

Smoking cessation help for cancer patients – a pilot project “Quitting Supports Treatment”

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Available data suggest that up to 50% of cancer patients, who were smoking before diagnosis, continue to smoke during treatment, unaware of the damage caused due to continued tobacco use and the undervalued benefits of quitting smoking after a cancer diagnosis. Structured initiatives aimed at helping cancer patients give up smoking was undertaken at the M. Skłodowska-Curie National Research Institute of Oncology in Warsaw (Poland) within the pilot project “Quitting Supports Treatment (QST)”. QST was launched in September 2019 and was a joint initiative of two departments: 1. The Cancer Epidemiology and Primary Prevention Department and 2. The Soft Tissue/Bone Sarcoma and Melanoma Department. Moreover, QST works with the significant support of Department of Nurses and Midwives Professional Development. The preliminary results suggest the need for several organizational improvements in order to increase QST participation rates. Revision of previous experiences could bring valuable conclusions with regards to the effectiveness of QST, but also for other similar projects.

Key words: smoking cessation, cancer patients, tobacco, cancer prevention, Poland

Tobacco smoking is known to cause a number of malignancies, and it remains the single main cause of premature death worldwide, with over 480,000 deaths each year [1]. It has been linked to more than 15 types of cancer, including lung, bladder, and esophageal cancer [2], with ongoing detrimental effects of continued cigarette smoking on patients’ health after cancer diagnosis. These effects include decreased overall and cancer-specific survival and increased risk of cancer recurrence, treatment toxicity, secondary malignancy, depression, stress, and reduced quality of life [3]. Smoking cessation is especially important for patients with cancer because tobacco use can compromise the effects of their cancer treatment, shorten pa-

tients’ survival, increase mortality and toxicity from therapeutic interventions, and even in some cases result in an increased incidence of recurrence and secondary malignancies [4]. Furthermore, smoking in the perioperative period can increase the risk of pulmonary embolism and poor wound healing, diminish the efficacy of chemotherapy, impair the function of the immune system, thus resulting in an increased risk of infection.

Available data suggest that up to 50% of patients who were smoking before a cancer diagnosis, continue to smoke during treatment [5], unaware of the harm related to continued tobacco use and the undervalued benefits of quitting smoking after a cancer diagnosis. Such benefits include a reduced risk

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of death by 30% to 40% [6], longer survival, improved chances of successful cancer treatment, less serious adverse events, increased energy and a better quality of life [7].

Moreover, health care professionals do not always encourage their patients to quit smoking and do not provide tobacco cessation assistance for continuing tobacco users [8], with about 62% of smoking cancer patients receiving smoking cessation counseling from their physicians in a sample from a study conducted by Lola Burke et al. [9]. Interventions to achieve tobacco abstinence include pharmacotherapy and counseling, and these often require repeated attempts, as helping patients with cancer to quit smoking cigarettes is far from an easy process [10]. Nevertheless, the accumulation of evidence provides strong grounds for incorporating smoking cessation as a standard component of treatment within all cancer centers. Consequently, all cancer patients should be advised of the health benefits of cessation and provided with help in quitting. Support should also be given to patients who have recently quit smoking, due to the high probability of relapse [11].

A structured initiative aiming to help in smoking cessation for cancer patients was undertaken at the M. Skłodowska-Curie National Research Institute of Oncology in Warsaw (Poland) within the pilot project “Quitting Supports Treatment (QST)”. QST started in September 2019 and was a joint initiative of two departments: the Cancer Epidemiology and Primary Prevention Department and the Soft Tissue/Bone Sarcoma and Melanoma Department. Moreover, QST works with the significant support of the Department of Nurses and Midwives Professional Development.

The program consists of three main elements.

- **Stage 1:** all patients admitted to cancer hospitals are given a questionnaire about smoking and their willingness to stop. Additionally, all patients receive a leaflet on the benefits of quitting smoking after cancer diagnosis, prepared specifically for QST needs.
- **Stage 2:** if they are smokers and they declared a willingness to stop smoking, their data are transferred to the National Quitline. The quitline counselors arrange a telephone consultation and provide a support call to them. The number of calls depends on the individual needs of the patient.
- **Stage 3:** in the case if the patient declares that she or he smokes and does not want to quit, the anti-tobacco minimal intervention (MI) is provided by a nurse in a medical ward. If as the results of MI patient changes his mind, the quitline counselors provide a proactive call (counselors initiate a contact with a given patient).

Looking at the preliminary data from the months which were not affected by the SARS-CoV-2 pandemic (September–December 2019), we can assume that even before this specific event, in regular hospital admission circumstances, cancer patients were not eager to quit smoking. In the analyzed pe-

riod, 296 patients expressed initial interest in QST and received a quitline call. Only about 13% (40) of them wished to have a second call and to receive help in quitting. Furthermore, 65% (26) of them changed their smoking habits: 40% (16) decreased smoking substantially and 25% (10) quit smoking completely.

Undoubtedly, cancer disease is connected with a particular physical and psychological burden for patients. However, some lessons on QST functioning have also been learned since the start of the program. The most important one is that in the face of health professional shortages in Poland (including nurses), as well as the constantly increasing incidences of cancer, there is a need to consider the introduction of additional health educators on medical wards. This solution could bring about higher effectiveness in smoking cessation among cancer patients, however, it demands extra funding and further organizational facilities (additionally, it could be difficult in the current epidemiological circumstances). In contrary to the enlargement of human resources needed to QST implementation and conduction, it should also be considered a modification of the QST promotion – focusing on more tailored and efficient communication regarding the health benefits of quitting. Finally, changes in QST methodology should be taken into consideration as well.

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