

The Consensus Conference on smoking cessation (Conférence de Consensus sur l'Arrêt de la consommation du tabac) was held on October 8-9, 1998. A jury, made up of twelve non-specialists in smoking cessation, listened to 26 expert presentations on the different topics related to the 4 questions detailed below, and was provided with written documentation from a group of 5 other experts. After the 2-day presentation, the jury was allowed a 2-day meeting to reach its recommendations.

FOREWORD

This conference was organised and conducted in accordance with the methodological rules recommended by the National Agency of Accreditation and Evaluation in Health (ANAES : Agence Nationale d'Accréditation et d'Evaluation en Santé). Conclusions and recommendations presented in this document were written by the conference jury in total independence. ANES has no responsibility for these conclusions and recommendations.

Introduction

In 1998, there can be no more controversy about the deleterious effects of tobacco consumption and the beneficial effects of smoking cessation. The reduction of tobacco consumption is by far the most important factor with potential to would reduce morbidity and premature deaths.

In France, around one third of the adult population smoke regularly, and the incidence reaches 50% in young adults aged 18-24. Tobacco is responsible for one third of all cancers , and has a major role in pulmonary and cardiovascular morbidity. Tobacco consumption is, in our country, a priority in Public Health.

Facing this reality, our society behaves paradoxically. For the vast majority of smokers, the pleasurable sensations produced by the psychoactive effects of tobacco smoking far outweigh the relatively long-term health risks. This attitude is reinforced by the difficulties of quitting smoking, which are mostly due to the addictive potential of nicotine.

Individual and collective actions taken in favor of tobacco control have been until now of limited efficacy. The Consensus Conference on Smoking Cessation, held in Paris on October 8-9, 1998, chose to define practical objectives. The proposed recommendations aim at informing all health professionals on the different pharmacological and non-pharmacological therapies, their advantages, their limitations, the difficulties of setting up such therapies, and encouraging greater professional involvement. These recommendations are also aimed at public opinion, through health professionals, to fight against the despondency and disillusion of many smokers. They are also aimed at public health authorities, to lobby for a political framework favouring smoking cessation.

Question 1 : Data on tobacco use, the risks associated with its consumption and the consequences of smoking cessation.

CONSUMPTION

Industrial production of cigarettes exploded after the second world war, to reach by now about 95% of all consumed tobacco products. In France, cigarette sales reached their peak in 1991.

From 1991 to 1997, tobacco sales among the adult population of 15+ declined by 11%. In the most recent period, however, the decline has seemed to plateau, with even a slight increase (+1% on one year) observed.

Women's consumption is progressively matching men's consumption, and in younger people, women's consumption now exceeds men's.

The smoking rate in the French population has stabilised around 34% (42% in men, among whom consumption is slightly declining, and 31% in women, a percentage still increasing).

Three phenomena can be observed:

- 1) A still high proportion, even if in slightly reducing, of young smokers, with a steep increase starting at age 15, the average starting age being 14.
- 2) A still high proportion of smoking pregnant women (15% in 1981, raised to 25% in 1995).
- 3) A smoking rate among physicians close to that observed in the general population.

Recommendations:

- 1) The best way to reduce the number of smokers in the population being to avoid people ever starting to smoke, special attention should be directed towards actions (education, taxes, regulation) that aim at the reduction of tobacco smoking in youth.
- 2) It is important to reinforce our capacity to describe the different profiles of tobacco consumption in the population through large epidemiological and sociological studies.

IMPACT ON HEALTH

Impact on health is considerable. In France, tobacco causes 60,000 premature deaths each year, one out of 9 deaths. Half of regular smokers who started smoking during adolescence will die from tobacco smoking. Among these smokers, 50% will die before the age of 69.

Because tobacco smoking was primarily a male fashion, deleterious effects of tobacco smoking are predominant in men. An estimated 56,000 deaths are presently observed in men, while more than 3,000 are observed in women. The mortality is higher in the age range 45-64, representing around 30% of male deaths (4% of female deaths). The effects on morbidity are not only considerable in terms of reduction of life expectancy, but also in terms of disability, suffering, dependency and loss in quality of life. In pregnant women, tobacco smoking affects the foetus, the new-born, the infant and the child. The impact of tobacco smoking on health is observable at both the middle- and long-term.

