Australian doctors can contribute to the welfare of the African people by helping to educate black doctors at undergraduate and postgraduate level and by serving in understaffed rural areas in mission hospitals. This practical expression of concern has not been encouraged at official levels in Australia.

John K. McKechnie,
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Blood nicotine levels (ng/mL) after smoking cigarettes or chewing nicotine gum.*

Number of subjects	Blood nicotine levels (ng/mL) After smoking cigarettes containing 1 mg to 2 mg nicotine†	After chewing gum containing 4 mg nicotine‡	After chewing gum containing 2 mg nicotine†	t-test P value
21[2]	31.5±12.4	26.3±16.9		NS
15[3]	30.4±10.3		10.8±5.0	$P<0.001$

*From Russell *et al.*[2,3]
†Peak level two minutes after smoking one cigarette on a day with usual cigarette consumption.
‡Peak level 25 minutes after chewing one piece of nicotine gum. Gum had been chewed hourly from waking (no cigarettes smoked on that day).

Smoking

Madam: I was delighted to see a complete issue of the Journal (MJA, March 5, 1983) devoted to the greatest health problem of our time — smoking. It is pleasing to see the Journal dealing with a problem which affects all doctors.

While governments legislate against products that are potentially hazardous to health, tobacco, which kills 16 000 Australians each year, is immune from all but token criticism. Misleading advertising directed at young people is condoned. The financial reliance of the mass media on the tobacco companies makes adverse publicity of smoking difficult.

It is important that all concerned do what they can to campaign against smoking. Although little can be achieved by isolated efforts, such as writing a letter to a newspaper, the effect of many similar actions is cumulative.

The AMA, as a national organization, carries a certain amount of clout, and AMA Branches throughout the country should be active in this area. The Capital Territory Group for example, recently received newspaper and television coverage for its condemnation of an advertisement which appeared to link the Prince and Princess of Wales (who are non-smokers) with smoking. At a national level, the AMA should vigorously pursue the abolition of cigarette advertising, the abolition of subsidies to tobacco growers, a steep increase in the taxes on tobacco products and an end to sports sponsorship by tobacco companies. The ultimate aim should be the phasing out of smoking over, say, a ten-year period.

We should all be conscious that we as individuals can do something to discourage smoking.

Alan D. Shroot,
Dickson Chambers,
Dickson, ACT 2602.

Madam: The issue of the Journal (MJA, March 5, 1983), devoted to the epidemic of diseases associated with smoking, raised many very pertinent issues. A further example of our society's inconsistent attitude towards cigarettes and their contents is the scheduling of nicotine under the provisions of the Poisons Act.

Nicotine is recognized as a dangerous chemical. Nicotine chewing tablets containing four mg nicotine or less are included in Schedule 4 of the Poisons Act. Schedule 4 covers substances which should, in the public interest, be supplied only on medical, dental or veterinary prescription, and also potentially harmful substances pending evaluation of their toxic or deleterious nature. All other forms of nicotine, apart from tobacco, come under Schedule 7. This schedule applies to exceptionally poisonous substances which require special precautions and restrictions on their manufacture, use and sale. Even for use in animals, nicotine comes under Schedule 6, which includes substances that are required to be readily available to the public for agricultural, pastoral, horticultural or veterinary purposes, or for the control or destruction of pests and vermin, or for industrial purposes.

Studies have shown that some of the toxic effects of nicotine, such as vasoconstriction, are related to its levels in the blood.[1] The blood nicotine concentrations achieved by smoking cigarettes containing one mg to two mg nicotine are similar to those achieved by chewing gum containing four mg nicotine[2] and higher than those achieved by chewing gum containing two mg nicotine (Table).[3] These differences occur because nicotine, when chewed and swallowed, is rapidly metabolized in its first passage through the liver to cotinine and nicotine-*N*-oxide, which are both psychopharmacologically inert. However, when it is absorbed through the lungs and the buccal mucosa, nicotine bypasses the liver and is thus able to

circulate in its active form.[4] It has been proposed to the Poisons Schedule Standing Committee that these inconsistencies be rectified and that nicotine be rescheduled uniformly, irrespective of its mode of administration.

J. L. Benzie,
A. W. Musk,
Sir Charles Gairdner Hospital,
Nedlands, WA 6009.

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2. Russell MAH, Sutton SR, Feyerabend C, *et al.* Nicotine chewing gum as a substitute for smoking. *Br Med J* 1977; 1:1060-1063.
3. Russell MAH, Feyerabend C, Cole PV. Plasma nicotine levels after cigarette smoking and chewing nicotine gum. *Br Med J* 1976; 1:1043-1046.
4. Russell MAH. Nicotine intake and its regulation. *J Psychosom Res* 1980; 24:253-264.

