

POOR CIGARETTES

When the etiology of a disease entity is unknown it is quite common for lay people and physicians alike to blame some extrinsic factor, usually some sort of a vice to explain the presence of a pathological entity, no matter how remote the connection may seem. In cirrhosis of the liver, alcohol has long been considered a probable etiological factor although this has never been proven. It is well known that vitamin deficiency plays at least an important part in the production of cirrhosis in some instances, and even though alcohol has never been proven as an etiological factor, there are some who still insist on classifying cirrhosis of the liver as alcoholic and nonalcoholic.

There are very few disease entities of unknown etiology, in which cigarette smoking has not been considered the cause. This applies particularly to two various forms of cancer. For example, carcinoma of the lip, buccal mucosa, tongue, pharynx, larynx, and last but not least primary bronchogenic carcinoma of the lung are said to be due to cigarette smoking.

Cigarette smoking has been blamed for a variety of other maladies, nonneoplastic. For instance, coronary heart disease has been considered by some to be due to the use of cigarettes. Generalized arteriosclerosis, although the connection seems vague, has been said to occur more frequently in cigarette smokers. Some generations ago cigarette smoking was considered the cause of tuberculosis.

The most recent fad is to blame cigarette smoking for the *apparent* increase in primary bronchogenic carcinoma of the lung. Some have even gone so far as to classify bronchogenic carcinoma of the lung into cigarette-carcinoma and noncigarette-carcinoma, ridiculous as this may seem. As was pointed out in a previous communication, the apparent increase in bronchogenic carcinoma of the lung directly parallels the rapid strides in thoracic surgery. Thirty years ago when thoracic surgery was confined to an occasional drainage of an empyema, it was proven on a survey of autopsy material at the University of Minnesota, from 1910 to 1930, that there was no increase in primary bronchogenic carcinoma. It is important to note that this survey and study were based entirely on autopsy material, since there was no surgical material available during this period of time.

During this period, when carcinoma of the lung was found at autopsy, it was the duty of the pathologist to comb with a fine toothed comb, every organ of the body to find a primary lesion. In most instances this could be found even though the primary lesion might be extremely small. One instance is clearly remembered of an individual with what appeared to be a primary bronchogenic carcinoma of the lung on radiographic and post mortem examination. Histologic examination revealed squamous cell, oat cell and adenocarcinoma. After careful searching these were found to be metastases to the lung from a primary carcinoma of the ampulla of Vater.

It is suggested that if all statistical surveys of primary bronchogenic carcinoma of the lung were confined to a study of autopsy material there would be found no actual increase. To those of us who have confined our major activity in the field of oncology, it is a well known fact that there is no characteristic histological pattern for primary bronchogenic carcinoma of the lung. It has a protean microscopic picture. The lung is the mirror of primary carcinoma occurring elsewhere and is the site of metastasis more frequently than any other organ. Therefore, one may say that it is impossible, except in very rare instances, to make an unequivocal diagnosis of bronchogenic carcinoma on the basis of study of surgical material, since the histological pattern means nothing.

We have in our files thirteen patients who have been diagnosed as bronchogenic carcinoma of the lung on the basis of lobectomy or pneumonectomy, all of whom at autopsy were found to have primary carcinoma elsewhere with metastasis to the lungs.

Further food for thought is the fact that primary bronchogenic carcinoma of the lung is twice as frequent in Great Britain as in the United States but cigarette consumption there is half as great as it is here.

To quote from a recent article in the March-April, 1959, Volume IX, Bulletin of Cancer Progress by Dr. L. Henry Garland, "There was a British physician who got so irritated at all the articles he read about smoking that he gave up — reading."

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