PATIENT POWER

Northwestern Memorial Hospital

Why Quit Smoking?

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Introduction

Andrew Schorr:
Cigarette smoking causes about one out of every five deaths in the US each year. Coming up, Dr. Shari Meyerson, a thoracic surgeon from Northwestern Memorial Hospital, explains the effects of smoking on your lungs and the best strategies for quitting. It's all next on Patient Power.

Hello and welcome to Patient Power sponsored by Northwestern Memorial Hospital. I'm Andrew Schorr.

We have talked time and time again about smoking and most people who smoke in the United States at least, most have tried to quit, some many, many times, and I've even heard it may take 14, 15 times, attempts by someone to quit smoking. Very difficult. It's one of our most addictive substances, for sure. But the effects of smoking are so serious. I was looking at statistics that said that, for someone who smokes, [that person] may be shortening [his or her] life expectancy by 13 years, maybe 14 years or more for a female. How tragic, and all the illnesses that come along the way and the suffering. We don't want you to get there.

So we're going to discuss with someone who knows all too well the effects of smoking, a thoracic surgeon who deals with people who are facing emphysema, COPD and certainly lung cancer. And we're going to try to help you get there, quit smoking if you do or a reminder not to smoke or a reminder to help you help family members who do.

Our guest is Dr. Shari Meyerson. As I said, she's a thoracic surgeon at Northwestern Memorial Hospital. Dr. Meyerson, over the years as you've become a surgeon and now several years as a chest surgeon you've met a lot of people with these chest diseases and lung cancer, and I know it must grieve you when you see people with these illnesses saying, "Gee, if only they had either not smoked in the first place or somehow earlier been able to quit."

Dr. Meyerson:
There's no question about that. I've met thousands of patients over the years who have not only wished they could quit, tried to quit, failed to quit, tried again and kept

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going at it.

Andrew Schorr:
Now, let's talk about that. So some people, and unfortunately where I live, you know, every once in a while you see a teenager, and you just shake your head. What don't they know? The people you meet probably--do you feel they have an understanding of the damage that smoking does?

Dr. Meyerson:
Oh, yes. Most smokers will absolutely tell you that it causes lung cancer, that it causes breathing problems. This isn't a secret.

Andrew Schorr:
So there you go. So they understand it. Am I right that nicotine is one of the most addictive substances?

Dr. Meyerson:
It is. One of my very clear memories from medical school was working with people with drug addiction problems, people who had gotten themselves off of cocaine, off of heroin, and they said they were able to do that but they still couldn't get rid of the cigarettes.

Andrew Schorr:
So when you're in the exam room with somebody you're checking and they have lung disease, and you get in conversation, you get to know them over time, what was smoking as part of their routine? Did they say, "Well, I guess I did it to relieve stress or it was always part of my habit after I ate or when I woke up in the morning"? How did it fit into their daily routine?

Dr. Meyerson:
Different people have different roles for it, and some of it depends on who you talk to. A lot of my patients are older gentlemen who learned to smoke in the military and were given cigarettes with their meals, so it becomes something they routinely do after a meal. It's very common for people to roll over in the morning and want a cigarette. It's very common for people who quit smoking 20 years ago to wake up in the morning and still reach for a cigarette. This is something that becomes as much a psychological addiction as it is a physical addiction. It's just part of life.

Andrew Schorr:
And do people say, well, it just helps calm me down, that it helps relieve stress?

Dr. Meyerson:
Absolutely. It gives them something to focus on other than whatever their stressor is.

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The Negative Effects of Smoking

Andrew Schorr:
When smoking continues, there's that teenager that started or that man in the military may have been 18 or 19 years old started to do it, what starts to happen? I understand there's this whole constellation of toxic chemicals in cigarette smoke. Goes into your lungs, what's--what's going on? How is that affecting healthy tissue?

Dr. Meyerson:
So there are a lot of things that happen, mainly because there are a lot of different components to what's in these cigarettes. And it's amazing. We have a cartoon that I show to kids when I talk to them, and it's just a cartoon that shows what's in cigarette smoke. And when you really look at it you can break it down into compounds like lighter fluid, vinegar, rocket fuel, solvents and toilet cleaner, quite a wide variety of things.

