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BPCO, tabagisme: attentes des patients et réponses des professionnels de santé

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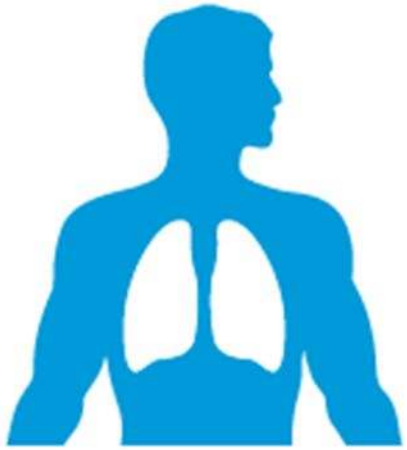
Remerciements : J. Perriot, M. Underner.

I – Tabagisme des patients atteints de BPCO :



85-90% des cas de BPCO sont dus au tabagisme*

15-20% des fumeurs développent une BPCO

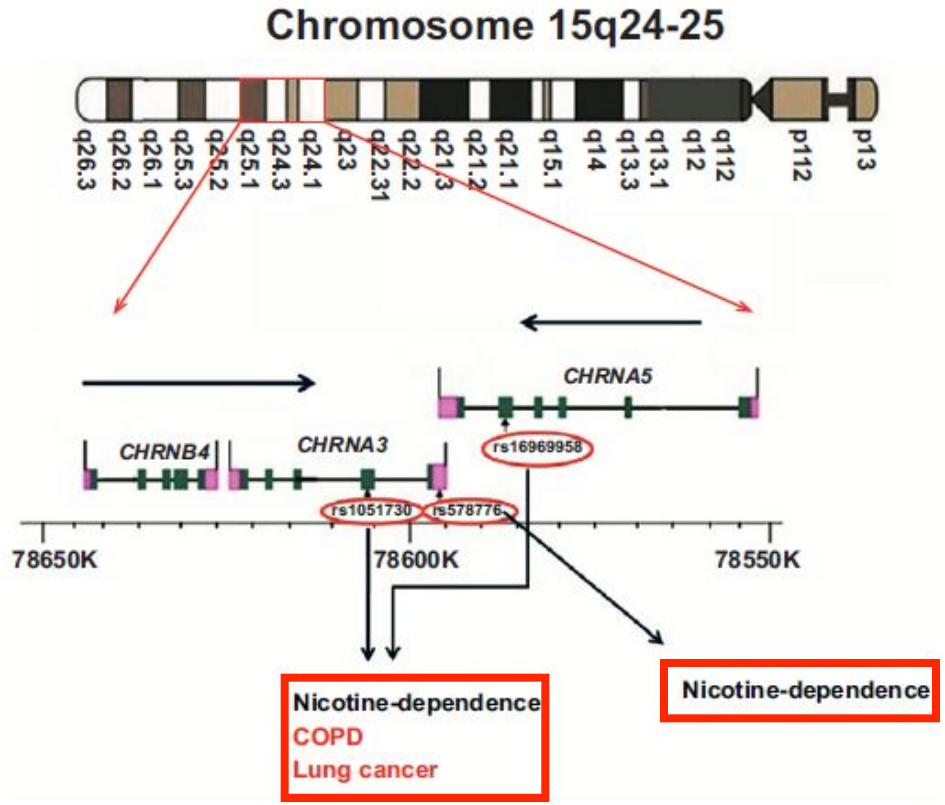
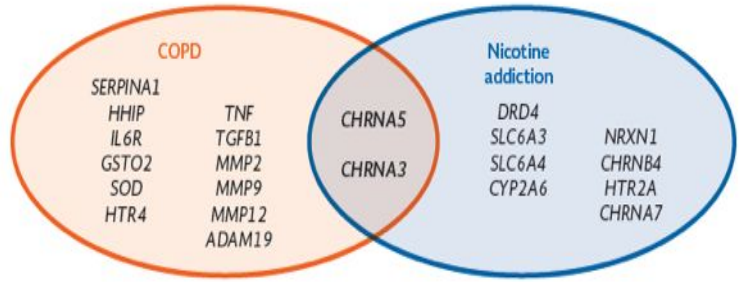


Figure 1. Main genes associated with chronic obstructive pulmonary disease and nicotine addiction, as well as those that have been associated in both pathologies.

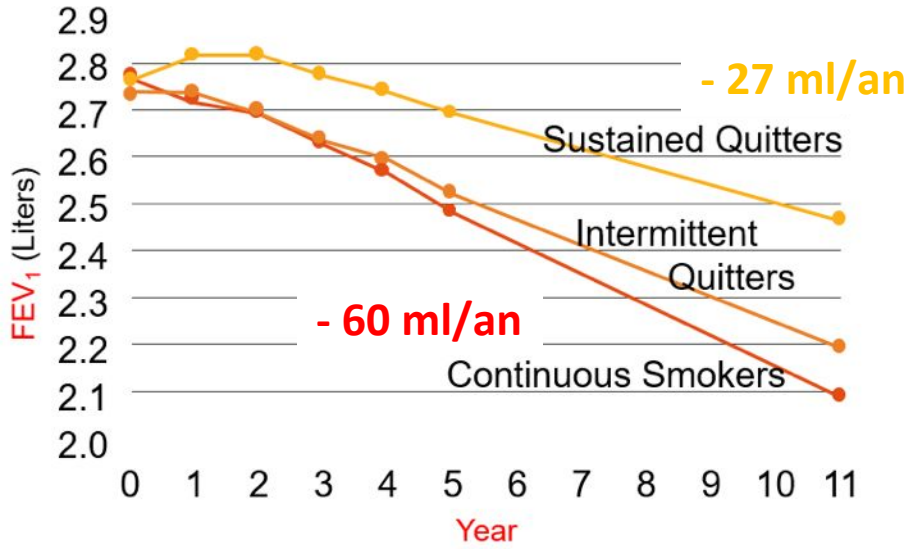


Jimenez-Ruiz CA et al Arch Bronchoneumol 2014: 49: 354-63.
Santoro A et al Recent Patents on Anti-Cancer Drug Discovery, 2019, 14, 39-52
Perez-Rubio G et al Rev Invest Clin 2019; 71: 36-54.

Portrait du patient atteint de BPCO et fumeur : « hard core smokers »

- Dépendance tabagique plus élevée :
  - Quantité de cig./ j plus importante
  - Inhalation de fumée plus profonde
  - Fagerström plus élevé
  - Taux de CO expiré plus haut
- 30 % de troubles anxio-dépressifs
- Co-dépendances : alcool, cannabis
- Déni, minimisation du risque à fumer
- Niveau de revenus et d'éducation inférieur à la moyenne
- Faible croyance d'un bénéfice au sevrage
- Limites de la spirométrie et de l'âge pulmonaire

- Bénéfices de l'arrêt :
  - Ralentit la décroissance du VEMS : (LHS)



  - Diminution de la fréquence des exacerbations de BPCO
  - Diminution de la mortalité par cancers et toutes causes (LHS), en particulier cardio-vasculaires

Perriot J et al Rev Pneumol Clin2018;74(3):170—80.
Anthonisen et al. Am J Respir Crit Care Med. 2002;166:675-679.

II- BPCO et tabac : attentes des patients

International Journal of COPD

Dovepress

ORIGINAL RESEARCH

Patient-perceived treatment burden of chronic obstructive pulmonary disease

Nathan Harb[1,2]
Juliet M Foster[1]
Claudia C Dobler[1–3]

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Background: While chronic morbidity and mortality from COPD is well documented, little is known about the treatment burden faced by patients with COPD.

Subjects and methods: Patients with severe airflow obstruction (forced expiratory volume in 1 second [FEV_1] <50% predicted) representing different age-groups, sex, and number of comorbidities participated in a semistructured interview. Interviews were conducted until thematic saturation was reached. Interviews were recorded, transcribed, and analyzed thematically using an established treatment-burden framework.

