EDITORIAL

Smoking cessation in old age: closing the stable door?

The current issue of *Age and Ageing* features a paper confirming that doctors are less likely to provide smoking cessation advice to older patients than to younger ones [1]. The study supports data from the United States, which showed similar age-related differences in both attitude and clinical practice among health care professionals [2, 3]. It highlights some important questions: is smoking cessation advice to elderly people worthwhile? What is the likelihood of their patients following such advice? Is there any health benefit? These are of particular significance as chronic airways obstruction, largely due to smoking, is the single most common cause of respiratory disability in old age. Respiratory problems are the second most common cause of disability in old age [4]. Up to 30% of those over 65 are still smokers [5–7].

As the British Thoracic Society Guidelines on Smoking Cessation [8] point out, smoking cessation strategies are effective and economically cost-effective (in terms of cost per life year gained). Guidelines from the National Health Service Executive [9, 10] emphasize the importance of targeting health promotion efforts on areas likely to produce greatest improvements. Smoking cessation strategies for younger adults and the young elderly (for whom evidence is available) fall into this category [11–13].

Permanent smoking cessation is difficult. Nicotine is powerfully addictive and smoking a pleasurable experience. How often do we hear the phrase “it’s the only pleasure I have left”? Whilst emotionally compelling, this argument would not be accepted as justification for lack of intervention in younger subjects. An objective assessment of the evidence is needed.

In younger smokers, the most important factor predicting successful cessation (defined as quitting smoking and remaining stopped at 12 months) is motivation, particularly when measured by previous unsuccessful attempts to stop. There are few studies on quit rates in old age (particularly in the over-70s), but cessation can be as successful in the motivated elderly person as in the young—possibly more so, with quit rates approaching 15% [14, 15]. In younger patients nicotine replacement therapy for the motivated person improves quit rates. This is also true in old age, with 1-year cessation of 20% [15, 16]. Further studies in this area and into the acceptability of nicotine replacement (patches, gum, or inhalators) in elderly subjects would be useful. Geriatricians should encourage motivated elderly patients to use nicotine replacement therapy as a cessation aid, and should prescribe it. (It is now available on prescription in Health Action Zones in the UK.)

Several studies from the United States have examined the attitude of the older smoker to quitting. These unfortunately suggest that older smokers are less likely to accept evidence that smoking is detrimental to health [17]. However, among those who do recognize the dangers, there is greater motivation to stop, and a greater success rate [18]. Among those across all age groups who are motivated to quit, older people seem to perceive best the urgency of this and plan to quit within the next few weeks or months [19]. Studies of health attitudes may be culturally dependent, and whether these US studies can be generalized is uncertain.

In younger patients, simple advice from a medical practitioner to stop smoking produces a quit rate of 2–3% [20]. Whilst a 97% failure rate is likely to result in a nihilistic attitude, achieving a 2% quit rate by such simple measures would save more lives in the course of a medical career than using currently available therapies in the management of acute stroke [8]. There is no published evidence on the effect of simple smoking advice on elderly patients.

Some elderly people can stop smoking, but should they do so? Does not the receipt of such advice and attempts to act upon it reduce quality of life, heighten anxiety and lead to increased morbidity? A few grandparents may be motivated to quit smoking because they recognize adverse effects of their habit on their grandchildren [21–23]. Evidence of potential health benefit to the individual is usually needed before health care professionals can advocate smoking cessation in this age group. Surprisingly, there has been little research interest shown in the attitudes of elderly people or their relatives and carers to the practice of smoking restrictions in hospitals.

The Fletcher–Peto model [24] of accelerated decline of lung function with smoking suggests that smoking cessation leads to a re-adoption of the normal (and much more gradual) rate of decline with ageing. Whilst the benefits of cessation on the slope of the Fletcher–Peto graph do decline with age, they may remain up to the age of 80, particularly in women [25]. There is no evidence that the beneficial effects of
cessation upon irritative and productive cough are affected by ageing.

In primary and secondary prevention of stroke, smoking cessation is beneficial for younger age groups. To what extent this benefit extends into old age is not clear [26, 27]. The main smoking risk probably relates to ischaemic (as opposed to embolic) stroke. Interestingly, in ischaemic stroke the benefit of stopping smoking occurs early [28].

The decline in risk of myocardial infarction after stopping smoking (to almost the pre-smoking levels after 2–3 years) is not modified by ageing [29].

Multidisciplinary education programmes (including smoking cessation advice) can reduce the complications of diabetes-related peripheral vascular disease and are acceptable to elderly patients with diabetes mellitus [30–35]. There is no evidence (in any age group) to show that stopping smoking reduces the rate of bone loss in either primary or secondary prevention of age-associated osteoporosis.

The smoking-related disease epidemic has probably passed its peak in men. In women, the maximum smoking uptake began with those born in the 1920s and 1930s. Smoking prevalence is highest in poorer people [34], with the result that those elderly patients with smoking-related diseases tend also to have many other poverty-related medical and social problems. The question of whether we should be advising our elderly (female) patients to stop smoking is likely to remain for years. It is an important problem worthy of more than anecdote and opinion. The paper by Maguire and co-workers is a step in the right direction.

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References