And essentially what they all do over time is destroy the cells that line the insides of the airways of the lungs.

Andrew Schorr:
Let's understand how the lungs work for a second. So you talk about the cells on the inside of the lung, so that's where gas comes in, whether oxygen and carbon dioxide and hopefully just healthy things come in. And then are your cells inside your lung just trying to grab the oxygen out of that, and when you have cigarette smoke it's sort of inhibiting that function?

Dr. Meyerson:
So the way the lungs work is that when you breathe in air the air needs to get into your bloodstream, and it can only do that if there's a very, very thin layer of cells. It's actually a single cell layer between the blood and the air, and it's those single cells that get affected. If those cells get diseased, they get scar tissue around them, then the oxygen can't transfer from the air into the blood.

Andrew Schorr:
So let's talk about, short of lung cancer for a second, the type of diseases that develop in the lungs. Like what's emphysema?

Dr. Meyerson:
So emphysema means that the air sacs in the lung, which normally they look like a very tiny bunch of grapes. Each air sac is at most a millimeter or so large. The walls between them just become completely destroyed, so instead of a bunch of grapes we now have one big open sac, and that doesn't allow the oxygen to get from the inside of that big sac to the little tiny blood vessels in the wall.

Andrew Schorr:
So we have emphysema. We also hear of this term COPD now. Is emphysema a

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part of COPD, or I think it's chronic obstructive pulmonary disease?

Dr. Meyerson:
Yes, it's chronic obstructive pulmonary disease, and that covers a number of conditions and emphysema is one of them. They're all different forms of the same idea, the idea that the lung tissue itself has been destroyed, and it can either just completely destroy it or leave large sacs or it can cause chronic inflammation. People who have that chronic cough, that's often related to COPD.

Andrew Schorr:
Right. Chronic bronchitis, is that where they've done damage to their lungs and the inflammation is causing them to cough all the time?

Dr. Meyerson:
Exactly. It's a combination of inflammation and the fact that we all normally have mucus in our lungs. That's what allows your body to clear things. The toxins in the cigarette smoke actually kill the normal system that moves that mucus around and gets it out, so it builds up in the lungs and they have to cough it up.

Andrew Schorr:
Now, we will talk about lung cancer in a minute, but I understand smoking is the bad guy, if you will, related to other illnesses, other cancers as well--you're at higher risk.

Dr. Meyerson:
Absolutely. It's actually the bad guy for a lot of different things. Probably the most common thing we talk about is lung disease in terms of both COPD and cancer, but it's also a significant component of heart disease.

Andrew Schorr:
Right. So what's going on there? So I've heard that. So is that that it's damaging the heart muscle or the blood supply, blood flow?

Dr. Meyerson:
What it's equally doing is a couple of different things, one of which is damaging the blood flow. So the nicotine itself causes changes in the blood vessels so that normal amounts of blood can't get to the heart, and with that happening over a long period of time parts of the muscle of the heart start to die.

Andrew Schorr:
Now, I've also heard that people are at risk for even other cancers--

Dr. Meyerson:
Yeah, absolutely.

Andrew Schorr:
--pancreatic cancer, a whole bunch. They think there's a stomach cancer, oral cancer for sure.

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Dr. Meyerson:
Uh-huh. Bladder cancer, kidney cancer, things that you wouldn't necessarily think of as being attached to a drug that you breathe in, but once it gets into your bloodstream it can go anywhere in the body.

Andrew Schorr:
And we should mention of course a big killer and huge in disability is stroke, and you talked about blood flow, so certainly it plays a role in stroke.

Dr. Meyerson:
Absolutely.

Strategies to Quit Smoking

Andrew Schorr:
So all these bad things, and you have these people who want to quit. We talked about the addiction, so is that the biggest obstacle, or is it just a habit and they can't break the habit, or they can't switch to something else? Let's talk about when you've seen it difficult for people and then maybe examples where you've had patients where, maybe even after lung surgery, where they were able to quit.

