

Smoking prevalence in Texas

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Smoking remains an important health issue in the United States. *The Morbidity and Mortality Weekly Report* for October 7, 2016, provided state specific prevalence rates for current cigarette smoking and smokeless tobacco use in adults for the year 2014.¹ The prevalence of current smoking ranged from 9.7% of adults in Utah to 26.7% of adults in West Virginia. The prevalence in Texas was 14.5% (95% confidence interval [CI]:13.6-15.6). The prevalence of smokeless tobacco use in Texas was 4.2% (95% CI: 3.7-4.8). The combined prevalence of any cigarette or any smokeless tobacco use in Texas was 16.4% (95% CI: 15.4-17.4). The rates were higher in men (16.7%) than in women (12.5%). The prevalence rates were higher in White adults (19.2%) than in Black non-Hispanic adults (14.6%), Hispanic adults (13.7%), and non-Hispanic Other adults (13.4%). This report suggested reductions in tobacco use will depend on population based interventions, including increased tobacco prices, enforcing comprehensive smoke-free laws, public education through the mass media, and increasing access to clinical interventions with counseling and FDA approved medications.

The Truth Initiative website provided the following economic information about tobacco use in Texas in

2017.² Healthcare costs in Texas directly related to smoking were approximately \$8.85 billion. Lost productivity due to smoking was approximately \$8.22 billion. Texas received \$1.92 billion in tobacco settlement payments and taxes in fiscal year 2017 and allocated \$10.2 million in state funding for tobacco prevention in fiscal year 2017. Clearly, the health and economic costs related to tobacco use in Texas are substantial, and state efforts to reduce and prevent tobacco use are very modest.

This issue of the *Southwest Respiratory and Critical Care Chronicles* includes an article by Limsuwat and colleagues on the pharmacotherapy of smoking cessation and an article by Nugent and Berdine on the importance of media literacy to counter efforts by companies to increase tobacco use.

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Cyclosporiasis outbreak in Texas

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On July 2, 2018, the Texas Department of State Health Services announced that their officials are investigating 56 new cases of cyclosporiasis. State officials believe this outbreak started in the beginning of May; the epidemiological source of infection remains unclear to this date.¹

Cyclosporiasis is caused by the parasite *Cyclospora cayetanensis*, which is a coccidian (protozoan parasite) that can cause gastrointestinal infections.² *C. cayetanensis* was initially described in the 1980s, when it produced severe diarrheal disease in HIV-infected patients. Since then it has been reported

to cause disease in both immunocompromised and immunocompetent hosts around the globe, including children and adults.^{2,3} Transmission is usual by the fecal-oral route with an incubation period of approximately 7-14 days. Associated symptoms include watery diarrhea, anorexia, nausea, flatulence, abdominal cramping, low-grade fever, and weight loss which can last for weeks to months.³

In the United States, there have been multiple outbreaks described in the past. The most famous outbreak in 1996 required an extensive epidemiological investigation, and the source was eventually traced to Guatemalan raspberries. At least 1,465 cases were confirmed at that time.⁴ Cyclosporiasis may not be as uncommon as previously thought, and this outbreak in Texas is not the first outbreak reported this year. Through July 5, 2018, outbreaks in Illinois, Indiana, Iowa, Michigan, Minnesota, and Wisconsin with at least 212 confirmed cases have been linked to vegetable trays containing fresh broccoli, cauliflower, celery sticks, carrots, and dill dip from Del Monte Fresh Produce.⁵ The diagnosis of cyclosporiasis is established with stool microscopy, special stains are required (e.g., modified acid-fast stain) to identify the oocyst in the stools,³ and new molecular diagnostic stools allow earlier detection.²

The Department of State Health Services recommends thoroughly washing all fresh produce, even though *Cyclospora* may be difficult to wash off.¹ When the infection is confirmed, treatment for immunocompetent persons is usually with trimethoprim-sulfamethoxazole for 7-10 days.³ In immunocompromised patients, such as in AIDS, higher and longer doses of antibiotics may be required, as well as treatment of the underlying immunodeficiency.

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