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LETTER TO THE EDITOR

A man who has been smoking since he was 12-month-old

L. Filik[1], S. Yildirim[2], O. Ozyilkan[3]

[1]Department of Internal Medicine, [2]Check-Up Clinic, Bayindir Tip Merkezi-Medical Center; [3]Department of Medical Oncology, Baskent University, Ankara, Turkey

Dear Editor

Although tobacco use in the world goes back to 4000 years ago, the first consumption of tobacco as cigarette has a history of only 100-150 years. Smoking as a habit took the form of an epidemic in the 20th Century [1]. It is one of the major causes of death from cancer, cardiovascular and pulmonary diseases and also a risk factor for gastric diseases, osteoporosis, and reproductive disorders [1,2]. Even though the efforts to treat smoking-related diseases are continual, prevention strategies against smoking seem to be the mainstay to solve this public problem.

Herein, we report on a 63-year-old man admitted to our check-up clinic for general examination. He gave a history of smoking of 86.5 packet-years. Spirometry showed mild restrictive pattern and chest X-ray and thoracic CT revealed mild emphysematous changes. The very interesting point in his past history was that his father let him start to smoke when he was 12-month-old.

Male gender is an important psychosocial identity for patriarchal families in Asian and Middle-East countries. Our case was born as first son after 4 daughters of the chief of a tribe in southeastern Turkey. His father had thought that the earlier he started to smoke, the earlier he had been accepted as a "real man" in his society with respect to the sociocultural norms.

The percentage of smoking is around 30% in both sexes, and is decreasing in developed countries. But in Turkey these numbers are 60-70% in males and 20-25% in females. The difference between sexes comes from patriarchal cultural features and male gender predominance on the social traditions and attitudes. Another feature different from developed countries is the high ratio of non-cigarette tobacco consumption. Especially in rural areas, tobacco chewing is a common traditional habit. Tobacco addiction has been increasing in emerging countries, especially in South-East Asia, Middle-East and Pacific countries. High expenditure for tobacco-related health problems forces all countries to build prevention strategies against smoking [1].

As a conclusion, we would like draw the attention that the sociocultural attitudes are one of most important educational problems in emerging countries. Authorities should advise parents not to smoke in the presence of children, and also should insist that child care facilities be smoke-free and for recommending smoking restrictions in work sites and other public places [3].

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Author and address for correspondence:

Levent Filik, MD
Cemal Gursel Caddesi, Erk Apt.
No: 52 / 2, Kurtulus
Ankara TR06600
Turkey
Tel: +90 532 435 25 96
Fax: +90 312 433 53 46
E-mail: leventfilik@yahoo.co.uk

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UICC Cancer Fellowships

A. Yamagiwa-Yoshida Memorial UICC International Cancer Study Grants (YY) fund 3-6 month long bilateral research projects (with UICC stipend support for 3 months) that exploit complementary materials or skills and provide advanced training in experimental methods. Candidates should be qualified and experienced investigators with publications in international peer-reviewed periodicals. (Funded by the Kyowa Hakko Kogyo Company Ltd., Toray Industries Incorporated, Tokyo, and the Japan National Committee for UICC).
Application closing date: 1 July; Selection results: October
Number of grants: about 8, Average value: US$ 9,000

B. AstraZeneca, Aventis and Novartis UICC Translational Cancer Research Fellowships (TCRF) fund 12 month long research projects designed to enhance the translation of basic, experimental, and applied research insights into their clinical or population applications in the form of new drugs and treatments, and of vaccines and other effective prevention or intervention strategies. Candidates and hosts, each from a different country, should be experienced scientists or clinicians and willing to enter into an enduring collaboration. (Funded by AstraZeneca UK, Ltd., Aventis Pharma Research Development, and Novartis).
Application closing date: 1 December; Selection results: April the following year
Number of fellowship: 3 a year; Fellowship value: US$ 55,500

C. American Cancer Society UICC International Fellowships For Beginning Investigators (ACSBI) fund 12 month long research projects with the objective of fostering a bi-directional flow of knowledge, experience, expertise and innovation between countries (previous requirement for hosts to be located in the USA no longer applies). Funding preference will be given to projects that address preclinical, clinical, epidemiology, psychosocial, behavioural, health services, health policy and outcomes, and cancer control aspects of the disease. Candidates should be in the early stages of their careers with a minimum of two and a maximum of 10 years postdoctoral experience. (Funded by the American Cancer Society).
Application closing date: 1 December; Selection results: April the following year
Number of grants: 8-10 a year; Average value: US$ 40,000

Applications are encouraged for projects in the following fields/disciplines:
Epidemiology, biostatistics, registries; Biochemistry, molecular biology & biophysics; Virology; Carcinogenesis, environmental factors, prevention (incl. tobacco control); Cell biology & cell genetics; Pathology (incl. histopathology & cytology); Immunology; Experimental therapeutics; Surgery; Medical oncology; Paediatric oncology; Radiobiology & radiotherapy; Clinical trials; Detection, diagnosis, screening; Behavioural & psycho-social aspects, counselling;
Palliative care; Public health: policy, services, advocacy; Cancer information and education.

