Carboxyhaemoglobin levels of smokers and non-smokers working in the City of London

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The association between smoking and cardiovascular disease in man is now well established (Royal College of Physicians Report, 1971; Report of the Surgeon General, 1971). Hitherto nicotine was believed to be the main constituent in cigarette smoke affecting the cardiovascular system, even though increased blood levels of nicotine have never been directly demonstrated in man. More recently carbon monoxide (CO), a constituent of tobacco smoke, has been more closely examined for its role in causing some of the pathological conditions known to be associated with smoking. Tobacco smoke contains up to 5% CO (Wynder and Hoffman, 1967) which when inhaled combines with haemoglobin to form a stable compound, carboxyhaemoglobin (COHb). This compound interferes with oxygen carriage by the blood in two ways. First it has the effect of decreasing the amount of haemoglobin available for oxygen carriage, and secondly there is a less well-known effect of increasing the oxygen affinity of the remaining oxyhaemoglobin so that oxygen is given up to the tissues less readily than normally. This is described as a 'shift to the left' of the haemoglobin dissociation curve and has been shown to occur in subjects who smoke (Birnstingl, Cole, and Hawkins, 1967).

In the experimental animal Astrup (1972) and Kjeldsen, Astrup, and Wanstrup (1972) have shown that cholesterol fed rabbits breathing carbon monoxide in sufficient quantity to raise the COHb to about 17% have more atheroma in the aorta than those breathing air. In man, with levels of 5-10% COHb, Ayres, Giannelli, and Mueller (1970) found that the coronary arteriovenous oxygen difference decreased while coronary blood flow increased, probably indicating that the myocardium was insufficiently oxygenated, and at COHb levels of 14%, they detected a decrease in arterial and mixed venous oxygen tension. Ayres et al. (1970) further showed that some patients with coronary artery disease developed altered lactate and pyruvate metabolism following an increase in their COHb levels, again suggesting a degree of myocardial hypoxia. The falls in oxygen tension found by Ayres et al. (1970) have been explained by the fact that COHb not only shifts the curve to the left but also changes its shape from the normal sigmoid towards that of a rectangular hyperbola (Haldane, 1912). This results in a subsequent increase of the effect of any existing venous admixture to the arterial circulation (Brody and Coburn, 1969; 1970). Chevalier, Krumholz, and Ross (1966) demonstrated that the degree of oxygen debt induced in smokers after exercise could be simulated in non-smokers if they had previously inhaled carbon monoxide. Thus it is possible that tobacco angina previously thought to be
due to catecholamine release (Oram and Sowton, 1963) may in fact be caused by raised COHb levels resulting in myocardial hypoxia.

Recent work has demonstrated the correlation between COHb levels and smoking, and that smokers who inhale have far higher levels than non-smokers (Cole, Hawkins, and Roberts, 1972; Russell, Cole, and Brown, 1973a; Castleden and Cole, 1973), but the relationship between occupation, smoking, and COHb levels in the population at large is at present unknown.

Goldsmith and Landaw (1968) have correlated the smoking habits of 331 longshoremen with their COHb levels. These blood levels were estimated indirectly by measurement of the carbon monoxide concentration in expired air. If the direct estimation of blood COHb is a good indication of inhalation of smoke, it can provide physicians with the certain knowledge that a patient is at risk from smoking. However, it is first necessary to establish the COHb level in the average subject. We therefore report the results of a survey carried out in the City of London in sedentary and manual workers.

Method

Two groups of subjects were studied towards the end of their working day—manual workers (Smithfield meat porters) and sedentary workers (City office workers, the majority of whom were blood donors). Samples of venous blood were taken into heparinized syringes, capped and iced, and analysed for COHb on the same day by means of a CO Oximeter (Instrumentation Laboratories 1 Model 182) (Russell et al., 1973a). Some estimations were duplicated by means of the method of Commins and Lawther (1965) to ensure accuracy (Commins and Lawther, 1965; Lily, Cole, and Hawkins, 1972). Each subject completed a short questionnaire on his smoking habits. Twenty spot samples of the atmosphere breathed by each group were taken, dried, and analysed for CO on a Uras 2 CO analyser (Hartmann and Braun).

