

Tobacco Cessation and Control a Decade Later: American Society of Clinical Oncology Policy Statement Update

Nasser Hanna, James Mulshine, Dana S. Wollins, Courtney Tyne, and Carolyn Dresler

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Nasser Hanna, Indiana University Health Simon Cancer Center, Indianapolis, IN; James Mulshine, Rush University Medical Center, Chicago, IL; Dana S. Wollins and Courtney Tyne, American Society of Clinical Oncology, Alexandria, VA; and Carolyn Dresler, Arkansas Department of Health, Little Rock, AR.

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Corresponding author: American Society of Clinical Oncology, 2318 Mill Rd, Suite 800, Alexandria, VA 22314; e-mail: cancerpolicy@asco.org.

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INTRODUCTION

Tobacco use constitutes the largest preventable cause of death and disability in developed countries and a rapidly growing health problem in developing nations. It is responsible for 30% of all cancer deaths and 80% of lung cancer deaths and is associated with increased risk for at least 17 types of cancer.^{1,2} In addition to the tremendous human toll tobacco has taken in the 20th and 21st centuries, the economic costs of tobacco-related illnesses remain enormous. From 2000 to 2004, the United States spent approximately \$193 billion each year on tobacco-related illnesses and lost productivity because of tobacco-related premature death.³ Loss in productivity and increased health care costs associated with secondhand smoke (SHS) were reported in 2005 to have cost the United States an additional \$10 billion per year.⁴

Although the United States has witnessed a decline in cigarette use, the use of other tobacco products is on the rise.^{5,6} Furthermore, the rate of reduction of youth tobacco use is no longer as rapidly decreasing, despite intense public education and policy efforts to reduce youth tobacco use. At the global level, the epidemic of tobacco-related disease and death has just begun, because of the several-year lag between when individuals begin using tobacco and when their health suffers. Tobacco caused 100 million deaths in the 20th century.⁷ If current trends continue, it will cause up to 1 billion deaths in the 21st century.⁷ Unchecked, tobacco-related deaths will increase to more than 8 million per year by 2030. More than 80% of those deaths will be in low- and middle-income countries.⁷

As the leading professional organization representing physicians involved in cancer treatment and research, the American Society of Clinical Oncology (ASCO) is dedicated to the prevention and treatment of cancer. The overarching goal of the tobacco cessation and control efforts of ASCO are to promote the rapid, worldwide reduction and ultimate elimination of tobacco-related disease through discouraging the use of tobacco products and exposure

to secondhand tobacco smoke. The tobacco control efforts of ASCO are led by a subcommittee of the Cancer Prevention Committee. The primary tobacco control goals of ASCO are multifaceted: 1) to develop an oncology workforce that effectively integrates tobacco cessation and control into its practices; 2) to collaborate with other organizations and professional societies to promote rapid, worldwide reduction in tobacco use and ultimate elimination of tobacco-caused disease, including disease resulting from secondhand smoke; and 3) to urge oncology providers to become proponents of tobacco policy change.

In 2003, ASCO released a policy statement on tobacco cessation and control, which set forth specific recommendations and called for personal accountability in eradicating tobacco use domestically and globally.⁸ Since that time, there have been significant developments in tobacco cessation and control that have changed the political and scientific landscape. In response, the ASCO Cancer Prevention Committee commissioned this update of the previous ASCO statement to reflect the evolving regulatory and policy environment. This statement reviews advancements that have been made in tobacco cessation and control since 2003 and sets forth a refined set of recommendations for addressing tobacco cessation and control based on current challenges and opportunities. Key principles in the statement are as follows:

- Given that the scientific and medical evidence is indisputable that tobacco use poses a huge burden in cancer incidence and death in the United States and worldwide, it is our responsibility as health care professionals and cancer specialists to address the devastating consequences of tobacco use and to help patients with cancer quit.
- ASCO is committed to providing oncology providers with the evidence-based and practical information they need to successfully integrate tobacco cessation activities into their practices.
- ASCO recognizes the responsibility it has to take action to combat this problem globally

and affirms its commitment to supporting policies to eliminate the growth and persistence of tobacco use, to increase access to tobacco cessation services, and to expand funding for more research on tobacco cessation and control interventions.

- ASCO reaffirms its commitment to educating the oncology community on the successful integration of tobacco cessation services into practice, as well as to educating patients, their families, and the public at large about the risks caused by tobacco use in general and specifically in the population of patients with cancer.
- ASCO has set forth a set of recommendations for leading by example as health care professionals. At every opportunity, ASCO will strive to address the importance of decreasing the tobacco epidemic in the societies in which our members live, whether by supporting policy changes at the national level or one on one in the clinical setting.

ADVANCES IN TOBACCO CESSATION AND CONTROL SINCE 2003

Since the initial ASCO statement on tobacco cessation and control was published in 2003, evidence demonstrating the carcinogenic effect of tobacco use and exposure has expanded significantly. In 2004, the US Surgeon General listed bladder and kidney, cervical, esophageal, laryngeal, acute myelogenous leukemia, lung, oral and pharyngeal, pancreatic, and stomach as cancers induced by smoking.⁹ Two years later, the dangers of SHS were emphasized in another Surgeon General report, which confirmed SHS causes premature death and disease in children and in adults who do not smoke and that there is no risk-free level of exposure to SHS.¹⁰ The International Agency for Research on Cancer, in its updated review, listed the following as tobacco-caused cancers: oral cavity, oropharyngeal, nasopharyngeal, hypopharyngeal, esophageal, stomach, colorectal, liver, pancreatic, nasal cavity and paranasal sinuses, laryngeal, lung, cervical, ovarian (mucinous), bladder, kidney (body and pelvis), ureteral, and acute myelogenous leukemia.¹ In 2010, the Surgeon General report updated the state of the science for tobacco-related diseases, including cancer.¹¹ Included in this report is a substantial presentation of the increasing knowledge of the biologic mechanisms of tobacco-related cancers.

