



# Community & Hospital Letter

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## Smoking Restriction Survey, KCMO 2006

The Kansas City Health Department's Tobacco Use Prevention Program contracted with locally based ETC Institute to conduct a social behavior survey on tobacco restrictions. Its primary purpose was to gather input from residents about the potential impact of smoking restrictions at restaurants and bars in Kansas City.

Some of the specific issues in the survey included:

- The frequency that residents visit different types of dining establishments;
- Issues that were most important to residents when they are selecting a place to dine;
- Type of seating preferred by residents (smoking vs. non-smoking);
- Willingness of residents to sit in another section if the type of seating they prefer is not available;
- How residents thought the frequency they visit full-service restaurants would change if smoking restrictions were implemented at full-service restaurants;
- How residents thought the frequency they visit bars and taverns would change if smoking restrictions were implemented at bars and restaurants;

**Residents preferred non-smoking areas by an overwhelming margin.**

**Many residents would eat at restaurants more often if smoking was restricted.**

**Many residents would visit bars and tav-**

erns in the City. Approximately 7 days after the surveys were mailed, residents who received the surveys were contacted by phone. Those who indicated that they had not returned the survey were given the option of completing it by phone.

Of the 1,500 surveys, 700 were completed (203 by phone, 497 by mail). Smokers comprised 15.4% of respondents (20.3% of the weighted sample). The major findings are given below.

As expected, the "type of food offered" was the most important issue to residents when selecting a place to dine.

One of the interesting findings, however, was that "how well smoking sections are separated from non-smoking sections" tied with "cost" as the second most important factor. Residents placed significantly more importance on having separate areas for smoking than they did on

other factors such as location and how quickly they are served. Also, less than one-third or 29% of the smokers surveyed selected the "ability to smoke" as one of the most important factors that influence where they dine.

Seventy-five percent (75%) of those surveyed indicated that they typically request "non-smoking" areas for seating; only 12% indicated they typically request "smoking" areas; 12% indicated they request the "first available" area, and 1% did not have an opinion.

Thirty percent (30%) of those surveyed indicated that they would eat at full-service restaurants more often if smoking restrictions were implemented; only 13% indicated that they would eat at full-service restaurants less often; 55% did not think smoking restrictions would affect the frequency that they dine at full-service restau-

- Whether residents had worked in restaurants or bars that allowed smoking and the perceived impact of working in such an environment on the person's health

In October 2006, the survey was mailed to a randomly selected sample of 1,500 households



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rants and 2% did not have an opinion.

Twenty-six percent (26%) of those surveyed indicated that they would visit bars and taverns more often if smoking restrictions were implemented; 15% indicated that

they would visit bars and taverns less often; 51% did not think smoking restrictions would affect the frequency that they visit bars and taverns, and 8% did not have an opinion.

## Obesity Causes May Be Varied

Obesity prevalence in the United States has been increasing for at least 100 years, with an apparent acceleration in the past 3 decades. Reduced physical activity and specific food manufacturing and marketing practices comprise the Big Two explanations for the epidemic. As such, they are the target of potential public health interventions. Yet, the evidence of their role as primary causes of the obesity epidemic is both equivocal and largely circumstantial. So are there additional explanations for the increase in obesity?

Ten putative contributors to the increase in obesity have been suggested by a group of international obesity experts (*Inter J Obesity* 2006;30:1585-1594). These include: sleep deprivation, endocrine disruptors, reduction in variability in ambient temperature, decreased smoking, pharmaceutical iatrogenesis, changes in distribution of ethnicity and age, intrauterine and intergenerational effects, greater BMI is associated with greater reproductive fitness yielding selection for obesity predisposing genotypes, and assertive mating and floor effects. For more detail on these possible contributors, the reader is referred to the free article online that is cited above. Here we will take a quick look at some of the reasoning for each item.

Sleep deprivation alters metabolism. Leptin, the hormone that signals satiety, falls while ghrelin, which signals hunger, rises and this, boosts appetite. In other words, sleep deprived people are hungrier than people who get 8 or more hours of sleep each night. In 1960, people in the US slept an average of 8.5 hours per night, but by 2002 this had declined to less than 7 hours. The decline in average sleep duration mirrors the rise in obesity.

When humans consume chemicals that are endocrine disruptors there is interference with the functioning of hormones such as estrogen. When estrogen is not functioning properly, deposition of fat increases. The expo-

sure of the population to endocrine disrupting chemicals is on the rise.

Shivering and sweating burn calories, and high temperatures reduce the amount of food people eat. As we normalize the temperatures to which we are exposed we burn less metabolic energy. Obesity rates are highest in the southern states where the largest percentage of homes and work places are air conditioned.