Results: A total of 26 patients (42% male, mean age 66.7±9.8 years) with severe (n=15) or very severe (n=11) airflow limitation (mean FEV_1 32.1%±9.65% predicted) were interviewed. Participants struggled with various treatment-burden domains, predominantly with changing health behaviors, such as smoking cessation and exercise. Interviewees often only ceased smoking after a major health event, despite being advised to do so earlier by a doctor. Recommended exercise regimens, such as pulmonary rehabilitation classes, were curtailed, although some patients replaced them with light home-based exercise. Interviewees had difficulty attending medical appointments, often relying on others to transport them. Overall, COPD patients indicated they were not willing to accept the burden of treatments where they perceived minimal benefit.

Conclusion: This study describes the substantial treatment burden experienced by patients with COPD. Medical advice may be rejected by patients if the benefit of following the advice is perceived as insufficient. Health professionals need to recognize treatment burden as a source of nonadherence, and should tailor treatment discussions to fit patients' values and capacity to achieve optimal patient outcomes.

Keywords: patient perspective, patient experience, treatment burden, burden, chronic obstructive pulmonary disease, COPD

Introduction

Treatment burden can be defined as the workload and impact of health care regimens on patient functioning and well-being, separate to that caused directly by disease.[1] For many chronic conditions, managing an illness requires an investment of a significant amount of time and effort from the patient, their family, or carers. This patient "workload" is often driven by a complex treatment regimen, which includes the need to navigate health services, interact with multiple health professionals, undergo tests, carry out treatment-taking, and change diet and exercise habits. In such instances, patients often lack the "capacity" to fulfill the requirements of maintaining these regimens, causing disruptions to the patients' daily functioning and overall well-being. Treatment burden is characterized by the workload of treatment outweighing the capacity of the patient to fulfill the requirements of treatment. In this regard, it is important to

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ORIGINAL ARTIC
SMOKING CESSATI

Recommendations to improve smoking cessation outcomes from people with lung conditions who smoke

Sarah Masefield[1], Pippa Powell[1], Carlos Jiménez-Ruiz[2], Peter Hajek[3], Keir Lewis[4], Stefan Andreas[5], Philip Tønnesen[6], Onno van Schayck[7], Christina Gratziou[8], Bertrand Dautzenberg[9], Serena Tonstad[10], Thomas Hering[11], Stephano Nardini[12] and Monica Fletcher[13]

Affiliations: [1]European Lung Foundation, Sheffield, UK. [2]Institute of Public Health, Smoking Cessation Cli... Madrid, Spain. [3]Wolfson Institute of Preventive Medicine, Queen Mary University of London, London, ... [4]Prince Philip Hospital and Swansea College of Medicine, Dept of Respiratory Medicine, Wales, UK. [5]Dept ... Cardiology and Pneumology, Lungenfachklinik Immenhausen, Immenhausen, Germany. [6]Gentofte Hosp... Pulmonary Medicine, Hellerup, Denmark. [7]Care and Public Health Research Institute (Caphri), Maastri... University, General Practice, Maastricht, The Netherlands. [8]Sotiria Hospital, Smoking Cessation Cent... Athens, Greece. [9]Groupe Hospitalier Pitie-Salpetriere, Pulmonology, Paris, France. [10]Department ... Preventive Cardiology, Ullevål University Hospital, Oslo, Norway. [11]Stellvertretender Vorsitzender d... Bundesverbandes der Pneumologen, Lungenarztpraxis Tegel, Berlin, Germany. [12]Ospedale Civile, Pulmon... and TB Unit, Vittorio Veneto, Italy. [13]Education for Health, Warwick, UK.

Correspondence: Sarah Masefield, European Lung Foundation, 6A2 Glossop Road, Sheffield, S10 2PX.
E-mail: Sarah.masefield@europeanlung.org

ABSTRACT This study aimed to gain insight into the impact of lung conditions on smoking behavio... and smoking cessation, and identify recommendations for smoking cessation and professional-pati... communications. The study was led by the European Lung Foundation in collaboration with the Europe... Respiratory Society Task Force on "Statement on smoking cessation in COPD and other pulmon... diseases and in smokers with comorbidities who find it difficult to quit".

A web-based observational cross-sectional questionnaire was developed from a patient-cente... literature review. Topics covered were cohort characteristics; perspectives on smoking cessati... interactions with healthcare professionals; and recommendations to improve cessation outcomes.

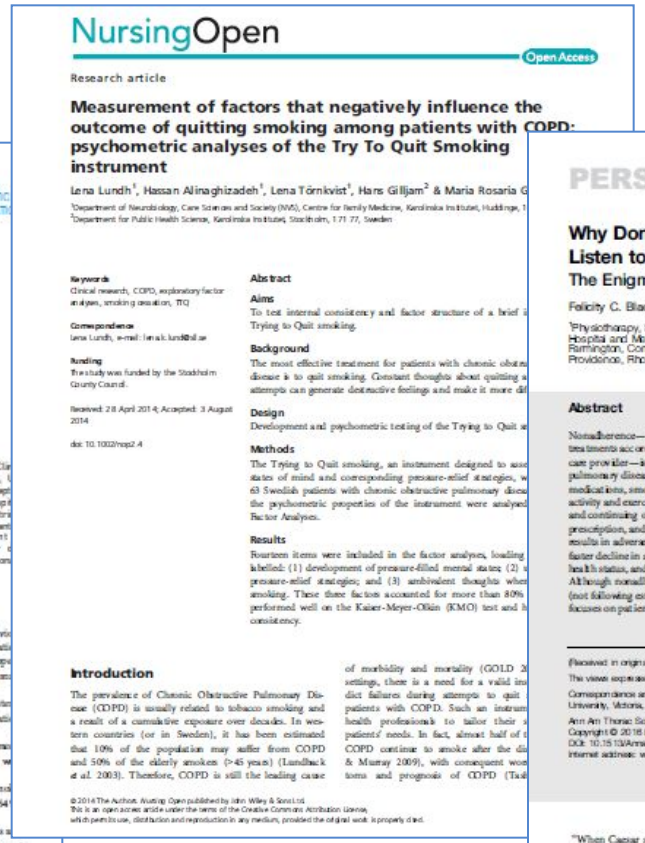
The questionnaire was disseminated via existing patient and professional networks and social me... channels. The survey was available online for a period of 4 months in 16 languages. The data w... analysed as a whole, not by country, with thematic analysis of the open responses.

Common characteristics were: male (54%); age 40–55 years (39%); 11–20 cigarettes a day (39%); smo... within 30 min of waking (61%); and has made 1–5 cessation attempts in the previous 12 months (54... 59% had tried cessation treatments, but, of these, 55% had not found any treatments helpful.

Recommendations were: earlier intervention; discussion of the patient's smoking beliefs, behaviours a... motivation; giving constructive advice; understanding addiction; informed decision-making and treatment... options. Areas for new and further research have been highlighted through exploring the smoking cessation perspectives and recommendations of people with lung conditions in Europe who smoke.

@ERSpublications
People across Europe with lung conditions and who smoke make recommendations to improve smoking cessation outcomes http://ow.ly/10w3GC

This article has supplementary material available from openres.ersjournals.com
Received: Jan 26 2016 | Accepted after revision: March 28 2016
Conflict of interest: M. Fletcher was European Lung Foundation chair at the time of the study. S. Masefield and P. Powell are employees of the European Lung Foundation. Further disclosure can be found alongside this article at openres.ersjournals.com



NursingOpen

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Research article

Measurement of factors that negatively influence the outcome of quitting smoking among patients with COPD: psychometric analyses of the Try To Quit Smoking instrument

Lena Lundh[1], Hassan Alinaghizadeh[1], Lena Törnkvist[1], Hans Gilljam[2] & Maria Rosaria G...

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Keywords
Clinical research, COPD, exploratory factor analyses, smoking cessation, TTQ

Funding
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Received: 28 April 2014; Accepted: 3 August 2014

doi: 10.1002/nop2.4

Abstract

Aims
To test internal consistency and factor structure of a brief ... Trying to Quit smoking.

Background
The most effective treatment for patients with chronic obstru... disease is to quit smoking. Constant thoughts about quitting a... attempts can generate destructive feelings and make it more dif...

Design
Development and psychometric testing of the Trying to Quit s...

Methods
The Trying to Quit smoking, an instrument designed to asse... states of mind and corresponding pressure-relief strategies, w... 63 Swedish patients with chronic obstructive pulmonary disea... the psychometric properties of the instrument were analysed... Factor Analyses.

