Assessing the efficacy of spirometry for smoking cessation

In a recent issue of *Thorax* Bednarek et al.1 presented interesting results from a large-scale prospective cohort study on the effect of combining spirometric tests with simple smoking cessation advice in 3077 middle-aged smokers with previously undetected airflow obstruction compared with smokers without airflow obstruction. Carbon monoxide-validated smoking cessation rates after 12 months of follow-up were 16% in subjects with airflow obstruction and 12% in smokers without airflow obstruction. These results are promising; however, we think that the authors’ conclusion that spirometric screening of chronic obstructive pulmonary disease (COPD) is effective in smoking cessation is too far-reaching because of the limitations of the study design.

The conclusion by Bednarek et al.1 that spirometry is efficacious in smoking cessation is limited by the fact that their study was not a randomised controlled trial but a prospective cohort study comparing smokers with previously undetected airflow obstruction with those without airflow obstruction. This might have introduced bias. It is possible, for example, that the smokers with airflow obstruction in this study might have been more susceptible to the “health warnings” given by the doctor who evaluated the spirometric test results with them. This higher susceptibility to health warnings is supported by the fact that the follow-up response rate was significantly higher among subjects with airflow obstruction (87%) than in those without airflow obstruction (62%), and that the follow-up response rate was associated with disease severity (90% in moderate to severe airflow obstruction compared with 81% in mild obstruction).

Another problem is that neither prospective nor retrospective data appear to have been collected on whether smokers used pharmacological aids for smoking cessation on their own. The use of pharmacological aids for smoking cessation (such as nicotine replacement therapy, bupropion or nortriptyline) is more effective than behavioural treatment (advice) alone.2 It cannot be ruled out that this use was higher in the group with airflow obstruction compared with those with no airflow obstruction. It would be of interest to use this form of treatment in addition to advice from the physician.

The results of the study by Bednarek et al.1 are promising and in line with results from other studies.2 However, evidence from well-designed randomised controlled trials is needed on the efficacy of spirometry for smoking cessation. Smokers with airflow obstruction probably respond differently to smoking cessation treatment compared with those who do not suffer airflow obstruction. It has been shown in previous studies that the former group is more likely to be older, to be more addicted to nicotine and tobacco and to have a longer smoking history (and therefore more pack years)—all of which are predictors of treatment outcome.3 We therefore suggest that the use of spirometry for smoking cessation should be tested in a homogeneous group of smokers with previously undetected airflow obstruction who are randomised to undergo either counselling including confrontation with spirometry or counselling without confrontation. We are currently conducting such a trial (ISRCTN 64881813).

References

1 Bednarek M, Gorecka D, Wielgosz J, et al. Smokers with airway obstruction are more likely to use pharmacological treatment by the authors and, with reservations, in the accompanying editorial by Mannino4 as evidence to support the introduction of spirometric screening to detect early chronic obstructive pulmonary disease (COPD). This goes against the evidence of the study itself, and opposes the results of the comparative study of spirometric screening published by the same workers in 2004.5 Bednarek et al show an effect of spirometric screening in smokers with moderate or severe COPD (using the Global Initiative for Chronic Obstructive Lung Disease-European Respiratory Society criteria), but no effect in mild COPD despite the large numbers in their study. They repeat the findings of their earlier study, which is not mentioned in this paper by the authors themselves, nor is it mentioned by Mannino in his editorial. What is the difference? Is there any significance in the fact that this work comes out of a programme entitled National Program of Early Detection and Prevention of COPD? What seems to be clear from this work is that there is no evidence that early detection leads to prevention in COPD itself.

In the first study Gorecka et al.6 also claimed that their findings supported spirometric screening in mild disease. In fact they showed no effect overall, found evidence of an effect in a subgroup analysis of subjects with moderate or severe obstructive lung disease, and went on to make claims for the role of screening: “All smokers irrespective of their lung function tried to modify the habit as the result of screening for COPD combined with smoking cessation advice. The diagnosis of AL (airway limitation) motivated smokers to quit smoking.”7 Yet the results state unequivocally that there was no difference between smokers who had airflow limitation diagnosed and those who had normal lung function (NLF): “The we cannot exclude the possibility that deviation from the protocol may have occurred in some cases, it seems unlikely. Pharmacological treatment of nicotine dependence is not reimbursed and is relatively expensive in Poland. Bupropion is on prescription and only nicotine replacement therapy is available over the counter. This suggestion that approaching younger smokers would be more rewarding is worth exploring. In our experience, airflow obstruction is much less frequent (10%) in smokers aged 35–40 years than in older age groups. Since younger smokers are also less inclined to stop smoking, perhaps smoking cessation clinics would be more cost effective for this group than the spirometric testing.

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