Dr. Meyerson:
So I think it's different for everyone. Some people the predominant problem is just the physiologic body's need for nicotine, and those are people who may be able to stop with just a patch. And these are people who may have reasonably straight-forward success with it. But then you add in things like the psychologic component, the fact that they've convinced themselves over the years that they need the cigarette, that they're too stressed without it--that can be a much harder thing to get past.

And then there's always the habit. Like I said, those habits don't go away even when people have stopped smoking. So it's a very complicated picture. There's not one thing that makes people smoke.

Andrew Schorr:
Now, we have more programs and more tools than ever before to help people, don't we?

Dr. Meyerson:
Absolutely. We have a lot of different nicotine replacement therapies. We have a lot of different support systems. But what it comes down to, number one is that the patient has to honestly believe that they're ready to make the effort. This isn't something someone else can force on you. It's not something that your brother can tell you, you have to quit smoking or your wife can tell you, you have to quit smoking. You have to want to do it.

Andrew Schorr:
And that's why I always have heard that the first thing to do is set a quit date. Maybe

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it's not today, maybe it's a week from now or a month from now, but you have to set a quit date.

Dr. Meyerson:
Yes, exactly.

Andrew Schorr:
So going on then, so let's say somebody quits and they say, "Well, gee, Doctor, I know of all these terrible things that will happen to me, but I've smoked for X number of years, but if I stop now is it too late?"

Dr. Meyerson:
So I tell all of my patients it's never too late because at the very least it will make your lung function better fairly quickly. It will get the breathing better, it will decrease the cough and start making people feel better. In a fairly short term, month or two, lung function will start getting measurably better. There's no question about that. And the risk of developing a cancer or developing emphysema will start decreasing. Unfortunately, it never completely goes down to zero. Anyone who has smoked will always have a slightly higher risk of lung cancer.

Andrew Schorr:
But all is not lost, so it's only to the good.

Dr. Meyerson:
Absolutely.

Andrew Schorr:
Let's just talk about some of the strategies for a minute. So we talked about nicotine patches. I know there's been nicotine gum. My mother-in-law promised us when we got married as a wedding present that she would quit smoking, and so for I think a couple of years after that it was like her jaw was going to fall out. But she did chew, chew, chew, and she was determined, and we held her to it because Mom, you know, it's the wedding present, and she was able to quit. So that was where she had been addicted to the nicotine, and she had the personal commitment. But there are quitlines now. There are support groups. Northwestern certainly has programs.

Dr. Meyerson:
I think that's a huge part of quitting for most people. It's something that's very difficult to do on your own. It's helpful if you have, like you did for your mother, family support. That's a huge thing. If other people in the house are still smoking, that makes it very difficult. And having quitlines, having support groups, having places where people can go and helping them develop an alternative. Chewing gum is a common one. Unfortunately, a lot of people tend to substitute food and gain weight when they quit smoking. So it's finding a system that will work for you.

And it's also not just nicotine patches. There's a lot of different ways to do nicotine

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replacement. Everyone knows about the patches and the gum, but there are certainly other forms available. There are little lozenges, like cough drops; there are tablets you can take. There are inhalers. There are a lot of different things we can do to help people.

Andrew Schorr:
One other thing. There's a drug, Chantix, that's widely advertised on television. I don't know if there are others as well, but a pill. Is that part of the process for some people, too?

Dr. Meyerson:
It often is. There are actually several different types of pills available that a lot of people find very helpful. What they do is actually suppress some of the urges to smoke.

Advances in Lung Surgery

Andrew Schorr:
Well, what I'd like to do is if people need intervention--we'll continue our discussion in a minute and learn about intervention. After all, you're a surgeon and I know there are many other kinds of surgeries you could do, and this one unfortunately [you] have to do all too often, but it can bring relief and I'm sure save some lives. So we'll talk about that as we continue Patient Power right after this.

Welcome back to Patient Power. Andrew Schorr here. And we're speaking with a thoracic surgeon at Northwestern who unfortunately over the years has met many people who have suffered from the complications of smoking and needed lung surgery. But even after that, you know, there are some people you hear about, they have lung surgery, and they just can't quit smoking, which got them in trouble in the first place. But there are many people who have quit, and we've talked about some of the strategies. But we need to understand the interventions now if you do need lung surgery and rehabilitation perhaps after that.

