Original Article

Smoking Reasons

Smoking Among Patients Attending Chest Department Bahawal Victoria Hospital, Bahawalpur

Somia Khan[1], Muhammad Ahmad[2] and Arbab Anwer[3]

ABSTRACT

Objectives: Objectives of Our Study were to know the frequency of smokers attending the chest outpatient department and chest ward and determine the reasons of smoking.
Study Design: Cross Sectional Study
Place and Duration of Study: This study was conducted at Chest Ward and Chest OPD of BV Hospital Bahawalpur from 18th May to 5th June 2016.
Materials and Methods: Sample of 100 patients were taken by using non-probability sampling technique. Patients of all ages and both sexes were included and Unwilling patients were not included. It was descriptive cross sectional epidemiological study. Data Collection Procedure: The data was collected by means of a preformed questionnaire. The Patients were interviewed by the researchers themselves. Data was analyzed by SPSS 20 and frequencies were calculated and presented in the form of Tables.
Results: In the study it was found that the frequency of smokers attending the chest outdoor & chest O.P.D was 59%. This study showed that 30% of smokers had been smoking for more than 30 years while almost 7% were smoker for more than 40 years. This study showed that 20.3 % of smokers started smoking to relieve depression, 28% due to peer pressure another 19% for fashion, 12 % for copying elders and 21% gave other reasons
Conclusion: It was concluded that smoking was quite prevalent in the patients attending the chest OPD and chest ward. Efforts should be made at community level as well as individual level to control and prevent smoking.
Key Words: Patients; Chest ward; Smoking; Respiratory disease

Citation of article: Khan S, Ahmad M, Anwer A. Smoking Among Patients Attending Chest Department Bahawal Victoria Hospital, Bahawalpur. Med Forum 2016;27(11):54-56.

INTRODUCTION

Although people have used tobacco for centuries, cigarettes did not appear in mass-manufactured form until the 19th century. Since then, the practice of cigarette smoking has spread worldwide on a massive scale and now cigarette smoking is the leading cause of preventable death and disease in the US.[1] Smoking accounts for majority of lung cancer cases and it is an important risk factor for cardiovascular disease.[2] In addition, a recent panel of experts concluded that smoking is even more deleterious than previously thought for both smokers and those exposed to environmental tobacco smoke , causing cancer in many more organs of the body than previously believed.[3] Further; many youths underestimate the risk of addiction and health consequences of smoking.[4]

The role of smoking in causing respiratory diseases is mainly by way of producing airway hyper-responsiveness.[5-6] Airway hyper-responsiveness is the sensitivity of the airways to a variety of pharmacological and physical stimuli that induce bronchoconstriction.[7] It is associated with an increased risk of developing respiratory symptoms and asthma and more rapid than normal decline in lung function. Its presence worsens the prognosis of patients with chronic obstructive pulmonary disease (COPD), which is in turn associated with increased mortality.[8]

The World Health Organization estimates that approximately 5 million people die each year worldwide from tobacco related illnesses. If current trends continue, this figure will rise to about 10 million per year by 2025. Worldwide approximately 1.3 billon people smoke cigarettes or other tobacco products, almost one billion men and 250 million women.[9] Tobacco consumption is one the rise in Pakistan but Pakistan lacks any authentic data on cigarette-related diseases and deaths. Rough estimates suggest that tobacco causes around 100,000 deaths annually, according to a report by the Tobacco Free Initiative-Pakistan [TFI-P]. [10]

The aim of this study was to determine the prevalence of smoking and its patterns in patients attending Chest OPD and Chest Ward at Bahawal Victoria Hospital, Bahawalpur which provided an opportunity to gain insight into how and when these patients started smoking, the duration for which they smoked and what methods they used.

[1.] Department of Gynae & Obs / Surgery[2] / Medicine[3], THQ Taunsa Sharif, D.G. Khan.

Correspondence: Dr. Somia Khan, WMO, Department of Gynae & Obs, THQ Taunsa Sharif, D.G. Khan
Contact No: 0333-6413083
Email: drsomiakhan@gmail.com

Received: August 17, 2016; Accepted: September 29, 2016

MATERIALS AND METHODS

This Cross Sectional Study, conducted at chest ward and chest OPD of BV Hospital Bahawalpur, from 18th May to 5th June 2016. Sample of 100 patients were taken by using non-probability sampling technique.

Patients of all ages and both sexes were included and Unwilling patients were not included.

It was descriptive cross sectional epidemiological study. Data Collection Procedure: The data was collected by means of a preformed questionnaire. The Patients were interviewed by the researchers themselves.

Data was analyzed by SPSS 20 and frequencies were calculated and presented in the form of Tables.

RESULTS

In this study it was found upon cross tabulation & subsequent CHI-Square test application that the age has no significant relationship with smoking (Table 1). Also age distribution among smokers showed that 71% of the smokers were in between the age group, above 40 years.

On application of chi square on sex distribution it was found that cigarette smoking had a strong gender association with males (Table 2).

In this study it was found that socio economic status had no effect on whether a person was smoker or not (Table 3). Test of significance revealed that education & smoking association was insignificant (Table 4). This study showed that married people were more prone to smoking (Table 5).Residential status had no effect on the distribution of smokers. In this study it was found that smoking was more prevalent 51% in persons with urban background than in rural population.

Table No.1: Age distribution among smokers and non-smokers

Age	Smokers	Non-Smokers	Total
Below 20	0	7	7
20-40	17	13	30
Above 40	42	21	63
Total	59	41	100

X^2=15.05 d.f=2 P<0.05 (Significant)

Table No. 2: Sex distribution among smokers and non-smokers

Sex	Smokers	Non-Smokers	Total
Male	52	21	73
Female	7	20	27
Total	59	41	100

X^2=19.16 d.f=1 P<0.05 (Significant)

In the study it was found that the frequency of smokers attending the chest outdoor & chest O.P.D was 59%. This study showed that 30% of smokers had been smoking for more than 30 years while almost 7% were smoker for more than 40 years. Majority of smokers 54% smoked up to 1 pack daily, 16.9% of smokers smoked more than one pack daily.