In addition to its well-established role in causing cancer, tobacco use has been shown to pose unique risks to individuals already diagnosed with cancer by compromising the effectiveness of treatment, increasing the risk of treatment-related complications, and increasing the risk of a second primary cancer¹²⁻¹⁴ (Table 1). Tobacco use is a serious concern for patients at all stages of disease and points of treatment, including for survivors of cancer and those with advanced-stage disease.^{17,18} Because tobacco use has a direct impact on cellular function, by inhibiting apoptosis, stimulating proliferation, and decreasing the efficacy of chemotherapy, quitting tobacco may improve response rates and survival, as well as lower the risk of developing a second cancer.^{15,19-27}

Scientific advances also have increased our understanding of nicotine addiction and tobacco-caused illness.¹¹ An important finding is that low-tar and light cigarettes do not reduce overall disease risk and that the overall health of the public could be harmed if novel

Table 1. Benefits of Tobacco Cessation and Risks of Continued Use in Patients With Cancer After Diagnosis and During Cancer Treatment

| Benefits of Tobacco Cessation and Risks of Continued Use | |
|---|--|
| Benefits of cessation | |
| Tobacco cessation leads to: | |
| Improved treatment outcomes | |
| Reduced adverse effects | |
| Improved survival | |
| Decreased risk of infection | |
| Improved breathing and increased energy | |
| Improved quality of life | |
| Risks of continued use | |
| Tobacco use after diagnosis leads to: | |
| Higher complication rates from surgery and slower recovery | |
| Higher treatment-related toxicity from chemotherapy and radiotherapy | |
| Increased risk of cancer recurrence | |
| Increased risk of other serious ailments, such as cardiovascular or respiratory disease | |
| Reduced treatment effectiveness | |
| Safety risks for patients with reduced consciousness or those receiving oxygen | |
| Increased risk of second primary cancer | |
| Shorter survival | |
| Impact of tobacco use on cancer treatments | |
| Surgery | |
| Increased complications from general anesthesia | |
| Increased risk of severe pulmonary complications | |
| Detrimental effects on wound healing, including: | |
| Compromised capillary blood flow | |
| Increased vasoconstriction | |
| Increased risk of infection | |
| Irradiation | |
| Reduced treatment efficacy | |
| Increased toxicity and adverse effects, including: | |
| Xerostomia (ie, dry mouth) | |
| Oral mucositis | |
| Loss of taste | |
| Pneumonitis | |
| Soft tissue and bone necrosis | |
| Poor voice quality | |
| Chemotherapy | |
| Potential exacerbation of adverse effects, including: | |
| Immune suppression | |
| Weight loss | |
| Fatigue | |
| Pulmonary and cardiac toxicities | |
| Increased incidence of infection | |
| Altered metabolism of drug with lower effective dose | |
| NOTE. Data adapted. ^{8,13-16} | |

tobacco products (eg, electronic cigarettes or snus) serve to encourage tobacco product uptake among unlikely users or delay cessation among those looking to quit tobacco completely.¹¹

The evidence base for tobacco cessation therapies has grown substantially over the last decade. Nicotine replacement therapy (eg, nicotine gum and patches) has been available over the counter for more than a decade. Nicotine lozenges and varenicline (a partial nicotinic receptor agonist) have been the latest therapies added to the slowly growing list of medications approved by the US Food and Drug Administration (FDA) and other regulatory agencies around the world for tobacco-use cessation.^{28,29}

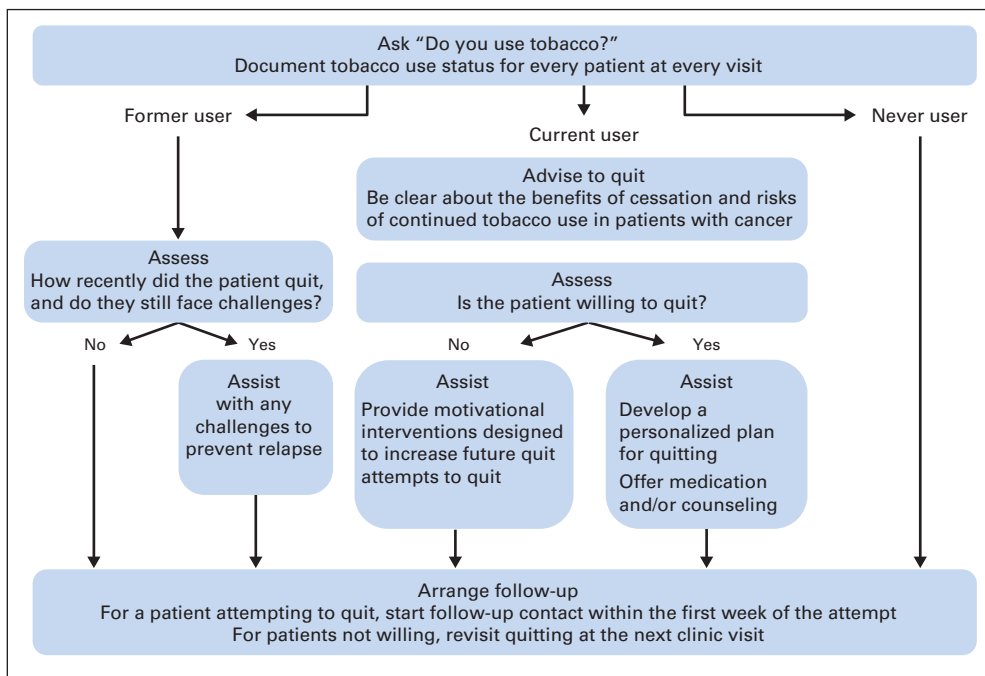


Fig 1. Incorporating the five As of tobacco cessation into practice. Data adapted.¹⁶

From a tobacco-use cessation standpoint, it is recognized that individuals who attempt to quit tobacco using evidence-based programs are twice as likely to succeed as those who try to quit on their own; these programs represent one of the most cost-effective interventions in health care.^{16,30-32} To assist individuals in gaining access to evidence-based cessation services, in 2004, the US Department of Health and Human Services established a national toll-free number (1-800-QUIT-NOW), in which callers are routed to their states' tobacco cessation quit lines. Unfortunately, the extent of services provided vary significantly because of funding resources available from state and national funding agencies.³³⁻³⁵

