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Smoking and mortality in 81 344 drivers in Guangzhou, China

T H Lam, C Q Jiang, S Y Ho, W S Zhang, W W Liu, J M He

Objectives: Previous studies on drivers focused on the effect of their exposure to vehicle exhaust and there is little evidence of the effect of smoking. This cohort analytical study aimed to examine the mortality of drivers relative to smoking and professional driving in Guangzhou, China.

Methods: Information on demographic characteristics, type of driver (professional and non-professional), smoking, and drinking were retrieved from medical records of drivers who applied for driving licences from March to December 1992. Vital status and causes of death of 81 344 men aged 30 or above were ascertained to the end of September 1999 (follow up, mean=7.14 years, median=7.17 years).

Results: At baseline, the mean (SD) age was 40.8 (5.6) years. One third were professional drivers; 49.0% were daily smokers. 858 Deaths were identified. The relative risk of overall mortality for ever smoking was 1.24 (95% confidence interval (95% CI) 1.07 to 1.44) after adjusting for age, alcohol drinking, education, and type of drivers. Compared with non-professional drivers, professional drivers had similar risks of death, and their relative risk of overall mortality for ever smoking was 1.35 (1.06 to 1.71).

Conclusions: Smoking is a more important cause of death than professional driving itself. The results show serious public health problems in the early stage of the tobacco epidemic and support urgent measures to help drivers stop smoking.

Most reported prospective studies on the health of drivers have focused on a comparison of their mortality patterns with that in the general population. Some studies compared a cohort of drivers with another cohort of unskilled male laborers or other employed men. The main aim was to detect whether there was any excess mortality in drivers and if so the results would be interpreted as supportive evidence for the harmful effects of exposure to vehicle exhaust. However, drivers tend to have higher prevalence ratios of smoking than the general population, and the risk estimates from most studies were not adjusted for the individual driver's smoking habit. There is little evidence of the effect of smoking on mortality of drivers. The objective of the present study was to examine the mortality of drivers relative to smoking and to compare the mortality of professional drivers with that of non-professional drivers in Guangzhou, China.

METHODS

Guangzhou is the provincial capital of Guangdong Province in the south east part of the People's Republic of China. The Guangzhou Occupational Diseases Prevention and Treatment Centre is responsible for occupational health surveillance of workers. Drivers are required to have an annual medical examination and be certified before they apply for or renew a driving licence. The Centre is also responsible for the administration and supervision of the medical examination of drivers.

A standardised record form was designed to abstract information from medical records, including identity number, age, sex, educational level, type of driver (professional and non-professional), smoking, alcohol drinking, and the results of the medical examinations. A daily smoker was defined as one who had smoked at least one cigarette a day for 6 months or more. Occasional smokers were those who smoked less than one cigarette a day, and ex-smokers were those who had stopped smoking for 6 months or more. These three categories were also grouped as ex-smokers.

Since 1 March 1992, 13 driver examination stations and three substations were set up. Two main stations and three substations had inadequate record systems and were excluded. The remaining 11 stations were included and these stations covered over three quarters of all the eligible drivers who were Guangzhou residents. The records of all drivers who were examined from 1 March to 31 December 1992 and were aged 30 years or above were retrieved by a team of two trained researchers and the station chief. The data were entered on intelligent character recognition forms, checked, and scanned into the computer. The computer data file was checked again and errors were corrected by referring to the original records. The checked computer data file was sent to the Guangzhou Public Security Bureau Population Information Centre. With the unique identity number in our data file to match with the data files in the Centre, those who had died up to September 1999 were identified by this method. For those who were identified as dead, the causes of death were ascertained from local police stations, public health bureau statistics offices, and funeral homes. Those who were not known to have died were considered to be alive in September 1999. Causes of death were coded according to the ninth revision of the International classification of diseases by two physicians together and checked by an epidemiologist.

Altogether, information on all the 86 404 drivers (81 344 men and 5060 women) were retrieved and entered. As there were few deaths in women, the present report only includes men. The number of person-years was enormous with relatively few deaths occurred during the study period. As the number of person-years was relatively constant over time, a proportional hazards model is in general equivalent to a Poisson regression model with a fixed intercept.

Abbreviations: RR, relative risk

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All data were analyzed with SPSS 10.0 and Cox's proportional hazards model was used to calculate the hazard ratio, which estimates relative risk (RR) of mortality for smoking, and type of drivers (professional vs non-professional) after adjusting for each other, age, educational level, and alcohol drinking.

Ethical approval was obtained from the ethics committee, Faculty of Medicine, The University of Hong Kong.

RESULTS

The total follow up was 580 983 person-years and the mean (SD) duration of follow up was 7.14 (0.34) years; the median duration of follow up was 7.17 years. Up to September 1999, there were 858 deaths, and causes of death were known for 807 deaths (94.1%). The mean (SD) age at baseline was 40.8 (5.6) years.

Table 1 shows that 57% of the drivers were aged 35–39 years, and 35%, 40–49 years. Almost all had secondary education or above. About one third were professional drivers. The prevalence of daily smokers was 49.0% (95% confidence interval 48.6% to 49.3%) (table 1). Among daily smokers, the mean (SD) number of cigarettes smoked daily was 13.6 (6.0), and the mean duration of smoking was 12.4 (7.2) years. About 12% were ever drinkers.

