Doctors campaign for ban on smoking in enclosed public places

Kay McIntosh *London*

A campaign for a total ban on smoking in all enclosed public places in England has been launched by a coalition of medical organisations and health charities. Smokefree Action, set up this week by the BMA, the Royal College of Physicians, and five charities, warns that the government's proposed partial ban has not gone far enough.

John Britton, chairman of the royal college's tobacco advisory group, said: "The coalition is making clear the extent of support throughout the whole health professional community for radical leadership on tobacco policy." He said it was "frustrating that in the face of strong advice from health professionals and the chief medical officer we seem to be the slowcoaches of the UK in England in introducing good tobacco policy."

The government's proposals for England would ban smoking in enclosed public places except pubs and clubs that do not serve

food (*BMJ* 2005;330:1468). Up to 30% of licensed premises would be exempt. In contrast Scotland will introduce a complete ban in all pubs and enclosed public places in 2006. The Welsh Assembly is also set to introduce a complete ban.

Professor Alex Markham, chief executive of Cancer Research UK, said: "A comprehensive ban on smoking in enclosed public places, without exceptions, is the only practical way we can give workers the protection they deserve."

The new campaign group will ensure that medical organisations and health charities campaigning against smoking speak with a single voice, he added. "We all agree on the simple message that secondhand smoke kills and exposure in the workplace is unacceptable."

Smokefree Action, whose members include Action on Smoking and Health (ASH), Asthma UK, the National Heart Forum, the British Heart Foun-

dation, and the Chartered Institute of Environmental Health, is launching a summer of campaigning as the government consults on its proposals. Members are set to meet the health minister Caroline Flint next week to press their case. Further action will include publishing medical research on passive smoking, economic research on the effect of a ban on the pub industry, and legal action to support employees who are seeking damages for workplace expo-

sure to environmental tobacco.

Professor Britton criticised the government for "failing to lead by example" by waiting until 2006 before making all NHS premises smoke free.

Research unveiled by the campaigners this week shows that 75% of local councils in England have failed to take action on smoking beyond a ban in their own buildings.

For more information see www.smokefreeaction.org.uk.

Peter Moore, aged 74, from Cavan, Ireland, enjoys a cigarette in a pub the day before the smoking ban came into effect in Ireland last year. Now doctors in England want their country to follow Ireland's lead

Study highlights insensitivity of PSA screening

Susan Mayor *London*

Many prostate cancers, including high grade tumours, can be missed when the prostate specific antigen (PSA) test is used in screening, even when the concentration of PSA at which further investigations are carried out is set low.

New research shows that there is no specific cut-off concentration for PSA below which the risk of prostate cancer is zero. The large follow-up study has showed a continuum of risk at all concentrations of PSA (*JAMA* 2005;294:66-70). It confirmed previous concerns about the value of PSA testing, with no studies showing that it reduced prostate cancer mortality.

The study analysed data from 8575 men in the placebo group of the prostate cancer prevention

trial, a study of nearly 19 000 healthy US and Canadian men aged 55 years or older who don't have prostate cancer and with PSA concentrations ≤ 3 ng/ml and whose results of digital rectal examination were normal.

The men were followed up for seven years and had annual measurement of PSA and digital rectal examination. A prostate biopsy was recommended if their PSA concentration exceeded 4 ng/ml or results of rectal examination were abnormal.

Nearly two thirds of them (5587 or 65%) had at least one biopsy. Of these, just over a fifth (1225) received a diagnosis of prostate cancer (14% of the whole placebo group).

In the 1213 cases of cancer in which the Gleason grade was recorded, 250 (21%) were recorded as Gleason grade 7 or higher and 57 (5%) were Gleason grade 8 or higher.

Results showed that with the commonly used cut-off value for PSA of 4.1 ng/ml (above which a prostate biopsy is generally done) only 21% of cancer cases

would have been detected (the sensitivity) and that the false positive rate (specificity) was 6.2%.

Lowering the cut-off value to 1.1 ng/ml would have detected 83.4% of cancer cases but would have resulted in 61% of men without cancer having a biopsy. Overall the results showed that there was no single cut-off concentration that would simultaneously yield both high sensitivity and high specificity.

PSA thresholds of 2.1 and 3.1 ng/ml yielded sensitivities of 53% and 32%, respectively, and specificities of 73% and 87%.

The lead researcher, Ian Thompson, who is the Henry B and Edna Smith Dielman Memorial Professor in Urologic Science at the University of Texas Health Science Center at San Antonio, said: "There is no cut-point of PSA with simultaneous high sensitivity and high specificity for monitoring healthy men for prostate cancer, but rather a continuum of prostate cancer risk at all values of PSA."

"The implications of this analysis are substantial. Prior to

clinical use of biomarkers or other tests for cancer screening, properly designed validation studies are essential."

The fact that many prostate cancers, including high grade tumours, are missed at low PSA concentrations could explain the discrepancy between the high rate of PSA screening over the past 15 years and the lack of reduction in prostate cancer mortality in the United States, Professor Thompson said.

He concluded: "Patients and healthcare professionals must be re-educated that there is a continuum of risk and no clearly defined PSA cutpoint at which to recommend biopsy. It will be the patient, in concert with his healthcare professional, who will ultimately have to weigh the sensitivity-specificity trade-offs in combination with the uncertain natural history of the disease to determine whether further evaluation with a prostate biopsy is appropriate."

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