Smoking Cessation in the Oncology Setting - How Smoking Adversely Affects Cancer Treatments and Outcomes

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8th Annual Conference on Health Disparities: The Intersection of Smoking, HIV/AIDS and Cancer
University of North Texas Health Science Center
Fort Worth, Texas
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Overview

- Cancer incidence and projected disparities
- Cancer mortality and survivor trends
- Smoking prevalence among cancer survivors
- Adverse effects of smoking on cancer treatments and outcomes
- Addressing tobacco use in the oncology setting
- NCI conference on Treating Tobacco Dependence at Cancer Centers
- MD Anderson Tobacco Treatment Program
- Policy Implications
Disparities in Estimated Cancer Incidence from 2010-2030

- From 2010-30, total cancer incidence will increase by an additional 45% from 1.6 to 2.3 million, driven disproportionately by age and race/ethnicity.
- A 67% increase is anticipated for patients $\geq$ 65 years, compared to 11% for patients $\leq$ 65.
- A 99% increase is anticipated for minorities, compared to 31% for whites.
- Percentage of all cancers diagnosed in minorities will increase from 21% to 28%.

Projected cases of all invasive cancers in the United States by race and origin. (*) Nonmelanoma skin cancers were excluded from projections. The Hispanic origin group contains individuals of any race. The race groups white, black, Asian/Pacific Islander (PI), American Indian (AI)/Alaska Native (AN), and multiracial contain only non-Hispanic individuals.

Cancer in the United States, 1990-2008: Survival Rising, Mortality Decreasing

Data from the National Cancer Institute on estimated number of cancer survivors and age-adjusted cancer deaths per 100,000 people.
Cigarette Smoke

• Largest single contributor to cancer risk
  – Shifting views on largest contribution to preventable health risks as compared with obesity

• Over 7000 constituents in cigarette smoke
  – 60+ known carcinogens
    • Aldehydes
    • Benzene
    • Metals (cadmium, nickel, polonium)
    • Nicotine
    • Nitrosamines
    • Polyaromatic hydrocarbons

• Large number of additives
  – Enhance absorption
  – Increase flavor
  – Increase addiction
Additives to Cigarettes (~600)

Here are the first 65 (alphabetical order)

<table>
<thead>
<tr>
<th>Acetanisole</th>
<th>Ammonium Phosphate Dibasic</th>
<th>1-Asparagine Monohydrate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetic Acid</td>
<td>Ammonium Sulfide</td>
<td>1-Aspartic Acid</td>
</tr>
<tr>
<td>Acetoine</td>
<td>Amyl Alcohol</td>
<td>Balsam Peru and Oil</td>
</tr>
<tr>
<td>Acetophenone</td>
<td>Amyl Butyrate</td>
<td>Basil Oil</td>
</tr>
<tr>
<td>6-Acetoxydihydrotheaspirane</td>
<td>Amyl Formate</td>
<td>Bay Leaf, Oil and Sweet Oil</td>
</tr>
<tr>
<td>2-Acetyl-3-Ethylpyrazine</td>
<td>Amyl Octanoate</td>
<td>Beeswax White</td>
</tr>
<tr>
<td>2-Acetyl-5-Methylfuran</td>
<td>alpha-Amylcinnamaldehyde</td>
<td>Beet Juice Concentrate</td>
</tr>
<tr>
<td>Acetylpyrazine</td>
<td>Amyris Oil</td>
<td>Benzaldehyde</td>
</tr>
<tr>
<td>2-Acetylpyridine</td>
<td>trans-Anethole</td>
<td>Benzaldehyde Glyceryl Acetal</td>
</tr>
<tr>
<td>3-Acetylpyridine</td>
<td>Angelica Root Extract, Oil and Seed Oil</td>
<td></td>
</tr>
<tr>
<td>2-Acetylthiazole</td>
<td>Anise</td>
<td>Benzoic Acid, Benzoin</td>
</tr>
<tr>
<td>Aconitic Acid</td>
<td>Anise Star, Extract and Oils</td>
<td>Benzoin Resin</td>
</tr>
<tr>
<td>dl-Alanine</td>
<td>Anisyl Acetate</td>
<td>Benzophenone</td>
</tr>
<tr>
<td>Alfalfa Extract</td>
<td>Anisyl Alcohol</td>
<td>Benzyl Alcohol</td>
</tr>
<tr>
<td>Allspice Extract, Oleoresin, and Oil</td>
<td>Anisyl Formate</td>
<td>Benzyl Benzoate</td>
</tr>
<tr>
<td>Allyl Hexanoate</td>
<td>Anisyl Phenylacetate</td>
<td>Benzyl Butyrate</td>
</tr>
<tr>
<td>Allyl Ionone</td>
<td>Apple Juice Concentrate, Extract, and Skins</td>
<td>Benzyl Cinnamate</td>
</tr>
<tr>
<td>Almond Bitter Oil</td>
<td>Apricot Extract and Juice Concentrate</td>
<td>Benzyl Propionate</td>
</tr>
<tr>
<td>Ambergris Tincture</td>
<td>Asafetida Fluid Extract And Oil</td>
<td>Benzyl Salicylate</td>
</tr>
<tr>
<td>Ammonia</td>
<td>Ascorbic Acid</td>
<td>Bergamot Oil</td>
</tr>
<tr>
<td>Ammonium Bicarbonate</td>
<td>Apricot Extract and Juice Concentrate</td>
<td>Bisabolene</td>
</tr>
<tr>
<td>Ammonium Hydroxide</td>
<td>Black Currant Buds Absolute</td>
<td>Borneol</td>
</tr>
</tbody>
</table>
Noted throat specialists report on 30-day test of Camel smokers...

