The War on Cancer Starts with Tobacco

Reducing Tobacco-Related Cancer Incidence and Mortality
A National Cancer Policy Forum Workshop
Institute of Medicine
June 12, 2012

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Outline for my talk

1. Where do efforts to curb tobacco use fit in the war on cancer?

2. Do cancer care organizations see themselves as having a stake in tobacco control? If so, how?

3. What could cancer care organizations be doing more of to advance tobacco control?

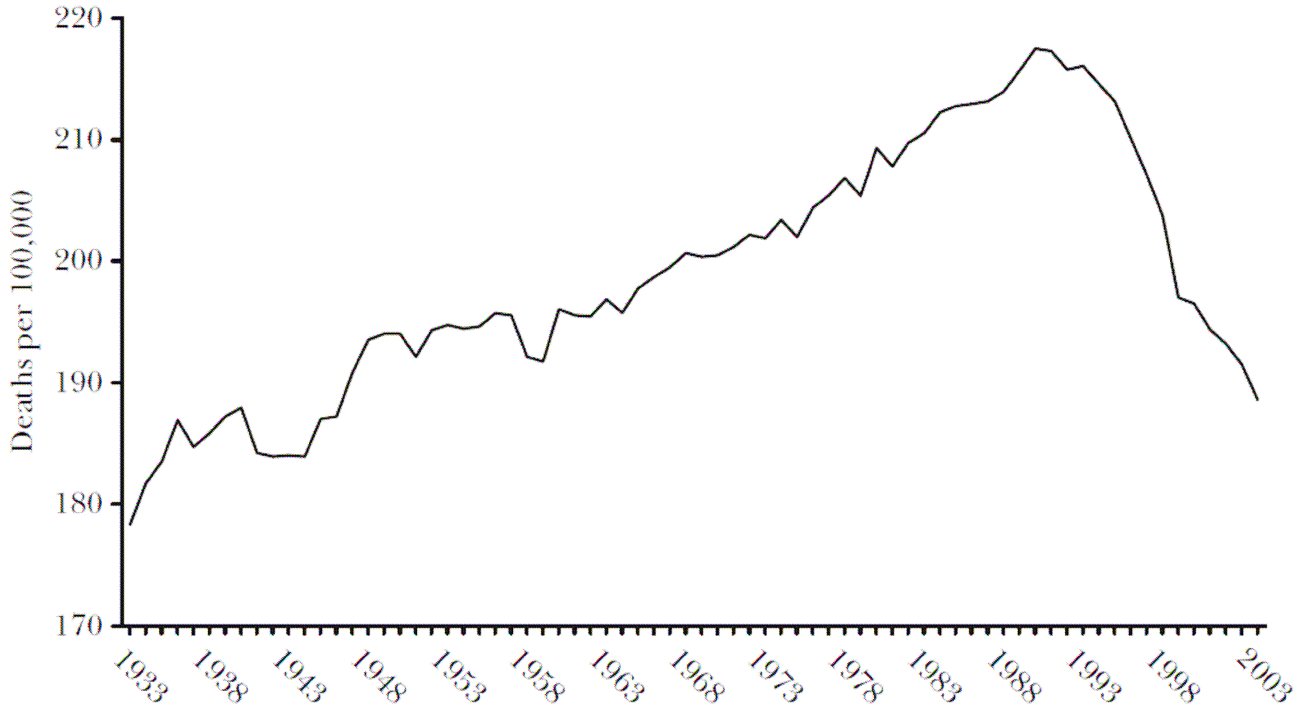
President Richard Nixon signs the National Cancer Act in 1971

….41 years later, the annual death toll from cancer is still >1/2 million per year

progress is being made

Figure 1

Age-Adjusted Cancer Mortality, 1933–2004



Note: Data are adjusted to the 2000 population distribution and corrected for changes in the classification of deaths over time.

…since the early 1990s death rates have dropped 22% for men and 14% for women

Why Tobacco?

1 out of 3 cancer deaths due to smoking

If the population ceased smoking, this single behavior change would be tantamount to a vaccine against one-third of cancer deaths.

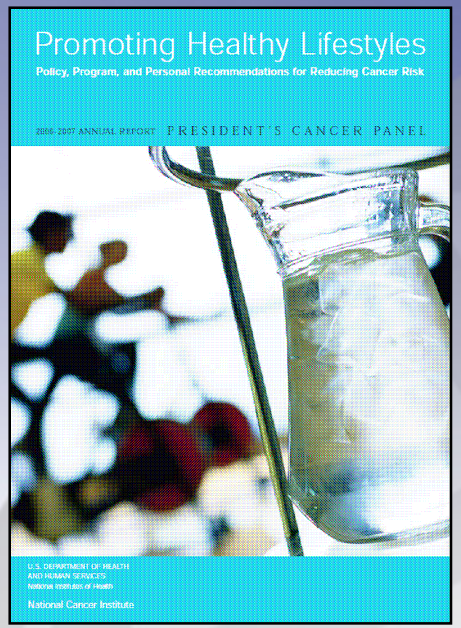
2006-2007 Annual Report President's Cancer Panel

