

## In-hospital Smoking and Its Implications: A Short Case Series

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Tobacco usage in any form, be it smoking, chewing or inhalational, has been banned at public places in India, particularly in and around hospitals.<sup>1</sup> However, because of the potential for addiction with nicotine, laxity of enforcement mechanism and ignorance of the patient or his attendants, some patients are still found smoking inside the hospital harming themselves, causing environmental pollution and also setting a bad example for others.<sup>2</sup> This also has a huge detrimental effect on their own and others' health. In-hospital smoking is also a major factor in deciding the fate and prognosis of patients. We present a short series of cases that provide us an opportunity to study the risk behaviour and dangers associated with in-hospital smoking.<sup>3</sup>

**Case 1.** An 80-year-old male was admitted for low-to-moderate grade and continuous fever of one month duration and productive cough. He was so weak, unable to walk or stand on his own and bed-ridden.

He was a heavy *bidi* smoker since his adolescence and continued despite suffering from pulmonary tuberculosis in the past. Appropriate antibiotics and bronchodilator treatment were started. A day later, during the daily morning round, we found him lying in his usual lateral decubitus position with a stick of *bidi* in his hand and smoking unconcerned. His son was on his bedside and denied giving the stick to the patient. We counselled the son not to allow him to smoke in view of his multiple pulmonary problems and poor general condition.

On the 5th day of the hospital stay, the patient developed severe respiratory distress and arterial blood gases showed hypoxaemia and carbon dioxide (CO<sub>2</sub>) retention. He suffered a massive transmural myocardial infarction and sudden cardiopulmonary arrest from which he could not be revived.

**Case 2.** A 65-year-old male admitted in hospital with cough, expectoration and respiratory distress. He was put on non-invasive ventilation. The chest radiograph showed emphysematous changes. He was also detected to have hypertension, elevated TSH (thyroid stimulating hormone) and vitiligo. He was put on bronchodilators, through nebulisation, thyroid

replacement therapy, diuretics and intermittent oxygen therapy. After recovering a little he was found smoking in bed without showing any guilt for the same.

**Case 3.** A 65-year-old male belonging to low socio-economic strata was admitted in cardiac care unit (CCU) with history of chronic obstructive pulmonary disease (COPD) and chest pain secondary to STEMI (anterior wall). He was thrombolysed in accordance to guidelines but was still adamant to smoke. When counselled against this, he was caught smoking in CCU toilet.

**Case 4.** A 75-year-old male being treated for carcinoma bladder was admitted for acute anterior wall myocardial infarction. He was unable to quit and was caught smoking in bed in the CCU with his attendant by his side.

**Case 5.** A patient was admitted many times earlier with different problems. He had hypertension, COPD and also suffered multiple episodes of seizures secondary to neurocysticercosis. Despite all these co-morbidities, he continued to smoke in the ward. He is now being followed in the tobacco cessation clinic.

Health-care organisations provide a key channel for delivering smoking cessation interventions to populations. Illness, especially a tobacco-related illness, boosts a smoker's motivation to quit smoking, presumably by increasing his perceived vulnerability to the health hazards of tobacco use.<sup>4</sup> Our short series suggests that despite a ban on tobacco usage in hospital premises, smoking by patients is not uncommon. Craving for cigarettes and symptoms consistent with nicotine withdrawal occurred frequently in hospitalised smokers. These patients continue to smoke during hospitalisation despite several comorbidities, often in bed or in or any other secluded place in the hospital. Some may even go out of hospital premises for satisfying their craving for tobacco and come back to be caught later by the obvious presence of nicotine smell during rounds. It is important to note that admission in a smoke-free hospital does not guarantee that patients will refrain from smoking. This proves the highly addictive nature and need counselling measures to help the patient in

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quitting smoking completely.<sup>5</sup> We offer a few suggestions to deal with this problem.

1. Approach the smoke-free policy as a health and wellness initiative. Hospital administrators should try and collaborate with other organisations in the community.
2. We should take a compassionate but firm and consisted approach when interacting with smokers. Nursing, paramedics, attending doctors, sanitary and security staff have to be constantly vigilant about any source of smoke or tobacco pouches emanating in wards, corridors, wash rooms and toilets. Factors associated with compliance identified may be modified by tailored smoking cessation interventions.<sup>6</sup>
3. All clinical areas should provide posters, leaflets, and other forms of information, advising on the dangers of smoking, and include signage directing smokers to sources of help.
4. Several areas frequently present special challenges to smoke-free policy enforcement. The area outside the Emergency Department, secluded corridors, and toilets is perhaps the most common. A compassionate, non-confrontational approach can be particularly helpful here. Use of anti-smoking sign-boards in these places in vernacular language with possible penalty may prove to be a deterrent.
5. A dedicated tobacco cessation clinic should be in place in all hospitals. Smokers should be enrolled and instructed to follow a customised anti-smoking programme which must include counselling and pharmacotherapy.<sup>7-9</sup>

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