Sevrage tabagique: quelques points de repère pour guider la démarche (1)

28 novembre 2019

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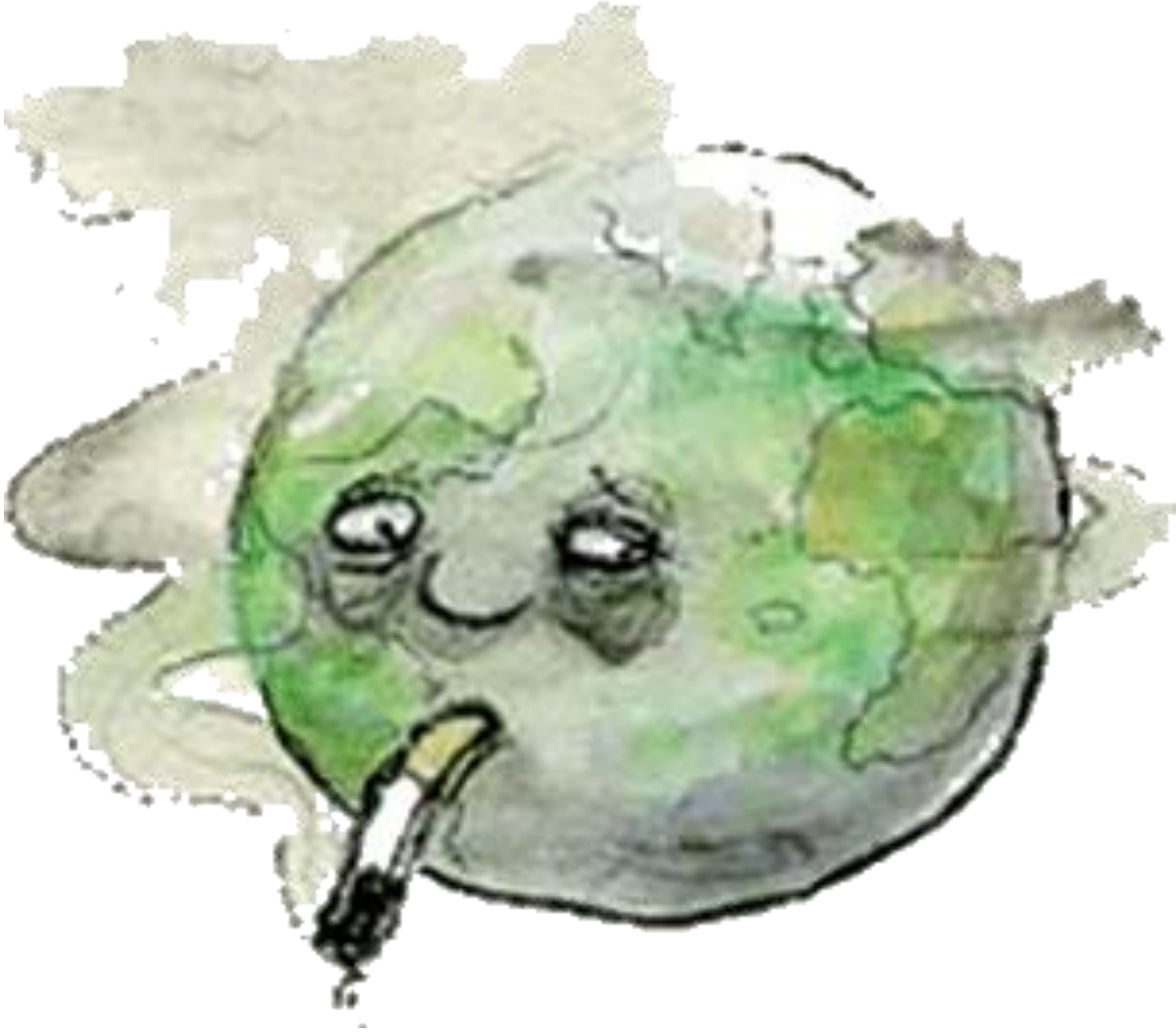
Plan

- rôle des soignants; prévalence tabagisme en CH
- données chiffrées sur les risques
- dépendance nicotinique
- dialoguer avec un fumeur
- approches pharmacologiques
- vaporettes et produits de tabac chauffé
- messages à retenir



Prévalence du tabagisme en Suisse

- selon derniers chiffres de l'OFSP
- 27.1% de fumeurs en CH (âgés de plus de 15 ans)
- H 31% et F 23.3%
- 31.7% chez 15-24 ans
- recul depuis 15 ans mais stagnation depuis 2011
- 9'500 décès/an; 15% des décès; 26 personnes/j

OFSP, 2017

Vaporette/cigarette électronique

- en 2016, 15% ont essayé au moins une fois
- en 2013, 6.7% seulement
- consommation au moins une fois/sem chez 0.7%
- tendance à la hausse

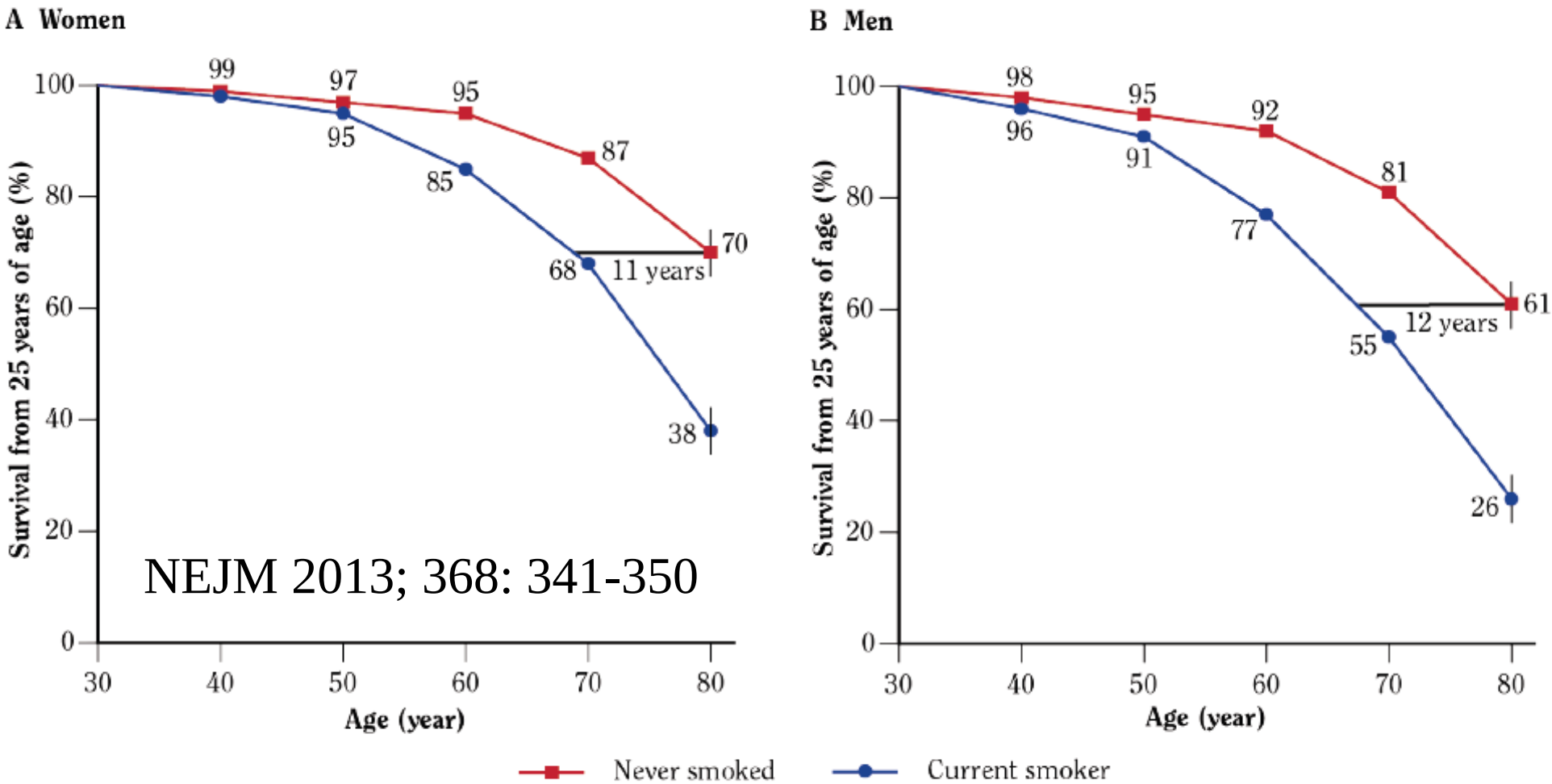
OFSP 2017

Tabagisme passif

- exposition involontaire au moins 1 h./j a baissé de 35% en 2002 à 6% en 2017
- explication principale est entrée en vigueur de la loi sur la protection contre le tabagisme passif en 2010
- baisse des infarctus aux Grisons et Tessin (-21%)
- hosp. pour mal. pulm. chron. ou pn. à GE (-19%)

OFSP 2017

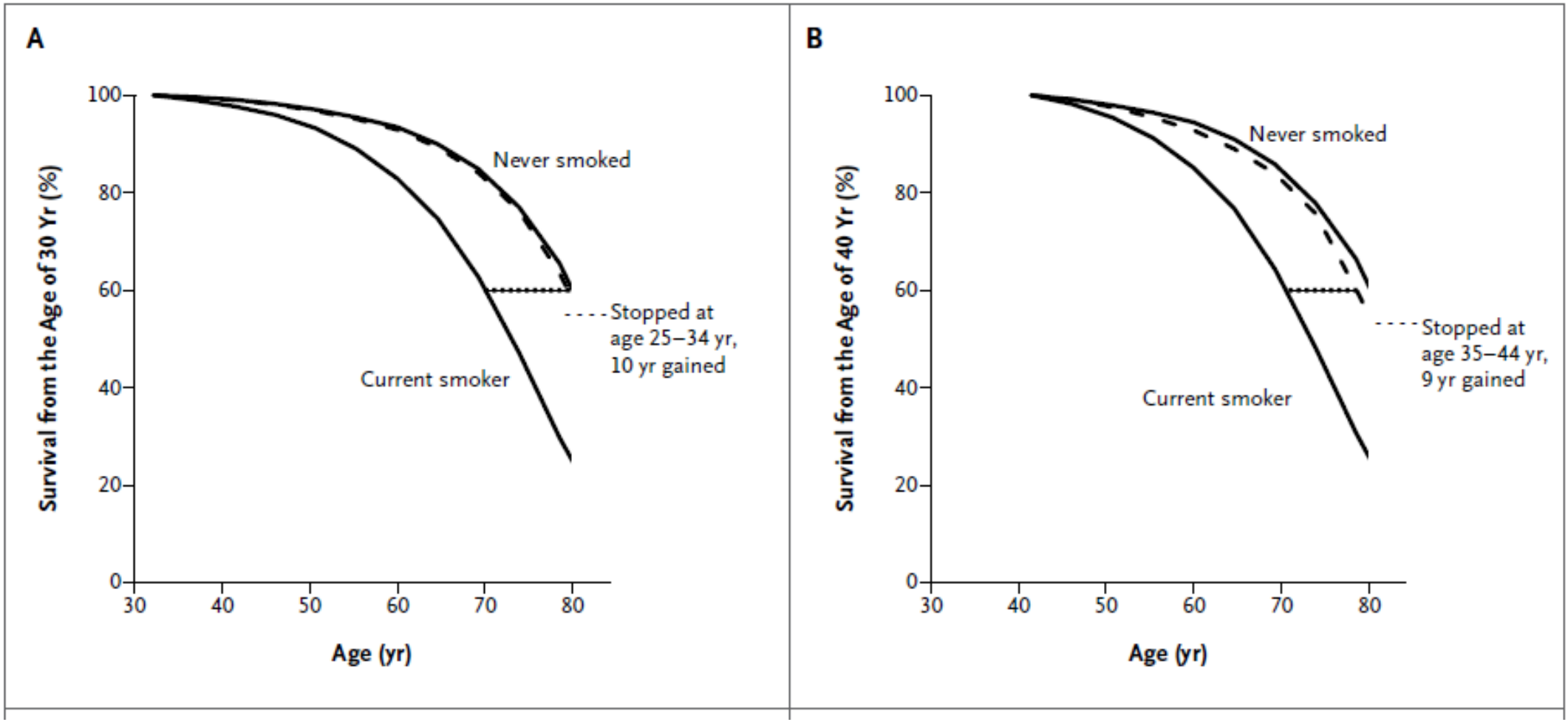
Figure 11.6 Survival probabilities for current smokers and never smokers for women and men



NEJM 2013; 368: 341-350

Source: Jha et al. 2013. Reprinted with permission from Massachusetts Medical Society, © 2013.

Note: Survival probabilities for current smokers and never smokers among men and women 25–80 years of age. The vertical lines at 80 years of age represent the 99% cumulative survival probabilities, as derived from the standard errors estimated with use of the jackknife procedure. Survival probabilities have been scaled from the National Health Interview Survey to the U.S. rates of death from all causes at these ages for 2004, with adjustments for differences in age, educational level, alcohol consumption, and adiposity (body mass index).



