LETTERS TO THE EDITOR

Letters intended for publication should be a maximum of 500 words, one table, or figure, and 10 references and should be sent to Simon Chapman, deputy editor, at the address given on the inside of this cover. The corresponding articles or correspondence published in the journal should be received within six weeks of publication.

Differences in self-reported health status between ever-smokers and never-smokers

To the Editor—We refer to the report by Lyons et al, who found, using the SF-36 health status questionnaire, that ever-smokers in Wales, United Kingdom, had significantly poorer self rated health on scales relating to physical functioning, bodily pain, general health perception, and vitality compared with never-smokers. We have also collected representative population data for South Australia on the SF-36 and examined differences by smoking status.

Our survey involved a multistage, systematic, clustered area sample of 4200 households, with 75% of the sample being selected from the Adelaide metropolitan area and the remainder from country centres with a population of more than 1000. At each selected household, one person aged 15 years or older was selected for interview, being the person whose birthday was next. Interviews were conducted by the respondents' own home by trained interviewers, with six call back visits if the selected respondent was not at home. The survey yielded 3010 completed interviews, with a response rate of 72.4%. The data were weighted by household size, age, sex, and local government area to the South Australian population.

Of the 3010 respondents to the survey, 47.1% had never smoked. The remaining 52.9% comprised 27.8% smokers and 25.2% ex-smokers. Using multiple regression, we compared the mean scores on each scale of the SF-36 for ever-smokers and never-smokers, adjusting for age, sex, occupational status, and alcohol consumption (see table). Overall, we found statistically significant deficits in functioning among ever-smokers for all scales (p<0.01), and among young adults, deficits pertaining to physical functioning, bodily pain and general health perception. This use of our sample size was larger than that of Lyons et al, and statistical significance was more easily achieved in our study. The magnitude of score differences was broadly similar to the Lyons study for the four-scale measuring aspects of mental health, but the first four scales that measured aspects of physical health showed smaller decrements for ever-smokers. This may partly be accounted for by the fact that our sample included 15 to 19 year olds, whereas the Wales study did not.

When directly queried about the effects of smoking on their health, many smokers do not accept that their health has been adversely affected by cigarette smoking, or may attribute health changes to the effects of aging or other factors. Numerous studies show that smokers are less likely than nonsmokers to believe that smoking causes disease. Furthermore, smokers show unrealistic optimism in rating their own likelihood of developing a smoking related disease compared to the "average" smoker. The effects of smoking on their present and future health is an important cognitive mechanism which facilitates continued smoking.

Given these studies, it is important to note that the SF-36 measures self perceived health status. This study has shown that when smokers are asked to make judgments about their health without a causal attribution, those who have ever smoked perceive their health as significantly worse than never-smokers. This is so, even for young adults.

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Recurrent aphthous ulcers

To the Editor—I was recently faced with a 52 year old adult Ethiopian who had smoked for 40 pack-years and didn't stop smoking. During periods of smoking abstinence he developed multiple, painful, mucocutaneous ulcers in the oral cavity, which disappeared as soon as he restarted smoking. He had made several attempts to stop smoking in the past, the longest being for two years, but he couldn't tolerate the painful oral ulcers and was advised by his family to restart smoking, which he did. He had no genital ulcers and enjoyed good health otherwise. He had never sampled a pipe as a replacement for cigarettes.

This was an unusual situation I faced as a chest physician, and I thought I should bring it to the attention of your readers. I will be very grateful to hear from others who might have had a similar experience, and I would like to be advised on the management of this condition.

