonsmokers was substantially higher for men who started to smoke under age 20 than for men who started after age 25. The mortality ratio was increased as the number of years of smoking increased.

In two studies which recorded the degree of inhalation, the mortality ratio for a given amount of smoking was greater for inhalers than for noninhalers. Cigarette smokers who had stopped smoking prior to enrollment in the study had mortality ratios of about 1.4 as against

[Cont. on following page]

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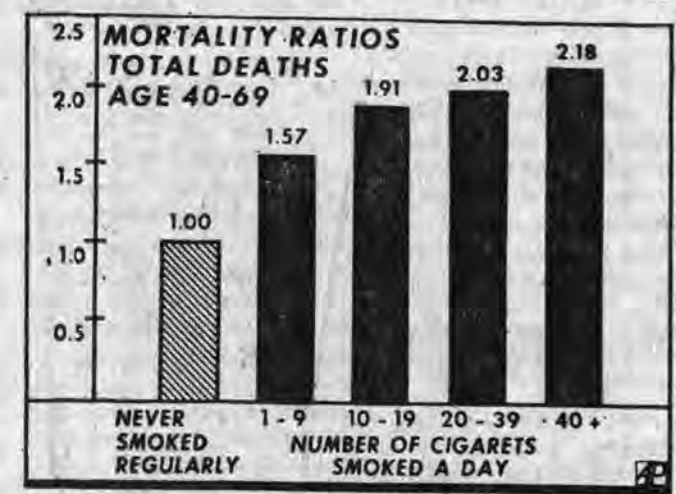
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Partial Text of U. S. Report on Smoking



Mortality ratios of total deaths for 40-69 age group in terms of cigarette consumption.

[Cont. from preceding page] 1.7 for current cigarette smokers. The mortality ratio of ex-cigarette smokers increased with the number of years of smoking and was higher for those who stopped after age 55 than for those who stopped at an earlier age.

The biases from nonresponse and from errors of measurement that are difficult to avoid in mass studies may have resulted in some overestimation of the true mortality ratios for the complete populations. In our judgment, however, such biases can account for only a part of the elevation in mortality ratios found for cigarette smokers.

For cigar and pipe smokers combined, there was a suggestion of high mortality ratios for cancers of the mouth, esophagus, larynx and lung, and for stomach and duodenal ulcers. These ratios are, however, based on small numbers of deaths.

risk of death from influenza and pneumonia, an association of cigarette smoking and infectious diseases is not otherwise substantiated.

CARDIOVASCULAR DISEASE
Smoking and nicotine administration cause acute cardiovascular effects similar to those induced by stimulation of the autonomic nervous system, but these effects do not account well for the observed association between cigarette smoking and coronary disease. It is established that male cigarette smokers have a higher death rate from coronary disease than nonsmoking males.

The association of smoking with other cardiovascular disorders is less well established. If cigarette smoking actually caused the higher death rate from coronary disease, it would on this account be responsible for many deaths of middle-aged and elderly males in the United States.

Other factors such as high blood pressure, high serum cholesterol, and excessive obesity are also known to be associated with an unusually high death rate from coronary disease. The causative role of these factors in coronary disease, tho not proven, is suspected strongly enough to be a major reason for taking counter-measures against them. It is also more prudent to assume that the established association between cigarette smoking and coronary disease has causative meaning than to suspend judgment until no uncertainty remains.

Male cigarette smokers have a higher death rate from coronary artery disease than nonsmoking males, but it is not clear that the association has causal significance.

OTHER CONDITIONS: PEPTIC ULCER
Epidemiological studies indicate an association between cigarette smoking and peptic ulcer which is greater for gastric than for duodenal ulcer.

TOBACCO AMBLYOPIA
Tobacco amblyopia, dimness of vision unexplained by an organic lesion has been related to pipe and cigar smoking by clinical impressions. The association has not been substantiated by epidemiological or experimental studies.

CIRRHOSIS OF THE LIVER
Increased mortality of smokers from cirrhosis of the liver has been shown in the prospective studies. The data are not sufficient to support a direct or causal association.

MATERNAL SMOKING AND INFANT BIRTH WEIGHT
Women who smoke cigarettes during pregnancy tend to have babies of lower birth weight. Information is lacking on the mechanism by which this decrease in birth weight is produced.

It is not known whether this decrease in birth weight has any influence on the biological fitness of the newborn.

SMOKING AND ACCIDENTS
Smoking is associated with accidental deaths from fires in the home.

No conclusive information is available on the effects of smoking on traffic accidents.

MORPHOLOGICAL CONSTITUTION OF SMOKERS
The available evidence suggests the existence of some morphological differences between smokers and nonsmokers, but is too meager to permit a conclusion.

PSYCHO-SOCIAL ASPECTS OF SMOKING
A clear-cut smoker's personality has not emerged from the results so far published. While smokers differ from nonsmokers in a variety of characteristics, none of the studies has shown a single variable which is found solely in one group and is completely absent in another. Nor has any single variable been verified in a sufficiently large proportion of smokers and in sufficiently few nonsmokers to consider it an "essential" aspect of smoking.

The overwhelming evidence points to the conclusion that smoking—its beginning, habituation, and occasional discontinuation—is to a large extent psychologically and socially determined. This does not rule out physiological factors, especially in respect to habituation, nor the existence of predisposing constitutional or hereditary factors.



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