NEJM 2013; 368: 341-350

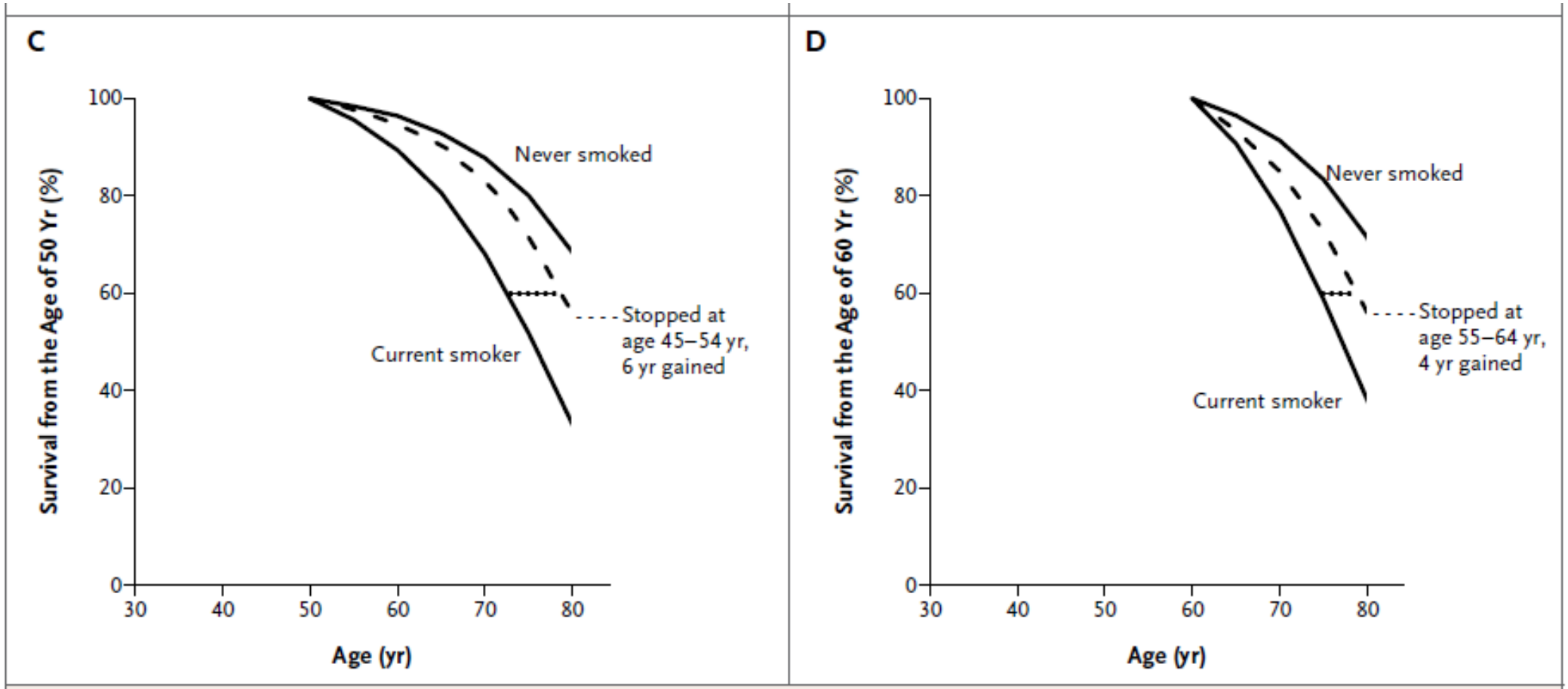
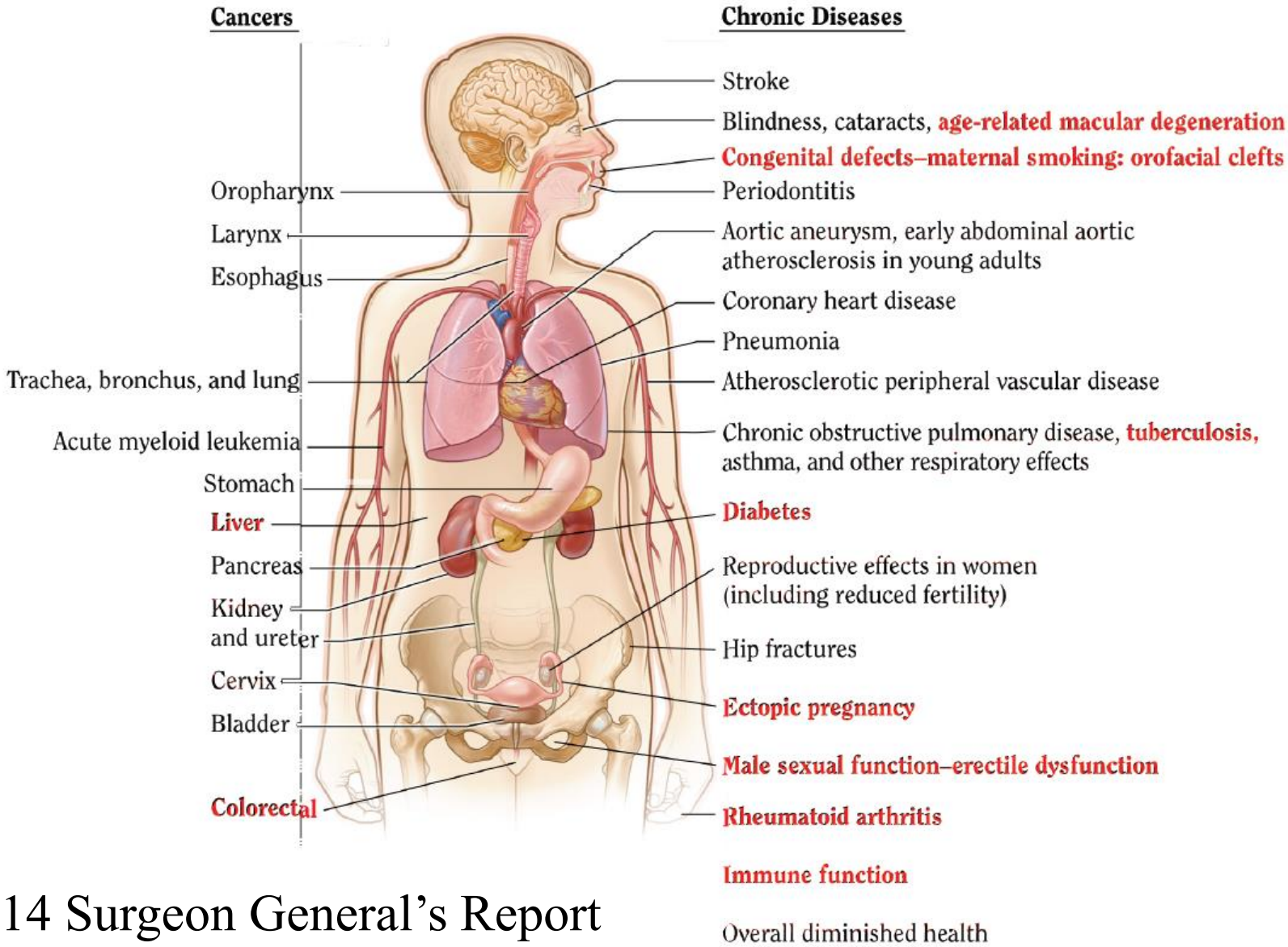


Figure 3. **Effect of Smoking Cessation on Survival to 80 Years of Age, According to Age at the Time of Quitting.**

NEJM 2013; 368: 341-350

Figure 1.1A The health consequences causally linked to smoking



2014 Surgeon General's Report

Source: USDHHS 2004, 2006, 2012.
Note: The condition in **red** is a new disease that has been causally linked to smoking in this report.

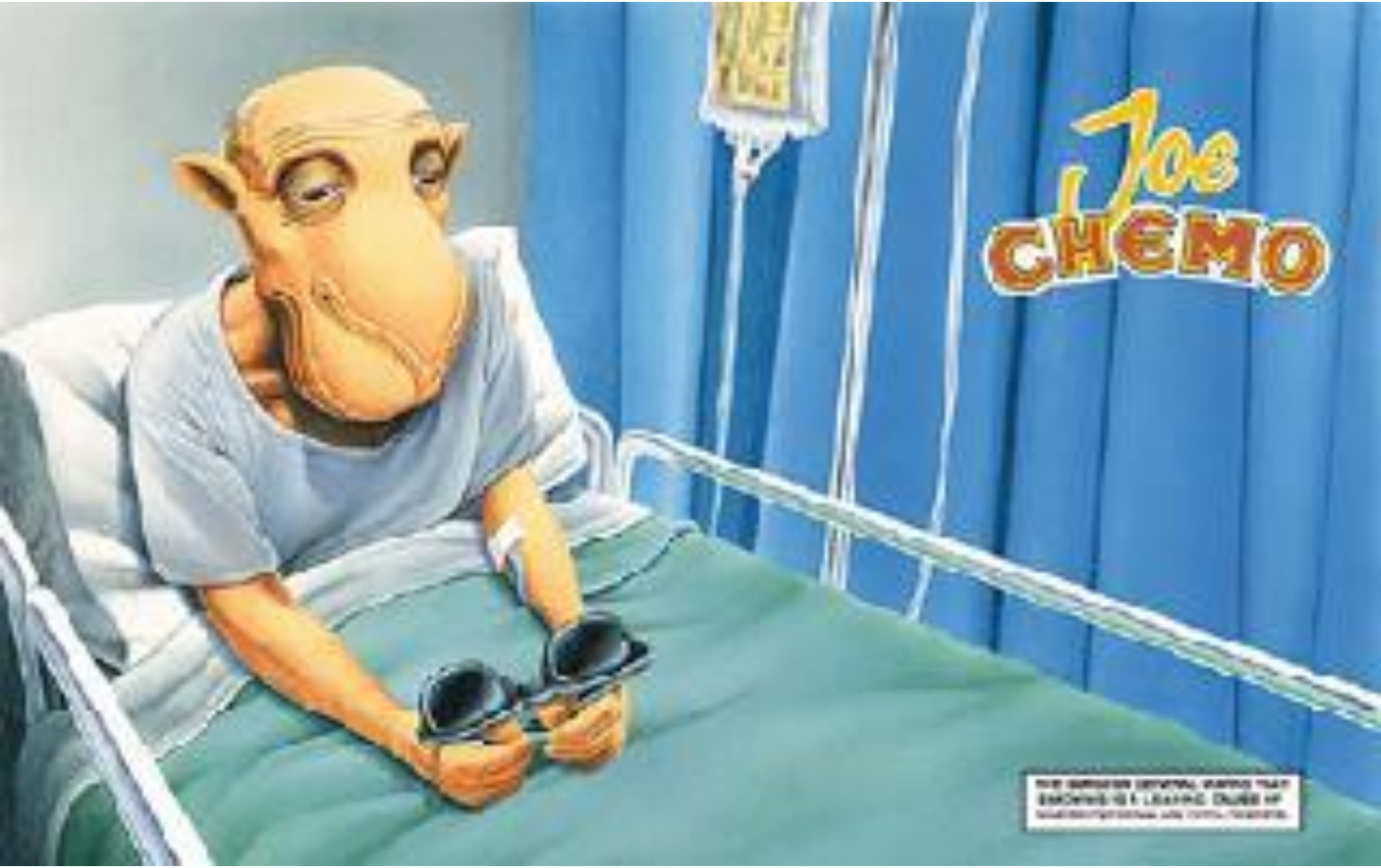
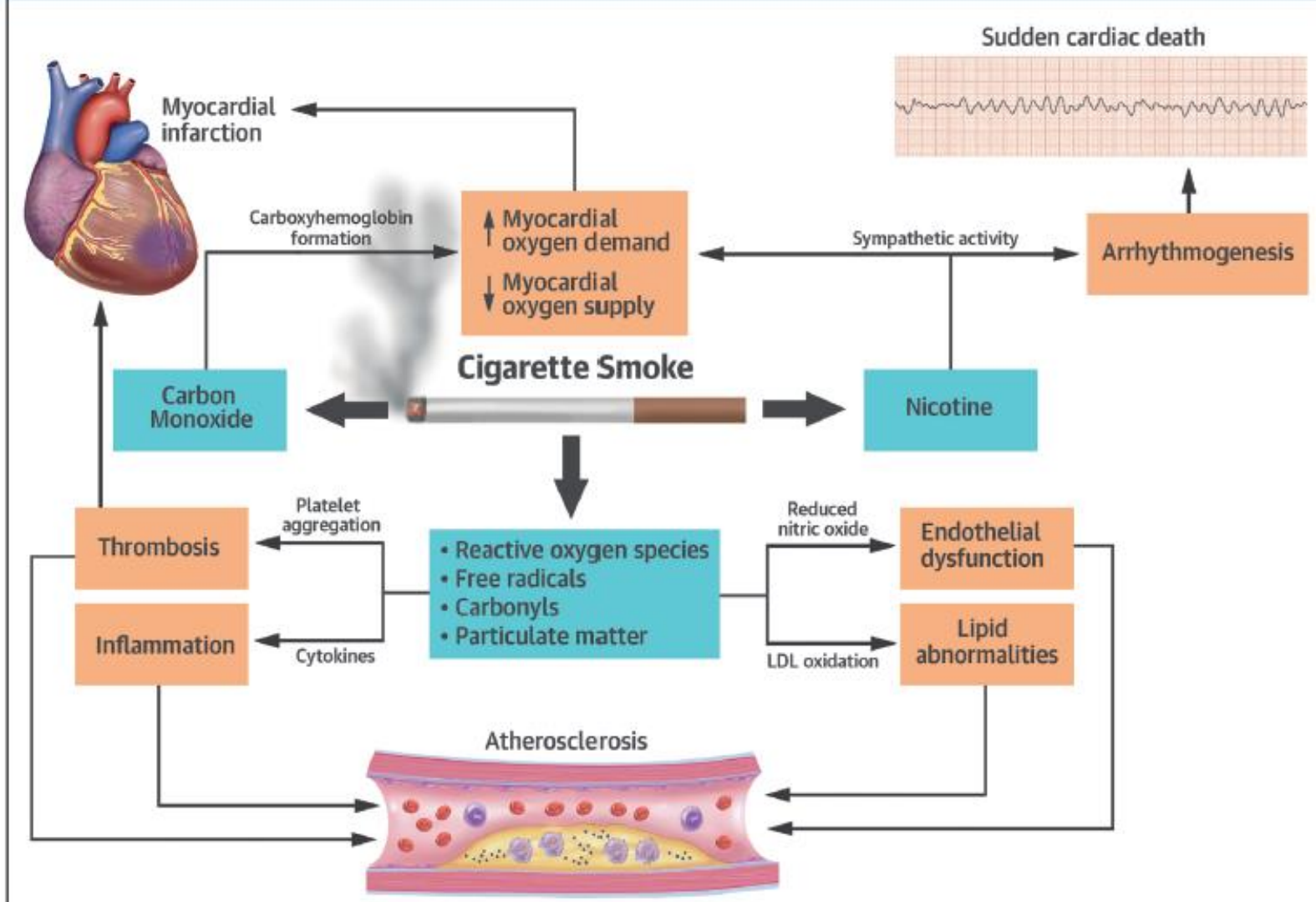

