Effect of the Italian Smoking Ban on Population Rates of Acute Coronary Events

Giulia Cesaroni, MSc; Francesco Forastiere, MD, PhD; Nera Agabiti, MD; Pasquale Valente, MD; Piergiorgio Zuccaro, PhD; Carlo A. Perucci, MD

Background—Several countries in the world have not yet prohibited smoking in public places. Few studies have been conducted on the effects of smoking bans on cardiac health. We evaluated changes in the frequency of acute coronary events in Rome, Italy, after the introduction of legislation that banned smoking in all indoor public places in January 2005.

Methods and Results—We analyzed acute coronary events (out-of-hospital deaths and hospital admissions) between 2000 and 2005 in city residents 35 to 84 years of age. We computed annual standardized rates and estimated rate ratios by comparing the data from prelegislation (2000–2004) and postlegislation (2005) periods. We took into account several time-related potential confounders, including particulate matter (PM$_{10}$) air pollution, temperature, influenza epidemics, and total hospitalization rates. The reduction in acute coronary events was statistically significant in 35- to 64-year-olds (11.2%, 95% CI 6.9% to 15.3%) and in 65- to 74-year-olds (7.9%, 95% CI 3.4% to 12.2%) after the smoking ban. No evidence was found of an effect among the very elderly. The reduction tended to be greater in men and among lower socioeconomic groups.

Conclusions—We found a statistically significant reduction in acute coronary events in the adult population after the smoking ban. The size of the effect was consistent with the pollution reduction observed in indoor public places and with the known health effects of passive smoking. The results affirm that public interventions that prohibit smoking can have enormous public health implications. (Circulation. 2008;117:1183-1188.)

Key Words: tobacco smoke pollution ■ prevention ■ myocardial infarction ■ heart diseases ■ social class

The adverse effects of exposure to environmental tobacco smoking (ETS) are well established. Several well-conducted studies have shown a higher risk of coronary artery diseases, lung cancer, respiratory diseases, and stroke associated with exposure to passive smoke. On the basis of this research, many countries have enacted legislation that prohibits smoking in public places, which include bars and restaurants. Smoking restrictions in the workplace have already been implemented in several European nations. A recent report illustrates the policies worldwide for ETS prevention. Evidence is mounting that smoking bans reduce ETS exposure and respiratory symptoms among service industry workers and that they reduce hospitalizations for acute myocardial infarction (AMI) in the general population. Because coronary heart disease is the leading cause of death in developed countries, even a small reduction in risk could lead to large public health gains.
At the same time, the per capita sale of cigarettes declined in 2005 compared with 2004 and the sale of nicotine-replacement products increased, which suggests that the smoking ban in Italy reduced both active smoking and passive smoking exposures. 

We evaluated changes in acute coronary event rates in residents of Rome from 2000–2004 to 2005, after the smoking ban, while taking into account the effect of several potential factors that could confound the association. We postulated that the effect of the smoking ban would be small and would be more evident in young people.

Methods

Area of the Study and Population Data

The study was conducted on residents of Rome between 35 and 84 years of age (total population of ~2.7 million) between 2000 and 2005. Annual population data by gender and age (in 5-year age groups) were obtained from the municipal population register.

Data on Acute Coronary Events

Episodes of acute coronary events in the population were obtained from 2 reliable population registers: the hospital discharge database, which records all hospitalizations of city residents at public and private hospitals in Rome, and the regional register of causes of deaths, which includes all deaths of city residents regardless of where in the country they occurred. To evaluate occurrence rates in the total population, we evaluated both out-of-hospital deaths and hospitalized cases.

We defined hospitalizations for acute coronary events from all discharge reports of residents of Rome (35 to 84 years of age) between 2000 and 2005 that listed a principal diagnosis of “acute myocardial infarction” (as subsequently defined) and “other acute and subacute forms of ischemic heart disease” (International Classification of Diseases, 9th Revision, Clinical Modification [ICD-9-CM] code 411). We defined hospitalizations for AMI as all discharges with a principal diagnosis of AMI (ICD-9-CM code 410) or a secondary diagnosis of AMI when the principal diagnosis indicated AMI complications (427.1, paroxysmal ventricular tachycardia; 427.41, ventricular fibrillation; 427.42, ventricular flutter; 427.5, cardiac arrest; 428.1, left heart failure; 429.5, rupture of chordae tendineae; 429.6, rupture of papillary muscle; 429.71, acquired cardiac septal defect; 429.79, mural thrombus atrial/ventricular acquired, after myocardial infarction; 429.81, other disorders of papillary muscle; 518.4, acute edema of lung, unspecified; 780.2, syncope and collapse; 785.51, cardiogenic shock; 414.10, aneurysm of heart; 518.91, aneurysm of heart [wall]; and 423.0, hemopericardium). We considered 2 events that occurred within 28 days of each other as a single episode.

