



AFMP
**Association Franco-Méditerranéenne
de Pneumologie**

Lutte Anti-Tabac

Actualités

Habib Ghédira



counseling Teams

- Pharmacists¹: 2 RCT (training, stage of change,...)
 - 484 patients RR 5.2 (2.2-12.1), 14.3 vs 2.7%
 - 474 patients, RR 1.62 (0.92-2.85), 12.0% vs 7.4%
- Nurses²: pooled 35 studies (>17,000 pts)
 - RR 1.29 (1.20-1.39), 13.3% vs 11.3%
 - Mostly in hospital but some out, mid quality.
- Doctors³: 42 RCTs (>31,000 pts)
 - Minimal (ask): 1.66 (1.42-1.94), 5.8% vs 3.7%
 - More intense: 1.86 (1.60-2.15), 11.8% vs 6.4%

Brief Interventions

- 2-3% of people quit without anything per year.
- In 3 minutes you can...
 - **A**sk permission in non-threatening way
 - **A**dvice to quit smoking
 - **R**efer (**A**ssist)- link them to services
- Brief intervention: ↑ cessation rates 2.3% (NNT 44)

Supporting (Nagging)

- Printed self-help material¹
 - Simply giving a printed quit material (11 RCT, 13,241 pts): 1.19 (1.04-1.37), 6.2% vs 5.1%
- Telephone (Proactive)²:
 - Any Proactive calling: 51 RCTs (30,246 pts): RR 1.27 (1.20-1.36), 13.1% vs 9.7%
 - Number of Calling: ≤ 2 RR 1.07 (0.91-1.26)
 - Vs 3-6 RR 1.32 (1.23-1.42) or ≥ 7 RR 1.29 (1.11-1.50)

Frightening Smokers

- Biomed feedback: spirometry, cancer risk, ultrasound of carotids, etc.¹
 - Two pairs of trials (from primary care):
 - Carbon Monoxide RR 1.06 (0.85-1.32)
 - Spirometry RR 1.18 (0.77-1.81)
 - Most no difference
 - “Lung Age” (uses spirometry): RR 2.1 (1.2-3.6)
 - Cessation was 13.6% vs 6.4% (NNT 14).²
 - Although seems promising, “lung age” group got more³

Nicotine Replacement Therapy

- Tons of trials: 150 RCTs, >50,000 pts
- NRT, any type, 6-12 months: RR1.60 (1.53-1.68)
 - Gum: 1.49 (1.40 - 1.60)
 - Patch: 1.64 (1.52 - 1.78)
 - Lozenge: 1.95 (1.61 - 2.36)
 - Inhaler: 1.90 (1.36 - 2.67)
- NRT combo (patch plus gum vs 1 NRT):
 - RR 1.34 (1.18-1.51)

Anti-depressants

- Bupropion: 44 RCTs with >13,000 pts
 - RR 1.62 (1.49 – 1.97): 19.7% vs 11.5%, NNT 13
 - 150mg SR maybe as good as 300mg SR.²
- Nortriptyline: 6 RCTs with 975 pts
 - RR 2.03 (1.48 – 2.78): 19.8% vs 9.9%, NNT 11
- None of the others work.

Nicotine Receptor Agonists

- Cytisine: 2 trials with 937 pts
 - RR 3.98 (2.01 – 7.87): 8.5% vs 2.1%, NNT 16
- Varenicline: 27 RCTs, 12,625 pts, ≥6 months
 - RR 2.27 (2.02 – 2.55): 26% vs 11%, NNT 7
 - Low dose
 - Vs placebo, 2.08 (1.56-2.78), 20% vs 10%, NNT 11
 - Hi vs Lo: RR 1.25 (1.00-1.55), 24.5% vs 19.6%, NNT 21

Harms: NRT & Bupropion

- NRT: Palpitations/chest pain¹
 - RR 1.88 (1.37-2.57), 2.5% vs 1.4%, NNH 91
 - “NRT does not increase CVD in those with past CVD”
 - RR serious CVD²: 1.38 (0.58-3.26)
- Bupropion: 7-12% withdraw due to AE³
 - Common: insomnia (30-40%) & dry mouth (10%)
 - Serious AE: 1.30 (1.00-1.69), 2.1% vs 1.9%
 - Seizure ~1 / 1,000
 - Suicidal thoughts/behav: ? ~1/700 (but inconsistent)
 - CVD: RR 1.03 (0.71-1.50).² High risk same.

