Yatsuya and Folsom (1) published data on and conclusions about cardiovascular disease incidence in smokeless tobacco users from the Atherosclerosis Risk in Communities Study data set. They concluded, “Current users of smokeless tobacco should be informed of its harm and advised to quit the practice. Current cigarette smokers should also be given sufficient information on safe, therapeutic methods of quitting which do not include switching to smokeless tobacco” (1, p. 600). These conclusions were not supported by either the literature review or the findings presented in their article. In their introductory literature review, the authors noted a number of prospective studies that showed no increase in risk of cardiovascular disease and concluded that the “health effects of smokeless tobacco are inconclusive” (1, p. 600).

Yatsuya and Folsom presented their findings in 3 models, with each subsequent model adjusted for a wider range of confounding variables. In model 3, the most completely adjusted model, they found a 21% increase in risk that was marginally statistically significant, with a confidence interval that included 1.00. That model was dismissed because of speculation that some of the variables might be mediators rather than independent risk factors. Yatsuya and Folsom then based their discussion and conclusions on the middle of the 3 models, one that showed an excess risk of 27% (95% confidence interval, 1.06, 1.52). The findings of either model, in the light of the uncertain literature and the major “limitations of the present study” (1, p. 604), warrant a conclusion no stronger than advising current users of smokeless tobacco of possible cardiovascular risks.

Nowhere in the study do Yatsuya and Folsom reference the relative risks posed by cigarette smoking from the Cancer Prevention Studies-II data set. These risks range from 2.80 to 4.00 for heart disease and stroke for men and women 35–64 years of age (2). Although not directly comparable, these data suggest levels of risk 10–15 times higher than those suggested by Yatsuya and Folsom for smokeless tobacco (1).

Nowhere did they reference the relative lack of efficacy of currently available nicotine replacement therapy products when those products are used as directed (3). They did not reference the fact that nicotine replacement therapy products have never been approved by the US Food and Drug Administration for long-term use. They failed to note the potential public health benefit of informing current smokers that those unable or unwilling to quit can eliminate almost all risk of future tobacco-related illness by switching to snus (4). Not having discussed these topics, Yatsuya and Folsom should have refrained from drawing any conclusions relative to current smokers or the potential utility of “safe, therapeutic methods of quitting” (1, p. 604).

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