

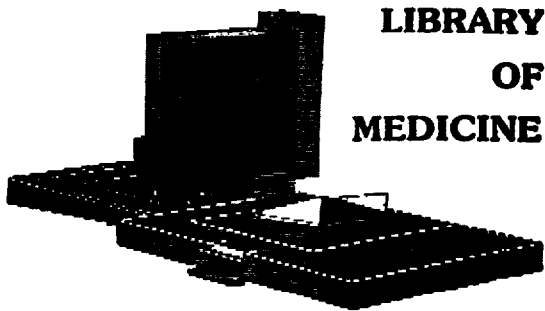
**Summary
of the Health
Consequences
of Smoking**

**CHRONIC OBSTRUCTIVE
LUNG DISEASE**

*A Report of the
Surgeon General*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
National Institutes of Health
National Heart, Lung, and Blood Institute

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Two decades have passed since Dr. Luther Terry issued the first Surgeon General's report on smoking and health. That report pointed out in great detail many of the health hazards of cigarette smoking and was the beginning of a concerted effort to change the smoking habits of the American public.

The *Report of the Surgeon General on the Health Consequences of Smoking* for 1984 concentrates on chronic obstructive lung disease (COLD), which comprises emphysema and chronic bronchitis. The evidence brought forth in this report indicates that COLD would almost disappear if Americans quit smoking. Some 80 to 90 percent of COLD mortality is associated with smoking; most of the rest is the result of a relatively rare genetic defect in which the patient lacks a certain enzyme that protects against lung damage.

The importance of the report of the Surgeon General is very substantial. It underscores the overwhelming evidence that has been amassed over the years which clearly establishes the cigarette as public enemy number one for a healthy lung. I hope it provokes the medical community to be even more vigorous in counseling their smoking patients to quit. What follows is an extraction of the overview and conclusions of the report, which we hope will serve as a convenient summary.

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Overview

Scientists from a variety of disciplines have investigated the role of cigarette smoking in the development of COLD; today we can trace the progressive decline in lung function in smokers with increasing smoke exposure. We can describe the concurrent pathologic changes, demonstrate that both COLD prevalence and COLD death are limited largely to smokers, and perhaps most important, we can describe in detail a plausible mechanism by which cigarette smoking can lead to the development of emphysema. Some gaps in the understanding of the details of this process may still exist, but the experimental and epidemiologic evidence leaves no room for reasonable doubt on the fundamental issue: cigarette smoking is the major cause of COLD in the United States.

The earliest recognized response to cigarette smoke is an increase in airway resistance that occurs with the inhalation of smoke by the smoker. This increase in resistance is a response to the irritants in the smoke, as is coughing, which is known to be more frequent in smokers than in nonsmokers, even in adolescents. By the time smokers become young adults, a substantial proportion of them will have developed pathologic changes in their small airways. These abnormalities are demonstrable using a variety of physiologic tests, and result from pathologic changes of inflammation in the airways less than 2 mm in diameter. Part of this small airways response, but perhaps a later manifestation of it, is the development of smooth muscle hypertrophy, goblet cell hyperplasia, and mild peribronchiolar fibrosis. The prevalence of abnormalities on tests of small airways function increases as these young smokers grow older and is greater in heavy smokers than in light smokers. While it is clear that changes in the small airways represent an early response to cigarette smoking and that they are a significant finding in the

pathophysiology of COLD, it is not clear that abnormal function of the small airways, per se, is useful as a marker for identifying who will progress to develop symptomatic COLD. It may identify a large group of smokers who manifest an irritant response to smoke in the small airways, of whom only a subset actually develop symptomatic airflow obstruction.

Measurable differences in tests of expiratory airflow exist between smokers and nonsmokers after age 25. Smokers as a group have a more rapid decline in FEV₁ with age than that observed in nonsmokers, and the decline is even greater among heavy smokers. However, this increased rate of decline in lung function is not distributed evenly, even among smokers with similar smoking histories. Some smokers have a far more rapid decline than the average smoker, and clearly those individuals who have developed symptomatic chronic airflow obstruction have had a larger total decline in lung function than the average smoker. This has led to the suggestion that individuals with a particularly rapid decline in FEV₁ early in life may represent a group especially susceptible to the later development of symptomatic COLD. The nature of this susceptibility remains unclear, but differences in depth or pattern of inhalation, variations in the cellular and biochemical response of the lung to smoke, differences in immune or repair mechanisms, and childhood infections or exposure to environmental tobacco smoke as a child have been suggested as potential factors.