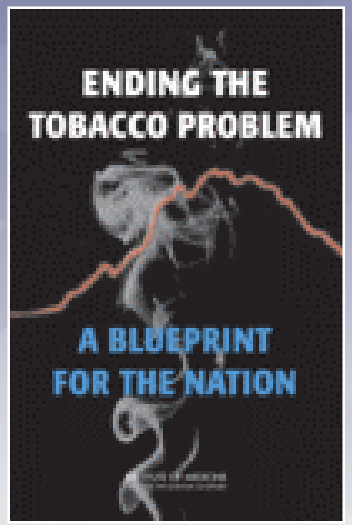
43.5 million people in the U.S. still smoke cigarettes

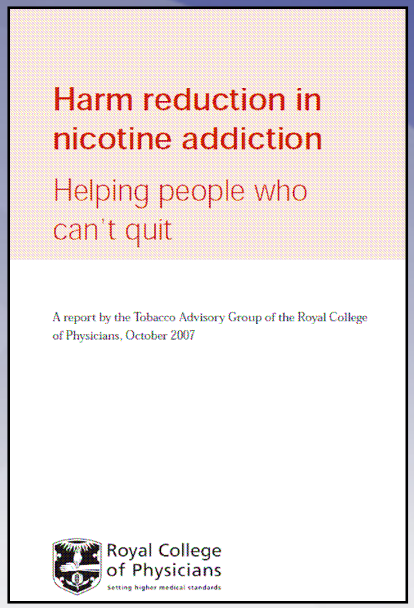
Reducing tobacco use – the nation's leading cause of cancer death – remains the greatest unmet potential for improving control of cancer and many other chronic diseases.

James H. Doroshow, Robert T. Croyle, John E. Niederhuber,
The Oncologist, 2009

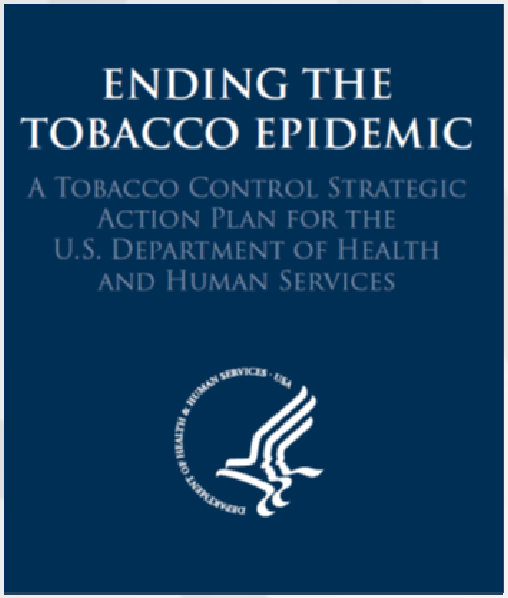
What can we do to accelerate a more rapid reduction in cigarette use?

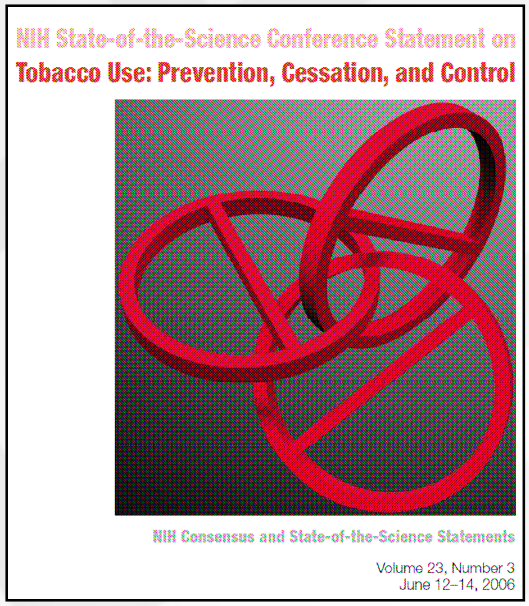


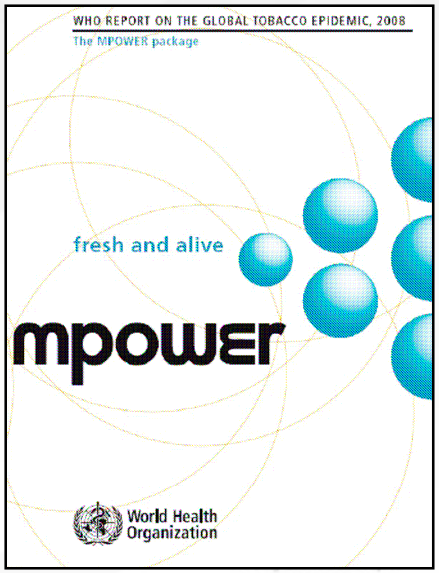




Call for research to find ways to speed up population level changes in tobacco use behaviors to minimize tobacco related deaths