For the listing of fellows selected at this year's Spring selection, please visit for Yamagiwa-Yoshida Grantees: http://fellows.uicc.org/webyy102.shtml
Translations Research Fellows: http://fellows.uicc.org/tcrfav02.shtml
http://fellows. uicc. org/tcrfaz02.shtml
http://fellows.uicc.org/tcrtno02.shtml
ACS Beginning Investigators Fellows: http: //fellows.uicc.org/webacsbi02.shtml

For further information please contact:

Mrs Brita M. Baker
Head, UICC Fellowships Programme
International Union Against Cancer (UICC)
3 rue Conseil Général
1205 Geneva, Switzerland
E-mail: fellows@uicc.org
Tel: (4122) 809 18 40
Fax: (4122) 809 18 10
Or consult our website at http://fellows.uicc.org/

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WTP and PTW

Fishing in the stagnant waters of the 2nd Conference of the International Society of Geriatric Oncology (SIOG) held in Lyon, September 2001, I caught WTP, a brand-new oncological abbreviation. WTP stands for willingness to pay.

According to serious professional panelists "WTP appears to be an extremely useful tool in situations where *the choice is treatment versus no treatment*, for example where GCSF support enables chemotherapy to be administered" (emphasis added).

WTP has special features as "firstly increases significantly with both age and the income, and, secondly, evaluations of cost-benefit, quality of life measures and WTP are crucial for further developments in the management of elderly patients with cancer". I think that, as in Western societies elderly people's poverty declines whereas children's poverty rises, this suggestion hits exactly where the money is.

WTP triggered my old passion about clinical decision analysis (CDA), the core idea of which was initially developed for strategic war decisions during World War II and later on found in many commercial and medical applications.

Key features of CDA are utilities (patients' outcome values for various hypothetical scenarios) estimating risks and benefits on purely medical grounds.

WTP goes beyond ordinary utilities, creating a new necessity for a, let's say, money-based medicine.

However, patients are not always willing to follow data-driven suggestions and at least in two cases there is a very lazy motivation. So, in the first case, patients in bad condition are suffering sometimes from the "happy slave" syndrome. They develop an adaptive mechanism of acceptance and they are reluctant to promising but uncertain therapeutic options. In the second case, patients in rather good shape could be quite content and further small improvements of their fitness in "the hedonistic treadmill" do not mean so much to them. Sharing decisions with patients is not an easy task for one more reason: they usually retain only 20 per cent of what have been told. Anyhow, I am very skeptical about WTP because it predisposes a very laborious workout like estimations of patient's PS (purse situation) and all direct and indirect costs – including VAT of course – of diagnostic and therapeutic interventions. Perhaps the final solution could come through technology by a palm PC armed with algorithms with levels of evidence (key-feature of evidence-based medicine) and money estimations (key-feature of money-based medicine) resulting in a real individualized income-adjusted oncology.

Tailor-made oncology in another sense was also a bright highlight of another congress (12th International Congress on Anti-Cancer Treatment), held in Paris, February 2002. DNA-microarrays technique ("fingerprints" of patients' oncogenes compared with known oncogenes patterns of various prognoses) leads to custom-tailored treatment plans and replaces a one-size-fit-all approach to health care. Of course we have to wait for new clever drugs to come, because DNA-microarrays could be just another case of "knowledge pollution", which, according to Sir J.W. Black (Nobel laureate in Medicine, 1988) represents the greatest threat to science itself and to life. Until then, societies under the pressure of patients and trade are asked to pay, exhausting valuable resources for all questionable scientific innovations, in the name of marginal statistical benefit. Under these experimental conditions it is easily understandable how WTP is transformed into its trans equivalent PTW, which stands for "payment for trade's well-being".

At this point please allow me to cite W. Osler. Read the following keeping a bitter smile as "the practice of medicine is not a business and never be one .... Great monetary prosperity has weakened the influence of ideas and blurred the eternal difference between means and end". Fulfillment of life, for Osler's Christian ethic comes through self-sacrifice and not necessarily through personal wealth and health. Some fifty years later P.Rieff signifying the change of focus of contemporary ethic wrote: "the hospital is succeeding the church and parliament as the archetype institution of Western culture". I don't know if we are ready for that, but nevertheless, I have the feeling that we really have missed the point. In an area of self-concern, affluent, hedonistic, alienated for traditional values, with agony for eternal youth, patient care seen solely as biomechanical cure and death

considered as treatment failure, the sense of well-being has become - speaking in oncology terms – the primary endpoint instead of a secondary or even a surrogate endpoint of our personal trial on earth.

No doubt this lifestyle has great impact on our profession and eventually has weakened physicians' commitment to idealism.

Anyhow, your affirmative head-shaking could be very rewarding, but unfortunately we are in desperate search for the secret recipe to transform ideals into a world of practice and politics.

PS. My apologies for too many references in the paradox meta-analyses to Western culture. It is at least unfair to think about it as something very remote from us living in the Balkans.

Suggested reading

Guidelines for the use of growth factors in the elderly. Report from the 2nd Congress of SIOG. Oncology Rev 2001; 16 (Suppl): 1-4.

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Rieff P. Freud: The mind of the moralist. University of Chicago Press, 1979, Chicago.

Correspondence to:
Nicholas Karvounis, MD
Metaxa Cancer Hospital
Department of Medical Oncology-A
51 Botassi Street
185 37 Piraeus
Greece
E-mail: NicholasKarvounis@yahoo.gr