Letters to the Editor

THE AUTHORS REPLY

We thank Nitzkin (1). We reported (2) a significantly increased incidence of cardiovascular disease (CVD) associated with the current use of smokeless tobacco in cigarette nonsmokers in the Atherosclerosis Risk in Communities Study (2). As stated in the Results section of our article, the hazard ratios for current smokeless tobacco use were similar among never-smokers (hazard ratio = 1.43, 95% confidence interval: 1.01, 2.03) and former cigarette smokers (hazard ratio = 1.37, 95% confidence interval: 1.02, 1.82). We also reported that the crude incidence rate of CVD in smokeless tobacco users was higher than that for cigarette smokers (21.4 vs. 16.4 per 1,000 person-years), although a formal comparison was not performed (Table 2 of our original article). Furthermore, dual use of both smokeless tobacco and cigarette smoking is being promoted by tobacco companies through co-branding of cigarettes and snus, or moist snuff (i.e., Marlboro snus, Camel snus), with snus being the “solution” to the problem of being unable to consume nicotine in smoke-free places (3, 4). Indeed, out of 3,744 current cigarette smokers in the Atherosclerosis Risk
in Communities Study, 102 (2.7%) reported concurrent use of smokeless tobacco. The CVD incidence rate for dual users was higher than the rate for those who only smoked cigarettes (22.9 vs. 16.1 per 1,000 person years; Table 3 of our original article), although the association between smokeless tobacco use and CVD incidence in current cigarette smokers was not independent of the confounding factors. We also performed an analysis in which we categorized participants into 4 categories by current smokeless tobacco use (yes or no) and current cigarette smoking (yes or no). Crude hazard ratios compared with no smokeless tobacco and no cigarette use were 1.60 (95% confidence interval, 1.30, 1.96) for smokeless tobacco only, 1.68 (95% confidence interval, 1.54, 1.83) for cigarette smoking only, and 1.81 (95% confidence interval, 1.28, 2.55) for dual use. Thus, even though the CVD risks associated with cigarette smoking might be higher than those for smokeless tobacco, we believe it is inappropriate to advocate converting cigarette smokers to smokeless tobacco users as Nitzkin does (1), especially given the other harmful effects of smokeless tobacco, such as oral cancer (5). Users of any type of tobacco should quit.

We disagree with Nitzkin’s other arguments as well. We did not dismiss our finding that the increased risk of CVD associated with smokeless tobacco was partly explained by several mediators (see Table 1 of our original article). We pointed out that smokeless tobacco remained statistically significantly associated with CVD in model 3 (P = 0.047). Our aim in presenting that model was to help readers understand how smokeless tobacco might influence CVD incidence. Nitzkin also states that nicotine replacement therapy lacks efficacy; however, the article he cited (6) does conclude that nicotine replacement therapy is efficacious. In addition, there are smoking cessation aids that, when used alone or in combination with nicotine replacement therapy, have proven efficacy (7).

In conclusion, we still believe that our data support our conclusions that current users of smokeless tobacco should be informed of its harmful effects and be advised to quit the habit and that current cigarette smokers should also be given information on other safe, therapeutic modalities for quitting, which do not include switching to smokeless tobacco.

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REFERENCES

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