NOT ONE SINGLE CASE OF THROAT IRRITATION due to smoking CAMELS!

Yes, these were the findings of noted throat specialists after a total of 3,670 weekly examinations of the throats of hundreds of men and women who smoked Camels—and only Camels—for 30 consecutive days.

Start your own 30-Day Camel MILDNESS Test Today!

It's fun—it's enlightening! All you do is smoke Camels, and only Camels, for 30 days. Compare them to your "T-Zone" (T for throat). See if that rich, full Camel flavor and that cool, cool Camel mildness doesn't win you to Camels for keeps.
Figure LCS1: Percentage of cancer survivors aged 18 years and older who were current cigarette smokers by sex: 1992-2010

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey.
Figure LCS2: Percentage of current smokers among cancer survivors and remaining U.S. population by age: 2000-2010

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey.
Data are age-adjusted to the 2000 standard using age groups: 18-24, 25-34, 35-44, 45-64, 65+. Analysis uses the 2000 Standard Population.
Current Smoking Among Chronic Disease Populations – NHIS, 2006

- Any smoking-related chronic disease: 36.9%
- No chronic disease: 19.3%
- Smoking-related cancers (excl lung): 38.8%
- Lung cancer: 20.9%
- CVD: 30%
- Emphysema: 49.1%
- Chronic bronchitis: 41.1%
Adverse Effects of Continued Smoking on Treatment Outcomes for Cancer

Surgery
- Increased complications from general anesthesia
- Increased risk of severe pulmonary complications
- Detrimental effects on wound healing
  - Compromised capillary blood flow
  - Increased vasoconstriction
  - Increased risk of wound infection

Radiation
- Reduced treatment efficacy
- Increased toxicity and side effects
  - Xerostomia, oral mucositis, loss of taste, pneumonitis, soft tissue and bone necrosis, poor voice quality

Chemotherapy
- Potential exacerbation of side effects: immune suppression, weight loss, fatigue, pulmonary and cardiac toxicity
- Exacerbation of drug toxicity
- Increased incidence of infection

Benefits of Smoking Cessation Following Cancer Diagnosis

• Decreased risk of treatment complications
• Decreased risk of second primary tumors
• Improved survival rates
• Improved quality of life
• Greater treatment efficacy

Variables that Can Influence Beneficial Effects

• Duration and intensity of smoking history
• Timing of smoking cessation relative to diagnosis and treatment

