

Smoking in the elderly

"For thy sake, Tobacco, I
Would do anything but die."

Charles Lamb's couplet from *A Farewell to Tobacco* may have sinister undertones today, but it still expresses only too clearly the merciless power with which the smoking habit enslaves its victims. Few people, even hardened smokers, will disagree with James I that it is "a custom loathsome to the eye, hateful to the nose, harmful to the brain and dangerous to the lungs," but in spite of his views and the more scientifically based warnings sounded by the Royal College of Physicians 350 years later millions of otherwise rational men and women continue to smoke. By so doing they expose themselves (most of them wittingly) to the risk of premature death from lung cancer, chronic bronchitis, and coronary heart disease.

There are certain circumstances in which doctors have a clear duty to put relentless pressure on their patients to stop smoking. Such pressure must be applied to all healthy young and middle aged people, patients with chronic bronchitis whatever their age, and those who have developed coronary heart disease or peripheral arterial disease in their 40's and 50's. These are people who, by giving up smoking, can either increase their life expectancy significantly or, in the case of patients who have already developed chronic bronchitis or coronary artery disease, improve their prognosis. There might, however, be a case for adopting a less rigid attitude towards smoking in the elderly. To many old people, particularly those who are living alone and have no outside interests, smoking may be one of their few remaining pleasures. If they are to be urged to give up the habit, they are entitled to know what benefits are likely to accrue from what to them may be a traumatic experience. It has been shown that when men stop smoking their death rate from lung cancer falls to 50% of the rate in heavy smokers in five years and to 25% in 10 years¹ and that there is also a substantial reduction in mortality from chronic bronchitis. If, however, a smoker has survived to retiring age without developing chronic bronchitis or lung cancer any benefit he or she is likely to derive in terms of increased longevity from abandoning the habit will be relatively small. Even this may in later years be offset by deteriorating health from other causes, notably cerebrovascular disease. In the case of coronary artery disease there is even less justification for advising healthy men over the age of 65 to stop smoking, since according to a recent report² the risk at that age of developing the disorder is essentially the same whether they continue to smoke or not.

In the end a decision on whether or not to advise an elderly patient to give up smoking must depend on individual circumstances. Only a fanatical antismoking propagandist would, for example, impose this advice on a contented old man who has puffed happily at his pipe for 40 years or deny the comfort of an occasional cigarette to a patient in the terminal stages of chronic bronchitis or lung cancer. On the other hand, it is equally irresponsible not to try to convince an elderly cigarette smoker with a distressing cough that this symptom would improve if he or she smoked fewer cigarettes or preferably none at all.

There is another hazard of smoking which is often forgotten—the risk of fire. No figures are available to show how many old people living alone or in inadequately staffed institutions die from this cause, but the number may be considerable. A lighted match or a live cigarette dropped from

an old man's shaky fingers can be just as lethal as lung cancer.

¹ Doll, R, and Hill, A B, *British Medical Journal*, 1964, 1, 1399.

² Seltzer, C C, *American Journal of the Medical Sciences*, 1975, 269, 309.

Management of acute cholecystitis

Probably most patients admitted to hospital in Britain with an acute cholecystitis are managed conservatively: put to bed, given analgesics and a drip, and, in many hospitals, put on to broad-spectrum antibiotics. Emergency exploration is carried out if the diagnosis is in doubt or if progressive symptoms suggest the danger of imminent perforation of the gall bladder. After the attack has resolved the patient will be investigated radiologically, and if the diagnosis is confirmed advised to undergo an elective cholecystectomy after two or three months.

With this conservative regimen, it is most unlikely that frank perforation of the inflamed gall bladder will take place in hospital. Ellis and Cronin¹ reported 11 examples of bile peritonitis among 795 patients admitted with acute cholecystitis; yet 10 of these had established peritonitis before coming to hospital and only one patient perforated while under observation on the seventh day of his (until then undiagnosed) illness. Du Plessis and Jersky² supported this conservative approach on the grounds of the uncertainty of emergency diagnosis, the risks of emergency operation on patients—often elderly and with associated diseases—and the low mortality of conservative treatment. Nevertheless, Sir Rodney Smith³ has cogently argued that within the first 48 hours surgery is relatively easily performed and avoids what may be a very difficult later "elective" cholecystectomy, when structures may be densely bound down by adhesions. After 48 hours he advised exploration only if the diagnosis was not certain or if the patient's progress was not satisfactory; and then, if the ducts were not easily displayed, cholecystotomy alone should be performed with removal of the stones and a subsequent cholecystectomy advised at a later date.

Clearly this is a controversial topic, so that the controlled clinical trial set up in Liverpool comparing the two methods of treatment is welcome. In preliminary reports^{4 5} a total of 32 patients studied to date have been presented. In 17 managed conservatively there were two misdiagnoses (a perforated duodenal ulcer and a carcinoma of the colon invading the gall bladder), while three further patients required urgent operation because of failed medical treatment. Of the 15 patients treated by early surgery, one was a misdiagnosis (acute pancreatitis) and two patients had technically difficult operations. No patient in either group died. The conservative group spent an average of 11 more days in hospital. The authors concluded that early cholecystectomy meant less time in hospital and the avoidance of the complications of failed conservative treatment without any added risk of more postoperative complications or deaths.

These findings will be of even greater value when more patients have been studied. But, whatever the conclusions, two important points will need to be borne in mind. Firstly, the study excluded patients with jaundice, with symptoms of over seven days, with evidence of intercurrent disease, and

those older than 80 years; more and more such patients are presenting in our ageing society. Secondly, the emergency operations were performed by highly skilled surgical teams in two leading hospitals and preoperative emergency intravenous cholangiography was usually available, as was peroperative choledochography. In more and more British hospitals these luxuries no longer obtain, and in such unsatisfactory circumstances conservatism is undoubtedly the safer approach to take.

