# Errata

## Volume 34, issue 10, page 845.

The list of authors should read as follows:

"Jonatas Reichert[1], Alberto José de Araújo[2], Cristina Maria Cantarino Gonçalves[3], Irma Godoy[4], José Miguel Chatkin[5], Maria da Penha Uchoa Sales[6], Sergio Ricardo Rodrigues de Almeida Santos[7] e Colaboradores"

## Volume 34, issue 10, page 870, first column, final paragraph.

Due to a problem in the layout, a section of the text was not published (subheading Harm Reduction). The missing passage is printed here below:

"A reduction of 50% in the number of cigarettes smoked/day did not improve AMI-related mortality and incidence rates.[207-210] The use of smokeless tobacco, either as snuff or chewed tobacco, defended as a way to reduce CVD risks in smokers who cannot stop smoking, was associated with an increased risk of AMI and cerebrovascular accident (CVA).[211-214] Therefore, we can conclude that there is no scientific evidence that decreasing the number of cigarettes smoked provides a reduction in CVD risks (level B).

Cancer mortality rates are lower among former smokers than among current smokers. Between former smokers and current smokers who reduce by half the number of cigarettes smoked, the differences are not significant.[217] When tumor markers are studied, the effects of smoking reduction are varied, ranging from a small decrease in nitrosamine metabolites to no effect at all.[216,217]

However, other studies show that there is sufficient evidence to indicate that the use of snuff and chewed tobacco causes cancer of the oral cavity and pancreas in human beings, due to the presence of two tobacco-specific nitrosamines.[218,219] Therefore, there is no conclusive evidence that these strategies reduce the risk of cancer in human beings (level B).

A reduction of 50% in the number of cigarettes/day decreased the inflammatory process of the airways, with a decrease in neutrophils and macrophages, although not reaching the levels seen in nonsmokers.[220,221]

Some studies have shown a decrease in the respiratory symptoms of COPD patients when they reduced the number of cigarettes smoked.[222,223] However, this reduction did not improve the forced expiratory volume in one second, did not lower the risk of hospital admission for COPD and did not decrease mortality rates.[214,224,225]

Therefore, there is also no conclusive evidence that harm reduction decreases the risk or complications of COPD (level B). As a result, the scientific evidence does not allow us to conclude that harm reduction in smoking is beneficial.

It is almost impossible to evaluate the cost/benefit relation of strategies to reduce damages to the human health, because there are no accurate markers of the risks of these forms of exposure to tobacco products.[226,227] In addition, all forms of smokeless tobacco contain and produce nicotine in quantities that are comparable to those found in the cigarette smoke. Tobacco consumers who discontinue their use present withdrawal and "craving" symptoms—confirming the potential of these products to cause dependence[212] and various types of damage to human health.[214,228,229]

The PREPs were developed to release low concentrations of cancerous substances, especially nitrosamines and aromatic polycyclic hydrocarbons.[230] However, some studies concluded that PREPs increase the serum levels of carbon monoxide to concentrations higher than those observed in the users of common cigarettes.[231] In addition, PREPs users compensate by reducing the interval between drags and dragging deeply, in order to satisfy their nicotine dependence.[232]

As for the reduction in the number of cigarettes, the central problem is that the smokers modify their manner of smoking, inhaling more deeply and with greater frequency in order to maintain their serum nicotine levels.[232,234] Therefore, a percentage reduction in the number of cigarettes might not produce an equivalent reduction in the exposure to tobacco toxins.

Harm reduction should not be the final goal, but a way to achieve the definitive cessation, or a strategy to reinforce the individual motivation, considering that SRD risks remain the same. Since most smokers who try to reduce tobacco use report various withdrawal symptoms, NRT (nicotine gum) is suggested as a reduction regimen for at least three months (level A).[234]"