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Dates: Received: 02 August, 2017; Accepted: 30
August, 2017; **Published:** 31 August, 2017

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Keywords: Smoking; Anesthesiologist; Endoscopy

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Editorial

Role of an Anesthesiologist in Smoking Patients Undergoing Endoscopic Procedures

Abstract

Physicians generally know that smoking increases the risks of post procedural morbidity and mortality. Stopping smoking before surgery and other medical procedures has been shown to improve procedural outcomes. Anesthesiologists are well-positioned as perioperative physicians to take full advantage of the leadership role in the area of smoking cessation. However, some anesthesiologists do not routinely implement in their practice. Some barriers for smoking cessation interventions may include the lack of time and knowledge about these interventions as well as inadequate training and funding to offer counselling.

Editorial

Smoking is associated with a range of diseases, causing a high level of morbidity and mortality and is a risk factor for several perioperative complications [1]. The consequences of smoking on surgical outcomes are associated with the toxic effects of recent smoke inhalation and the cumulative chronic effects of tobacco exposure. Many smoking patients require some medical interventions and care by anesthesiologists. Consequently, smoking is of direct concerns to perioperative management [1,2]. The preoperative clinic is an ideal setting to initiate interventions for smoking cessation. Importantly, preoperative interventions for tobacco use are effective to decrease postoperative complications and increase the likelihood of long-term abstinence. If intensive interventions are impractical, brief interventions should be implemented in preoperative clinics as a routine practice [3]. Anesthesiologists should ask their patients about smoking, advise the smokers to quit, and connect them directly to counseling resources. However, most anesthesiologists ask their patients about smoking but frequently do not advise smokers to quit [4].

For endoscopic patients, smoking has been shown to be an important risk factor for colorectal neoplasia in several studies [5-7]. A previous study evaluated the relationship between smoking and flat colorectal neoplasia. Six hundred asymptomatic patients presenting for first-time colonoscopic screening were studied. The study confirmed that smoking might be significantly associated with flat adenomas, especially those that might be the most clinically relevant [8]. Moreover,

cigarette smoking was associated with an increased risk of Barrett's esophagus, a premalignant condition to esophageal adenocarcinoma. Being an ever-smoker was associated with an increased risk of Barrett's esophagus. A greater number of pack-years smoked were related with a higher risk of Barrett's esophagus [9].

Almost all anesthesiologists reported asking their patients whether they smoked cigarettes. However, the frequency of counseling is less in their practices when compared with primary care physicians [10]. Generally, anesthesiologists have the opportunity to support the patients' quit attempt, the intervention should contain of helping the patient with a quit plan, providing practical counseling and assisting the patient obtain extra-treatment. The most logical time for anesthesiologists to conduct the intervention is during a visit to the preoperative clinic [11,12]. Our previous study demonstrated that brief advice provided during the pre-assessment preparation of ambulatory endoscopic patients by busy anesthetic personnel to quit smoking was an effective intervention in the setting of a developing country. The result of the study was also confirmed that anesthetic personnel could help the smoker patients to quit smoking [13]. The development of pre-anesthetic preparation for medical procedures in the hospitals should be implemented.

Smoker patients are more likely to accept brief advice given by anesthetic personnel than their physicians. In addition, smoker patients are also afraid of higher postanesthetic complications if they do not agree with the preoperative preparation.

Interestingly, the well-educated smokers who know that smoking is a risk factor of gastrointestinal diseases, trend to quit smoking by themselves because of their health problems. Brief advice for smoking cessation intervention consists of ask about tobacco use, advice to quit, assess willingness to make attempt to quit, assist with treatments, and arrange follow up [14]. Several factors associated with successful smoking cessation are age, sex, social status, housing condition, spouse/cohabitant's smoking behavior, daily consumption of tobacco, and willingness to make repeated pharmacotherapy-assisted quit attempts [15]. However, the lack of time and knowledge about smoking cessation interventions as well as inadequate training and funding to offer counselling are still barriers for anesthesiologists [16].

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