Results
Fourteen items were included in the factor analyses, loading ... labelled: (1) development of pressure-filled mental states; (2) ... pressure-relief strategies; and (3) ambivalent thoughts when ... smoking. These three factors accounted for more than 80% ... performed well on the Kaiser-Meyer-Olkin (KMO) test and b... consistency.

Introduction

The prevalence of Chronic Obstructive Pulmonary Disease (COPD) is usually related to tobacco smoking and a result of a cumulative exposure over decades. In western countries (or in Sweden), it has been estimated that 10% of the population may suffer from COPD and 50% of the elderly smokers (>45 years) (Lundback *et al.* 2003). Therefore, COPD is still the leading cause of morbidity and mortality (GOLD 2... settings, there is a need for a valid ins... dict failures during attempts to quit ... patients with COPD. Such an instrum... health professionals to tailor their ... patients' needs. In fact, almost half of ... COPD continue to smoke after the di... & Murray 2009), with consequent wor... tions and prognosis of COPD (Tai...

PERSPECTIVES

Why Don't Our Patients with Chronic Obstructive Pulmonary Disease Listen to Us?

The Enigma of Nonadherence

Felicity C. Blackstock[1], Richard ZuWallack[2,3], Linda Nici[4], and Suzanne C. Lareau[5]

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Abstract

Nonadherence—not taking pharmacologic or nonpharmacologic treatments according to agreed recommendations from a health care provider—is common in patients with chronic obstructive pulmonary disease. Nonadherence in taking maintenance medications, smoking cessation, maintaining regular physical activity and exercise, starting and staying in pulmonary rehabilitation and continuing on with the postrehabilitation exercise/activity prescription, and successfully following self-management directions results in adverse outcomes across multiple areas. These include a faster decline in airway function, higher symptom burden, impaired health status, and increased health care use and mortality risk. Although nonadherence can also occur in health care providers (not following established treatment guidelines), this perspective focuses on patient nonadherence. Factors such as social/economic, health system, therapy-related, patient-related, and condition-related factors all impact this problem. To improve patient adherence, we need to consider these factors in the context of people with chronic obstructive pulmonary disease and implement strategies directly targeting underlying issues. Strategies may include customizing and simplifying learning and intervention regimes, identifying barriers to adherence and addressing them, ensuring patient support structures are in place, and improving self-efficacy. Future directions should focus on research and development in educational design; use of technology to assist education; psychological intervention strategies to support learning, motivation, self-efficacy and behavior change; and ways to improve healthcare providers' engagement with patients.

Keywords: chronic obstructive pulmonary disease; adherence; health behavior; education; self-management

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This views expressed in this article do not communicate an official position of the affiliated institutes of the authors.

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Internet address: www.atsjournals.org

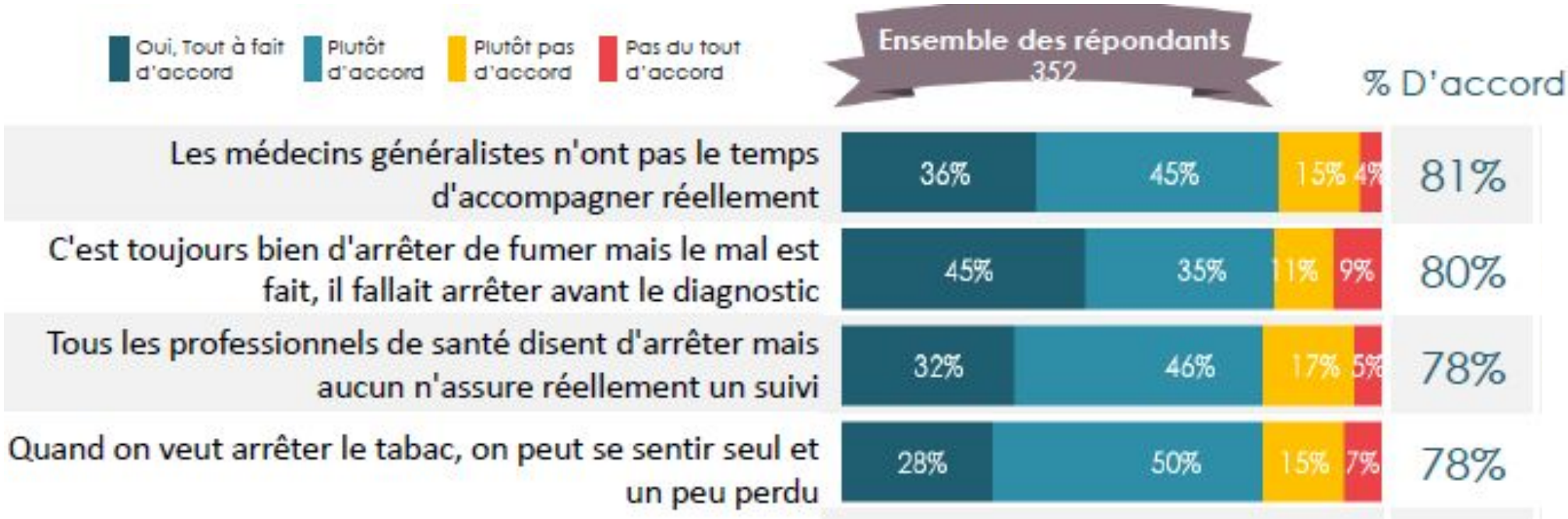
"When Caesar says 'do this,' it is perform'd." This line by Mark Antony in Shakespeare's play, Julius Caesar, sets the stage for our discussion of treatment adherence in individuals with chronic obstructive pulmonary disease (COPD). Too often, clinicians (like Caesar) naively assume patients uniformly follow their treatment recommendations to the letter, and their clinical responsibility ends there. This is a mistake: patients may not understand, may be unwilling, or may be unable to follow through with these recommendations due to physical, emotional, or cognitive barriers. We have to deal with the realities of medicine in the 21st century: "Drugs don't work in patients who don't take them" (former Surgeon General, C. Everett Koop). The title of this article, implying listening and then doing on the part of our patients, represents an oversimplified, didactic approach to improving adherence. In reality, the title better describes what not to do to have an appreciable, positive influence in our patients.

It is also important to acknowledge that nonadherence extends beyond the patient to health care professionals who may not follow clinical guidelines or make referrals for appropriate therapies. The problem of nonadherence transcends COPD, affecting successful treatment of all patient groups (1). Our goal in this document is to focus on patient nonadherence in COPD, emphasizing its complex and pervasive nature, present across all aspects of its management. We then briefly outline some general approaches to address this problem.

Enquête FFAIR (France en 2016) :

Fédération Française des Associations Amicales de malades, Insuffisant ou handicapés Respiratoires

- Echantillon de 352 personnes atteintes de maladies respiratoires
  - Mieux connaitre le parcours de soin face au tabac
  - Evaluer la qualité de la prise en charge pour le sevrage tabagique
- Accompagnement insuffisant des professionnels de santé /Tabagisme :



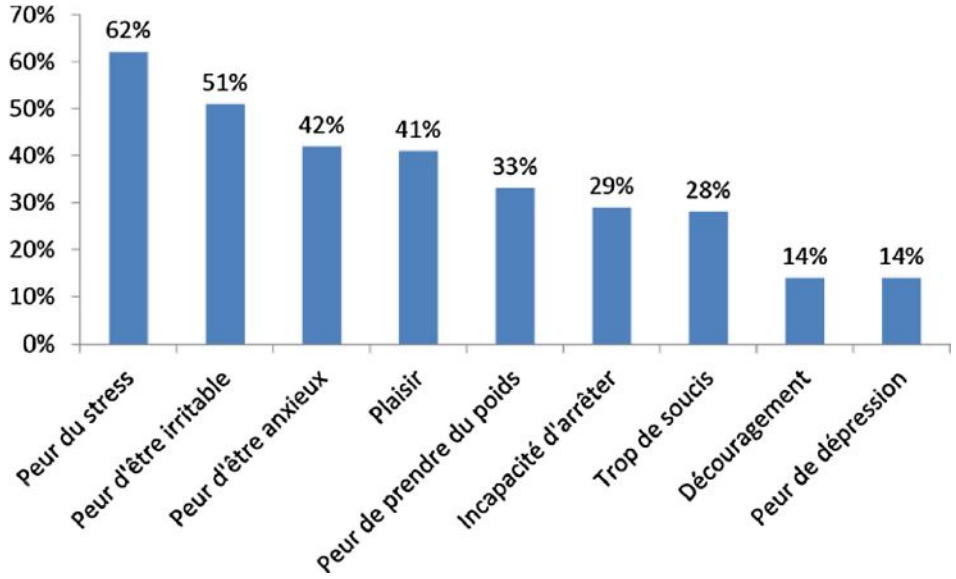
http://www.societe-francophone-de-tabacologie.org/dl/csft2016_S9_Belenko.pdf