Our guest is Dr. Shari Meyerson, and as I said Dr. Meyerson is a thoracic surgeon at Northwestern Memorial Hospital in Chicago. Dr. Meyerson, how do you know when somebody needs surgery, and what are realistic options for surgery?

Dr. Meyerson:
So most of the patients that I see for lung cancer surgery are patients who have an early stage of the disease, and often this is actually caught incidentally. They got a chest X-ray because they were having back surgery, or they had some abdominal pain and went to the ER and it was seen on the scan of the abdomen. Those are the times that we tend to catch things really early. Unfortunately, most of our lung cancer patients won't really have symptoms from the lung cancer until it's actually very late and has spread.

Andrew Schorr:
Lung cancer is actually slow growing, am I right, typically?

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Dr. Meyerson:
Lung cancer has a lot of variability to it. Some lung cancers will grow slowly. Some lung cancers will grow quickly. Unfortunately, we don't know which one an individual patient has unless we watch it and wait for it to grow, which I would never recommend.

Andrew Schorr:
Right. So just one comment, you know, many months ago there was this study that came out that was a big deal that said that a certain type of CT scan might be advisable for people who smoked or smoked a lot so that lung cancer could be detected earlier, and it could be lifesaving. So there is that surveillance that's starting to happen, isn't there?

Dr. Meyerson:
That study was a huge deal because until that was published we actually had no real screening test for lung cancer. Everybody knows that if you are worried about breast cancer you can get a mammogram. If you're worried about colon cancer you can have a colonoscopy. Up until now there was really nothing that showed a benefit for lung cancer, so this has been huge news in our community.

Andrew Schorr:
So at Northwestern, if somebody is a regular smoker then, is this typically happening now? Is it worked out with insurance and all that? Where are we now?

Dr. Meyerson:
So, unfortunately, it is not yet worked out with insurance although we are offering some lower cost scans to anyone who fits into the category. But eventually we are hoping that all of the insurance companies will agree to cover this.

Andrew Schorr:
Sure hope so. So let's say you spot it, and I understand that if it's early enough by cutting it out basically could certainly save someone's life. So is that removing a lobe of the lung? Or it's going to vary, I guess. But take us through that. How do you do it? Are there less invasive ways of doing it? And then we'll get into recovery.

Dr. Meyerson:
Okay. So when a patient comes to me with an early-stage lung cancer ideally we want to take out the cancer itself and any cells that are starting to spread, so that requires understanding how lung cancers spread. They'll usually start as a mass of abnormal cells within one part of the lung, and the lung is divided into portions called lobes. On the right side each person has three lobes. On the left side each person has two. Everyone's left lung is a little bit smaller than their right because the heart takes up some of the space over there.

So we identify which lobe of the lung the tumor is in. And we know that from there cells will break off of that tumor and spread within that lobe, eventually working their way back to its root, to the lymph nodes. Lymph nodes are your body's filter system.

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You have millions of them all over the body, and they're designed to pick up things that shouldn't be there, things like infection or like cancer cells that are trying to escape. So when we take out a lung cancer we take out the entire lobe that that cancer is in and get all the lymph nodes at its base so that we catch any cells that are already trying to escape.

Andrew Schorr:
Now, sort of a [term] that's very much in vogue as we talk about surgery these days is minimally invasive. I can imagine operations on the lungs where you have to open somebody's chest or go in from the back, but are there approaches now that are less invasive to do some surgeries?

Dr. Meyerson:
Absolutely, and in the past even when I was training the vast majority of surgeries were done by making about a 10-inch incision on the side, sort of onto the back onto the tip of the shoulder blade, and spreading the ribs apart and having the surgeon put their hand into the chest. You can imagine that's going to hurt for quite a while. Now somewhere around 80 to 85 percent of our lung cancer surgeries can actually be done with just two small incisions without spreading the ribs at all.

Andrew Schorr:
Wow. So this would qualify as minimally invasive surgery.

