Smoking and the young

A blot on the health of the nation

In 1962 the Royal College of Physicians' report on smoking and health brought the risks of smoking to public attention. Further reports followed, but it is the college's fifth report, published this week, that in many ways is the most disturbing. Not only does Smoking and the Young remind us of the very limited progress of the past 30 years but it also draws attention to the fact that in Britain the fall in smoking's prevalence results more from people giving up smoking than from fewer people taking it up. Indeed, one in four 15 year olds (who may, of course, not be legally sold cigarettes) are already regular smokers; in Britain 450 children start smoking every day. Smoking and the Young considers how this has arisen (and persisted), describes the effects of active and passive smoking on the health of young people, and discusses what action should be taken to improve the outlook for future generations.

The tobacco industry spends £72m on advertising in Britain each year; it would be nice to have some of this to disseminate the facts in this report. For example, cigarette smoking makes subarachnoid haemorrhage six times more likely in young smokers than non-smokers and doubles or trebles the chance of female infertility. The journalists who have been keen to blame asthma's increasing prevalence on antiasthma drugs have seemed less interested in publicising the role of maternal smoking in asthma. Although the report quotes the work of Weitzman and colleagues on maternal smoking and asthma, it was printed before publication of work confirming parental smoking's substantial contribution to the development of allergic diseases during infancy. The presence of one or more smokers in the household of asthmatic children increased by 63% the number of emergency room visits by the children; and parental smoking accounted for one in three cases of middle ear effusion in those aged 6-7.

In Britain a lower proportion of schoolteachers and doctors smoke than in any other country of the European Community yet, as this report describes, their influence on the young is mitigated by the effects of peer pressure, the easy availability of the drug, and successful advertising, which is clearly aimed at young people. Presumably this is why the prevalence of smoking among young people has not changed in the past decade. More girls than boys now smoke, and the prevalence of maternal smoking during pregnancy is high. This results in more miscarriages and cases of premature labour and higher perinatal mortality and has effects extending beyond infancy, with a reduction in growth and educational achievement.

If the royal college has to produce a sixth report on smoking then this generation of adults will have completely failed its successors. What should be done? Smoking and the Young describes clearly how young people begin to smoke and the effects of personal and social factors on both the initiation and continuation of the habit. It summarises the responsibilities of parents, teachers, and doctors and gives a clear pointer towards a greater role for local government and local health authorities. Trading standards officers should more vigorously enforce the laws on the sale and advertising of tobacco, and local councils should set an example by banning smoking in all their premises visited by young people. They should also encourage others to introduce policies to control smoking. Purchasers of health services should demand from providers a commitment for health professionals to give special attention to this problem—especially among children, parents, and pregnant women. The prevalence of smoking during pregnancy should be monitored.

None of these initiatives alone are likely to achieve the desired effect, and this latest report will similarly have little impact unless accompanied by firm and decisive leadership from the government. Let us hope that this report acts as the final catalyst for government action. We need comprehensive legislation banning tobacco advertising and sponsorship and progressively more expensive cigarettes—these measures would have the most impact on smoking by young people.

Anything short of this makes mockery of any commitment to the health of the nation.

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Reducing home accidents in elderly people

Everybody's challenge—but general practitioners can lead the way

Over 300 000 people aged over 65 attend accident and emergency departments annually in England and Wales after accidents in the home, with falls being the most important. Direct questioning during systematic evaluation after elderly people have been admitted to hospital shows that most falls go unreported. They are simply accepted as a "normal" accompaniment of "old age." The intermingling of the various factors leading to accidents often makes diagnosis difficult. Indeed, the lack of a simple cause and effect relation commonly provides too great a challenge for some doctors.

Under these circumstances, the diagnostic dustbin of "it's just your age, m'dear" can be quickly provided.

Despite many home accidents being associated with personal injury and falls, more than three quarters of them
Adenosine and cardiac arrhythmias

The preferred treatment for supraventricular tachycardia

Adenosine is an endogenous purine nucleoside that is capable of causing atrioventricular nodal conduction block in humans. It is approved by the United States Food and Drug Administration for terminating paroxysmal supraventricular tachycardia, and it has recently gained a product licence in the United Kingdom for use as both a therapeutic agent for supraventricular tachycardia and a diagnostic agent in broad or narrow complex regular tachycardia of uncertain cause. If adenosine does terminate a tachycardia the strong presumption is that the tachycardia was due to an arrhythmia involving the atrioventricular node, whereas if the tachycardia continues unaffected it is highly likely to be of ventricular origin. Atrial arrhythmias (such as atrial flutter) will not be terminated, but the diagnosis should become apparent because of transient atrioventricular nodal block. The half life of adenosine in human plasma is as short as 0.6-1.5 seconds so that any unwanted effects are transient.

The diagnostic information provided by atrioventricular nodal blockade in a patient with a broad complex tachycardia is independent of that provided by the patient's history and the electrocardiographic appearances—and, indeed, in the two studies in which the information was given the diagnostic value of adenosine compared favourably with the use of standard electrocardiographic criteria. Adenosine is easy to administer, and in cases of diagnostic difficulty the interpretation of the response (termination or non-termination) is likely to be simpler for junior doctors than the use of complicated electrocardiographic rules.

The atrioventricular nodal blocking actions of adenosine have been known since 1929, so it may seem strange that the agent has taken so long to be used widely in Britain. Part of the reason for the delay may have been the initial unsuccessful attempts to use it to terminate atrial fibrillation. A related compound, adenosine triphosphate, has been widely used in France for many years, but its evaluation has been poorly documented even in the French literature. Another possible reason for the delay may have been pharmaceutical companies' lack of enthusiasm for development—for adenosine itself cannot be patented because it is a naturally occurring compound. Furthermore, there is no stable oral form of