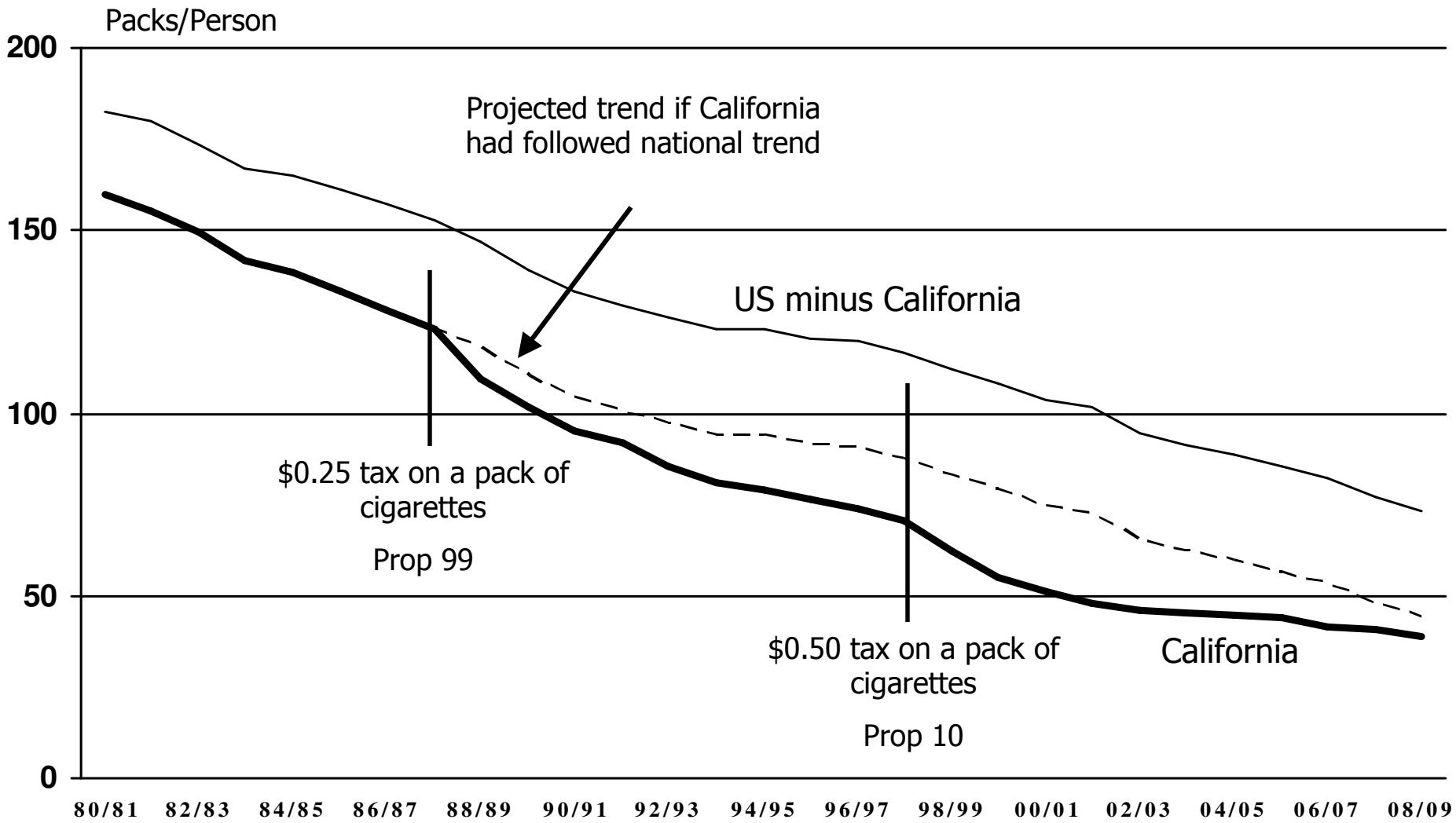




All of these reports note the importance of strong government action in order to make a difference in reducing cigarette consumption