Joe
CHEMO

FIGURE 2 Mechanisms by Which Smoking Causes Cardiovascular Disease



The major components of cigarette smoke that contribute to cardiovascular disease include nicotine, carbon monoxide, reactive oxygen species, free radicals, carbonyls (such as acrolein), and particulate matter. LDL = low-density lipoprotein.

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WARNING: SMOKING CAUSES IMPOTENCE


www.ich-werde-nichtraucher.de

Tableau 1 Risque relatif de contracter une pneumonie en fonction du nombre de cigarettes fumées.

Cigarettes/j	Témoins contrôles	Patients	RR IC 95 %
0	208	72	1
1–9	83	25	1,24 (0,67–2,29)
10–20	108	62	2,36 (1,37–4,07)
> 20	57	38	2,97 (1,52–5,81)

D'après [55] Almirall J, Bolibar I, Balanzo X, Gonzales CA. Risk factors for community acquired pneumoniae in adults: a population-based case control study. Eur Respir J 1999;13:349–355.
$p < 0,001$.

Encadré 1 : Pneumopathies interstitielles diffuses associées à une intoxication tabagique.

- Histiocytose langerhansienne pulmonaire ;
- Bronchiolite respiratoire du fumeur ;
- Pneumopathie interstitielle desquamative ;
- Fibrose pulmonaire idiopathique ;
- Syndrome emphysème-fibrose ;
- Pneumopathies infiltrantes diffuses de la polyarthrite rhumatoïde ;
- Pneumopathie aiguë à éosinophiles ;
- Hémorragie alvéolaire du syndrome de Goodpasture.

D'après [71]. Marchand-Adam S, Carmier D, Crestani B. Diagnostic des pneumopathies infiltrantes diffuses chroniques. EMC - Pneumologie 2015;12(4):1—13 [Article 6-039-K-60].

Tableau 2 Effet du tabagisme actif et passif sur les risques de cancer bronchique, de BPCO, d'asthme, de tuberculose, d'apnées du sommeil.

Cancer bronchique	
Tabagisme actif	10,92 (8,28–14,40)
Tabagisme passif	1,41 (1,21–1,65)
BPCO	
Tabagisme actif	4,01 (3,18–5,05)
Asthme (adulte)	
Tabagisme actif	1,61 (1,07–2,42)
Apnée du sommeil	
Tabagisme actif	1,97 (1,02–3,82)
Tuberculose	
Tabagisme actif	1,57 (1,18–2,10)

D'après [9] Jayes L, Haslam PL, Gratziou CG, Powell P, Britton J, Vardavas C SmokeHaz: systematic reviews and meta-analyses of the effects of smoking on respiratory health. Chest 2016;150(1):164–179.

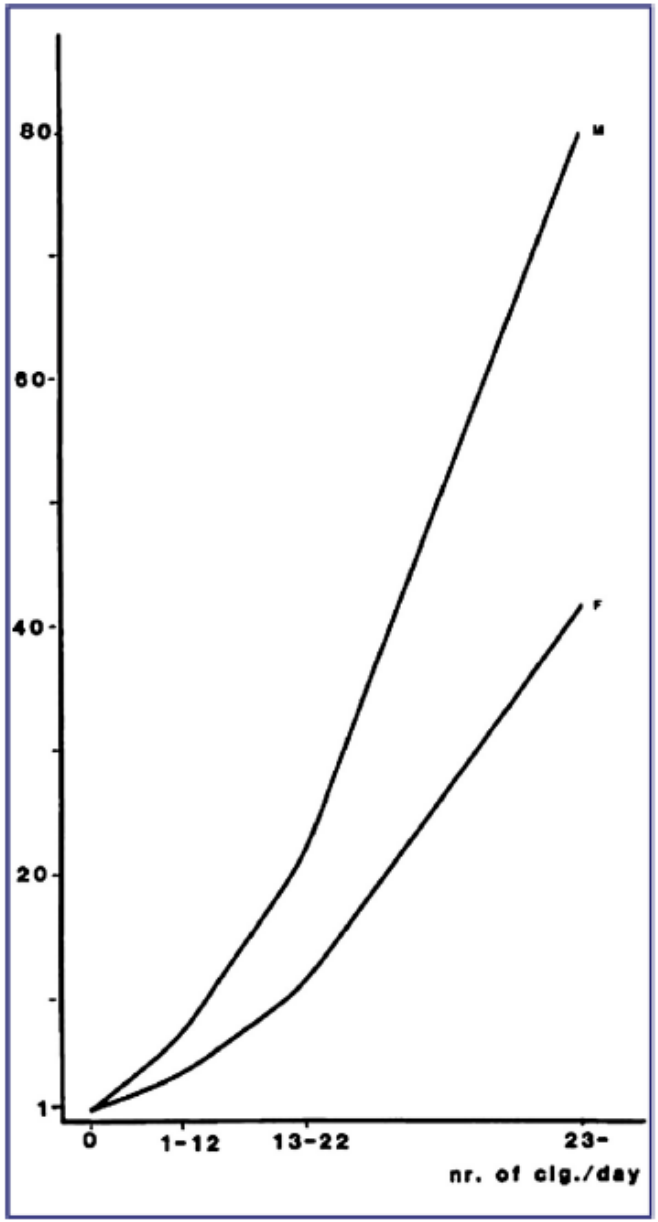


Figure 3. Risque de pneumothorax spontané et consommation tabagique.
D'après [103] Bense L, Eklund G, Wiman LG. Smoking and the increased risk of contracting spontaneous pneumothorax. Chest 1987;92:1009—12.

Revue de Pneumologie clinique (2018) **74**, 133—144

Low cigarette consumption and risk of coronary heart disease and stroke: meta-analysis of 141 cohort studies in 55 study reports

WHAT THIS STUDY ADDS

Men who smoke about one cigarette per day have a 48% higher risk of heart disease than never smokers and a 25% higher risk of stroke (or 74% and 30%, respectively, when allowing for confounding factors)

The estimates are higher in women: 57% for heart disease and 31% for stroke (or 119% and 46% when allowing for multiple confounders), again compared with never smokers.

People who smoke about one cigarette each day have about 40-50% of the excess risk associated with smoking 20 per day (coronary heart disease and stroke)

Cite this as: *BMJ* 2018;360:j5855
http://dx.doi.org/10.1136/bmj.j5855


OÙ TU VOIS ÉCRIT "LA CHICHA NUIT GRAVEMENT À LA SANTÉ"?
SUR TA TÊTE..

Le point de vue d'un fumeur

- ainsi commence la journée: sur les promesses béates de mille plaisirs partagés. Mais bientôt surviennent les marécages de la vie quotidienne... On n'aspire pas, on tire... La fumée devient opaque. Au point, lorsque la nuit approche de brouiller la carte des plaisirs. Habitude, monotonie et dépendance l'ont emporté. Une fois encore, on rêve de séparation. Comme chaque soir. Mais il ne faut pas s'alarmer: avec le tabac tout recommence toujours. Il suffit d'attendre le matin.

Dan Franck, Tabac, Editions du Seuil, 1995


HELP!

Dépendance nicotinique (1)

- propriétés psycho-actives de la nicotine:
  - plaisir, bien-être
  - relaxation
  - stimulation intellectuelle
  - action anti-nociceptive
  - effet régulateur de l’appétit
- à l’origine d’un renforcement positif

Dépendance nicotinique (2)

- symptômes de sevrage quand taux de nicotine ⬇
  - pulsion irrésistible de fumer
  - pensée obsédante de la cigarette
  - troubles de la concentration
  - nervosité, agitation, irritabilité
  - anxiété, dépression, troubles du sommeil
  - augmentation de l'appétit
- à l'origine d'un renforcement négatif

LA CIGARETTE BIENTÔT INTERDITE DANS TOUS LES LIEUX PUBLICS

TU NOUS A FOUTU LA TROUILLE : ON CROYAIT QUE C'ÉTAIT LES FLICS !

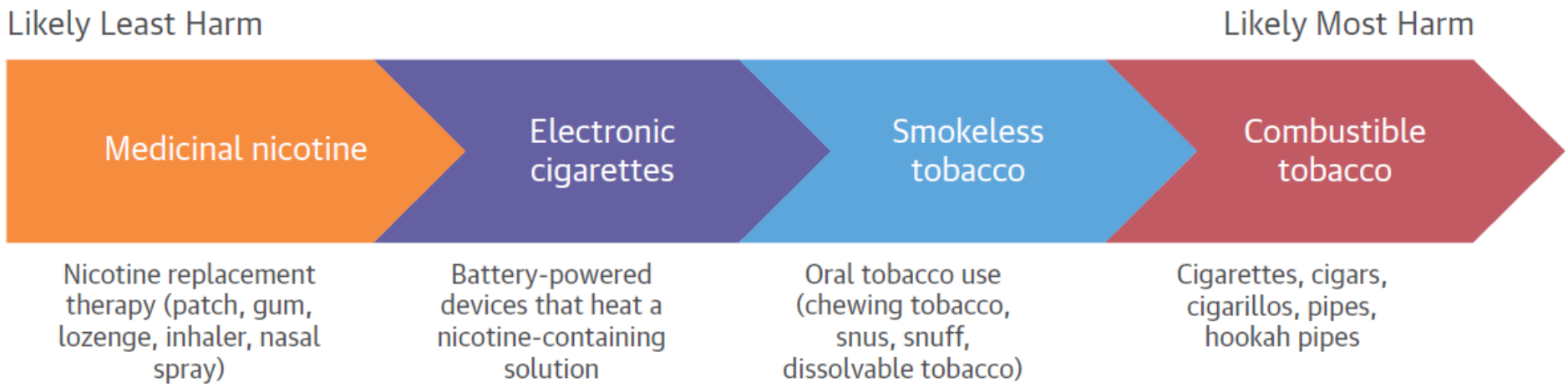
Evaluation de la dépendance

test de Fagerström

<u>2 questions cruciales:</u>

- combien fumez-vous de cigarettes/jour?
- combien de temps après le réveil, allumez-vous votre 1ère cigarette?

FIGURE 3 **Risk Continuum of Nicotine-Containing Products**



Nicotine comes in many forms, with varying degrees of potential harm to users. Medicinal nicotine, such as that contained in nicotine replacement therapy, is least likely to cause harm, whereas combustible tobacco, such as cigarettes, is most likely to cause harm. It is not known where heat-not-burn tobacco (also known as heated tobacco) products fall on this spectrum given the limited evidence on their health effects.