Madam: I would like to commend you for your courageous issue (MJA, March 5, 1983), dealing with the almost insuperable problem of combating smoking — a problem made all the more difficult by the tobacco industry's extensive assistance to sport, the arts, and so on. Your description of the situation which obtains in Australia was most illuminating.

Your stand will encourage others to confront all those practices, whether of corporations or of individuals, which prejudice health in its widest sense.

Your attack on smoking comes at a time when the practice is increasing among young women in the West,[1] and among Third World populations, at least in urban areas.[2] In Johannesburg, about 70% of black, Indian and coloured men, and about 60% of white men, smoke. The prevalence of smoking remains low among black and Indian women.[3]

A problem of just as much concern is that of excessive drinking. In Western countries, alcohol consumption has increased enormously,[4] as have its damaging effects on health.[5] Recent reports show that alcohol is a primary, if not a principal, cause of premature death among middle-aged men in Sweden.[6] Like smoking, the consumption of alcohol is increasing rapidly among Western women,[7] and among men in many Third World countries.[8] In Africa, prominent leaders, including Nyerere, Kaunda, Banda, and others, have repeatedly upbraided their countrymen over excessive drinking, now the number one community health problem in urban areas.

Another injurious practice, which affects not adults, but young children, is the misuse of infant formula foods. This practice greatly distresses many health care workers and public health authorities, especially in Third World countries. Manufacturers "encourage their sales staff to distribute free samples to mothers, use posters claiming that powdered baby milks are 'the best start in life', use radio advertising which tells mothers the product should be 'the first choice' . . .".[9] Certainly, as Dugdale has emphasized, there is need for a balanced approach to this vexed and highly emotive subject.[10] Yet the likelihood of voluntary controls being successfully imposed through a Code of Marketing Practice is very remote, according to a report published by the International Baby Food Network. The report set out "over 200 alleged violations of the October recommendations, by 19 companies in 33 countries between January and April of this year (1982)".[11]

Traffic accidents are another prominent, but preventable, cause of suffering and death. In South Africa, as in Australia, motor vehicle accidents account for about 10% of all deaths in people aged between 15 and 64 years.[12] A very high proportion of accidents is associated with alcohol.[13] If even a small fraction of these deaths occurred in war, the public would be convulsed with outrage, and governments would fall overnight. Yet the maimings and killings on the roads are shrugged off as almost inevitable, and the penalties for irresponsible driving remain trivial. There are no high-powered lobbies dedicated to the combating of carnage on the road, and which have sufficient clout to ensure that severe penalties are imposed on negligent drivers.

It is popular nowadays to make forecasts concerning the standard of health the world's people can look forward to in the year 2000.[14] Although it is a forlorn hope, just think of the enormous improvements in health that would inevitably follow a worldwide reduction in tobacco and alcohol consumption and a drastic fall in the numbers of traffic accidents.

A. R. P. Walker,
South African Institute for Medical Research,
Johannesburg, South Africa.

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3. Van der Burgh L. Smoking behaviour of white, black, coloured and Indian South Africans: some statistical data on a major public health hazard. *S Afr Med J* 1979; 55: 975-978.
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5. Anonymous. Alcoholism: time for action (Editorial). *Br Med J* 1981; 1: 1177-1178.
6. Peterson B, Kristensen H, Sternby N, *et al.* Alcohol consumption and premature death in middle-aged men. *Br Med J* 1980; 1: 1403-1406.
7. Saunders JB, Davis M, Williams R. Do women develop alcoholic liver disease more readily than men? *Br Med J* 1981; 1: 1140-1143.
8. Wilson A. Alcoholism, a rising tide. *World Health* December 1982: 2-5.
9. Chetley A. Marketing breast milk substitutes. *Lancet* 1980; 2: 258.
10. Dugdale A. Infant feeding in the developing world. *Med J Aust* 1980; 2: 710.
11. Anonymous. Infant feeding: Code of marketing practice. *Lancet* 1980: 1: 1239-1240.
12. Wyndham CH. Deaths from destructive life styles (largely preventable) among economically active whites in South Africa. *S Afr Med J* 1982; 62: 1017-1026.
13. Tayside Safe Driving Project. Problem drinking among drunk drivers. *Br Med J* 1983; 1: 1319.
14. Anonymous. Taking off into health for all by the year 2000. *World Health Stat Q* 1982; 35: 2-10.