ROLE OF THE ONCOLOGY PROVIDER IN TOBACCO CESSATION AND CONTROL

Over the last decade, there has been increased recognition of the important role health care providers can play in curbing the tobacco epidemic by emphasizing the importance of tobacco cessation and referring their patients who use tobacco to evidence-based cessation programs. Physician-relayed advice on smoking cessation increases the likelihood that patients will try to quit and enhances the odds that those who do so will remain tobacco free. Even brief tobacco-dependence treatment interventions are effective and should be offered to all tobacco users. Long-term cessation rates include 15% with counseling, 22% with medication alone, and 22% to 28% when counseling is combined with pharmacotherapy.¹⁶

In the oncology setting, tobacco use should be addressed at presentation and throughout treatment. A person newly diagnosed with cancer is often motivated to stop using tobacco and therefore receptive to discussions on how to do so. Nonetheless, tobacco cessation can prove difficult after a patient has received a cancer diagnosis. A recent study showed that survivors of a tobacco-related cancer had a higher

persistent smoking prevalence (27%) than other cancer survivors (16%).³⁶ Understanding how to effectively target these high-risk populations is important.³⁷⁻³⁹

In 2008, the US Public Health Service (USPHS) updated its 2000 guideline on treating tobacco use and dependence to include new, effective clinical treatments for tobacco dependence that had become available. The 2008 update of the USPHS Clinical Practice Guideline—Treating Tobacco Use and Dependence—calls on physicians to change clinical culture and practice patterns to ensure that every patient who uses tobacco is identified, advised to quit, and offered scientifically sound treatments (Fig 1).¹⁶ Although the guideline recommendation was written broadly for physicians, this guidance is relevant to the practice of oncology.

Despite the proven effectiveness of tobacco cessation services, many providers are reluctant to maintain consistent tobacco screening protocols, and fewer still offer assistance to their patients in their efforts to stop using tobacco.⁴⁰ This reluctance results from several factors, including lack of knowledge by clinicians about how to assess tobacco use and dependence quickly and consistently, limited understanding about the current state of knowledge regarding efficacy of treatment, uncertainty about how to implement brief interventions for their patients into a busy practice, lack of patient motivation, varying and limited insurance coverage for interventions, limited reimbursement, and limited availability of cessation programs.⁴⁰ These findings were similar to those of recent surveys performed in oncology practices within ASCO and the International Association for the Study of Lung Cancer.^{41,42} In addition, Goldstein et al⁴³ found that most cancer centers do not provide tobacco cessation services, nor do they have the expertise to address cessation. Peters et al⁴⁴ and Gregorio et al⁴⁵ found a paucity of tobacco use information collected in actively accruing cancer trials.^{44,45}

RECOMMENDATIONS

Education and Awareness

To encourage and improve the integration of tobacco cessation into oncology practices, it is vital that providers have the tools and resources necessary to be able to effectively offer cessation services, whether provided by physicians, clinics, or hospital nurses or through referral to cessation programs within treatment facilities or quit lines. Most importantly, the oncology practice should improve its systematic assessment of tobacco use and cessation to address this topic in both a time- and cost-effective manner. ASCO promotes the inclusion of tobacco cessation–focused educational offerings at ASCO meetings and in its publications, and it also fosters educational relationships with external organizations that share its goal of promoting cessation. ASCO has highlighted tobacco cessation in a number of its meetings and educational materials, including a chapter dedicated to tobacco control in the ASCO Curriculum on Cancer Prevention. Recently, ASCO developed a set of resources to help oncology providers integrate tobacco cessation counseling services into practice. The resources include provider and patient guides, detailing immediate steps patients can take to help quit tobacco use (available at www.asco.org/tobaccocessationguide). The patient guide has recently been translated into Spanish.

The WHO Framework Convention on Tobacco Control (FCTC) and the 2008 update of the USPHS guideline recommend that all health care professionals, including students in health care training programs, receive education on the treatment of tobacco use and dependence.^{16,46} Despite these recommendations, students in health professions receive inadequate training for treating tobacco use and dependence. In an international survey assessing tobacco-related content in health professional school curricula, < 40% of students reported that they received training on smoking cessation techniques.⁴⁷ To address this issue, ASCO recommends the following:

Expand education, tools, and resources for providers. To achieve an oncology workforce that is well educated in providing tobacco cessation services to patients, ASCO recommends and is committed to fostering the creation of a new generation of tobacco cessation leaders. ASCO will continue to develop a variety of cessation tools and resources to assist providers in integrating tobacco cessation into their practices. In doing so, ASCO will continue to assess the need for and support the development of ASCO-generated guidance and practice tools on tobacco counseling and treatment among patients with cancer and survivors.

Increase focus on tobacco cessation in medical training. ASCO strongly supports education on tobacco use prevention and cessation at all levels of medical training and encourages oncology providers to participate in continuing education activities and programs related to prevention or cessation of tobacco use. ASCO also strongly encourages organizations involved in the ongoing credentialing of oncologists to include questions about tobacco-dependence treatment in examinations and test preparation materials. ASCO will seek to partner with the American Board of Internal Medicine to ensure sufficient examination content on tobacco cessation in oncology specialty training boards.

In addition to its mission of educating practitioners, ASCO also seeks to identify and promote tobacco cessation messages via patient education and communication directed toward patients with cancer,

survivors, their families, and the general public. ASCO has developed educational materials (available at www.cancer.net) specifically for patients with cancer and their families on the use of tobacco during and after cancer treatment. There is current federal support of a mass media public education campaign about tobacco prevention and treatment. To this end, ASCO recommends the following:

Expand education for the public. ASCO recommends that all tobacco users in the United States be aware of the existence of evidenced-based, FDA-approved therapies and counseling as described in the USPHS guideline.¹⁶ Increased efforts are needed on the part of private and public health entities to educate the public at large about the connection between tobacco and SHS exposure and many types of cancer, not just lung cancer.

