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Effect of strategies to reduce exposure of infants to environmental tobacco smoke in the home: cross sectional survey

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Abstract

Objective To examine parents' reported knowledge and use of harm reduction strategies to protect their infants from exposure to tobacco smoke in the home, and the relation between reported use of strategies and urinary cotinine to creatinine ratios in the infants.

Design Cross sectional survey.

Settings Coventry and Birmingham.

Main outcome measures Parents' reported knowledge and use of harm reduction strategies and urinary cotinine to creatinine ratios in their infants.

Participants 314 smoking households with infants.
Results 86% of parents (264/307) believed that environmental tobacco smoke is harmful, 90% (281/314) believed that infants can be protected from it in the home, and 10% (32/314) were either unaware of measures or reported using none. 65% of parents (205/314) reported using two or more measures, but only 18% (58/314) reported not allowing smoking in the home. No difference was found in mean log e transformed urinary cotinine to creatinine ratio in infants from households that used no measures compared with households that used less strict measures. Mean log cotinine to creatinine ratios were significantly different in households banning smoking in the home compared with those using less strict or no measures. Banning smoking in the home was independently associated with a significant reduction in urinary cotinine to creatinine ratio by a factor of 2.6 (1.6 to 4.2) after adjustment for average household cigarette consumption, tenure, and overcrowding.

Conclusions Less than a fifth of parents in smoking households ban smoking in the home. Banning smoking was associated with a small but significant

reduction in urinary cotinine to creatinine ratio in infants, whereas less strict measures compared with no measures had no effect on the infants' exposure to environmental tobacco smoke.

Introduction

Exposure of infants to environmental tobacco smoke is associated with an increased risk of sudden infant death syndrome, asthma, and other respiratory conditions.¹ In England, children's exposure to tobacco smoke has decreased since the late 1980s, but there is little evidence of reduced consumption of tobacco by parents in the presence of their children.² Smoking cessation among household members is the only effective way of reducing passive smoking among young people. Changing smoking practices in the home and in the presence of young people has been suggested as a means of reducing exposure to tobacco smoke when cessation is not possible. To date the evidence on the use and effectiveness of such measures is limited and confusing.

We report parents' knowledge and use of measures to reduce exposure of their infants to environmental tobacco smoke and the impact of harm reduction measures on urinary cotinine to creatinine ratios in infants. Our sample was community based and representative of UK smoking households with infants (mean age 12.8 weeks).

Participants and methods

We used a cross sectional survey design to collect data from a sample of parents of infants living in households with one or more smokers. The parents of



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infants born to mothers living within the boundaries of two community NHS trusts in the West Midlands over a nine month period were asked to participate in the study by their family health visitors. Infants with major perinatal illnesses were excluded.

Interviews took place at home when infants were between 4 and 24 weeks old. Data were collected on knowledge and use of harm reduction strategies, tobacco consumption of household members, personal details, and characteristics of the home environment. A sample of the infant's urine was collected, by a pad inserted into the nappy, for estimation of the urinary cotinine to creatinine ratio. Smoking households were defined as households with one or more resident tobacco smokers (cigarettes, pipes, or cigars).

To examine the relation between use of harm reduction strategies and infant urinary cotinine to creatinine ratios, we dichotomised the strategies as strict (smoking banned in the home) versus less strict (smoking permitted in the home but restrictions placed on smoking in the vicinity of the baby or active steps taken to air room after smoking) or none used or main carers not aware of strategies. To adjust for potential confounding by respondent's and partner's average daily cigarette consumption (continuous variables), housing tenure (rented versus owner occupied), and overcrowding (more than one person per room versus one or fewer people per room), linear regression models including these variables were fitted on log urinary cotinine to creatinine ratios. Only bottle fed infants were included in this analysis, as nicotine and cotinine are transmitted to infants through breast milk.³

Results

Overall, 314 smoking households with young infants took part in our study (table 1). Compared to all UK households with infants, the study households were more likely to be from a lower social class and mothers were more likely to have left school aged 16 years or less, reflecting the association between tobacco use and social disadvantage.

A high proportion of parents believed that children's health is affected a great deal or quite a lot by people smoking in the home and that it is possible to protect children from exposure to tobacco smoke (table 2). Only one in 10 parents was unaware of any measures to reduce exposure. More than half the parents reported using more than one measure (table 3). Just under a fifth reported banning smoking in the home.

Complete data were available on 164 bottle fed infants. The following analyses relate to these infants only. The mean log cotinine to creatinine ratio for use of strict harm reduction measures was 1.26 (0.68 to 1.82) and was significantly lower than that for less strict or no measures (2.58, 2.38 to 2.78). In linear regression models fitted on the log cotinine to creatinine ratio, strict harm reduction was associated with a significant reduction in the ratio independent of respondent's and partner's average daily cigarette consumption, tenure, and overcrowding. The final model including all these exposure variables accounted for 31% of the variance in urinary cotinine to creatinine ratio. Expressed as an arithmetic mean, use of strict harm reduction measures

is associated with a reduction in urinary cotinine to creatinine ratio of 2.6 (1.6 to 4.2).

