tobacco industry has privately said, "the social acceptability issue will be the central battleground on which our case in the long run will be lost or won"[4] and therefore, of all the six policy objectives for smoking control proposed by the International Union Against Cancer,[5] an advertising ban is the measure the industry most strenuously resists. For health policy experts to accept advertising of low tar cigarettes is to permit the social legitimation of cigarette smoking to continue and give a totally unwarranted recommendation of the benefits of low yield cigarettes to adult smokers and to children taking up the habit. In particular, it has been suggested that low yield cigarettes increase the propensity of girls to start smoking,[6] a trend which has been noted in many countries.

Price policy and product modification are more effective than advertising for promoting the switch to lower tar and have less potential side effects. It may be that the government declines to implement the effective measures. It still remains the responsibility of medical opinion to inform the public of the scientific evidence and to refuse to support the advertising of low yield cigarettes, which could convey unfounded reassurances and blunt the powerful campaign mounted by the BMA for a total ban on cigarette advertising.

F LEDWITH

Department of Education,
University of Manchester,
Manchester M13 9PL

MATTI RIMPELA

Department of Community Health,
London School of Hygiene and Tropical Medicine,
London WC1E 7HT

1 Daube M. The politics of smoking: thoughts on the Labour record. *Community Med* 1979;**1**:306-14.
2 Benovitz NL, Hall SM, Herning RI, Jacob P, Jones RT, Osman Al. Smokers of low-yield cigarettes do not consume less nicotine. *N Engl J Med* 1983; **309**:139-42.
3 Sorsa M, Falck K, Heinonen T, Vainio H, Norppa H, Rimpela M. Detection of exposure to mutagenic compounds in low tar and medium tar cigarette smokers. *Environ Res* 1984;**33**:312-21.
4 Bruckner D. Memo concerning the Fourth World Conference on Smoking and Health to J M Hartogh, Philip Morris, Lausanne. 1979.
5 Daube M, Gray N. *Guidelines for smoking control.* Geneva: UICC, 1976.
6 Silverstein B, Feld S, Kozlowski LT. The availability of low nicotine cigarettes as a cause of cigarette smoking among teenage females. *J Health Soc Behav* 1980;**21**:383-8.

Tobacco tarred gold?

SIR,—Minerva wonders (24 November, p 1459) whether or not research funding should be accepted from the ill named Health Promotion Research Trust and compares it to an American body, the Council for Tobacco Research. There are, however, important differences between the two organisations. The American council was established specifically to research into smoking whereas smoking is specifically excluded as a major research topic by the Health Promotion Research Trust. This exclusion, imposed by the tobacco industry that funds the trust, has been likened by one commentator to the Mafia funding research into the promotion of law and order but ruling out the topic of organised crime.[1]

The most important difference, however, is that the trust has an important role for the tobacco industry in its seeking to avoid further restriction of tobacco advertising and promotion. The tobacco industry established the trust in 1982 with funding of £11m—a price it was more than willing to pay to avoid such restriction. Indeed, the establishment of the trust was announced by the Secretary of State as part of a voluntary agreement with the industry. A secondary function of the trust has been to stimulate research into topics unconnected with smoking in health education and health promotion. Such generously funded research is designed to shift attention away from smoking, which, as we all know, is our largest preventable cause of death and disease. This attempt at buying off government and health professionals is to be achieved by providing a sum which is tiny in comparison with cigarette advertising budgets.

The medical profession has, however, rejected this chicanery. In July this year, at the Manchester annual representative meeting, the BMA overwhelmingly carried a motion recommending that no doctor or health authority should associate with the trust. The chairman of the BMA's board of science and education clearly stated that it was unethical for doctors to accept what he described as tobacco tarred gold. The director general of the Health Education Council has called it "blood money," and the trust has been overwhelmingly boycotted by established researchers in health promotion.

The BMA's recently launched campaign on smoking has been eagerly awaited and warmly welcomed. The battle is now joined to force the government to curb the activities of the "merchants of death." How regrettable it would be if, within sight of victory, the campaigners were stabbed in the back by greedy researchers whose concerns are limited to their departmental budgets.

