Table 1 Initial smoking characteristics and smoking status at one-year follow up for 50 occasional smokers

Smoking status at follow up	Number	Initial characteristics			
		Cigarettes per week*	Years smoked	Prior regular† (%)	Quit attempt‡ (%)
Quit	27	5.0	2.3	41	NA
Occasional	17	7.8	3.1	41	18
Regular	6	10.3	1.2	0	50

* P = 0.025.

† "Prior regular" is the percentage of each group who were ever previously regular smokers.

‡ "Quit attempt" is the percentage of each non-quitting group who tried to quit during the follow-up year.

NA = not applicable.

smokers, despite having smoked for the shortest time period. This finding is consistent with our earlier retrospective survey.² We were surprised that none of those who had previously been regular smokers returned to regular smoking. There were relatively few unsuccessful quit attempts. Of those who tried to stop in the follow-up year, 83% succeeded.

Almost all college students who smoke plan to stop within the next five years and about two-thirds report prior attempts to stop, averaging about one attempt a year.⁶ This is virtually the same proportion having tried to quit as seen among the occasional smokers in our longitudinal study. Thus occasional smokers report similar quitting patterns as regular smokers, but much more success at quitting when they attempt to stop.

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Smoking prevalence in younger Italians

EDITOR—We investigated the age-specific prevalence of smoking in Italy using data from the 1990–91 and the 1994 (first cycle) National Health Surveys, conducted by the National Institute of Statistics (ISTAT) on samples of 55 989 and 13 048 individuals aged 15 or over, respectively.^{1,2}

The design of the National Health Surveys has already been described.^{1,2} Briefly, interviews were organised and conducted by civil servants appointed by each municipality included in the study on samples of 25 878 households in the 1990–91 survey and of 5700 households in the first cycle of the 1994 survey, randomly selected within strata of geographical area (region), size of the municipality and of the household, to be representative, on a regional level, of the general Italian population. The 12 metropolitan areas (over 250 000 inhabitants) were included, together with a random sample of other municipalities, stratified in four levels according to geographical area and size of the municipality. No substitution was allowed, and the overall participation rate was over 90%. Proxy interviews were permitted for members not present in the house (about a quarter of the study samples). All interviews were conducted in the houses of the families identified.

Questions on smoking included smoking status (never/former/current smoker), type of tobacco product mainly smoked (including a distinction between filter and non-filter cigarettes), average number of cigarettes or pipes/cigars smoked per day, duration of smoking in years, and (for ex-smokers) time (years) since stopping.

We obtained a copy of the original computer tape from ISTAT, including all available information for each subject interviewed. Information on smoking was elicited only for those above age 14. Consequently, subjects below age 15 were not considered, thus leaving total samples of 27 135 males and 28 854 females in the 1990–91 survey, and 6307

Table 1 Self-reported smoking prevalence (%), and corresponding standard errors (SE), by age and sex, Italy, 1990–91 and 1994 National Health Surveys

Age groups (years)	Males		Females	
	1990–91 % (SE)	1994 % (SE)	1990–91 % (SE)	1994 % (SE)
15–24	28.9 (0.9)	19.8 (1.3)	17.0 (0.6)	9.9 (1.0)
25–34	43.3 (0.9)	42.0 (1.9)	26.1 (0.7)	22.8 (1.3)
35–44	45.7 (1.0)	42.3 (1.9)	26.1 (0.7)	29.1 (1.6)
45–54	42.6 (1.0)	39.8 (2.0)	17.8 (0.6)	19.9 (1.4)
55–64	35.3 (0.9)	31.0 (2.3)	12.3 (0.5)	12.6 (1.3)
65–74	29.0 (1.1)	22.3 (1.8)	6.7 (0.4)	7.2 (0.9)
≥ 75	18.8 (1.0)	16.7 (2.2)	2.2 (0.3)	2.5 (0.7)
Total	37.2 (0.4)	32.6 (0.7)	17.4 (0.2)	16.3 (0.4)
No of subjects	27 135	6307	28 854	6741

males and 6741 females in the first cycle of the 1994 survey.

For comparative purposes, we derived age-specific smoking rates, as well as overall age-standardised rates (by the direct method, based on the overall distribution in quinquennia of age).