Risk of neuropsychiatric AE with Varenicline

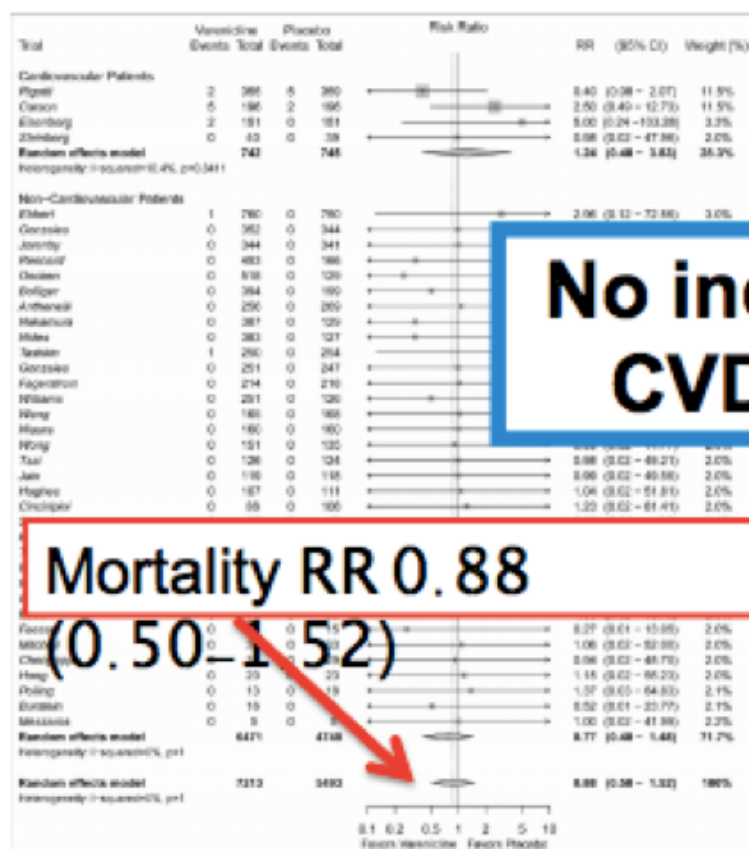
- Meta, 44 RCTs (11146 pts), 1mg BID vs placebo, ~1-52 wks.
- No diff in depression (~3% both), suicide ideation (~0.7%), attempted suicide, or suicide complete/attempted ($\leq 0.1\%$)
 - Other no diff: aggression, death (0.2%), irritability, somnolence

Difference Found	Varenicline	Control	NNH
Abnormal Dream	10.8%	4.7%	17
Fatigue	5.1%	4.3%	119
Insomnia	12.1%	8.0%	25
Anxiety	4.2%	5.1%	112 (NNT)

- **Bottom-Line:** Does not seem to be an increased risk for serious psychiatric events like suicidality or depression. Abnormal dreams & insomnia are more common.

Does varenicline increase CVD risk?

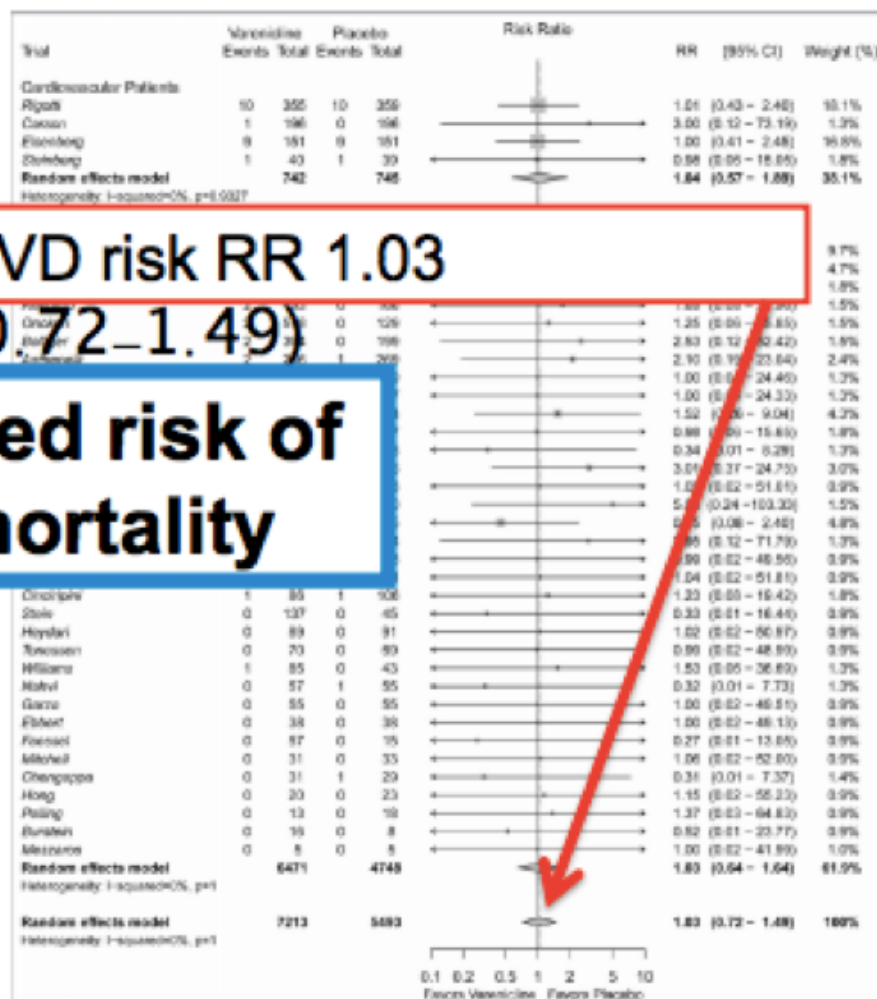
- CMAJ 2011 (14 RCTs, 8216 pts): OR 1.72 (1.09-2.71)
 - Risk ~1 year: 1.06% vs 0.82%.
- 2016: 38 RCTs, 12,706 pts



CVD risk RR 1.03
(0.72-1.49)

No increased risk of CVD or mortality

Mortality RR 0.88
(0.50-1.52)



