

Active Smoking at the Time of A Lung Cancer Diagnosis

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Provider: “you have lung cancer...”
 Patient: “oh ... but I have never smoked.”

Receiving a lung cancer diagnosis can be devastating news. Globally, lung cancer remains the primary cause of cancer death in men and second leading cause of death in women.^[1] Despite preventive lung cancer screening for high-risk individuals where available, and treatment advances for patients including new targeted therapies and surgical strategies, 5-year overall survival rates remain low compared with other types of cancers with rates from 10% to 20% globally.^[1]

While there are other risk factors, cigarette smoking is established as the primary cause of lung cancer linked to about 50% of lung cancer death in women and 75% in men worldwide.^[1] Globally, Asians have higher rates of smoking but lower rates of lung cancer as compared to individuals from the United States secondary to potential genetic differences, reduced toxins in cigarette products, and lifestyle factors.^[2] However, these statistics do not imply that cigarettes are safer for Asians. Risk for developing lung cancer increases as a result of the length of time and intensity of smoking behaviors.^[1]

Public awareness of risks associated with smoking behaviors for lung cancer as well as other diseases has grown exponentially as a result of public health campaigns, growth of the Internet and social media, state-level tobacco control programs, and efforts by organizations such as the American Cancer Society and Centers for Disease Control. Smoking rates have declined in several western countries with resulting decreases in lung cancer mortality against this public health backdrop of widespread recognition of the risks associated with sustained smoking.^[1] A second outcome has been an associated reduced public acceptance of smoking, perceptions that smoking is a personal choice, and perceived stigmatization of individuals who continue to smoke.^[3]

In a large study that included 2456 individuals with lung cancer, 90% of the sample were formal smokers; almost 38.7% were currently smoking at the time of diagnosis, and 14.2% were still smoking 5 months after diagnosis.^[4] Patient factors associated with persistent smoking 5 months following diagnosis included not being married, having less emotional support, higher depression, having public insurance, not receiving surgery, reporting heightened symptoms and pain, having poorer perceived health, and

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reporting higher intensity of daily smoking.^[4] Another study evaluated smoking status, psychological distress, and health environment perceptions of 52 adults who were undergoing diagnostic evaluation for actual or suspected lung cancer.^[5] Findings demonstrated that patients ($n = 12$) who were current smokers were inclined to report more anxiety, higher worry, reduced levels of perceived effective cognitive functioning, and less positive perceptions about the health environment experience compared with patients who had quit or had never smoked.^[5] They also had significantly higher cancer-related worry.^[5]

The two above-mentioned studies depict active smoking at the time of a lung cancer diagnosis as an added parameter of vulnerability. Patients with lung cancer are documented to carry a higher symptom burden, lower perceived quality of life, and higher distress as compared to other cancers. However, for patients who are active smokers at the time of diagnosis, this distress may be exacerbated since smoking behaviors are also used as stress management strategies. Given societal stigmatization surrounding smoking behavior, patients can also be sensitized to assume that their health providers would be negative and judgmental relative to ongoing smoking.^[4]

Patients can be highly motivated to stop smoking at the time of a lung cancer diagnosis. However, smoking is an addiction disorder and the management of repetitive cravings when cognitively and emotionally overwhelmed is an enormous challenge. Negative thoughts and emotions such as guilt, self-blame and self-deprecation, regret, anger, and stigmatization experiences are recognized to occur in patients with lung cancer with smoking history.^[3] Factors identified in Park *et al.*^[4] above-mentioned study associated with persistent smoking such as lack of emotional support, depression, and intense daily smoking (suggesting stronger addiction) imply a need for multipronged supportive programs that expand beyond smoking cessation counseling and nicotine supplementation. Unsuccessful efforts to stop smoking may compound perceptions of failure and low self-worth, thus subsequently affecting adaptation to the illness and its treatment adversely.

Improved clinical outcomes for patients who are successfully able to stop smoking following a lung cancer diagnosis are recognized. Thus, bolstering available resources to increase the likelihood that cessation is permanent is essential. For example, augmenting cognitive behavior strategies that focus on restructuring thought patterns about smoking urges with practices that incorporate mindfulness meditation and relaxation training for calming somatic activation may be incorporated. Provision of referrals for mental health counseling may also be needed to support coping with a new diagnosis of lung cancer.

Finally, the burden of association of lung cancer with smoking remains an ongoing challenge for the patients' experience whether or not they have a life history of smoking. Nurses can energize the conversations around this issue bringing rational and humane discussion about the kind of care all humans, no matter what their life experiences, are indeed deserving of receiving. For the patient with a new diagnosis of lung cancer – worried and stressed in the middle of an uncertain future in a unfamiliar terrain, the journey may be lightened.

Conflicts of interest

There are no conflicts of interest.

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