Discussion

Banning smoking in the home is associated with a small but significant reduction in urinary cotinine to creatinine ratios in infants, whereas less strict measures compared with no measures to reduce tobacco smoke in the home had no effect on exposure of infants. Our study is the first to report, in detail, parents' knowledge and use of measures to reduce the exposure of their infants to tobacco smoke in the home. Our sample was more socially disadvantaged than all UK households with infants, consistent with the known association between smoking and social disadvantage.⁴

Only a small proportion of respondents reported not knowing of any harm reduction measures or knowing of measures but not using them. This suggests that health promotion messages urging parents to protect their children from tobacco smoke may have had some success. However, we found that parents would benefit from more information on what measures actually work. Many of the harm reduction strategies used by the parents, such as opening windows when smoking and using fans and ionisers, were ineffective. The parents frequently used a combination of measures, making it difficult to determine the extent to which individual practices affect exposure.

Table 1 Personal characteristics of smoking households with infants. Values are numbers (percentages) of households unless stated otherwise

Characteristics	Households (n=314)
Parent's age (years):	
≤24	100 (32)
≥25	214 (68)
Status:	
Living with partner	267 (85)
Not living with partner	47 (15)
No of children:	
1-3	267 (85)
≥4	47 (15)
Self reported ethnic group:	
White (United Kingdom or European)	256 (82)
Other	58 (18)
Tenure:	
Owner occupied	148 (47)
Rented or other	166 (53)
Parent's educational achievement:	
No qualifications	72 (23)
Qualifications	242 (77)
No of rooms per person:	
≤1	103 (33)
>1	204 (65)
Missing data	7 (2)
Social class of household:	
Non-manual	70 (22)
Manual	131 (42)
Part time worker	14 (4.5)
Unemployed	97 (31)
Missing data	2 (0.5)
Total household income per annum:	
<£10 000	148 (47)
≥£10 000	166 (53)
Mean age of infants studied	12 weeks
Mean (SD) cotinine to creatinine ratio (ng/ml:mmol/l); range (n=216)	30.3 (73.0); 1-726

Our finding that banning smoking in the home is associated with a significant reduction in infant urinary cotinine, after adjustment for household cigarette consumption, is consistent with three studies of older children.⁵⁻⁷ In contrast to our findings, however, two reported significant reductions in cotinine levels associated with less strict measures.^{5, 6} The age range of our infants was chosen to coincide with the age of greatest vulnerability to sudden infant death; harm reduction measures that are effective in households with older children may be ineffective in households with young

Table 2 Beliefs and knowledge of parents from 314 smoking households about exposure of their infants to environmental tobacco smoke

Beliefs and knowledge	% (No)
Exposure to tobacco smoke affects children's health:	
A great deal	50 (155)
Quite a lot	35 (109)
A little or not at all	14 (43)
Are there practical things people can do to protect children from environmental tobacco smoke?:	
Yes	89 (281)
No or do not know of any	10 (32)
Able to recall one or more measures to protect infants from environmental tobacco smoke	
Measures parents were able to recall*:	
Do not smoke, or allow smoking, in house	30 (94)
Stop smoking	25 (80)
Avoid smoky places	34 (106)
Smoke fewer cigarettes	11 (35)
Do not smoke in same room as child	56 (175)
Do not smoke, or allow smoking, in living room	18 (58)
Do not smoke, or allow smoking, where child sleeps or naps	25 (80)
Air room when smoking or someone else is smoking	31 (97)
Air room after smoking or after someone else has smoked	24 (75)
Other†	24 (75)

*Sum of percentages exceeds 100%, as carers reported more than one measure.

†Includes: do not allow smoker to hold baby wearing smoky clothes or soon after smoking; wash hands after smoking; use ioniser or fan; do not smoke over child (assume still in same room); use air freshener.

Table 3 Use of measures by parents from 314 households to reduce exposure of their infants to environmental tobacco smoke at home

Details of measures	% (No)*
No of measures used:	
None	12 (38)
1	22 (70)
2	12 (38)
≥3	53 (167)
Measures used:	
Do not smoke, or allow smoking, in house	18 (58)
Stopped smoking	3 (9)
Smoke fewer cigarettes	14 (43)
Do not smoke, or allow smoking, in same room as child	49 (153)
Do not smoke, or allow smoking, in living room	24 (74)
Do not smoke, or allow smoking, where child sleeps or naps	34 (106)
Air room when smoking or someone else smoking	46 (144)
Air room after smoking or after someone else has smoked	43 (134)
Other*	39 (124)
Severity of measures used:	
Strict	18 (58)
Less strict	69 (218)
None or not aware of any	12 (38)

Sum of percentages exceeds 100% as carers reported more than one measure.

*Includes: do not allow smoker to hold baby wearing smoky clothes or soon after smoking; wash hands after smoking; use ioniser or fan; do not smoke over child (assume still in same room); use air freshener.