E-cigarette components

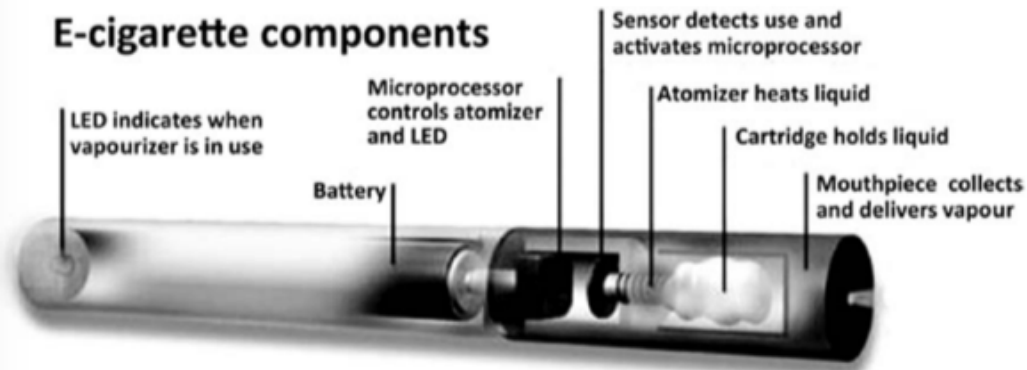


Figure 1.1 Diversity of e-cigarette products

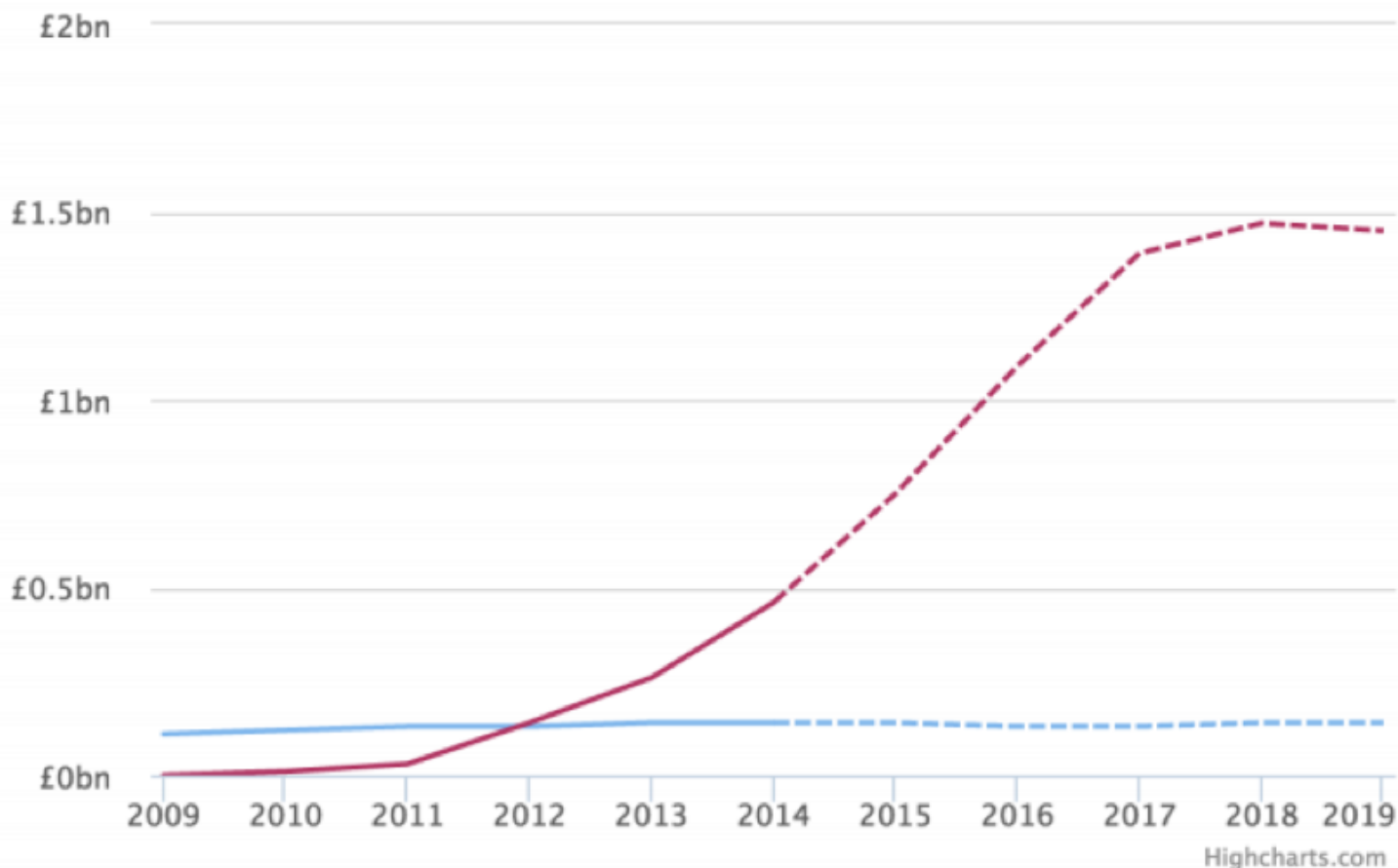


Who is Using Ecigs? United Kingdom

Brits are using e-cigarettes instead of nicotine patches



Source: Euromonitor International



NECs in those Motivated to quit **ASCEND trial**

- RCT 657 New Zealand smokers motivated to quit
 - ~55% attempted quit in last year
 - 43 yo, 63% ♀, 33% Maori, 50% live w smokers
- NECs, nicotine patch, placebo Ecs x 12 wks
 - 4:4:1 randomization
 - All offered counseling (~40% uptake)
- Quality: AC, ITT, blinded patients, adjudicators

