metastasis is microscopic, especially in adenocarcinoma. Our results suggest that a certain type of lung adenocarcinoma develops distant metastasis with no regional lymph node swelling, and such hematogenous distant metastasis may not necessarily be associated with size of primary lesion. Although a small percentage of N0 patients had distant metastasis, two thirds of them were silent. Considering the appropriate treatment for these patients, for patients with lung adenocarcinoma we do recommend full staging procedures using imaging studies even if they do not show any symptoms.

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Our Antismoking Campaign

To the Editor:

It was in San Francisco at Chest 2000 where I heard Ann Woolock speak on the campaign against smoking. Despite decades of effort and great expense, the campaign is apparently not doing well. She sounded forlorn and quite pessimistic. Instead of being brought under control, the tobacco habit is in fact getting worse. What with the pernicious message of tobacco being pushed onto “soft” targets such as women, children, and the Third World, the outlook globally is gloomy. Dr. Woolock did not forget to gently chide us “respirologists” for not measuring up to the challenge of tobacco.

On past experience, I cannot help some personal introspection. I was just out of school when I smoked my first cigarette, although it was later that I became a regular smoker. Why did I start smoking? The answer is a mixture of curiosity, the thrill of stepping into the unknown, and a perception that by smoking one has grown up and “arrived.” There was subtle pressure on us to conform and to follow the accepted pattern of adult behavior that included smoking. This happened to some 60% of us, and we fell in line. Only one fourth of our peers were of sterner stuff and would not be pushed. But for the majority, the die was cast. A creeping habit was taking hold, and the habit became a compulsion and then an addiction. As an addiction, it is pure and simple; never mind the euphemisms, such as habit-forming, dependence, and the like. For most of us, the first experience was unpleasant: cough, choking, and burning, plus a sense of guilt. Yet, we soldiered on and were trapped. I tried kicking the habit not once but many times. I failed repeatedly for 40 long years. Every failed effort brought on painful despondency, and each failure was followed by accelerated and worsened smoking. The antismoking campaign has been in operation for decades. It has evolved in two stages. The first stage is comprised of dissemination of information regarding health hazards of smoking, and the second step was the follow-up of the first stage. Awareness generation through positive propaganda has been well done. This has been a success, and no one can say they are unaware of the dangers of smoking. But real success lies in translating this information gain into fruitful behavioral change in the form of tobacco abstinence. This has not come about, and we must own up to our responsibility for the failure.

Future Direction

We have a duty to perform in evolving and nurturing a tobacco-free society. We must do some soul searching on the adequacy and efficacy of our efforts to date. If it is time to take corrective action, we must not hesitate to redraw our strategy.

Smoking is not a minor evil. It should not be considered an irritating niggle that refuses to go away. It must be seen and recognized for what it really is: a major debilitating pandemic and a slowly evolving man-made ecological disaster. A global debate is needed, and we should make changes in the antitobacco campaign so that a new thrust and direction is given to our fight. I put forward a few suggestions for consideration and debate.

Dealing With the Young

We took a parental line when dealing with the young. Genuine concern drove us to warn them about what may befall them as a result of smoking. But the youth of the world do not like to be frightened into changing their habits. They are not impressed because our prognostications do not carry any immediacy and also because they sound sanctimonious. They are the “now” generation, and the “name of the game” in their language is defying authority and taking risks in the face of danger. They may balk at warnings, but they welcome clean habits and health-promoting physical activities. A shift of emphasis from dangerous results to clean living might help. We should try to create the general perception that smokers have unclean habits, they pollute the atmosphere, and therefore they are not welcome to population groups that are clean and elegant, a perception that they often have of themselves.

Central and state governments in India have recently moved to create more and more smoking-free areas in public places. It is heartening that the judiciary lent its considerable weight and prestige in this matter. The judiciary/executive concurrence is a significant gain, and we should try to universalize this confluence of intentions.

On Passive Smoking

The recognition of passive smoking as a major health hazard has surprisingly come only recently. This danger to health has been grossly underplayed to/by us. This needs correction by
aggressive propaganda. It is my personal and unproved experience that ex-smokers are particularly vulnerable to the dangers of passive smoking.

In most places in India, the menfolk get together frequently (sometimes daily) in houses, clubs, and other meeting places. This takes place in the evening hours, and the venue is for reasons of space and privacy, necessarily a small and congested room. Here they play card games, drink the local brew, and smoke away for hours. Across the country, this is an unquantifiable source of respiratory morbidity. These are veritable incubation chambers of chronic bronchitis. The prevalence of these “smoking rooms” may well be global.

Chronic bronchitis and not lung cancer should take the top place in the list of smoking hazards. The former is not only numerically more frequent, but more importantly, the cause-and-effect relationship is more evident in this condition.

**Doctors and Smoking**

Many people cling to the fatuous belief that “it’s all in the genes.” They use this as an excuse to continue smoking. One suspects that some doctors also belong to this category. There cannot be any other reasons why doctors continue to smoke. They do great harm to the campaign. I have no hesitation to recommend a total ban on smoking in public by doctors and other health professionals. Smoking should be banned in surgeries, nursing homes, waiting rooms, and canteens. Prominent placards to this effect should be mandatory in these premises. Passive smoking should be brought to public sensibilities and awareness very strongly.

**The Press and Media**

We should feed the media with the problems we are trying to tackle to protect the health of the community. They can help us greatly in our efforts. They may be persuaded to be discreet in printing pictures of our heroes and heroines in the act of smoking. Any write-up that glorifies smoking should be omitted. Our public relations officers could cultivate film personalities such as stars, directors, and producers. Too often, we see gratuitous smoking in films when it has very little to do with the story line or effect. The impressionable youth should be protected.

**Erratum**

In the November 1999 issue, the article “Gastroesophageal Reflux in Asthmatics: A Double-Blind, Placebo-Controlled Crossover Study With Omeprazole” (CHEST 1999; 116:1257-1264), by Kiljander et al, contained an error. The abstract and “Results” sections both reported an improvement in FEV1 during omeprazole treatment in the subgroup of patients with intrinsic asthma (p = 0.049). In fact, the FEV1 declined in these patients during omeprazole treatment (p = 0.049).