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The above letter was referred to Dr Arden Christen, professor of oral biology and director of the Indiana University Nicotine Dependence Program, who offers the following reply:

In reply—Recurrent aphthous ulcers (RAU, canker sores) is a condition characterised by the formation of one or more extremely painful oral ulcers, which typically occur on non-keratinised oral mucosal membranes. Although the precise cause of RAU is unknown, investigators have suggested that it can be related to environmental, immunological, hormonal, genetic, familial, or psychologic factors, including those which concern stress, food consumption, and allergic reactions. These ulcers can make eating, swallowing, or talking extremely painful or difficult. This disorder is very common, occurring in 10% to 20% of the general population.1

About a dozen investigators have reported that smokers have fewer aphthous ulcers than do non-smokers or people who have never smoked, and that smoking cessation is often followed by the appearance or reappearance of these extremely uncomfortable oral ulcerative lesions. It has been postulated that both smoking and smokeless chewing of tobacco may provide protection against RAU because their use increases keratinisation of oral mucosa.2

Some clinicians are successfully treating RAU lesions with the topical or systemic use of steroids, or a combination of both, and an adjuvant application of a 0.12% chlorhexidine prescription plaque control rinse (Peridex). In addition, patients who suffer from various oral mucosal diseases should

Mean SF-36 scores (and standard errors) for never-smokers and ever-smokers, by age group (corrected for age, sex, alcohol consumption, and occupational status)

<table>
<thead>
<tr>
<th>Scale</th>
<th>Smoking status</th>
<th>Age 15-29 (n = 763)</th>
<th>Age 30+ (n = 2207)</th>
<th>Total (n = 3010)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (SE)</td>
<td>Mean (SE)</td>
<td>Mean (SE)</td>
<td></td>
</tr>
<tr>
<td>PF</td>
<td>Never</td>
<td>94.1 (1.0)</td>
<td>83.5 (1.3)</td>
<td>84.3 (0.9)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>91.9 (0.8)†</td>
<td>81.5 (1.0)</td>
<td>82.0 (0.9)</td>
</tr>
<tr>
<td>RP</td>
<td>Never</td>
<td>87.2 (2.7)</td>
<td>80.0 (2.3)</td>
<td>80.6 (1.7)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>83.4 (2.2)</td>
<td>75.6 (2.7)</td>
<td>76.7 (1.6)†</td>
</tr>
<tr>
<td>BP</td>
<td>Never</td>
<td>83.9 (3.0)</td>
<td>78.2 (1.7)</td>
<td>79.4 (1.3)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>79.3 (1.7)†</td>
<td>74.3 (1.6)</td>
<td>74.9 (1.2)‡</td>
</tr>
<tr>
<td>GH</td>
<td>Never</td>
<td>77.4 (4.7)</td>
<td>67.0 (4.1)</td>
<td>71.5 (0.7)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>71.0 (4.1)‡</td>
<td>60.1 (4.3)</td>
<td>67.0 (1.0)‡</td>
</tr>
<tr>
<td>VT</td>
<td>Never</td>
<td>66.5 (1.7)</td>
<td>56.4 (1.4)</td>
<td>59.4 (1.0)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>63.4 (1.4)</td>
<td>51.5 (1.4)</td>
<td>56.4 (1.0)</td>
</tr>
<tr>
<td>SF</td>
<td>Never</td>
<td>87.4 (1.8)</td>
<td>80.9 (1.4)</td>
<td>82.4 (1.4)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>84.3 (1.4)</td>
<td>87.8 (1.1)</td>
<td>85.6 (0.9)</td>
</tr>
<tr>
<td>RE</td>
<td>Never</td>
<td>89.4 (2.6)</td>
<td>89.0 (1.9)</td>
<td>89.2 (1.8)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>84.2 (2.1)</td>
<td>85.6 (1.8)</td>
<td>84.7 (1.3)‡</td>
</tr>
<tr>
<td>MH</td>
<td>Never</td>
<td>75.2 (1.6)</td>
<td>80.2 (1.9)</td>
<td>77.1 (0.9)</td>
</tr>
<tr>
<td></td>
<td>Ever</td>
<td>73.6 (1.3)</td>
<td>78.5 (1.1)</td>
<td>76.6 (0.8)‡</td>
</tr>
</tbody>
</table>

PF, physical functioning; RP, role limitations-physical; BP, bodily pain; GH, general health; VT, vitality; SF, social functioning; RE, role limitations-emotional; MH, mental health.
† p < 0.01 for difference between never- and ever-smokers.
‡ p < 0.001 for difference between never- and ever-smokers.
Acute eosinophilic pneumonia: a new smoking related illness?