ASCEND Results @ 6 months

Product	50% ↓ daily cig use	Smoking Cessation	Still Using product	Recommend Ecigs to others
NECs (n =289)	57%*	7.3%	29%	88%
Nicotine Patch (n=295)	41%*	5.8%	8%	56%
Placebo ECs (n=73)	45%	4.1%	35%	92%

* = Statistical Significant

Compared to Nicotine patches, for every 7 patients on NECs 1 will have 50% ↓ in cigarette consumption

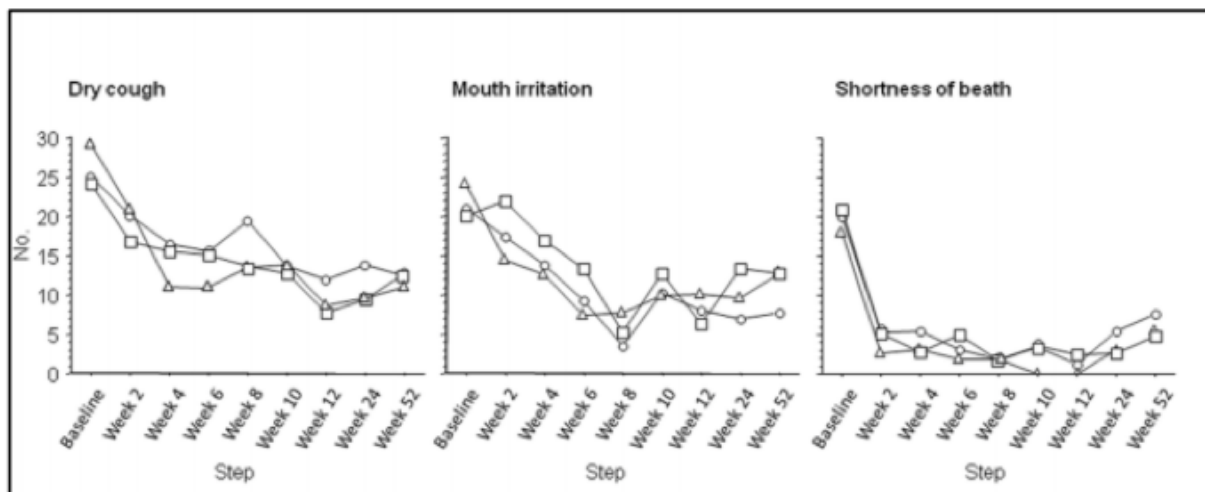
NECs in those not willing to quit: **ECLAT Trial**

- RCT 300 Italian smokers (63% ♂), < 1 previous quit attempt and:
 - Not intention of quitting stopping
 - Not interested in cessation program
- NEC, tapering NEC, or placebo EC x 12 wks
- At 12 months (NEC & TNEC combined)
- Quality: AC, ITT, blinded: patients, clinicians

Unmotivated Italian Men: ECLAT Outcomes @ 12 months

Product	≥ 50% ↓ cigarettes smoked per day (%)	Quitters (%)
NEC and Taper NEC	14.5	11*
Placebo EC	12	4

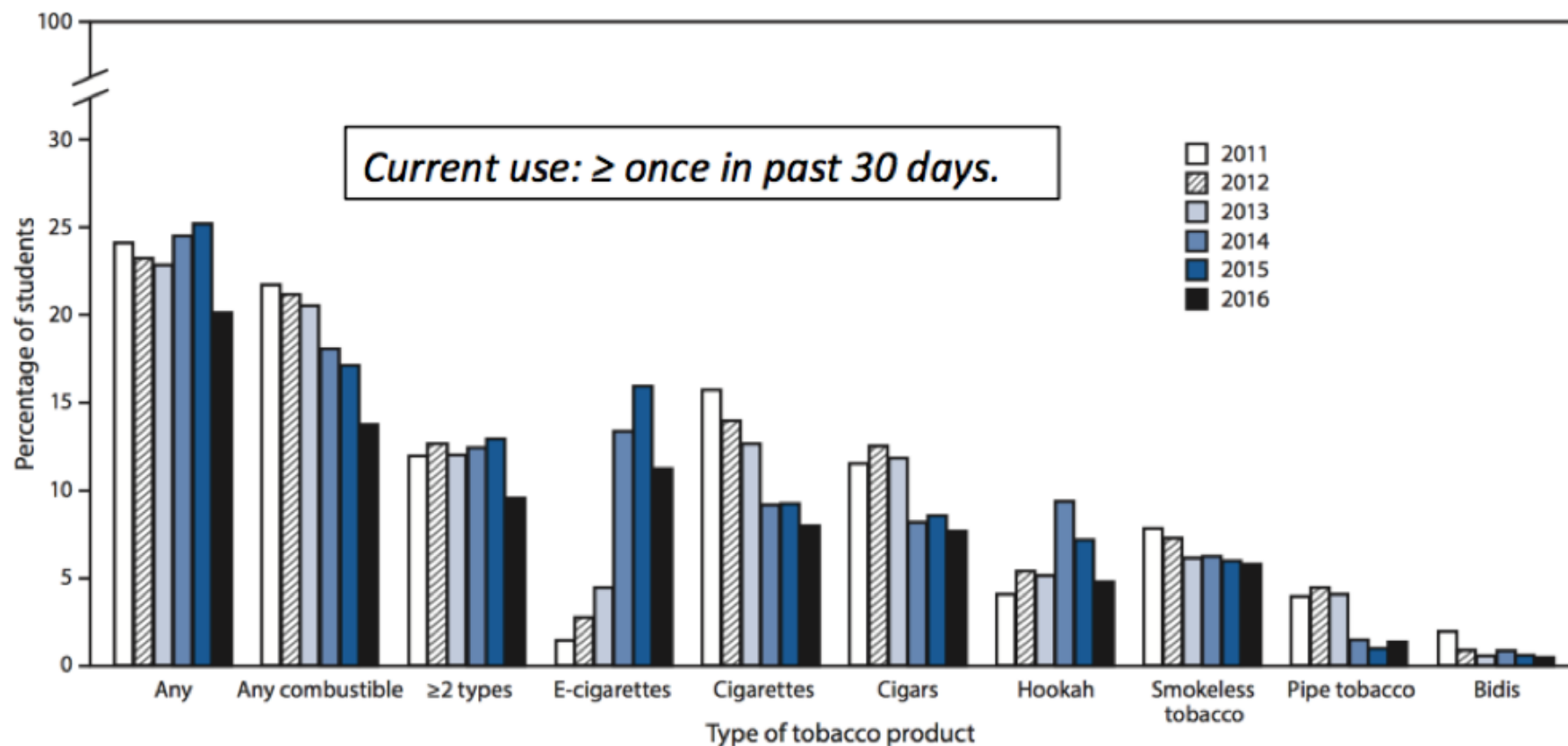
***For every 15 patients given NEC → 1 additional quit**