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Outcome (Smokers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rades <em>IJROBP</em> 71: 1134, 2008</td>
<td>NSCLC, 181 pts, RT +/- chemo</td>
<td>Decreased LRC</td>
</tr>
<tr>
<td>Tammemagi <em>Chest</em> 125: 27, 2004</td>
<td>Lung, 1155 pts.</td>
<td>Decreased survival</td>
</tr>
<tr>
<td>Hinds <em>J Nat Ca Inst</em> 68: 395, 1982</td>
<td>Lung, 223 women</td>
<td>Decreased 1-yr survival</td>
</tr>
<tr>
<td>Johnston-Early <em>JAMA</em> 244: 2175, 1980</td>
<td>SCLC, 112 pts, chemo +/- RT</td>
<td>Decreased survival</td>
</tr>
<tr>
<td>Stevens <em>Arch Oto</em> 109: 746, 1983</td>
<td>H/N, 269 pts.</td>
<td>Inc recurrence (75% less), dec survival</td>
</tr>
<tr>
<td>Rugg <em>Br J Radiol</em> 63: 554, 1990</td>
<td>H/N, 41 CHART pts.</td>
<td>Increased mucositis</td>
</tr>
<tr>
<td>Garces <em>Chest</em> 126: 1733, 2004</td>
<td>NSCLC, 1506 pts.</td>
<td>Decreased QOL</td>
</tr>
<tr>
<td>Pytinia <em>J Clin Oncol</em> 22: 3981, 2004</td>
<td>H/N, 100 pts.</td>
<td>Decreased OS, RFS, DFS</td>
</tr>
<tr>
<td>Marin <em>Plast Recon Surg</em> 121: 451, 2008</td>
<td>H/N, 89 pts, flap recon</td>
<td>Poor wound healing (cor with cotinine)</td>
</tr>
<tr>
<td>Videtic <em>J Clin Oncol</em> 21: 1544, 2003</td>
<td>SCLC, 189 pts., chemo/RT</td>
<td>Decreased MS and 5-yr OS</td>
</tr>
<tr>
<td>Marshak <em>IJROBP</em> 43: 1009, 1999</td>
<td>Glottic larynx, 207 pts., RT</td>
<td>Decreased LRC (UV)</td>
</tr>
<tr>
<td>Fox <em>Lung Cancer</em> 44: 237, 2004</td>
<td>NSCLC, 237 pts, RT +/- chemo</td>
<td>Decreased MS and 2-yr survival (early stg)</td>
</tr>
</tbody>
</table>
## Prostate Outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Outcome (Smokers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alsadius <em>Radiother Oncol</em>, 2011</td>
<td>834 prostate, tx with RT</td>
<td>Increased urgency, cramps, diarrhea</td>
</tr>
<tr>
<td>Kenfield <em>JAMA</em> 305:2548, 2011</td>
<td>Prospective 5366 prostate (Health Prof Follow-up Study)</td>
<td>Current increased overall, prostate, CVD mortality, reversed with 10+ yr cessation</td>
</tr>
<tr>
<td>Joshu <em>JNCI</em> 103:835, 2011</td>
<td>1416 prostatectomy</td>
<td>Current increase recurrence, cess by 1 yr post diagnosis with no increased risk</td>
</tr>
<tr>
<td>Chen <em>J Chin Med Assoc</em> 74:69, 2011</td>
<td>89 radiation enterocolitis pts</td>
<td>Increased need for surgery</td>
</tr>
<tr>
<td>Taira <em>IJROBP</em> 79:1336, 2011</td>
<td>1656 RT/brachy pts +/-ADT</td>
<td>Decrease OS (HR 2.9 curr, 1.4 former)</td>
</tr>
<tr>
<td>Ku <em>Can Urol Assoc J</em> 3:445, 2009</td>
<td>213 prostatectomy</td>
<td>Decreased QOL</td>
</tr>
<tr>
<td>Weinmann <em>Ca Caus Cont</em> 21:117, 2010</td>
<td>768 who died of prostate CA (Pros Ca Scr Mort Study)</td>
<td>Most recent smoking status most important predictor for prostate cancer death</td>
</tr>
<tr>
<td>Watters <em>CEBP</em> 18:2427, 2009</td>
<td>283312 men</td>
<td>Increased fatal prostate cancer (HR 1.7)</td>
</tr>
<tr>
<td>Huncharek <em>Am J Pub Hth</em> 100:693, 2010</td>
<td>24 cohort review</td>
<td>Increased prostate cancer and fatal PC</td>
</tr>
<tr>
<td>Shiels <em>Ca Caus Cont</em> 20:877, 2009</td>
<td>1275 non-cancer (NHANES III)</td>
<td>Increased serum+free testosterone</td>
</tr>
<tr>
<td>Simone <em>J Urol</em> 180:2447, 2008</td>
<td>5070 prostatectom (CaPSURE)</td>
<td>Increase non-prostate mortality</td>
</tr>
<tr>
<td>Bittner <em>IJROBP</em> 72:433, 2008</td>
<td>1354 brachy +/- ADT</td>
<td>Increased CVD and non-prostate mort</td>
</tr>
<tr>
<td>Boorjian <em>J Urol</em> 177:883, 2007</td>
<td>9780 prostate (CaPSURE)</td>
<td>Increased bladder CA esp. current sm+RT</td>
</tr>
<tr>
<td>Carlos <em>J Am Coll Surg</em> 200:216, 2005</td>
<td>22094 non-cancer men</td>
<td>Decreased CRC and prostate screening</td>
</tr>
</tbody>
</table>
## Breast Outcomes