Develop tools for diverse populations. Sustained support is also needed for the development and use of culture-, sex-, age-, and literacy-appropriate educational materials and skills, including those appropriate for people with cancer and their families, to address the benefits of cessation and the risks of tobacco use and exposure to SHS.³⁸

Access to Proven Tobacco Cessation Interventions

Medicare coverage for tobacco cessation services has been available since 2005. In 2011, the Medicare program expanded tobacco cessation coverage to include all Medicare beneficiaries using tobacco, covering up to eight face-to-face sessions in a 12-month period. Medicare beneficiaries have access to drug therapies for tobacco cessation under the Medicare prescription drug benefit, Medicare Part D. ASCO has included reimbursement information in the tobacco cessation guide resources reference discussed previously (<http://default.asco.org/policy-advocacy/coverage-patient-services>).

The Patient Protection and Affordable Care Act (ACA) addresses tobacco-related issues both directly and indirectly.⁴⁸ Key provisions of the ACA require certain private health insurers to cover, without cost sharing, any preventive services assigned an A (strongly recommended) or B (recommended) grade by the US Preventive Services Task Force (USPSTF).⁴⁹ The current USPSTF recommendations address tobacco cessation, although at the time of publication, the Center for Consumer Information and Insurance Oversight, which is overseeing implementation of the ACA for private-sector health insurers, has proposed allowing each state to define its own package of essential health benefits. Historically, tobacco cessation services have not been defined or covered in a consistent manner by health insurers. Concerns exist that some insurers may not cover a comprehensive range of evidence-based services and drug therapies for tobacco cessation under the existing USPSTF language without adequate clarification from federal or state officials.⁵⁰

Through Medicaid, the ACA establishes for pregnant women a more explicit requirement for coverage of comprehensive tobacco cessation services (including counseling and drug therapies), without cost sharing. Beyond the coverage for pregnant women, state Medicaid programs that voluntarily cover all USPSTF-recommended preventive services, including tobacco cessation, have had access to increased federal funding since January 1, 2013.⁵¹ Effective January 1, 2014, state Medicaid programs will no longer be able to exclude tobacco cessation drugs from their prescription drug coverage.⁵¹

Repeated clinical tobacco cessation counseling is one of the most important and cost-effective preventive services that can be provided in medical practice.^{12,30,52} As such, ASCO encourages all oncology

providers to adhere to the 2008 USPHS guideline, because persistent tobacco use will undermine treatment efficacy and shorten survival outcomes.⁵³ The United States is currently at a health care–provision crossroads, with critical decisions for the future of insurance coverage in the balance.⁵⁴ To ensure proven tobacco cessation interventions are accessible for all individuals, ASCO recommends the following:

Assure comprehensive coverage. ASCO recommends that all tobacco users have access to evidence-based tobacco cessation therapies and counseling. ASCO strongly supports health plan coverage (with no copay or deductible) and appropriate reimbursement for evidence-based tobacco cessation services, including intensive counseling services (including quit lines [1-800-QUIT NOW in the United States]) as well as FDA-approved cessation medications.

Support current initiatives on tobacco cessation services arising from the ACA. To ensure consistent and comprehensive coverage, ASCO advocates for the establishment of explicit safeguards regarding the scope of covered tobacco cessation services and products by state and local officials.

Tobacco Cessation As a Component of High-Quality Cancer Care

ASCO views tobacco cessation as a core prevention and treatment activity for all oncology providers. Because of the importance of tobacco use and its significant adverse impacts during treatment and follow-up of patients with cancer, oncologists must remain vigilant about tobacco use and its unfortunately high relapse rates. In parallel with cessation efforts, there are also growing efforts to obtain early diagnoses of lung cancer through low-dose computed tomography screening. ASCO supports the integration of tobacco cessation measures into spiral computed tomography screening for people who are still smoking.^{55–57}

As part of its effort to build awareness and encourage cessation counseling, in 2006, ASCO began integrating smoking-related measures into the ASCO Quality Oncology Practice Initiative (QOPI), an oncologist-led, outpatient practice–based quality assessment and improvement program. Practices' performance on QOPI measures may indicate gaps in care and help ASCO identify the need for research and tools, as well as provide individual practices with information to guide continuous quality-of-care improvement opportunities. Participating practices are asked three questions: 1) Was smoking/tobacco use status assessed in the last year? 2) What is the tobacco use status while under care of the practice (smoker/tobacco user, former user, never user)? 3) Did the smoker/tobacco user receive advice to quit, or were cessation strategies discussed or recommended in the last year? QOPI data consistently show that outpatient oncology practices are documenting smoking status the majority of the time (on average, 97%); however, tobacco cessation services are actually offered to less than half of smokers (on average, 47%).

Measures to assess and promote the integration of tobacco cessation into practice have been developed and/or endorsed by other quality measurement organizations, including the Commission on Cancer, the National Quality Forum, and the Joint Commission. Of note, the Joint Commission Tobacco Cessation Performance Measure Set is currently optional.⁵⁸ To help ensure that tobacco cessation is fully integrated into cancer care, ASCO recommends the following:

Assess and potentially expand current measures. The ASCO QOPI measures will be continuously assessed and improved as necessary to capture the integration of tobacco cessation into clinical

practices. Additionally, ASCO supports the adoption of the Joint Commission Tobacco Cessation Performance Measure Set as a required inpatient measure set, a step that has not yet been taken.

Research on Tobacco Use and Cessation

Despite the significant advances that have been made in the science of tobacco cessation, federal commitment to tobacco control research has been disproportionate to the burden of disease caused by tobacco.⁵⁹ Increased funding is needed to facilitate a broad array of tobacco control research, including epidemiologic studies; better understanding of the mechanisms of tobacco use and cancers; and behavioral and other treatment interventions. Increased funding is also needed to facilitate the ability of the scientific community to assess and assist regulatory bodies to establish valid scientific evidence with each new tobacco industry product. Scientific data regarding the safety and use of these new products as cessation aids are needed to inform both regulatory bodies and the public at large.