PLoSOne.2013;8(6):e66317

US High School Students 2016

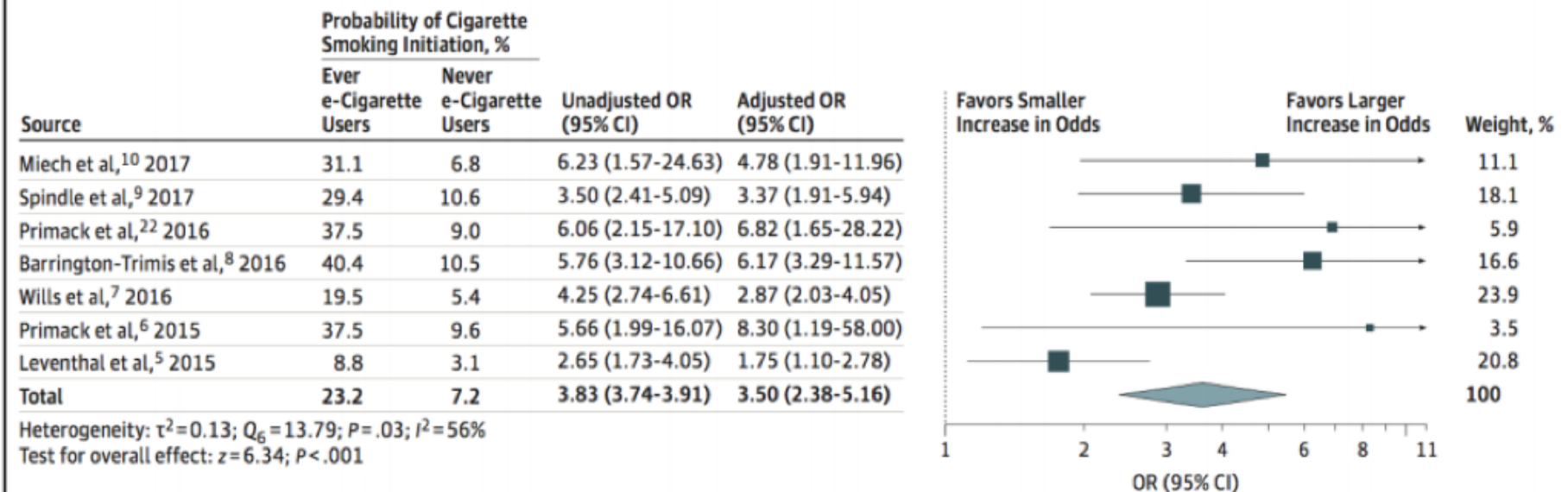
FIGURE 1. Estimated percentage of high school students who currently use any tobacco products,* any combustible tobacco products,[†] ≥ 2 tobacco products,[§] and selected tobacco products — National Youth Tobacco Survey, United States, 2011–2016^{¶,**,††}



Are NECs a Gateway to Cigarettes Adolescents / Young Adults?

- SR of 7 cohort studies of >17,000 young adults
 - All US: regional and national surveys

Figure 2. Meta-analysis of Adjusted Odds of Cigarette Smoking Initiation Among Never Cigarette Smokers at Baseline and Ever e-Cigarette Users at Baseline Compared With Never e-Cigarette Users at Baseline



Toxicants in ECigs

Chemical	Health Effects	Amount in ECigs
Formaldehyde, acetaldehyde, acrolein	Known carcinogen	Formaldehyde: ↓ levels unless supra normal voltage
Ethylene glycol	Not “recognized as safe”	Varies
Volatile Organic Carbons: toluene, xylene	? carcinogen	100 Xs less in Ecigs
Tobacco-Specific Nitrosamines (TSNAs)	Known carcinogens	40 – 400 Xs less in Ecigs

“Smoke for Nicotine, killed by tar”

