Study of the Smoking Status of Preoperative Patients in Chidoribashi General Hospital.

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Background

Cigarette smoking increases the risk of complications in patients undergoing surgery and even increases the risk of perioperative death. Postoperative respiratory complications and poor wound healing in particular tend to be higher in smokers compared to nonsmokers. Therefore, patients undergoing surgery should quit smoking. A patient who encounters a need for surgery could consider this a valuable opportunity to change their behavior. This may motivate them to quit smoking and gain the associated health benefits of long-term smoking cessation.

As yet, a preoperative smoking cessation program has not been established for patients in our hospital. It is up to patients' individual physicians to advise against smoking and give smoking cessation guidance.

We conducted a study of the smoking status of preoperative patients in our hospital and evaluated the effect of preoperative cessation guidance in it's present condition.

Method

The study was conducted from November 2013 to March 2014. When patients received a schedule for admission and operation in the outpatient department, they received brief (a few minutes) preoperative smoking cessation guidance from their physicians and outpatient department nurses. We then confirmed the patient's smoking status at the time of admission.

Details of Patients in This Survey

Sex	Age	Preoperative Diagnosis	Days *	Brinkmann Index	Brief Smoking Cessation Guidance	Smoking Cessation *
M	67	Hernia Inguinalis	19	940	×	×
M	65	Postoperative Hernia	12	1500	×	×
M	55	Lipoma	10	420	×	×
M	74	Lung Cancer	13	570	×	×
F	44	Cholelithiasis	5	300	×	×
M	69	Lung Cancer	22	750	×	×
M	80	Lung Cancer	3	600	○	×
M	65	Colon Cancer	14	900	×	○
M	59	Gastric Cancer	22	800	×	×
M	73	Lung Cancer	11	1000	○	○
M	53	Hernia Inguinalis	4	300	○	×
M	53	Hernia Inguinalis	2	600	×	×
M	29	Hernia Inguinalis	4	70	○	×
M	75	Gastric Cancer	21	2280	○	×

* From guidance to admission.

Result

In this survey, 34 patients were scheduled for an operation in the outpatient department. 14 of these patients were smokers and had received smoking cessation guidance. After guidance just 2 of these patients stopped smoking prior to admission. The average duration from guidance to admission was about 12 days. In interviews with these 2 patients, they stated that they had intended to stop smoking prior to decisions regarding surgery. It seems these 2 patients had used their impending surgery as an opportunity to become non smokers. However they did not remember much about the guidance they had received, which would suggest this guidance had little effect on their decision.

Conclusion

This survey suggested that current smoking cessation guidance has no effect. In Denmark, there is a smoking cessation program for elective surgery patients, it is known as the Gold Standard Program (GSP). It consists of an intensive intervention program lasting 6-8 weeks before and after surgery. The treatments include relapse prevention, dealing with the desire to smoke and nicotine replacement therapy, it is carried out by trained staff. In our hospital, there are trained staff to provide smoking cessation guidance, but not specifically prior to an elective operation. In addition, the average duration from the first guidance session to admission was just 12 days. This is too short to carry out smoking cessation intervention, it would also be necessary to continue postoperative intervention. This is not currently performed. In the future, in order to perform smoking cessation intervention in the perioperative period which will be effective long-term, we must address the training of smoking cessation intervention staff. This would require time and human resources. On that basis, we need to consider a preoperative smoking cessation program that can be implemented in our hospital.