

**2es Jornades
de la Societat Catalana
per al Control i Tractament
del Tabaquisme**

**III Trobada Programa
Atenció Primària
sense Fum**

Hotel Barcelo-Sants
3 de juny de 2011



Amb la col·laboració:



Consultes específiques vs pràctica habitual

Evidències

JM Ramón

Consultes específiques

AVANTATGES

- Millora la cartera de serveis de l'equip.
- Més confiança per part del pacient que espera millors resultats.
- Personalitzar al màxim la intervenció.
- El pacient que realment vol deixar de fumar valora satisfactoriament aquesta dedicació.
- La resta de personal mèdic descarrega amb tranquil·litat aquesta tasca i per tant s'anima més a aconsellar que abandonin l'hàbit.

INCONVENIENTS

- Superar i relativitzar el dogma del abordatge integral.
- Retard de la llista d'espera de la consulta.
- Probable deshinbició de l'equip si ho fa un altre.

Pràctica habitual

- **Model més adaptat a les característiques de l'Atenció Primària.**
- **Normalitza l'atenció al tabaquisme.**
- **S'arriba a més gent.**
- **Model d'equip no de persones concretes.**
- **Enforteix la rel·lació sanitari-pacient.**
- **Poden conviure varis models o models de transició.**

Desavantatges abordatge tabaquisme en equip

- **“Ho fem tots” i no uns quants amb una millor excel·lència.**
- **Variabilitat. El grau de motivació i d'eficàcia és heterogeni però, això s'observa en aqualsevol altre pràctica habitual de qualsevol problema de salut.**

Clinical Practice Guideline

Treating Tobacco Use and Dependence: 2008 Update

Guideline Panel

Michael C. Fiore, MD, MPH
(Panel Chair)
Carlos Roberto Jaen, MD, PhD, FAAP
(Panel Vice Chair)
Timothy B. Baker, PhD
(Senior Scientist)
William C. Bailey, MD, FACP, FCCP
Neal L. Benowitz, MD
Susan J. Curry, PhD
Sally Faith Dorfman, MD, MSHA
Erika S. Froelicher, PhD, RN, MA, MPH
Michael G. Goldstein, MD
Cheryl G. Heaton, DrPH
Patricia Nez Henderson, MD, MPH

Richard B. Heyman, MD
Howard K. Koh, MD, MPH, FACP
Thomas E. Kottke, MD, MSPH
Harry A. Lando, PhD
Robert E. Mecklenburg, DDS, MPH
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Cathlyn Lettke, MSN, RN-C (Project Researcher)

U.S. Department of Health and Human Services
Public Health Service
May 2008

Todos los pacientes deben ser interrogados por su consumo de tabaco y registrarse en la historia clínica. La evidencias disponibles indican que esta actitud incrementa las tasas de intervención por parte del clínico.

Nivel de evidencia : A

Todos los fumadores deben ser aconsejados que dejen de fumar. El consejo incrementa las tasas de éxitos.

Nivel de evidencia : A

El tratamiento del tabaquismo es efectivo y debe aplicarse independientemente de valoraciones especializadas. (*Hay pocos datos de que una valoración especializada sea útil para la adaptación del tratamiento*).

Nivel de evidencia : A

Prevention and health promotion in clinical practice: the views of general practitioners in Europe

Carlos Brotons*, Celia Björkelund, Mateja Bulc, Ramon Ciurana, Maciek Godycki-Cwirko,
Eva Jurgova, Pilar Kloppe, Christos Lionis, Artur Mierzecki, Rosa Piñeiro,
Liivia Pullerits, Mario R. Sammut, Mary Sheehan,
Revaz Tataradze, Eleftherios A. Thireos, Jasna Vuchak
on behalf of the EUROPREV network¹

Table 4
Responses to the second clinical scenario

	Should it be done? (yes as %)	Do I do it? (yes as %)
Measure cholesterol level	64.70	56.87
Measure blood pressure	84.53	76.46
Measure glucose level	77.67	67.72
Screening for colon cancer ^a	25.38	15.99
Screening for breast cancer ^b	78.19	68.25
Screening for cervical cancer with Pap smear	64.55	49.47
Tetanus immunisation	44.00	35.54
Advise smokers to quit	86.26	61.05
Advise heavy drinkers to reduce consumption	62.00	56.77
Estimate BMI	64.70	42.75
Advise overweight patients	84.58	59.46
Advise sedentary patients	80.45	54.37

BMI: body mass index.