Dr. Meyerson:
Absolutely. And it has a lot of benefits for the patient. Some of them are during the time of surgery. It's actually easier for me as a surgeon to see into the chest through the small hole with a very high quality camera than it is to try and peer between the ribs with the ribs open. So I see better. I probably have an easier time doing a more complete operation.

From a patient's standpoint, it hurts less. That's a huge deal. It not only hurts less right after the surgery but it hurts less in the long term because patients with a bigger incision, up to 10 percent will have chronic long-term pain, and that's very uncommon in the minimally invasive approach.

Pulmonary Rehabilitation

Andrew Schorr:
Let's talk about rehab. So someone has surgery, fortunately, hopefully, you were able to cut out the cancer, but now they need to get their lungs back in shape. Quit smoking for sure, but what happens next? What assistance it there in helping them get higher lung function?

Dr. Meyerson:
Absolutely. So most of my patients I ask them to try and set their quit date so that they have quit smoking at least two weeks before surgery. And the reason I do that is right after people quit there's a little bit of a rebound, and they may have more of a cough for the first week or two. I want to get past that and get them in the best

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possible shape for surgery. Some patients we will even have do rehab beforehand. And rehab for lungs is very similar to what people think of as rehab after heart surgery, walking on a treadmill in a supervised setting. For our lung patients we carefully monitor the oxygen levels while they're walking, and the lung really responds almost like a muscle. The more you exercise it the better it's going to be.

So once we get people in the best possible shape for surgery we want to keep them there and help them recover after surgery. For patients with normal lungs to start with, that really doesn't require anything than getting up off the sofa and taking a walk. For patients who have a lot of lung damage to start with, we'll often have them go to pulmonary rehab and do the supervised exercise where the therapist can help them push themselves to recover as much lung function as possible.

Andrew Schorr:
Let's talk about what would be reasonable expectations, knowing everybody is different. But you see some really sick people, and then if they are candidates for surgery you try to help them in that way. If they are diligent about the rehab can they expect to not just to have arrested the disease but gain a quality of life? And I know it's variable, but what sort of changes have you seen in people?

Dr. Meyerson:
So pulmonary rehab can really make a huge difference for patients. One of the problems of long-term lung disease is patients tend to adjust to it. As they don't breathe as well, they just don't walk as much. And sooner or later they start parking really close to the front door, and then they start getting one of the little carts at the grocery store, and they just get out of shape. So some really focused exercise can really make a significant improvement in quality of life for patients, and that can hold even through having part of the lung taken out.

Andrew Schorr:
So while maybe somebody's not going to climb Mount Kilimanjaro you've probably seen in your career people who have really bounced back and then doing more--pushing a little, doing more than they ever thought was possible.

Dr. Meyerson:
Absolutely. And sometimes we even get lucky and the tumor is in the part of the lung that has been most destroyed. With things like emphysema it's much more common for the top parts of the lungs to be damaged than the bottom parts, so if the top part of the lung is very damaged and that is also where the cancer is, they may find their breathing actually gets better after I take out that part of the lung.

Lung Transplant: Who is It Right For?

Andrew Schorr:
All right. Now, I want to go one step further. So people have heard of lung transplant. Where does this come in with these lung diseases? Whether it's cancer or COPD, people have terrible problems, are lung transplants a viable option. I

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imagine you do it at Northwestern. Where does that come in?

Dr. Meyerson:
Lung transplant really fits in more to the emphysema [and] COPD patient population. Right now we're not doing lung transplant for lung cancer at all. So it takes a patient who has these diseased lungs that has gotten to the point where they really can't function, and we have a lot of different criteria people have to meet. This is not an operation we do lightly. What I tell patients is that lung transplant is trading one disease for another. So you won't have the emphysema itself anymore but now you're going to have to be on medications to stop the body from rejecting the new lungs.

So it's really a trade-off, and we don't want to put a transplant in someone who is doing okay because we're going to make them feel worse. We want people who have reached the point where they're really not functioning well anymore, and those are the people who will benefit.

Andrew Schorr:
Actually just last night I watched the episode, the latest episode of the TV show *House, M.D.* I'm a big fan. It was exactly about lung transplant, and the woman was quite frankly near death. And the other thing that they were doing, which was very interesting, and I've done programs on this, is the donor lungs, they actually did some rehab on those before they were transplanted to make sure the donor lungs were as strong as possible to help give life back to that patient. So I know there's work going on in this area.