Certainly without adequate emergency laboratory back-up the diagnosis of acute cholecystitis is far from simple. Halasz⁶ has analysed 238 consecutive patients admitted to the university hospital in San Diego with a diagnosis of acute cholecystitis, which was confirmed in 191 cases. Fifty-two underwent emergency surgery, but of the 47 found to have conditions other than cholecystitis five underwent emergency exploration on the basis of the misdiagnosis. Of the 47 misdiagnoses, 18 had pain originating in the right kidney or ureter (such as calculus or pyelonephritis) and four of these had perfectly normal urine. In 12 cases there was liver disease; 10 had pancreatitis (seven with a normal serum amylase); five had appendicitis; and two had thoracic inflammatory disease. Twenty of the 47 patients with conditions other than acute cholecystitis had intravenous cholangiography, and false-positive results were obtained in three cases. There were no diagnostic errors in the 104 patients who underwent elective cholecystectomy, and a further 35 patients were not submitted to operation even though the diagnosis of biliary disease was subsequently confirmed by radiography. Halasz's conclusion was that emergency intravenous pyelography should be undertaken in patients with acute right upper quadrant pain because of the difficulty of excluding renal disease, and he suggests that interval operation may be the safer choice because it reduces the opportunities for misdiagnosis.

¹ Ellis, H, and Cronin, K, *British Journal of Surgery*, 1960, **48**, 166.

² Du Plessis, D J, and Jersky, J, *Surgical Clinics of North America*, 1973, **53**, 1071.

³ Smith, R, in *Surgery of the Gall Bladder and Bile Ducts*, eds R Smith and S Sherlock, p 113. London, Butterworths, 1964.

⁴ McArthur, P, et al, *British Journal of Surgery*, 1975, **62**, 850.

⁵ McArthur, P, et al, *Proceedings of the Royal Society of Medicine*, 1975, **68**, 676.

⁶ Halasz, N A, *American Journal of Surgery*, 1975, **130**, 189.

Cancer risks from hormone treatment

The unexpected withdrawal from the market of two oral contraceptives (Volidan 21 and Serial 28)—reported at p 657 of this week's *BMJ*—is evidence of the extreme caution of both official drug regulating bodies and pharmaceutical firms whenever there is a suspicion of a carcinogenic risk. The decision by Duncan, Flockhart and Company, which was fully approved by the Committee on Safety of Medicines, was based on work in beagles treated for seven years with high doses of the progestational compound megestrol acetate. Beagle bitches are known to be prone to breast neoplasms, but the treated animals developed significantly more tumours than untreated controls—and some of these tumours were malignant. Another

progestogen, chlormadinone acetate, was withdrawn from clinical use in 1970 on the basis of similar reports. The whole range of progestogens used in fertility control has now been tested in long-term studies in dogs, and only these two drugs have been associated with a higher frequency of breast tumours: the remaining progestogens in current use in Britain had no effect on the incidence of tumours.

The decision to withdraw pills containing megestrol acetate may, then, be seen as a safety-first approach—and one made easier by many alternatives available to satisfy contraceptive needs. Women who have been taking Volidan 21 or Serial 28 should complete their current cycles before switching to a new pill; they may be reassured and told that there is still no hint from epidemiological evidence (of the kind that linked the pill with thrombosis) that there has been any increase in breast cancer among women taking oral contraceptives: indeed, the studies so far reported suggest the contrary.^{1 2} No other pharmaceutical product has been monitored so carefully as the pill, and in over 20 years in many millions of women the only neoplasm linked with oral contraception by clinical evidence has been the excessively rare hepatic "adenoma".³

By an unfortunate coincidence of timing, last week saw the publication of two reports^{4 5} from the USA suggesting that oestrogen therapy in menopausal and postmenopausal women might be associated with an increased risk of uterine cancer. In both cases examination of the records of women with endometrial cancer showed that more of them had had earlier oestrogen treatment than had controls. Oestrogen therapy seems to increase the baseline risk by between 5 and 14 times—somewhat less than the effect of cigarette smoking on the baseline risk of lung cancer. More data will be needed before the clinical implications of these findings become clear, so it is reassuring that several more similar studies are already in progress.

Inevitably, the conjunction of these reports will cause anxiety among women who have been prescribed hormonal drugs. Those on the pill may be told that the overall picture remains unchanged: for most young women oral contraception represents a good compromise between safety and contraceptive reliability, though the risk of the serious thromboembolic side effects rises with age and is increased by factors such as cigarette smoking and hypertension. For menopausal women the advice is less clear, for we still know far too little about the long-term effects of hormone replacement therapy. In every case the potential benefits for the patient must be weighed against the known hazards. Before either form of hormonal treatment is prescribed the patient should be screened for the presence of risk factors, and the effects of treatment should be regularly assessed. In menopausal women this should include regular monitoring for endometrial carcinoma.⁶ Finally, these latest reports must surely reinforce the case for medical supervision of hormone therapy before or after the menopause: this is not an area where self-medication should be encouraged.⁷

¹ Vessey, M P, Doll, R, and Sutton, P M, *British Medical Journal*, 1972, **3**, 719.

² Vessey, M P, Doll, R, and Jones, K, *Lancet*, 1975, **1**, 941.

³ *British Medical Journal*, 1975, **4**, 484.

⁴ Smith, D C, et al, *New England Journal of Medicine*, 1975, **293**, 1164.

⁵ Ziel, H K, and Finkle, W D, *New England Journal of Medicine*, 1975, **293**, 1171.

⁶ *New England Journal of Medicine*, 1975, **293**, 1200.

⁷ *British Medical Journal*, 1975, **2**, 355.