Prise en charge souvent insuffisante :

- Trop d'incitations, d'injonctions à l'arrêt :
  - Sans réelle prise en charge*
  - Sans aides spécifiques
- Rôle délétère du tabac peu détaillé :
  - 59% : explications partielles
  - 15% : aucune allusion au tabac !
- Arrêts antérieurs :
  - Intense syndrome de sevrage
  - Craving persistant
  - Stress : pour 1 fumeur sur 2 : tabac important
  - Prise de poids

ELF EUROPEAN LUNG FOUNDATION

- Mêmes peurs de l'arrêt que pour la population générale :



The French Observational Cohort of Usual Smokers (FOCUS) cohort: French smokers perceptions and attitudes towards smoking cessation

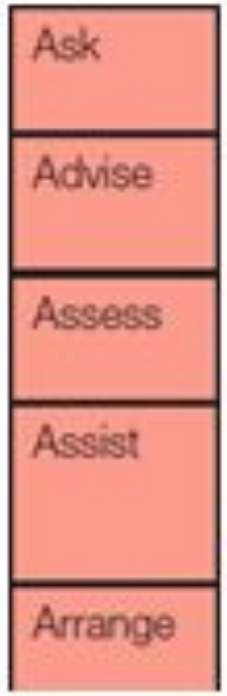
Henri-Jean Aubin[1*], Gérard Peiffer[2], Anne Stoebner-Delbarre[3], Eric Vicaut[4], Yasmine Jeanpetit[5], Anne Solesse[5], Geneviève Bonnelye[6], Daniel Thomas[7]

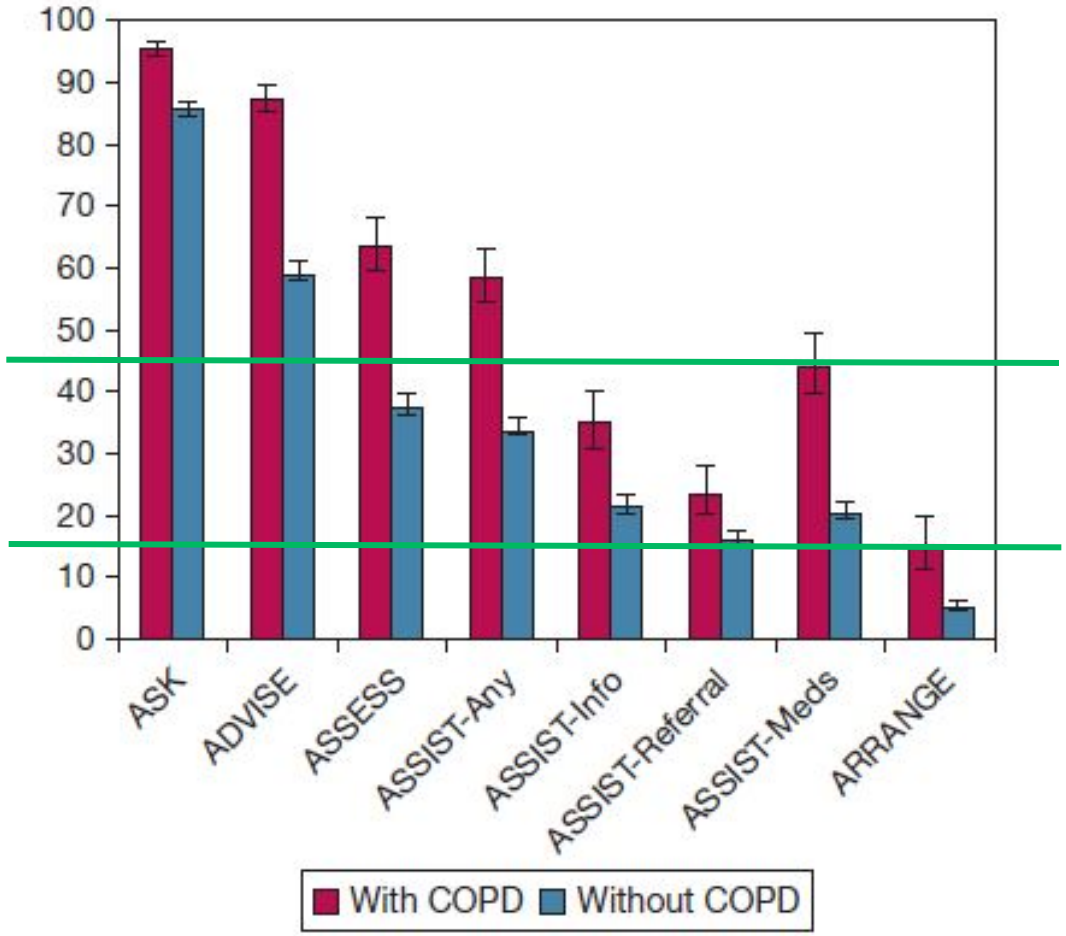
BMC Public Health 2010, **10**:100

USA : prise en charge des patients BPCO *versus* non-BPCO :

Les 5 A : BPCO , Non-BPCO

2009-2010 National Adult Tobacco Survey





Health-care Provider Screening and Advice for Smoking Cessation Among Smokers With and Without COPD

Gillian L. Schauer, PhD; Anne G. Wheaton, PhD; Ann M. Malarcher, PhD; and Janet B. Croft, PhD

CHEST 2016; 149(3):676-684

BPCO : 2339

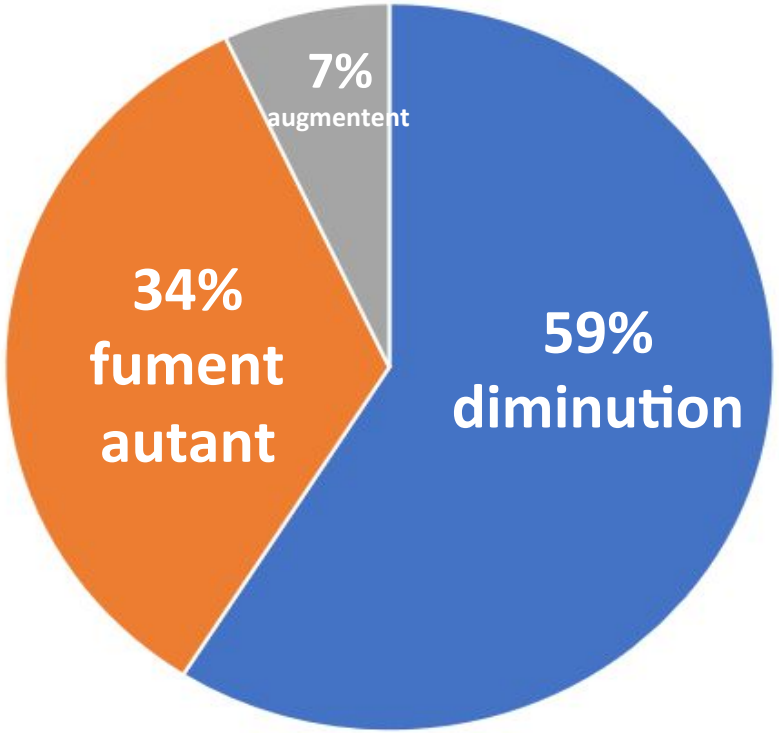
Non-BPCO : 17682

Autres manques signalés par les patients :

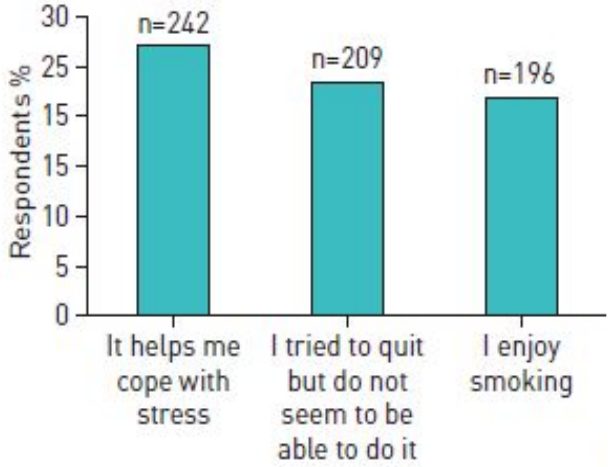
- Temps de consultation insuffisant
  problème tabac / autres addictions
- Motivations d'arrêt : peu renforcées
- Implication insuffisante dans le choix des traitements : (ELF)
  - 1 fumeur sur 3 : essai de TSN
  - 1 fumeur sur 5 : essai e-cigarette
- Réduction du tabagisme peu abordée
- Aides comportementales mal connues (TCC)
- Médecines alternatives souhaitées
  hypnose, acupuncture

Le diagnostic de maladie pulmonaire impacte-t-il sur la consommation de tabac ?

