By Andrew Holtz

The diagnosis of cancer is an under-utilized teachable moment for cessation among patients, family, and significant others. Program dissemination of existing interventions, effective in healthy populations, is rarely undertaken, especially in a high-tech environment focused on cancer diagnosis, treatment, and rapid discharge.

So write Ellen R. Gritz, PhD, Damon Vidrine, DrPH, and Amy Lazer, PhD, in the new book *Evidence Based Interventions in Oncology* (Givens CW, Champion V, Kesachatik S, Devos D [Eds], New York: Springer Publishers, in press).

About half of the patients diagnosed with smoking-related tumors are still smoking when their cancers are discovered. As the title to their chapter, “Smoking Cessation in Cancer Patients: Never Too Late to Quit,” makes clear, the M. D. Anderson researchers see opportunity in the moment of crisis.

“Patients are probably aware of the risks that their smoking has induced, but they’ve used a lot of denial to convince themselves that it wasn’t necessary to quit. Or maybe they’ve tried and failed, and thought that they could continue to smoke without a life-threatening impact,” Dr. Gritz notes.

“The time when you are being worked up for a malignancy or being diagnosed with a malignancy is when it basically confronts you. We’ve seen that in many of the smoking-related cancers, a large proportion of the patients are able to stop spontaneously with the advice of their physician and perhaps some formal assistance.”

Dr. Rowland also sees hope for better support of behavioral approaches to reducing cancer risk.

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“An example of that comes from the cardiovascular realm, where the dietary and exercise intervention programs are built into the comprehensive cardiac care. This hasn’t been part of the cancer world because physical activity isn’t seen as a compelling risk factor yet, except for colorectal cancer.”

The IOM report called for broader insurance coverage as an important step toward gaining more acceptance of behavioral modification programs in the clinical setting.

“To the extent that health insurers or health plans make those resources available part of their health care delivery, then it would be the same as a health care provider being able to refer to a specialist for an ingrown toenail or a rash,” Dr. Curry said.

Lifestyle Change continued from page 27

Different Patients, Different Responses

Dr. Rowland notes that just as with any treatment, individual patients will respond differently. “I think what you are going to find is that there is not going to be a single prescription for this. Some of our seniors prefer more group-based programs, they want to come in to some place and do it as a group. Others, often young people with kids, want to do it at home.”

Effective lifestyle interventions avoid lecturing. Dr. Curry warns against tactics that appear to “blame the victim” for the occurrence of cancer.

“If it were that simple, wouldn’t we be there already?” she said.

Some of the most effective measures to improve behavior look beyond individuals to a broader, societal approach. “We are really talking at the individual to a broader, societal approach. ‘I think what you are going to find is that there is not going to be a single prescription for this. Some of our seniors prefer more group-based programs, they want to come in to some place and do it as a group. Others, often young people with kids, want to do it at home.’”

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“Effective lifestyle interventions avoid lecturing. Dr. Curry warns against tactics that appear to “blame the victim” for the occurrence of cancer. For example, when you go to the doctor you get weighed. The doctor doesn’t write down, ‘I weighed my patient’ for reimbursement. It’s part of the visit. You get your blood pressure checked. They listen to your chest. Well, what about tobacco as a vital sign? When your kids are little they are compared against growth charts, and parents compare percentiles for height and weight; but they stop doing that for adults.”

“The type of tumor being treated affects how clinicians react, Dr. Gritz continued. Clinicians who deal with brain or breast cancers or other tumors not tightly linked to smoking may not see cessation as a top priority. Even though smoking is linked to bladder cancer, cessation rates among these patients are lower than those among lung cancer or head and neck cancer patients.

But even when these differences emerge, the causal link between smoking and cancer is tragically obvious, clinicians may not have the skills to effectively intervene.

“Those physicians who deal with head and neck cancer patients are acutely aware of the dangers that smoking induces and the importance of quitting, and they are usually quite emphatic with the patient,” she said. “However, they may convey their message primarily in a direct statement, ‘You must quit for your surgery,’” and (continued on page 33)

**Seizing the Moment of Diagnosis to Help Patients Stop Smoking**

“Do More

Dr. Gritz and her colleagues say clinicians need to do more to take advantage of this opportunity to remove tobacco from their patients’ lives.

“Certainly it is the medical obligation, of every oncologic practitioner who comes in contact with that patient to explain that this is a key factor in their disease.”