Taking into account tobacco consumption during the last decades, particularly in women, the peak of the epidemic of tobacco-related diseases is still to come : in 2025, it is estimated that more than 165,000 premature deaths will be directly attributable to tobacco each year, with a two-fold increase in men and a ten-fold increase in women.

The impact of tobacco consumption is mainly related to the duration of daily smoking. Thus, for lung cancer, the most studied, a two-fold increase in consumption leads to a two-fold increase in cancer risk, but a two-fold increase in duration of smoking leads to a twenty-fold increase in cancer risk. In regard of this observation, the main goal should be smoking cessation and long-term abstinence.

BENEFITS OF SMOKING CESSATION

Smoking cessation reduces the mortality and morbidity of all tobacco-related diseases, particularly for cardiovascular diseases and lung cancer.

The younger people quit smoking, the greater the tobacco-related risk reduction. However, it is never too late to stop smoking.

Smoking cessation before 44 leads to a progressive risk reduction of premature death towards the non-smoker level for cardiovascular diseases and lung cancer. If smoking cessation is beneficial for the individual, it is also beneficial for his/her family. Studies on passive smoking (involuntary inhalation by a non-smoker of tobacco smoke due to one or more surrounding smokers) have shown that :

- A child exposed to passive smoking has a 60% increase in risk of respiratory airways infection;
- Lung cancer risk is increased by about 25%, and is proportional to the duration of passive exposure;
- Risk for ischaemic events is increased by 30% in non-smokers living with smokers.

Recommendations:

Smoking cessation must happen as soon as possible in life. Long term abstinence must be the goal. However, independently of the age of the smoker, stopping smoking always leads to measurable health benefits.

OPINIONS AND EXPERIENCES OF HEALTH PROFESSIONALS ON SMOKING CESSATION

The physician and the smoking patients : missed opportunities. One third of the population is smoking, and one smoker out of three has tried to quit smoking during the past year, without support in many cases. If physicians desire to play a role in the smoking cessation attempts of their patients, less than one out of two declare having seen a patient for that purpose during the last week.

Why these differences between intentions and facts ? Proffered reasons are : lack of time, patients' resistance to talk about their smoking status, lack of education on smoking cessation and the desire to obtain a decent and distinct remuneration for prevention work. Moreover, physicians are still sceptical about their own efficacy on the smoking status of their patients.

The smoking physicians : example and credibility of the professional. More than one third of physicians are smokers. Their ability to heal their patients is not questionable, but their credibility

in terms of smoking cessation is affected. More than their non-smokers counterparts, they are reluctant to ask questions about their patients' smoking status.

Other health professionals. The success of smoking cessation programmes needs the participation of numerous actors. Integration of actors such as dentists, nurses, pharmacists, etc. has been shown in different countries to bring real efficacy in the sensitisation of smoking patients.

Recommendations:

The 1994 objectives of the High Committee on Public Health (Haut Comité de la Santé Public) concerning the smoking status of health professionals, is still justified ; however, its application has been delayed. Specific actions should be organised to reduce smoking rate in this population to less than 10%. Health professionals must then gain in efficacy in terms of example for the general population.

Question 2 : How to take into account the individual characteristics of a smoker to obtain smoking cessation ?

TOBACCO DEPENDENCE

Tobacco smoking could be defined as a pharmacologically-reinforced behaviour in which nicotine is responsible for the addiction. If smoking initiation is dependent upon sociological and cultural factors, smoking is maintained by a double dependency :

- Pharmacological dependence : smoking dependence is characterised by tolerance and withdrawal symptoms;
- Non-pharmacological dependence : smoking is maintained despite the smokers' knowledge about the health risks and despite the negative social and environmental pressure.

These two kinds of dependence may or may not coexist in one particular smoker, and may sometime be absent in others.

Criteria for tobacco smoking dependence

Two kinds of approaches are proposed to evaluate nicotine dependence : specific questionnaires and biological measures.

The Fagerström Test for Nicotine Dependence relies on simple questions that allow one to evaluate the intensity of nicotine addiction by a score :

- Score < 4 : low dependence
- Score between 4 and 7 : intermediate dependence
- Score > 7 : high dependence

This questionnaire is the most valuable tool for nicotine dependence evaluation.

The DSM IV criteria are used to evaluate tobacco dependence. Items 1 and 2 are used to evaluate physical dependence.

