

# How Anesthesiologists Can Help Beat Joe Camel

## Update from the ASA Smoking Cessation Initiative Task Force

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Anesthesiologists witness the devastating consequences of cigarette smoking on a daily basis.<sup>1</sup> Smoking-related diseases may either themselves require surgery, such as revascularization for coronary artery disease, or may complicate anesthetic management. Even the children of smokers are not immune, as exposure to environmental tobacco smoke increases the rate of perioperative airway complications.<sup>2</sup> Our usual approach is to ask patients whether they smoke, inwardly shake our head when they say “yes” and prepare for the consequences in the perioperative period—but do nothing else to address our patients’ tobacco use.

After all, nicotine is one of the most addicting substances known (the protestations of tobacco company executives aside), it is really tough to quit, and we only see patients for a brief time so there is really nothing we can do about our patients’ smoking. Just before surgery is not a good time for patients to quit—they have enough to worry about without facing nicotine withdrawal symptoms. Quitting smoking shortly before or after surgery will not improve perioperative outcomes and may even be dangerous. Even if we wanted to help our patients with their smoking, most of us do not know how. And besides, it is really none of our business whether someone chooses to smoke.

Most of these notions, though, are wrong. Yes, it is difficult for smokers to quit, but more than 70 percent of smokers want to quit, and the majority eventually succeed (after several attempts). There are currently more ex-smokers in America than active smokers.<sup>3</sup> There are now a variety of effective means to help smokers quit, including counseling and medications such as nicotine replacement therapy (nicotine patches, gum, lozenges, etc.).<sup>3</sup> Nicotine dependence specialists and clinics are available in many settings, but anyone can provide effective counseling, and nicotine replacement therapy is available over the counter. Even just a few minutes spent by a physician in advising smokers to quit can be

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effective, and there are now referral resources such as telephone “quitlines” that are available free of charge to all Americans (1-800-QUITNOW and <[www.smokefree.gov](http://www.smokefree.gov)>).

For these reasons, all physicians can and should help their patients quit smoking, and there are particularly good reasons for anesthesiologists to do so. First, quitting smoking improves perioperative outcomes, including a dramatic reduction in postoperative wound infections. The duration of abstinence necessary for benefit remains to be defined, but there are good reasons to think that even quitting the day before surgery may be beneficial.<sup>4</sup> And contrary to popular belief, there is little evidence to support the idea that quitting immediately before surgery increases the rate of pulmonary complications.<sup>1</sup> Second, surgery represents a “teachable moment” for promotion of long-term smoking cessation; i.e., smokers are more receptive to messages urging them to quit.<sup>5</sup>

If smokers take advantage of the opportunity to quit, they will benefit not only in the short term but will literally add years to their life, as the average smoker gains six to eight extra years after quitting. There is now good evidence that many smokers facing surgery want to quit and in fact are usually not bothered by nicotine withdrawal symptoms after surgery if they remain abstinent, which they must do for some period of time because medical facilities in this country are smoke-free.<sup>6</sup> Thus the question is not whether surgical patients will be abstinent but rather for how long. The question for anesthesiologists is whether we will act as perioperative physicians and take advantage of this opportunity to make a real difference in the lives of our patients who smoke.

So how can anesthesiologists help their patients quit? To be sure, there are several challenges, including limited preoperative patient contact and the fact that most of us know very little about the area. To help determine how best to meet these challenges, ASA has appointed a Smoking Cessation Initiative Task Force. Current members include Daniel R. Briggs, M.D., Lowell Dale, M.D., Michael H. Entrup, M.D., C. Alvin Head, M.D., Zeev N. Kain, M.D., Robert Klesges, Ph.D., and David O. Warner, M.D. This group is charged with formulating a proposal to increase the involvement of ASA members in smoking cessation efforts, with the goal of increasing abstinence rates for our patients who smoke. The task force hopes to develop a practical, effective program that will train and encourage anesthesiologists to help their patients quit smoking. In the meantime, there are a few simple steps that every anesthesiologist can take that require minimal time and expertise; these steps also are the subject of a recent review.<sup>5</sup>

First, every patient should be asked whether he/she uses tobacco. Even if your practice utilizes patient histories obtained by others to document smoking

status, you as a physician should personally ask about smoking as a part of your preoperative evaluation; patients need to know that you care enough about their smoking to ask. Next, every smoker needs to be advised to quit. This need not be a ponderous, moralizing sermon because most smokers already know that they should quit. Rather, concentrate on two points: that abstaining from smoking may help them better recover from their surgery and that many people find that surgery is a good time to make a sustained attempt to quit. Even if you are seeing the patients only moments before induction, encourage them to maintain postoperative abstinence for as long as possible. Finally, get to know what resources are available in your practice setting for those patients who want help in quitting. Even if there are not readily available referral resources such as nicotine dependence counselors, every patient has access to free telephone-based counseling.

We do not hesitate to insist that our patients change their behavior when we think that such changes will be beneficial. For example, we force our patients every day to abstain from food because we think that it is important for their safety, even though most find this unpleasant. Having been a surgical patient myself, I know that when I was staring up at my anesthesiologist in the holding area before surgery, I listened *very* carefully to what he had to say.

Take a few minutes to make a lasting difference in the life of your patient who smokes.

## References

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