The accumulation of lung damage, marked by the excess decline in FEV₁ and other measures of expiratory airflow, can lead to shortness of breath and other symptoms that characterize clinically significant COLD. These symptoms result in disability due to ventilatory limitation and may vary from patient to patient in severity and duration; many patients with clinically disabling COLD die with their disease rather than because of it. Death from COLD usually results only after extensive lung damage and commonly occurs because of failure of the severely damaged lungs to maintain adequate gas exchange.

The cessation of cigarette smoking has a substantial impact on the incidence and progression of COLD. Cigarette smokers who quit prior to developing abnormal lung function are unlikely to go on to develop ventilatory limitation; when the abnormalities are demonstrable only on tests of small airways function, cessation often results in a reversal of these changes and a return to normal function. The presence of significant fixed reduction in measures of expiratory airflow usually reflects the presence of substantial lung damage. Cessation of smoking at this stage of COLD results in a slowing in the rate of decline in lung function with age. After a period of cessation, this rate of decline in function may approximate the rate found in nonsmokers, but there is little evidence to suggest

that those who quit are able to regain their prior excess functional decline. Therefore, those who quit continue to have reduced lung function when compared with those who have never smoked, but their lung function begins to decline less rapidly with age when compared to the lung function of those who continue to smoke.

The importance of cigarette smoking as a causative factor in COLD is emphasized by cross-sectional studies of the populations in the United States where the only major predictor for developing or dying of COLD is smoking behavior. In the absence of cigarette smoking, clinically significant COLD is rare.

As the smoker enters the sixth decade of life, pathologically definable pulmonary emphysema begins to become evident. In older age groups, mild to moderate emphysema is present in most smokers and is rare in nonsmokers. Once again, however, only a small number of smokers develop severe emphysema, and this minority includes a disproportionate number of heavy smokers.

A mechanism for smoking-induced emphysematous lung injury has been proposed and continues to evolve as our understanding of cellular and biochemical responses of the lung increases. Emphysema can be produced by the presence of excessive amounts of elastase (an enzyme capable of degrading the structural elements of lung tissue) or by the absence of α_1 -antiprotease (an enzyme that inhibits the action of elastase). As part of the inflammatory response to cigarette smoke, an increased number of inflammatory cells are present in the lungs of smokers; these cells may result in an increased amount of elastase being present in the lung. In addition, cigarette smoke can oxidize the α_1 -antiprotease in the lung, further contributing to the imbalance between levels of elastase and levels of α_1 -antiprotease. The net result can be excess levels of elastase, leading to degradation of elastin in the lung, destruction of alveolar walls, and development of emphysema.

The text of this Report discusses in detail the relationship of cigarette smoking to COLD morbidity and mortality, the pathology of smoking-induced COLD, some of the mechanisms by which smoking results in COLD, the impact on the lung of low tar and nicotine cigarettes and of involuntary smoke exposure, the deposition and toxicology of tobacco smoke, and the role of the physician and of community intervention programs in smoking cessation.

The overall conclusion of this Report is clear: **Cigarette smoking is the major cause of chronic obstructive lung disease in the United States for both men and women. The contribution of cigarette smoking to chronic obstructive lung disease morbidity and mortality far outweighs all other factors.**

