

LEADERSHIP IN THE COMBAT AGAINST SMOKING-RELATED ILLNESS AND DEATH

Dr. Luther Terry, the courageous surgeon general during whose term the first landmark report on the nefarious influence of tobacco on health was published, died in April of this year. Dr. Terry would have been pleased with this issue of the *Delaware Medical Journal* which is devoted entirely to the medical costs and tragedies of smoking.

We think Dr. Terry would also be as proud as we are of Dr. Kevin Roberts who suggested the theme, solicited the papers, and served as guest editor. While serving as a resident on an adult medical service, Dr. Roberts' concern with the consequences of smoking on health became acute when he noted the almost invariable presence of smoking as a habit among those patients incurably ill with respiratory failure, as well as in those with lung cancer, and also in younger persons admitted with coronary heart disease.

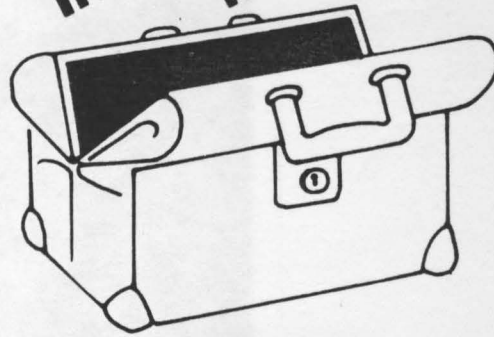
To effectuate changes in smoking habits, Dr. Roberts became active with the local chapter of DOC, the acronym for Doctors Ought to Care, a national program begun by Dr. Alan Blum, now editor of the *New York State Medical Journal*. (A local DOC chapter is chaired by Dr. Mark Glassner, through whose efforts our cover was obtained.)

Dr. Roberts has just completed his residency in family practice at the Medical Center of Delaware. His copy of this issue will be mailed to him at the Atlantic Medical Clinic in Oak Hill, Virginia, where he and his family moved on July 1 in order for him to fulfill his commitment of two years' work to the United States Public Health Services which helped him pay for his education at Temple Medical School. Dr. Roberts describes Oak Hill as consisting of one gas station and the medical clinic which serves much of Acomac County.

In his special report entitled "Cigarette Advertising and Media Coverage of Smoking and Health" recently published (February 7, 1985) in the *New England Journal of Medicine*, Dr. Kenneth Warner closed by saying:

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suiting to use its expertise and influence to address . . . this public health problem," but has "occasionally allowed itself to be part of the 'conspiracy of silence' on smoking and health."

Dr. Roberts and the other authors of the papers in this *Journal* are following Dr. Warner's injunction that "the profession reclaim its leadership role in combating smoking-related illness and death." The number of Americans who die from smoking-related illnesses each year is greater than the total number of deaths resulting from World War I, World War II, and the Vietnam War combined.

One percent of smokers who quit do so on their own; more than five times that many do so when their doctors recommend it. Let us all join the campaign.

BERNADINE Z. PAULSHOCK, M.D.

THE IMPORTANCE OF PASSIVE SMOKING

The importance of passive smoking, or "second-hand" smoke, needs to be brought to the attention of the public. Information must be disseminated to our patients to insure the long-term health and well-being of their families.

Experience in working with the problems of pediatric allergy has demonstrated the validity of the National Health Interview Survey of 1970.¹ Restricted activity days and bed-disability days per year were analyzed for children in families with smokers and nonsmokers. Children in families with no smokers averaged 1.1 fewer restricted activity days per year and 0.8 fewer bed-disability days per year than those in families with two smokers. The sick days of children from families with one smoker were somewhat less than those with two. In this survey two measures of cigarette smoking were used: number of smokers aged 17 years and over, and the total number of cigarettes smoked in the household. The children's exposure is increased with the number of cigarettes being smoked as well as the number of smokers. As expected, I have also seen that family smoking

shows a greater relationship to acute respiratory illness among children than to other types of childhood illnesses.

Examining the allergic nature of tobacco smoke as an offending factor in the family environment reveals little evidence for the occurrence of an immediate, type I, allergic reaction to tobacco smoke.^{2,3} As shown by McDougall and Gleich the radioallergosorbent test did not show any antibodies of the IgE class in response to the skin application of the protein contained in tobacco smoke. Keller and Doyle discussed allergy to tobacco smoke resulting from paralysis of the adrenergic receptors.⁴ The blocking of these receptors in the bronchial tract causes higher sensitiveness to histamine.⁶ In addition it has been found that the WBC count is elevated in smokers but the neutrophils may have reduced chemotactic activity.⁵

Two-thirds of the smoke of a burning cigarette goes into the environment, even when the smoker inhales. Tar, nicotine, carbon monoxide, cadmium, nitrogen oxide, ammonia, benzene, formaldehyde, hydrogen sulphide, and dozens of other compounds are parts of the smoke. Air-borne smoke is either "sidestream" or "mainstream."⁷ Sidestream smoke, the smoke that goes directly into the air from the burning cigarette, is most important for the nonsmoker.

Mainstream smoke, that which is pulled through the mouthpiece and inhaled or puffed, is a smaller quantity of smoke which has had some of the noxious compounds removed. A cigarette is being inhaled for only about 24 seconds of its twelve-minute burning time. There is twice as much tar and nicotine in sidestream smoke, three times as much 3-4 benzopyrene, five times as much carbon monoxide, and fifty times as much ammonia. However, a secondhand smoker inhales diluted smoke.⁶

Ninety percent of the typical urban resident's time is spent indoors. It is apparent to all of us that elevated contaminant concentrations are common in many buildings. One of the most important of these contaminants is tobacco smoke. Our air-tight, energy efficient modern housing allows for less than adequate ventilation. A study of respirable suspended particulates