



Passive smoking and chronic obstructive pulmonary disease mortality: findings from the Japan collaborative cohort study.

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| journal or publication title | International Journal of Public Health |
| volume | 62 |
| number | 4 |
| page range | 489-494 |
| year | 2017-07 |
| URL | http://hdl.handle.net/2241/00146749 |

doi: 10.1007/s00038-016-0938-1

1 Passive smoking and chronic obstructive pulmonary disease mortality: findings from the Japan
2 collaborative cohort study
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1 Abstract

2 Objectives: To elucidate the association between passive smoking at home and chronic obstructive
3 pulmonary disease (COPD) mortality via a large-scale nationwide cohort study in Japan.

4 Methods: Never smokers (n=34,604) aged 40–79 years at baseline (1988–1990; 4,884 men, 29,720
5 women) were included in the analysis. Passive smoking at home was measured based on self-reported
6 frequency of weekly exposure to passive smoking at home. An inverse probability of treatment weighted
7 competing risk model was used to calculate the hazard ratio (HR) and 95% confidence interval (CI) for
8 COPD mortality.

9 Results: During a median follow-up of 16.4 years, 33 participants (10 men, 23 women) died of COPD.

10 The HR for participants exposed to passive smoking at home ≤ 4 days per week or those who had almost
11 daily exposure to passive smoking at home had a significantly increased risk of COPD mortality (HR:
12 2.40, 95% CI: 1.39–4.15; HR: 2.88, 95% CI: 1.68–4.93, respectively).

13 Conclusions: The present findings suggest that avoiding passive smoking at home may be beneficial for
14 preventing death due to COPD among never smokers.

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16 Key words: Prevention, Secondhand smoke, Carcinogens

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1 Introduction

2 Chronic obstructive pulmonary disease (COPD) is characterized by a chronic abnormal inflammatory
3 response and an accelerated decline in lung function (Vestbo et al. 2012). COPD is estimated to become
4 the third most common cause of death by 2020 (Murray and Lopez 1997). Active smoking is the major
5 risk factor for COPD (Eisner et al. 2010), although approximately one quarter of diagnosed COPD cases
6 in Japan (25.0%) (Fukuchi et al. 2004), the US (24.9%) (Behrendt 2005), and the UK (29.5%) (Shahab et
7 al. 2006) occur in non-smokers. Several studies have examined this phenomenon, including two
8 cross-sectional studies (Hagstad et al. 2014; Yin et al. 2007), one case-control study (Sezer et al. 2006),
9 and one cohort study (He et al. 2012). Two of these studies reported that passive smoking at home was
10 significantly associated with an increased prevalence of COPD (Sezer et al. 2006; Yin et al. 2007).
11 However, only one cohort study has investigated the association between exposure to passive smoking at
12 home and death due to COPD among non-smokers, reporting no statistically significant association
13 (adjusted relative risk: 1.67, 95% CI: 0.49–5.78) (He et al. 2012). Thus, additional prospective evidence
14 regarding the association between passive smoking at home and COPD mortality among non-smokers is
15 needed. Therefore, the current study aimed to determine whether passive smoking at home is associated
16 with COPD mortality via a large-scale nationwide cohort study among Japanese never smokers who were
17 40–79 years old.

18

1 Materials and Methods

2 *Study population*

3 The Japan Collaborative Cohort Study for Evaluation of Cancer Risk (JACC Study) was
4 established in 1988–1990 and has been described in detail elsewhere (Tamakoshi et al. 2013). In brief,
5 110,585 apparently healthy individuals (46,395 men and 64,190 women; 40–79 years old) were enrolled
6 from 45 areas throughout Japan. Participants were generally recruited at the time of their health check-up
7 and were evaluated using a self-administered questionnaire, with a response rate of 83%. The design of
8 the present study was approved by the Ethical Board of Nagoya University School of Medicine.