Results

As the variance of the mean COHb tended to increase with the level of smoking, the data were transformed logarithmically and the resulting standard deviations were reasonably constant (Table 1).

**TABLE 1**

<table>
<thead>
<tr>
<th>No. of cigarettes/day</th>
<th>0</th>
<th>1-10</th>
<th>11-20</th>
<th>&gt; 20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean COHb %</td>
<td>0-079</td>
<td>0-523</td>
<td>0-767</td>
<td>0-794</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>0-23</td>
<td>0-24</td>
<td>0-20</td>
<td>0-16</td>
</tr>
</tbody>
</table>

The results were compared statistically by means of a two-way analysis of variance, and standard errors of group means of the transformed data were estimated from the residual mean square in the analysis of variance.

Manual workers had a different daily consumption of cigarettes compared to sedentary workers. The largest group of manual workers (42-9%) smoked more than 20 cigarettes per day whereas the majority of sedentary workers (58-4%) smoked between 11 and 20. However, even though they smoked more, on average the mean COHb level of the manual workers was significantly lower than that of the sedentary workers (Table 2).

There is a highly significant difference between the mean COHb level of all non-smokers (1-3%) and those smoking 1-10 cigarettes per day (3-8%). The difference is also highly significant between the mean COHb level of those smoking 1-10 cigarettes per day and 11-20 per day, but there is no difference between the two heaviest smoking groups, i.e., 11-20 and more than 20 per day (Table 3).

The mean COHb level of the non-smoking sedentary workers did not differ significantly from that of the manual workers despite the fact that the atmospheric carbon monoxide was higher for the manual workers (mean 10-3 ppm, range 8-16-5) than for the sedentary workers (mean 6-7 ppm, range 3-8).

Three out of 204 non-smokers (1-5%) had a COHb level above 2-5%, and a value of zero was not recorded in any subject. Of the smokers 5-7% have COHb levels in the range found in non-smokers.

**TABLE 2**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number of subjects</th>
<th>Mean COHb %</th>
<th>Log mean of total COHb</th>
<th>Standard error of log</th>
<th>Difference in log mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Smokers</td>
<td>Non-smokers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sedentary</td>
<td>318</td>
<td>6-1</td>
<td>1-3</td>
<td>2-9</td>
<td>0-378</td>
</tr>
<tr>
<td>Manual</td>
<td>97</td>
<td>5-0</td>
<td>1-5</td>
<td>3-8</td>
<td>0-463</td>
</tr>
</tbody>
</table>

***Significant at 1/1 000 level
TABLE 3
COMPARISON OF COHb LEVELS OF THE SMOKING GROUPS

<table>
<thead>
<tr>
<th>Number of cigarettes smoked each day</th>
<th>Number of subjects</th>
<th>Mean COHb %</th>
<th>Mean of sum of logs</th>
<th>Standard of logs</th>
<th>Difference in log mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>204</td>
<td>1.3</td>
<td>0.079</td>
<td>0.015</td>
<td>0.443****</td>
</tr>
<tr>
<td>1-10</td>
<td>59</td>
<td>3.8</td>
<td>0.523</td>
<td>0.028</td>
<td>0.244****</td>
</tr>
<tr>
<td>11-20</td>
<td>101</td>
<td>6.1</td>
<td>0.767</td>
<td>0.021</td>
<td>0.027 ns</td>
</tr>
<tr>
<td>&gt;20</td>
<td>51</td>
<td>6.7</td>
<td>0.794</td>
<td>0.030</td>
<td></td>
</tr>
</tbody>
</table>

****Significant at 1/10 000 level
ns = Not significant

Discussion

According to national figures, 65-70% of men are smokers (Royal College of Physicians Report, 1971). However, in our study the total number of smokers was approximately equal to that of the non-smokers. An explanation for our figures is that only 44% of the blood donors were smokers compared to 65% of the manual workers and 70% of the office workers who were non-blood donors. Hence there are many more non-smokers among blood donors than are found in the general population.

