LETTERS TO THE EDITOR

RE: "TOBACCO AS A CAUSE OF LUNG CANCER: SOME REFLECTIONS"

We read with great interest and pleasure Dr. Ernst Wynder's reflections on tobacco (1), especially with reference to the attitudes of health professionals in the United States over a period of half a century.

Italy is a country of great contrasts. We discovered a booklet, *The Damages of Tobacco*, that was published in 1645 by G. G. Cuffari, a physician from Palermo, Sicily (2). Dr. Cuffari's conclusions were (literal translation): "Anybody should be warned that tobacco use is harmful and deadly and—albeit it may not manifest any harm at the beginning—in due course, it will cause several damages. I wish everybody stopped such a habit." He mentioned tobacco-related cerebral damage, including sudden death and stroke, left-side heart disease, and a "black thing near the diaphragm," possibly lung cancer, as well as "primary nose cancer." He also remarked that women who did not smoke did not experience sudden death or other tobacco-related diseases (2).

Much later, in 1906, a paper by D. Mocchi (3) drew attention to the harmful effect of tobacco exposure during pregnancy. It showed an increased risk of spontaneous abortions and stillbirths among women who were employed in cigar manufacturing.

In spite of these cases of remarkable foresight, smoking among physicians and, consequently, in the general population in Italy started declining about two decades later than in the United States and Britain. In a 1985 survey of 709 physicians (nearly 90 percent of local physicians) from Pordenone Province, northeastern Italy, the percentage of "current cigarette smokers" (31 percent) was only marginally lower than that found in a random population sample from the same province (4). As Wynder suspected (1), a physician's smoking status was shown to affect perceptions of smoking-related risk and counseling practices (4).

A striking example, perhaps, of the persisting disregard of the threat posed by tobacco on the part of some members of the Italian scientific community comes from the Philip Morris Company's promotional campaign of December 31, 1992. "New Year's greetings" from Philip Morris, specifically addressed to the younger generation, occupied the entire last page of the two most widespread newspapers in Italy (*Il Corriere della Sera* and *La Repubblica*). The advertisements included a message signed by Nobel Prize winner for Medicine Rita Levi Montalcini under the heading "The Culture of Modern Times." Only a physician of Italian origin who was working abroad publicly complained (5).

REFERENCES


THE AUTHOR REPLIES

I thank Drs. La Vecchia and Franceschi (1) for their additions to my observations (2). Their comments are very much on target and remind us that early on there were, in many countries at various times, one or more individuals who recognized the injurious effects of tobacco use. Soemmering in 1795 (3), Goethe's physician Hufeland in 1798 (4), a group of British physicians in 1878 (5), and Abbe in 1915 (6) were among those in the medical professions who expressed great concerns about the use of tobacco in their time.

Additionally, in place of public health authorities, various rulers and leaders have at times regulated or banned tobacco use; among these was King James VI of Scotland, who, through his *Counterblaste to Tobacco* (7), was already warning in 1604 of the adverse consequences of smoking and who raised tobacco taxes in attempts to curb or diminish the import of tobacco to England. Russian Czar Michael Fedorovich (1613–1645) prohibited the sale of tobacco under penalty of physical punishment or death; similarly, Sultan Murad IV of Turkey made tobacco use punishable by death, as he believed that the habit caused infertility and reduced the fighting capability of his soldiers. Among the religious leaders and groups banning tobacco use were several Popes, John Wesley (the founder of Methodism), the Mormons, and the Seventh-day Adventists, as well as the Parsees and Sikhs of India, Buddhist monks, various Chinese sects, and Ethiopian Christians (8).

The question is, Why has it taken so long to get appropriate public health action in our time, when it is clearly tobacco use as such that sentences people to illness and premature death? Was it because individuals who smoke are more concerned about momentary enjoyment than about long term health consequences? Was it because of a lack of forcefulness on the part of our public health officials and political leaders? Or was it because of the strength of commercial interests, including media interests, that were in the way of such action? Most likely, all of these factors came together.

Yet, even now, with the first steps toward public health action being taken and provisions being made for regulatory mechanisms, we need to continue to be pragmatic and to
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focus on the best possible legislative agreements we can obtain. Above all, we need a firm commitment to health education for our children. Only with the involvement of parents, physicians, schools, and the media can we ensure that today's children will grow up without becoming habituated to nicotine and thus without the specter of tobacco-related illness shortening their lives.

REFERENCES

Ernst L. Wynder
American Health Foundation
320 East 43rd Street
New York, NY 10017

RE: "LACTATION HISTORY AND BREAST CANCER RISK"

Freudenheim et al. seem to have used an unfortunate choice of words in summarizing their findings regarding lactation history and breast cancer risk (1). In their abstract, they state, “Breast cancer risk was very weakly associated with long duration of lactation among premenopausal women” (1, p. 932), and yet the adjusted odds ratio given for this association is 0.5. By any standard, a behavior which could potentially reduce the risk of premenopausal breast cancer by approximately 50 percent would not be considered a "very weak" protective factor. What is "weak," as evidenced by the width of the accompanying 95 percent confidence interval (0.21–1.12), is the power of the study to determine whether an effect of this magnitude is very likely. Based on this wording, the authors would appear to have committed the classic error of confusing the estimated magnitude of an association with its significance level (2).

REFERENCES

Kenneth J. O'Dowd
Center for Health Statistics
New Jersey Department of Health and Senior Services
Trenton, NJ 08625–0360

THE AUTHORS REPLY

We appreciate the careful reading of our manuscript by Dr. O'Dowd (1). In our statement of the results in the Abstract (2), while we were concerned with both the magnitude and the precision of the risk estimates, we certainly did not confuse the two. Perhaps it was too strong to classify the risk reduction we saw as "very weak." We would still contend that the observed risk of 0.5 could be called moderate in contrast to the strong risks seen for associations such as for cigarettes and lung cancer. Lilienfeld and Stolley (3) refer to risk estimates on the order of the one we saw as "moderate." In his commentary regarding weak estimates, Wynder (4) discusses risk estimates below 2, which would obviously also refer to estimates between 0.5 and the null value. There is no question that if, indeed, lactation were responsible for a 50 percent reduction in risk, such a reduction would have important public health consequences. With regard to strength of association, however, there is the concern that less strong associations are more likely to be confounded. For the association between lactation and breast cancer, this concern remains.

REFERENCES