Individual records from the mortality register (using a personal identification number) were compared with hospital discharge records to identify out-of-hospital coronary deaths. These were deaths due to ischemic heart diseases listed on the death certificate (ICD-9 410 to 414), with no evidence of hospital admission for coronary causes in the previous 28 days and no evidence of hospitalization for any cause in the previous 2 days.

Environmental and Population Characteristics

Several factors that vary over time may confound the association between a smoking ban and acute coronary events. We collected daily mean data on particulate matter with an aerodynamic diameter <10 µm (PM_{10}) from 4 fixed monitors located in residential areas and run by the regional Environmental Protection Agency. We also considered influenza epidemics (based on estimates of weekly influenza incidence, as reported by the Italian National Health Service) and holidays. The Italian Air Force Meteorological Service provided daily apparent temperature (a climatological index that indicates the combined effect of air temperature and humidity). Data on cigarette sales in Rome during 2003 to 2005 were provided by the Italian National Health Institute (Istituto Superiore di Sanità). Data on population smoking habits (≥15 years) for the region of Rome during the years 2000 to 2003 and 2005, based on health surveys, were provided by the National Institute of Statistics (ISTAT).

We used a small-area index based on 2001 census data as a measure of socioeconomic position. We considered census information that represents various aspects of deprivation (education, occupation, home ownership, family composition, and nationality) from the 4888 census blocks in Rome with at least 50 inhabitants (average population 500 people). We performed a factor analysis and created a composite index of socioeconomic position, distributed in quintiles. Income data were not available.

Statistical Analyses

We computed directly age-standardized rates of annual acute coronary events considering the population of Rome on January 1 of each year as the denominator (European population as standard). A priori, we stratified the analyses into 3 age groups (35 to 64 years, 65 to 74 years, and 75 to 84 years of age) with the hypothesis that ETS exposure is higher in people of working age than among the very elderly. To evaluate changes over time, we used Poisson regression analyses on the calendar-time axis from January 1, 2000, to December 31, 2005. The number of daily episodes was the dependent variable, whereas daily predictors included air pollution, flu epidemics, a binary variable for holidays, and apparent temperature. For the latter, we used a linear spline with knots at 20°C and 26°C to accommodate nonlinear relationships. The gender and age distribution of the at-risk population was always considered as the offset variable. From the Poisson regression, we estimated relative rates (RRs; with 95% confidence intervals [CIs]) of acute coronary events occurring after January 10, 2005, with those that occurred before implementation of the ordinance.

Additional adjusted analyses using annual variables and subgroup analyses were conducted. To consider the effect of time trends in the occurrence of acute coronary events, we adjusted for a linear time term from 2000 to 2005. We also considered annual all-cause hospitalization rates for residents of Rome (from the age groups considered) as an adjustment factor to take into account that changes in the occurrence of acute coronary events may reflect the overall trends of hospital use. Finally, we also compared data from 2005 with data from 2004. Stratified analyses were conducted to evaluate possible gender and socioeconomic differences in the effect of the smoking ban. We performed separate analyses for out-of-hospital coronary deaths and hospitalizations. Finally, we analyzed incident cases only, namely, only people with a first event who had no admissions for an acute coronary event in the previous 4 years (ICD-9-CM 410, 411, or 412, any position) and no secondary diagnosis of previous AMI (ICD-9-CM 412) in the index hospitalization. Effect modification was evaluated with a log-likelihood ratio test.

The authors had full access to and take full responsibility for the integrity of the data. All authors have read and agree to the manuscript as written.

Results

Over the period studied, a small increase occurred in the total population of the 3 age groups, which was largest in the oldest group (Table 1). A decrease in all-cause hospital admission rates in the 3 age groups was evident. Slight changes occurred in population (≥15 years) smoking habits: The prevalence of smoking decreased from 34.9% to 30.5% in men and from 20.6% to 20.4% in women. Cigarette sales also decreased in Rome in 2005 compared with 2004 (~5.5%). Table 1 summarizes the statistics of the daily variables. The average concentrations of PM_{10} decreased (from 46 µg/m^3 in 2000 to 39 µg/m^3 in 2005), as did the number of days per year that PM_{10} rose above 50 µg/m^3 (144 days in 2000 versus 73 in 2005). Annual mean apparent temperature did not vary, but the number of days per year with temperatures above 25°C varied considerably, from 47

Table 2 illustrates the annual number of events and the annual age-standardized rates of acute coronary events for the 3 age groups. The test for trend indicated decreased annual rates in people 35 to 64 years of age, no trend in those 65 to 74 years old, and an upward trend in 75- to 84-year-olds. Compared with data from the years 2000 to 2004, a statistically significant reduction occurred in acute coronary events after the smoking ban in 35- to 64-year-olds (RR 0.89, 95% CI 0.85 to 0.93) and in 65- to 74-year-olds (RR 0.92, 95% CI 0.88 to 0.97). No evidence was found of an effect in the oldest group studied (75- to 84-year-olds).