Other important issues are the many new tobacco and nicotine delivery products, such as e-cigarettes, or orbs or sticks, about which little is known; however, these products are being aggressively marketed by the tobacco industry, promoting maintenance of nicotine addiction over tobacco cessation. Having regulatory authority over all tobacco products would assist the public health community in effectively combating the claims of some manufacturers that their products are safer than cigarettes, because valid substantive evidence would be required to make such claims. At the time of this article, the FDA Center for Tobacco Products (CTP) has regulatory authority over only cigarettes, smokeless tobacco, and roll-your-own products.⁶⁰ However, the FDA has signaled its intention to assert authority over all tobacco products through future rule making in the near future.⁶¹

Increased research also is needed to better implement tobacco cessation programs in specific populations, such as youth. The USPSTF will shortly issue updated recommendations addressing cessation in the youth population. Because of the paucity of research on cessation in youth populations, the strength of the evidence is limited, yet it is sufficiently strong for the USPSTF to recommend that health care providers assist youth in attempting to quit.⁶² Additionally, for individuals diagnosed with cancer, tobacco cessation treatment should be tailored to the specific needs of patients with cancer, including cancer survivors and those with late-stage diagnoses. However, data on effective tobacco cessation strategies for individuals after a cancer diagnosis are still incomplete.^{37–39}

In the current economic climate, maintaining levels of funding may be problematic, and this could have a negative impact on future tobacco cessation research efforts. Compounding the funding issue is the fact that despite the clinical impact of tobacco use on cancer, its treatment, and cancer outcomes, only 29% of National Cancer Institute Cooperative Group clinical trials assessed tobacco use status at enrollment, and even fewer (22%) continued to assess current tobacco use status.⁴⁴ Even when tobacco use status is collected, it is usually only collected as self-report at the beginning of the trial and is not documented or confirmed throughout the course of the patient's cancer treatment and follow-up.⁶³ The failure to obtain these data limits the ability to understand the impact of tobacco use on treatment efficacy and outcomes.^{12,45,64} If tobacco use data are systematically collected and analyzed, the information would provide clinicians and regulatory agencies with the data needed to understand the impact of existing and new tobacco products. Core data elements that include

tobacco use could also prove effective in identifying populations at high risk for continuing tobacco use after a cancer diagnosis.^{22,23,63} These data collected over time could also provide insight into practical and effective ways to decrease tobacco use in these high-risk populations and improve patient outcomes.

ASCO recognizes that we currently have a strong evidence base for tobacco control interventions to promote tobacco cessation technologies. However, significantly more research is needed to advance the tobacco control agenda in a comprehensive and effective manner. To fully advance the tobacco control research agenda, ASCO recommends the following:

Increase funding for tobacco research. It is the view of ASCO that more federal funding should be devoted to a broad array of tobacco control research on topics including understanding the mechanisms of tobacco use and cancers and improving tobacco use prevention and behavioral and other treatment interventions. Increased funding is also needed to establish valid scientific evidence with each new tobacco industry product as it emerges, as well as to understand how to best implement tobacco cessation in specific populations, including cancer patients and survivors.

Include tobacco use status as a core data element in oncology clinical trials where appropriate. ASCO supports including tobacco use history and status as core data elements that are collected throughout the course of a clinical trial in which concomitant medications are routinely captured: at diagnosis, trial registration, and follow-up and during long-term survival or at death.¹² ASCO also recognizes the importance of maximizing clinical trial resources and encourages the inclusion of tobacco-related data as concomitant medications in a strategic and nonburdensome manner.

US Tobacco Regulation

In 2007, the Institute of Medicine issued a blueprint for the nation for ending the tobacco epidemic.³⁰ The blueprint emphasized several tobacco control strategies, including financial support of comprehensive state tobacco control programs at the Centers for Disease Control and Prevention (CDC)—recommended levels (including increased support for quit lines), increased tobacco taxes as a means to discourage tobacco use, and stronger federal regulation and oversight

of tobacco products.³⁰ Since 2007, many of these recommendations have been enacted into law. Unfortunately, many comprehensive tobacco cessation programs, including quit lines, were not funded at CDC-recommended levels initially, and much existing funding has declined.

In 2009, the Family Smoking Prevention and Tobacco Control Act (FSPTCA) became law, granting the FDA authority to regulate the manufacture, distribution, and marketing of tobacco products (ie, cigarette, smokeless, and roll-your-own products) to protect public health through the newly formed CTP.⁶⁰ Via the FSPTCA, the FDA is tasked with aggressively restricting youth access, assessing tobacco industry research on the health and addictiveness of their products, reviewing product ingredients and additives, providing marketing orders to new tobacco products, and reviewing any health claims made by tobacco companies.⁶⁰ Also in 2009, the US Congress voted to increase the federal tax on cigarettes via the Children's Health Insurance Program Reauthorization.⁶⁵ There is substantial evidence establishing that increases in the prices of tobacco products help discourage the use of such products, especially for young children, teenagers, and low socioeconomic groups.⁶⁷

The rate of reduction of national youth tobacco use slowed its prior decline for much of the past decade. Recent data from Monitoring the Future 2012 demonstrated that youth use did decline in 2011 and 2012, probably in relation to the increase in cigarette prices from the 2009 law.⁶⁷ It is estimated that 88% of smokers start using tobacco by age 18 years, making youth a prime target for antitobacco use initiatives and tobacco companies alike.⁶⁸ Youth smoking is heavily dependent on the impact of the marketing activities of the tobacco industry, an industry with an aggregate annual marketing budget of \$10 billion for the United States alone, most of which is spent on cost promotions in the retail environment.⁶⁹ Convenience stores have become essential partners with the tobacco industry in fighting policies to reduce tobacco use.⁶⁹ This puts the public health community in a David-versus-Goliath situation in educating the next generation of potential tobacco users about its adverse health consequences.