Taking action is especially important for those patients diagnosed with early-stage disease, because they are likely to survive, yet they remain at elevated risk for recurrence or a new primary tumor.

Better Support

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Looking to the Future

While lifestyle interventions do not yet match medical and surgical treatments in terms of either evidence of specific effectiveness against cancers or support within the health care system, progress is being made.

Dr. Gruman said she has seen important advances since she began working on issues of health and behavior a decade ago. “These things were so far from anybody’s consciousness. I’d go out and talk about how these were the most important things in the world and people would laugh at me. Now a mere 10 years later, people are really recognizing they are important. They don’t know how to do them right, but they are recognizing their importance.”

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Creating the Right Environment

By Andrew Holtz

The general recommendation for most people is to try to engage in 30 minutes of physical activity on most days, says William Dietz, MD, PhD, Director of the Division of Nutrition and Physical Activity of the Centers for Disease Control and Prevention.

“The most important thing, though, is that more is better. If you have a patient who is doing nothing, just getting them moving should be the first goal. For somebody who is sedentary, getting them to 30 minutes a day is going to take some time, so the first task is to get them to five or 10 minutes, and then move on from there.”

That recommendation doesn’t necessarily mean patients should be told to sign up with a personal trainer at a gym. Indeed, the common perception of exercise as something that has to be put on the daily planner, separate from other activities, can be a barrier to increasing the amount of physical activity.

“We try to distinguish between ‘physical activity’ and ‘exercise,’ because the term exercise connotes uncomfortable, sweaty, repetitive activity, which needs to occur in a specific setting. Well, that’s not necessarily available to people,” Dr. Dietz notes.

“In the area of cancer, you have patients who are particularly motivated. They are likely to be very responsive to what their physician has recommended.”

But as every physician knows, simply writing a prescription does not guarantee that the patient will take the medicine. When it comes to a prescription for more physical activity, Dr. Dietz says one of the biggest barriers to action is the world we’ve created around us.

“We’ve engineered physical activity out of lives in so many ways, with TVs and cars to do the simplest errands and garage door openers and lawnmowers that you sit on and electric can openers. We need to begin re-engineering our environment so that it’s easy for people to be physically active as part of their everyday life. The stairwell is one of those opportunities.”

StairWELL

The CDC has tackled stairwell design as part of its efforts to look at ways to engineer activity back into our lives. Using their own building in a typical suburban Atlanta office park as a test site, researchers placed sensors to record when someone entered the stairwell. “We then set out to make the stairwells the nicest part of the building,” Dr. Dietz explained.

However, a fresh coat of paint, new carpeting, and even scenic murals at each landing weren’t enough to boost traffic.

So then they placed signs at the elevators displaying prompts including, ‘Use the stairs for your health.’ ‘No waiting, one door over,’ and ‘If you walk up the stairs you use 15 calories, if you ride the elevator, you use 1.’ Stairwell use rose 8%, but then returned to baseline within three months as the novelty wore off.

So the experimenters tried to keep the stairwell experience fresh, by adding satellite radio music with an ever-changing playlist.

“You can choose the genre of music and change it, so that you can have hip-hop for a week and country for a week and then classical for a week. It’s really pretty neat, and at a fairly modest price,” Dr. Dietz said. “And usage again went up 8%, but stayed up, because the music was constantly changing.

“We don’t believe that if you use stairwells, that that’s all you need to do; but it showed us that this was a relatively inexpensive way, that didn’t require special equipment or clothing, that enabled people to get physical (continued on page 34)

Beyond the Individual Patient

Clinicians also need to look beyond the individual patient to include the whole family, both because continued smoking by a spouse or other member of the household will make it more difficult for the patient to quit, and because the cancer diagnosis may motivate other smokers in the family to try quitting.

Dr. Lazev says these family issues may be something new for oncologists.

“It is somewhat unfamiliar to a lot of physicians; however, there is a growing focus on involving families in every aspect of patient care, so as physicians become more used to family members advocating for the patient and asking questions and being involved in the treatment, they can also then turn to the family members and give them something very powerful that they can be doing to contribute,” she says.

Dr. Gritz and her colleagues note that helping cancer patients to quit smoking isn’t always easy, and the first attempt often won’t succeed. Nevertheless, Dr. Gritz says, even after a tumor has already appeared, taking action against the chronic, relapsing, addictive behavior is imperative.

“It’s time the clinicians shaped up. They can’t just ignore it. They can’t just palm it off on someone else. It is as important as the primary medical treatment.”

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