GABRIEL SCALLY

Department of Community Medicine,
Queen's University,
Belfast BT12 6BJ

1 Coleman MP. Cigarette advertising. *Lancet* 1982;ii: 1106.

"Tobacco teabags"

SIR,—I should like to express my alarm at the recent introduction on to the English market of an American product called Skoal Bandits. These are individual portion packed pouches of mint flavoured smokeless tobacco. These tobacco teabags come with the recommendation that they be placed between the upper lip and gum, and left there for increasing lengths of time as the habit is acquired.

My cause for concern takes two forms. Firstly, this product is being advertised on television locally. It carries no health warning, statutory or otherwise, as other more conventional forms of tobacco do. My second and related point concerns the increased incidence of squamous cell carcinoma of the cheek associated with placing tobacco quids in the cheek.[1] Many other reports confirm this association, usually in relation to the betel quid. However, quid constituents (betel nut, betel leaves, and slaked lime) alone have not been shown to produce carcinoma. Only when tobacco is added is carcinoma the end result.[2] A study carried out by Cohen *et al* showed that histological changes, identical to those seen in early invasive lesions in betel quid users, were induced when tobacco was placed in cheek pouches of monkeys.[3] This is the position that is being recommended for Skoal Bandits.

At present in the United Kingdom oral carcinoma of the cheek is almost exclusively restricted to those Indian immigrants who still use betel quids or tobacco alone. It is an alarming prospect that widespread adoption of this or similar products may conceivably result in a much higher incidence of this particular type of cancer, a situation that has been predicted in the US,[4] where this habit is becoming increasingly popular.

I feel strongly that the medical and dental professions should take on the responsibility for alerting the general public, who may be led to believe that this product represents a "safe" alternative to more conventional tobacco products. A statutory health warning would go some way towards answering this problem, but only by widespread informed advice on this subject can we prevent smokers jumping "out of the frying pan into the fire."

A S HIGH

School of Dentistry,
University of Leeds, Leeds LS2 9LU

1 Pindborg JJ. *Oral cancer and precancer.* Bristol: John Wright and Sons, 1980:33-40.
2 Pindborg JJ. *Oral cancer and precancer.* Bristol: John Wright and Sons, 50-60.
3 Cohen B, Poswillo DE, Woods DA. The effects of exposure to chewing tobacco on the oral mucosa of monkey and man. *Ann R Coll Surg Engl* 1971; **48**:255-73.
4 Squire CA. Smokeless tobacco and oral cancer: a cause for concern. *Ca: Cancer Journal for Clinicians* 1984;**34**:242-7.

Serum cortisol concentrations during low dose dexamethasone suppression test to screen for Cushing's syndrome

SIR,—We read the paper by Dr L Kennedy and others (3 November, p 1188) with interest and an increasing sense of familiarity. Its content mirrors almost exactly the work reported by us in your journal in 1972 on plasma and urinary 11-hydroxycorticosteroids in the differential diagnosis of Cushing's syndrome.[1] The conclusions reached are likewise very similar, although, unlike the Irish authors, we found three patients, from a series of 19 with proved hyperplasia, who suppressed normally on low dose dexamethasone.

We believe that some reference should have been made to this work, which used appropriate non-Cushingoid controls, although admittedly it antedated the widespread use of radioimmune assays.

D MATTINGLY
CHRISTINE TYLER

Postgraduate Medical School,
Exeter EX2 5DW

1 Mattingly D, Tyler C. Plasma and urinary 11-hydroxycorticosteroids in differential diagnosis of Cushing's syndrome. *Br Med J* 1972;iii:17-21.

**Dr Kennedy and his colleagues reply below.—ED, *BMJ*.

SIR,—We acknowledge the points made by Professor Mattingly and Dr Tyler. The omission of any reference to their 1972 paper was an unintentional oversight on our part. We agree that our study design was similar to that in their paper in that both studies adopted the almost universally agreed protocol for the dexamethasone suppression test. There are, however, three essential differences between our studies. Firstly, as Professor Mattingly and Dr Tyler point out, we used the more specific radioimmunoassay for serum cortisol. Secondly, our comparison was with 24 hour urinary free cortisol, also measured by radioimmunoassay, which is accepted to be a more discriminating test than fluorometric measurement of 11-hydroxycorticosteroids. Finally, although Professor Mattingly and Dr Tyler included appropriate non-Cushingoid controls, they did not study a group of subjects with "possible" Cushing's syndrome—that is, people in whom there is a genuine suspicion that the syndrome may be present. As recourse to the low dose dexamethasone test is even more likely in these subjects, evaluation of