

Bring tobacco and alcohol control to the fore to achieve the health MDGs

Editor – I refer to the Round Table in the December 2004 issue of the *Bulletin* on achieving the Millennium Development Goals (MDGs) for health, with the main article by Jeffrey Sachs (1).

The Secretariat of the Pacific Community has recently produced a 160-page document on the Pacific Islands Regional MDGs, with statistical indexes for the various goals. Few people know the extent of the work of the Secretariat in this area and I would be happy to arrange for a copy of this report to be sent to WHO. The report was circulated to governments at the 34th Meeting of the Committee of Governments and Administrations, held in Noumea on 16–19 November 2004, with input from Mr Greg Urwin, Secretary General of the Pacific Islands Forum Secretariat. Much of this work contributes significantly to our understanding of the various goals and efforts to redress poverty and ensure more equitable outcomes in a range of social, health, environmental and economic indicators.

I was struck by what was missing from the *Bulletin's* Round Table. Dr Sachs recently supported a report from Professor Stephen Leeder on the challenge that cardiovascular disease poses in developing countries (2), and other recent publications point to the importance of noncommunicable disease risk factors in developing country situations. This is very evident in the Pacific Islands. The Comparative Risk Assessment Collaborating Group points out in the most recent burden of disease publication that some 5 million people die annually from tobacco use, with the majority now in developing countries, and just under 2 million die from alcohol use, with a comparatively greater burden of DALYs from alcohol when compared with tobacco (3). So

while Sachs points to the “respiratory infections because they breathe wood smoke” his silence on the issues of tobacco and alcohol in the MDG documents is “deafening”.

In June 2004, the Economic and Social Council of the United Nations received a report from the Ad Hoc Inter-Agency Task Force on Tobacco Control indicating that unless countries tackled the issue of tobacco control several of the key MDGs were unlikely to be achieved (4). My own sense of this in the Pacific is that we can expect continued poor health outcomes and poverty in a large number of the Pacific Islands unless we give higher profile to the importance of tobacco control and its key role in development at the individual, community and national levels. Tobacco control is a marker for development (5). Inclusion of such an emphasis in some of the writings by Sachs and others on the MDGs would go a long way in support of such efforts. In the Pacific, we have millions of dollars for HIV/AIDS, malaria and TB, but only thousands for tobacco and alcohol. Such resource allocation is fairly typical. ■

Competing interests: none declared.

Harley Stanton¹

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The first reports on smoking and lung cancer — why are they consistently ignored?

Editor – In his commentary on early reports on smoking and lung cancer, Michael J. Thun ignores the actual first reports and concentrates on the series of case-control studies published in 1950, first in the United States and then in the United Kingdom (1). He also claims (as others have done) that in the pre-1950 era the most popular hypothesis was that “lung cancer mortality ... was more likely to have resulted from the widespread tarring of roads and exhaust from motor vehicles than from cigarette smoking”. Could he please produce contemporary — i.e. pre-1950 — references on this hypothesis that match the veritable mountain of publications from pre-1950 implicating cigarette smoking (2), in particular, formal analytical studies of road tarring and motor exhaust similar to the many analytical studies of smoking and lung cancer?

Of course, as is now well known (3, 4, 5–10), extensive research on smoking and lung cancer appeared before 1950, much — but not all — of it from Weimar and then Nazi Germany. In 1928 Schönherr from Chemnitz drew attention to the high rates of smoking in a series of lung cancer patients (11). He explicitly studied where the lung cancer cases lived and reported they were not closer to roads than expected (tar and exhaust already being an unsupported hypothesis) and suggested that lung cancer in non-smoking wives of smokers was caused by passive smoke inhalation. In his comprehensive review of smoking and lung cancer in 1929 (reviews were already being written 20 years before the 1950 “discovery”) the influential actuary Frederick Hoffman wrote: “Unfortunately, German statistical discussions are invariably confusing and complicated by the omission of proper headings to statistical tables, which makes a full use of the elaborate investigation

¹ Secretariat of the Pacific Community, BP D5 98848, Noumea, New Caledonia (email: HarleyS@spc.int).

by Schönherr exceptionally difficult. Exceedingly rigorous reading is required to draw the best results from the mass of evidence presented. But every aspect of the problem is considered by this author, whose observations are deserving of being completely translated into English" (12). In a review published two years later, Hoffman considered that "smoking habits unquestionably increase the liability to cancer of the mouth, the throat, the oesophagus, the larynx and the lungs" (13).

In 1935, Fritz Lickint published an elegant synthetic review that considered time trends in lung cancer and cigarette smoking, ecological associations between smoking and lung cancer, autopsy series, experimental animal studies and clinical reports, which left him in no doubt that smoking was a cause of lung cancer (14). He had entitled a 1929 paper "Tobacco and tobacco smoke as etiological factors for carcinoma" (15); he simply did not think further studies were needed — what was required was to prevent smoking. His extraordinary 800-page work in 1939 (16) summarized all that was currently known from scientific research on the health consequences of smoking.

In 1939, a study of smoking habits of lung cancer cases compared with those of an ill-defined control group carried out by Franz Müller appeared in the *Zeitschrift für Krebsforschung* (17), a leading international cancer journal of its time (a time when many of the major science journals were in German). Four years later a considerably more sophisticated study by Schairer & Schöniger appeared in the same journal (18); an English translation is now readily accessible (19). This study involved a population and hospital control group (findings were similar in both), analysed the potential effect of people with illnesses quitting smoking, and tabulated results of their study together with previous data to show consistency (a formal statistical meta-analysis was not, unsurprisingly, performed. The odds ratios that can now be calculated from these early studies are very similar to those of the later studies published in the 1950s, and for the Schairer & Schöniger study alone statistical evidence for an association can be shown to be strong ($P < 0.0000001$).

The study by Schairer & Schöniger was carried out under the auspices of the Institute for the Struggle Against the Dangers of Tobacco based in Jena and supported, in part, by Adolf Hitler's personal funds. The history of anti-smoking activity in Nazi Germany and its links to the practice and ideology of the ruling party have been discussed in detail elsewhere (3, 5, 6), but there was no simple connection between science and ideology. For example, Fritz Lickint — the most scholarly, best informed and active scientist in this field during the Nazi period — had been a supporter of the Social Democrats and, as one of us (GDS) discovered on a visit to the archives of the Institute in 1994, was subject to an SS investigation because of his suspect (anti-Nazi) politics and was denied employment at the Institute because of this.

The understandable concern that acknowledging the roots of scientific investigation of the links between smoking and lung cancer may discredit anti-tobacco activity today is neither congruent with the multifaceted (and in no way simply "Nazi") history of such science or with a true account of the complex development of scientific ideas. ■

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**George Davey Smith¹
& Matthias Egger²**

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¹ Department of Social Medicine, University of Bristol, Canynge Hall, Whiteladies Road, Bristol BS8 2PR, England (email: zetkin@bristol.ac.uk).

² Institute for Social and Preventive Medicine, University of Berne, Switzerland.