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Tableau 1. Modèle des A

1. Ask

Interroger le patient sur son statut tabagique

2. Assess

Evaluer la motivation à arrêter de fumer et la dépendance à la nicotine

3. Advise

Recommander l'arrêt du tabac

4. Assist

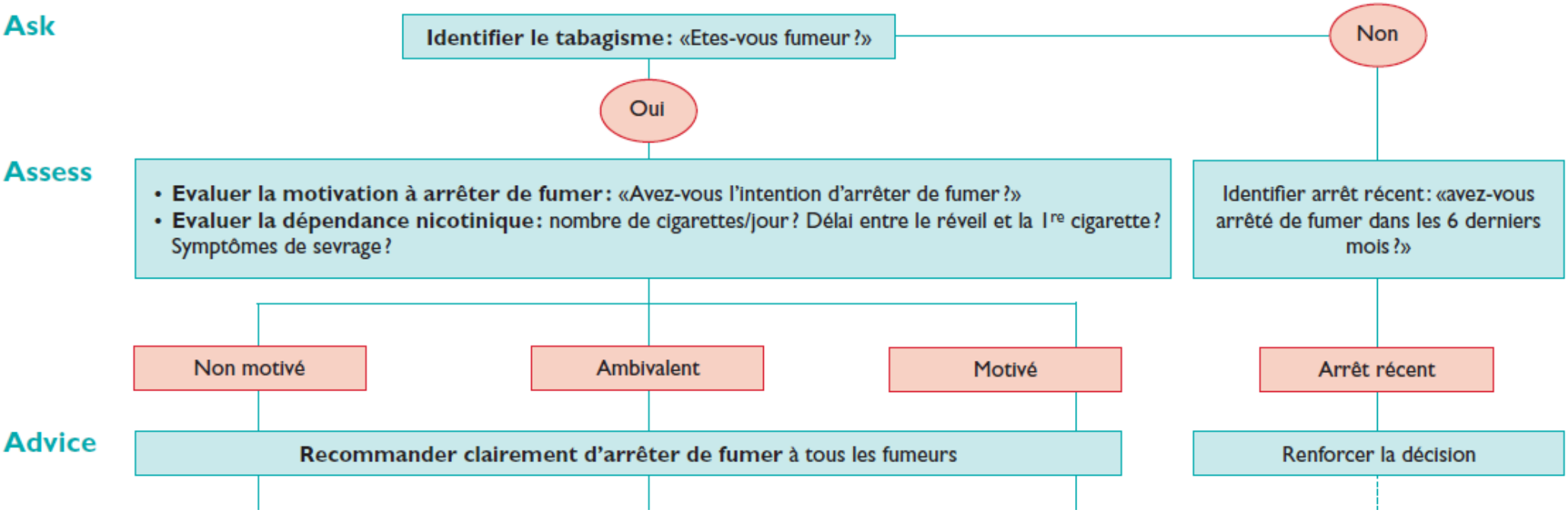
Intervention d'aide à l'arrêt adaptée à la motivation à arrêter de fumer

5. Arrange

Assurer un suivi des tentatives d'arrêt

Rev Med Suisse 2015; 11: 1276-1281

"Johnson here has devised a way to help you stop thinking about smoking."


Ask
Identifier le tabagisme: «Etes-vous fumeur ?»
Non
Oui
Assess
• Evaluer la motivation à arrêter de fumer: «Avez-vous l'intention d'arrêter de fumer ?»
• Evaluer la dépendance nicotinique: nombre de cigarettes/jour ? Délai entre le réveil et la 1re cigarette ? Symptômes de sevrage ?
Identifier arrêt récent: «avez-vous arrêté de fumer dans les 6 derniers mois ?»
Non motivé
Ambivalent
Motivé
Arrêt récent
Advice
Recommander clairement d'arrêter de fumer à tous les fumeurs
Renforcer la décision

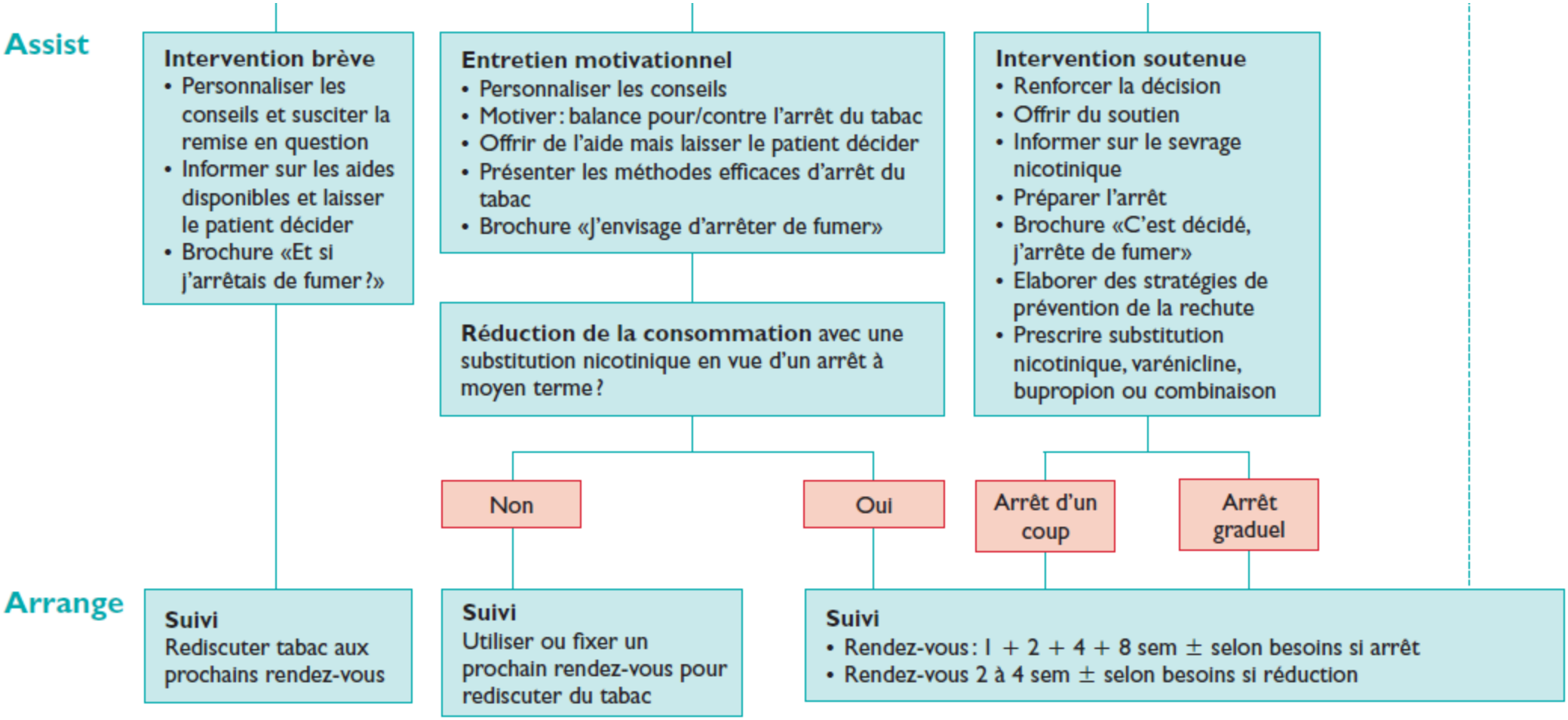


Figure 1. Algorithme de prise en charge du patient fumeur

Rev Med Suisse 2015; 11: 1276-1281

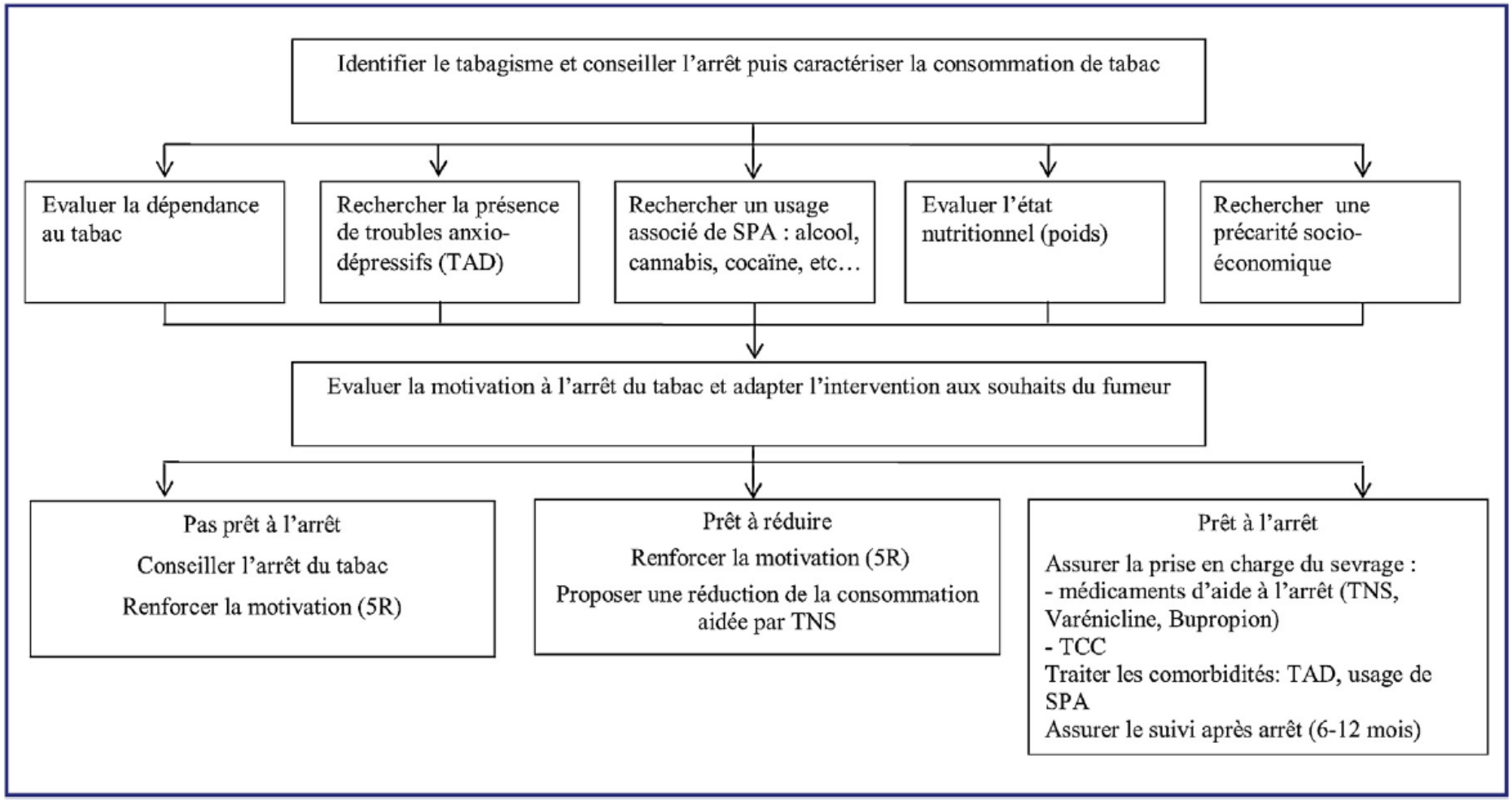


Figure 1. Prise en charge du sevrage tabagique. SPA : substance psychoactive ; TNS : traitement nicotinique substitutif ; TCC : therapies comportementales et cognitives ; 5R : stratégie d'intervention en « 5Rs » (*relevance* ; *risks* ; *rewards* ; *roadblocks* ; *repetitions*).

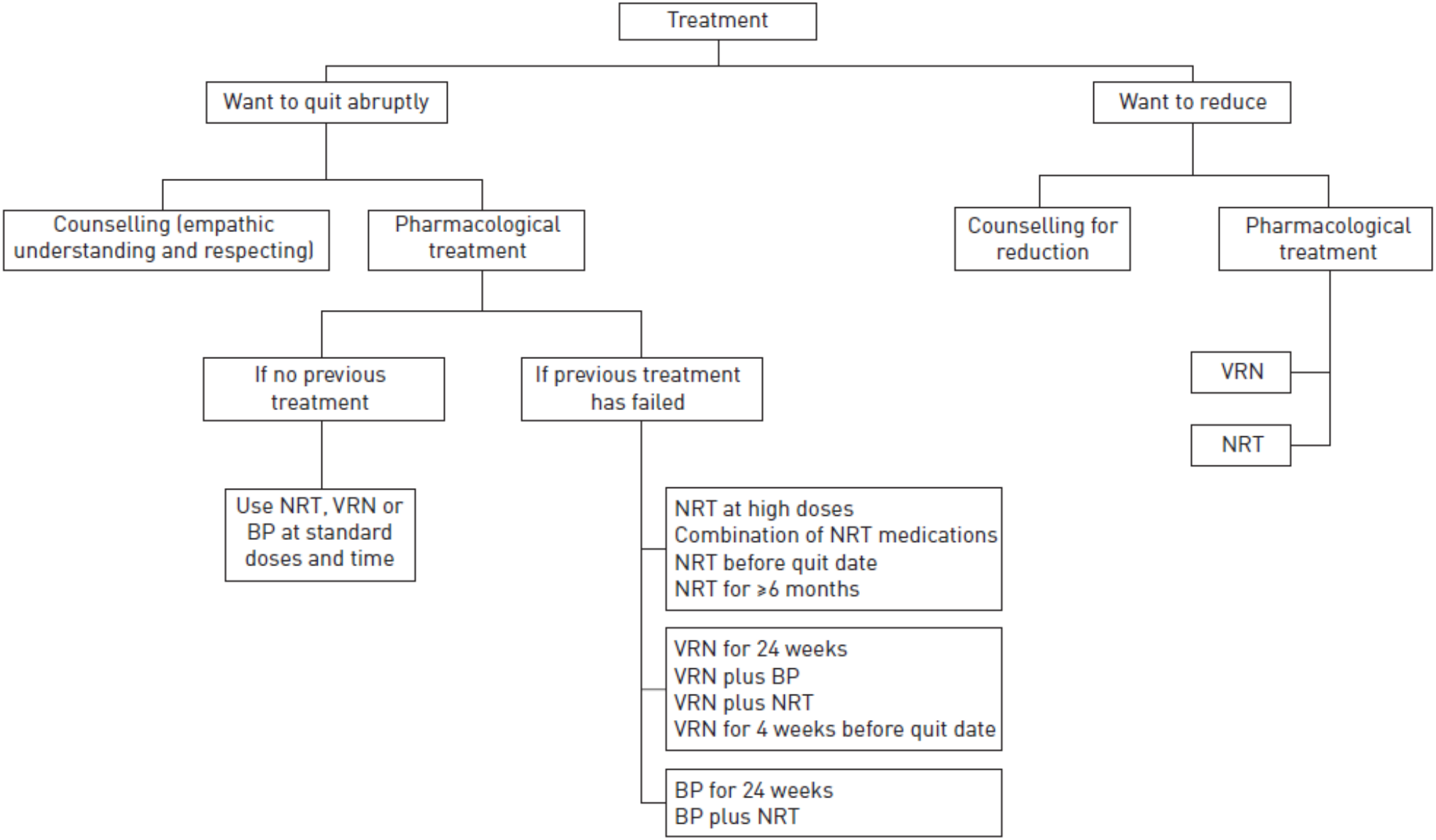


FIGURE 2 The therapeutic approach used by most Task Force members for smokers that find it difficult to quit. NRT: nicotine replacement therapy; VRN: varenicline; BP: bupropion.