The table gives the age-specific and age-standardised prevalence of smoking in Italian males and females in 1990–91 and 1994, with the corresponding standard errors. Approximate 95% confidence intervals are ± 2 standard errors of the estimates. Between 1990–91 and 1994, for both sexes, a substantial decline was observed in the youngest age group (15 to 24 years, from 28.9% to 19.8% in males, from 17.0% to 9.9% in females). In older age groups, a moderate but consistent decline in smoking prevalence was observed in males, whereas women aged 35 or over tended to have a higher smoking prevalence than in the previous survey. Overall, age-standardised prevalence declined from 37.2% in 1990–91 to 32.6% in 1994 among males, and from 17.4% to 16.3% among females.

Thus the data from these two National Health Surveys document a continuation of the long-term decline in smoking prevalence previously found among Italian males,³ in the absence, though, of appreciable changes in

prevalence among females. Of more interest, however, are the substantial falls in smoking prevalence among younger males and the even greater declines among younger females. These changes are too large to be totally attributable to information bias or chance, because the two surveys were large, representative of the Italian population, and based on similar methodology. This confirms, therefore, a clear change in smoking initiation among the most recent cohorts of Italian males and, especially, females,⁴ which is likely to reflect increased awareness of the health consequences of smoking, and changed sociocultural behaviours and attitudes.^{4,5}

These reductions in the youngest age group, even if restricted to a very limited proportion of the population, will support the continued decline in overall smoking prevalence, which has now reached 24.2%—that is, the lowest estimated prevalence since 1947 based on survey interviews.^{1,3} These proportions are also lower than those reported from several other European countries, as the overall smoking prevalence in the European Union in 1993 was about 40% among males and 28% among females (although the sources of data, the sampling methods, and the interview techniques are not comparable across various countries and calendar periods).^{6,8}

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100 Years ago

THE CIGARETTE

The cigarette in modern life is as ubiquitous as the bacillus, and if we are to believe some who profess to speak with authority, it is as mischievous as the most truculent of those invisible enemies. Let us listen for instance to the preaching of Dr. George F. Shrady, a man of light—laryngoscopic and general—and leading in the medical profession of New York, editor of the *Medical Record* of that city, and therefore, it must be presumed, accustomed to use words with an exact appreciation of their meaning:

"To smoke a cigarette is to use tobacco in its very worst form. It will produce physical irritability and mental and moral strabismus. It attacks the physical organisation at four points—the stomach, the brain, the heart, and the lungs. It deadens the sensibility of the membranes with which the smoke comes in contact, destroys the appetite, and causes the sufferer to endure all the attendant evils which attach themselves to the results of over-stimulation."

We think it right to state that we take this deliverance exactly as we find it in an evening

paper, where it is quoted without any indication of its source. Assuming it to be genuine, however, it is interesting in more ways than one. Dr. Shrady, in his catalogue of curses on the cigarette, seems to gasp with Falstaff, "O for breath to utter what is like thee!" Peradventure we may be of some slight assistance, as the mouse was able to help the lion. Why should not the cigarette be credited with producing moral amblyopia and mental glaucoma as well as strabismus? Might it not also be taxed with causing necrosis of the will, cloudy swelling of the conscience, and fatty degeneration of the finer feelings? Then why limit its baleful effects to the four points of the physical organisation which are specifically mentioned? Oddly enough Dr. Shrady makes no reference to the eye or the throat; but besides these *loci canonici* of nicotine pathology, are there not the kidneys, which, as some teach, may not be able to purge the system of the poison absorbed, and the reproductive organs on which, according to some learned Thebans, the influence of tobacco is so malefic that the cigarette is held to be a not insignificant factor in the depopulation of France? Again, the liver

might with tolerable safety have been included in the anathema, for that organ, like charity, suffereth all things, and no one would care to deny that it might be evil entreated of the cigarette. To Dr. Shrady, who, if rightly reported, thinks that "over-stimulation" is the secret of the mischievous effect of the cigarette, it would doubtless appear quite in the natural order of things that smokers should, as Calverley says,

"Go mad and beat their wives,
Plunge after shocking lives,
Razors and carving knives
Into their gizzards."

Yet we are thankful to say we know not a few smokers on whom the cigarette has an effect quite the reverse of stimulating—so sedative in fact that an attack, however furious or fatuous, on their favourite vice moves them to no more active demonstration than a smile.

Source: BMJ 1896;Feb 15:424.