Biological markers. Carbon monoxide and plasma saliva and urine cotinine are useful to quantify tobacco smoking in different conditions, but are weakly correlated to dependence and are in some instances difficult to obtain (particularly for GP).

Recommendations:

Evaluation of tobacco dependence and its subtypes helps to distinguish between different cessation strategies

- The Fagerström questionnaire is a simple clinical tool to evaluate nicotine dependence and to help to find the best individual approach to cessation;
- The use of biological markers is not necessary for dependence evaluation in usual clinical settings.

IS THE EXISTENCE OF A TOBACCO-RELATED DISEASE INFLUENCING THE MODALITIES OF SMOKING CESSATION ?

The diagnosis of a tobacco-related disease or the appearance of an acute complication are teachable moments for smoking cessation. The maintenance of this motivation is also necessary in the medium and long term. Differences are observed between conditions in terms of smoking cessation rates.

The benefit from cessation on cardiovascular and respiratory functions is obtained rapidly. The tobacco dependence process may explain why, when the information is given, which is not always the case, these smokers have great difficulties to maintain abstinence. The use of adequate nicotine replacement therapy in the early phase is an important help to achieve maintenance of abstinence.

ARE THE PRESENCE OF ANXIETY, DEPRESSION, ALCOHOL ABUSE, FEAR OF WEIGHT GAIN, INFLUENCING THE MODALITIES OF SMOKING CESSATION ?

These specific conditions should be taken into account to obtain successful quitting.

Anxiety and Depression. Several studies have shown an association between anxiety and tobacco smoking. The link seems obvious with agoraphobia, simple phobia and panic disorder. Evidence is weaker with social phobia and generalised anxiety. Smoking prevalence is high in depressed people, and they have more difficulties in quitting. The appearance of a depressive episode during or after smoking cessation is mostly a risk in those with history of depression.

History of depression or anxiety disorder should be ascertained before every smoking cessation attempt in order to anticipate the reappearance of a new episode. Use of psychotropic drugs, anxiolytics or antidepressants, should be based on individual consideration.

Alcohol abuse. The literature is focused on alcohol dependence. There is a positive correlation between tobacco and alcohol consumption.

More than 80% of alcoholics are smokers. They usually are highly dependent and smoking cessation is more difficult for them.

Weight gain. The fear of weight gain is a barrier to smoking cessation that is often underestimated, particularly in women. Smoking cessation is frequently followed by a weight gain, that in the vast majority of women, is limited to 6 Kg. A psychological encouragement, with no excess, aiming at the valorisation of body image through smoking cessation is important. Physical activity may be encouraged. Use of nicotine replacement therapy is useful to delay the weight gain.

DO SPECIAL SOCIAL SITUATIONS (DEPRIVATION, LOW EDUCATION OR SOCIAL LEVEL) INFLUENCE THE MODALITIES OF SMOKING CESSATION ?

Social and economical factors influence tobacco consumption. Cardiovascular risk associated to tobacco smoking is higher in deprived people, but mainly in men. On the contrary, tobacco smoking is higher in women of higher social level. However, smoking cessation attempts might not be linked to social or demographic factors.

Recommendations:

It does not seem wise to set up special programs for deprived people. This kind of approach may lead to opposite results than those expected, like increasing their social exclusion. However, accessibility to health care system and reimbursement of NRT must be facilitated.

DOES ADOLESCENCE INFLUENCE THE MODALITIES OF SMOKING CESSATION ?

Some differences exist in the attitude of adolescents towards smoking, compared to adults:

- Identification to models is very important. Tobacco smoking attitudes of relatives, peers, and educators are influential ; tobacco smoking could be view as a rite of passage to adulthood.
- Economic factors are frequently cited as a motivation for smoking cessation
- Use of health care system for smoking cessation is scarcely evoked.

It appears that health care offer is specifically oriented towards adults, and that it is poorly adapted to adolescents. Specific programs should be developed for them.

DOES PREGNANCY INFLUENCE THE MODALITIES OF SMOKING CESSATION ?

Based on French polls, 25% of pregnant women are smoking, 40% of them quit during the first trimester, while 5% quit during the second or third trimester. A great number of pregnant women have difficulties in stopping smoking during their pregnancy and to stay abstinent after giving birth. For these women smoking cessation interventions before, during and after pregnancy increase the rate of cessation, which after all is relatively low (6% to 20%). Special individualised intervention on smoking cessation with explanations, information and occasionally an expired CO measurement is more efficacious than minimal intervention (individual or group) without follow-up.