Furthermore, although cigarette use is declining, the use of other tobacco products, like cigars and cigarillos (Table 2), is on the rise.^{5,6} As such, tobacco companies are lobbying to have cigars and cigarillos

Table 2. Alternative Tobacco Products

| Product | Description |
|--|---|
| Cigars | Information about cigars and cancer is available in the NCI fact sheet Cigar Smoking and Cancer at http://www.cancer.gov/cancertopics/factsheet/Tobacco/cigars . |
| Smokeless tobacco | Information about smokeless tobacco and cancer can be found in the NCI fact sheet Smokeless Tobacco and Cancer at http://www.cancer.gov/cancertopics/factsheet/Tobacco/smokeless . |
| Pipes | Pipe smoking causes lung cancer and increases the risk of cancers of the mouth, throat, larynx, and esophagus. ^{70,71} |
| Hookahs or water pipes (other names include argileh, ghelyoon, hubble bubble, shisha, boory, goza, and narghile) | A hookah is a device used to smoke tobacco. The smoke passes through a partially filled water bowl before being inhaled by the smoker. Some people think hookah smoking is less harmful and addictive than smoking regular cigarettes, ⁷² but all forms of tobacco smoking are harmful and addictive. Tobacco smoke, including the smoke produced by a hookah, contains harmful chemicals such as carbon monoxide and cancer-causing substances. ⁷³ |
| Bidis | A bidi is a flavored cigarette made by rolling tobacco in a dried leaf from the tendu tree, which is native to India. Bidi use is associated with heart attacks and cancers of the mouth, throat, larynx, esophagus, and lung. ^{71,74} |
| Kreteks | A kretek is a cigarette made with a mixture of tobacco and cloves. Smoking kreteks is associated with lung cancer and other lung diseases. ⁷⁴ |

Abbreviation: NCI, National Cancer Institute.

excluded from tobacco product regulation, and legislation has already been introduced in the US Congress to have cigars (including premium cigars and cigarillos) excluded from regulation and FDA oversight, making them a potentially attractive option for youth.⁷⁵ These bills have the potential of opening the door to exemptions, thus undermining the FDA as the tobacco regulatory authority and undoing any positive impact made by tobacco control legislation in the last several years. The influence of strategic marketing by the tobacco industry, along with its lobbying efforts, has the potential to erode the success of government and public health efforts to reduce youth access to tobacco.

Tobacco control policies are rapidly changing in response to tobacco marketing and the tobacco lobby, as the health risks and costs are becoming increasingly evident—and unaffordable. Policy efforts aimed primarily at the tobacco industry have not been enough to eliminate tobacco use. Regulations need to be in place to ensure that the US tobacco Master Settlement Agreement (MSA) funds are spent more appropriately on health-related programs than they are currently. In 1998, the MSA provided \$246 billion over 25 years to 46 states. Unfortunately, even at the maximum, only approximately 3% of the MSA dollars were ever used to support tobacco control in the states, a number that has dropped to 1.9% in the current economic climate.⁷⁵ Finally, although policy progress has been made over the last 10 years, the newly passed federal regulations are not safe from litigation. Recent split court decisions in tobacco industry lawsuits over the proposed graphic warnings have resulted in the CTP reconsidering how to address these warning-label requirements within the FSPTCA.

Although many advances have been made in tobacco control, there remains a need for continued efforts to counter tobacco industry lobbying and marketing by enhancing federal regulation of tobacco products. In advocating for policy change, ASCO will work closely with state affiliates and local state departments of health eager for partnerships with physicians, including oncologists, who provide much-needed clinical expertise and credibility in advocacy and legislative efforts. ASCO recommends the following:

Increase tobacco excise taxes. Because increasing taxes on tobacco products provides a major disincentive to potential buyers, especially youth and low socioeconomic groups, ASCO supports the substantial increase in tobacco excise taxes. ASCO also supports the allocation of at least a portion of the taxes to support state comprehensive tobacco control programs.

Implement and enforce comprehensive clean indoor air policies. ASCO strongly supports prohibiting the use of combusted or inhaled tobacco products in all public places. ASCO encourages stakeholders to work with local governments and agencies to advocate for comprehensive clean indoor air ordinances and regulations. Such laws are effective in the denormalization of smoking, resulting in increased cessation by adults and decreased initiation among youth.

Ensure comprehensive funding of tobacco control programs. Comprehensive tobacco control programs, including quit lines and youth prevention programs, should be funded at the CDC-recommended level. Appropriate funding will ensure tobacco cessation services are comprehensive and available to all.

Eliminate advertising focused on youth tobacco use. ASCO supports public policy efforts for comprehensive and global elimination of advertising in the United States and throughout the world, especially lower-resource countries, particularly all forms of adver-

tisement intended for youth to start using tobacco or nicotine delivery products.

Establish minimum-price laws for tobacco products. Twenty-five states and the District of Columbia currently have enacted minimum-price laws for cigarettes, which prohibit cigarette products from being sold at a discount and can help counteract industry-supported discounts and multipack offers.⁷⁶ Parallel laws are needed for other tobacco products.

Increase retail licensing fees. Increasing licensing fees will work to combat uptake of tobacco products in two ways: by not allowing the tobacco industry to discount tobacco prices in the retail setting, and by using the fees in enforcement of current tobacco laws.

Mandate public disclosure of tobacco company discounts. Mandated reporting will allow individuals, stakeholders, providers, and so on to learn how much money the tobacco industry is providing in discounts to retailers by geographic area.

Ensure all tobacco products are subject to the same regulations. Cigars and cigarillos, nicotine delivery products, and all other new tobacco products should not be exempt from regulations. Having low-cost or flavored alternatives to cigarettes makes these alternative products attractive options and encourages youth uptake. Additionally, ASCO supports the recommendation of the FDA Tobacco Products Scientific Advisory Committee that the “removal of menthol cigarettes from the marketplace would benefit public health in the United States.”⁷⁷ The FDA CTP regulatory oversight of tobacco products should not be limited or restricted, including standards that lower the amount of nicotine in products to reduce their addictiveness.

