Letters to the Editor

HELICOBACTER PYLORI

Sir, In their review (*Proceedings* 1997; **27:** 37-45) Penman *et al* dealt with the indications for eradication therapy commonly encountered in routine 'medical' practice to the neglect, perhaps, of those patients who bypass the 'medical' pathway of management. They may have undergone emergency treatment with 'surgically' orientated interventional treatment modalities such as endoscopic haemostasis for bleeding peptic ulcer and endosocopic balloon dilatation for peptic ulcer-related gastric outlet obstruction. In the era antedating these interventional procedures, the surgical management of such complications would have included a procedure aimed at modifying the subsequent natural history of peptic ulcer disease, which, even in the modern era, is characterised by a relapsing course,[1] now acknowledged to be modifiable through the use of eradication therapy. These issues were highlighted by a recent study documenting a 9 per cent relapse of peptic ulcer-related haemorrhage in 91 patients with an initially successful response to endoscopic haemostasis, but no documentation or management of *H pylori* status.[2]

OMP Jolobe
Tameside General Hospital, Ashton-under-Lyne

REFERENCES

[1] Lindell G, Celebioglu F, von Holstein C, Graffner H. On the natural history of peptic ulcer. *Scand J Gastroenterol* 1994; **29:** 979-82.
[2] Kubba AK, Choudari C, Rajgopal C *et al*. Reduced long-term survival following major peptic ulcer haemorrhage. *Br J Surg* 1997; **84:** 265-8

Drs Penman, Palmer and Blackwell reply:

We thank Dr Jolobe for his comments about the indications for *Helicobacter* eradication therapy. As stated in our article, patients with acute or chronic peptic ulcer disease should have eradication therapy and this, naturally, should include those who present with peptic ulcer bleeding or gastric outlet obstruction. Patients such as these, who present with complicated peptic ulcer disease, should remain on acid suppression therapy until confirmation of successful eradication therapy is obtained.

PASSIVE SMOKING

Sir, Friend's analysis of passive smoking (*Proceedings* 1996, **26:** 598-602) mentions the issue of liberty of smokers but dismisses it as being outweighed by the demands of public health. This would be reasonable if (i) such a fundamental concern as liberty is not so significant in this case, (ii) if indeed the health of the public is so threatened and (iii) if it is even involuntarily threatened. We are not discussing here the risks posed by 'passive skiing' or 'passive mountain climbing' (the demand that rescue services retrieve ill-prepared climbers). Bernard Levin[1] answered the liberty issue by making it clear that, in contrast to the right of a citizen to smoke, the experience of passive smoking is a nuisance and thus the two are not comparable. Professor Graham[2] further eloquently argues the advantages of licences over the Prohibition.

Among the constituents of passive tobacco smoke Friend lists polonium-210. This is obviously an unavoidable incidental constituent of tobacco smoke and, while

it is salutary to be aware of this, it is similar to the observation that the air in granite buildings contains more niton-222 (radon) than the average UK house. Are we, therefore, to tear down or evacuate Aberdeen?

Active smoking, says Friend, causes 110,000 premature deaths a year, on average eight years prematurely, or a 'loss' of 880,000 'life-years' annually. Road accidents cause an average 3,000 deaths and 40,000 serious injuries per annum totalling perhaps 180,000 'life-years' lost per year. So while the scale of noxious effects from tobacco smoking must be acknowledged, it should be put in proportion and also borne in mind that the loss of years is at the end of one's active life in great contrast to road deaths, and that smokers starting now should be well aware of the dangers.

Although Friend makes passing reference to misleading activities of some tobacco companies, van den Broucke[3] showed unequivocally that of two papers with equal scientific merit, the one claiming deleterious consequences of passive smoking was significantly more likely to be published in the medical literature than the paper not finding such consequences. Furthermore, Mantel[4] elegantly showed that in the papers claiming to show deleterious consequences of passive smoking, the statistics used were incapable of demonstrating the purported findings.

The medical jury is, in my view, still 'out' on passive smoking but, whatever its findings, medical authority needs to bear in mind Levin's distinction between 'a right' and 'a nuisance'.

John Marks
Halton General Hospital, Widnes, Cheshire

REFERENCES
[1] Levin B. No smoke...without fire. *The Times* 22.12.83, 20.1.84.
[2] Graham G. Criminalization and control. In: Whynes DK and Bean P, eds. Policing and prescribing. Basingstoke: Macmillan, 199l, 245-60.
[3] van den Broucke JP. Passive smoking and lung cancer: a publication bias? 1998; **296:** 391-2
[4] Mantel N. Lung cancer and passive smoking. *BMJ* 1987; **294:** 440-1.