- Enquête ELF N=514 dans 26 pays
- Impact du diagnostic de BPCO sur le tabagisme :



- Raisons de poursuite du tabac : trois principales raisons



- Tentatives d'arrêt :
  - 54 % de 1 à 5 tentatives
  - 4 % plus de 20 tentatives
- Arrêt ou réduction :

  55 % souhaitent un arrêt complet

  45 % préfèrent réduire progressivement

Masefield S et al. ERJ Open Res 2016;2(2) [pii: 00009-2016.

III- BPCO et tabac : réponses des professionnels de santé

le sevrage tabagique des patients BPCO bien codifié

Statement on smoking cessation in COPD and other pulmonary diseases and in smokers with comorbidities who find it difficult to quit

Carlos A. Jiménez-Ruiz[1], Stefan Andreas[2], Keir E. Lewis[3], Philip Tonnesen[4], C.P. van Schayck[5], Peter Hajek[6], Serena Tonstad[7], Bertrand Dautzenberg[8], Monica Fletcher[9], Sarah Masefield[10], Pippa Powell[10], Thomas Hering[11], Stefano Nardini[12], Thomy Tonia[13] and Christina Gratziou[14]

Eur Respir J. 2015; 46(1):61-79

Respiratory Medicine (2009) 103, 963–974

available at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/rmed

ELSEVIER

REVIEW

Smoking cessation in chronic obstructive pulmonary disease

Donald P. Tashkin [a,*], Robert P. Murray [b]

Cochrane Library

Cochrane Database of Systematic Reviews

Cochrane Database of Systematic Reviews 2016, Issue 8. Art. No.: CD010744.

Smoking cessation for people with chronic obstructive pulmonary disease (Review)

van Eerd EAM, van der Meer RM, van Schayck OCP, Kotz D

REVUE GÉNÉRALE

Sevrage tabagique du fumeur atteint de bronchopneumopathie chronique

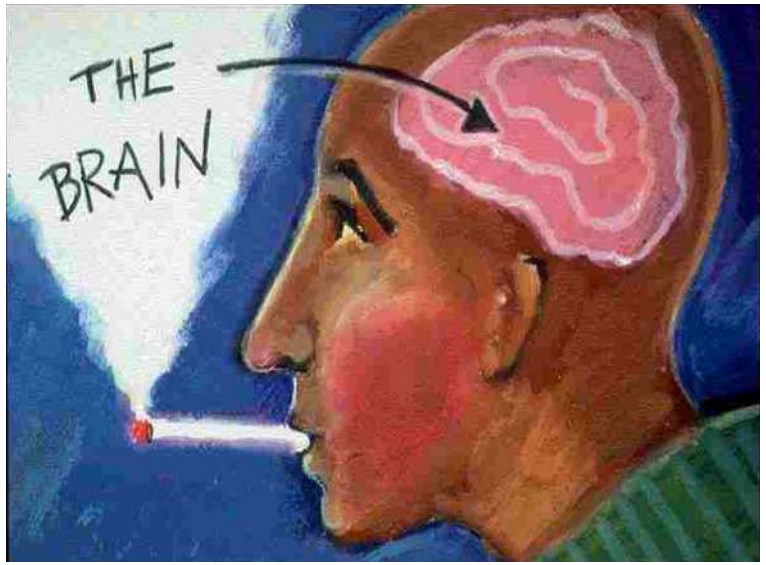
CrossMark

M. Underner [a,*], J. Perriot [b], G. Peiffer [c]

Revue des Maladies Respiratoires (2014) 31, 937–960

La BPCO trie les fumeurs résistants au sevrage !

- Tabagisme : « Maladie chronique récidivante »
- **Dépendance tabagique : changer le paradigme** B. Dautzenberg
  Revue de Pneumologie clinique (2018) 74, 121–123
- Si BPCO présente : patients ont été sélectionnés = incapacité à arrêter de fumer !
- Symptômes débutants & arrêt possible
  ➔ avant la BPCO !



Faire un « bilan tabac » complet :

- Evaluer la dépendance au tabac
- Rechercher la présence de troubles anxio-dépressifs (TAD)
- Rechercher un usage associé de SPA : alcool, cannabis, cocaïne, etc…
- Evaluer l'état nutritionnel (poids)
- Rechercher une précarité socio-économique

Perriot J et al Rev Pneumol Clin 2018; 74: 170-180.

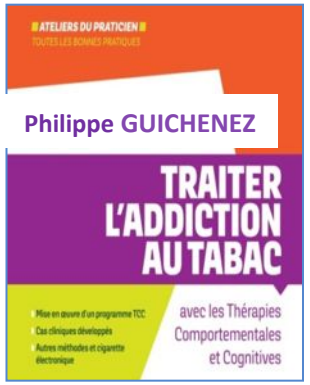
Aides thérapeutiques proposées :

- Entretiens motivationnels (Dansou)
- Développer la « self-efficacy » : (Martinez)
- Perspectives temporelles (Merson)

- Associer les traitements validés et la prise en charge psychologique
  - TSN efficaces (LHS)
  - Bupropion efficace (Tashkin 2001)
  - Varenicline efficace (Tashkin 2011)

Dansou A https://www.youtube.com/watch?v=dYSXq8LoOnQ
Martinez E et al. Addict Behav 2010;35:175-8.
Merson F, Perriot J Sante Publique2011;23:359-70.
Tashkin DP et al Lancet. 2001 May 19;357(9268):1571-5.
Tashkin DP et al Chest 2011;139:591-9.

- TCC (Guichenez)



- BPCO : 12 séances PEC psychologique améliorent le sevrage *NS* (Yap)
- Observance des traitements (Ma)
  Patchs : durée quotidienne de pose longue = meilleur taux d'abstinence
- Sevrage tabagique : les stratégies pharmacologiques différentes des traitements standards
  M. Underner[a,*], J. Perriot[b], G. Peiffer[c], G. Harika-Germaneau[a], N. Jaafari[a]
  Revue de Pneumologie clinique (2018) 74, 205–214