9

10 *Data collection*

11 Information regarding exposure to passive smoking at home was obtained by asking the following
12 question: “In the past, were you exposed to tobacco smoke at home?” Participants who answered “yes” to
13 this question were also asked to report the frequency of this passive exposure as “sometimes”, “1–2
14 days/week”, “3–4 days/week”, or “almost every day”. Owing to the low number of participants who
15 responded “sometimes”, “1–2 days/week” or “3–4 days/week”, we categorized the frequencies into three
16 groups: none, ≤ 4 days per week, and almost every day. We only evaluated never smokers ($n = 60,484$;
17 9,027 men and 51,457 women). We excluded 13,406 potential participants who lived in five areas, as the
18 questionnaires for those areas did not include the question regarding passive smoking at home. We also

1 excluded 12,474 additional participants with missing data regarding passive smoking at home. Therefore,
2 the present study analyzed data from 34,604 individuals (4,884 men and 29,720 women) who had never
3 smoked.

4

5 *Follow-up*

6 Dates and causes of death were confirmed using death certificates and were coded according to the 10th
7 revision of the International Classification of Disease. The primary outcome for the present study was
8 death due to COPD (J41–44 or J47).

9

10 *Statistical analysis*

11 The baseline characteristics of the study participants according to exposure to passive smoking at home
12 were compared using analysis of covariance or χ^2 test as appropriate. Multivariable hazard ratios (HRs)
13 and confidence intervals (CIs) for COPD mortality were calculated using a Cox proportional hazards
14 model. We attempted to care a small number of outcomes by using an inverse probability of treatment
15 weighted (IPTW) method based on generalized propensity scores (Robins et al. 2000). This approach is a
16 statistical alternative to implementing propensity score matching to balance for confounders in
17 non-randomized studies. To develop the generalized propensity score, we conducted a multinomial
18 logistic regression analysis using variables for all demographic information (Imbens 2008), such as age (a

1 continuous variable), sex, study area (as a dummy variable), body mass index (BMI; <18.5 kg/m², 18.5–
2 24.9 kg/m², ≥25.0 kg/m², or unknown), educational level (junior high school, high school, college
3 diploma, or unknown), alcohol consumption (never, former, current alcohol drinker, or unknown),
4 walking time (≤1 h/day, >1 h/day, or unknown), and a history of tuberculosis (yes or other) (Table 1). We
5 included variables such as study area in the model because the smoking rate and cause of death differ by
6 geographic region in Japan (Ministry of Health 2015a; Tamakoshi et al. 2013). The C-statistic of the
7 model was 0.677. To assess covariate balance, we showed propensity score overlap with kernel density
8 plots (Supplementary Figure 1). We then conducted an IPTW Cox proportional hazards model with robust
9 variance (Sugihara 2010). Furthermore, we implemented a competing risk model (So et al.) in which we
10 treated death from cancer (C00-97, D00-09), cardiovascular diseases (I00-99), and respiratory diseases
11 other than COPD (J00-39, 45, 46, 60-99) as a competing risk because they have been reported to be
12 associated with passive smoking (Cao et al. 2015; Gibbs et al. 2016; Lv et al. 2015). Trend p-values were
13 calculated to assess the associations between the categories of passive smoking at home (0, none; 1, <4
14 days per week; 2, almost every day) and the risk of COPD mortality. An alpha level of 0.05 was
15 considered to be statistically significant. All statistical analyses were performed using SAS software
16 (version 9.4; SAS Institute Inc., Cary, NC, USA) and JMP software (version 12.2.0; SAS Institute Inc.,
17 Cary, NC, USA).

18

1 Results

2 The mean participant age at baseline was 56.7 ± 10.0 years (men: 56.5 ± 10.3 years, women: 56.7 ± 10.0
3 years). Table 1 shows the participants' baseline characteristics according to their exposure to passive
4 smoking at home. Compared to the participants who had not been exposed to passive smoking at home,
5 participants with almost daily exposure to passive smoking at home tended to be younger, female, better
6 educated, daily walkers, not be alcohol drinkers, and to have non-normal BMI. The difference among
7 those three exposures of passive smoking at home was reduced after weighting (Supplementary Table 1).

