

## Quitting Smoking an Social Equity

### To the Editor:

We completely agree with the editorial by López García-Aranda<sup>1</sup> published in the November 2001 issue of the *REVISTA ESPAÑOLA DE CARDIOLOGÍA*, in which he concludes that there is no justification for a passive or less than diligent attitude toward smoking in cardiac patients. Recent results from the EUROASPIRE study,<sup>2</sup> which involved various European countries, indicated that 21% of patients with ischemic heart disease continued to smoke 6 months after hospital admission in 1999 (19% in 1995). In Cataluña these percentages were increased by 12% in 1995 by 18% in 1999, while the Spanish group in the PREVESE study<sup>3</sup> showed that only 9.5% of patients with heart disease continued to smoke. The EUROASPIRE study also showed that while 16% of coronary bypass surgery patients continued to smoke 6 months after surgery, this number increased to 26% in patients who had suffered an acute myocardial infarct and 22% in those who underwent angioplasty. We believe that these numbers indirectly show the general passivity that exists regarding smoking in some portions of the medical community. In addition to the epidemiologic evidence, the negative biological effects of cigarette smoke have been widely demonstrated.<sup>4</sup>

Nevertheless, the main reason we are writing this letter is to call attention to the fact that the occurrence of smoking is not homogenous among the populace. The results of the MONICA study in Spain show that, as in many other countries, the prevalence of smokers has a direct inverse relationship to education: in 1996, 33% of university-educated men smoked vs 53% of those with a high school education.<sup>5</sup> There are multiple reasons for these social differences, and their analysis was the objective of this letter, but it is important to remember that the origin and perpetuation of smoking go beyond than simple intellectual knowledge or lack of knowledge of the negative effects of tobacco on health.

The smoking cessation is not easy, as Morchon et al<sup>6</sup> showed in the article that motivated the López García-Aranda editorial, given that it requires a sustained effort over many months. The results of a 1980 multifactorial collaborative Study coordinated by the World Health Organization,<sup>7</sup> clearly showed that smoking cessation is feasible and easier to achieve in high risk patients due to the motivation of loss of health. But this study also showed another 2 aspects which are important in our opinion: first that results achieved are inversely proportional to the effort and the resources available, and second that in Spain and Poland, 2 countries which participated in the study with adverse social circumstances, results were less spectacular with smoking cessation than in the remaining countries.

Therefore, it is essential to be aware of the social

situation of our patients in order to keep this in mind when arranging an interventional course for decreasing cardiovascular risk by smoking cessation. This is imperative and must be considered among the risk factors and treated with the same intensity and dedication as that which cardiology applies to control of the heart disease symptoms. The creation of cardiac rehabilitation units staffed by multidisciplinary personnel would without a doubt help achieve these preventative objectives, but it is vital that these units be available as part of public health in order to assure that service is provided to those who need it most and to avoid the errors which have occurred in other countries.<sup>8,9</sup>

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