Conclusions of the 1984 Report

COLD Morbidity

1. Cigarette smoking is the major cause of COLD morbidity in the United States, and 80–90 percent of the COLD in the United States is attributable to cigarette smoking.
2. In population-based studies in the United States, cigarette smoking behavior is often the only significant predictor for the development of COLD. Other factors improve the predictive equation only slightly, even in those populations where they have been found to exert a statistically significant effect.
3. In spite of over 30 years of intensive investigation, only cigarette smoking and α_1 -antiprotease deficiency (a rare genetic defect) are established causes of clinically significant COLD in the absence of other agents.
4. Within a few years after beginning to smoke, smokers experience a higher prevalence of abnormal function in the small airways than nonsmokers. The prevalence of abnormal small airways function increases with age and the duration of the smoking habit, and is greater in heavy smokers than in light smokers. These abnormalities in function reflect inflammatory changes in the small airways and often reverse with the cessation of smoking.
5. Both male and female smokers develop abnormalities in the small airways, but the data are not sufficient to define possible sex-related differences in this response. It seems likely, however, that the contribution of sex differences is small when age and smoking exposure are taken into account.
6. There is, as yet, inadequate information to allow a firm conclusion to be drawn about the predictive value of the tests of small airways function in identifying the susceptible smoker who will progress to clinical airflow obstruction.
7. Smokers of both sexes have a higher prevalence of cough and phlegm production than nonsmokers. This prevalence increases with an increasing number of cigarettes smoked per day and decreases with the cessation of smoking.
8. Differences between smokers and nonsmokers in measures of expiratory airflow are demonstrable by young adulthood and increase with number of cigarettes smoked per day and with age.
9. The rate of decline in measures of expiratory airflow with increasing age is steeper for smokers than for nonsmokers; it is also steeper for heavy smokers than for light smokers. After the cessation of smoking, the rate of decline of lung function with increasing age appears to slow to approximately that seen in nonsmokers of the same age. Only a minority of smokers will

develop clinically significant COLD, and this group will have demonstrated a more extensive decline in lung function than the average smoker. The data are not yet available to determine whether a rapid decline in lung function early in life defines the subgroup of smokers who are susceptible to developing COLD.

10. Clinically significant degrees of emphysema occur almost exclusively in cigarette smokers or individuals with genetic homozygous α_1 -antitrypsin deficiency. The severity of emphysema among smokers increases with the number of cigarettes smoked per day and the duration of the smoking habit.

COLD Mortality

1. Data from both prospective and retrospective studies consistently demonstrate a uniform increase in mortality from COLD for cigarette smokers compared with nonsmokers. Cigarette smoking is the major cause of COLD mortality for both men and women in the United States.
2. The death rate from COLD is greater for men than for women, most likely reflecting the differences in lifetime smoking patterns, such as a smaller percentage of women smoking in past decades, and their smoking fewer cigarettes, inhaling less deeply, beginning to smoke later in life, and more frequently smoking filtered and low tar and nicotine cigarettes.
3. Differences in lifetime smoking behavior are less marked for younger age cohorts of smokers. The differences in male and female mortality rates from COLD are decreasing because of a more rapid rise in mortality from COLD among women.
4. The dose of tobacco exposure as measured by number of cigarettes or duration of habit strongly affects the risk for death from COLD in both men and women. Similarly, people who inhale deeply experience an even higher risk for mortality from COLD than those who do not inhale.
5. Cessation of smoking leads to a decreased risk of mortality from COLD compared with that of continuing smokers. The residual excess risk of death for the ex-smoker is directly proportional to the overall lifetime exposure to cigarette smoke and to the total number of years since one quit smoking. However, the risk of COLD mortality among former smokers does not decline to equal that of the never smoker even after 20 years of cessation.
6. Several prospective epidemiologic studies examined the relationship between pipe and cigar smoking and mortality from COLD. Pipe smokers and cigar smokers also experience higher mortality from COLD compared with nonsmokers; however, the risk is less than that for cigarette smokers.

7. There are substantial worldwide differences in mortality from COLD. Some of these differences are due to variations in terminology and in death certification in various countries. Emigrant studies suggest that ethnic background is not the major determinant for mortality risk due to COLD.

Pathology of Cigarette-Induced Disease

1. Smoking induces changes in multiple areas of the lung, and the effects in the different areas may be independent of each other. In the bronchi (the large airways), smoking results in a modest increase in size of the tracheobronchial glands, associated with an increase in secretion of mucus, and in an increased number of goblet cells.
2. In the small airways—conducting airways 2 or 3 mm or less in diameter consisting of the smallest bronchi and bronchioles—a number of lesions are apparent. The initial response to smoking is probably inflammation, with associated ulceration and squamous metaplasia. Fibrosis, increased muscle mass, narrowing of the airways, and an increase in the number of goblet cells follow.
3. Inflammation appears to be the major determinant of small airways dysfunction and may be reversible after cessation of smoking.
4. The most obvious difference between smokers and nonsmokers is respiratory bronchiolitis. This lesion may be an important cause of abnormalities in tests of small airways function, as well as being involved in the pathogenesis of centrilobular emphysema. The severity of emphysema is clearly associated with smoking, and severe emphysema is confined largely to smokers.