What is already known on this topic

Reducing exposure to environmental tobacco smoke in early life may reduce the risk of sudden infant death syndrome and improve health outcomes

Smoking cessation is difficult for some parents, especially those who are socially disadvantaged

Randomised controlled trials of strategies to reduce exposure of infants to smoke have shown little effect, but none report the effect of not smoking in the home

What this study adds

Banning smoking in the home has a small but significant effect on urinary cotinine levels in infants, independent of household cigarette consumption, housing tenure, and overcrowding

Harm reduction measures have little or no effect on urinary cotinine levels in infants

infants because of their lack of independent mobility and speed of metabolism.⁸

Limitations of study

Our study had some limitations. We measured urinary cotinine on only one occasion, although levels vary if serial measurements are taken.⁹ Individual cotinine levels depend on the number of smokers in the household, the number of cigarettes smoked, proximity to smokers, the extent of crowding in the home, the size of rooms, ventilation, and whether there is exposure to environmental tobacco smoke in vehicles.

Although we have included levels of smoking and overcrowding in the household in our model, we have no data on the size of the rooms or the extent of ventilation. The number of parents that used no harm reduction strategies was small, which may have reduced the precision of the mean urinary cotinine to creatinine ratio for this group making it difficult to detect a true difference between those using less strict strategies and those using none.

Strengths of study

The strengths of our study were that we sampled a representative population of smoking households with infants, we assessed the cotinine to creatinine ratio, which corrects for dilution of urine,⁴ and we studied a narrow age range of infants thus reducing the variation associated with differential speed of metabolism and excretion of nicotine. Previous observational studies were based on selected populations (hospital outpatients and children with asthma), parental reporting of cigarette consumption, and wide age ranges.⁵⁻⁷

The group we studied was chosen to coincide with the peak age for sudden infant death syndrome. Reducing the exposure of infants to tobacco smoke is likely to be important in preventing sudden infant death as there is a close association between the two. Our results suggest that, independent of major confounding variables, banning smoking in the home significantly reduces infant exposure to environmental tobacco

smoke but, as there are no data directly relating cotinine levels to risk of death, it is not possible to predict the likely effect of a reduction of this magnitude on the risk of sudden infant death. Our results also suggest that harm reduction measures short of a total ban on smoking in the home are likely to have little effect on the exposure of infants to tobacco smoke, but this requires verification with a larger sample.

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Retrospective review of care and outcomes in young adults with type 1 diabetes

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The national service framework for diabetes includes standards to improve care and outcomes for young people.¹ Good glycaemic control delays the onset and progression of microvascular complications, but control can be difficult to achieve, particularly in young people.²

Participants, methods, and results

We did this study in four of the important centres for the care of people with diabetes—Derbyshire Royal Infirmary; University Hospital, Nottingham; Northern General Hospital, Sheffield; and Leicester Royal Infirmary. Each centre has a dedicated clinic for young people.

We searched for people aged 16 to 25 who were being followed up for type 1 diabetes. We collected data retrospectively from case notes and computer records on glycaemic control, completeness of screening for and prevalence of complications of diabetes, hypertension, and clinic attendance.

Of the 397 patients included, mean HbA_{1c} concentration was 9.5% (SD 2.0%). (The assay was standardised to that used in the diabetes control and complications trial²; the upper limit of the reference range for people without diabetes is about 6%.) Glycaemic control was similar in 31 patients who had not had a recent measurement of HbA_{1c} concentration—their mean fructosamine concentration was 404.9 (93.9) $\mu\text{mol/l}$ (reference range 230-280 $\mu\text{mol/l}$).

Screening rates and the prevalence of complications varied between centres (table). The low prevalence of retinopathy in centre 2 was confirmed by an independent review of case notes.

Thirty four patients (15% of those tested) were hypertensive (systolic blood pressure was at least 140

mm Hg or diastolic blood pressure was at least 85 mm Hg). Of these, 24 (71%) had been tested for excretion of protein by the kidneys. Ten (42%) had proteinuria or microalbuminuria and eight of these were taking angiotensin converting enzyme inhibitors.

Comment

For young adults with type 1 diabetes in this study, glycaemic control is generally poor, attendance at the clinic and screening for complications are suboptimal, and microvascular complications are common. Achieving good glycaemic control in youth yields future health, quality of life, and cost benefits but is difficult for many psychological and social reasons. Cooperation between paediatricians and diabetologists should provide a smooth transition of care from childhood to adulthood; many centres have clinics for young adults. Previous studies of young adults in the United Kingdom found poor glycaemic control.³ In our study, control was comparable to that of conventionally treated adolescents in the diabetes control and complications trial.²

Some European cohorts have lower mean concentrations of glycated haemoglobin,⁴ perhaps due to structured programmes teaching self management. The dose adjustment for normal eating (DAFNE) programme, based on a programme used in Germany, was a success in the United Kingdom and is being evaluated on a wider scale.⁵

Each 1% fall in HbA_{1c} concentration leads to an estimated fall of 30% in the risk of microvascular complications.² Patients in our centres are at more risk than patients in centres with lower mean HbA_{1c} concentrations. Also, the prevalence of complications in our study concerns us. Screening for complications is sub-