Fully implement regulations requiring graphic warning labels on cigarette packaging. Graphic warning labels are an effective way to deter youth and nonusers from initiating tobacco use and encourage tobacco users to quit.^{78,79} Current warnings on tobacco products in the United States have not been updated since 1984, and the Surgeon General noted in 1994 that the warnings were already ineffective because of the size and familiarity of the messages.⁸⁰

Global Tobacco Control

On a global level, the FCTC is the first public health treaty enacted worldwide by the WHO; it came into force in 2005 with ratification by the first 40 countries. At present, slightly over 87% of the world population is covered by this convention.⁴⁶ This convention is a comprehensive treaty, which, if effectively enforced in each country, will be a deterrent to the still globally growing tobacco epidemic, particularly in developing economies. The United Nations, with partners from the Noncommunicable Disease (NCD) Alliance, made a landmark decision to reduce NCD mortality, including cancer, by 25% by the year 2025.⁸¹ This so-called 25 × 25 initiative will focus on reducing risk factors, including tobacco use, that have a negative impact on NCDs.⁸¹ The NCD Alliance recognizes the role the FCTC plays as the primary forum in the world for tobacco cessation efforts and will be identifying indicators to help monitor implementation of the FCTC on a global scale.

Significant efforts have been focused on global implementation of the FCTC. The European Commission in October 2011 committed €5.2 million to the FCTC Secretariat to particularly assist low- and middle-income countries to implement the convention.⁸² Even this amount of money is significantly dwarfed by the marketing budget of the tobacco industry in low- and middle-income countries, let alone in more developed economies. As another burden to this effort, some

governments have reported struggling with a perceived lack of public will to overcome the political lobbying and commercial forces supporting tobacco use.⁸³ Other governments, including the US Government, have yet to ratify the FCTC, even though the involvement of the United States could make global efforts more effective financially and practically.⁸⁴ The evidence is clear that funding evidence-based tobacco control will lower tobacco use prevalence, and cutting such funding will lead to increased tobacco use—and tobacco related deaths. Thus, the FCTC is a critical policy initiative to adequately and sustainably support tobacco control in local, regional, national, and international programs.

ASCO and its global members can be effective advocates for global policies and advocacy. There has been global use of the so-called five As (ie, ask, advise, assess, assist, and arrange) and two As and R (ie, ask, advise, and refer) approaches as evidence-based tobacco cessation

interventions.⁸⁵ However, implementing these guidelines into practice can be made more difficult in environments with minimal tobacco regulation and a culture of rampant tobacco use. Additionally, health care providers, including oncologists, often believe themselves to be too busy or are not knowledgeable enough to or connected with organizations within their countries to assist with such policy initiatives. ASCO will advocate for international policy initiatives and recommends that stakeholders around the globe work to do the following:

Ratify and implement the FCTC at a global level. At the time of this article, the United States has not ratified the FCTC. ASCO urges the US Government to ratify the FCTC and also stresses the importance of focusing our efforts on global implementation. ASCO will use its educational influence with the federal legislature and executive branches to implement this critical tobacco control convention.

Table 3. ASCO Recommendations on Tobacco Cessation and Control

| Recommendation |
|---|
| Education and awareness Expand education, tools, and resources for providers Increase focus on tobacco cessation in medical training Expand education for the public Develop tools for diverse populations |
| Access to proven tobacco cessation interventions Support current initiatives on tobacco cessation services arising from the Affordable Care Act Continue work to assure comprehensive coverage |
| Integrating tobacco cessation as a key component of quality care Expand quality measurement and improvement |
| Research Increase funding for tobacco research Include tobacco use status as a core data element in oncology clinical trials where appropriate |
| US tobacco regulation Increase tobacco excise taxes Implement and enforce comprehensive clean indoor air policies Ensure comprehensive funding of tobacco control programs Eliminate advertising focused on youth tobacco use Establish minimum price laws for tobacco products Increase retail licensing fees Mandate public disclosure of tobacco company discounts Ensure all tobacco products are subject to the same regulations Fully implement regulations requiring graphic warning labels on cigarette packaging |
| Global tobacco control Ratify and implement the FCTC at a global level Support the UN Summit Declaration on NCDs Develop country- and region-specific practice tools Expand tobacco control plans Support the passage of restrictive tobacco trade laws Integrate tobacco cessation services into health care delivery systems |
| Leading by example as oncology professionals Refrain from the use of all tobacco products Treat tobacco dependence as aggressively and compassionately as cancer, discussing the causal relationship between tobacco use and cancer and assisting the patient and family members to end tobacco dependency Help to ensure tobacco cessation services are widely available Advocate to ensure hospitals, universities, clinics, offices, and all other work and patient care settings are tobacco free Support 100% tobacco-free environments at all levels Refuse to collaborate with the tobacco industry in research, reviews, promotion, or any other activity Refuse any support (financial or otherwise) from the tobacco industry Support efforts to prohibit marketing of tobacco and nicotine products to children |
| Abbreviations: ASCO, American Society Clinical Oncology; FCTC, Framework Convention on Tobacco Control; NCD, noncommunicable disease; UN, United Nations. |

ASCO will assist in providing connections between ASCO members and their local tobacco control advocacy organizations.

Support of the United Nations Summit Declaration on NCDs. ASCO is a member of the NCD Alliance (<http://www.ncdalliance.org/>) and is working with other alliance members to keep pressure on the US Government to take steps to achieve the targets the government has agreed to support and will advocate for global resources in support of NCD targets throughout the world, especially in low- and middle-income countries.

Develop country- and region-specific practice tools. Develop the tobacco cessation guidelines, tools, and resources needed meet different countries' needs. ASCO can play a role in partnering with countries and other health care provider organizations, such as the Society for the Research on Nicotine and Tobacco, along with www.treattobacco.net, in the development of such guidelines.⁸⁵

Expand tobacco control plans. Advocate for the development and adoption of tobacco control plans within individual countries and practice settings. Most countries have been developing their own national tobacco control plans in coherence with their adoption of the FCTC.