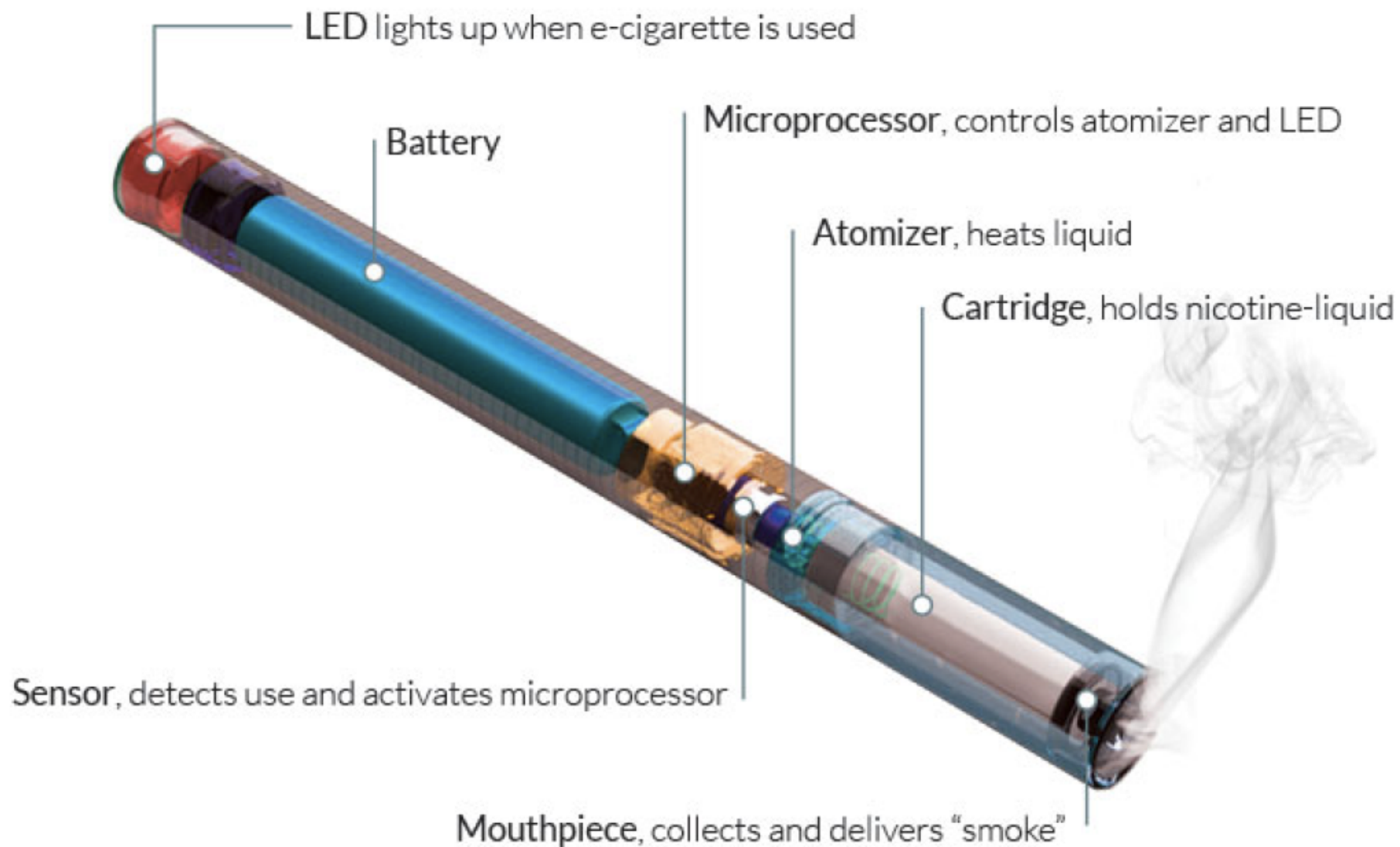


Table. Concentrations of 8 Volatile Organic Compounds, 16 Polycyclic Aromatic Hydrocarbons, 3 Inorganic Compounds, and Nicotine in Mainstream Aerosol and Temperature of the HNB IQOS Cigarette and Conventional Cigarettes

Analyzed Compound	HNB Cigarette		Conventional Cigarette		Proportion of the Chemical in HNB and Conventional Cigarettes, %
	Amount, Mean (SD)	No. of Replications for Each Assay	Amount, Mean (SD)	No. of Replications for Each Assay	
Volatile organic compounds, µg per cigarette ^a					
Acetaldehyde	133 (35)	5	610 ^b	1	22
Acetone	12.0 (12.9)	5	95.5 (13.5)	2	13
Acroleine	0.9 (0.6)	2	1.1	1	82
Benzaldehyde	1.2 (1.4)	5	2.4 (2.6)	2	50
Crotonaldehyde	0.7 (0.9)	5	17.4	1	4
Formaldehyde	3.2 (2.7)	5	4.3 (0.4)	2	74
Isovaleraldehyde	3.5 (3.1)	5	8.5 (10.8)	2	41
Propionaldehyde	7.8 (4.3)	5	29.6 (36.6)	2	26

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Polycyclic aromatic hydrocarbons, ng per cigarette ^c					
Naphthalene	1.6 (0.5)	4	1105 (269)	7	0.1
Acenaphthylene	1.9 (0.6)	4	235 (39)	7	0.8
Acenaphthene	145 (54)	4	49 (9)	7	295
Fluorene	1.5 (0.6)	4	371 (56)	7	0.4
Anthracene	0.3 (0.1)	4	130 (18)	7	0.2
Phenanthrene	2.0 (0.2)	4	292 (44)	7	0.7
Fluoranthene	7.3 (1.1)	4	123 (18)	7	6
Pyrene	6.4 (1.1)	4	89 (15)	7	7
Benz[a]anthracene	1.8 (0.4)	4	33 (4.2)	7	6
Chrysene	1.5 (0.3)	4	48 (6.2)	7	3
Benzo[b]fluoranthene	0.5 (0.2)	4	24 (2.9)	7	2
Benzo[k]fluoranthene	0.4 (0.2)	4	4.3 (2.8)	7	9
Benzo[a]pyrene	0.8 (0.1)	4	20 (2.9)	7	4
Indeno[1,2,3-cd]pyrene	ND	4	NA	NA	NA
Benzo[ghi]perylene	ND	4	NA	NA	NA
Dibenzo[a,h]anthracene	ND	4	NA	NA	NA

