Smoking makes Marlboro cowboy 'unfit'

To the Editor—In addition to dying from lung cancer and suffering from coronary artery disease, it is also likely that the Marlboro cowboy is impotent and infertile.

Adverse effects of smoking on male sexual health include erectile dysfunction, reduced volume of ejaculate, lowered sperm count, abnormal sperm shape, and impaired sperm motility.[1,2] Smoking has been shown to increase the risk of erectile dysfunction by about 50% for young men in their thirties and forties.[1] The Action on Smoking and Health, an anti-tobacco lobby group, and the British Medical Association estimated that up to 120 000 British young men were impotent as a direct consequence of smoking.[3] According to the same study, 88% of male smokers did not realise that smoking could cause impotence.[3] Anecdotally, we speculate that this number is probably even higher in Hong Kong.

As a result of the Problem-based Learning in Public Health Module in the Year III undergraduate clinical programme at the University of Hong Kong, we have produced a poster geared at Hong Kong's young people to warn them of the real risk of smoking-related impotence and infertility (Fig). This may be as powerful a message as any in deterring teens from starting to smoke and in getting young smokers to stop 'lighting up'.

Fig. Smoking makes Marlboro cowboy 'unfit'

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Non-melanoma skin cancer in Hong Kong

To the Editor—We read with interest Cheng et al's[1] article on non-melanoma skin cancer (NMSC). This is an issue that has a potentially significant impact on health care provision. We are confused, however, about the source of the quoted incidence figures for basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) in Cheng et al's paper. Hong Kong Cancer Registry data details the incidence of NMSC, but not the incidence of BCC's or SCC's individually.[2]

Cheng et al's is a clinic-based, not a population-based study. As such, the data quoted falls short of representing the territory's true incidence. On this basis, the data is, at best, their clinical impressions. In order

to transform impressions into statistically meaningful figures, well-designed population-based epidemiological studies are needed. We undertook a 10-year retrospective review of patients presenting to the Prince of Wales Hospital, Shatin, with BCC. All cases of BCC between 1990 and 1999, recorded on the pathology database at the Prince of Wales Hospital were identified, and the medical records and histology reviewed. Of 184 such patients, 164 had distinctive Chinese names, indicating Chinese ethnic origin.

We determined a catchment population of just over 1 million, using Hospital Authority information, which gave an incidence figure of approximately 1.5 cases per 100 000. The sex ratio was equal, age of presentation later than in Caucasian studies, and the majority of BCC's were found to occur in the head and neck region. The major criticism of our study is that, like Cheng et al's study, it is not population-based. In Cheng et al's paper, the quoted incidence of BCC among the Hong Kong Chinese population in 1999 of 0.92 per 100 000 is significantly lower than our findings. A true population-based study may indicate an incidence even higher than determined by our study.

Incidence figures are important in public health terms, for rationalising resource allocation for both prevention and treatment. The fact is that we do not have accurate incidence figures for Hong Kong. Registration is the key.[3] The incidence of BCC is reported in Cheng et al's paper to be increasing. Lifestyles in Hong Kong are changing, and the increase in incidence of BCC indicated in this article is a cause for concern.[4] Causes and predisposing factors for BCC in Chinese patients need to be explored.

Although existing data is incomplete, both our own, and Cheng et al's study, suggest that major differences exist between Chinese and Caucasian populations regarding BCC. Could such differences be due to genetic or environmental factors?

Recent breakthroughs in molecular biology provide a better understanding of the pathogenesis of BCC. Hedgehog pathway mutations have been linked to the pathogenesis of BCC, and Lam et al[5] have identified one such mutation which occurs more frequently in Chinese patients. The precise mechanisms of environmental and genetic influences, however, remain unclear.

In order to further our understanding of BCC and other NMSCs, with a view to implementing effective prevention and treatment strategies, we agree with Cheng et al that the priority has to be the establishment of a territory-wide comprehensive skin cancer registry.

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A case of phenacetin-induced skin cancer in Hong Kong

To the Editor—I read with interest the article on non-melanoma skin cancer in Hong Kong.[1] It recalled memories of a patient I treated 20 years ago.

This patient, a Chinese merchant, aged 70 years, presented with several small lumps in the skin of both hands. Excisional biopsy of each lesion identified squamous cell carcinoma. As the lesions kept recurring, requiring many further sessions of cryosurgery, the suspicion of constant exposure to a carcinogen was raised. Eventually, the patient admitted that he was the manufacturer of a well-known 'traditional Chinese medicine' for rheumatic bone and joint pain. The principal active ingredient was phenacetin, which he had learnt about from past study of western pharmacology—including its toxicity and carcinogenicity. In spite of my repeated earnest pleas to the contrary, the patient was convinced that the reward from phenacetin