activities of textile industry such as dyeing, printing and bleaching were interviewed out of which 845 were textile workers from 33 textile industries, and 395 comparative group non textile workers. From each worker, information on Socio-demographic aspects and smoking habits were recorded in pre-structured schedules. The workers, who worked in the textile industry for at least one year were considered for the present study. Chi-square test and proportion test were applied.

Analysis of data revealed that 96.9 percent were male workers and majority of workers (55.3%) belonged to 18 to 30 years age group.

Among textile group 51.4 percent workers were smokers whereas in comparative group, 46.8 percent. Percentage of smokers were observed to be significantly higher in the textile workers than comparative group (P<0.05). The work category-wise the highest smokers were found among the printing group (34.5%) followed by finishing (33.6%), Dying (22.9%) and least in the bleaching and caustisizing group (8.9%).

Smoking ‘Beeri’ and consuming ‘Gutka’ were higher in textile workers (25.0 and 30.1%) than comparative group (16.7 and 24.8%), whereas, the percentages of consumers of ‘Zarda’ and ‘Cigarette’ were significantly higher in comparative group (50.8 and 5.9%) than textile workers (P<0.05). It means that textile workers opt for the smoking which is cheaper, easily available and contains higher tobacco contents which give them more relaxation during their heavy work in contrast to the comparative group.

Age-wise distribution of smokers revealed high percentage of workers (53.5%) than comparative group (50.2%) in less than 30 years age groups. Religion showed no association with smoking but in Muslims, percentage of smoking was higher in textile workers (8.5%) than comparative group (2.7%) though statistically insignificant (P=0.05).

Education-wise, upto primary standard, the percentage of smokers was observed significantly high (55.1%) in the textile workers showing an inversely proportionate relationship whereas in comparative group, the association was found proportionate to the educational qualification which may be attributed either a status symbol or luxury.

Earlier studies reported from India on students showed prevalence of smoking varying from 7.1% to 8.2%. The high percentage (54%) of smokers in early age groups (upto 30 years) among textile workers may be due to their low education, as 55.1% of smokers were educated only upto primary standard, which is further responsible for their unawareness regarding the various hazards of smoking in relation to health. So there is a strong need of organizing anti smoking campaigns for them to change their attitude towards smoking which in turn will be beneficial for their health.

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THROMBOPHILIA MARKERS IN ACUTE MYOCARDIAL INFARCTION OF THE YOUNG

SIR,

We have read the results of the study “Combination of thrombophilia markers in acute myocardial infarction (MI) of the young” published in Indian Journal of Medical Sciences with great interest.1 As already known, data about thrombophilic conditions are derived mainly from Caucasian populations and this study is especially important because it is one of the unique studies addressing thrombophilic factors in Indian population.

Another unique feature of the study is the higher incidence of factor V Leiden in cases with arterial thrombosis (young acute MI patients) while factor V Leiden is reported considerably low in Indian population. According to the proposals based upon previous studies, it is accepted that hereditary thrombophilia is a major risk factor for venous thrombosis and it is not recommended to perform tests such as factor V Leiden and prothrombin gene mutation except antiphospholipid antibody and hyperhomocysteinemia.2 Parallel to these, it is interesting that in this study at least one thrombotic risk factor was established in 72.5% of cases with arterial thrombosis. We wonder whether the young acute MI study patients who have thrombotic risk factors (except dysfibrinogenemia, MTHFR and hyperhomocysteinemia) experienced any venous thrombotic event before? Finally, were these patients investigated for sticky platelet syndrome? As you know, sticky platelet syndrome is characterized by hyperaggregability of platelets and it is accepted as the underlying cause in 21% of unexplained arterial events.3 In conclusion, as the authors implied, more comprehensive studies are needed in young MI patients for correct interpretation of the study results which are quite different from previous studies.

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Hemoglobinopathies are characterized by production of structurally defective hemoglobin due to abnormalities in formation of the globin part of hemoglobin. Some of the hemoglobinopathies which are common in our country are discussed below.

SICKLE CELL ANEMIA

The sickle hemoglobinopathies are hereditary disorders in which the red cells contain Hb S instead of Hb A. Hb S differs from Hb A in the substitution of valine for glutamic acid in the sixth position from the N terminal end of the beta chain. The solubility of Hb S in the deoxygenated state is ten percent that of Hb A. Thus in parts of microcirculation where flow rate is slow, cell transit is delayed and oxygen tension is low, the red cells sickle. This leads to further slowing of circulation and reduction in oxygen tension and more red cells sickle eventually leading to blockage of the vessel. This blockage is the cause of painful crisis observed in sickle cell disease.

PREVALENCE

Hb S is prevalent in tropical Africa. In India this condition is common among certain tribes in south India, Assam, Bihar and Orissa. It is also seen in certain communities in and around Aurangabad, Nagpur and Gujarat.

CLINICAL FEATURES

Though the condition is inherited and hence present since birth, clinical manifestations begin only after several months. This is because of Hb F present at birth which protects against sickling.

Anemia is present since early childhood. The child also has icterus and splenomegaly. A chronic anemic state is interspersed with acute episodes of painful crises during which the patient has severe pain in the limbs and even severe abdominal pain which can mimic acute appendicitis, pancreatitis or other causes of acute abdomen.

During childhood the spleen is moderately enlarged. Owing to repeated episodes of splenic infarction, spleen shrinks in size as the child grows so that in the adult patient with sickle cell anemia, spleen is usually not palpable.

Depending upon the site of blockage of microcirculation, the patient manifests with pain in that area as well as other symptoms, for e.g. Blockage of renal vasculature can lead to hematuria and loss of ability to concentrate the urine. Similarly involvement of pulmonary vasculature leads to episodes of pulmonary infarcts which may eventually lead to