

Tobacco Use and Dependence Treatment: A Critical Component of Cancer Care

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Recently, a patient nearing completion of her breast cancer treatment came to our Nicotine Dependence Program. When asked why she wanted to quit, she said that she did not want to go through breast cancer again. She had wanted to quit before beginning chemotherapy, but her physician advised against it, thinking that quitting during treatment would be too stressful.

Several concerns help to explain why oncology providers sometimes hesitate to address tobacco use with their patients. Some question the wisdom of engaging in smoking cessation during active cancer treatment. Patients are already overwhelmed and the prospect of coping with withdrawal symptoms and attending additional appointments feels like too much. Some providers are unfamiliar with tobacco cessation medications; others fear that these medications may cause side effects, potentially interfering with cancer treatment. Some question the utility of intervention; if cancer diagnosis did not make the patient quit, then nothing will.

Oncology providers who do want to incorporate smoking cessation into cancer care may initially find little institutional support. A comprehensive system may not exist to identify tobacco users and educate providers and patients about effective interventions. Clinicians who do advise patients to quit may not know where to refer them for additional resources and ongoing support. The function of a cancer center is to screen patients, diagnose cancer, and provide comprehensive treatment. Smoking cessation, if provided at all, is often viewed as an ancillary service, outranked in terms of prominence and resources by

nutrition, mental health, education, acupuncture, and massage. This is surprising given that quitting smoking is proven to reduce a patient's chance of a future cancer diagnosis.

Research demonstrates that failure to address tobacco addiction in patients with cancer is unjustified at best and negligent at worst. Smoking causes cancer (Kuper, Boffetta, & Adami, 2002). Continued smoking among individuals who have cancer causes more cancer. Patients who continue to smoke after diagnosis experience decreased recurrence-free survival (Fleschner et al., 1999; Stevens, Gardner, Parkin, & Johnson, 1983) and increased risk for a second primary tumor (Do et al., 2004; Johnson, 1998; Richardson et al., 1993; Tucker et al., 1997). Smoking is associated with complications in patients receiving radiation (Eifel, Jhingran, Bodurka, Levenback, & Thames, 2002; Rugg, Saunders, & Dische, 1990) and may also impact the metabolism of chemotherapy (Hamilton et al., 2006; van der Bol et al., 2007). Continuing smokers experience diminished quality of life across multiple physical, psychological, and social domains (Garces, Yang, et al., 2004) and are more likely to report higher pain scores than nonsmokers or former smokers (Daniel et al., 2009). Surgical procedures cost more and do not work as well for tobacco

users because of complications such as delayed healing, wound dehiscence, and postoperative infections (Al-Sarraf et al., 2008; Kearney, Lee, Reilly, DeCamp, & Sugarbaker, 1994; Krueger & Rohrich, 2001).

Given the adverse outcomes associated with continued smoking, cancer di-

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agnosis and treatment provide an excellent opportunity to intervene (McBride & Ostroff, 2003). The timing is right; patients who receive tobacco use treatment within three months of diagnosis have higher abstinence rates (Garces, Schroeder, et al., 2004). The setting is right; patients with cancer interact with multiple healthcare professionals over a short period of time and receive regular long-term follow-up. Oncology nurses are uniquely positioned to develop relationships with their patients over time and to advocate for those who want to quit.

Oncology nurses can and should play a critical role in helping patients with cancer overcome tobacco use and dependence (Cooley, Sipples, Murphy, & Sarna, 2008). However, nurses do not do this optimally (Sarna et al., 2009).

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