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Outcome (Smokers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angarita <em>J Hosp Infect</em> 79:328, 2011</td>
<td>199 breast cancer</td>
<td>Increased postop infection</td>
</tr>
<tr>
<td>Zaman <em>Ann Oncol</em> 2011</td>
<td>261 tam/let breast (BIG 1-98)</td>
<td>Decreased bone mineral density</td>
</tr>
<tr>
<td>Land <em>Ca Prev Res</em> 4:1393, 2011</td>
<td>NSABP P-1 (prevention)</td>
<td>Decreased adherence to tamoxifen</td>
</tr>
<tr>
<td>Hellmann <em>Eur J Ca Prev</em> 19:366, 2010</td>
<td>528 breast (Copen Ht St)</td>
<td>Increased mortality</td>
</tr>
<tr>
<td>Baumann <em>Plas Rec Surg</em> 125:1335, 2010</td>
<td>228 br recon, prosp (MDACC)</td>
<td>Increased fat necrosis</td>
</tr>
<tr>
<td>Dragun <em>Cancer</em> 117:2590, 2011</td>
<td>11914 Tumor registry</td>
<td>Decreased OS</td>
</tr>
<tr>
<td>Cowen <em>Br Ca Res Treat</em> 121:627, 2010</td>
<td>141 postop recon, (prospective)</td>
<td>Increased implant failure</td>
</tr>
<tr>
<td>Li <em>J Clin Oncol</em> 27:5312, 2009</td>
<td>1089 unilateral ER+ breast</td>
<td>Increased contralateral breast CA</td>
</tr>
<tr>
<td>Stefan <em>J Neurooncol</em> 94:221, 2009</td>
<td>1274 stroke unit pts (+/- Ca)</td>
<td>Increased thrombosis, similar stroke risk as in non-cancer patients</td>
</tr>
<tr>
<td>Wadhwa <em>Br Ca Res Treat</em> 117:357, 2009</td>
<td>152 traztuzumab pts</td>
<td>Increased cardiomyopathy risk (~5 fold)</td>
</tr>
<tr>
<td>Dal Maso <em>Int J Cancer</em> 123:2188, 2008</td>
<td>1453 breast</td>
<td>Increased OM and DSM</td>
</tr>
<tr>
<td>McCarthy <em>Plas Rec Surg</em> 121:1886, 2008</td>
<td>1170 breast, surgery (MSK)</td>
<td>Increased complications and recon failure</td>
</tr>
<tr>
<td>Sagiv <em>JNCI</em> 99:365, 2007</td>
<td>1273 breast with post dx assess</td>
<td>Increased OM and DSM</td>
</tr>
<tr>
<td>Jagsi <em>Cancer</em> 109:650, 2007</td>
<td>828 breast, sx+RT</td>
<td>Increased MI and MI req intervention</td>
</tr>
<tr>
<td>Sorenson <em>Eur J Surg Oncol</em> 28:815, 2002</td>
<td>415 mastectomy (prospective)</td>
<td>Increased infection, necrosis, epidermolysis</td>
</tr>
</tbody>
</table>
## Smoking at Diagnosis and Survival

