LETTERS

Smoking and a Surgeon General

"The Surgeons General and Smoking" [*PHR* 112:440-2] was timely and interesting. However, I was dismayed to see a pioneering thoracic surgeon, Dr. Evarts Graham, dismissed in a highly misleading paragraph suggesting that he had little interest in the connection between cigarette smoking and lung cancer. Graham did not merely become "more convinced of the connection between smoking and lung cancer"; he played an important role in the clinical and epidemiological advances that verified this linkage.

Dr. Graham performed the first successful one-stage removal of an entire lung in April 1933, beginning a new era in the treatment of lung cancer. The patient lived 30 years after his pneumonectomy. According to a November 1984 paper in the *Journal of Thoracic and Cardiovascular Surgery*, "The patient's long survival caused the diagnosis of lung cancer to be openly questioned. To lay to rest these rumors, Dr. Graham asked Dr. Lauren V. Ackerman, the Chief of Surgical Pathology, to review the findings in this case. The ensuing report dispelled all doubts."

As Chair of Surgery at the Washington University School of Medicine for 38 years (1919 to 1947), Graham trained and influenced two generations of chest surgeons. In 1948, he allowed a third-year medical student, Ernst Wynder, to interview lung cancer patients on his service as a means to study the epidemiology of the disease. In 1950 they published an important paper, "Tobacco Smoking As a Possible Etiological Factor in Bronchogenic Carcinoma." Though their research ultimately proved correct, these findings were rejected not only by tobacco companies but also by peers. As Wynder wrote, "It would have been easy to become discouraged if not for Dr. Graham's strong support." In a 1953 joint report, Graham and Wynder showed for the first time that tobacco smoke condensate was carcinogenic to mouse skin. Tragically, Dr. Graham, himself a former smoker, died of lung cancer in 1957.

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Nutrition Among Homeless Children

The health and educational needs of young children are popular topics of discussion. One group of children left out of these conversations are those who experience homelessness.

I recently undertook a study of 75 preschool children living with their mothers at a homeless shelter in Houston, Texas. I was primarily interested in assessing the food services provided by the shelter to children in this critical stage of cognitive and physical development.

In a representative sampling of menus over a four-week period, I found that the children were consistently offered fewer than the recommended number of servings of pastas/breads and vegetables as indicated by the food pyramid. Fresh fruit was not available, and the number of servings of canned fruit was minimal. Milk was served in excess, along with meats and sweets.

I also surveyed children's mothers to determine actual eating habits. Like other children, these homeless children generally disliked vegetables. However, I was surprised to find that they also neglected to eat the sweets offered with their meals.

While the shelter conscientiously served three meals each day, food was not provided outside of mealtimes and thus the nutritional needs of preschool children were unmet. Preschool-age children need frequent, small meals, usually five or six per day. Most preschoolers in homeless shelters cannot consume all of the food they need in only three meals, no matter how nutritionally balanced those meals might be.

A recent study[1] showed how poor diet in early childhood has implications for the long-term health and cognitive development of children.

Nurses and nutritionists can effect changes to improve homeless children's long-term health. Food service personnel at shelters must be taught the importance of small, numerous servings of pastas, vegetables, and fresh fruit. Sweets should be replaced with foods such as bread sticks, apple wedges, and carrot sticks. Nurses and nutritionists can help those mothers who need to learn to prepare appropriate meals for their children. These relatively inexpensive health interventions could provide large payoffs in the futures of these children and our country.

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Healthy People 2010

Just as the scientific base for health promotion and disease prevention has evolved since the Healthy People process began in the late 1970s, the "management by objectives" approach that guided the development of Healthy People 2000 objectives has been supplanted by performance monitoring concepts in both the personal health care and public sectors. Thus it is good to see in the article by Maiese and Fox ("Laying the Foundation for Healthy People 2010," *PHR* 1998;113:92-5) that new frameworks for national health objectives are being considered.

A new Institute of Medicine report, *Improving Health in the Community: A Role for Performance Monitoring,*[1] develops two ideas that can help modernize the Healthy People process: (a) health is a shared responsibility of many, diverse community entities; and (b) a performance monitoring framework can help ensure that these entities are held accountable for the activities they undertake to improve the community's health. This suggests that the Healthy People 2010 process should incorporate two central steps.

First, participants should agree on a short list of health status and risk reduction measures that would serve as national health objectives. This list would include 25 to 50 outcome-oriented measures instead of the more than 300 objectives in Healthy People 2000. These objectives should employ measures that, as far as is possible, are applicable at the state and local as well as the national level.

Second, in a variety of focus areas such as heart disease, tobacco, environmental health, maternal and infant health, and violent and abusive behavior, sets of performance indicators should be developed for actions that can be taken by Federal agencies, professional groups, and voluntary organizations at the national level to promote these national health objectives. These indicators could serve as a toolbox of models that states and communities might use to develop performance indicators appropriate for local conditions, problems, and capabilities.

This approach would solve the dilemma that Maiese and Fox describe about Healthy People 2000—that there are simultaneously too many and too few objectives. The large number of objectives makes it difficult to focus on the overall message or identify priority actions, yet they are needed to guide topic-specific action. The proposed short list of national health objectives would provide focus and a clear message while the more numerous and flexible performance indicators would provide national, state, and local measures to guide action.

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TB Reporting

Few studies have been published of the completeness of hospitals' reporting of tuberculosis (TB) cases to health departments. We report an evaluation of the completeness of TB reporting from hospitals in Missouri. We reviewed *International Classification of Diseases, Ninth Revision, Clinical Modification* [*ICD-9-CM*] codes[1] for discharges from acute care hospitals in the state, excluding Veterans Administration hospitals, for January 1994 through June 1995 to identify records with TB-related discharge diagnoses (*ICD-9-CM* codes 010-018.9). We then manually matched those records by name to the state's TB registries. Records of patients with TB-related *ICD-9-CM* codes that were not found in the registries were reviewed by a physician or TB nurse specialist to verify the diagnosis of TB.

TB-related *ICD-9-CM* codes were found in 866 hospital records. Registry matching and review of medical records identified 168 duplicate records (patients with more than one hospital admission during the study period). Registry matching of the remaining 698 records found that 240 patients (34%) had been reported to the TB registry. Of the remaining 458 patients, 18 (4%) had confirmed TB, 137 (30%) were infected with nontuberculous mycobacteria, 69 (15%) had a history of TB that was clinically inactive at the time of hospitalization, 51 (11%) were reported in another state, and 143 (31%) were miscoded. In addition, 40 (9%) charts were missing, so their reporting status could not be determined.

The Missouri TB surveillance registry detected 93% of patients hospitalized with TB. Not counting the 40 patients whose records were missing, the predictive value of hospital discharge *ICD-9-CM* codes for identifying active TB cases was 47%, considering the 240 TB cases reported to the TB registry, 51 TB cases counted in another state, and 18 unreported cases (309/658).

Thus TB-related *ICD-9-CM* discharge codes were not a reliable predictor of active TB. Crossmatching TB registries with *ICD-9-CM* data was labor-intensive but detected 18 TB cases not in the registry. Active surveillance for TB in Missouri hospitals that had unreported cases should be considered to ensure complete reporting of hospital-diagnosed TB cases.

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