

## Correspondence

# Profile of Lung Cancer in Predominantly *Bidi* Smoking Rural Population of Northern Himachal Pradesh

**To The Editor:** We read with great interest the article by Sharma and Bansal.<sup>1</sup> The authors have discussed the presentation of lung cancer in predominantly *bidi* smokers in northern Himachal Pradesh. There are some interesting observations of the study. Out of the current *bidi* smokers, 40% had squamous cell carcinoma and 32% had adenocarcinoma histologically, suggesting that the incidence of squamous cell carcinoma and adenocarcinoma is equal among *bidi* smokers. However, the Indian studies have uniformly shown that squamous cell carcinoma is the predominant cell type among smokers.<sup>2</sup> We have also studied lung cancer in Himachal Pradesh covering almost the entire population. We found that overall squamous cell carcinoma was the dominant cell type (59.8%) and 21% females had adenocarcinoma.<sup>3</sup> In another study carried out exclusively among *bidi* smokers 57.5% had squamous cell type followed by small cell carcinoma (22%) whereas adenocarcinoma was significantly more in females (23.5%).<sup>4</sup> We further studied pattern of lung cancer among *bidi* smoking women wherein 44.7% *bidi* smoking women had squamous cell carcinoma followed by small cell carcinoma (22.4%); adenocarcinoma was found in (14.9%) cases, and in this particular study *bidi* smoking did not have any bearing on the cell type.<sup>5</sup> Similar results were reported in another study.<sup>6</sup> Therefore, it can be concluded from the foregoing discussion that squamous cell type is the dominant lung cancer among *bidi* smokers in Himachal Pradesh. The conclusion of the authors that incidence of squamous cell cancer and adenocarcinoma lung is almost equal sounds very interesting and suggests that adenocarcinoma of the lung may be on the rise among smokers in the population under study. Nevertheless, a study in larger number of patients should clear the picture.

The increase in the occurrence of adenocarcinoma particularly in the western countries has been possibly attributed to the changing pattern of tobacco smoking involving low tar and high nitrate content. However, a recent Indian study<sup>7</sup> has attributed the increase in the incidence of adenocarcinoma of lung to the factors other than smoking since the increase has been shown in non-smokers as well.

The authors have also noticed that in 16% of the patients with lung cancer, the cell type was not classifiable. It is possible that some of these unclassified patients were of specific cell type, and thus, distorting the picture of overall pattern of histopathological distribution of lung cancer.

**S. Kashyap**

Director

Kalpana Chawla Government Medical  
College and Hospital, Karnal (Haryana)  
and

**Kartikeya Kashyap**

Government Medical College and Hospital  
Chandigarh

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**The Author's Reply:** We appreciate and completely agree with the observations of esteemed authors. In our study we have also concluded that more such and larger studies are needed to analyse the perceptible increase in adenocarcinoma in this population. The authors are also right in their observations that the unclassifiable 16% in our study could affect the ultimate outcome. To address both these issues we are continuing with our study and getting the unclassifiable slides reviewed by more than one pathologist. This discrepancy in various studies from similar population could be because majority of the studies are hospital based. So we feel that there is an urgent need of a population based study on lung carcinoma in this population.

**P.K. Sharma**

Associate Professor

Department of Pharmacology

Dr R.P. Government Medical College

Kangra at Tanda Pin-176 001 (Himachal Pradesh), India

E-mail: drdotsharma@gmail.com