Smokers tend to be thinner than non-smokers and smokers who quit tend to gain weight. Nicotine is an appetite suppressant and appears to raise your metabolic rate. The National Center for Health Statistics estimated that about 20% of the national increase in obesity between 1978 and 1990 was due to people giving up smoking (*N Engl J Med* 1995;333:1165-1170).

Neuroleptic and other drugs, prescription and non-prescription, can cause significant weight gain in persons taking them. The rise in the consumption levels of these drugs mirrors the rise in obesity in the US.

Some groups of people tend to be fatter than others. Adults 40 to 79 years old are about 3 times as likely to be obese than younger people. Non-white females tend to be heavier: Mexican American women are 30% more likely than white women to be obese, and black women have twice the risk (*JAMA* 2006;295:1549-1555). The US population is growing older and non-whites are gaining as a proportion of the population. These demographic shifts may account in part for the increased prevalence of obesity.

Children born to obese mothers tend to become obese later in life; this may be the result of genetics and intrauterine programming. In addition, energy restriction in the womb can lead to obesity later in life, especially if there is a period of rapid catch-up growth in the first two years of life. Since the mid-1980s the incidence of low birthweight

has been rising in the US reaching its highest level, 8.2%, in 2005 ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)).

Mothers are getting older. The age at first birth in the US has risen from 21.4 years in 1970 to 26.5 years in 2005. The odds of child being obese increases about 14% for every 5 extra years of their mother's age, according to the National Heart, Lung, and Blood Institute's growth and health study.

Heavier people have more children (average of 3.5) than do women of normal weight or below (average of 3.2). Being obese may stem from issues related to too many

children (eg, sleep deprivation). However, twin studies suggest that 65% of obesity is genetic so having a large family would cause the proportion of overweight people to go up.

Heavier people tend to marry heavier people. By itself, like marrying like cannot account for any increase in obesity. But when combined with others, particularly the fact that obesity is partly genetic, and that heavier people have more children, it amplifies the increase from other causes.

## Testicular Cancer

Cancer of the testicles is uncommon, but it is the most common form of cancer in men between the ages of 20 and 34 (*J Urol* 2003;170:5-11). According to the American Cancer Society, some 8,250 men in the US will be diagnosed with testicular cancer during 2006 and about 370 will die from the disease. Men have a lifetime risk of 1 in 300 of developing testicular cancer, and a lifetime risk of dying from the disease of 1 in 5,000. In Missouri, between 1999 and 2003, the age-adjusted death rate for testicular cancer was 4.8 per 100,000 population ([www.naaccr.org](http://www.naaccr.org)).

While the testicular cancer rate has increased in both whites and blacks, the rate of increase has been greater in white men. It is 5 to 10 times more common among whites in the US than blacks. In addition, whites have twice the risk than Asian males. The risk for Hispanics falls between that of Asians and whites.

Most testicular cancers are discovered early by the men themselves or their sex partners. A lump on the testicle is often the first sign, but some testicular cancers do not cause symptoms until they have reached an advanced stage. Because the testicles have several kinds of cells these cells may develop into one or more types of cancer. The three main types are germ cell tumors, stromal tumors, and secondary testicular tumors (develop from

cancer that has spread from another body location). And, there are subcategories of tumors within these groups. Treatment varies with the type of tumor as does the chance of survival. Yet, overall, testicular cancer is one of the most highly curable forms of cancer known.

Self-screening for testicular cancer, although practiced by many men, has no known efficacy and therefore it is not recommended by either the US Preventive Services Taskforce or the American Cancer Society. *THE PULSE 2006*, a health assessment of men-who-have-sex-with-men (MSM) conducted by the Kansas City Health Department, found that 35% of MSM routinely perform self-examination of their testicles for cancer. This rate is nearly identical to that of college-aged men in Britain (36%) and twice that of university students in Europe (*J Men's Health Gender* 3(3), [www.jmhg.org](http://www.jmhg.org)).

The causes of testicular cancer are largely unknown. A few risk factors have been identified such as cryptorchidism, family history, certain types of moles, HIV infection, carcinoma in situ, cancer of the other testicle (3-4% risk), and body size (tall, slim men). More recently, being a firefighter was identified as having a probable association with development of testicular cancer (*J Occupational Environ Med* 2006;48:1189-1202).