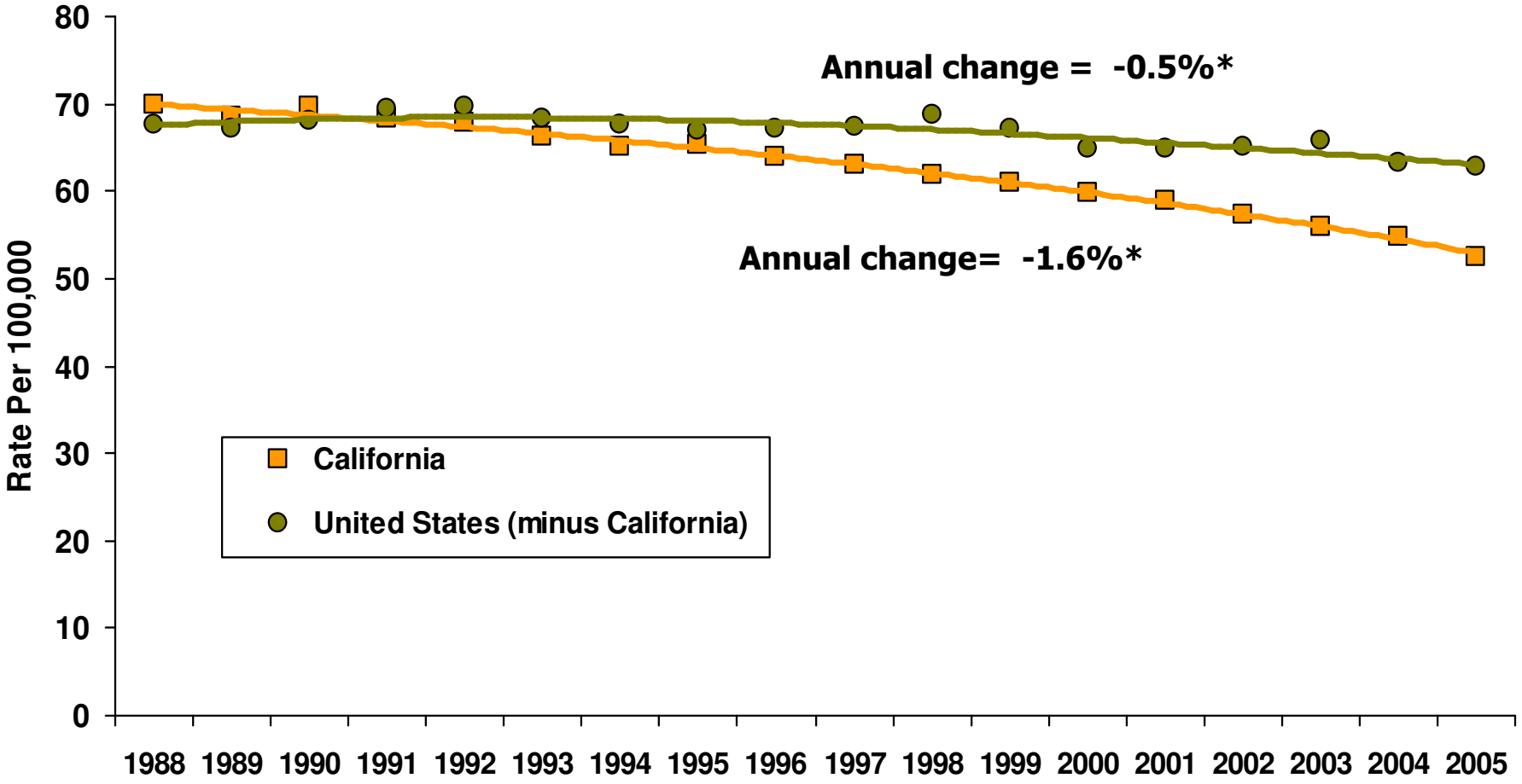
California Anti-Smoking Campaign Has Worked

Adult per capita cigarette pack consumption, 1981-1982 to 2008-2009



Source: California State Board of Equalization (packs sold) and US Census (population).
Note that data is by fiscal year (July 1-June 30).
Prepared by: California Department of Public Health, California Tobacco Control Program, October 2009.

Lung and bronchus age-adjusted cancer incidence rates, 1988-2005



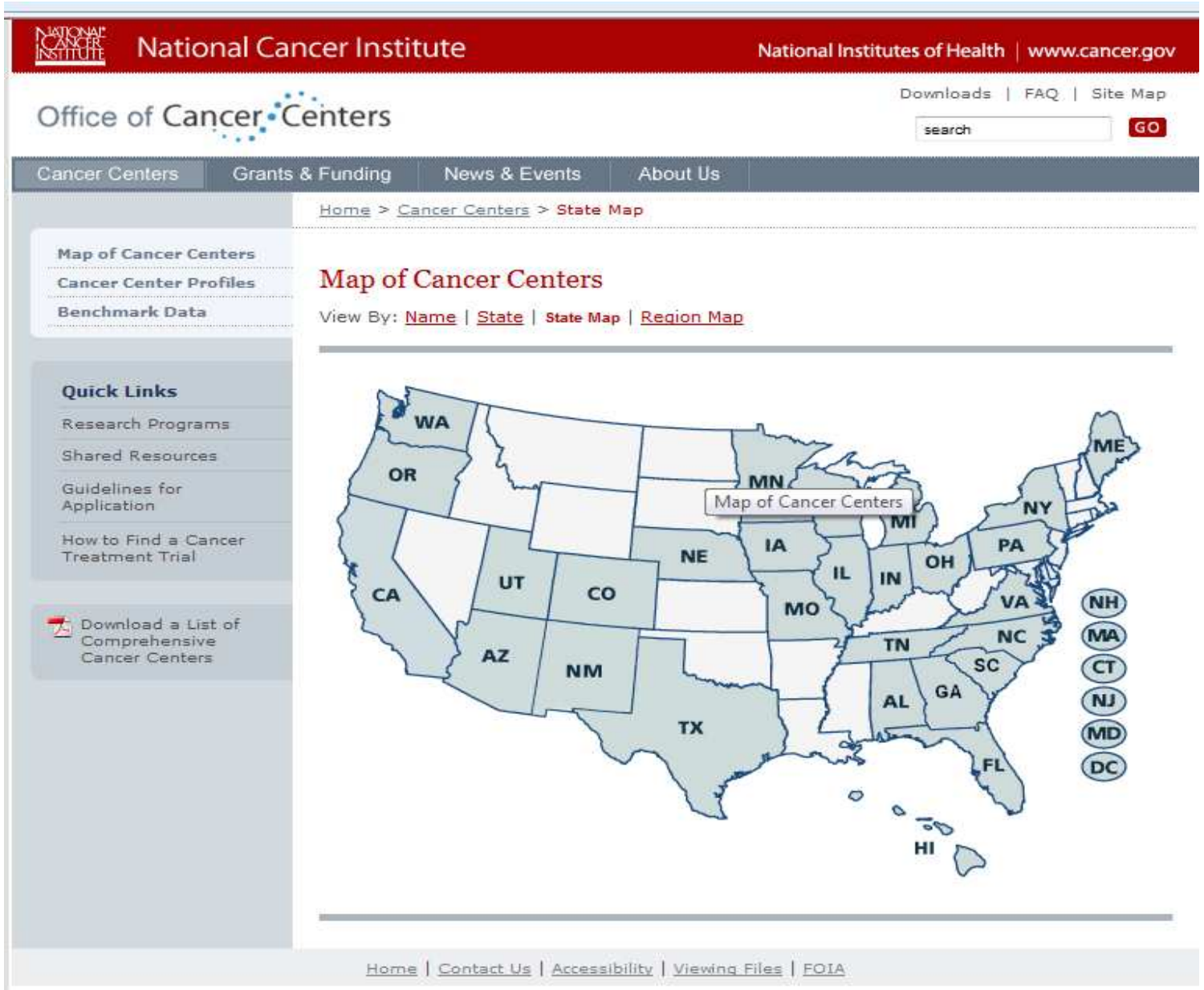
Rates are per 100,000 and age-adjusted to the 2000 U.S. standard (19 age groups).
* The annual percent change is significantly different from zero ($p<0.05$).
Source: Cancer Surveillance Section. Prepared by: California Department of Public Health, California Tobacco Control Program, 2008.