Mechanisms of COLD

1. Increased numbers of inflammatory cells are found in the lungs of cigarette smokers. These cells include macrophages and, probably, neutrophils, both of which can release elastase in the lung.
2. Human neutrophil elastase produces emphysema when instilled into animal lungs.
3. Alpha₁-antiprotease inhibits the action of elastase, and a very small number of people with a homozygous deficiency of α_1 -antiprotease are at increased risk of developing emphysema. The α_1 -antiprotease activity has been shown by lung lavage to be reduced in the bronchoalveolar fluids obtained from cigarette smokers and from rats exposed to cigarette smoke.
4. The protease-antiprotease hypothesis suggests that emphysema results when there is excess elastase lytic activity as the

- result of increased concentrations of inflammatory cells in the lung and of decreased levels of α_1 -antiprotease secondary to oxidation by cigarette smoke.
5. Cigarette smokers have been shown to have a more rapid fall in antibody levels following immunization for influenza than nonsmokers. Whole cigarette smoke has been shown to depress the number of antibody-forming cells in the spleens of experimental animals.
 6. Cigarette smoke produces structural and functional abnormalities in the airway mucociliary system.
 7. Short-term exposure to cigarette smoke causes ciliostasis in vitro, but has inconsistent effects on mucociliary function in man. Long-term exposure to cigarette smoke consistently causes an impairment of mucociliary clearance. This impairment is associated with epithelial lesions, mucous hypersecretion, and ciliary dysfunction.
 8. Chronic bronchitis in smokers and ex-smokers is characterized by an impairment of mucociliary clearance.
 9. Both the particulate phase and the gas phase of cigarette smoke are ciliotoxic.

Low Tar and Nicotine Cigarettes

1. The recommendation for those who cannot quit to switch to smoking cigarette brands with low tar and nicotine yields, as determined by a smoking-machine, is based on the assumption that this switch will result in a reduction in the exposure of the lung to these toxic substances. The design of the cigarette has markedly changed in recent years, and this may have resulted in machine-measured tar and nicotine yields that do not reflect the real dose to the smoker.
2. Smoking-machines that take into account compensatory changes in smoking behavior are needed. The assays could provide both an average and a range of tar and nicotine yields produced by different individual patterns of smoking.
3. Although a reduction in cigarette tar content appears to reduce the risk of cough and mucous hypersecretion, the risk of shortness of breath and airflow obstruction may not be reduced. Evidence is unavailable on the relative risks of developing COLD consequent to smoking cigarettes with the very low tar and nicotine yields of current and recently marketed brands.
4. Smokers who switch from higher- to lower-yield cigarettes show compensatory changes in smoking behavior: the number of puffs per cigarette is variably increased and puff volume is almost universally increased, although the number of cigarettes smoked per day and inhalation volume are generally

unchanged. Full compensation of dose for cigarettes with lower yields is generally not achieved.

5. Nicotine has long been regarded as the primary reinforcer of cigarette smoking, but tar content may also be important in determining smoking behavior.
6. Depth and duration of inhalation are among the most important factors in determining the relative concentration of smoke constituents that reach the lung. Considerable interindividual variation exists between smokers with respect to the volume and duration of inhalation. This variation is likely to be an important factor in determining the varying susceptibility of smokers to the development of lung disease.
7. Production of low tar and nicotine cigarettes has progressed beyond simple reduction in tobacco content. Additives such as artificial tobacco substitutes and flavoring extracts have been used. The identity, chemical composition, and adverse biological potential of these additives are unknown at present.