<table>
<thead>
<tr>
<th>Analysis Type</th>
<th>Current vs. Former</th>
<th>Current vs. Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Mortality (Cox Prop HR)</td>
<td>1.29 (95% CI 1.17-1.29)</td>
<td>1.38 (95% CI 1.23-1.54)</td>
</tr>
<tr>
<td>Disease Spec. Mortality (Cox Prop HR)</td>
<td>1.23 (95% CI 1.09-1.39)</td>
<td>1.18 (95% CI 1.03-1.36)</td>
</tr>
<tr>
<td>3-year Overall Mortality (Log Reg)</td>
<td>1.50 (95% CI 1.19-1.89)</td>
<td>1.45 (95% CI 1.14-1.85)</td>
</tr>
<tr>
<td>3-year Disease Spec. Mortality (Log Reg)</td>
<td>1.57 (95% CI 1.22-2.01)</td>
<td>1.43 (95% CI 1.10-1.84)</td>
</tr>
</tbody>
</table>

Adjusted for disease site, gender, age, stage, race, diagnosis date, body mass index, and pack year smoking history


G. Warren, MD, PhD
Smoking Status – Definitions
Patient History Database (PHDB), MD Anderson Cancer Center

- Self-reported clinical intake assessment questionnaire completed by all newly registered patients.

- Approximately 93% of all newly registered patients completed the questionnaire.

- Smoking status is categorized as follows: current, recent quitter (quit less than 1 year prior to presentation to MDA), former (quit longer than 1 year prior to presentation to MDA) and never smokers.
Smoking Status of Cancer Patients 2000-2010
MD Anderson Cancer Center

Patient History Database, unpublished data

Note: ~ 45% of MDACC patients ≥ 60 yrs
Accuracy of Self-Reported Tobacco Assessments in a Head and Neck Cancer Treatment Population

- N=50 head and neck cancer patients.
- Prospective analysis – self-reported and biochemically confirmed (serum cotinine) tobacco use during treatment (baseline and weekly → week 7): 93% compliance.
- 29.4% patients misrepresented smoking status according to cotinine levels
- Accuracy increased by 14% with weekly vs. baseline self-report.

Smoking and Tobacco Use are Important to Address in the Oncology Setting

- Rates of current smoking at diagnosis among patients with lung or H&N tumors are 40-60%.
- Initial high quit rates following surgery decline over time: 36.9% of patients were smoking 1 year after surgery for non-small cell lung cancer (NSCLC).
- Patients with cancers less strongly associated with smoking have lower long-term quit rates.
- Overall, up to 30-50% of patients smoking at diagnosis do not quit, or relapse following initial quit attempts.
- Relapse even occurs among patients who quit ≥ 1 year earlier

Tailoring Smoking Cessation Interventions to Patients with Cancer

- Education about the link between cancer and smoking.

- Sensitivity to physical limitations imposed by disease and treatment (especially pertaining to diet and exercise).

- Medical contraindications to certain types of pharmacologic treatment must be recognized and appropriately managed.

- Psychological issues such as guilt, depression, anxiety, and stress should be considered and addressed.

- Recognition of delayed relapse.

National Cancer Institute Conference on Treating Tobacco Dependence at Cancer Centers

By Glen Morgan, PhD, Robert A. Schnoll, PhD, Catherine M. Alfano, PhD, Sarah E. Evans, PhD, Adam Goldstein, MD, MPH, Jamie Ostroff, PhD, Elyse Richelle Park, PhD, Linda Sarna, DNSc, RN, and Lisa Sanderson Cox, PhD

Tobacco Control Research Branch and Office of Cancer Survivorship, National Cancer Institute; Bethesda, MD; Department of Psychiatry, University of Pennsylvania, Philadelphia, PA; Department of Family Medicine, University of North Carolina, Chapel Hill, Chapel Hill, NC; Behavioral Science Service, Memorial Sloan-Kettering Cancer Center, New York, NY; Department of Psychiatry and Health Policy, Harvard Medical School, Boston, MA; School of Nursing, University of California, Los Angeles, Los Angeles, CA; Department of Preventive Medicine and Public Health, University of Kansas Medical Center, Kansas City, KS
National Cancer Institute Conference on Treating Tobacco Dependence at Cancer Centers
December 2009

• Highlighted the importance of treating tobacco dependence in the context of cancer care and survivorship.
• Reviewed guidelines for treating tobacco dependence in cancer patients and cancer survivors.
• Discussed models for tobacco dependence treatment in the oncologic context.
• Discussed barriers to the implementation of tobacco dependence treatment in cancer centers.
• Reviewed strategies to overcome barriers.
• Explore scientific questions related to tobacco dependence treatment that require further study.

