Letters to the Editor

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Knowledge of smoking health risks among Iraqi smokers

Corresponding Author:
Name: Omar Thanoon Dawood
Email: othd2000@yahoo.com

Dear Editor,

Smoking is a major public health problem around the world especially in developing countries. Despite smoking prevalence declining in many countries through tobacco control polices and interventions to increase awareness of its health risks, tobacco use is still widespread.[1] Knowledge of the health risks of smoking is an important factor in predicting smoking-related behaviour.[2] Increases in the perception of smoking risks are not always sufficient to reduce smoking on their own.[3] In the USA, increases in health knowledge are strongly associated with reductions in smoking, increases in cessation behaviour and long-term abstinence from smoking.[3,4] The majority of research on knowledge of the health risks of smoking has been conducted in Western countries; very little is known about the knowledge of risks effect of tobacco use among Iraqi smokers.

In the present study, self-administered questionnaires were distributed among 54 patients visiting the out-patient clinic of Tikrit Teaching Hospital during January 2013 in Tikrit city, Iraq. A convenience sampling method was used to recruit the participants in this survey. Patients over 18 and able to communicate with the researcher were invited to participate in the survey. Participants who smoked cigarettes daily were recruited in the survey regardless of their sex and social status. However, patients who declined to participate in the survey, those who suffered cognitive impairment and/or could not complete the interview were excluded. Approval for this study was obtained from the Medical Committee of Tikrit Teaching Hospital. The researchers explained the aim of study to all participants and a signed consent form was obtained from them before interviews. The questionnaire was adapted from the International Tobacco Control questionnaire. The questionnaire was translated into Arabic and the face and content validity were checked by tobacco control experts to ensure the accuracy of the questionnaire. The Arabic version of the questionnaire used close-ended questions. All respondents were current smokers at the time of recruitment. Socio-demographics data were obtained to determine participants' age, sex, education level, monthly income and suffering from chronic diseases. The heaviness of smoking was assessed depending on the number of cigarettes smoked per day and coded as 0=1-10, 1=11-20, 2=21-30, 3=more than 30 cigarette per day. Participants asked whether they knew or believed that smoking may or may not causes stroke in smokers, impotence in male smokers, lung cancer in smokers, decay in the lungs of smokers, stained teeth in smokers, premature ageing, and lung cancer in non-smokers from second-hand smoke. Responses coded as 0=no/don't know versus 1=yes. Quitting intentions was measured by 'Are you planning to quit smoking?' with the response options within the next month and within the next six months coded as positive intention, while sometime in the future and not planning to quit coded as no intention. The questionnaire was handed to all respondents to fill in immediately and returned upon completion. Out of 60 respondents, the majority (90%) successfully completed the questionnaire. The mean age of respondents was 40.3 years (range: 20-60). The majority of participants (92.6%) were males. The education levels of the respondents were low: primary/secondary (33.3%), medium: high school/institute (29.6%) and high: college and above (37.1%). In addition, the monthly income levels were low (48.1%), moderate (24.1%) and high (27.8%). Regarding health status, 20.4% reported having a chronic disease. According the heaviness of smoking over two-thirds (70.4%) of respondents were heavy smokers, reporting to smoke more than 20 cigarettes per day. The results suggested that a majority of respondents knew that smoking may cause lung cancer (88.9%) and decay in the lung (90.7%). Similarly most said that smoking can lead to stained teeth (85.2%), and premature aging (75.9%). Fewer were aware of the risk of stroke (66.7%) and fewer still about impotence in males (55.6%). In contrast, only a minority of respondents knew that smoking can cause lung cancer to non-smokers from second-hand smoke (25.9%). Pertaining to quit intentions, most respondents had no intention of quitting; only 13% reported the intention to quit in the next six months and 3.7% in the next month. Intentions to quit are also very low among Iraqi smokers comparing to other developing countries such as Malaysia (55.5%) and Thailand (40.3%).[5] This study has a number of limitations. Firstly we only

