

Polish Forum for Prevention Guidelines on smoking

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Introduction

There is overwhelming evidence for an adverse effect of smoking on health. In long-term smokers, smoking is responsible for over 50% of all avoidable deaths and one half of these are due to cardiovascular disease. These adverse effects of smoking are related to the amount of tobacco smoked daily and to the duration of smoking.

A substantial reduction in the proportions of smokers in the Polish population could be seen over the last 25 years. This is especially true for men, in whom this trend is still present. In the early eighties almost 60% of all adult men smoked, whereas by 2006 this number had decreased to 37%. Unfortunately, in women this trend was not so evident. Particularly, there has been virtually no change in the smoking rates in women during the last 10 years in Poland. In 2006, 23% of all adult women smoked. The National Health Survey in Poland – Project WOBASZ [1] showed considerable regional variation in smoking rates. The highest proportion of smoking men (age 20–74 years) was found in Podlasie voivodeship (48%), and the lowest in Małopolska voivodeship (34%). Even greater regional differences were found in women: the smoking rates

varied from 15% in Podkarpacie voivodeship to 34% in Warmia and Mazury voivodeship. The project showed that the vast majority of smokers in Poland (over 80% of smokers) would like to quit smoking. This last figure shows the potential for health care providers.

Quitting smoking should be encouraged in all smokers. There is no age limit to profit from the benefits of smoking cessation. Some advantages are almost immediate, while others take more time. However, it should be underlined that smoking cessation is a complex and difficult process, because this habit is strongly addictive both pharmacologically and psychologically.

The momentum for quitting smoking is particularly strong at the time of diagnosing a smoking-related disease and in connection with invasive treatment. These opportunities should not be omitted. Patients hospitalized due to ischaemic heart disease were studied in the Cracovian Program for Secondary Prevention of Ischemic Heart Disease [2]. The results showed that among active smokers during the month before admission to the hospital about half still smoked one year later. Recent unpublished data suggest that this problem remains unresolved.

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The Fagerström test is a very useful tool in assessing the degree of addiction. As it is not time consuming it can be performed on every occasion to every patient. The result of this test is strongly correlated with the cessation rate both with and without the help of pharmacotherapy. Some other tests are also available. Although there are no published high quality data on the comparison between behavioural counselling and pharmacotherapy, such comparison was done for nicotine replacement therapy and oral drugs, showing higher effectiveness of oral medicines. Among them, varenicline was proved to be significantly more effective than bupropion.

Passive smoking has been shown to increase the risk of coronary heart disease and other smoking-related diseases. The effects of second-hand smoke on the cardiovascular system as well as on the development of cancers may be even greater than was expected. Consequently, improvement in the protection of non-smokers against the harmful effects of second-hand smoke in public places is required. In many European countries a favourable change in tobacco-related morbidity has been observed with the creation of 'smoke-free' environments, including a smoking ban at work sites, in public transport vehicles, pubs, restaurants, etc. These observations provide an improved atmosphere for the creation of a smoking ban in public places in Poland.

Guidelines

1. Smoking is a leading cause of neoplasms and cardiovascular morbidity and mortality worldwide. About 30% of the Polish adult population smoke; therefore smoking is considered as a social disease. The number of smoking men has been decreasing gradually over recent years (37% in 2006). Unfortunately, a similar trend is not present in women (23% in 2006). Most people start smoking before the age of 18 years. About 70% of children at the age of 12 years admit to having had contact with tobacco. Almost 3 million Polish children are passive smokers.
2. About half of active smokers will die due to tobacco-related diseases. Even a few cigarettes smoked daily are related to significantly increased risk of myocardial infarction, stroke, cancers as well as reduced length of life and worsening of its quality.
3. From a population point of view passive smoking (constrained exposure to tobacco smoke) at least is as harmful as active smoking. Health consequences of passive smoking are not significantly different from those related to active smoking. It is thus necessary to improve the protection of non-smokers against the harmful effects of second-hand smoke in public places.
4. In respect of cardiovascular diseases smoking is especially harmful in those with other cardiovascular risk factors, such as: hypertension, dyslipidaemia, diabetes, obesity, sedentary lifestyle and positive family history.
5. The question concerning smoking should be asked during every visit to a physician's office. The answer

should always be noted in the medical records. The character and the degree of addiction as well as the motivation to give up smoking should also be assessed.

6. Every smoker should be made aware that nicotine is a disease which can and should be treated. In clinical practice health care providers should at least follow the recommended minimal intervention:
 - ASK: Systematically identify all smokers at every opportunity.
 - ASSESS: Determine the person's degree of addiction and his/her readiness to cease smoking.
 - ADVISE: Unequivocally urge all smokers to quit.
 - ASSIST: Agree on a smoking cessation strategy including behavioural counselling, nicotine replacement therapy and/or pharmacological intervention.
 - ARRANGE a schedule of follow-up visits.
7. The Fagerström test – which is a set of questions about the number of cigarettes smoked and the circumstances of smoking – is a useful tool in assessing the degree of addiction. Depending on the results of the test the addiction can be qualified as:
 - Low degree: 0-4 points.
 - Medium degree: 5-6 points.
 - High degree: ≥ 7 .
8. A significant reduction in the proportion of smokers in the general population can be achieved mainly by means of education of the whole society. Anti-tobacco education should be started in children. Although the 6-month effectiveness of a physician's brief advice is estimated to be about 2-3%, if the advice was provided by every physician to all his smoking patients, about 100 000 – 150 000 persons would quit smoking annually.
9. Pharmacotherapy and/or behavioural counselling aimed at supporting the motivation to cease smoking should be offered to the vast majority of smokers. Pharmacotherapy can consist of: nicotine replacement therapy or oral drugs such as bupropion or varenicline. Nicotine replacement therapy (high dose) or oral agents should be prescribed to all smokers with high-degree addiction.
10. The pharmacotherapy of nicotine should be considered as standard treatment of other risk factors. Recent research showed that pharmacotherapy for nicotine is used only occasionally in Poland. The management of nicotine is one of the most cost-effective methods in modern medicine. Therefore, the cost of nicotine pharmacotherapy should be at least partly reimbursed by the national health system.

References

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