What are the organizations focused on cancer control doing about tobacco?

Who are the main players

- Government
  - NCI and NCI designated cancer centers
  - DHHS
    - CDC
    - AHRQ – practice guidelines
  - State governments
- Voluntary agencies
  - ACS
  - ASCO
  - AACR
  - NCCN
  - Armstrong Foundation

68 NCI designated cancer centers, help set the standards for cancer care



NCI's Commitment to Tobacco Control Research

- Long term commitment to tobacco control research…but today with 30% of cancer deaths due to tobacco, fewer than 4% of NCI grants are on tobacco
- Tobacco control is not meaningfully integrated into NCI's designated cancer centers
  - Limited cessation services for patients even though the evidence is strong that continued tobacco use adversely impacts treatment outcomes
  - < 1/3rd of NCI clinical trials even ask about tobacco use
  - Cancer Centers have very little stake in tobacco control beyond cessation and some limited research
  - No standards for delivery of tobacco control programming
- Lung cancer spore grants focus on treatment of disease rather than tobacco control
- Tobacco control research *may* be shifted away from NCI to a newly created Addiction Institute within NIH, with unclear consequences

DHHS Commitment to Tobacco Control

- Only 1% of CDC budget goes to Office on Smoking & Health (<$100 million) and this number is declining
- Tobacco control "best practices" guidelines have been advanced by CDC , but few states adhere to the standards and there are no consequences to noncompliance
- AHRQ published practice guidelines for treating tobacco use and dependence. However, there is nothing specific for cancer patients and limited incentives for adherence to the guidelines

AMERICAN LUNG ASSOCIATION.
lung.org / 1-800-LUNGUSA

2012 State of Tobacco Control®

REPORT CARD

SOUTH CAROLINA

SUBJECT:	GRADE:
Tobacco Prevention	F
Smokefree Air	F
Cigarette Tax	F
Cessation	F

CANCER ORGANIZATIONS UNITE TO ADVOCATE FOR NIH FUNDING

AACR collaborates with AACI, Friends, ONS and ASCO to build support for cancer research

On May 17, the five organizations brought more than 80 researchers, oncology nurses, clinicians, and advocates to Capitol Hill to meet with 150 House and Senate offices, including House and Senate leadership, from 30 states. Read more

Rep. Brian Bilbray (R-Calif.) addresses participants during the May 17 Hill Day.