This study showed that 20.3 % of smokers started smoking to relieve depression, 28% due to peer pressure another 19% for fashion, 12 % for copying elders and 21% gave other reasons.

Table No. 3: Socio-economic status among smokers and non-smokers

Earning	Smokers	Non-Smokers	Total
< 5000	37	25	62
5000-10,000	20	12	32
>20,000	4	2	6
Total	61	39	100

X^2=8.5 d.f=2 P<0.05 (Significant)

Table No. 4: Education status among smokers and non-smokers

Education Status	Smokers	Non-Smokers	Total
Illiterate	42	25	67
Middle	10	13	23
Matric	7	3	10
Total	59	41	100

X^2=8.06 d.f=2 P<0.05 (Significant)

Table No. 5: Marital status among smokers and non-smokers

Marital Status	Smokers	Non-Smokers	Total
Married	56	33	89
Unmarried	3	8	11
Total	59	41	100

X^2=9.67 d.f=1 P<0.05 (Significant)

DISCUSSION

The results of this study can be compared with nationally and internationally published data, but the variations were due to differences in population characteristics & geographical settings.

A study carried out in Karachi showed that 4.3 55% of citizens were indulged in smoking.[11]

In Peshawar University in 2005, 27% of students are found smokers out of which 5% were females.[12]

The frequency of smoking in our study was 59% of the percentage of female smokers was

12.5%. The frequency of smokers in our study was almost comparable to the one conducted in Karachi.

Frequency of smokers in our study was quite high as compared to the frequency found in the students of Peshawar University. The probable reasons were their higher educational status and their increased knowledge regarding the hazards of smoking. In our study most of the people were either uneducated or had just completed primary education.

The percentage of female smokers in both the studies was similar. Internationally, a study was carried out on Chinese-Filipino American adults.[13] The smoking

prevalence was lowest among Chinese (14%), followed by non-Hispanic whites (19%), African Americans (22%), Filipino Americans (24%), American Indians/ Alaska Natives (29%) pacific islanders (32%).[14] A Brazilian study in general hospital in patients showed 21% of patients were smokers. A study conducted on Irani Population showed current prevalence of smoking in males and females as 18.8% and 1.2%.[15]

These values regarding the frequency of smokers in different countries were quite low as compared to our study. The probable reasons for these variations were lack of education, lack of health education and lack of awareness regarding the hazards of smoking in our country.

CONCLUSION

It was concluded that smoking was quite prevalent in the patients attending the chest OPD and chest ward. Efforts should be made at community level as well as individual level to control and prevent smoking.

Conflict of Interest: The study has no conflict of interest to declare by any author.

REFERENCES

1. World Health Organization. The World Health Report 2002: Reducing Risks, Promoting Healthy Life. Geneva: WHO; 2002.p.1–248.
2. Jha P, Chaloupka FJ, Corrao M, et al. Reducing the burden of smoking world-wide: effectiveness of interventions and their coverage. Drug Alcohol Rev 2006;25:597–609.
3. Lo nnroth K, Raviglione M. Global epidemiology of tuberculosis: prospects for control. Semin Respir Crit Care Med 2008;29:481–491.
4. World Health Organization. Why is tobacco a public health priority? 2009. www.who.int/ tobacco/healthpriority/en/index. html Date last accessed: October 27, 2009; Date last updated: 2009.
5. Janes DF, Timens W, Karan J, Rijcken B, Postma DS. Asymptomatic bronchial hyper responsiveness and Asthma, Respair Med 1997;91:121-134.
6. Hopp RJ, Townley RG, Biven Re, Bewtra AK, Nair NM. The presence of airway reactivity before the development of asthma Am Rev Respir Dis 1990;2-8.
7. XU X, Rijken B. Schouten JP, Weiss ST. Airway responsiveness and development and remission of chronic respiratory symptoms in adults. Lancet 1997;350 1431-34.
8. Postma DS, Rijcken B. The role of atopy and hyperresponsiveness in the development ofCOPD, Eur Respir Rev 1997:7:159-62.
9. World Health Organization. A WHO/The Union Monograph on TB and Tobacco Control: Joining efforts to control two related global epidemics. Geneva, WHO 2007.
10. Postma DS, wempe JB, Renkena TEJ, Van Der Mark TW, Koeter GH, hyper responsiveness as determinant of the outcome in COPD, Am Rev Respair Dis 1991;143:1458-62.
11. CDC. Cigarette smoking among Chinese, Vietnamese and Hispanics-California, 1989-1991 Mortal Wkly Rp 1992;362-7.
12. Slama K, Chiang CY, Enarson DA, et al. Tobacco and tuberculosis: a qualitative systematic review and meta-analysis. Int J Tuberc Lung Dis 2007;11: 1049–1061.
13. Gorber SC, Schofield-Hurwitz S, Hardt J, et al. The accuracy of self- reported smoking: a systematic review of the relationship between self-reported and cotinine-assessed smoking status. Nicotine Tob Res 2009;11:12–24.
14. Langhammer A, Johnsen R, Holmen J, et al. Cigarette smoking gives more respiratory symptoms among women than among men. The Nord-Trondelag Health Study (HUNT). J Epidemiol Comm Health 2000; 54: 917–922.
15. vanWalbeek C. Recent trends in smoking prevalence in South Africa – some evidence from AMPS data. S Afr Med J 2002; 92: 468–472.