Dr. Meyerson:
Lung transplant is a huge area of research, and unfortunately it's mostly limited by the availability of donor lungs. Lungs are one of the first things that can be injured in a lot of the patients who do donate organs, and they're not useable in a lot of those patients. So we have to carefully look at a donor to make sure that what we're giving our patient are good healthy lungs.

An Important Message for Smokers

Andrew Schorr:
So, Doctor, let's just remind people, let's just tick through for them again. If you have a family member, if somebody is thinking about smoking, you've got that kid who is just starting--stop. Don't do it. And we do a lot of education, certainly with children, trying to have it not be cool to smoke.

Dr. Meyerson:
Unfortunately, that is our fastest growing group of smokers right now, teenage women.

Andrew Schorr:
And in your experience, what's driving it? Is it supposed to be cool, or they see it in

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the movies, or?

Dr. Meyerson:
That's a lot of it. They see it in the movies, it's cool, and it's a sense of something they can do that's a little dangerous. It's a little exciting. And at that age they don't--even if they can repeat back to you the consequences--they don't think it will happen to them.

Andrew Schorr:
But when they breathe in those toxic chemicals you talked about at the beginning of the program, damage is starting right then, right?

Dr. Meyerson:
Absolutely.

Andrew Schorr:
You don't get a free pass.

Dr. Meyerson:
No.

Andrew Schorr:
But the sooner you quit the better off you are, so again strategy is you're breaking an addiction, you're breaking a habit in your daily life, but you have to get to the point where you want to make the change. And then there's a wealth of support now, nicotine replacement, quitlines, support groups, other medications to help, and doctors like you who want to help.

Dr. Meyerson:
Absolutely. Any doctor, whether it's their primary care physician, family practice doctor, even a gynecologist would be happy to help anyone get in touch with the resources they need.

Andrew Schorr:
So a lot of people have quit, and I believe our president, President Obama, has quit, so there's hope isn't there? While a lot of people are trying--and it's really tough--you can get there, and I'm sure you've seen it in people.

Dr. Meyerson:
And I have a lot of people who are succeeding, and sometimes it takes a big event, something like going for lung surgery, to really make it sink in that this is something that needs to happen.

Andrew Schorr:
So we talked about earlier screening. Do you think that we can reduce the numbers of deaths? And I said at the very outset how, you know, we have, unfortunately, a very high statistic of deaths from smoking related illnesses. We want people to quit or not start. But we also know that early detection can make a difference. It sounds

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like we are making some progress there.

Dr. Meyerson:
Absolutely. And like I said before, I think screening is going to make a huge difference. And that study that you mentioned showed up to a 20 percent decrease in deaths from lung cancer in patients who had it picked up on the screening. This is a huge difference.

Andrew Schorr:
So another message here is if you are a smoker who hasn't been in a regular relationship with your doctor and talking about not only quitting but also monitoring as you go on your journey through life, that discussion of, "What monitoring do I need?" [and] "Help me quit, but let's take a look at how my lungs are doing," that's an important discussion these days.

Dr. Meyerson:
Absolutely.

Andrew Schorr:
I make a joke of this sometimes, but I think you'll agree, if you could go on and do other kinds of surgery and the need for this was decreased, that would be okay with you.

Dr. Meyerson:
I would be just fine with that. I don't think anyone should worry about continuing to smoke so that I'll be busy.

Andrew Schorr:
Dr. Shari Meyerson, thoracic surgeon at Northwestern Memorial Hospital and very devoted to helping you quit smoking or not start. If you need surgical intervention it's there, but, as you heard, she'd rather do something else if she could and people could live longer, healthier lives. Thank you so much for being with us.

Dr. Meyerson:
No problem.

Andrew Schorr:
This is what we do on Patient Power, connect you with leading experts and help you really be inspired, I hope, so that you can have the best possible health and if you need treatment get the treatment that's right for you.

I'm Andrew Schorr. Thank you for joining us. Remember, knowledge can be the best medicine of all.

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