Voluntary Agencies Commitment to Tobacco Control

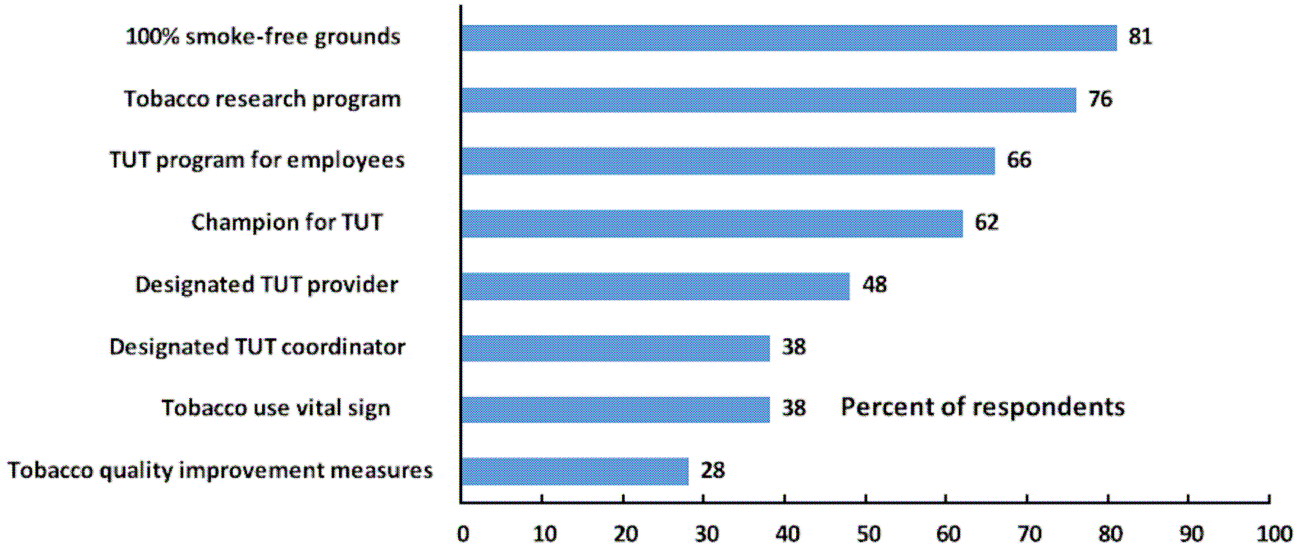
- ACS - supported CPS I & CPS II; major focus on advocacy for tobacco control policies
- AACR/ASCO – committee on tobacco control formed but otherwise, limited focus on tobacco control at annual meetings and in dissemination efforts
- NCCN – nothing on tobacco control
- Armstrong Foundation – advocacy for tobacco control

What are cancer centers doing?

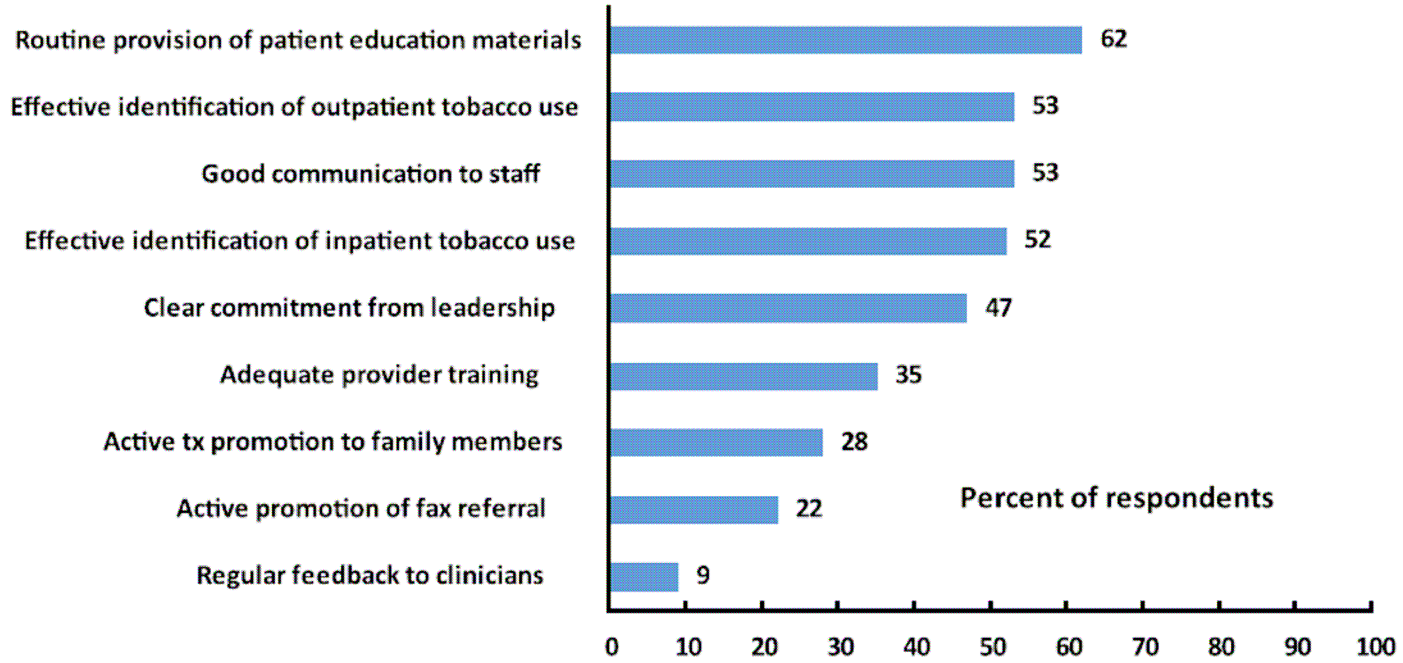
Original Investigation

Tobacco Use Treatment at the U.S. National Cancer Institute's Designated Cancer Centers

Adam O. Goldstein, M.D., M.P.H.,[1] *Carol E. Ripley-Moffitt, M.Div., C.T.T.S.,*[1] *Donald E. Pathman, M.D., M.P.H.,*[1,2] *& Katharine M. Patsakham, M.P.H., C.T.T.S.*[1]



Tobacco use treatment at U.S. NCI Cancer Centers



What could cancer care organizations be doing more of to advance tobacco control?