8 During the median follow-up of 16.4 (maximum, 22.0) years, 33 participants (10 men and 23
9 women) died as a consequence of COPD, 6,372 participants moved away from the study area, 9,227
10 participants died from cancer, 8,330 participants died from cardiovascular diseases, 3,150 participants
11 died from respiratory diseases other than COPD, and 6,274 participants died from other causes. Table 2
12 shows the HRs for COPD mortality that were associated with passive smoking at home. Compared to the
13 participants who were not exposed to passive smoking at home, participants who were exposed to passive
14 smoking at home ≤ 4 days per week and those who were exposed to passive smoking at home almost daily
15 had a significantly increased risk of COPD mortality (HR: 1.98; 95% CI: 1.07–3.88; HR: 2.27; 95% CI:
16 1.27–4.03, respectively), but there was no dose-response relationship ($P = 0.09$). In the competing risk
17 analysis, participants who had ≤ 4 days per week exposure and almost daily exposure to passive smoking
18 at home had a significantly increased risk of COPD mortality (HR: 2.40; 95% CI: 1.39–4.15; HR: 2.88;

1 95% CI: 1.68–4.93, respectively) with a dose-response relationship ($P < 0.001$).

2

3 Discussion

4 In this large cohort study, we found that exposure to passive smoking at home significantly increased the
5 risk of COPD mortality, compared to individuals without exposure to passive smoking at home, among
6 Japanese never smokers.

7 Potential pathways by which passive smoking might lead to COPD mortality are not fully
8 established. One possibility is that despite low levels of passive smoking, exposure increases levels of
9 elastin degradation products such as isodesmosine (Slowik et al. 2011); these products are chemotactic for
10 neutrophils and macrophages in the lung (Houghton et al. 2006; Senior et al. 1980) and cause an
11 inflammatory state, resulting in lung degradation (Hogg et al. 2004). Furthermore, experimental studies
12 have demonstrated that the acute detrimental effects of passive smoking on the respiratory system are
13 similar to those of active smoking (Flouris et al. 2009; Slowik et al. 2011). Thus, passive smoking can
14 increase the levels of proinflammatory cytokines (including interleukin-4, interleukin-5, interleukin-6,
15 tumor necrosis factor- α , and interferon- γ), as well as serum and urine levels of cotinine. Moreover, a
16 review article reported the presence of several candidate genes for COPD susceptibility and COPD
17 pathophysiology which influence the development of chronic airflow obstruction in response to smoking
18 (Silverman 2006). All of these factors can negatively affect lung function, which indicates the biological

1 plausibility of passive smoking as a causal factor for COPD mortality.

2 To our knowledge, this is the first cohort study to report a statistically significant association
3 between passive smoking at home and COPD mortality among never smokers. This association is
4 consistent with the findings of three previous studies, which included a Chinese cross-sectional study
5 (Yin et al. 2007) and a Turkish case-control study (Sezer et al. 2006). There was an association between
6 self-reported exposure to passive smoking at home and the prevalence of COPD (adjusted odds ratio: 1.60,
7 95% CI: 1.23–2.10 for high-level exposure, equivalent to 40 h/week for >5 years) among 20,430 Chinese
8 men and women who were >50 years old (Yin et al. 2007) and among 74 cases and 74 controls that were
9 selected from among Turkish housewives (adjusted odds ratio: 4.96, 95% CI: 1.65–14.86 for >30 years of
10 exposure) (Sezer et al. 2006). In contrast, a cohort study with a 17-year follow-up evaluated the
11 relationship between passive smoking and death due to COPD among 910 Chinese individuals (439 men
12 and 471 women) who never smoked, but there was no statistically significant association between passive
13 smoking and COPD mortality (adjusted relative risk: 1.67, 95% CI: 0.49–5.78) (He et al. 2012). However,
14 the results of both previous studies were highly imprecise. Furthermore, the confidence intervals around
15 the estimated measures of association in those were similar; thus, the results were not mutually
16 inconsistent.

17 The smoking rate in Japan is one of the highest among developed countries (Schultz 1998). For
18 example, the prevalence of smoking in 1990 was 53.1% for men and 9.7% for women (Ministry of Health

1 1993), compared to that in the present cohort of 53.1% and 5.5%, respectively. Although the prevalence
2 of smoking has gradually decreased in Japan (34.1% for men and 9.0% for women in 2012) (Ministry of
3 Health 2012), the smoking rate remains high, thus non-smokers are frequently exposed to passive
4 smoking. For the country of Japan, the present findings reemphasize the importance of implementing an
5 effective smoking cessation campaign, including public education to reduce passive smoking exposure in
6 the home; such a campaign should be based on the World Health Organization's Framework Convention
7 on Tobacco Control (World Health Organization 2014).