Following a survey involving 3 311 longshoremen Goldsmith and Landaw (1968) reported a correlation between the number of cigarettes smoked and the COHb level which they had calculated from the CO in their expired air. They found a mean level of 6.8% in those smoking two ‘packs of cigarettes’ per day, of 5.9% in those smoking ½-2 packs per day, and 3.8% if they smoked less than ½ ‘a pack a day’. We too have found that the mean COHb level tends to increase with the number of cigarettes per day, but that this trend was only statistically significant between groups 1-10 and 11-20 (Table 3).

A comparison between the two types of workers shows that there are highly relevant differences. The mean COHb level of manual workers is significantly lower than that of sedentary workers even though the manual workers tend to smoke more heavily.

An explanation for these findings might be that either the manual worker does not inhale the smoke of his cigarettes to such an extent as the sedentary worker or that he is eliminating the accumulated carbon monoxide at a quicker rate. We know of no evidence that manual workers smoke their cigarettes in a different manner from other people, but there are several reports that an increase in the rate of fall of COHb levels can be achieved by hyperventilation and by exercise (Forbes, Sargent, and Roughton, 1945; Coburn, Forster, and Kane, 1965; Shields, 1971).

The manual workers were Smithfield meat-porters and hence fitter and more active than the sedentary group who worked in offices. The significantly lower COHb levels of the meat-porters who smoke compared to the other group of smokers can therefore be explained by the relatively increased alveolar ventilation inherent in their occupation. This will result in an increased elimination of carbon monoxide, thereby maintaining their COHb at a lower level.

A comparison of the levels of COHb found in smokers (mean 5.8%) with that of non-smokers (mean 1.3%) breathing city air shows that cigarette smoke is a far more potent elevator of COHb than any other form of air pollution in normal circumstances. Two investigators have attempted to show the effects of comparatively high levels of carbon monoxide produced from car exhaust on COHb levels in non-smokers. Lawther and Commins (1970) measured COHb levels in policemen after about three hours on point duty. Eight were non-smokers and 17 were smokers. The mean COHb level was 1.9% in the non-smokers, compared to 1.3% in our subjects, and 3.6% in the smokers. Jones, Commins, and Cernik (1972) found a difference between the COHb levels of non-smoking taxi-drivers on day duty (mean 2.3%) and those on night duty (mean 1.0%). Both these authors concluded that the effect of smoking on COHb levels outweighed that of exposure to street air. Goldsmith and Landaw (1968) tried to minimize the effect of community pollution in their longshoremen by taking samples before work, but the calculated mean COHb level in non-smokers (1.2%) was only 0.1% below that of our subjects who had been exposed to city air for at least six hours.

Eighteen of our smokers (5.7%) had low COHb levels, that is, similar to the levels found in non-smokers. In 12 of these it is known that they smoked within four hours of blood being taken. The average increase in COHb level in the blood of inhalers following a cigarette is 1-1.5% (Russell et al., 1973b) and the half-life of COHb during light activity is between two and four hours (Castleden and Cole, 1974). Hence we conclude that a small percentage of cigarette smokers do not inhale.

In conclusion, although the exact role of carbon
monoxide in causing disease in man is yet uncertain
the estimation of the degree of inhalation of tobacco smoke with
all its constituents, and therefore, secondly the
degree of risk to the subject of any subsequent
disease whatever the mechanism. The difference in
the COHb levels that occurs between smokers and
non-smokers is so marked that an inhaling smoker
can easily be recognized. If a physician advises a
patient to stop smoking, a subsequent estimation of
his COHb will be an absolute indication of whether
or not the patient had heeded his advice.

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