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Tobacco Journal International
April 1988, p. 80
THE US TOBACCO INDUSTRY IN
TRANSITION
Humphries, B.

Speakers at the US Agricultural Outlook Conference in December 1987 sounded highly optimistic about the future of US tobacco. American cigarette consumption is declining, but prospects are good for increased leaf exports and smaller leaf imports. Also, US cigarette exports have risen dramatically, particularly to Japan and other parts of Asia. Leaf production will increase for the next several years. A leading leaf export official said production would continue to expand if the industry dealt with marketing and quality and kept its product competitive.

Science
April 29, 1988, p. 606
v. 240
INDOOR RADON: THE DEADLIEST
POLLUTANT

RADON gas is invisible, odorless, and tasteless. It does not make your eyes water or turn the air over Denver a dismal brown. It is not oozing from barrels in a landfill, spouting from industrial smokestacks, or even leaking invisibly from nuclear power plants. There is no industrial malefactor to be sued. But even the lowest estimates of the risk make radon's radioactivity the biggest killer among environmental hazards.

The estimated lifetime risk of dying of radon-related lung cancer is about 0.4% for the average U.S. exposure, which dwarfs the lethal risks of typical exposures to asbestos, pesticides like ethylene dibromide, and air pollutants like benzene. The radon risk falls in the neighborhood of the far higher risk of dying in your home from a fall or a fire.

Radon is deadly, but it is natural, raising for the first time the problem of limiting exposure to a natural, background source of radiation. And that limitation must occur in millions of private homes, each requiring its own monitoring and control measures. Dealing with radon, a chore that will fall to the homeowner with state and federal guidance, is sure to challenge a society in which perception of risk is often more important than measured risk. Everyone may not be equally vulnerable, however, because ironically a lethal interaction between radon and smoking may account for most radon-related deaths.

Journal of the American Medical
Association
May 20, 1988, p. 2901
CLONIDINE, DEPRESSION, AND
SMOKING CESSATION

Pharmacologic treatment of smoking is not a new idea.¹ However, the search for effective pharmacologic treatments for smoking has increased dramatically in the last ten years due to the realization that smoking is a dependence disorder²; that behavioral strategies are not having a large effect on the prevalence of smoking³; and that nicotine dependence is becoming more prevalent in smokers due to a selection process.⁴ This latter process is occurring because smokers who are quitting appear to be smokers who are less dependent on nicotine. Thus, if this trend continues, in ten to 20 years the population of smokers will be almost exclusively smokers who are highly dependent on nicotine.

Journal of the American Medical
Association
May 20, 1988, p. 2900
UNITING PHYSICIANS AGAINST
SMOKING: THE NEED FOR A
COORDINATED NATIONAL STRATEGY

In the late 1960s, the Public Health Service produced and distributed a simple black-and-white poster that stated in bold letters, "100 000 Doctors Have Quit Smoking Cigarettes." Small print at the bottom of the poster explained that "maybe they know something you don't." Since that time, recognition has grown that physicians can play a major role in the campaign to achieve a smoke-free society.

There are at least four major reasons why physicians are perceived as important participants in the antismoking campaign. First, physicians are among the most well-respected and trusted of all professionals. Smokers may ignore cajoling by concerned family members and may resent the stern looks of annoyed "passive" smokers. But they will accept with good graces strong words of advice from physicians, dignified in their white coats. Moreover, most physicians are good role models with respect to not smoking—a survey of 1000 randomly selected physicians conducted in early 1987 for the American Medical Association showed that only 9% were smokers.¹

Clearly, the vast power of the medical profession to curb the use of tobacco has not been fully tapped. Medical societies, voluntary health organizations, public health agencies, and

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other interested parties need to better coordinate their activities to mobilize a medical assault on smoking. Collectively, these groups should examine how scarce resources should be apportioned to accomplish this goal.

As Kottke et al¹⁶ have shown in this issue of THE JOURNAL, our prospects for success depend less on any specific intervention modality than on the need to deliver personalized smoking cessation advice to patients, repeated in different forms by several sources over a long period. Our challenge is to find the will and the way to achieve this for the 47 million Americans who smoke. The first step should be to develop a coordinated national strategy for expanding physicians' participation in the campaign for a smoke-free society.

Journal of the American Medical Association
May 20, 1988, p. 2883

ATTRIBUTES OF SUCCESSFUL SMOKING CESSATION INTERVENTIONS IN MEDICAL PRACTICE Kottke, T.E. et al.

Meta-analysis was used to examine 108 intervention comparisons in 39 controlled smoking cessation trials. Type of intervention (face-to-face advice being better than all others), type of intervenor (both physician and nonphysician counselors better than either alone), the number of reinforcing sessions, and the duration of reinforcing sessions were related to success six months after the initiation of intervention. The number of modalities used by the intervention predicted success with borderline statistical significance. Multivariate analysis predicted that a team of physicians and nonphysicians using multiple intervention modalities to deliver individualized advice on multiple occasions would produce the best result. Program success 12 months after the initiation of intervention was related to the type of intervention session (group and individual sessions combined better than either alone), the number of intervention modalities, and the number of reinforcing sessions. With multivariate adjustment for confounding, the number of intervention modalities alone had a positive association with intervention success.

Journal of the American Medical Association
May 20, 1988, p. 2863

HEAVY SMOKERS, SMOKING CESSATION, AND CLONIDINE Glassman, A.H.

Seventy-one heavy smokers who had failed in previous attempts to stop smoking participated in a randomized clinical trial to test the efficacy of clonidine as an aid in smoking cessation. The success rate in clonidine-treated subjects (verified by serum cotinine concentration) was more than twice that in the placebo-treated subjects. When the data were stratified by gender, a strong effect present in women was not apparent in men. After six months, cessation rates remained significantly higher among smokers treated with clonidine than those receiving placebo. The data also revealed an unexpectedly high prevalence (61%) of a history of major depression in this sample and a significant negative effect of such a history on cessation regardless of treatment. These findings, highly suggestive of an important role of clonidine in smoking cessation, warrant further studies to establish the long-term (≥ 12 months) efficacy of this drug and to replicate the association between nicotine dependence and depression.

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