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Commentary: Dogma and data

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In 1964, Luther Terry, US Surgeon General, released the first statement related to the harmful effects of smoking, including that it is a cause of lung and laryngeal cancers and the most important cause of chronic bronchitis. These conclusions were based on more than 7000 articles available at the time linking smoking to various diseases.¹ Although the entire world has known about the harmful effects of smoking for 2 generations, people continue to smoke. Most begin smoking as teenagers or in their early 20s, at a time when the harmful health effects that develop decades later are not thoroughly considered. In America, nearly 70% of adult smokers want to quit and more than 50% actually attempted to quit at least once in the past year.² Clearly, most active smokers are motivated to quit, but they are fighting uphill battles of chemical and psychological dependency.

It is unclear why 40% of thoracic surgeon respondents indicated a requirement of smoking cessation before pulmonary resections. Perhaps well-intended surgeons believe patients can be helped by leveraging an operation to further incentivize smoking cessation. Even if patients quit smoking long enough to undergo lung cancer operations, recidivism remains a significant concern. It is customary for transplant centers to require at least 6 months of tobacco abstinence before considering patients for a lung transplant. Following a protracted period of chemically confirmed tobacco abstinence, more than 10% resume smoking after the transplant and recidivism rates are even greater among patients transplanted with a history of chronic obstructive pulmonary disease.³ Requiring smoking cessation before surgical resection of lung cancers appears to be an

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CENTRAL MESSAGE

Smoking cessation does not influence operative mortality or morbidity for pulmonary resections and is unlikely to affect long-term abstinence.

ineffective means of helping active smokers rid themselves of the unwanted habit.

Delman and colleagues⁴ presented a single institutional retrospective study showing that current smokers had similar rates of operative mortality and major complications following elective pulmonary resections for lung cancer compared with prior smokers. These results are consistent with previous findings of a larger, but less granular study using the General Thoracic Surgery Database.⁵ This study of nearly 8000 patients found that the risk for pulmonary complications were similar between current smokers and 3 different cohorts of prior smokers stratified by their duration of smoking abstinence before surgery. Only when compared with never-smokers could differences in mortality or morbidities be appreciated. Collectively, Delman and colleagues,⁴ Mason and colleagues,⁵ and others have demonstrated no benefits for requiring that patients quit smoking before proceeding to surgery for lung cancer. We need to continue counseling patients and providing resources to assist with smoking cessation. However, requiring that patients quit before offering surgery shows no benefit and is unlikely to result in long-lasting abstinence.

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