

ARE "SAFER" CIGARETTES SAFER?

Starting with the Cold Springs Harbour Conference, and subsequently during the U.S. Surgeon General's Bethesda Conference, there has been a good deal of debate over the merit of low delivery cigarettes. Epidemiologists have observed a lowering of lung cancer and other "smoking related" mortality rates which they suggest has been caused by cigarette filters and by reduction in tar deliveries, over time. Some scientists who have measured actual smoke intake, have not found convincing evidence of a reduction commensurate with the lowering of smoke deliveries. Perhaps mostly as a red herring, anti smokers and even the U.S. Surgeon General imply that the use of additives, or changes in the biological activity of low delivery smoke, may be offsetting the benefit of lower delivery cigarettes.

TAC has been considering whether to promote (sponsor?) epidemiology in order to demonstrate the benefit of low delivery cigarettes. It was epidemiology that damned smoking, and it seems reasonable to believe that only epidemiology can afford relief. However the epidemiology must be really well planned. Starting now, and in the years ahead, it will be possible to find categories of people ranging through:

Lifetime high delivery smokers
Lifetime low delivery smokers
Former high delivery smokers converted to low delivery cigarettes
Quitters from high delivery
Quitters from low delivery

Thus now is the time to start epidemiology. But to be totally convincing it would be highly desirable to sample people from all of the epidemiology "cells" in order to measure their smoke intake.

Such a two-pronged investigation should settle the matter in an unquestionable fashion. The evidence against smoking indicates a dose response mechanism. Accordingly, the evidence to support the benefit of low delivery products must be dual in nature:

Epidemiology - measures the response
Measurements of human smoke intake - measures the dose

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To the above two kinds of information should be added a third: appropriate bioassays of smoke quality in order to cover the question of possible differences in specific biological activity of the smoke intake by members of the epidemiological "cells." A fourth dimension of the research should be to use psychological testing to determine whether the epidemiological "cells" should be further subdivided into classes based on individuals' "need for smoke." It is probably true that smoker response to a switch to low delivery cigarettes varies from individual to individual according to his psychological make-up and that one explanation for confusing results of human smoker studies is small samples of populations that are not homogenous in "need for smoke" terms. If this is true, the epidemiological "cells" ought to take this into account.

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