Table 2. Adjusted relative risks for selected causes of death by smoking and by type of driver in Guangzhou 1992–99

<table>
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<tr>
<th>Causes of death</th>
<th>All drivers, ever smokers</th>
<th>Professional vs non-professional</th>
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<tr>
<td></td>
<td>RR 95% CI</td>
<td>RR 95% CI</td>
</tr>
<tr>
<td>All causes</td>
<td>858</td>
<td>1.24 (1.07 to 1.44)**</td>
</tr>
<tr>
<td>All cancers</td>
<td>414</td>
<td>1.22 (0.99 to 1.50)</td>
</tr>
<tr>
<td>Lung cancer</td>
<td>40</td>
<td>1.41 (0.90 to 2.22)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>33</td>
<td>1.22 (0.60 to 2.47)</td>
</tr>
<tr>
<td>Vascular</td>
<td>129</td>
<td>1.22 (0.83 to 1.79)</td>
</tr>
<tr>
<td>Others</td>
<td>231</td>
<td>1.26 (0.95 to 1.67)</td>
</tr>
<tr>
<td>Injury</td>
<td>50</td>
<td>0.89 (0.49 to 1.61)</td>
</tr>
</tbody>
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*p<0.05; **p<0.01.

RR, relative risks for smoking and type of driver were adjusted for each other, age, alcohol drinking, and education. Others, causes of death other than malignant neoplasm, respiratory, or vascular.
Table 2 shows that professional drivers had similar risks of death due to most causes when compared with non-professional drivers, except for deaths due to other causes for which the RR for professional drivers was 1.43 (1.09 to 1.87). This was partly due to the excess risk of death due to injury (RR=1.49) in professional drivers.

For deaths from all causes combined or overall mortality, the RR (95% CI) from ever smoking was significantly increased 1.24 (1.07 to 1.44), after adjusting for age, alcohol drinking, education, and type of driver. The RR’s were greater than unity for all cancers, all respiratory, all vascular, and all other causes (other than cancer, respiratory and vascular) of death but were not significant. The RR for lung cancer was the highest (1.41 (0.90 to 2.22)).

The adjusted RR of overall mortality for ever smoking was 1.35 (1.06 to 1.71) in professional drivers and 1.18 (0.98 to 1.42) in non-professional drivers.

Significant linear trends were found with RR’s increasing with amount smoked daily for all causes combined, all cancers, and lung cancer, and with RR increasing with duration of smoking for all causes, all cancers, and other causes (table 3).

**DISCUSSION**

To the best of our knowledge, this is one of the largest cohort studies on drivers, one third (about 28,000) of whom were professional drivers. The most prominent finding was that the risks of mortality in professional drivers were not higher than those in non-professional drivers after adjusting for smoking. Smoking was found to be associated with a 24% excess risk of overall mortality in this young cohort (mean age of 40.8 years) after a follow up of only 7 years.

Previous prospective studies on professional drivers, which based their standardised mortality ratio on the comparison of the mortality of drivers with those in the general population, showed inconsistent results. An excess of deaths from lung cancer was found by Borgia et al in taxi drivers in Rome compared with regional rates but they had difficulty in interpreting the association. However, Ralinson and Gunnarsdottir found an increased standardised mortality ratio from lung cancer among truck drivers in Reykjavik compared with the Iceland national rates. The authors suggested exposure to engine exhaust gases as the possible cause, but the role of smoking cannot be excluded. Paradis et al compared bus drivers with the male population of Montreal and found no excess deaths from lung cancer and a small increase in ischaemic heart disease.

Reference groups, which were presumed to be more comparable with drivers than the general population were also used in a few studies. Alfredsson et al compared mortality in male bus drivers with that in other employed men and found no increased relative risk of lung cancer in the bus drivers. However, drivers had an increased incidence of myocardial infarction. Hansen compared mortality of truck drivers and unskilled male labourers and found an increased SMR of lung cancer in drivers. Exposure to diesel exhaust was the alleged cause. It should be noted that all of these studies did not have individual smoking data in the cohorts of drivers.

Our comparison of professional drivers and other drivers showed that the professional drivers had a lower level of education and a higher prevalence of smoking. After adjusting for these differences, professional drivers did not have a significant excess in overall mortality (RR=1.10) or in specific causes of death when compared with non-professional drivers, except for deaths from other causes (RR=1.43). The excess risks from injury (RR=1.49), although not significant, could be explained by the excess risks from traffic accidents, a result of more driving. We did not have data on the nature of the accidents. As professional drivers had smoked more and for a longer period.
Main messages

- In Guangzhou, China, professional drivers smoked more heavily than non-professional drivers.
- The risks of mortality for professional drivers were similar to those of non-professional drivers after adjusting for smoking.
- Mortality of drivers who smoked was 24% higher than that of never-smokers even in early middle age.

Policy implications

- Stopping smoking should be an important strategy in occupational health services for drivers who smoke.
- Stopping smoking in professional drivers may also benefit the passengers by reducing their exposure to passive smoke.

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REFERENCES