Passive Smoking

1. Cigarette smoke can make a significant, measurable contribution to the level of indoor air pollution at levels of smoking and ventilation that are common in the indoor environment.
2. Nonsmokers who report exposure to environmental tobacco smoke have higher levels of urinary cotinine, a metabolite of nicotine, than those who do not report such exposure.
3. Cigarette smoke in the air can produce an increase in both subjective and objective measures of eye irritation. Further, some studies suggest that high levels of involuntary smoke exposure might produce small changes in pulmonary function in normal subjects.
4. The children of smoking parents have an increased prevalence of reported respiratory symptoms, and have an increased frequency of bronchitis and pneumonia early in life.
5. The children of smoking parents appear to have measurable but small differences in tests of pulmonary function when compared with children of nonsmoking parents. The significance of this finding to the future development of lung disease is unknown.
6. Two studies have reported differences in measures of lung function in older populations between subjects chronically exposed to involuntary smoking and those who were not. This difference was not found in a younger and possibly less exposed population.
7. The limited existing data yield conflicting results concerning the relationship between passive smoke exposure and pulmonary function changes in patients with asthma.

Deposition and Toxicity of Tobacco Smoke in the Lung

1. The mass median aerodynamic diameter of the particles in cigarette smoke has been measured to average approximately 0.46 μ m, and particulate concentrations have been shown to range from 0.3×10^9 to 3.3×10^9 per milliliter.
2. The particulate concentration of the smoke increases as the cigarette is more completely smoked.
3. Particles in the size range of cigarette smoke will deposit both in the airways and in alveoli; models predict that 30 to 40 percent of the particles within the size range present in cigarette smoke will deposit in alveolar regions and 5 to 10 percent in the tracheobronchial region.
4. Acute exposure to cigarette smoke results in an increase in airway resistance in both animals and humans.
5. Exposure to cigarette smoke results in an increase in pulmonary epithelial permeability in both humans and animals.
6. Cigarette smoke has been shown to impair elastin synthesis in vitro and elastin repair in vivo in experimental animals (elastin is a vital structural element of pulmonary tissue).

The Role of the Physician in Smoking Cessation

1. At least 70 percent of North Americans see a physician once a year. Thus, an estimated 38 million of the 54 million adults in the United States who smoke cigarettes could be reached annually with a smoking cessation message by their physician.
2. Current smoking prevalence among physicians in the United States estimated at 10 percent.
3. While the majority of persons who smoke feel that physician advice to quit or cut down would be influential, there is a disparity between physicians' and patients' estimates of cessation counseling, with physician advice being reported by only approximately 25 percent of current smokers.
4. Studies of routine (minimal) advice to quit smoking delivered by general practitioners have shown sustained quit rates of approximately 5 percent. Followup discussions enhance the effects of physician advice.
5. A median of 20 percent of pregnant women who smoke quit spontaneously during pregnancy. That proportion can be doubled by an intervention consisting of health education, behavioral strategies, and multiple contacts.
6. Large controlled trials of cardiovascular risk reduction have demonstrated that counseling on individual specific risk factors, including smoking cessation techniques, can be effective.
7. Studies of pulmonary and cardiac patients indicate that severity of illness is positively related to increased compliance

in smoking cessation. Survivors of a myocardial infarction have smoking cessation rates averaging 50 percent.

8. Nicotine chewing gum has been developed as a pharmacological aid to smoking cessation, primarily to alleviate withdrawal symptoms. Cessation studies conducted in offices of physicians who prescribe the gum have produced mixed results, however, with outcome depending on motivation and intensive adjunctive support or followup.
9. Physician-assisted intervention quit rates vary according to the type of intervention, provider performance, and patient group. In general, quit rates in recent research appear lower than in older studies.

Community Studies of Smoking Cessation

1. Community studies of smoking cessation and prevention are becoming an established paradigm for public health action research. Such studies emphasize large-scale delivery systems, such as the mass media, and include community organization programs seeking to stimulate interpersonal communication in ways that are feasible on a large-scale basis.
2. Although there are methodological limitations to nearly all communitywide studies, the results yield fairly consistent positive results, indicating that large-scale programs to reduce smoking can be effective in whole populations. Person-to-person communication appears to be a necessary part of a successful community program to reduce smoking.
3. Further research is needed, with both improved methodology and more emphasis on low socioeconomic status groups that have not yet shown population trends toward reduced smoking.
4. Several promising directions for research are clear, but the most important future trends will be toward the establishment of smoking reduction programs within existing health services, the combination of chronic disease prevention with mental health promotion via mass media and community intervention, and the development of social policy to establish integrated strategies for smoking cessation and prevention.