Support the passage of restrictive tobacco trade laws. ASCO also supports efforts to exempt tobacco from the Trans-Pacific Partnership Agreement, which by its nature would give the tobacco industry enhanced rights and privileges. Additionally, ASCO does not support any duty reductions for tobacco products, which would reduce the cost of US tobacco products abroad. Finally, ASCO supports efforts to insure individual international governments are able to impose and enforce their own regulatory policies on imported tobacco products, regardless of country of origin, including graphic warning labels on packaging.

Integrate tobacco cessation services into health care delivery systems. ASCO supports the complete integration of tobacco cessation into health care delivery systems worldwide, including oncology practices.

Leading by Example As Oncology Professionals

Oncology professionals must lead by example in combating the tobacco epidemic. ASCO has taken several steps as an organization to lead by example. ASCO strives to provide tobacco-free work and meeting environments, settings in which tobacco usage is expressly prohibited, for its employees and meeting attendees. Additionally, ASCO provides tobacco cessation support and counseling for its employees and is a member of the CEO Cancer Gold Standard Program (www.cancergoldstandard.org). ASCO is prohibited from receiving any kind of tobacco industry support and from providing support to the tobacco industry. Furthermore, ASCO supports institutions, such as universities, in prohibiting financial support from the tobacco industry.⁸⁶ On the basis of these principles, ASCO encourages its members and all oncology professionals to do the following:

- Refrain from the use of all tobacco and nicotine delivery products.

- Treat tobacco dependence as aggressively and compassionately as cancer.
- Advocate for the wide availability of tobacco cessation services.
- Advocate for tobacco-free hospitals, universities, clinics, offices, and all other work and patient care settings.
- Support 100% tobacco-free environments at all levels.
- Refuse to collaborate with the tobacco industry in research, reviews, promotion, or any other activity.
- Refuse any support (financial or otherwise) from the tobacco industry.
- Support efforts to prohibit marketing of tobacco and nicotine products to children.

DISCUSSION

In conclusion, as a group of physicians and other health care professionals who care for patients with cancer, ASCO is committed to decreasing death and suffering resulting from cancer. Given that the scientific and medical evidence is indisputable that tobacco use poses a huge burden on cancer incidence and death in the United States and worldwide, it is our responsibility as health care professionals and cancer specialists to address the devastating consequences of tobacco use and to help patients with cancer quit. To this end, ASCO reaffirms and strengthens its commitment to providing oncology providers with the evidence-based and practical information they need to successfully integrate tobacco cessation activities into their practices. ASCO is also committed to educating patients, their families, and the public at large about the risks tobacco use poses in general and specifically to the population of patients with cancer. Importantly, ASCO recognizes the responsibility it has to take action to combat this problem globally. In doing so, ASCO reaffirms its commitment to supporting policies to eliminate the growth and persistence of tobacco use, to increase access to tobacco cessation services, and to expand funding for research on tobacco cessation and control interventions. Finally, ASCO has set forth a set of recommendations for leading by example as health care professionals. The recommendations outlined in this policy statement update (summarized in Table 3) codify the commitments and priorities of ASCO in this vital area. At every opportunity, ASCO will strive to address the importance of decreasing the tobacco epidemic in the communities in which our members live, whether by supporting policy changes at the national level or one on one in the clinical setting.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

AUTHOR CONTRIBUTIONS

Administrative support: Dana S. Wollins, Courtney Tyne

Manuscript writing: All authors

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Appendix

This statement was developed by the Tobacco Cessation and Control Subcommittee (Carolyn Dresler, MD, Nasser Hanna, MD, and James Mulshine, MD). It was reviewed and transmitted to the American Society of Clinical Oncology Board of Directors by the Cancer Prevention Committee: Eva Szabo, MD (National Cancer Institute, Bethesda, MD); Banu Arun, MD (University of Texas MD Anderson Cancer Center, Houston, TX); James Bearden, MD (Gibbs Cancer Center, Spartanburg, SC); Abenaa Brewster, MD (University of Texas MD Anderson Cancer Center); Kerry Courneya, PhD (University of Alberta, Edmonton, Alberta, Canada); Carolyn Dresler, MD, MPA (Arkansas Department of Health, Little Rock, AR); Carol Fabian, MD (University of Kansas, Westwood, KS); Paul Fisher, MD (Stanford Medical Center, Stanford, CA); Lewis Foxhall, MD (University of Texas MD Anderson Cancer Center, Houston, TX); Gary Gordon, MD (Abbot Labs, Abbott Park, IL); Nasser Hanna, MD (Indiana University Health Simon Cancer Center, Indianapolis, IN); Joe Harford, PhD (National Cancer Institute, Bethesda, MD); Madhuri Kakarala, MD, PhD (Van Andel Institute, Grand Rapids, MI); Larissa Korde, MD (University of Washington, Seattle, WA); Jennifer Ligabel, MD (Dana-Farber Cancer Institute, Boston, MA); Noralene Lindor, MD (Mayo Clinic, Scottsdale, AZ); Steven Lipkin, MD, PhD (Weill Cornell Medical School, New York, NY); Sanford Markowitz, MD, PhD (Case Western Reserve University, Cleveland, OH); Frank Meyskens, MD (Chao Family Comprehensive Cancer Center, Orange, CA); James Mulshine, MD (Rush University Medical Center, Chicago, IL); Therese Mulvey, MD (Southcoast Centers for Cancer Care, Fall River, MA); Howard Parnes, MD (National Cancer Institute, Bethesda, MD); Frances Shepherd, MD (Princess Margaret Hospital, Toronto, Ontario, Canada); Imad Shureiqi, MD, MS (University of Texas MD Anderson Cancer Center, Houston, TX); Luz M. Rodriguez Traver, MD (National Cancer Institute, Bethesda, MD); William William Jr, MD (University of Texas MD Anderson Cancer Center, Houston, TX); Marie Wood, MD (University of Vermont, Burlington, VT); and Stuart Wong, MD (Medical College of Wisconsin, Milwaukee, WI).