

While the short-term abstinence rates among the patients followed up were encouraging, and not dissimilar to rates found in clinical trials,^{2,3} there is clearly a need to look at strategies to encourage patients to adhere to the prescribed course of treatment and to make use of cessation support services. We suggest patients be invited back for at least two follow-up GP visits following prescribing of bupropion, as well as being made aware of other support services.

Competing interests: NAZ and RLR have received funding from GlaxoSmithKline to conduct education programs in smoking cessation for health professionals.

Acknowledgements: The contribution of the general practice registrars and the support provided by the Primary Health Care Research Network to this project is gratefully acknowledged.

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Thalidomide and cancer

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TO THE EDITOR: Thalidomide (N- α -phthalimidoglutarimide) was first marketed as a sedative-hypnotic in 1957. It was withdrawn from the market in 1961 as it was found to cause congenital malformations.¹ Infant mortality statistics in Germany for the years 1959 to 1963 show that about 40% of thalidomide-affected babies died in the neonatal period.² The main causes of death were atresia of the bowel, renal dysgenesis and heart malformations.

As a result of extensive studies on the pathogenesis of the malformations, it was found that thalidomide is an immunosuppressant.³ The use of two different ¹⁴C-labelled thalidomide preparations showed that a portion or the whole of the glutarimide molecule binds to the DNA of rabbit embryos.⁴

In Britain and Ireland, 480 thalidomide-affected infants survived. Of these, 25 died before reaching the age of 40 years. The causes of death were cancer (4), heart disease (4), diabetes (3), hypertension and renal failure (3), motor accidents (3), and substance misuse or suicide (8) (M Johnson, Director, the Thalidomide Trust [United Kingdom], personal communication).

Four deaths from cancer before the age of 40 years in a cohort of 480 is an incidence of 0.83%. The death rate from cancer in England and Wales before the age of 40 is

9.4 per 100 000 population, or 0.0084%.⁵ Thus, the thalidomide-affected individuals had a 99-fold increase in the age-related cancer death rate. Another of the cohort died aged 41 years of round-cell sarcoma.

The high incidence of malignancy, together with the knowledge that a portion of the thalidomide molecule binds with the DNA of laboratory animals, suggest a possible mutational change in some of the cells of thalidomide-affected people.

Thalidomide is currently being used to treat a variety of diseases, some because of its immunosuppressant properties. These diseases include graft-versus-host disease, leprosy, AIDS, Behçet's syndrome, tuberculosis, multiple myeloma and many dermatoses. It is also being used for treating some cancers. Its chemotherapeutic value probably results from the ability of the glutarimide component of the thalidomide molecule to bind with the DNA of rapidly dividing cells. However, if the genetic injury is not accurately repaired, it may result in mutations or even cell death.

Although thalidomide is now proving to be a useful therapeutic agent, its ability to bind with DNA makes it dangerous, not only when taken by pregnant women, but also potentially when taken by men, whose sperm might be affected.⁶

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Surgeons' views about colorectal cancer screening before and after national guidelines

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TO THE EDITOR: In November 1999, the National Health and Medical Research Council (NHMRC) released *Guidelines for the prevention, early detection and management of colorectal cancer*.¹ One chapter addressed screening for colorectal cancer