^a Either with faecal occult blood test or with sigmoidoscopy.

^b Either with mammography or clinical examination.

Effectiveness of a Minimal Contact Smoking Cessation Program for Dutch General Practitioners: A Randomized Controlled Trial¹

Marcel E. Pieterse, Ph.D.,*² Erwin R. Seydel, Ph.D.,* Hein DeVries, Ph.D.,† Aart N. Mudde, Ph.D.,† and Gerjo J. Kok, Ph.D.‡

TABLE 2
Treatment Effects

Independent variables	Abstinence at follow-up					
	1 month		12 months		Consecutive (6 + 12)	
	OR (95% CI)	<i>P</i>	OR (95% CI)	<i>P</i>	OR (95% CI)	<i>P</i>
Variables at base-line						
Daily cigarette consumption		ns		ns		ns
Nicotine dependency	1.19 (1.0–1.3)	0.016	1.31 (1.1–1.5)	0.000	1.39 (1.2–1.7)	0.001
Quitting motivation	1.13 (1.0–1.2)	0.004		ns		ns
Social support		ns		ns		ns
Self-efficacy		ns		ns		ns
Attitude		ns		ns		ns
Positive outcome expect		ns		ns		ns
Negative outcome expect	1.15 (1.0–1.3)	0.019	1.13 (1.0–1.3)	0.032		ns
Intervention	2.56 (1.8–3.8)	0.000	1.51 (1.1–2.1)	0.009	3.04 (1.7–5.6)	0.000
Interaction terms						
Intervention ×						
Nicotine dependency		ns		ns		ns
Quitting motivation		ns		ns		ns
Attitude		ns		ns		ns
Positive outcome expect		ns		ns		ns
Negative outcome expect		ns		ns	1.21 (1.1–1.4)	0.009

Note. Effects of treatment on smoking status (including nonrespondents as smokers) in a backward-stepwise logistic regression analysis ($n = 481$), correcting for baseline differences. Odds ratios (OR) are reported with the corresponding 95% confidence interval (95% CI) and probability ($P <$). Base-line variables were recoded in such a way that a high score should, as predicted by theory, be associated with a



Comparison 1. Effect of advice versus control (subgroups by intensity)

Outcome or subgroup title	No. of studies	No. of participants	Statistical method	Effect size
1 Smoking cessation (at longest follow up)	26	22240	Risk Ratio (M-H, Fixed, 95% CI)	1.76 [1.58, 1.95]
1.1 Minimal intervention	17	13724	Risk Ratio (M-H, Fixed, 95% CI)	1.66 [1.42, 1.94]
1.2 Intensive intervention	11	8516	Risk Ratio (M-H, Fixed, 95% CI)	1.84 [1.60, 2.13]



General practitioners' views on and referral to NHS smoking cessation services

A. McEwen^{a,*}, R. West^a, L. Owen^b, M. Raw^c

Table 1 General practitioners' views on the impact of their local specialist smoking cessation service upon their practice of intervening with smoking patients.