Table 3 shows results from additional adjusted analyses and subgroup analyses of the 35- to 64-year and 65- to
74-year age groups. The effect of the smoking ban on both age groups remained after adjustment for the temporal trend of acute coronary events. Adjustment for annual all-cause (directly standardized) hospitalization rates did not change the results substantially from the main analysis. When we simultaneously adjusted the same model for both time trends and hospitalization rates, as a way to test the robustness of the findings to an extreme correction, the results were borderline statistically significant in the youngest group (RR 0.94, 95% CI 0.89 to 1.01) and basically unchanged in the 65- to 74-year-olds (RR 0.90, 95% CI 0.84 to 0.96). When we compared post–smoking ban data with those from the previous year only, the effect was slightly attenuated in both age groups (RR 0.94, \(p=0.040\) for 35- to 64-year-olds; RR 0.94, \(p=0.044\) for 64- to 74-year-olds). Although the interaction between gender and the smoking ban was not statistically significant, the effect of the ordinance was statistically significant on men but not on women. The protective effect of the law seemed to be stronger for residents living in low socioeconomic census tracts than for those living in high socioeconomic areas, even though no evidence was found of a statistically significant interaction. In both age groups, out-of-hospital deaths and hospitalizations decreased. The effect of the smoking ban was slightly attenuated when we

<table>
<thead>
<tr>
<th>Year</th>
<th>35–64 y*</th>
<th>Rate (&lt;1000)</th>
<th>RR</th>
<th>95% CI</th>
<th>65–74 y†</th>
<th>Rate (&lt;1000)</th>
<th>RR</th>
<th>95% CI</th>
<th>75–84 y*</th>
<th>Rate (&lt;1000)</th>
<th>RR</th>
<th>95% CI</th>
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<tr>
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<td>2433</td>
<td>2.05</td>
<td>1.00</td>
<td>...</td>
<td>2093</td>
<td>7.30</td>
<td>1.00</td>
<td>...</td>
<td>1783</td>
<td>11.44</td>
<td>1.00</td>
<td>...</td>
</tr>
<tr>
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<td>1.98</td>
<td>0.97</td>
<td>0.92–1.03</td>
<td>2131</td>
<td>7.33</td>
<td>1.02</td>
<td>0.96–1.09</td>
<td>1922</td>
<td>11.91</td>
<td>1.06</td>
<td>1.00–1.13</td>
</tr>
<tr>
<td>2002</td>
<td>2538</td>
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<td>1.04</td>
<td>0.98–1.10</td>
<td>2239</td>
<td>7.66</td>
<td>1.08</td>
<td>1.01–1.14</td>
<td>2158</td>
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<td>1.15</td>
<td>1.08–1.22</td>
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<td>1.95</td>
<td>0.96</td>
<td>0.91–1.02</td>
<td>2336</td>
<td>7.86</td>
<td>1.12</td>
<td>1.06–1.19</td>
<td>2365</td>
<td>13.15</td>
<td>1.20</td>
<td>1.13–1.28</td>
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<td>2004</td>
<td>2281</td>
<td>1.92</td>
<td>0.92</td>
<td>0.87–0.98</td>
<td>2227</td>
<td>7.39</td>
<td>1.03</td>
<td>0.97–1.10</td>
<td>2382</td>
<td>12.65</td>
<td>1.15</td>
<td>1.08–1.22</td>
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<tr>
<td>2005</td>
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<td>1.80</td>
<td>0.87</td>
<td>0.82–0.92</td>
<td>2126</td>
<td>6.95</td>
<td>0.97</td>
<td>0.91–1.03</td>
<td>2477</td>
<td>12.59</td>
<td>1.15</td>
<td>1.08–1.23</td>
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</table>