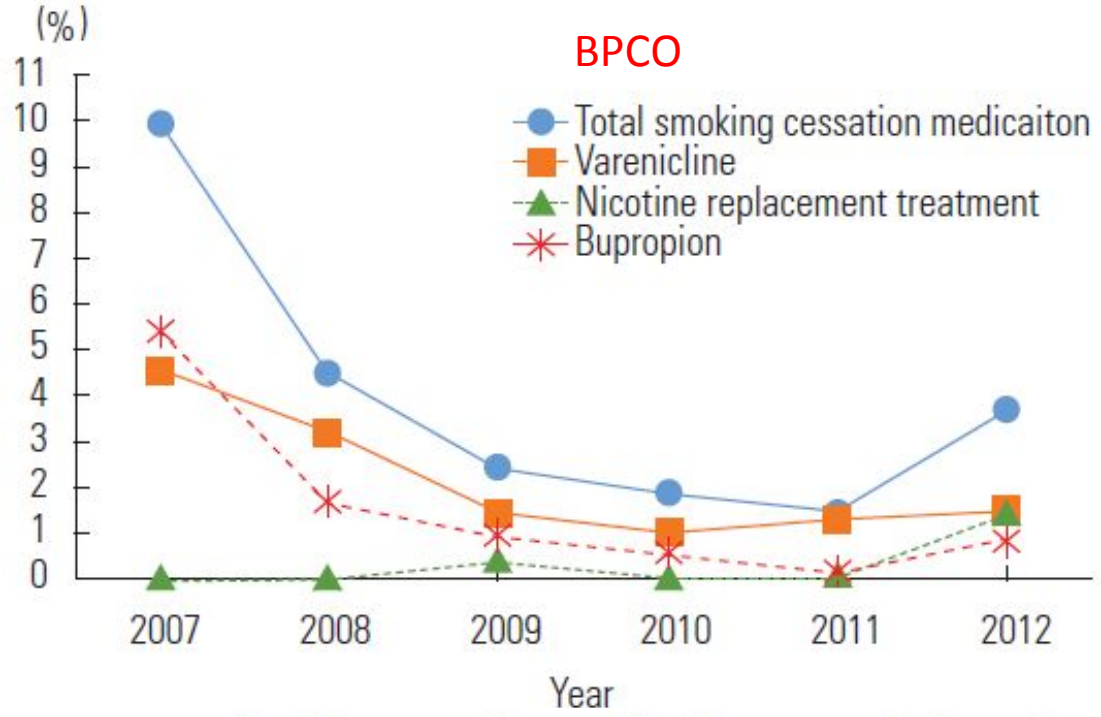
Guichenez P Traiter l'addiction au tabac avec les TCC. Dunod.
Yap SY et al Chron Respir Dis 2015;12:230-7.
Ma P et al Drug Alcohol Depend 2016;169:64—7.

Insuffisances de prescription des aides :

- Taux de prescription dans le ST chez les patients BPCO :
  - USA : 8,8 % (Vaidya)
  - USA : 16.9 % (Melzer)

- Danemark N = 4700 **BPCO** 2008-2012 :
  après la 1ère consultation, au cours des 6 mois, seulement 5% des patients achètent bupropion ou varenicline (non remboursé) ! (Tottenborg)

- National Trends in Smoking Cessation Medication Prescriptions for Smokers With Chronic Obstructive Pulmonary Disease in the United States, 2007-2012 (Kwak)



Smoking cessation medications prescription rate among smokers with chronic obstructive pulmonary disease.

Vaidya V et al Curr Med Res Opin. 2014 Jun;30(6):1043-50.
Melzer AC et al J Gen Intern Med. 2016 Jun;31(6):623-9.
Tottenborg SS et al Int J Chron Obstruct Pulmon Dis. 2018 ;13:1775-1781.

Kwak MJ et al J Prev Med Public Health 2018; 51(5): 257-262.

Mieux impliquer le patient dans le choix des traitements :

- Outil d'aide à la décision pour choix du médicament du sevrage
- Quantité restreinte d'informations sous forme de tableau
  ➔ comparaisons rapides entre les options à disposition.

Policlinique Médicale Universitaire CH-Lausanne

ARRÊT TABAC : CHOIX D'UN MÉDICAMENT QUI VOUS CONVIENT

Vivre sans TABAC

	MÉDICAMENT	DOSAGE QUOTIDIEN	PRIX PAR BOÎTE	PRIX PAR JOUR	EFFICACITÉ	EFFETS SECONDAIRES PRINCIPAUX
	**GOMMES À MÂCHER** Nicotinell/Nicorette ®	8-12x/j selon besoin	30 gommes de 2 mg **~ 20 CHF**	~ 5 CHF/j	++	Irritation bouche et gorge, Hoquet Nausées
	INHALATEUR Nicorette®	6-12x/j selon besoin	18 cartouches de 10 mg **~ 27 CHF**	~ 9 CHF/j	++	
	COMPRIMÉS Nicotinell/Nicorette ®	8-12x/j selon besoin	36 comprimés de 2 mg **~ 25 CHF**	~ 6 CHF/j	++	
	SPRAY BUCCAL Nicorette ®	12-25x/j selon besoin	150 pulvérisations **~ 60 CHF**	~ 6 CHF/j	++	
	**PATCH** Nicotinell/Nicorette ®	1x/jour sur 16h ou 24h	14 patches de 15 mg **~ 90 CHF**	~ 7 CHF/j	++	Irritation de la peau
	**COMBINAISON PATCH ET AUTRE SUBSTITUT NICOTINIQUE**	Patch 1x/j + autre substitut selon besoin	14 patches et 1 boîte de substitut de courte durée **~ 120 CHF**	~ 11 CHF/j	+++	Irritation peau, bouche et gorge, hoquet et nausées
	**VARÉNICLINE** Champix ®	2x/jour	56 comprimés de 1 mg **~ 120 CHF** peut être pris en charge par l'assurance de base sous certaines conditions	~ 4 CHF/j	+++	Nausées, sommeil perturbé, changement d'humeur
	**BUPROPION** Zyban ®	2x/jour	30 comprimés de 150 mg **~ 60 CHF** peut être pris en charge par l'assurance de base sous certaines conditions	~ 4 CHF/j	++	Sommeil perturbé, bouche sèche, maux de tête, changement d'humeur, troubles digestifs

Policlinique Médicale Universitaire de Lausanne, version du 08.06.2016

Source: Cornuz J., Jacot Sadowski, Humair J.-P., Conseil médical aux fumeurs et fumeuses, 3e édition, vivre sans tabac, 2015

SAM | CHUV | 19936

Jakob J, Cornuz J, Auer R, Jacot-Sadowski I, Cardinaux R,Selby K. Rev Med Suisse2017;13:1191-4.

A plus long terme : nécessité d'un suivi prolongé 6-12 mois

- Travail sur l'acceptation de la BPCO & de la « maladie tabagique » : (Grassion)

	Groupe 1 Acceptation de la pathologie	Groupe 2 Rejet de la pathologie	*p*
n	257	99	–
Sexe (% Homme)	53	37	< 0,001
Âge	65 (57–73)	68 (61–75)	0,016
Tabagisme actif	10 (6–14)	25 (16–34)	<0,001

- Suivre le craving : *French Tobacco Craving Questionnaire* (Berlin)
- Associer l'activité physique : (Underner, Bernard)
  - Pas une aide à l'arrêt*, mais diminue l'intensité du syndrome de sevrage
  - Limite les affects négatifs, le stress et l'irritabilité.
  - Moyen de contrôle du craving à court terme

Grassion L et al Rev Mal Respir. 2019 Apr;36(4):461-467
Berlin I et al Eur Addict Res 2005;11:62-8.
Underner M et al Rev Mal Respir 2016;33(6):431-43.
Bernard P. Bénéfices de l'activité physique dans le cadre du sevrage tabagique. Courrier Addict 2014;16:14—5

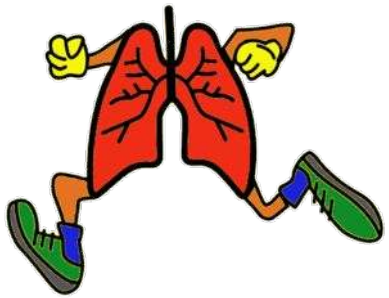
Spécificités du sevrage chez les patients BPCO :

- ETP : atelier « nicotinophobie » (Galera) fumeurs en rééducation CV ou Resp.
  - Taux de sevrage à 1 mois amélioré* 81 *vs* 48 % pour témoins
  - Avec diminution* des scores d'anxiété-dépression

Tableau 3 Évolution des scores d'Anxiété-Dépression[a].