To the Editor – Initiation of smoking begins primarily during the teenage years. The increase in the number of underage smokers and young women smoking is one of Japan's most important health problems.1 Young people may not be impressed by long term health risks such as lung cancer, chronic bronchitis, and emphysema. Recently, two young patients with acute eosinophilic pneumonia (AEP), which occurred just after smoking initiation. A 19 year old woman and 18 year old man, both previously healthy, were admitted to our hospital because of acute respiratory distress and diffuse pulmonary infiltrates on chest radiographs. Eosinophilic pneumonia was diagnosed by bronchoscopic lavage and transbronchial lung biopsy. There was no evidence of an infectious aetiology. Both patients rapidly improved with corticosteroid therapy, and AEP was diagnosed by its clinical course.

It is the fact that one patient had started smoking 10 days before the onset, and the other 3 days before. In the male patient, a challenge test was performed 44 days after his initial episode of AEP (two weeks after withdrawal of corticosteroids). He was asked to smoke three cigarettes in three hours. Subjective symptoms, physical findings, and pulmonary function tests were assessed after smoking each cigarette. He showed dry cough, dyspnoea (4 L/min) and saturation (SpO2 92%) 15 minutes after he smoked the last cigarette. Although a chest radiograph taken at that time revealed no abnormalities, FVC, FEV1, and diffusing capacity (transfer factor) were decreased significantly. He recovered quickly again following the administration of corticosteroids.

From a review of the literature and abstracts of medical congresses, we found approximately 40 cases of AEP reported in Japan, and most of them were under 20 years old or in their early 20s. To our knowledge, there were eight other cases that suggested a relationship between smoking and eosinophilic pneumonia (EP). In a computer based search of the literature – using the key words “smoking” or “cigarette” and “acute eosinophilic pneumonia” in combination – we were unable to find reports of a possible association between smoking and AEP.

Although AEP is a newly recognised clinical entity and a hypersensitivity reaction to inhaled antigen is suggested,2 no particular precipitating cause has been identified in any patient with AEP.3 It is well known that cigarette smoke is a complex mixture of more than 4000 compounds. Numerous clinical studies have documented smoking induced alterations in immune and inflammatory function.4 Cigarette smoking has also been shown to be a cause of heightened airway responsiveness.5 The possibility that inhalation of cigarette smoke might play a role in the onset of AEP should be further explored. We encourage other investigators to report cases of AEP to assess whether they may be related to smoking.

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What should we call ex-smokers?

To the Editor – Efforts to integrate the treatment of nicotine and tobacco dependence into the mainstream of addiction treatment have been hampered by resistance on the part of physicians, treatment professionals, and their patients. Physicians want their patients who smoke to quit because smoking causes illness and premature death, but the success of standard treatment methods is so poor that many, both physicians and patients, stop trying. Most addiction treatment professionals concede that nicotine and tobacco dependence should be included in addiction treatment, but they fail to make the effort. Seventy five percent of alcoholics and other drug addicts are smokers; most state that they would be “better off” if they stopped smoking, but few are willing to acknowledge that nicotine and tobacco dependence represents an addiction similar to their other addictions.

Part of this resistance may have a semantic basis. Alcoholics refer to the state of recovery from alcoholism as being sober. Heroin and cocaine addicts refer to the state of recovery from their addictions as being clean. As yet, no equivalent term referring to the state of recovery from nicotine and tobacco dependence has received general acceptance. “Smoke-free” has been used, but it lacks the necessary emotional impact. “Clean” has been suggested by Charyn Sutton (John Slade, personal communication), but it has failed to excite interest at professional meetings or in patient groups.

We propose the phrase “clean and free” to indicate the state of recovery from nicotine and tobacco dependence. “Clean” suggests the salutary result of quitting smoking (clean lungs, clean breath, clean ashen), and “free” suggests physical, emotional, and spiritual freedom from being controlled by an addiction.

SIMON CHAPMAN
Deputy Editor


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