JOP, 2011

Original Contribution

National Cancer Institute Conference on Treating Tobacco Dependence at Cancer Centers

By Glen Morgan, PhD, Robert A. Schnoll, PhD, Catherine M. Alfano, PhD, Sarah E. Evans, PhD, Adam Goldstein, MD, MPH, Jamie Ostroff, PhD, Elyse Richelle Park, PhD, Linda Sarna, DNSc, RN, and Lisa Sanderson Cox, PhD

Tobacco Control Research Branch and Office of Cancer Survivorship, National Cancer Institute; Bethesda, MD; Department of Psychiatry, University of Pennsylvania, Philadelphia, PA; Department of Family Medicine, University of North Carolina, Chapel Hill, Chapel Hill, NC; Behavioral Science Service, Memorial Sloan-Kettering Cancer Center, New York, NY; Department of Psychiatry and Health Policy, Harvard Medical School, Boston, MA; School of Nursing, University of California, Los Angeles, Los Angeles, CA; Department of Preventive Medicine and Public Health, University of Kansas Medical Center, Kansas City, KS

Introduction

Despite prevention efforts, changes in social policy, and the advent of effective medications for tobacco dependence, 21% of the US population currently smokes. Further, upward of 50% of patients with cancer who were smokers before their diagnosis continue to smoke, and, even for patients who are able to quit after their diagnosis, relapse rates are substantial. Tobacco use is the leading cause of preventable death in the United States, and continued smoking by patients with cancer can reduce medical treatment effectiveness and diminish quality of life.

The National Cancer Institute (NCI) cancer centers represent nodal points to treat tobacco dependence. NCI cancer centers possess the credibility to help smokers quit, and with the greater life expectancies forecast for patients with cancer, addressing smoking at cancer centers has taken on greater importance. Consequently, in December 2009, the NCI Tobacco Control Research Branch and the Office of Cancer Survivorship sponsored a 1-day meeting at the National Institutes of Health on treating tobacco dependence at NCI cancer centers. This meeting included presentations, discussion, and question-and-answer sessions; 65 members from 40 cancer centers participated. This meeting and overview may help build capacity for the delivery of tobacco dependence treatment at NCI cancer centers.

The Problem

Smoking causes 30% of all cancers and 80% of mortality from head and neck and lung cancer.[1-3] Despite policy and scientific advances, 21% of Americans currently smoke tobacco, upward of 50% of patients with cancer who smoked before diagnosis continue to smoke,[4] and relapse rates after completion of medical treatment are high.[5] There are more than 11.7 million cancer survivors in the United States, including more than 325,000 adult survivors of childhood/adolescent cancer.[6] Upward of 25% of survivors are smokers, including 14% of adolescent cancer survivors.[7] Continued smoking by patients and survivors decreases survival time,[8] increases risk for a second primary cancer,[9] reduces medical treatment effectiveness,[10,11] and diminishes quality of life after treatment.[12,13]

Patients with cancer who try to quit smoking typically do so without formal assistance,[14] which yields low success rates.[15] Further, the provision of tobacco use treatment is not considered a "core service" at most NCI cancer centers. The results of a survey of tobacco use treatment at 58 NCI cancer centers presented at this meeting for the first time[16] showed that, although 60% of cancer centers offered some form of tobacco use treatment, such services were often confined to one disease subspecialty. Including tobacco use as a "vital sign" on patient medical charts increases the rate of identification of smokers, rates of treatment, and cessation rates.[18,19] Currently, fewer than half of the 58 cancer centers assess smoking status as a vital sign,[16] yet this procedure is cheap, simple, and effective.

Treatment Guidelines

The US Public Health Service's *Treating Tobacco Use and Dependence Clinical Practice Guideline* identifies effective treat-

THE PROBLEM

Fewer than ½ of the cancer centers have designated personnel to offer tobacco use treatment. The availability of tobacco use programs at cancer centers lags behind that of other models of care (e.g., nutrition support)

4 possible game changers

- All clinical studies of cancer treatments (whether chemo or radiation or newer emerging genetic therapies) **MUST** include objective measures of tobacco exposure (i.e., cotinine), both active and passive.

- NCI and other accrediting organizations should make the presence of an active tobacco use treatment program for cancer patients a standard of care, with quality indicators to document delivery of services to cancer patients (i.e., % of tobacco users enrolled in cessation treatment services, appropriate follow-up to address relapse, cessation rates)

- NCI and other accrediting organizations should make the presence of a lung cancer screening program for *high risk* current and former smokers a standard of care for designated cancer centers, with quality indicators for delivery of screening services to the target population (i.e., % of target population screened, appropriate follow-up of those with positive lesions, etc.).