	Anxiété/dépression Initiale	Anxiété/dépression À 1 mois	*p value*
Groupe intervention	A : 10,2 D : 6,3	A : 5,3 D : 4,1	< 0,0001 0,003
Groupe témoin	A : 8,0 D : 5,8	A : 8,1 D : 5,8	0,99 1

- Rééducation resp. avec ST : abstinence continue OR 4.34, p < 0.001 (Paone)



- Sevrage en hospitalisation et post-hospitalisation :
  - **Melzer :** ST dans les 90 jours après la sortie de BPCO hospitalisés (exacerbation) :
    - TSN, varenicline
    - A 6-12 mois : abstinents sous patch 18,6 % et sous varenicline 30,6 %.
  - **Sundblad :** hospitalisation de 2 semaines, en cours d'un réentraînement à l'effort :
    - Groupe ST (TSN, rappels téléphoniques réhospitalisation courte) /groupe témoin
    - Abstinence à 1 an : 52 % *versus* 7 %
    - Abstinence à 3 ans : 38 % *versus* 10 %.
  - **Efficacité ? coût-efficacité ?**

Galera O et al Rev Pneumol Clin 2018; 74: 221-225.
Paone G et al J Rehabil Med 2008;40(8):672–677
Melzer AC et al Ann Am Thorac Soc 2018;15:341-7.
Sundblad BM et al Nicotine Tob Res 2008;10:883-90

BPCO : coach, lignes téléphoniques, télémédecine, mindfullness :

- Désignation d'un « soutien » : augmente l'abstinence; à 1 an :
  si soutien fumeur : 33% abstinents; si soutien ex-fumeur : 73.5% abstinents (Murray)
- BPCO plus sensibles au suivi téléphonique *versus* non-BPCO (Melzer)
- Télémédecine BPCO : plus jeunes, plus souvent si hommes,
  si niveau socio-éducatif plus élevé. (Witry)
- Mindfullness : N= 50 BPCO, après exacerbation (Perkins-Porras)
  - N= 24 séance de mindfullness
  - N= 26 contrôles
  - Tendance +; mais **NS**

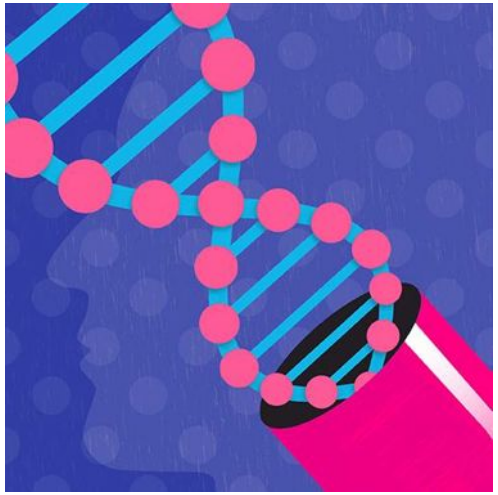
Murray RP et al Addict Behav 1995; 20: 159
Melzer AC et al Ann Am Thorac Soc. 2018 Mar;15(3):341-347.
Witry M et al J Med Internet Res. 2018 Apr 2;20(4):e125.
Perkins-Porras L et al Chron Respir Dis. 2018:1479972318766140.

Pistes à développer pour le ST des patients BPCO (1) :

- Renforcer la motivation, en pratiquant l'entretien motivationnel, « self-efficacy »
- Compréhension personnalisée de l'addiction tabagique
- « Teachable moment » :
  - Au diagnostic de la BPCO
  - Au moment de la réhabilitation respiratoire
- Développer les sevrages en groupe
- Pharmacogénomique ? des traitements du sevrage tabagique : TSN, varenicline
- Reprises du tabagisme

AFDEM

L'Association Francophone de Diffusion de l'Entretien Motivationnel



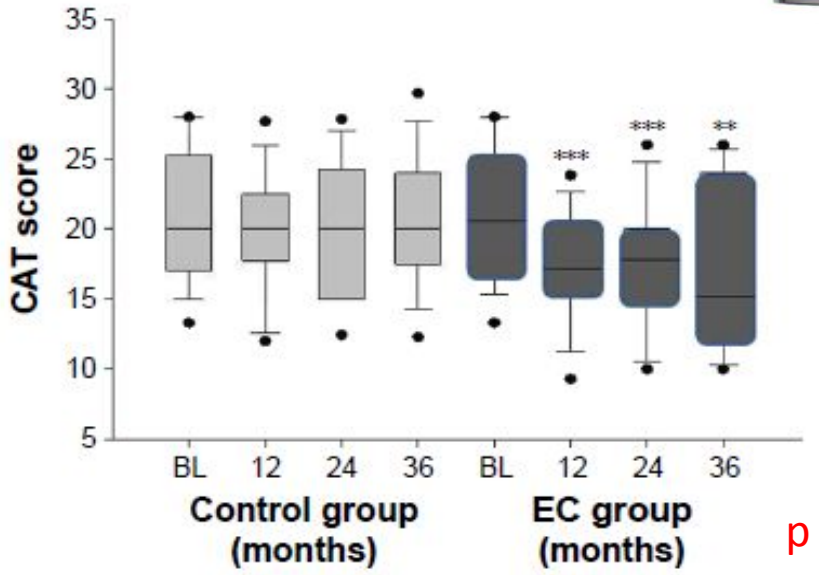
Pistes à développer pour le ST des patients BPCO (2) :

- Réduction des risques : **rôle de l'e-cigarette ?**
  - **Etude Polosa BPCO 48 BPCO**
    24 avec vapoteuse *vs* 24 suivi pendant 3 ans

    Réduction* des exacerbations à 1 et 2 ans, chez les vapoteurs - même chez les vapo-fumeurs.

    Réduction des symptômes avec ↘ score CAT. Limites
  - **Etude Bozier** [ERJ Open Res 2019; 5: 00192-2018.]

    Plus d'inflammation avec la e-cig. que chez les non-BPCO ?



p <0.01

Figure 4 Changes in the CAT scores from baseline, at follow-up visit 1 (12±1.5 months), visit 2 (24±2.5 months), and visit 3 (36±3 months) separately for COPD EC users (dark gray boxes) and COPD controls (light gray boxes).

- Prévention globale et individuelle du tabagisme

Health effects in COPD smokers who switch to electronic cigarettes: a retrospective-prospective 3-year follow-up

Riccardo Polosa[1–3,*]

International Journal of COPD 2018:13 2533–2542

Conclusions :

- Le malade n'est pas un mauvais patient !
  - Victime d'une dépendance
  - Hyponicotinémie
- Tout faire pour que le sevrage tabagique : 1er traitement de la BPCO :
  - Arrêt confortable : apport suffisant de nicotine (associer les formes de TSN) ou autres aides + soutien psychologique
  - "Aggressive smoking cessation is recommended" (ERS)
- On doit sans cesse s'améliorer : c'est pas facile, mais c'est notre rôle !

Lettre de Napoléon à son médecin Jean-Nicolas Corvisart

«Ne vous livrez pas à des idées mélancoliques ; **j'espère que vous vivrez encore pour rendre des services »**