Conception desire and post-partum follow-up are also good circumstances to motivate smoking cessation in women.

Recommendations:

Obstetrical and gynaecological services are privileged structures to motivate and encourage smoking cessation. These actions should include physicians, midwives and other health professionals. The risks for the foetus and the infant must be taught and recalled to parents.

Question 3 : What are the methods used to help smokers to quit and which ones are scientifically proven ?**CRITERIA FOR JUDGEMENT OF ABSTINENCE MAINTENANCE**

The main objective of smoking cessation is to achieve abstinence.

- Three biochemical markers are used to validate claims of abstinence: cotinine (sensitive and specific), expired CO and thiocyanate (less sensitive and specific, but not influenced by NRT use);
- However, the cost and the relatively low availability of these markers make them not suitable outside of smoking cessation clinics.
- In general practice and minimal intervention, one can most of the time simply ask about smoking status.

MINIMAL INTERVENTION FOR SMOKING CESSATION

Minimal intervention consists of asking systematically each patient his/her smoking status and if he/she has been thinking about quitting.

Minimal intervention is intended for all patients: smokers that consult for something other than smoking-related disease, satisfied smokers, pre-contemplator smokers, smokers not asking for help of any kind. Minimal intervention should be given by all physicians whatever their professional status or speciality.

Minimal intervention is efficacious. Controlled and randomised studies have shown that cessation rates are between 2% and 5%. Although quite low, these rates are significantly better than waiting a request from the patient. Evaluation has shown that two questions : "are you a smoker ?" and "Do you want to quit ?" along with leaflets for those answering yes to the second question, double the success rate in long term compared to spontaneous quit in the control group. Minimal intervention may induce a discussion with pre-contemplator smokers and may provoke a request for help. If these questions are systematically asked by physicians, a cessation rate of 2% in the population of smokers seen by these physicians can produce a gain of 200,000 quit a year in France.

PHARMACOLOGICAL TREATMENTS

Nicotine replacement therapy has been shown to be efficacious for smoking cessation. It is desirable that the **use of NRT should be incorporated into an integrated programme**, including psychological intervention and follow-up

Two preparations of NRT are sold in France :

Nicotine gum is available, without prescription for the 2 mg dose, and with prescription for the 4 mg dose.

Nicotine transdermal systems are available in two forms : 24h continuous administration or 16h administration (daytime only); these preparations are available in dosages of 7, 14 and 21 mg or 5, 10 and 15 mg, respectively. These two preparations are prescription only. Gums and patches have equivalent efficacy.

Administration mode. Several are possible, taking into account the special needs of each smoker. If dependence is important the 2 mg gum may not allow sufficient nicotine replacement. It is then necessary to use the 4 mg gum or the patches. With the transdermal systems nicotine replacement is greater in extent, more regular and can be modulated according to need. Existence of two products (24h and 16h) is useful in case of side effects (cutaneous reactions) or practical difficulties with one of them.

The Safety profile of NRT with recommended use is excellent.. However, NRT are not always able to suppress nicotine withdrawal symptoms. Cardiovascular risks appear to be low.

BEHAVIOURAL TREATMENT

Behavioural support is only one component among educational and psychosocial approaches. Behavioural therapies are less easily assessable than pharmacological approaches (randomisation, double-blindness, control group, biological measures). It is difficult to isolate the active ingredient and to collect homogeneous data because of the variability in practice. Nevertheless, some controlled studies argue in favour of these methods. In France, behavioural therapy is not very popular.

OTHER METHODS: ACUPUNCTURE, HOMEOPATHY, MESOTHERAPY, HYPNOSIS

Acupuncture and homeopathy have been evaluated but the low methodological quality and the contradictory results of numerous studies do not allow clear conclusions. For all these methods it is particularly difficult to dissociate the influence of empathy towards the patients from the specific effect of the intervention.

Recommendations:

- Although individual impact of minimal intervention is low, with widespread application it can help to increase the proportion of successful quitting attempts. It is necessary to sensitise health professional to its use.
- A large number of NRT products are now available, their efficacy and safety have been largely confirmed.

Question 4 : What are the conditions to set up that will allow more health professionals to intervene effectively with an increasing number of smokers ?