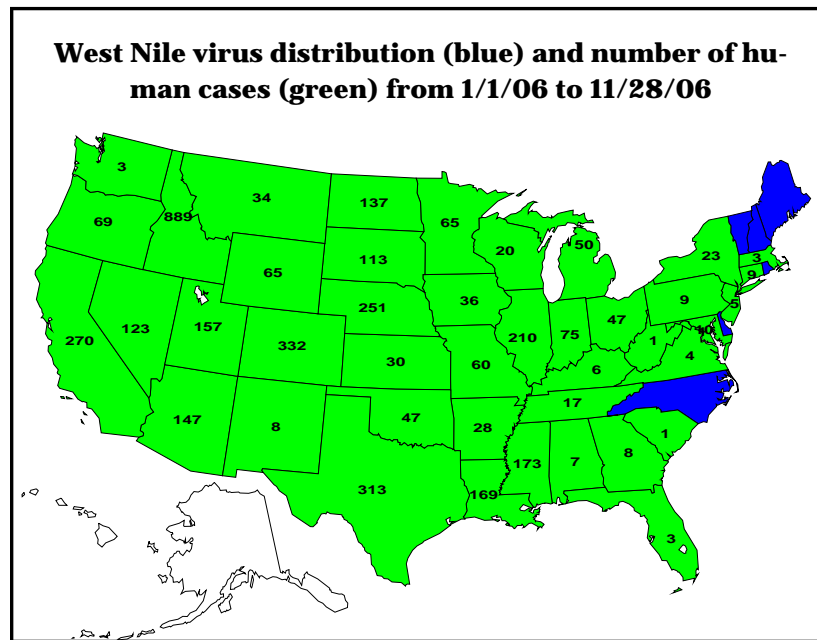
# West Nile Virus, 2006

As of the 28<sup>th</sup> of November, 4,028 people in the US were diagnosed with illnesses resulting for infection with West Nile virus (WNV); 135 died as the result of their infections (see map). Sixty Missourians and 30 Kansans were among those infected with 4 deaths occurring in Kansas and 3 in Missouri. Fourteen cases occurred in the metropolitan area: 4 in Johnson County, 8 in Jackson County, 1 each in Cass and Clay counties. Five of the 14 infections were fatal: 3 in Jackson County and 2 in Johnson County.

In addition, nationally 331 blood donors were found to be viremic for WNV (11 in Kansas, 4 in Missouri). Seventy-five of these blood donors went on to develop clinical disease and were counted in the numbers shown above.

Clinical WNV disease cases are classified as meningitis/encephalitis (1,386 cases to date in 2006), fever (2,445 cases), or other clinical/unspecified diagnoses (197 cases). Of the 60 cases in Missouri, 47 were meningitis/encephalitis, 12 were fever, and 1 was other clinical/unspecified. The 30 Kansas cases comprised 17 with meningitis/encephalitis and 13 with fever. It should be noted

that of the 75 WNV viremic blood donors who developed clinical WNV disease, 3 had meningitis/encephalitis, 70 had fever, and 2 were other clinical/unspecified diagnoses.



WNV is not the only mosquito transmitted agent affecting US residents. As of the 28<sup>th</sup> of November, 94 people have been diagnosed with other mosquito or tick transmitted viral infections. There have been 50 cases of La-Crosse (a Californian encephalitis group virus), 22 cases of dengue (typically imported, but can be acquired in southern Texas), 7 cases

each of St Louis encephalitis and Eastern equine encephalitis, 1 case of Powassan (tick transmitted agent), and 7 cases of infection with viruses that were identified only to group. One of the dengue cases was reported from the St Louis area.

Mosquito surveillance for WNV in Missouri yielded 6 isolates of St Louis virus: 1 from Boone County, 1 from Cape Girardeau County, 2 from Jefferson County, 1 from St Louis County, and 1 from Taney County. Five of the isolates were from mosquitoes of the *Culex pipiens* complex while one was from an *Aedes* sp.

## Leading Causes of Death, 2004

In 2004, the 10 leading causes of death in the US were: 1) heart disease, 2) cancer, 3) stroke, 4) chronic lower respiratory diseases, 5) accidents, 6) diabetes, 7) Alzheimer's disease, 8) influenza and pneumonia, 9) kidney disease, and 10) septicemia ([www.cdc.gov/nchs](http://www.cdc.gov/nchs)).

For Kansas City, the 10 leading causes were: 1) heart dis-

ease, 2) lung cancer, 3) stroke, 4) chronic lower respiratory disease, 5) mental and behavioral disorders, 6) diabetes, 7) Alzheimer's disease, 8&9) pneumonia and influenza and kidney disease, and 10) homicide (*Community Health Assessment 2006*, ([www.kcmo.org/health](http://www.kcmo.org/health))).

**Healthy People, Healthy Communities**

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