Tobacco smoking: options for helping smokers to quit--reply

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Dear Editor

Tobacco smoking: options for helping smokers to quit

Zwar, Mendelsohn and Richmond’s exclusive reliance on nicotine replacement therapy (NRT) clinical trial efficacy findings in their article “Tobacco smoking: options for helping smokers to quit”1 (AJP June 2014) leaves readers with the false impression that clinical efficacy has translated into population level effectiveness.

Doran et al 20062 involved a cross-sectional survey of 8333 Australian general practice patients. They found that cold-turkey quitting was roughly twice as effective as NRT. They also found that cold-turkey quitting accounted for 88% of all successful quitters (1942 of 2207).2 More recently, a July 2013 US Gallup Poll found that only 8% of ex-smokers credited any quit smoking product (NRT or prescription medication) for their success.3

Imagine the assault on motivation endured by the average patient attempting to quit cold turkey when nearly every internet quitting site repeatedly echoes the authors’ Figure 3 efficacy suggestion that they are substantially more likely to fail. Although formal study of the keys to successful abrupt cessation has been neglected, practitioners would be wise to spend a few minutes exploring sites devoted exclusively to cold-turkey education, counselling and/or support.

What is the most critical lesson about abrupt cessation physicians can share? I submit that it flows from lapse/relapse studies, that the high rate of return to regular smoking (88%) once a cigarette is tasted suggests that the distinction between an initial lapse and full relapse may be unnecessary.4 And let’s not forget that at least 10% of smokers are consistently identified as non-dependent chippers.5

Patients who smoke need to understand that recovery from nicotine dependence is all or nothing, that one puff will be too many, while thousands are never enough. They need to know that while most people who attempt cheating walk away feeling as if they have gotten away with it, just one puff and up to 50% of a4b2-type nicotinic receptors become occupied by nicotine.6 And it won’t be long before the lapsed patient who has lapsed finds their brain wanting, conspiring to obtain or even beg for more.

As for the tease of e-cigarettes, vaping and cleaner delivery, remind them that being free is vastly more doable and far more wonderful than their wanting for that next fix will suggest. Ask them why they would devote weeks or months towards adjusting to a new form of nicotine delivery when they could become 100% nicotine-clean and move beyond peak withdrawal within 72 hours. Just 1 hour and challenge at a time, yes they can!

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Competing interests: Pro bono director of WhyQuit, an abrupt nicotine cessation website, and author of Freedom from Nicotine – The Journey Home.

References

Reply

Dear Editor

We thank Dr Polito for his response to our article. We do not believe that offering help to people who smoke when they present in general practice, or other clinical settings, in any way undermines those smokers who prefer to try to quit without assistance from a health professional. It is also important to note that population surveys, such as the study by Doran et al,1 inevitably have risks of selection bias that may lead to underestimation of the effectiveness of smoking cessation treatment.2–5 Clinical trials remain the most reliable measure of effectiveness and have been conducted in a range of settings with a variety of populations.

We agree with Dr Polito that nicotine is a highly addictive drug and given the fact that dependence can be rapidly re-established after further exposure, the not-a-puff rule makes good sense and indeed we recommend this approach in our article.

The issue of whether e-cigarettes have a possible role in harm reduction for people who are unable to stop using nicotine is quite a separate one and a question that needs further research.

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References
Sentinel lymph node biopsy

Dear Editor

In their viewpoint article concerning sentinel node biopsy (SNB) in melanoma management (AFP, July 2014), Dixon et al appear to overlook the two main conclusions of the Multicenter Selective Lymphadenectomy Trial-I (MSLT-I):

- ‘Biopsy-based staging of intermediate-thickness or thick primary melanomas … identifies patients with nodal metastases who may benefit from immediate complete lymphadenecomy.’
- ‘Biopsy-based management prolongs … melanoma-specific survival for patients with nodal metastases from intermediate-thickness melanomas.’

The authors acknowledge that SNB is a diagnostic procedure but fail to realise that diagnostic procedures only have prognostic and therapeutic value in patients in whom the pursued abnormality is indeed found, eg a lymph node biopsy for suspected lymphoma will only lead to treatment if the disease is found, and only then can an impact on survival be expected. This is also true for SNB. Appropriate subsequent therapy can only improve survival in patients with an involved sentinel node. Therefore, the most important outcome of MSLT-I concerns the patients with intermediate thickness melanomas in whom lymph node metastasis is found. In this presuppecified target population, management determined by SNB substantially increases the survival rate compared to those who did not undergo SNB staging and developed palpable nodal disease later (10-year survival 62% vs 41%). Such an improvement in survival is exceptional in oncology and cannot be ignored.

The MSLT-I final report also shows that occult metastases in lymph nodes progress to clinically relevant disease over time. SNB-positive patients have a 12–20% risk of having more involved nodes. Whether a completion node dissection is required in all these patients is not known. This is the subject of another trial, MSLT-II, but it appears prudent to perform completion lymph node dissection until the outcome of this study is known.

We conclude that there is now convincing evidence to recommend SNB in patients with a clinically localised melanoma of intermediate Breslow thickness and to consider the procedure in patients with a thinner or thicker lesion. The American Society of Clinical Oncology and the Society of Surgical Oncology, the most respected medical and surgical oncology groups in the world, made the same recommendation in their joint, evidence-based guideline.

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References


Reply

Dear Editor

Thank you for the opportunity to respond to the suggestion that a sub analysis within the multicentre selective lymphadenectomy trial (MSLT-I) data justifies continued usage of sentinel lymph node biopsy (SLNB) as a treatment.

Like any randomised controlled trial (RCT) the important data is on an intention to treat (ITT) basis. The ITT data is clear. There was no 10-year melanoma specific survival benefit for intervention patients (77%), versus observation (76%). Even intermediate thickness melanoma patients failed to gain a survival benefit from SLNB and completion lymphadenectomy (CL). This is a negative study. Examination of sub analyses is always fraught with danger. There is naturally a wish to try and salvage something of clinical relevance from these seminal studies.

So, what of these subanalyses? We agree that SLNB gives patients added prognostic information; coming with the risks of surgery.

More melanoma lymph nodal involvement (MNI) occurred in the intervention group (19.9%), versus the observation group (17.4%). The intervention group MNI comprises SLNB positive patients (15.9%) and patients that were biopsy negative but later developed nodal disease (4%). This demonstrates that the SLNB test is not perfect. This discrepancy explains many other curious subanalyses.

We are asked to compare all in intervention patients with MNI (this 19.9%) with observation patients that developed MNI later. There is a suggested survival advantage in finding MNI early (62%), versus waiting for MNI to become clinically apparent (41%). But this is an extracted data set from an RCT showing no ITT survival benefit. Therefore it is not surprising that those in the intervention group that never had MNI still had a high ten year mortality rate of 17%. This compares unfavourably with 10-year mortality in the observation group that never developed MNI (12.5%).

If we are to believe doing an SLNB and finding an early positive node saves lives, then we would have to believe that having negative SLNB test is killing other patients. Of course, neither is the case. It is just another example of the serious pitfalls in straying from an ITT analysis.

The current MSLT-II trial will provide further useful data. In this trial patients who have a positive SLNB are randomised to either CL or observation. We encourage patients who have a positive SLNB test to consider enrolment in this trial.

We disagree that SLNB positive patients should be invited to proceed to CL outside of the MSLT 2 clinical trial. Indeed to encourage patients to have this further major procedure with a 37% complication rate with no apparent survival benefit raises ethical and moral questions. MSLT-1 has taught us that we need to avoid a presumption of surgical benefit. Let us not repeat history.

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