Madam: Reading your anti-smoking issue was fun and gave me pride in the profession. Dr Tom Dadour's effectiveness suggests that we could do with more doctors in public office to carry health issues into the political arena. For years the most gifted matriculants have entered medicine and been effectively lost to any comprehensive contribution in the area of social policy, while solicitors and managers have called the shots. I'm for a powerful health lobby where it counts — in power, and in control.

Peter Rout,
Chatham Road,
Eastwood, NSW 2122.

Madam: The back covers of many of the popular magazines found in doctors' waiting rooms feature a packet of cigarettes invitingly opened, with a plush cigarette lighter close by and often with an invitation to the reader to light up. It would be reasonable to expect that a magazine's back cover would face upwards 50% of the time. Therefore, our waiting rooms are probably stimulating our patients to smoke cigarettes either just before or just after their consultation, particularly if they have been waiting for some time or if they are apprehensive about the appointment.

To tear the back page from waiting room magazines is a rather untidy solution. For those of my colleagues who may be unaware of this malignant invasion of their waiting rooms, may I recommend an alternative? Across each back cover can be attached a gummed label with a suitable warning inscribed in large letters. I prefer, "Smoking smells. Smoking kills".

David Close,
Melbourne Street,
North Adelaide, SA 5006.

Madam: November 10, 1982 was Smoke Free Day in Western Australia. On this day we decided to promote awareness of the dangers of tobacco smoking by conducting spirometric testing in Fremantle Hospital.

The survey was far from ideal in the scientific sense, but our main objective was to see if it was possible to have an impact on smokers by making them aware of their reduced lung function. Participants were told how their FEV_1 compared with that predicted on the basis of their height, age and sex.

Our findings were consistent with those of more comprehensive studies. The mean

percentage of predicted FEV_1 for non-smokers was 100.8%, and for smokers, 92%. An FEV_1 of 80% was arbitrarily designated "normal". Twenty-five per cent of all smokers, and 50% of smokers over the age of 40, fell below this level.

However, the main point of the exercise was not to collect data but to educate the public. The term "puffability" was coined to describe the percentage of predicted FEV_1 obtained and, after testing, each participant was given a badge bearing the statement, "My puffability is (for example) 80%", to wear for the remainder of Smoke Free Day. This had an enormous subjective impact by reinforcing the positive aspects of not smoking.

This exercise is just one example of the ways in which members of the medical profession can promote health by appealing to people's self-image. Is this not, after all, the method used by the tobacco industry?

Andrew G. Dunn,
Medical Registrar,
Fremantle Hospital,
Fremantle, WA 6160.
Pauline Dunn,
Registrar in Psychiatry,
Norma Nickel,
Resident Medical Officer,
Sir Charles Gairdner Hospital,
Nedlands, WA 6009.

Madam: I enclose a two-page spread from *The Canberra Times* of Friday, March 11, 1983. On one page there is a glossy full-page advertisement for a particular brand of cigarettes and on the page facing it, lost among articles and advertisements, is a four-line item on the AMA's opposition to cigarette advertising at airports.

In my view, this illustrates the extent of the popular press's commitment to big dollars on the one hand and to the AMA and public health on the other.