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	Amount, Mean (SD)	No. of Replications for Each Assay	Amount, Mean (SD)	No. of Replications for Each Assay	
Inorganics, ppm in the mainstream smoke ^d					
Carbon dioxide	3057 (532)	5	>9000	3	NA
Carbon monoxide	328 (76)	5	>2000	3	NA
Nitric oxide	5.5 (1.5)	5	89.4 (71.6)	3	6
Other measures					
Nicotine, µg per cigarette ^a	301 (213)	4	361	1	84
Temperature, °C	330 (10)	2	684 (197)	1	NA
Puff total count	12.6 (2.4)	32	13.3 (3.1)	6	NA



WE WILL FIND THESE
GLOBAL MASS KILLERS,
WHEREVER THEY HIDE,
WE WILL SMOKE THEM
OUT AND BRING THEM
TO JUSTICE!



WORLD
The Miami Herald



WE WILL FIND THESE
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TO JUSTICE!

RELAX... HE'S
REFERRING TO
ISLAMIC TERRORISTS...





Dépositaire

État des traités

Notifications dépositaires

Exemplaires certifiés conformes

Photos des cérémonies

Modèles d'instruments

Titres des traités

Traités de la Société des Nations

État des traités (1959-2009)



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VOIR EN PDF



VUE INTÉGRALE



VOIR CTC



VUE XML



FAVORIS

CHAPITRE IX

4.

État au : 03-04-2018 05:00:31EDT

CHAPITRE IX

SANTÉ

4. Convention-cadre de l'OMS pour la lutte antitabac

Genève, 21 mai 2003

Enregistrement : 27 février 2005, No 41032

État : Signataires : 168. Parties : 181

Texte : Nations Unies, *Recueil des Traités*, [vol. 2302](#), p. 167.

Note : La Convention susmentionnée a été adoptée au cours de la cinquante-sixième Assemblée mondiale de la santé, qui a eu lieu au Palais des Nations à Genève, du 19 au 28 mai 2003. La Convention a été ouverte à la signature de tous les États Membres de l'Organisation mondiale de la santé, ou de l'Organisation des Nations Unies, ainsi que des organismes d'intégration économique régionale, du 16 au 22 juin 2003, au Siège de l'Organisation mondiale de la santé à Genève, et, du 30 juin 2003 au 29 juin 2004 au Siège de l'Organisation des Nations Unies à New York.



FCTC

CONVENTION-CADRE DE L'OMS
POUR LA LUTTE ANTITABAC



ariat

Instruments
d'application du traité

Plateforme de
coordination

Soumission
des rapports

Centre
des médias

Chercher

Convention-cadre de l'OMS pour la lutte antitabac



La Convention-cadre de l'OMS pour la lutte antitabac est le premier traité international négocié sous les auspices de l'Organisation mondiale de la Santé. Elle a été adoptée par l'Assemblée mondiale de la Santé le 21 mai 2003 et est entrée en vigueur le 27 février 2005. Elle est devenue depuis l'un des traités ayant remporté la plus rapide et la plus large adhésion dans l'histoire des Nations Unies.

La Convention-cadre de l'OMS a été élaborée à la suite de la mondialisation de l'épidémie de tabagisme. Il s'agit d'un traité fondé sur des données factuelles qui réaffirme le droit de tous les peuples au niveau de santé le plus élevé possible. La Convention représente un jalon dans la promotion de la santé publique et apporte une dimension juridique nouvelle à la coopération internationale en matière de santé.



CONVENTION-CADRE DE L'OMS
POUR LA LUTTE ANTITABAC

La Convention-cadre de l'OMS pour la lutte antitabac : présentation générale

Contexte

La **Convention-cadre de l'OMS pour la lutte antitabac** (Convention-cadre de l'OMS) est le premier traité mondial de santé publique. Il s'agit d'un traité fondé sur des données factuelles, qui réaffirme le droit de tous les peuples au niveau de santé le plus élevé possible.

La Convention-cadre de l'OMS a été élaborée par les pays à la suite de la mondialisation de l'épidémie de tabagisme. Elle vise à s'attaquer à certaines causes de cette épidémie, dont un ensemble de facteurs complexes ayant des effets transfrontaliers, notamment la libéralisation des échanges commerciaux et les investissements étrangers directs, les activités transnationales de publicité, de promotion et de parrainage, et le commerce illicite des produits du tabac.