Dr Friend replies:

Dr John Marks's letter raises important and widely held views. To begin with the issue of active smoking, Dr Marks implies that smoking is a less serious issue than road accidents because the loss of years is at the end of one's life. While this is true for some, physicians are all too well aware of the increasing numbers of younger people, and particularly women, who are succumbing to smokers' diseases. Indeed, lung cancer accounts in Scotland for more deaths among women than breast cancer. Major differentials in death rates remain between smokers and non-smokers in the 'prime of life' - 15 per cent of non-smokers die before reaching retirement age, but among heavy smokers (>25 cigarettes a day), 40 per cent die before retirement; many of these suffer severely, despite treatment, from the relentless breathlessness of chronic obstructive airways disease or from lung cancer. I believe that the public at large, and many of the medical profession, fail to perceive the *scale* of the problem of smokers' diseases, and the *relative* risk to which smokers are exposed. The lifetime risks of death by smoking are 25 times those of death by lifelong car driving.

Despite these risks, I have no wish to prevent smokers from smoking, provided they make that choice when fully informed of the risks. Sadly, most smokers adopt the habit of addiction as children at a time when future health risks are not appreciated or seem irrelevant, and then find it difficult to stop as adults. Every day

chest physicians try to help smokers who were unable to stop smoking before their disability or fatal disease had developed. Such patients regret that they ever started smoking and that they had not stopped earlier; and the physician experiences a recurring sadness at dealing with basically preventable illness.

Dr Marks implies that he believes that the liberty of smokers to smoke in public places outweighs any possible risk to the health of non-smokers; he questions whether the evidence for a health hazard from passive smoking is valid and balanced. While accepting that negative studies on the passive smoking issues are less likely to be published, there is a consistency in over thirty cohort and case-control studies, demonstrating the association between passive smoking and lung cancer. The association is biologically plausible and consistently dose-related. Studies of the links between passive smoking and respiratory disease in children, as summarised in my paper, are also consistent, broad-based in many countries, and significant.

The burden of human disease from passive smoking, compared with that from active smoking, is relatively less; but passive smoking needs to be acknowledged by smokers, as an issue for the freedom of the majority who choose not to smoke.

CORRIGENDUM

Reference 13 in my article should have read: Blair, PS, Fleming PJ, Bensley D *et al.* Smoking and the sudden infant death syndrome; results for 1993-5 case-control study for confidential enquiry into stillbirths and deaths in infancy. *Br Med J* 1996; **313:** 195-8.

PASSIVE SMOKING

Sir, I was most interested in Dr Friend's article (*Proceedings* 1996; **26:** 598-602) especially his quote of Dr Samuel Johnson (1709-1784) cited by James Boswell (1740-1795) in his *Journal of a Tour of the Hebrides*.[1] Dr Samuel Johnson considered George Buchanan (1506-1582) to be 'the only man of genius his country ever produced', again according to his biographer Boswell.[2] It is therefore of interest that George Buchanan also attacked tobacco in one of his *Miscellaneorum Liber* i.e. Miscellaneous Poems, entitled *De Nicotiana Falso Nomine Medicaea Appellata* i.e. On tobacco wrongly called the 'herbe médicée'.[3] Since Buchanan was tutor to the young James VI of Scotland and I of England (1566-1625) one wonders if the King's lively publication, *A Counterblaste to Tobacco* in 1604[4] was influenced by his famous tutor. In the 1616 edition, which contains authorial alterations, King James waxed eloquent on the 'great iniquitie, and against all humanitie' of the secondary smoke: 'the husband shall not be ashamed, to reduce thereby his delicate, wholesom and cleane complexiouned wife, to that extremity, that either she must also corrupt her sweet breath therwith, or else resolve to live in perpetual stinking torment'.[5]

George Buchanan was the first eminent Scot to be buried in the Greyfriars' Kirkyard in Edinburgh.[6] In my biased opinion (genes count!) I would humbly suggest (a virtual impossibility for a Scot!) that George Buchanan be recognised as the original critic of the abominable practice of smoking tobacco.

W. W. Buchanan
Sir William Osler Health Institute, 565 Sanatorium Road, Hamilton, Ontario L9C 7N4, Canada

REFERENCES
[1] Boswell J. The journal of a tour of the Hebrides. Chapman RW, ed. Oxford: Oxford University Press, 1985.
[2] Boswell J. Life of Johnson. Chapman RW, ed. Oxford: Oxford University Press, 1985.
[3] Ford PJ. George Buchanan, prince of poets. Aberdeen: Aberdeen University Press, 1982, 162-3.
[4] Jack RDS, ed. James VI's A counterblaste to tobacco. In: Scottish Prose 1550-1700. London: Calder and Boyars, 197l, 111-18.
[5] Buchanan WW. Jamie the Saxt's A counterblaste to tobacco. *Ann R Coll Physicians Surg Can* 1996; **29:** 417-20.
[6] Brown HP. George Buchanan, humanist and reformer: a biography. Edinburgh: David Douglas, 1890.