ERJ 2015; 46: 61-79

Stratégie générale

- réduction du nombre de cigarettes fumées avant le jour d’arrêt
- arrêt brutal sans réduction préalable
- taux d’abstinences semblables

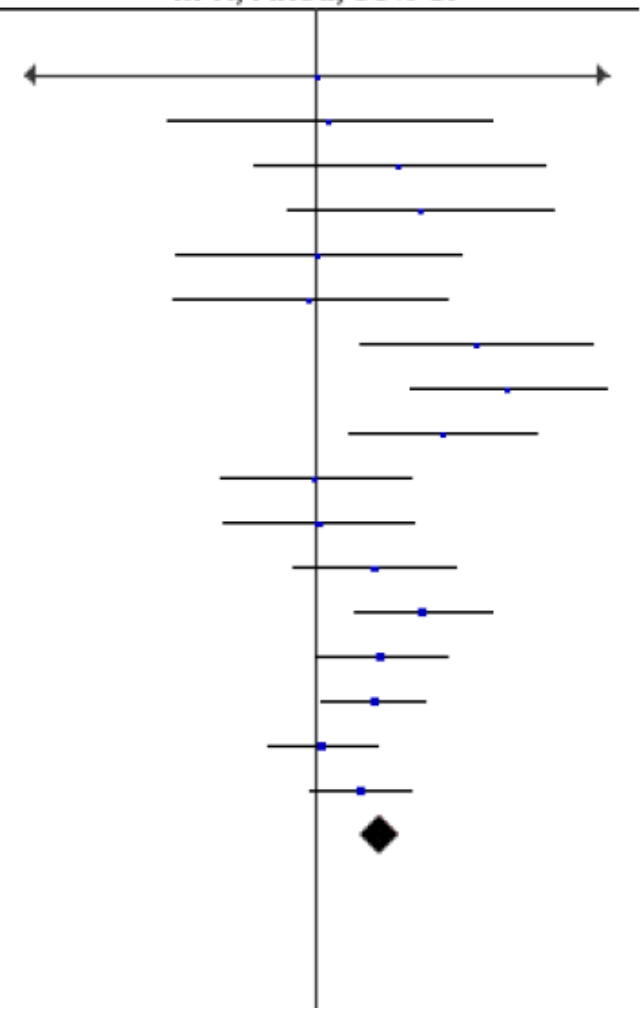
Cochrane Database of Systematic Reviews 2013

Appendix F Figure 7. Effect of Advice vs. Control (by Intensity): Smoking Abstinence at Longest Followup (Stead, 2013b)[139]

Study or Subgroup	Treatment Events	Treatment Total	Control Events	Control Total	Weight	Risk Ratio M-H, Fixed, 95% CI
1.1.1 Minimal intervention						
Slama 1990	1	104	1	106	0.2%	1.02 [0.06, 16.08]
Porter 1972	5	101	4	90	0.9%	1.11 [0.31, 4.02]
Demers 1990	10	292	4	227	0.9%	1.94 [0.62, 6.12]
Nebot 1989	11	208	5	216	1.0%	2.28 [0.81, 6.46]
Stewart 1982	11	504	4	187	1.2%	1.02 [0.33, 3.16]
Page 1986	8	114	5	68	1.3%	0.95 [0.33, 2.80]
Slama 1995	42	2199	5	929	1.4%	3.55 [1.41, 8.94]
Russell 1979	34	1031	8	1107	1.6%	4.56 [2.12, 9.81]
Haug 1994	31	154	8	109	1.9%	2.74 [1.31, 5.73]
McDowell 1985	12	85	11	78	2.3%	1.00 [0.47, 2.14]
Betson 1997	14	443	13	422	2.7%	1.03 [0.49, 2.16]
Janz 1987	26	144	12	106	2.8%	1.59 [0.84, 3.01]
Wilson 1990	43	577	17	532	3.6%	2.33 [1.35, 4.04]
Vetter 1990	34	237	20	234	4.1%	1.68 [1.00, 2.83]
Higashi 1995	53	468	35	489	7.0%	1.58 [1.05, 2.38]
Russell 1983	43	740	35	637	7.7%	1.06 [0.69, 1.63]
Jamrozik 1984	77	512	29	274	7.7%	1.42 [0.95, 2.12]
Subtotal (95% CI)		**7913**		**5811**	**48.5%**	**1.66 [1.42, 1.94]**
Total events	455		216			

Heterogeneity: Chi² = 23.33, df = 16 (P = 0.11); I² = 31%

Test for overall effect: Z = 6.33 (P < 0.00001)



1.1.2 Intensive intervention

Slama 1990	5	101	1	106	0.2%	5.25 [0.62, 44.14]
Richmond 1986	23	100	2	100	0.4%	11.50 [2.79, 47.49]
Hilberink 2005	18	243	5	148	1.3%	2.19 [0.83, 5.78]
Pieterse 2001	22	269	8	261	1.7%	2.67 [1.21, 5.89]
Severson 1997	25	1073	10	802	2.3%	1.87 [0.90, 3.87]
Unrod 2007	29	237	17	228	3.5%	1.64 [0.93, 2.90]
Morgan 1996	43	279	31	380	5.4%	1.89 [1.22, 2.92]
Schnoll 2003	27	203	28	206	5.7%	0.98 [0.60, 1.60]
Meyer 2008	39	402	41	609	6.7%	1.44 [0.95, 2.19]
Jamrozik 1984	160	1049	29	274	9.4%	1.44 [0.99, 2.09]
Rose 78-92	162	714	74	731	15.0%	2.24 [1.74, 2.89]
Subtotal (95% CI)		**4670**		**3845**	**51.5%**	**1.86 [1.60, 2.15]**
Total events	553		246			

Heterogeneity: Chi² = 20.15, df = 10 (P = 0.03); I² = 50%

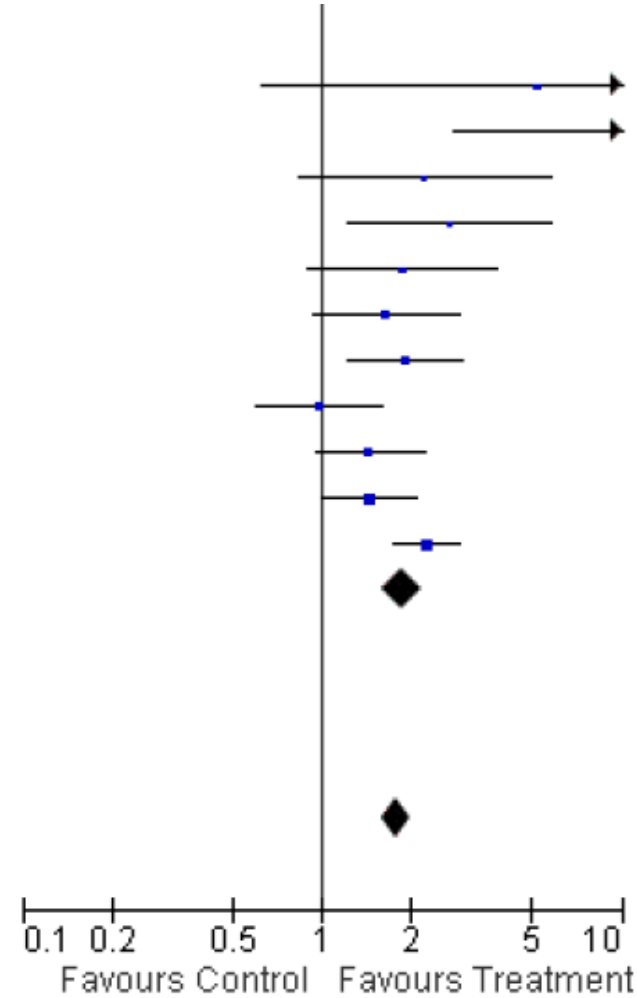
Test for overall effect: Z = 8.31 (P < 0.00001)

Total (95% CI)		**12583**		**9656**	**100.0%**	**1.76 [1.58, 1.96]**
Total events	1008		462			

Heterogeneity: Chi² = 44.64, df = 27 (P = 0.02); I² = 40%

Test for overall effect: Z = 10.38 (P < 0.00001)

Test for subgroup differences: Chi² = 1.03, df = 1 (P = 0.31), I² = 2.9%



Source: Stead LF. Physician advice for smoking cessation (Review). Cochrane Database of Systematic Reviews 2013, Issue 5. *Permission to reprint this figure granted by John Wiley and Sons.*

Recommendations: The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration-approved pharmacotherapy for cessation to adults who use tobacco. (A recommendation)

Ann Intern Med 2015; 163: 622-634

Substitution nicotinique (NRT)

- revue systématique de 133 essais avec 64’640 participants :

RR d’abstinence avec substitut nicotinique versus contrôle:

1.55 (IC 95%, 1.49 à 1.61)

Cochrane Database of Systematic Reviews 2018

Patchs transdermiques

- revue systématique:

RR 1.64 (IC 95%, 1.53 à 1.75; 51 essais; 25754 participants)

Cochrane Database of Systematic Reviews 2018

Gommes de nicotine

- revue systématique:

RR 1.49 (IC 95% 1.40 à 1.60; 56 essais; 22’581 participants)

Cochrane Database of Systematic Reviews 2018

Tablettes orales de nicotine

- revue systématique:

RR 1.52 (IC 95%, 1.32 à 1.74; 8 essais; 4439 participants)

Cochrane Database of Systematic Reviews 2018

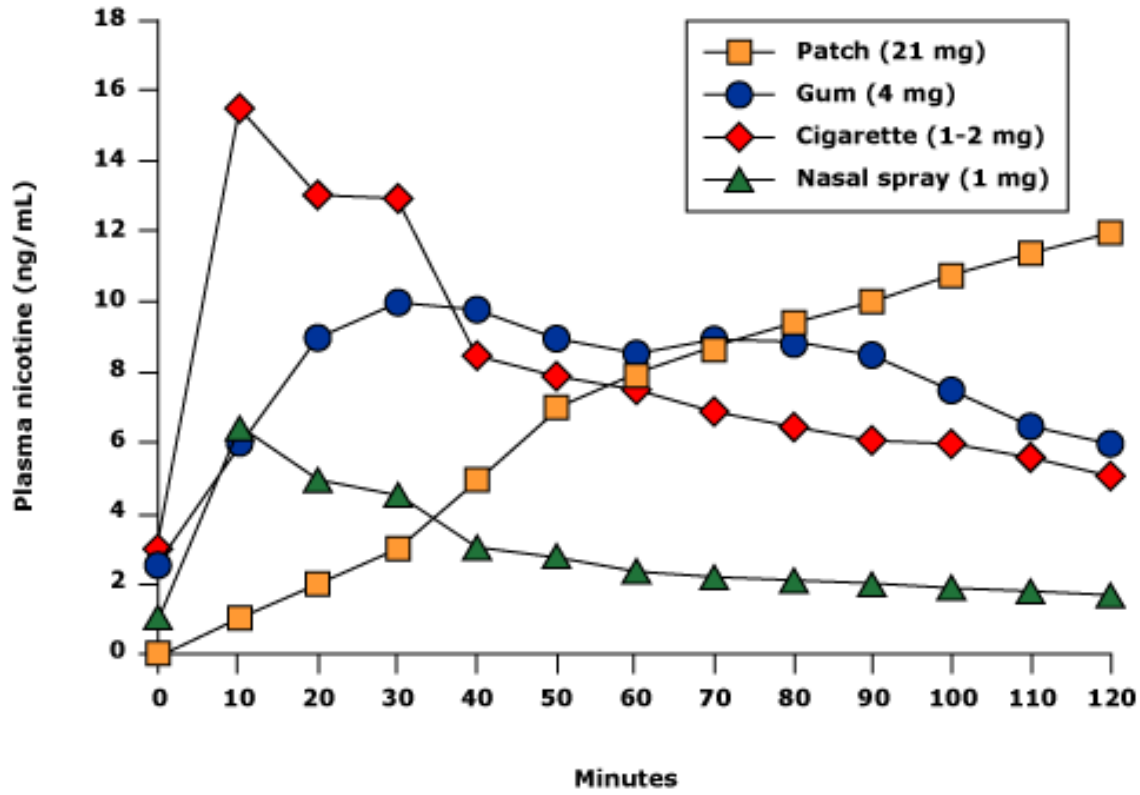
Inhalateur de nicotine

- revue systématique:

RR 1.90 (IC 95%, 1.36 à 2.67; 4 essais; 976 participants)

Cochrane Database of Systematic Reviews 2018

Plasma nicotine levels after a smoker has smoked a cigarette, received nicotine nasal spray, begun chewing nicotine gum, or applied a nicotine patch



The amount of nicotine in each product is given in parentheses. The pattern produced by the use of the nicotine inhaler (not shown) is similar to that for nicotine gum. Modified from Garrett et al.[12]

Bupropion (Zyban) 150 mg

- *Posologie:* 1 x 150 mg/j de J1 à J6 puis 2 x 150 mg/j x 7-11 sem dès J7
  - Arrêt du tabac programmé entre J8 et J14
  - Si effets indésirables importants ou situation exigeant des précautions, réduire à 1 x 150 mg/j ou arrêter
  - Durée: 2-3 mois, considérer jusqu'à 6 mois si besoin
- *Risque surdosage:* insuffisances hépatique et rénale
- *Effets indésirables:* troubles du sommeil, sécheresse buccale, sensation vertigineuse, réaction anxieuse. Epilepsie (1/1000)
- *Contre-indications:* épilepsie, anorexie/boulimie, sevrage alcool ou sédatifs, cirrhose hépatique, tumeur cérébrale, prise d'IMAO, troubles bipolaires, grossesse, allaitement, < 18 ans
- *Précautions:* abaissement du seuil épileptogène: abus d'alcool, médicaments (par exemple: antidépresseurs, neuroleptiques, tramadol, quinolones, antipaludéens, corticoïdes systémiques), diabète traité par hypoglycémiants ou insuline, traumatisme cranio-cérébral, prise de stimulants ou d'anorexigènes. Interaction CYP2D6

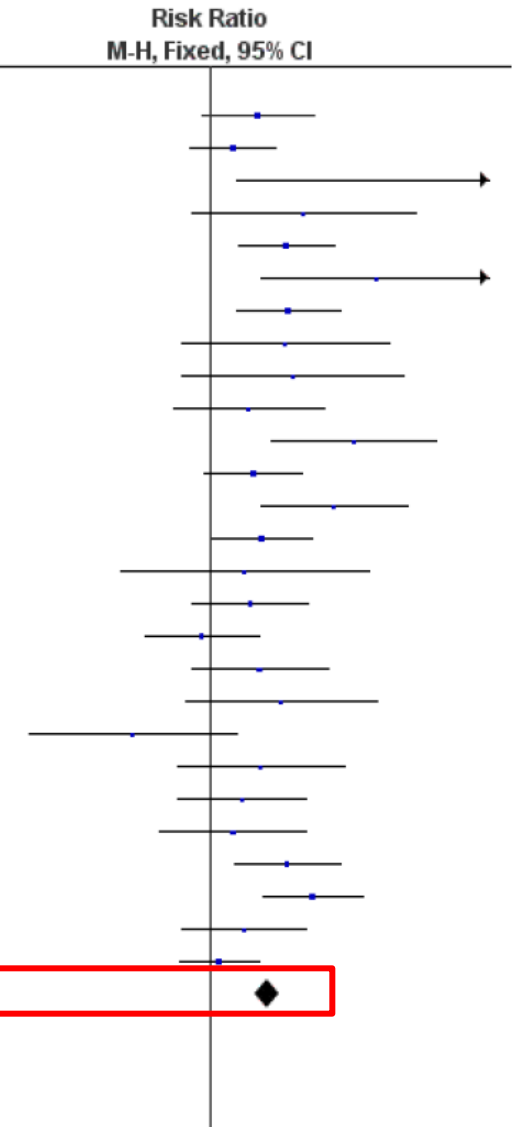
Rev Med Suisse 2015; 11: 1276-1281

Figure 2. Forest plot of comparison: 1 Bupropion. Abstinence at 6m or greater follow-up, outcome: 1.1 Bupropion versus placebo/control. Subgroups by length of follow-up.

Study or Subgroup	Bupropion Events	Bupropion Total	Control Events	Control Total	Weight	Risk Ratio M-H, Fixed, 95% CI
1.1.1 Twelve month follow-up						
Brown 2007	38	255	27	269	3.5%	1.48 [0.93, 2.36]
Eisenberg 2013	49	183	43	194	5.5%	1.21 [0.85, 1.73]
Ferry 1992	10	23	0	22	0.1%	20.13 [1.25, 324.00]
Ferry 1994	13	95	6	95	0.8%	2.17 [0.86, 5.46]
Fossati 2007	101	400	26	193	4.6%	1.87 [1.26, 2.78]
Gonzales 2001	20	226	5	224	0.7%	3.96 [1.51, 10.38]
Gonzales 2006	53	329	29	344	3.7%	1.91 [1.25, 2.93]
Hall 2002	13	73	7	73	0.9%	1.86 [0.79, 4.39]
Holt 2005	19	88	5	46	0.9%	1.99 [0.79, 4.98]
Hurt 1997	21	156	15	153	2.0%	1.37 [0.74, 2.56]
Jorenby 1999	45	244	9	160	1.4%	3.28 [1.65, 6.52]
Jorenby 2006	50	342	35	341	4.6%	1.42 [0.95, 2.14]
Levine 2010	42	195	12	156	1.8%	2.80 [1.53, 5.13]
McCarthy 2008	48	229	32	234	4.2%	1.53 [1.02, 2.31]
Nides 2006	8	128	6	127	0.8%	1.32 [0.47, 3.70]
Piper 2007	42	224	21	156	3.3%	1.39 [0.86, 2.26]
Planer 2011	23	75	25	76	3.3%	0.93 [0.58, 1.49]
Rigotti 2006	25	124	17	127	2.2%	1.51 [0.86, 2.65]
Rovina 2009	14	40	7	36	1.0%	1.80 [0.82, 3.96]
Schmitz 2007	7	78	13	76	1.7%	0.52 [0.22, 1.24]
Selby 2003	18	141	12	143	1.6%	1.52 [0.76, 3.04]
SMK20001	26	143	20	143	2.6%	1.30 [0.76, 2.22]
Tashkin 2001	21	204	17	200	2.3%	1.21 [0.66, 2.23]
Tonnesen 2003	111	527	20	180	3.9%	1.90 [1.21, 2.96]
Tonstad 2003	68	313	29	313	3.8%	2.34 [1.56, 3.52]
Wittchen 2011	22	108	27	175	2.7%	1.32 [0.79, 2.20]
Zellweger 2005	117	501	36	166	7.1%	1.98 [0.77, 1.59]
Subtotal (95% CI)		**5444**		**4422**	**70.9%**	**1.59 [1.44, 1.76]**
Total events	1024		501			

Heterogeneity: Chi² = 42.59, df = 26 (P = 0.02); I² = 39%

Test for overall effect: Z = 9.06 (P < 0.00001)



Cochrane Database of Systematic Reviews 2014, Issue 1. Art. No.: CD000031.

Tableau 3. Posologie, effets indésirables et contre-indications de la varénicline

Varénicline (Champix) 0,5 mg/1 mg

- *Posologie:* 1 x 0,5 mg/j de J1 à J3 puis 2 x 0,5 mg/j de J4 à J7 puis 2 x 1 mg/j x 11 sem dès J8
  - Arrêt du tabac programmé dès J8
  - Suivre et arrêter la varénicline si troubles du comportement, dépression, idées ou comportement suicidaires. Si effets indésirables importants, réduire à 2 x 0,5 mg/j ou arrêter
  - Durée: 3 mois, considérer jusqu'à 6 mois si besoin
- *Effets indésirables: nausées, insomnies, rêves. Possibles troubles neuropsychiatriques*
- *Contre-indications:* insuffisance rénale sévère, grossesse/allaitement, < 18 ans
- *Précautions:* troubles psychiatriques

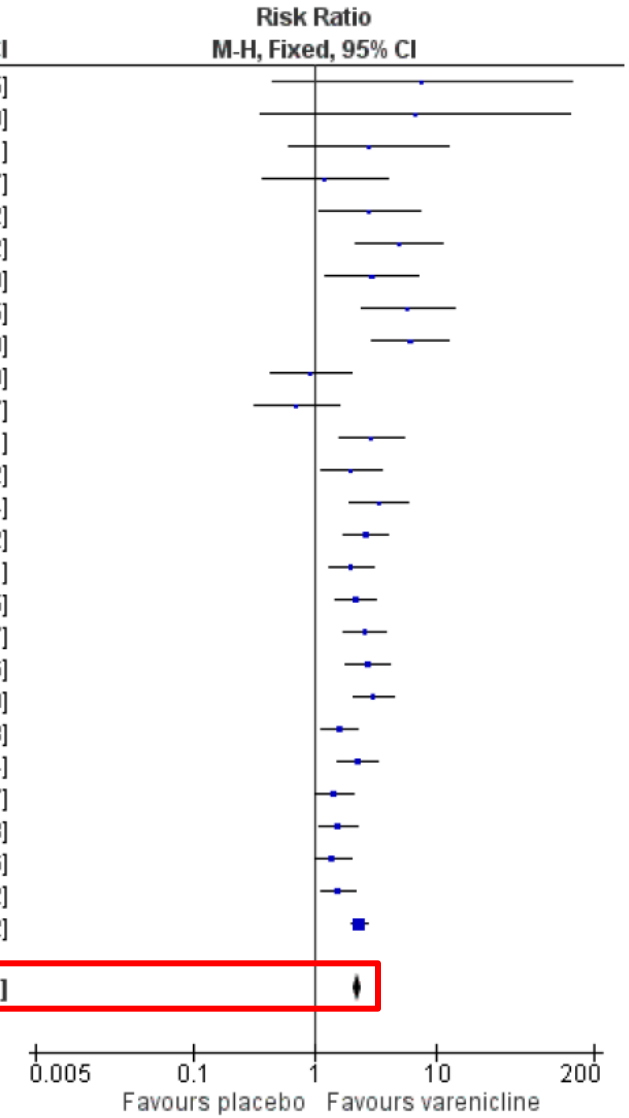
Rev Med Suisse 2015; 11: 1276-1281

Figure 2. Varenicline (1.0 mg 2/d) vs placebo, outcome: 3.1 Continuous abstinence at longest follow-up (24+ weeks)

Study or Subgroup	Varenicline Events	Varenicline Total	Control Events	Control Total	Weight	Risk Ratio M-H, Fixed, 95% CI
De Dios 2012 (1)	3	10	0	11	0.1%	7.64 [0.44, 131.75]
Nahvi 2014a (2)	3	57	0	55	0.1%	6.76 [0.36, 127.89]
Chengappa 2014	6	31	2	29	0.3%	2.81 [0.61, 12.81]
Westergaard 2015 (3)	5	26	4	25	0.6%	1.20 [0.36, 3.97]
Evins 2014	12	40	5	47	0.7%	2.82 [1.09, 7.32]
Heydari 2012 (4)	29	89	6	91	0.9%	4.94 [2.16, 11.32]
Nides 2006	18	125	6	123	0.9%	2.95 [1.21, 7.19]
Oncken 2006	58	259	5	129	1.0%	5.78 [2.38, 14.05]
Gonzales 2014	50	249	8	245	1.2%	6.15 [2.98, 12.70]
NCT00828113	10	50	11	51	1.6%	0.93 [0.43, 1.99]
Steinberg 2011 (5)	8	40	11	39	1.6%	0.71 [0.32, 1.57]
Niaura 2008	35	160	12	160	1.7%	2.92 [1.57, 5.41]
Cinciripini 2013	24	86	15	106	2.0%	1.97 [1.11, 3.52]
Tashkin 2011	46	248	14	253	2.0%	3.35 [1.89, 5.94]
Rigotti 2010	68	353	26	354	3.8%	2.62 [1.71, 4.02]
Anthenelli 2013	52	254	28	269	3.9%	1.97 [1.28, 3.01]
Tsai 2007	59	126	27	124	3.9%	2.15 [1.47, 3.15]
Gonzales 2006	77	352	29	344	4.3%	2.59 [1.74, 3.87]
Rennard 2012	171	493	21	166	4.6%	2.74 [1.81, 4.16]
Bolliger 2011	155	394	26	199	5.0%	3.01 [2.06, 4.40]
Nakamura 2007	56	155	35	154	5.1%	1.59 [1.11, 2.28]
Jorenby 2006	79	344	35	341	5.1%	2.24 [1.55, 3.24]
Wong 2012 (6)	55	151	34	135	5.2%	1.45 [1.01, 2.07]
Carson 2014 (7)	56	190	36	189	5.2%	1.55 [1.07, 2.23]
Eisenberg 2016	53	148	39	151	5.6%	1.39 [0.98, 1.96]
Wang 2009	63	165	42	168	6.0%	1.53 [1.10, 2.12]
EAGLES 2016 (8)	444	2037	191	2035	27.7%	2.32 [1.98, 2.72]
Total (95% CI)		**6632**		**5993**	**100.0%**	**2.24 [2.06, 2.43]**
Total events	1695		668			

Heterogeneity: Chi² = 64.85, df = 26 (P < 0.0001); I² = 60%

Test for overall effect: Z = 19.01 (P < 0.00001)



Cochrane Database of Systematic Reviews 2016, Issue 5. Art. No.: CD006103.