<table>
<thead>
<tr>
<th>Year</th>
<th>35–64 y*</th>
<th>Rate (&lt;1000)</th>
<th>RR*</th>
<th>95% CI</th>
<th>65–74 y†</th>
<th>Rate (&lt;1000)</th>
<th>RR*</th>
<th>95% CI</th>
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<td>0.89</td>
<td>0.85–0.93</td>
<td>2126</td>
<td>0.92</td>
<td>0.88–0.97</td>
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<tr>
<td>2001</td>
<td>2136</td>
<td>0.93</td>
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<td>2126</td>
<td>0.88</td>
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<tr>
<td>2002</td>
<td>2136</td>
<td>0.90</td>
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<td>2003</td>
<td>2136</td>
<td>0.94</td>
<td>0.88–1.01</td>
<td>2126</td>
<td>0.90</td>
<td>0.84–0.96</td>
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</table>

Table 3. Results of Additional Adjusted Analyses and Subgroup Analyses of the Association Between the Italian Smoking Ban and Acute Coronary Events in 35- to 64-Year-Olds and 65- to 74-Year-Olds

<table>
<thead>
<tr>
<th>All events</th>
<th>35–64 y*</th>
<th>RR*</th>
<th>95% CI</th>
<th>65–74 y†</th>
<th>RR*</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
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<td>Main analysis</td>
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<td>0.89</td>
<td>0.85–0.93</td>
<td>2126</td>
<td>0.92</td>
<td>0.88–0.97</td>
</tr>
<tr>
<td>Adjusted for time trend</td>
<td>2136</td>
<td>0.93</td>
<td>0.88–0.99</td>
<td>2126</td>
<td>0.88</td>
<td>0.83–0.94</td>
</tr>
<tr>
<td>Adjusted for all-cause hospitalization rates</td>
<td>2136</td>
<td>0.90</td>
<td>0.86–0.95</td>
<td>2126</td>
<td>0.89</td>
<td>0.85–0.94</td>
</tr>
<tr>
<td>Adjusted for time trends and all-cause hospitalization rates</td>
<td>2136</td>
<td>0.94</td>
<td>0.88–1.01</td>
<td>2126</td>
<td>0.90</td>
<td>0.84–0.96</td>
</tr>
</tbody>
</table>

By gender

| Only men | 1712  | 0.88 | 0.84–0.93 | 1408 | 0.90 | 0.85–0.96 |
| Only women | 424   | 0.90 | 0.81–1.00 | 718  | 0.95 | 0.88–1.04 |

By socioeconomic position (quintiles)

| 1 (High) | 340  | 0.92 | 0.82–1.03 | 342  | 0.97 | 0.86–1.09 |
| 2         | 383  | 0.90 | 0.81–1.01 | 388  | 0.90 | 0.81–1.01 |
| 3         | 408  | 0.88 | 0.79–0.98 | 465  | 0.97 | 0.87–1.07 |
| 4         | 470  | 0.90 | 0.81–0.99 | 417  | 0.83 | 0.75–0.92 |
| 5 (Low)   | 535  | 0.85 | 0.77–0.93 | 514  | 0.94 | 0.86–1.04 |

By type of event

| Out-of-hospital deaths | 224  | 0.85 | 0.74–0.99 | 312  | 0.84 | 0.74–0.95 |
| Hospital events       | 1912 | 0.89 | 0.85–0.94 | 1814 | 0.94 | 0.89–0.99 |
| Only incident cases   | 1680 | 0.93 | 0.88–0.98 | 1528 | 0.95 | 0.90–1.01 |

*All rate ratios comparing 2005 vs 2000–2004 are adjusted for PM10, flu epidemics, holidays, and apparent temperature.

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Table 2. Age-Standardized Rates and Rate Ratios* of Acute Coronary Events by Age Group and Year

*Rate ratios are from a Poisson regression model of daily acute coronary events considering PM10, flu epidemics, holidays, and apparent temperature. \(p_{trend\ (year)}<0.001; p_{trend\ (year)}=0.578.\)
considered only incident cases (RR 0.93, 95% CI 0.88 to 0.98 for 35- to 64-year-olds; RR 0.95, 95% CI 0.90 to 1.01 for 65- to 74-year-olds).

Discussion

After smoking was banned in all public places in Italy, we observed in the population of Rome fewer acute coronary events (11.2% fewer in the 35- to 64-year-old population and 7.9% fewer in 65- to 74-year-olds) than in previous years. No evidence was found of a reduction in coronary episodes in people >74 years of age. Men in the youngest population and young people living in low socioeconomic census blocks appeared to have the greatest reduction after the smoking ban. The effects seen were robust in several additional adjusted analyses.