sampled adult smokers over 18-years-old so responses might not reflect the awareness of possible health risks of smoking and smoking behaviour in adolescents. A convenience sampling method was used to recruit the sample; this sampling method is likely to have contributed biases into the study. Furthermore, the survey was conducted in Tikrit city and the responses may or may not represent all smokers in the country. The questionnaire used closed-ended questions to obtain the data by ticking the answer. This method may have inflated the rate of awareness in the study. Acknowledging these limitations, knowledge seems fairly high for many health conditions. However, awareness of the risks of second-hand smoke is very low and this could be used to persuade more Iraqi smokers to quit. Health care professionals should play an active role in educating their patients about the risks of tobacco use. Anti-smoking programs are needed to disseminate information about the risks of second-hand smoke and the health benefits of quitting smoking.

Sincerely

Omar Thanoon Dawood,[1] Mohammed Abd Ahmed Rashan,[2] Rahmat Awang,[3] Maizurah Omar[4]

[1] M.Sc. of Social and Administrative Pharmacy, National Poison Centre, Universiti Sains Malaysia, Penang, Malaysia

[2] F.I.C.M.S, Specialist of internal medicine, Department of Internal Medicine, Tikrit Teaching Hospital, Tikrit, Iraq

[3] Pharm D, Clearing House for Tobacco Control, National Poison Centre, Universiti Sains Malaysia, Penang, Malaysia

[4] Clearing House for Tobacco Control, National Poison Centre, Universiti Sains Malaysia, Penang, Malaysia

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A family with Waardenburgh syndrome

Corresponding Author:
Name: Yogendra Singh Verma
Email: drvermayogendra@yahoo.co.in

Dear Editor,

Waardenburg syndrome (WS) is a rare cause of hereditary hearing loss. It is named after the Dutch ophthalmologist Petrus Johannes Waardenburg, who in 1947 first described WS type I[1] and in 1971 Arias defined the phenotype of WS type 2 (WS2), which includes all of the WS1 features except dystopia canthorum.[2] We report three cases from the same family with all features of WS. Prior written consent was obtained from the family in question to use their images and information. We also looked for other systemic abnormalities.

A 9-year-old girl admitted to this hospital for acute upper respiratory infection was found to have heterochromia of the iris, lateral displacement of inner canthi (dystopia canthorum), hypertrichosis of eyebrows (synophrys), pigment disturbances included a white forelock, dental aberration and a patch of Hypopigmentation of skin of leg. She also had mild sensorineural hearing deficit. A hearing loss of 40 dB at dB HL (hearing level) scale was found on puretone audiometery. Visual acuity and fundus examination of eyes was normal. Anthropometric measurements were normal for her age. A systemic examination revealed no other abnormal findings. Hematological tests were all normal with Hb at 11.5gm, TLC-9400/mm^3 and Platelet count at 2.5 lakhs. Other red cell indices and WBC morphology were reportedly normal. No abnormality in biochemical tests including renal and liver function test was noted. Ultrasound of the abdomen was normal. We also examined her brother and mother both of whom showed similar findings indicating the hereditary nature of the condition however heterochromia of the iris was absent in the mother. The father was unaffected. Family history showed that maternal aunt and grandfather were both reported to be affected.

The overall incidence of WS is approximately 1/42,000 to 1/50,000 people. Types I and II are the most common, whereas types III and IV are relatively rare. About 1 in 30 students in schools for the deaf have WS. There are five major and five minor diagnostic criteria for WS. Major criteria include sensorineural hearing loss, iris pigment abnormality, dystopia canthorum (lateral displacement of inner canthi), hair hypopigmentation (white forelock or white hairs at other sites on the body), and a first-degree relative previously diagnosed with WS. Minor criteria include medial eyebrow flare (synophrys), skin hypopigmentation (congenital leukoderma/white skin patches), broad nasal root, hypoplasia alae nasi, premature graying of the hair (before age 30). Both the auditory and the pigment abnormalities of WS can be explained by a failure of melanocyte differentiation. Melanocytes are required in the stria vascularis for normal cochlear function. With the exception of those in the retina, melanocytes are derived from the embryonic neural crest. Genes responsible for syndromic forms of hearing loss in WS include PAX3 on band 2q37. PAX3 belongs to a family of paired-domain proteins that bind DNA and regulate gene expression, observed in types I and III, and MITF gene mapped on band 3p12-p 14.1, WS2B gene on1p21-p13.3 and WS2C gene mapped on 8p23 for type II. WS is autosomal dominant for most persons with types I, II or III. WS type IV is autosomal recessive with variable penetrance and is due to SOX10 or endothelin-B receptor (EDNRB) gene mutations, which appear to correlate with the intestinal and/or neurological symptoms manifested in patients.[3, 4] Many affected families have been reported from India as well.[5, 6]