Survey of 58 NCI cancer centers – 60% offer some form of tobacco use treatment (often limited to disease sub-populations); <50% have designated personnel; availability of tobacco use treatment programs lags behind other models of care (e.g., nutrition). Resource needs – motivation and commitment of oncology leadership, funding, personnel.

Priorities to enhance quality of care for tobacco dependence:
- Develop consensus regarding assessment of smoking status
- Refine EMRs and clinical trials to ensure identification and referral of smokers
- Evaluate novel treatment of cancer patients
- Evaluate methods to overcome barriers to providing treatment

MD Anderson Tobacco Treatment Program

A comprehensive tobacco-cessation and relapse prevention program for all MD Anderson Cancer Center patients and employees

- In-person and/or telephone behavioral counseling
- Prescription medications & nicotine replacement
- Multidisciplinary team (psychologists, psychiatrist, social workers, PA, nurse)
- Assessment and treatment of comorbid psychiatric disorders, depressive/anxiety symptoms, substance use and abuse
- No charge
TTP Referral Processing – Service Offerings

Referral Received

Research Assistant calls patient (4 attempts)

Yes
Patient answers

TTP in-person consult scheduled
or
Phone option selected
or
Patient Education Packet mailed
Follow-up call attempt in 3 months

No
Patient Education Packet mailed
Follow-up call attempt in 3 months
Patients can be referred by more than one source.
In that case, only one source is credited in the following order of precedence: Health Care Provider, Self, AER based on EHR.
Patient counts are unique within source, and across sources.

* September 1, 2012 – April 30, 2013

<table>
<thead>
<tr>
<th>Source</th>
<th>Referrals</th>
<th>TTP</th>
<th>Educational Packets Only</th>
<th>Educational Packet &amp; Program Call</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Provider</td>
<td>444</td>
<td>138 (31%)</td>
<td>91 (20%)</td>
<td>215 (48%)</td>
</tr>
<tr>
<td>Self</td>
<td>76</td>
<td>45 (59%)</td>
<td>6 (8%)</td>
<td>25 (33%)</td>
</tr>
<tr>
<td>AER(^1) based on EHR(^1)</td>
<td>2883</td>
<td>201 (7%)</td>
<td>731 (25%)</td>
<td>1951 (68%)</td>
</tr>
</tbody>
</table>
Cessation Rates by Contact Status over Time: Intent-to-Treat (ITT) & Respondent-Only (RO) 2006-2012

EOT = 3 months
ITT – N = 2564 – non-responders are assumed to be smoking
RO – non-responders are dropped from analyses
N at 3 month = 2291; N at 6 month = 2093; N at 1899
Any Assessment of Tobacco (29%)

No Assessment of Tobacco (71%)

G. Warren, MD, PhD
Conclusions

• Most actively accruing cooperative group clinical trials do not assess tobacco use.

• No trials assess nicotine dependence or interest in quitting during enrollment or follow-up.

• Failure to incorporate standardized tobacco assessments will limit the ability to provide evidence-based cessation support and will limit the ability to accurately understand the precise effect of tobacco use on cancer treatment outcomes.

International Association for the Study of Lung Cancer (IASLC) Survey

Practice Patterns and Perceptions of Thoracic Oncology Providers on Tobacco Use and Cessation in Cancer Patients

- Tobacco use is associated with poor outcomes in cancer patients, but there is little information from oncology providers on their practice patterns or perceptions regarding tobacco use and smoking cessation in these patients.
- Online survey of 1,507 members of IASLC (40.5%)
- Results:
  - 90% believe smoking affects outcome & cessation should be part of clinical care
  - 90% Ask about tobacco use; 81% Advise to quit; 79% Assess intention to quit, but only 39% Assist with cessation or refer (Arrange)
  - 48% Lack of training experience
- Conclusions: Increasing tobacco cessation activities by thoracic oncology providers will require:
  - ↑assessment & cessation at diagnosis and during follow-up
  - ↑clinician education, and improved tobacco cessation methods

AACR Policy

Assessing Tobacco Use by Cancer Patients and Facilitating Cessation: An American Association for Cancer Research Policy Statement

- Statement calls for greater efforts in smoking cessation in oncology patients and survivors
- Tobacco use should be evaluated as a confounding factor in oncology clinical trials
- Surveys show tobacco use is often not measured in oncology trials and care