Cochrane Library

Cochrane Database of Systematic Reviews

Nicotine receptor partial agonists for smoking cessation (Review)

Cahill K, Lindson-Hawley N, Thomas KH, Fanshawe TR, Lancaster T

Cahill K, Lindson-Hawley N, Thomas KH, Fanshawe TR, Lancaster T.
Nicotine receptor partial agonists for smoking cessation.
Cochrane Database of Systematic Reviews 2016, Issue 5. Art. No.: CD006103.
DOI: 10.1002/14651858.CD006103.pub7.

The pooled RR for continuous or sustained abstinence at six months or longer for varenicline at standard dosage versus placebo was 2.24 (95% CI 2.06 to 2.43; 27 trials, 12,625 people; *high-quality evidence*). Varenicline at lower or variable doses was also shown to be effective, with an RR of 2.08 (95% CI 1.56 to 2.78; 4 trials, 1266 people). The pooled RR for varenicline versus bupropion at six months was 1.39 (95% CI 1.25 to 1.54; 5 trials, 5877 people; *high-quality evidence*). The RR for varenicline versus NRT for abstinence at 24 weeks was 1.25 (95% CI 1.14 to 1.37; 8 trials, 6264 people; *moderate-quality evidence*). Four trials which tested the use of varenicline beyond the 12-week standard regimen found the drug to be well-tolerated during long-term use. The number needed to treat with varenicline for an additional beneficial outcome, based on the weighted mean control rate, is 11 (95% CI 9 to 13).

Tableau 2. Critères pour le remboursement des traitements de varénicline et bupropion

- Présence d'une dépendance au tabac selon le Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) ou de la Classification internationale des maladies (CIM-10)*
- ET au moins un des 2 critères suivants :
  - Score ≥ 6 au test de Fagerström**
  - Présence d'une pathologie induite par le tabagisme (bronchite chronique, maladie cardiovasculaire ou cancer)

Le traitement est remboursé pour les adultes dès 18 ans, pour une durée de 12 semaines pour la varénicline et 7 semaines pour le bupropion, une fois par tranche de 18 mois

Rev Med Suisse 2015; 11: 1276-1281

Pharmacothérapie et interventions comportementales combinées (1)

- **Lung Health Study (~5’000 participants):**

  - RR 3.88 (IC 95% 3.35 to 4.50)

  - gommes, sessions de groupe, long terme

- **52 autres études (19’488 participants):**

  - RR 1.83 (IC 95% 1.68 to 1.98)

Cochrane Database of Systematic Reviews 2016

Figure 2 Different generations of electronic cigarettes

It is probably best to try a second generation e-cigarette (often referred to as vape pens). First generation devices (cig-a-likes, which look like cigarettes) deliver less nicotine and may be less satisfying and not work as well. Third and fourth generation devices may be more complicated to use for people new to e-cigarettes

BMJ 2018; 360: J5543

Though we can't say e-cigarettes are 100% safe, experts overwhelmingly agree that they are considerably less harmful than traditional cigarettes. Some experts estimate that e-cigarettes are 95% safer than traditional cigarettes

BMJ 2018; 360: J5543

It is important to take a stand now and not wait for another 30 years to start fighting “healthier” alternatives to smoking. Smoking cessation should be strongly recommended, with evidence-based interventions and supported by accredited professionals and peer help; and in this context, the evidence that e-cigarettes are at all helpful is exceedingly weak [3]. Nicotine is addictive, and any recreational nicotine use should be opposed root and branch. Instead, we should promote a healthy lifestyle. We commend the recent US report on e-cigarettes as a far better statement than that which the BMJ has seen fit to publish [5].

BMJ 2018; 360: J5543

Professor Mina Gaga, President, European Respiratory Society

Professor Tobias Welte, President Elect, European Respiratory Society

Professor Thierry Troosters, Vice President, European Respiratory Society

Professor Andrew Bush, Chair of Publications Committee, European Respiratory Society

Response BMJ 2018; 360: J5543

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

A Randomized Trial of E-Cigarettes versus Nicotine-Replacement Therapy

DOI: 10.1056/NEJMoa1808779

Table 2. Abstinence Rates at Different Time Points and Smoking Reduction at 52 Weeks.*

Outcome	E-Cigarettes (N = 438)	Nicotine Replacement (N = 446)	Primary Analysis: Relative Risk (95% CI)†	Sensitivity Analysis: Adjusted Relative Risk (95% CI)
Primary outcome: abstinence at 52 wk — no. (%)	79 (18.0)	44 (9.9)	1.83 (1.30–2.58)	1.75 (1.24–2.46)‡
Secondary outcomes				
Abstinence between wk 26 and wk 52 — no. (%)	93 (21.2)	53 (11.9)	1.79 (1.32–2.44)	1.82 (1.34–2.47)§
Abstinence at 4 wk after target quit date — no. (%)	192 (43.8)	134 (30.0)	1.45 (1.22–1.74)	1.43 (1.20–1.71)¶
Abstinence at 26 wk after target quit date — no. (%)	155 (35.4)	112 (25.1)	1.40 (1.14–1.72)	1.36 (1.15–1.67)‡
Carbon monoxide–validated reduction in smoking of ≥50% in participants without abstinence between wk 26 and wk 52 — no./total no. (%)	44/345 (12.8)	29/393 (7.4)	1.75 (1.12–2.72)	1.73 (1.11–2.69)‖

* Abstinence at 52 weeks was defined as a self-report of smoking no more than five cigarettes from 2 weeks after the target quit date, validated biochemically by an expired carbon monoxide level of less than 8 ppm at 52 weeks. Abstinence between week 26 and week 52 was defined as a self-report of smoking no more than five cigarettes between week 26 and week 52, plus an expired carbon monoxide level of less than 8 ppm at 52 weeks. Abstinence at 4 weeks was defined as a self-report of no smoking from 2 weeks after the target quit date, plus an expired carbon monoxide level of less than 8 ppm at 4 weeks. Abstinence at 26 weeks was defined as a self-report of smoking no more than five cigarettes from 2 weeks after the target quit date to 26 weeks; there was no validation by expired carbon monoxide level.

Pulmonary Illness Related to E-Cigarette Use in Illinois and Wisconsin Preliminary Report

There were 53 case patients, 83% of whom were male; the median age of the patients was 19 years. The majority of patients presented with respiratory symptoms (98%), gastrointestinal symptoms (81%), and constitutional symptoms (100%). All case patients had bilateral infiltrates on chest imaging (which was part of the case definition). A total of 94% of the patients were hospitalized, 32% underwent intubation and mechanical ventilation, and one death was reported. A total of 84% of the patients reported having used tetrahydrocannabinol products in e-cigarette devices,

DOI: 10.1056/NEJMoa1911614

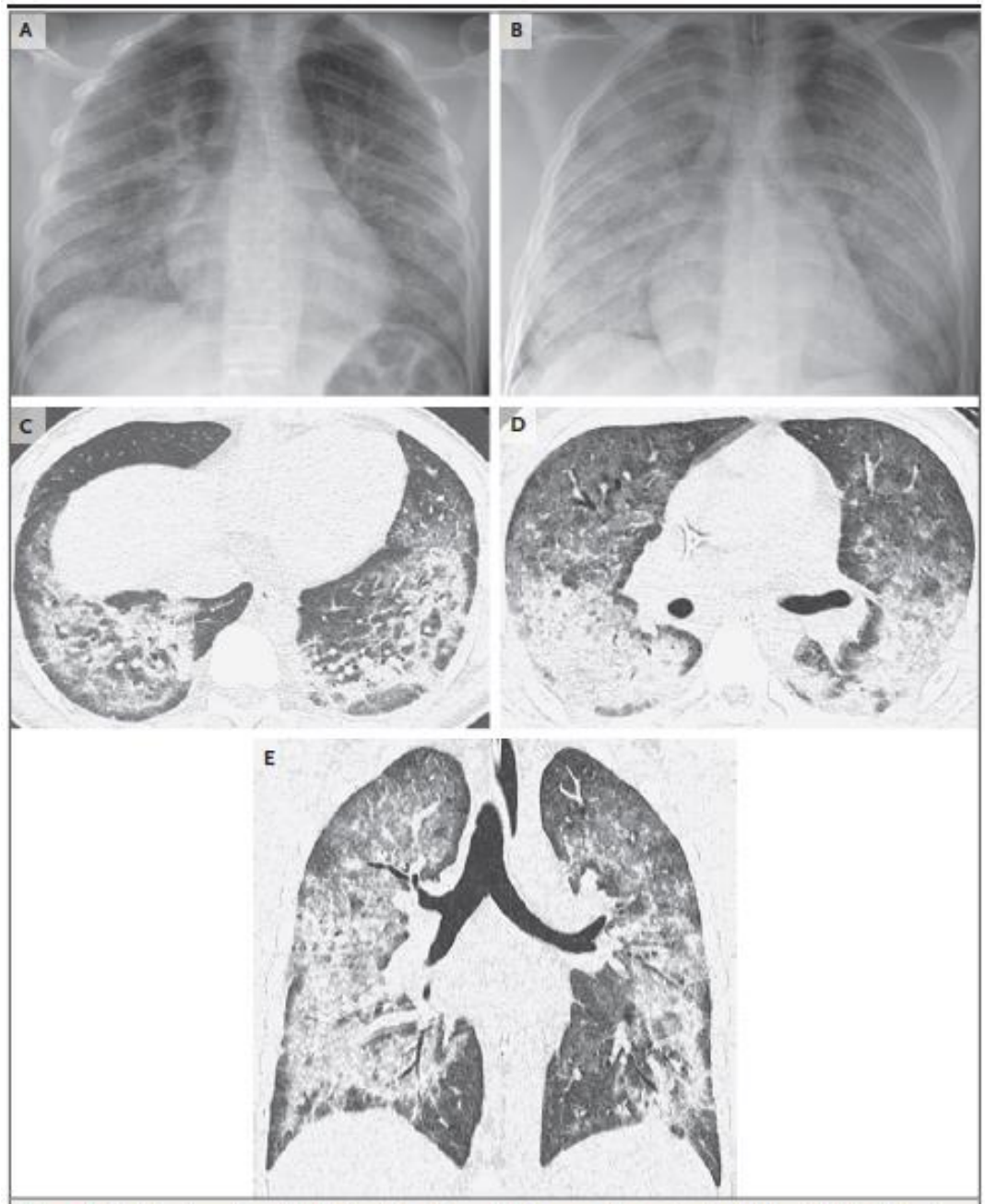


Figure 2. Chest Radiographs and High-Resolution Computed Tomographic Imaging in a 17-Year-Old Male Patient with Diffuse Lung Disease.

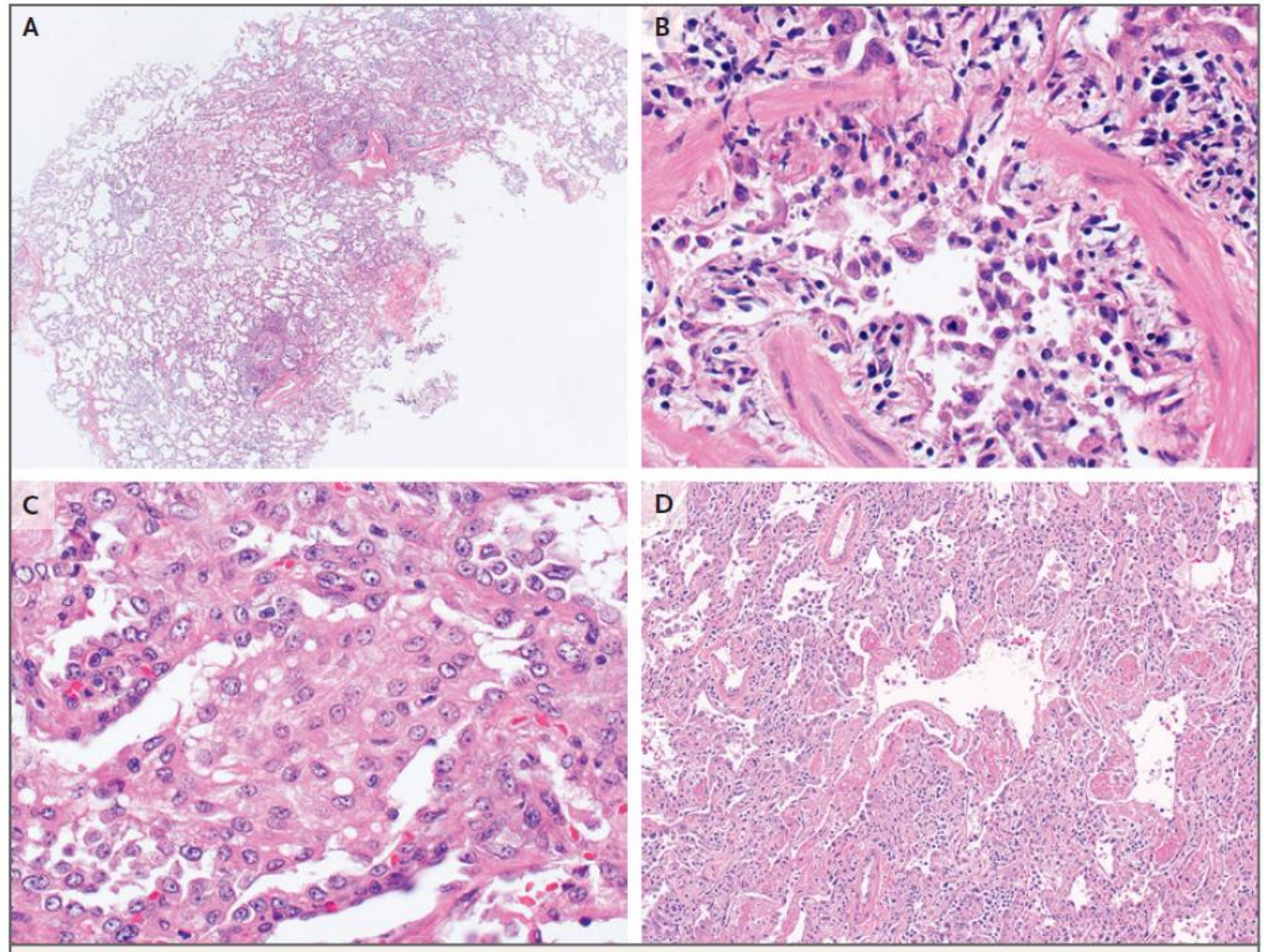


Figure 1. Histopathology of Acute Lung Injury Associated with Vaping.