The life span of subjects with WS is reported to be normal. In this family all three subjects had typical features of this syndrome although differed in various symptoms. All major symptoms were present in both children including sensorineural hearing loss, iris pigment abnormality, white forelock or white hairs at other sites on the body) and dystopia canthorum. First-degree relative (mother) was also diagnosed with WS. It is not necessary for all family members to have the same features. Both the siblings had different eyes affected. The presence of different manifestations of WS in different combinations in the other family members of the first patient represented the well-known variable expressivity of the disease. Our case series also emphasises the importance of examination of all the family members to identify undiagnosed cases. No other systemic complication was noted. There is currently no treatment or cure for WS. The symptom most likely to be of practical importance is deafness, and this is treated as any other irreversible deafness would be. In marked cases there may be cosmetic issues.

Figure 1: Siblings showing heterochromia of the iris, lateral displacement of inner canthi (dystopia canthorum), hypertrichosis of eyebrows (synophrys), pigment disturbances including a white forelock

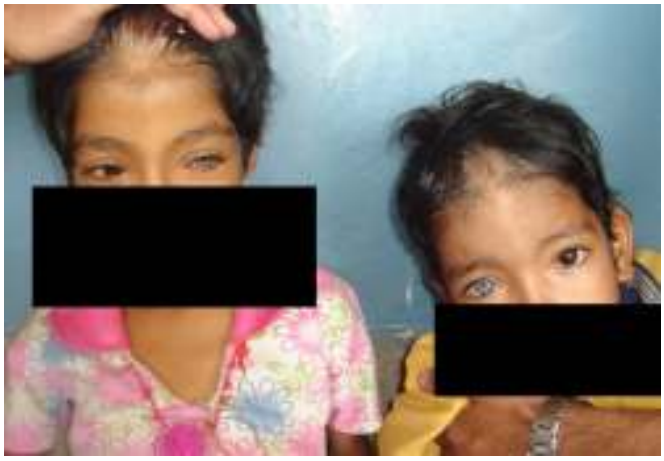
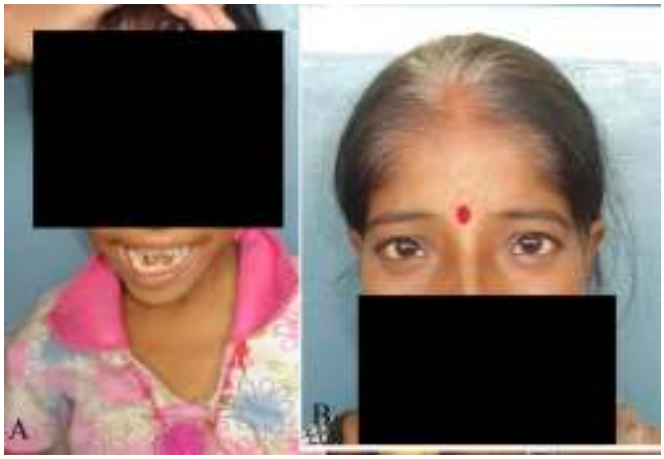


Figure 2a: girl with dental aberrations. Figure 2b: Mother showing absence of heterochromia of the iris, lateral displacement of inner canthi (dystopia canthorum), hypertrichosis of eyebrows (synophrys), pigmentary disturbances including a white forelock.



Sincerely

Yogendra Singh Verma, Neelam Rajput
Kamla Raja Hospital and Gajra Raja Medical College,
Gwalior, Madhyapradesh, India

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