Quelques références : BPCO et tabagisme

- Tashkin DP, Murray RP Smoking cessation in chronic obstructive pulmonary disease. Respir Med. 2009 Jul;103(7): 963-74. doi: 10.1016/j.rmed.2009.02.013. Epub 2009 Mar 14.
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- Underner M, Perriot J, Peiffer G,et al Rev Pneumol Clin. 2018 Sep;74(4):205-214. doi: 10.1016/j.pneumo. 2018.04.008.
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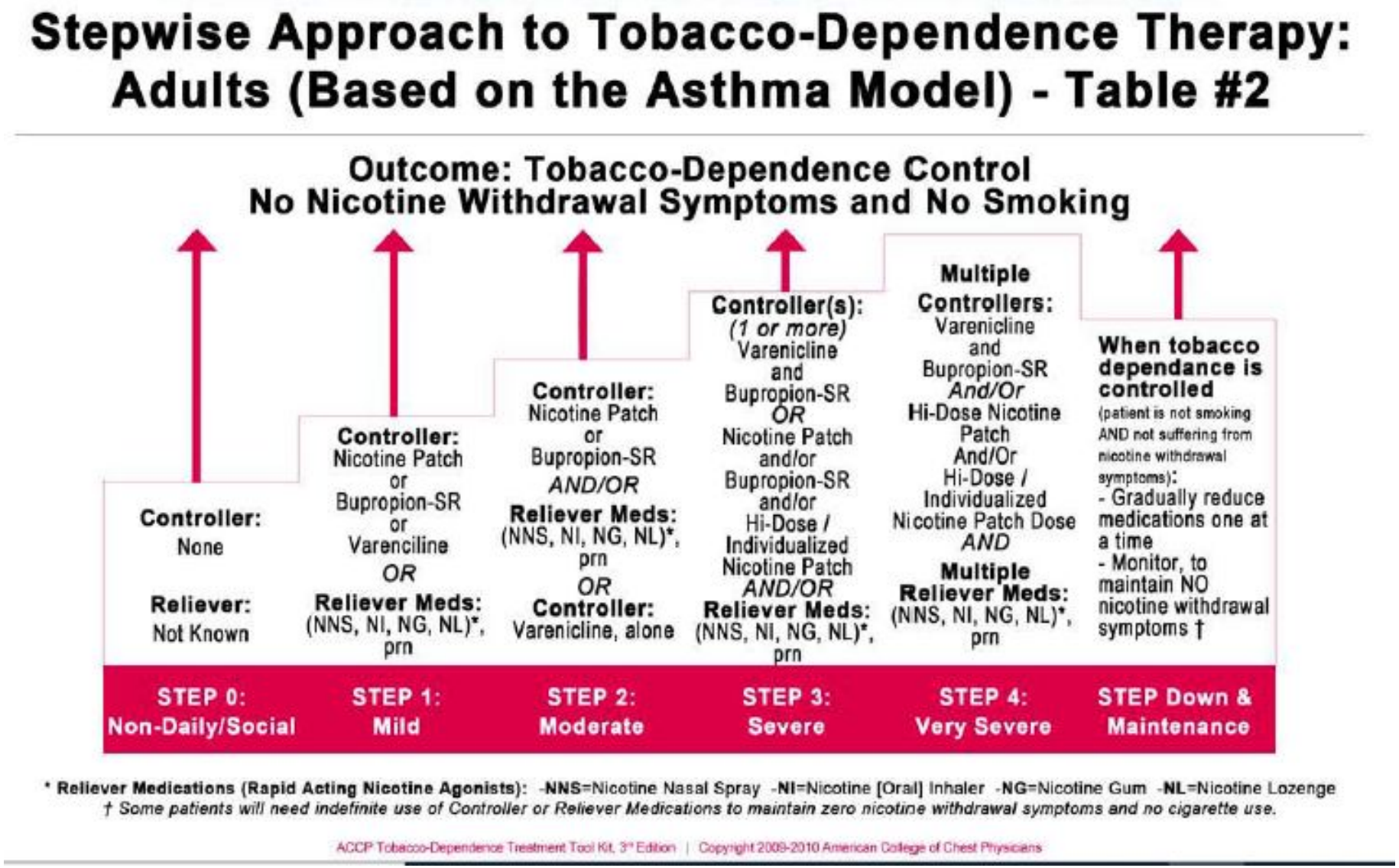
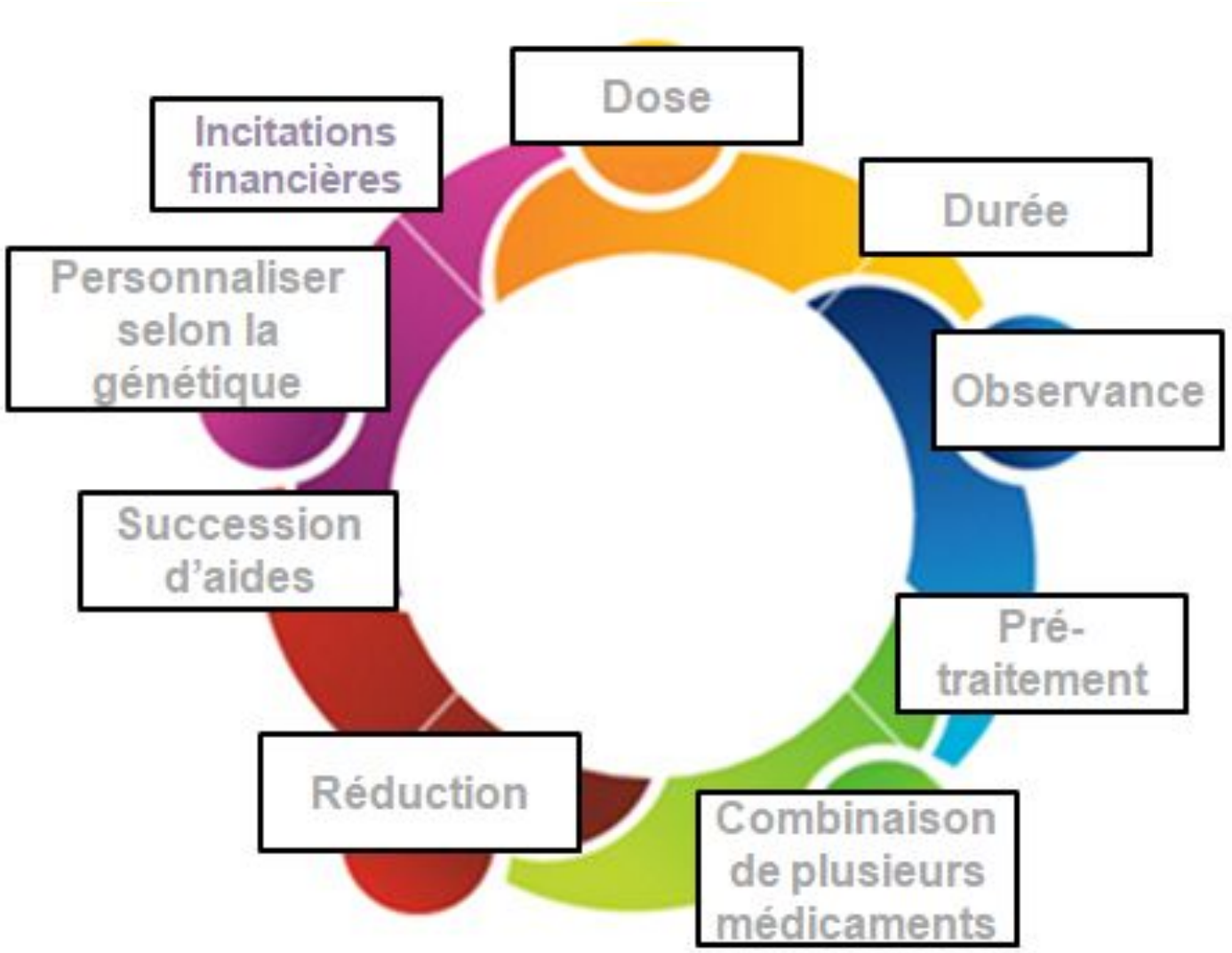
- Peiffer G, Perriot J, Underner M. Rev Mal Respir. 2017 Mar;34(3):177-179. doi: 10.1016/j.rmr.2016.10.872.

L'American College of Chest Physicians (ACCP) propose un protocole 2010 : http://www.tobaccodependence.chestnet.org.



Autres façons de manier les pharmacothérapies :



Corvisart : Napoléon : « Je ne crois pas en la médecine, mais je crois en Corvisart »

- Autant d'activités qui lui valent l'attention de Napoléon Bonaparte. Après être devenu médecin personnel de Joséphine de Beauharnais, le premier consul s'attache ses services en l'an X déclarant : « Je ne crois pas en la médecine, mais je crois en Corvisart Je vois qu'il a compris ma nature et qu'il est le médecin qui me convient ».
- Corvisart, qui accompagne le souverain en dans ses campagnes italiennes et autrichiennes, devient un officieux ministre de la Santé.
- Fait baron d'empire, il s'occupe de près de la santé de Napoléon lui imposant un régime alimentaire strict.
- À la nouvelle de l'abdication de l'empereur en 1814, Corvisart sombre dans la mélancolie.
- Pendant ce temps, l'Empereur, avant d'embarquer pour l'île d'Elbe, rend hommage à la fidélité de son médecin : « J'ai vu avec plaisir la bonne conduite que vous avez tenue ces derniers temps où tant d'autres se sont mal conduits. Ne doutez jamais des sentiments que je vous porte, ne vous livrez pas à des idées mélancoliques et j'espère que vous vivrez encore longtemps pour rendre des services ».
- Corvisart , redevient médecin de Napoléon durant les Cent-Jours
- **Corvisart mourut en 1821 à Courbevoie. Il aura formé quelques uns des plus grands médecins du XIXe siècle : Laënnec, Bichat, Dupuytren, Broussais, Bayle…**