	Yes % (n)	Do not know % (n)	No % (n)
Has the existence of a local specialist smoking cessation service made it easier for you to raise the topic of smoking with your patients?	58 (191)	5 (17)	36 (119)
Has the existence of a local specialist smoking cessation service increased the number of patients you have advised to stop smoking?	41 (133)	7 (22)	53 (173)
If the local specialist smoking cessation service ceased to exist, would you be less inclined to advise smoking patients to stop?	13 (43)	6 (21)	81 (265)
Would you recommend to your local primary care trust that the specialist smoking cessation service in your area should continue to be funded in its current form?	70 (226)	18 (59)	12 (39)

Effectiveness of specialist group treatment for smoking cessation vs. one-to-one treatment in primary care[☆]

Andy McEwen^{a,*}, Robert West^a, Hayden McRobbie^b

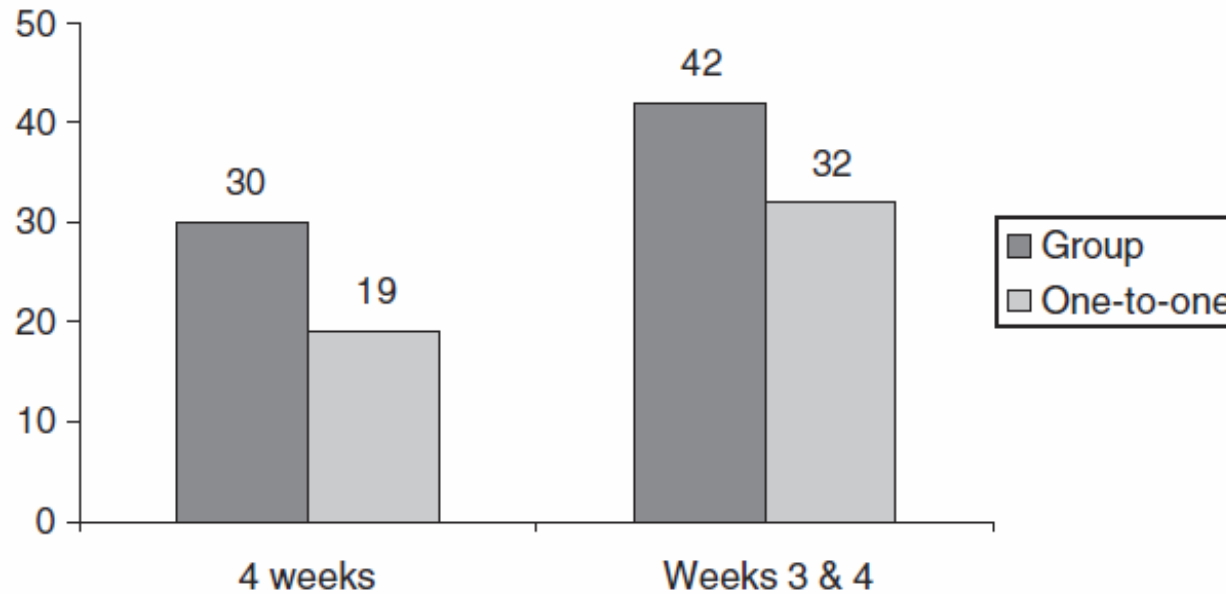


Fig. 1. Percentage of clients abstinent for 4 weeks, and at weeks 3–4, post-quit by treatment type.

Effectiveness of specialist group treatment for smoking cessation vs. one-to-one treatment in primary care[☆]

Andy McEwen^{a,*}, Robert West^a, Hayden McRobbie^b

Table 3
Results of forced-entry logistic regression for co-validated 4-week continuous abstinence

	Odds ratio	<i>p</i> value
Treatment type (group or one-to-one) ^a	2.27	<0.001
Age	1.01	0.13
Ethnicity	1.48	0.19
Married or living with a partner	1.34	0.09
Educational level	1.14	0.49
Free prescriptions	0.71	0.07
Dependence (FTND)	0.99	0.83
Smoking hand-rolled cigarettes	1.02	0.92
Longest duration of previous quit attempt	1.00	0.62
Use of cardiac medication	1.13	0.65
Use of respiratory medication	1.21	0.49
Use of mental health medication ^a	0.45	0.02
Use of bupropion ^a	0.65	0.03

^a *p* < .05.

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