REGULATORY STATUS OF NRT

Nicotine transdermal systems can only be sold in pharmacies with a medical prescription. The same is true for the 4 mg gum, but the 2 mg gum is available OTC in pharmacies. No reimbursement by the health care system is available.

There is currently a debate around both accessibility and reimbursement of the products. Between OTC status and prescription only, an intermediate solution may exist. It should be possible to obtain:

- Reimbursement for prescribed NRT;
- No reimbursement for non-prescribed NRT.

IMPLICATION AND OBJECTIVES OF PROFESSIONALS

Objectives of all the professionals concerned with smoking cessation are :

- Amelioration of access to information, and the measures and structures necessary for taking care of smokers;
- Optimisation of the means, whatever the level of intervention or the importance of the dependence;
- Support of the smoker.

General practitioners must be recognised as real actors in public health. In this sense, their role in smoking cessation must be valorised. Smokers' motivation to quit is encouraged when they can count on a help from a credible source such as a GP. The legitimacy of their public health action, and particularly in the domain of smoking cessation, must be reinforced by:

- Initial training and continuing education;
- Availability of appropriate technical support;
- Time, and specific remuneration;
- Possibility of participation in networks.

All **other physicians** must also:

- Develop a sensitivity to the problem of tobacco smoking;
- Convey clear messages coherent with a tobacco control policy;
- Be open to professional collaborations.

The **objectives for the pharmacists** are:

- To be an example;

- Respect of smoking ban in pharmacies;
- Underline the risks linked to tobacco smoking;
- Encourage smoking abstinence;
- Counselling, help and follow-up of quitting smokers.

Teachers and social workers have the ability to transmit information on tobacco smoking risks, and to plan actions to encourage consciousness of the problem.

The objectives of **smoking cessation centres** are various:

- Taking care of heavily dependent smokers, those motivated who have failed previously, but also those with tobacco-related diseases;
- To promote teaching and continuing medical education;
- Set up a network for smoking cessation;
- Develop research in collaboration with other specialised services and general practitioners;
- Participate in policy making for tobacco control.

Education and training

Initial education. Within the framework of medical education, future physicians should be taught how to treat tobacco dependence. Tobaccology Teaching about tobacco and its effects needs to be started early in their education should also be reintroduce at the end of courses, and particularly emphasised in the most relevant specialisms, with the participation of human sciences specialists as well as field actors. This initial education of the physicians should be accompanied by similar education for the other health professionals, particularly nurses, dentists, and pharmacists.

Continuing medical education. As in the domain of AIDS and drug abuse, means should be allowed (public or private) to gather all the personnel implicated in smoking cessation in a common programme. Participation of physicians and other health professionals in health promotion is another alternative, maybe more efficient than continuing medical education.

ACTION

Individual intervention. With appropriate training, health professionals can act at two levels :

- **First level.** Minimal intervention by GP and specialists within the framework of their activity, particularly of advice on smoking cessation volunteered without any expressed request. Industrial medicine, schools medical services , other health professionals and social workers are also implicated. At this first level, the GP can evaluate the dependence level, decide which treatment to use, and realise the follow-up of the smoker. A special role needs to be given to the pharmacist, because whatever the nicotine substitution, it should be distributed through pharmacies.
- **The second level** is devoted to specialised structures, which apart from their role in education and research, should be focused on highly dependent smokers. It is the role of the government to provide financial support for such structures.

Participation of a significant number of GP in smoking cessation efforts implies that the time they spend in continuing education and in consultations, longer than usual, should be correctly remunerated.

Collective information and intervention. The methods for smoking cessation are usually unknown by the general population. It appears necessary to develop a national, but also regional, information policy on all the possibility to achieve tobacco abstinence through GPs and pharmacists.

A barrier to the campaigns mounted up until now , particularly by the Comité Français d'Education à la Santé (CFES, French Committee for Health Education), has been the lack of interest, but also the lack of education, of health professionals in terms of prevention and hygiene education. They should now be involved at the regional level in the preparation of documents and campaigns.

Within this framework, it also seems important to develop an educational policy oriented toward children in middle school and high school.

General conclusions :

Smoking cessation is a major problem for public health. It justifies new policy initiatives and concerns the whole population; smokers and non-smokers, health professionals, administrative and political authorities, who should collaborate with mutual respect for a better health for all.

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