- NCI and other accrediting organizations should require designated cancer centers to implement interventions to reduce tobacco use in their catchment areas with quality indicators that demonstrate that these efforts are lowering tobacco use rates (i.e., evidence of programming and advocacy for tobacco control, monitoring of tobacco use rates in the community)

Perhaps some day soon…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SEVENTY-TWOS
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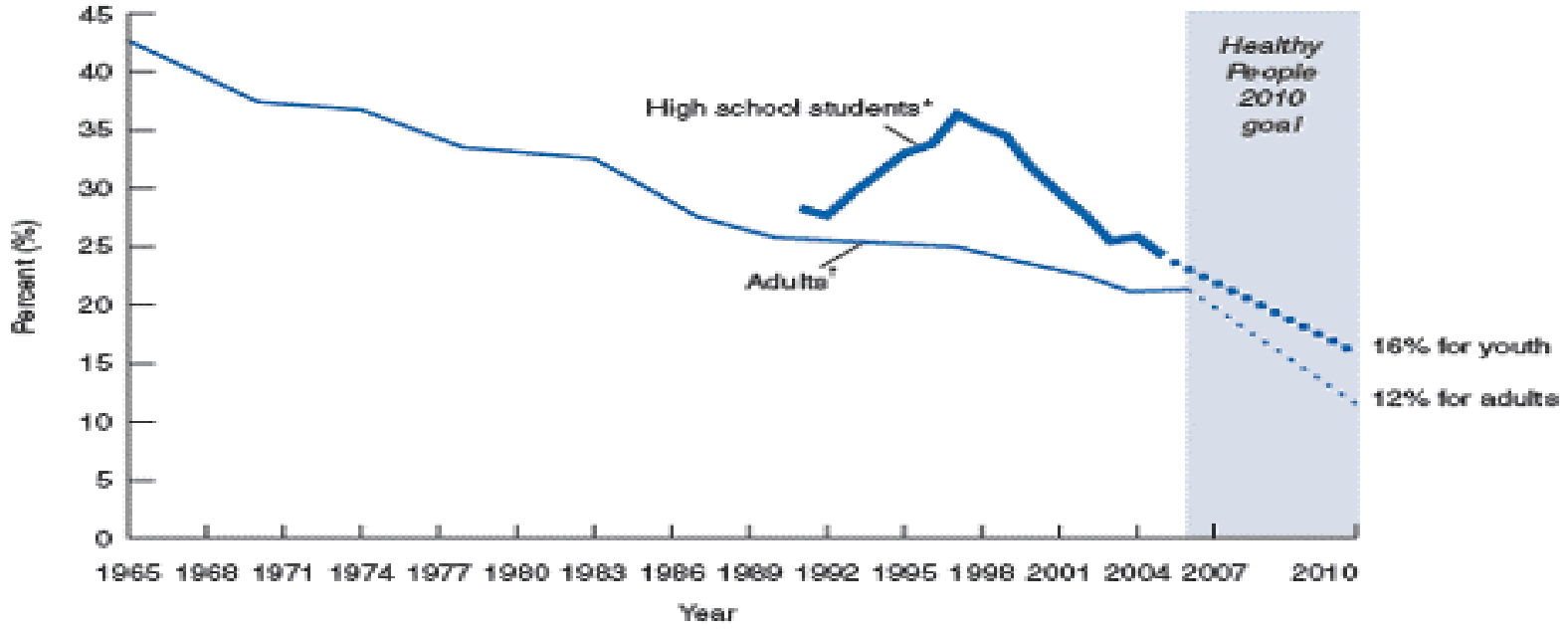
BUYING TOBACCO FOR MINORS COULD COST YOU.
Please Have Your ID Ready
San Diego Daily Transcript
Cancer doctors refuse to send patients to pharmacies that continue to sell tobacco products
NOW IN POUCHES
5-hour ENERGY
BUTTERFLY
COCADA
MAVERICK
BUYING

Accountability: Cancer care agencies committed to the goal of reducing smoking prevalence.

Healthy People 2020

Trends in Current Cigarette Smoking by High School Students and Adults, United States, 1965–2006



* Percentage of high school students who smoked cigarettes on 1 or more of the 30 days preceding the survey (Youth Risk Behavior Survey, 1991–2005).

† Percentage of adults who are current cigarette smokers (National Health Interview Survey, 1965–2006).

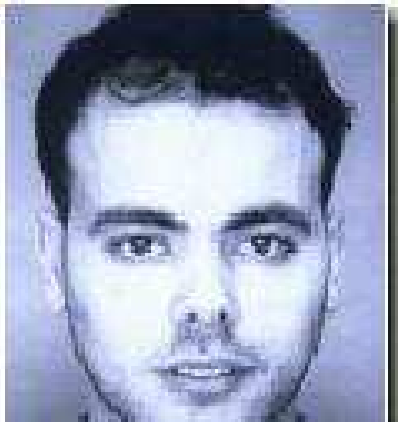
We need an agreed upon measurable goal

Reduce ***cigarette*** smoking prevalence rates by at least 1 percentage point every year among children and adults

Resulting in a gradual phasing out of cigarette use by children by 2020 and by adults by 2030

How about some new ideas???

Contraband Tobacco



Cancer care groups advise the government to establish a national tax collection system on tobacco products to curb illicit trade linked to global terrorisms

Cancer care agencies advocate for earmarked tobacco taxes to pay for cancer research

We're making progress, but we're seem to be lacking an urgency to address the problem

Questions