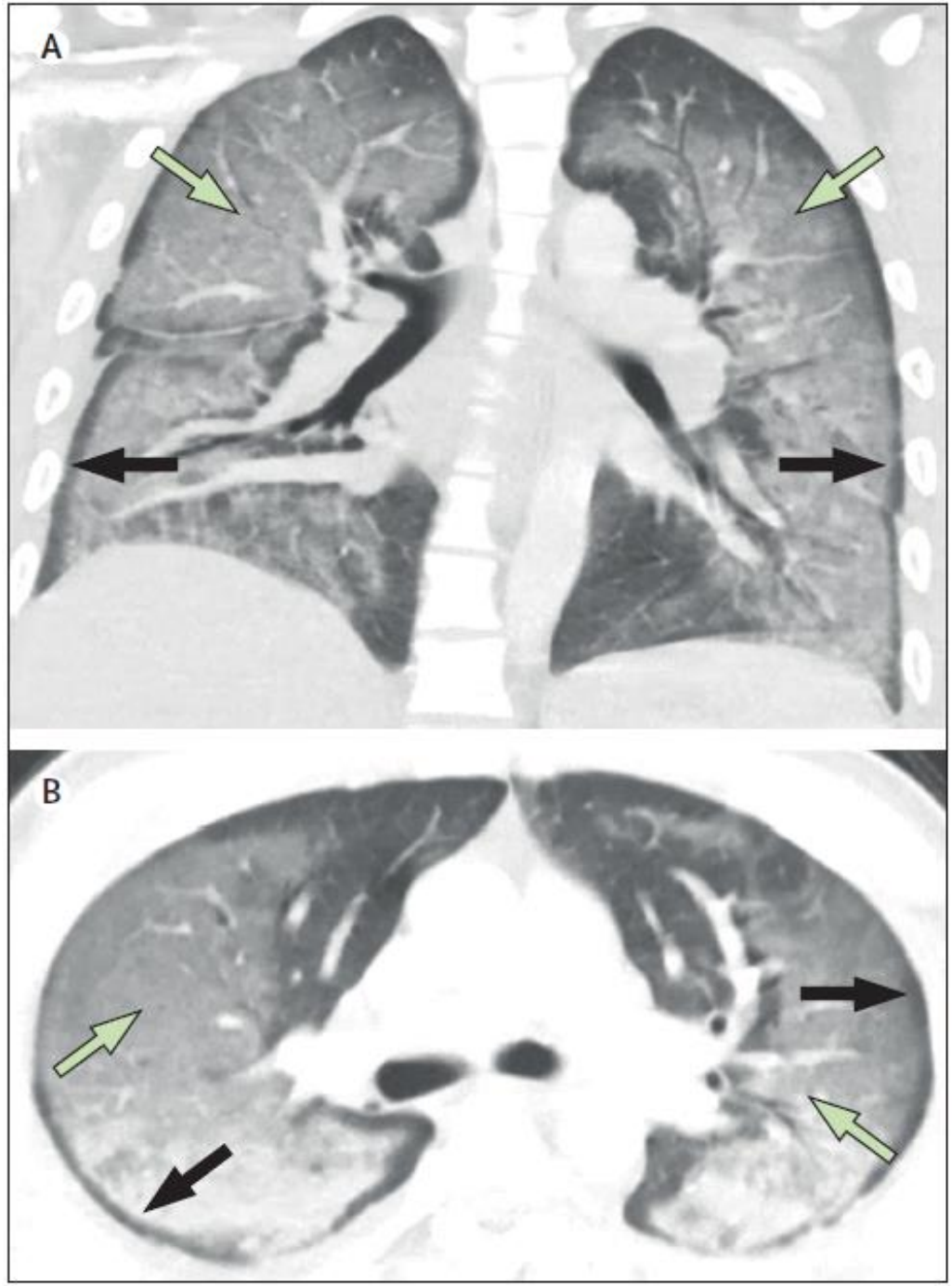
Most cases showed airway-centered acute lung injury (Panel A), often with severe bronchiolitis accompanied by marked mucosal edema, sloughing of bronchiolar epithelium, and peribronchiolar organization (Panel B). All cases showed accumulation of foamy or vacuolated macrophages in peribronchiolar airspaces with pneumocyte vacuolization (Panel C). Four cases showed severe injury, with diffuse alveolar damage and hyaline membranes (Panel D); two of these patients died.

E-cigarette, or vaping, product use associated lung injury (EVALI): case series and diagnostic approach

Findings We report 12 cases treated for suspected EVALI at our medical centre between June 6, 2019, and Sept 15, 2019. Ten (83%) patients had dyspnoea, fever, and emesis and nine (75%) had cough. 11 (92%) patients reported the use of e-cigarette cartridges containing tetrahydrocannabinol oil. Although eight (67%) patients required admission to the intensive care unit for hypoxaemic respiratory failure, no deaths occurred. The median hospitalisation duration was 7 days (IQR 7–8). All patients completing follow up (6 [50%]) had resolution of previous chest CT findings and normal spirometry.

Lancet Respir Med 2019

Published Online
November 8, 2019
https://doi.org/10.1016/
S2213-2600(19)30415-1


A
B

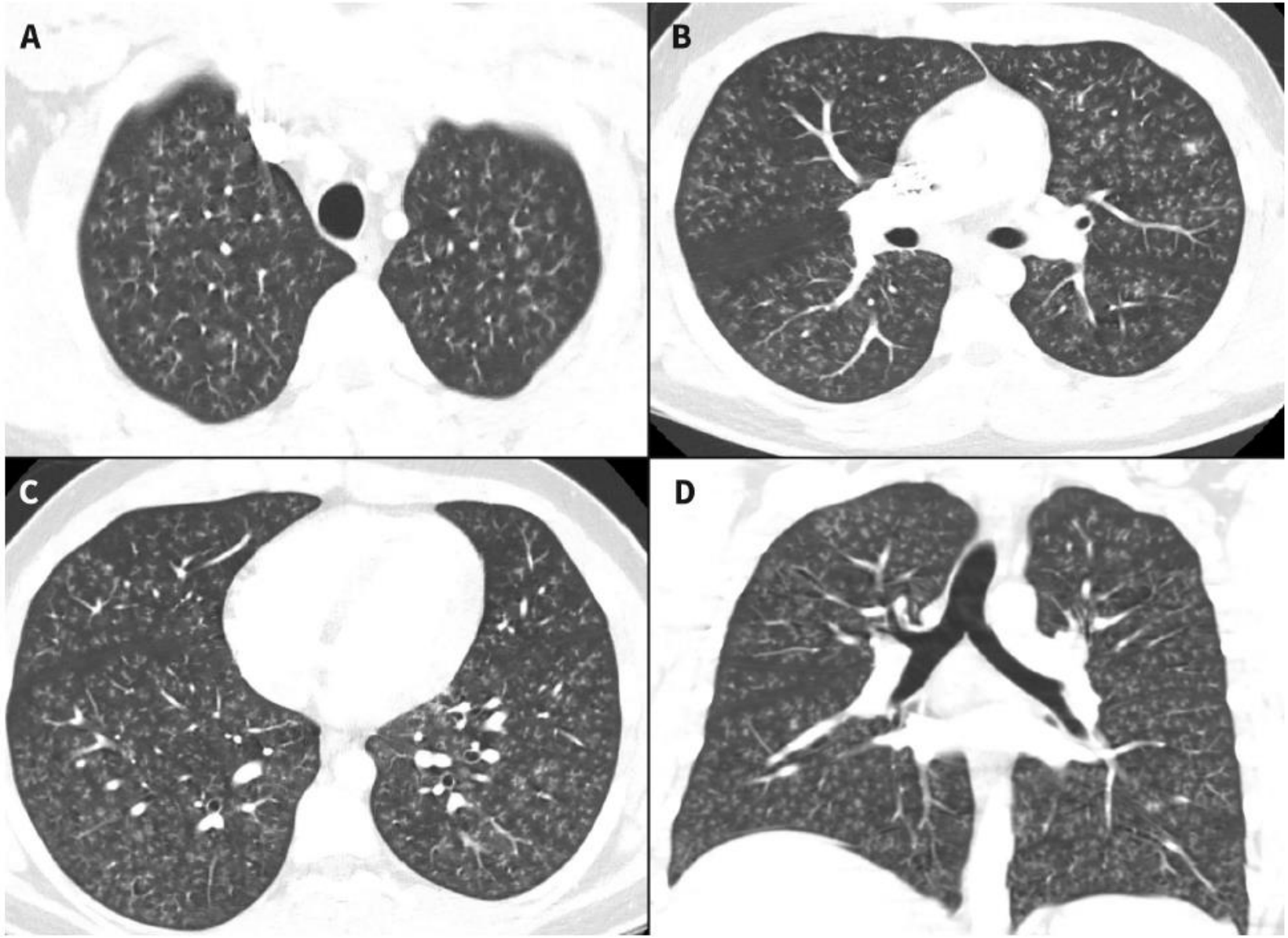


Figure 2: Computed tomography chest imaging on day 1 of hospital admission. Axial (panels A, B and C) and coronal (panel D) images show diffuse bronchiolitis manifested by innumerable tree-in-bud opacities throughout both lungs with subpleural sparing. Note the absence of mosaic attenuation, ground-glass opacity and consolidation.

Cite as: *CMAJ* 2019;191. doi: 10.1503/cmaj.191402; early-released November 21, 2019

TABLEAU 1 **Caractéristiques des produits du tabac «chauffé»**

BAT: British American Tobacco; JTI: Japan Tobacco International; PMI: Philipp Morris International .

	IQOS™	*glo™*	*Ploom™ Tech*
			
Fabricant	PMI	BAT	JTI
Nom du produit par le fabricant	*Tobacco heating system* (TSH 2.2)	*Tobacco heating product* (THP1.0)	*Novel tobacco vapor (NTV) system*
Marque des sticks ou capsules de tabac	*HEETS™*	*Kent Neostiks™*	Capsules de tabac *Winston™*
Température de chauffe	< 350 °C	< 250 °C	30 °C
Dispositif de chauffe	Une résistance sous forme de lame	Une chambre composée de deux zones distinctes incluant chacune une résistance	Une batterie qui chauffe un liquide de support. Le liquide vaporisé traverse une capsule de tabac granulé
Durée d'utilisation	20 secondes pour atteindre la température d'utilisation, puis 6 minutes	30-40 secondes pour atteindre la température d'utilisation, puis 3 minutes	Plusieurs utilisations avant de changer la capsule de tabac
Composition du tabac	Tabac reconstitué (feuilles moulées) à partir de poudre de tabac, d'eau, de glycérine, de gomme de guar, de fibres de cellulose, de propylène glycol, d'éthanol et d'arômes	Un mélange de tabac traité par un procédé de reconstitution. Celui-ci permet d'homogénéiser la composition chimique du matériau fini et d'incorporer une concentration élevée de glycérol	Tabac granulé

Rev Med Suisse 2018; 14: 1935-41

PLAN CANCER


C'EST POUR DISSUADER LES FUMEURS DE FUMER QU'ON A AUGMENTÉ LE PRIX DES CIGARETTES...


N'IMPORTE QUOI !


POUR DISSUADER LES FUMEURS D'AVOIR LE CANCER, C'EST LE PRIX DE LA CHIMIO QU'IL FALLAIT AUGMENTER !
CHARB.

Messages (1)

- tabagisme cause une mortalité/morbidité majeures
- nicotine induit une dépendance
- sevrage tabagique est une entreprise difficile
- soignants ont un devoir d’action
- compétences sont nécessaires pour s’investir

Messages (2)

- stratégies de sevrage efficaces (soutien/empathie)
- aide pharmacologique double le taux de succès
- vaporette (pour qui? pourquoi?); produits du tabac chauffé (données? déjà un succès commercial)
- mobilisation politique et mesures contraignantes sont complémentaires en terme de santé publique