8 The strengths of the present study include its prospective cohort design, long follow-up period,
9 and inclusion of participants from throughout Japan. However, the present study also includes some
10 limitations that warrant consideration. First, a meta-analysis reported patients with COPD were more
11 likely to die due to lung cancer (Wang et al. 2012). Therefore, as COPD and lung cancer share cigarette
12 smoking as a common risk factor, some misclassification of the outcome might occur, leading to an
13 underestimation of deaths due to COPD (Caramori et al. 2011). To avoid this bias, we conducted a
14 competing risk analysis. Second, data regarding passive smoking was obtained via self-report, thus there
15 may have been inaccurate reports of exposure to passive smoking (Kim et al. 2013). Third, the
16 information on passive smoking and potential confounders was collected only at baseline and was not
17 updated during the study period. Since we could not consider the time-dependent nature of the
18 characteristics of the study participants, our results might have included some information and residual

1 confounding bias. Particularly, as the proportion of active smokers and passive smokers is gradually
2 decreasing in Japan (Ministry of Health 2015b), there may have been an overestimation of passive
3 smoking. Fourth, there are potential confounders, such as history of asthma (Silva et al. 2004), history of
4 respiratory infection in infancy (van der Zalm et al. 2009), and exposure to air pollution (e.g.
5 traffic-related air pollution (Schikowski et al. 2005), for which information was not obtained. To clarify
6 the magnitude of the effect of passive smoking exposure on COPD mortality, further epidemiologic
7 studies are needed that collect comprehensive baseline information regarding potential confounders. Fifth,
8 due to the relatively low number of deaths from COPD, the risk estimate might not be precise. Further
9 epidemiologic studies with a larger sample size or a pooled analysis of multiple cohort studies would help
10 to clarify the present results.

11 In conclusion, this nationwide cohort study provides the first evidence that passive smoking at
12 home increases the risk of COPD mortality among Japanese never smokers who were 40–79 years old.
13 Thus, reducing exposure to passive smoking at home may help prevent COPD mortality among never
14 smokers.

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13

Table 1. Baseline participant characteristics according to exposure to passive smoking at home in Japan, 1988–1990

| Characteristic | Category | Exposure to passive smoke at home | | | P-value |
|------------------------------------|-----------|-----------------------------------|---------------------------------|----------------------------------|---------|
| | | None (n = 14,359) | ≤4 days per week (n = 5,519) | Almost every day (n = 14,726) | |
| Age, years | | 57.6 ± 10.5 | 56.3 ± 9.7 | 55.9 ± 9.5 | <0.001 |
| Sex, male | | 3,098 (21.6) | 886 (16.1) | 900 (6.1) | <0.001 |
| Body mass index, kg/m ² | <18.5 | 888 (6.2) | 289 (5.2) | 805 (5.5) | <0.001 |
| | 18.5–24.9 | 9,901 (69.0) | 3,751 (68.0) | 9,937 (67.5) | |
| | ≥25.0 | 2,863 (19.9) | 1,272 (23.0) | 3,525 (23.9) | |
| | Unknown | 707(4.9) | 207 (3.8) | 459 (3.1) | |
| College education | Yes | 9,719 (67.7) | 3,661 (66.3) | 10,445 (71.0) | <0.001 |
| | No | 3,879 (27.0) | 1,607 (29.1) | 3,608 (24.5) | |
| | Unknown | 761 (5.3) | 251 (4.5) | 663 (4.5) | |
| Alcohol consumption | Current | 4,197 (44.3) | 1,588 (28.8) | 3,682 (25.0) | <0.001 |
| | Former | 253 (1.8) | 107 (1.9) | 189 (1.3) | |
| | Never | 9,638 (67.1) | 3,684 (66.8) | 10,543 (71.6) | |
| | Unknown | 271 (1.9) | 140 (2.5) | 312 (2.1) | |
| Daily walking time, h/day | >1 | 6,111 (39.7) | 2,811 (46.0) | 7,479 (45.9) | <0.001 |
| | ≤1 | 7,765 (54.1) | 2,811 (50.9) | 7479 (50.8) | |
| | Unknown | 483 (3.4) | 172 (3.1) | 482 (3.3) | |
| History of tuberculosis | Yes | 690 (4.8) | 217 (3.9) | 686 (4.7) | <0.001 |

Values are expressed as mean ± standard deviation or number (%). P-values were calculated using analysis of covariance or χ^2 test as appropriate.