The smoking ban in Rome led to a reduction in exposure to passive smoking, as confirmed by improved indoor air quality measured in public places, and a reduction of active smoking, as shown by the decrease in cigarettes sales and the increase measured in public places, and a reduction of active smoking, as confirmed by improved indoor air quality. The greatest reduction after the smoking ban. The effects seen were robust in several additional adjusted analyses. The smoking ban in Rome led to a reduction in exposure to passive smoking, as confirmed by improved indoor air quality measured in public places, and a reduction of active smoking, as shown by the decrease in cigarettes sales and the increase measured in public places, and a reduction of active smoking, as confirmed by improved indoor air quality. The present study is the first in Europe to evaluate the effect of a smoking ban on acute coronary events over 1 year, to consider several other determining factors, and to compare the postlegislation data with a long reference period. The present study is the first in Europe to evaluate the effect of a smoking ban on acute coronary events over 1 year, to consider several other determining factors, and to compare the postlegislation data with a long reference period.

Specific effects were investigated according to socioeconomics position and gender. The smoking ban took effect nationally, which means no control population was available, and this aspect represents the present study’s major weakness.4,7 A comparison with a city in another country, such as Paris, France, or Athens, Greece, would have led to comparability issues because of marked differences in smoking habits and time trends in these countries. Because no solution to this problem existed, we decided to perform several additional analyses, including considering the time trend and adjusting for total hospitalization rates. The model with a simple time trend in acute coronary events may take into account all unmeasured confounders that change over time. A decline in all-cause hospital admissions also occurred in all age groups considered, which possibly reflected a change in health service organization independent of the specific cause of the hospitalization. However, acute coronary events necessitate hospital treatment. In any case, results did not vary substantially when we adjusted for overall hospitalization rates in the Poisson regression. We were specifically interested in evaluating a reduction in the number of episodes of acute coronary syndrome, not just incident cases. This implies some intra-individual correlation. However, when we analyzed incident cases only, a statistically significant reduction in acute coronary events among 35- to 64-year-olds remained. Finally, we studied 3 different age groups, with the hypothesis that the elderly would be less likely to be affected by a ban of smoking in public. The weaker effect on 65- to 74-year-olds compared with 35- to 64-year-olds and the lack of effect on the elderly (75 to 84 years old) support our hypothesis.

Alternative explanations for the reduction were investigated. During the study period, new diagnostic criteria for AMI were implemented because of the new European Society of Cardiology/American College of Cardiology definition18 (ie, measurement of troponin levels became available in hospitals in Rome). It is reasonable to consider that these changes could have caused an increase in acute coronary hospital admissions starting in 2002 to 2003. One factor that could have influenced the observed decrease is the change in cardiac medications. In Italy, the daily defined doses of statins increased from 10 to 55 per 1000 residents per day during the study period, and these medicines are used more often in Rome than in other areas of the country.19 Because statins are generally prescribed to people <75 years of age, an increase in their use actually could be responsible for at least part of the decrease. Nevertheless, when we considered a time trend term in the analysis, we took into account the linear changes of various unmeasured factors, such as the use of statins, and we still obtained a statistically significant reduction in acute coronary events after the smoking ban.

Because the prevalence of cigarette smoking is not evenly distributed across socioeconomic groups of the population, Koh and colleagues3 indicate that tobacco control is a fundamental effort in eliminating health inequalities. A variety of interventions have been undertaken, such as increased taxation, the availability of nicotine-replacement therapies, and limits on advertising and sponsorship, but it is not clear whether they help all socioeconomic groups equally or whether they are more effective with the affluent portion of the society, therefore...
increasing socioeconomic inequalities. In general, an impoverished smoker who attempts to quit is more likely to fail than an affluent smoker.20,21 Siahpush and colleagues22 showed that affluent people are responsible for more of the calls to telephone quit lines, and hard-hitting advertisements on the health risks of smoking did not alter that distribution. A modeling study on the smoking ban in the United Kingdom urged the government to extend the ban to all public places and not to limit the prohibition to pubs that serve food, to prevent increases in socioeconomic inequalities.23 In the present study, we found a stronger effect of the ban on low socioeconomic groups than on more affluent members of the population, which indicates that a comprehensive ban could contribute effectively to the reduction of inequalities in health.

In conclusion, this study indicates that the Italian smoking ban of 2005 had a measurable impact on health. Because coronary heart diseases are the leading causes of death in Italy and elsewhere, even the small reduction we observed could have enormous public health implications.

Acknowledgments
We thank Margaret Becker for her help in editing the manuscript.

Sources of Funding
This study was funded by the Lazio Region Health Authority.

Disclosures
None.

References
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*Circulation*. 2008;117:1183-1188; originally published online February 11, 2008;
doi: 10.1161/CIRCULATIONAHA.107.729889
*Circulation* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

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World Wide Web at:
http://circ.ahajournals.org/content/117/9/1183