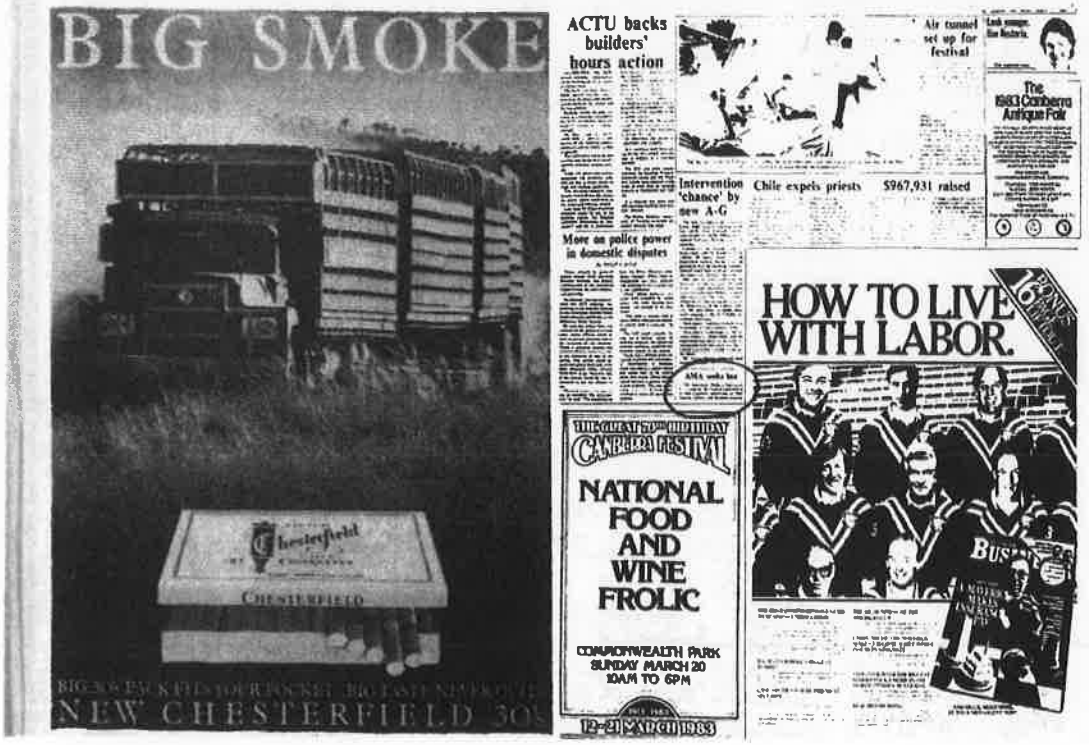
John A. Calder,
Darwin Place,
Canberra City, ACT 2601.

Madam: I'd like to congratulate you on the issue of March 5, 1983. It is sad that only the sellers of harmful products, such as cigarettes, alcohol and motor cars, can afford the really big advertising promotions.

D. C. Henchman,
Prince Street,
Goulburn, NSW 2580.

Madam: I read with great interest the articles on smoking and health in the March 5 issue of the Journal. In Japan, the sale of tobacco is a Government monopoly. Sensible people are ashamed of this, and say that the Government is selling not only tobacco but also tobacco-related diseases. Though they are manufactured in Japan, most cigarettes have English brand names. Advertisements for cigarettes with English names such as "Partner", "Tender", or "Mild Seven" appeal to Japanese people, and these brands sell well. But cigarettes are the "Partner" in causing many diseases, and smokers are "Tenderly" and "Mildly" undermining their health by smoking them.

In many cases, Japanese smokers themselves should be chastised for their smoking habit. They smoke in public, on trains, and even in the office at work. The harmful effects of passive smoking on non-smokers do not appear to concern them. Smokers tend to regard the ground as the biggest ashtray on earth, and they litter the streets with ash and cigarette butts. Coffee and tea breaks are times for relaxation and



refreshment. Smokers should refrain from smoking at these times unless a "tobacco break" is specified.

It is now believed that about 30% of primary school pupils, 50% of junior high school students, and 70% of senior high school students in Japan have smoked cigarettes at least once or twice. I think, therefore, that it is too late to start teaching children about the health hazards of smoking in high school. Anti-smoking education should begin in kindergarten.

I hope that an antismoking movement like that in Australia will come to have power in Japan in the near future.

Hiroshi Kawane,
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Japan.

Total colonoscopy in the diagnosis of colonic disorders

Madam: I wish to correct inaccuracies in the recent article "Importance of total colonoscopy in the diagnosis of colonic disorders", in which the results of 108 total colonoscopies performed over a five-year period were assessed.[1]

The article contained the statement: "... our study showed the results of barium enema X-ray examination to be accurate in only 47% of cases". This must be untrue. I would assume that at Concord Hospital three or four such examinations are performed daily, adding up to several thousand over the five-year period in question. This base figure from which the colonoscopies would be drawn would be further increased by the number of barium enema X-ray examinations performed in adjacent smaller hospitals and private practices. Of these, 175 found

Colonoscopy and double-contrast barium enema examinations are excellent examinations if performed with appropriate preparation, care, and experience. Both examinations have advantages and disadvantages, and each may have to be repeated in order to confidently demonstrate or exclude significant colonic pathology.

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1. McPherson A, Payne JE. Importance of total colonoscopy in the diagnosis of colonic disorders. *Med J Aust* 1983; 1: 170-172.

Madam: It would seem a great omission if the figures in the article by McPherson and Payne were not questioned and clarified.[1] The reported accuracy of the barium enema X-ray examinations in their study is quite