1

2

Table 2. Hazard ratios of chronic obstructive pulmonary disease mortality according to exposure to passive smoking at home using a Cox proportional hazards model in Japan, 1988–1990

| Category | Exposure to passive smoking at home | | | P for trend |
|--------------------------|-------------------------------------|-------------------|-------------------|-------------|
| | None | ≤4 days per week | Almost every day | |
| Person-years | 237,456 | 94,700 | 236,188 | |
| Number of cases | 11 | 7 | 15 | |
| HR (95% CI) ^a | ref | 1.95 (0.75–5.03) | 2.41 (1.08–5.37)* | 0.03 |
| HR (95% CI) ^b | ref | 2.38 (0.89–6.35) | 2.86 (1.23–6.68)* | 0.09 |
| HR (95% CI) ^c | ref | 2.40 (1.39–4.15)* | 2.88 (1.68–4.93)* | <0.001 |

HR: hazard ratio, CI: confidence interval; ref, reference. *p<0.05

^aadjusted for age and sex

^binverse propensity of treatment weighted model with robust variance.

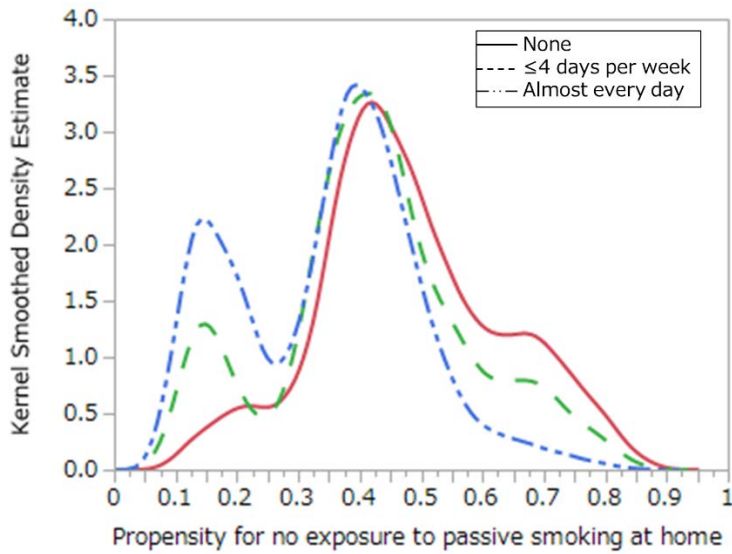
^cinverse propensity of treatment weighted competing risk model with robust variance.

P for trend was calculated across the categories of exposure to passive smoking at home.

1

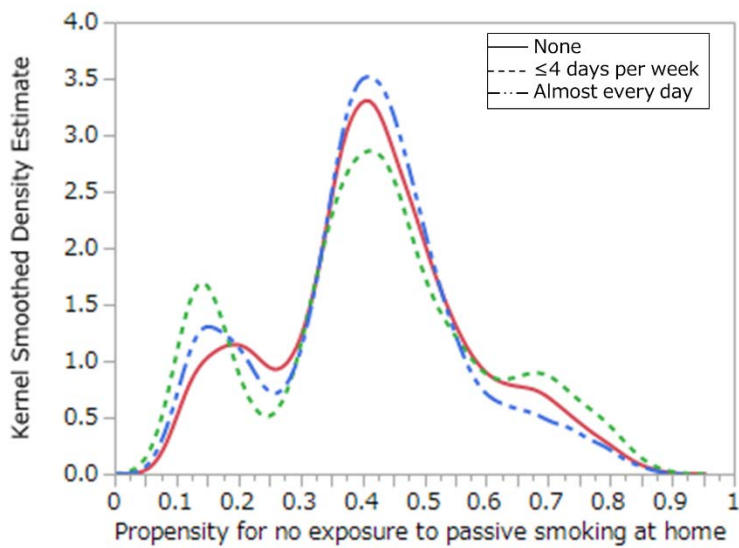
2

1 A. Unadjusted estimates



2

3 B. Adjusted estimates



4

5 **Supplementary Figure 1. Kernel smoothed density estimate of propensity for no exposure**

6 **to passive smoking at home in Japan, 1988–1990**

7 Kernel smoothed density estimates show improved overlap of propensity for no exposure to

8 passive smoking after inverse probability of treatment weighting.