

Paper Alert

Smoking Cessation in Bladder Cancer Patients

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Cigarette smoking remains the greatest preventable risk for developing bladder cancer (BC), with roughly 75% of patients with newly diagnosed BC having a strong smoking history, and roughly 25% still being active smokers [1]. As physicians we all ask about current and former smoking histories, but rarely do urologists (or medical oncologists or radiation oncologists) actually initiate the conversation about stopping smoking, and make appropriate referrals to smoking cessation programs. This problem is highlighted in a recent article in the “Comments and Controversies” section in *The Journal of Clinical Oncology* by Mossanen et al. [2].

Association guidelines (e.g. American Urological Association [AUA] and American Society of Clinical Oncology [ASCO]) recommend clinicians encourage smoking cessation but rarely do clinicians take the next several measures. Surprisingly at least 10% of smokers do not know about the association between BC and smoking [3]. Thus discussing this with all smoking BC patients, and if possible their families, is critical. Urologists probably have the best opportunity to do this, not only because only a minority of BC patients ever see medical or radiation oncologists, yet all see urologists, but more importantly because urologists see their BC patients frequently and develop strong relationships with them. Thus urologists can bring this issue up often and inquire directly about what prior attempts patients have taken to stop smoking and why they were unsuccessful. While the relationship between active smoking and

disease outcome is not as robust as one might expect, [4] smoking is associated with a higher risk of recurrence after a transurethral resection (TURBT) [4]. Moreover, in a multi-institutional, retrospective, radical cystectomy database, smoking history in terms of intensity, duration, time since cessation, and cumulative exposure was associated with disease recurrence, cancer specific mortality and overall mortality [5]. However oncological outcomes were similar between current and former smokers who had quit within 10 years, and only those with >10 years free of smoking had oncological outcomes that approached those of patients who had never smoked [5].

Mossamen, et al.’s “Comment” does not discuss the 80% of BC patients who have non-muscle invasive BC (NMI BC). Indeed, it is in this group that smoking cessation will have the greatest benefit—because such patients are relatively unlikely to succumb to their BCs and in general they will live longer than those with muscle invasive disease. Thus they will accrue more overall health benefits from smoking cessation. Smoking cessation programs have a 40 to 96% success rate, [6] can lower overall health care costs, [7] and improve a variety of clinical outcome(s). Moreover it has been reported that upon a diagnosis of BC, current smokers have a 5 times greater likelihood of success quitting smoking [6].

So how can we encourage urologists to be more actively involved? The first approach would be to simplify their role. Urologists should bring up the topic at the diagnostic office cystoscopy when a tumor is found, and discuss this again at the post TURBT office consultation. However, to have a real impact, the urologist must develop a connection with smoking

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cessation teams and a means of facilitating rapid referrals to them. At most universities and/or cancer centers this is not usually difficult to achieve. However, it may be more challenging in a private practice setting. While one could refer BC patients back to primary care providers who get reimbursed for smoking cessation counseling, facilitating the appointment to formal smoking cessation programs is critical. The urgency of rapid referral should not be underestimated, since patients are most receptive at the time of initial diagnosis [6].

Engaging the entire urology team, particularly Advanced Practice Providers (APPs) and nurses who are frequently involved in office administration of Intravesical therapy is also important. It lessens the burden for busy urologists by encouraging more urology providers to interact with patients and their families, asking about progress in stopping smoking, encouraging compliance, and inquiring about recidivism.

At the policy level it is hard to know if urologists (or their APPs) were actively reimbursed for smoking cessation counseling (which can take a considerable time) would have a positive impact on their patients' attempts to quit. Currently most urologists have neither the time nor expertise to conduct successful smoking cessation programs by themselves, and the relatively small incentives that PCPs receive is unlikely to change most urologists' behaviors. Unfortunately, it is possible that financial penalties for failing to refer patients for such counseling might be more effective.

A second question is whether before a diagnostic cystoscopy for hematuria is scheduled, should

the discussion about smoking cessation begin? If the urology team already has its connections with smoking cessation programs in place, for the health of our patients, it should.

CONFLICTS OF INTEREST

Nothing to disclose.

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