

Facilitating smoking cessation in cancer patients

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Smoking is directly attributable to almost one third of cancer deaths, including causal relationships with cancers of the lung, oral cavity, larynx, and oesophagus, and linkages to cancers of the bladder, pancreas, kidney, stomach, and uterine cervix.^{1,2} Treating nicotine addiction is an obvious component of any disease management program for cancer patients, but also requires explicit and sensitive tailoring to meet patient needs.

Lung cancer patients who smoke often experience tremendous guilt and responsibility for their disease, and feel it might be too late for them. Others, like head and neck cancer patients, may not be aware of the relation of their smoking to their cancer. By discussing the causal risk factors related to their disease and how tobacco use jeopardizes their treatment (for example, impairing wound healing, compromising the immune system, increasing the risk of developing another cancer, and reducing their likelihood of survival), many patients can be propelled from a precontemplator stage into an action stage of quitting. Benefits are immediate, and patients feel that they are taking part in their own treatment and contributing toward their own recovery.^{3,4}

The timing of the intervention must be tailored to the individual patient. At diagnosis, some patients may be overwhelmed with information, and are not able to absorb quitting messages. Providers may want to wait until the initiation of medical treatment or until the patient comes in for hospitalisation.⁵ However, stopping smoking several weeks before surgery decreases postoperative pulmonary complications.⁶ Other patients may want to take action immediately, and are ready for brief counselling or pharmacological treatment, or both. The repetitive support message is the most crucial component. We use a stepped care model, increasing the level and intensity of support as necessary, in addition to behavioural counselling and pharmacotherapy. This may include telephone counselling, intensive counselling, and patient support groups. We also encourage all members of the treatment team to provide support, including surgeons, oncologists, radiation therapists, dentists, nurses, dietitians, rehabilitation specialists, and mental health professionals.⁴

Providers can work with family and friends in the patient's support system to help them understand the depression, anxiety, and

serious psychological issues that often occur during the treatment and recovery from cancer. Some family members and friends will need help in transferring their feelings of urgency (grappling with the patient's lack of readiness to quit) and past negativity ("If you don't stop smoking, something terrible will happen") into support. Suggesting coping mechanisms for cancer patients also requires tailoring to the individual's particular abilities at a specific point in time. Often you cannot suggest eating a lot of fruits and vegetables, or starting an exercise routine, while a patient is undergoing surgery or radiation treatment.

Our work with head and neck cancer patients indicates that relapse may be delayed in this population. Typically, in a healthy population, most relapses occur during the first month. In our prospective study, very few patients relapsed immediately.^{7,8} Most of the relapses occurred between one and six months following surgery. Relapsers were more likely to report anxiety and depression than those who successfully quit, and had higher rates of craving. Invasive treatment (surgery), older age of initiation, and lower addiction scores were protective factors. Those who were in the contemplation or action stage also had significantly higher rates of successful quits.

Tailoring smoking cessation as part of disease management programs to the specific needs of cancer patients is likely to yield higher rates of long term quits, and result in improved disease outcomes. For early stage cancer patients, these may be lifesaving changes which also significantly improve quality of life.

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