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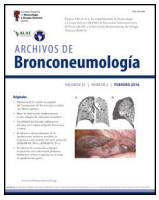

Editorial

Do COPD Treatment Guidelines Correctly Address the Treatment of Smoking?☆

¿Las guías de tratamiento de la EPOC abordan adecuadamente el tratamiento del tabaquismo?

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Tobacco consumption is the main risk factor for the development of chronic obstructive pulmonary disease (COPD). About half of all hardened smokers develop COPD and approximately 80% of the comorbidities associated with COPD are caused by smoking.[1] All studies agree that the only effective treatment for impeding the chronic obstructive process in COPD is to stop smoking,[1,2] yet between 30% and 45% of patients with moderate or severe COPD continue to smoke.[1]

Populational studies have shown that smokers with COPD have specific features that distinguish them from smokers without COPD.[3] Smokers with COPD smoke more cigarettes per day, they have a higher degree of physical dependence on nicotine, and they have lower levels of motivation and self-efficacy and much higher rates of depression than smokers without COPD.[3]

These characteristics make it more difficult for smokers with COPD to give up, and this specific group of patients needs more intensive treatment to help them achieve their goal.[4,5]

If we study the various guidelines for the diagnosis and treatment of COPD, it is surprising to see the scant consideration that these scientific documents give to the study of smoking in COPD patients.[1,2] Only the Spanish GesEPOC guidelines[2] dedicate considerable attention to this important aspect of the integral care of the COPD patient.

When treating smoking in COPD patients 3 aspects of the habit must always be studied: degree of nicotine dependence, degree of motivation for stopping smoking, and the presence of depression.[2,3]

Smokers with COPD have a high degree of nicotine dependence, even though some smoke very few cigarettes per day.[3] Asking these patients how soon they smoke their first cigarette after waking time gives a very good idea of their degree of nicotine dependence.[6]

Up to 45% of smokers with COPD do not want to give up, even if they know that their disease is caused by tobacco consumption.[3] The use of a visual analogue scale that helps determine a patient's motivation for stopping smoking has been advocated.[4,5] Both patients who wish to stop smoking and those that do not should receive treatment to reinforce or change their attitude, respectively, and to help them quit; the approach varies slightly between one group and the other.[4,5]

Depression is a very common comorbidity in COPD patients, and is even more common among those who smoke.[7] Thus, the presence of depression in smokers with COPD must be analyzed, and if detected, the patient should be offered the appropriate treatment. The Beck Depression Inventory is recommended for this purpose.[4,5]

All recommendations for the treatment of smoking in COPD patients coincide in that the most effective treatment for helping patients to give up is a combination of psychological support and pharmacological treatment.[4,5] Psychological support given to smokers must meet some specific criteria, as discussed below.

Support and counseling that healthcare professionals offer to smokers with COPD must be transmitted with empathy, understanding and respect. The subject must be aware that: (a) stopping smoking is the only effective therapeutic measure for controlling the progress of their disease; (b) treatment with bronchodilators and/or inhaled corticosteroids are less effective if they continue to smoke, and (c) the healthcare team that cares for them will help them stop smoking (they must even be informed of this by post, SMS, email and new technologies).[4,5]

Calculating "lung age" compared to actual age with the Morris-Temple linear equation is also useful.

A randomized study showed that the group of smokers who had been informed of their lung age, compared to the group who were only given the results of their spirometry test were more motivated not only to give up smoking, but also to continue to abstain after receiving treatment (13.6% versus 6.4%).[8]

Another important point when advising and supporting smokers with COPD is the need to prescribe specific follow-up visits to help them give up, separately from the COPD follow-up visits.

Pharmacological treatment of smoking in this group of patients is a fundamental part of the process. Three types of drugs have demonstrated their efficacy in helping smokers with COPD to quit: nicotine replacement therapy (NRT), varenicline, and bupropion.[4,5]

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These drugs should be prescribed at standard doses and regimens in smokers with low or moderate nicotine dependence.[4,5] For smokers with a high degree of dependence or in patients who have made several attempts to give up and failed despite correct treatment, these drugs must be prescribed at high doses or for longer periods, or in combination.[4,5]

The treatment of smoking must include smokers with COPD who do not want to give up the habit. In this population, support and counseling must be aimed at getting them to gradually reduce the number of cigarettes smoked per day, as a first step towards definitive cessation.[4,5] The prescription of pharmacological treatment to help smokers reduce their tobacco use and to maintain a lower consumption has been shown to be safe and effective.[9,10]

To summarize, the main guidelines for the diagnosis and treatment of COPD pay scant attention to the treatment of smoking. Treatment of smoking in smokers with COPD must be offered to both patients who want to give up, and patients who do not.[4,5] Treatment must always consist of a combination of psychological support and pharmacological treatment.[4,5]

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