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Opinion

Death smoke:

Tobacco remains a major health threat in India while air pollution adds to lung cancer risk, with Kolkata and Bengal seeing a growing burden among non-smokers

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In 1604, King James I of England penned the treatise, "A Counterblaste to Tobacco", merely 50 years after its introduction to the French court by Jean Nicot. What the king learnt, even after taxing tobacco to 2000%, is relevant even now. That the market will sell for profit and people won't quit, once addicted, despite all the cautions. Of course, he didn't know about lung cancer, or about nicotine, the addictive alkaloid in tobacco.

In 1912, I. Adler, a New York physician, intent on writing a monograph on lung cancer, wondered if it would be a worthwhile subject. Within four decades, that rarest of diseases became a common killer. Sir Richard Doll, a British physician in 1950, proved the culprit was tobacco with a direct dose response relation: a person smoking 25 cigarettes a day is 25 times more prone to develop lung cancer. The impact of heavy smoking in Western countries, rampant by 1900 with the availability of cheap, machine-rolled cigarettes, was seen a few decades later in increased lung cancer incidence. It took many more decades of anti-tobacco measures to reverse that trend. The West now records sharp declines in tobacco usage, with a 2%-4% drop annually in lung cancer incidences.

India-specific data, however, are confounding. Successive Global Adult Tobacco Surveys (GATS I & II) and National Health Family Surveys (NHFS-5 and NHFS-6) have indicated reduction in smoking and use of smokeless tobacco. But Household Consumption Expenditure Survey (HCES 23-24) reports point to an increase in expenditure for tobacco and a rise in consumption by women in some states like West Bengal. The use of harmful beedis, hookahs along with gutkha, khaini, and dokta remains ubiquitous.

Some of the changes seen in Western countries are already evident in India, including Calcutta and West Bengal where 35% lung cancers now occur in non-smokers. Except the northeastern states, Calcutta tops lung cancer incidences nationally. The rising affliction in both smokers and non-smokers is suggestive of tobacco use and air pollution. In addition to second-hand tobacco smoke, residents here inhale air with 80-150 µg/m³ of carcinogenic fine particulate matter (PM_{2.5}), many times over the safe limit of 25µg/ m³ set by the World Health Organization. Polycyclic hydrocarbons, benzene, and heavy metals from dusty roads and construction sites, small-scale industries operating on old technology, vehicular exhausts, and biomass burning add to the risk. Some genetic susceptibilities have been suspected too for lung cancers in non-smokers, in Asian women, and in youth.

Smoking is not the only cause for lung cancer; nor does it cause lung cancer only. It has strong causative and aggravating links with other cancers and all major non-communicable killer diseases. The WHO estimates nearly 10% of annual deaths in India are attributable to tobacco; the figure is 45.7% for men dying between 35 years and 54 years. All these major non-communicable diseases are included in the national programme for prevention and early detection through NCD clinics in Ayushman Arogya Mandirs (previously Swasthya Kendras) and government hospitals specially tasked to screen for oral, cervical, and breast cancers. The recent addition of counselling and tobacco cessation programmes would hopefully be contributory. Improved methods such as sputum cytology, liquid biopsy, and urinary biomarkers might add value in screening processes. Awareness campaigns against tobacco and strong pollution control measures remain the best bet though.