Le Préambule de la Convention-cadre de l'OMS résume les préoccupations qui ont amené les pays à juger nécessaire l'élaboration d'un instrument juridique international de cette nature.

http://www.who.int/fctc/WHO_FCTC_summary_January2015_FR.pdf?ua=1&ua=1

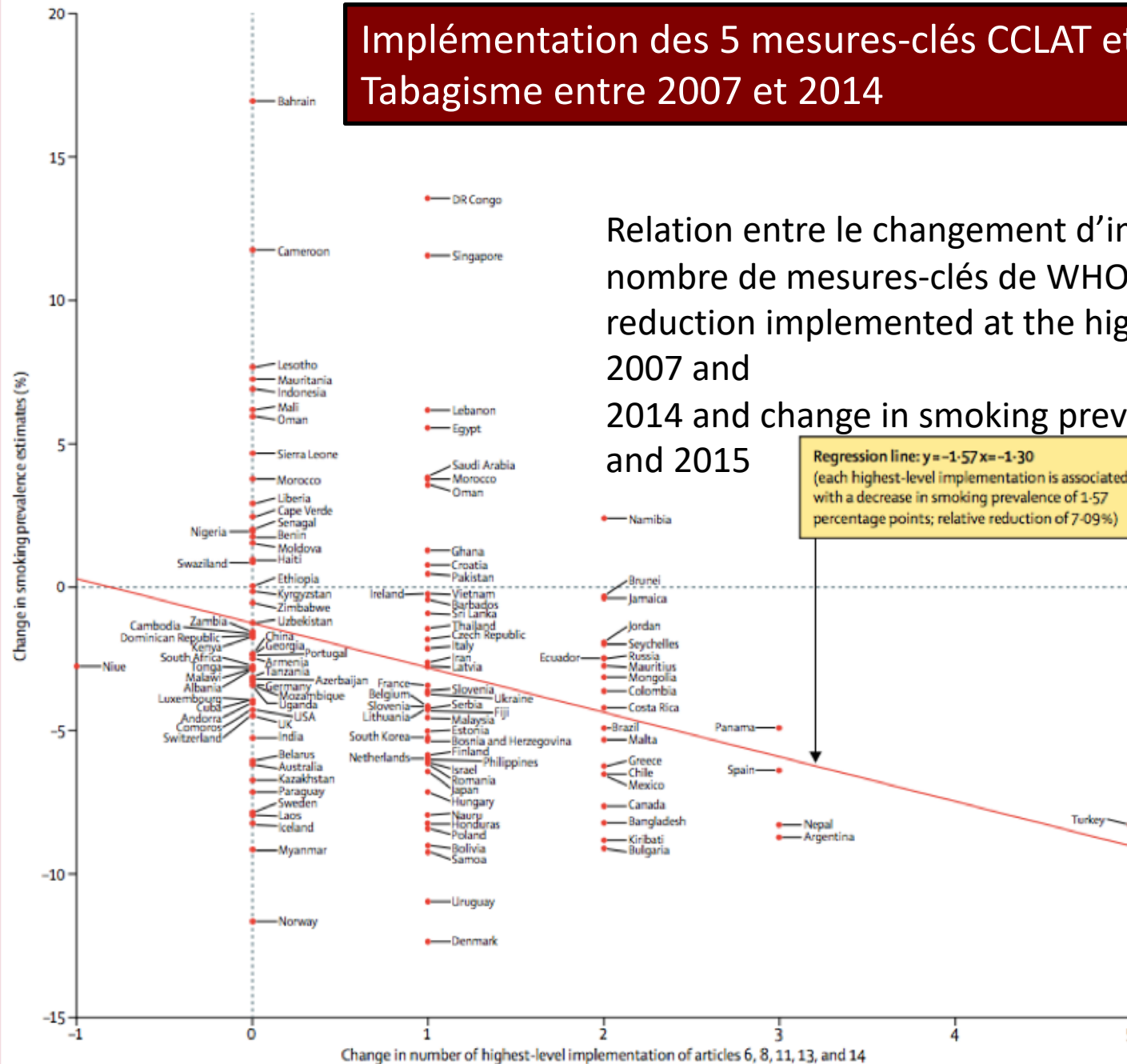
Taxation (article 6)	Smoke-free policies (article 8)	Warning labels (article 11)	Bans on advertising, promotion, and sponsorship (article 13)	Cessation programmes (article 14)
Taxes comprise at least 75% of retail price of the most popular brands of cigarettes	All public places completely smoke-free: • Health-care facilities • Educational facilities • Universities • Government facilities • Indoor offices • Hospitality venues (restaurants, bars, pubs, etc) • Public transportation	Large warnings covering an average of at least 50% of the front and back of the package* with all appropriate characteristics: • Specific warnings are mandated and rotated • Describing the harmful effects of tobacco use on health • Located on individual packs and any outside packaging used in retail sale • Large, clear, visible, and legible • Written in (all) principal language(s) of the country • Including pictures or pictograms (photographic or graphic)	A ban on all forms of direct and indirect advertising: • National television and radio • Local magazines and newspaper • Billboards (and all other outdoor advertising) • Point-of-sale advertising • Free distribution by mail or other means • Promotional discounts • Non-tobacco goods and services identified with brand names • Brand name of non-tobacco goods and services used for tobacco products • Appearance of tobacco brands or products in television and films • Sponsored events	A national toll-free quit line, and both nicotine replacement treatment and some or all cessation services partially or fully cost-covered

Figure 1: WHO criteria for the highest level of achievement of key tobacco control demand-reduction measures

*Replaced 2007 criterion, which did not require warning to cover an average of 50% of the front and back (only at least 50% of the principal display area of the pack).

Implémentation des 5 mesures-clés CCLAT et Prévalence du Tabagisme entre 2007 et 2014

Relation entre le changement d'implémentation du nombre de mesures-clés de WHO FCTC demand-reduction implemented at the highest level between 2007 and 2014 and change in smoking prevalence between 2005 and 2015

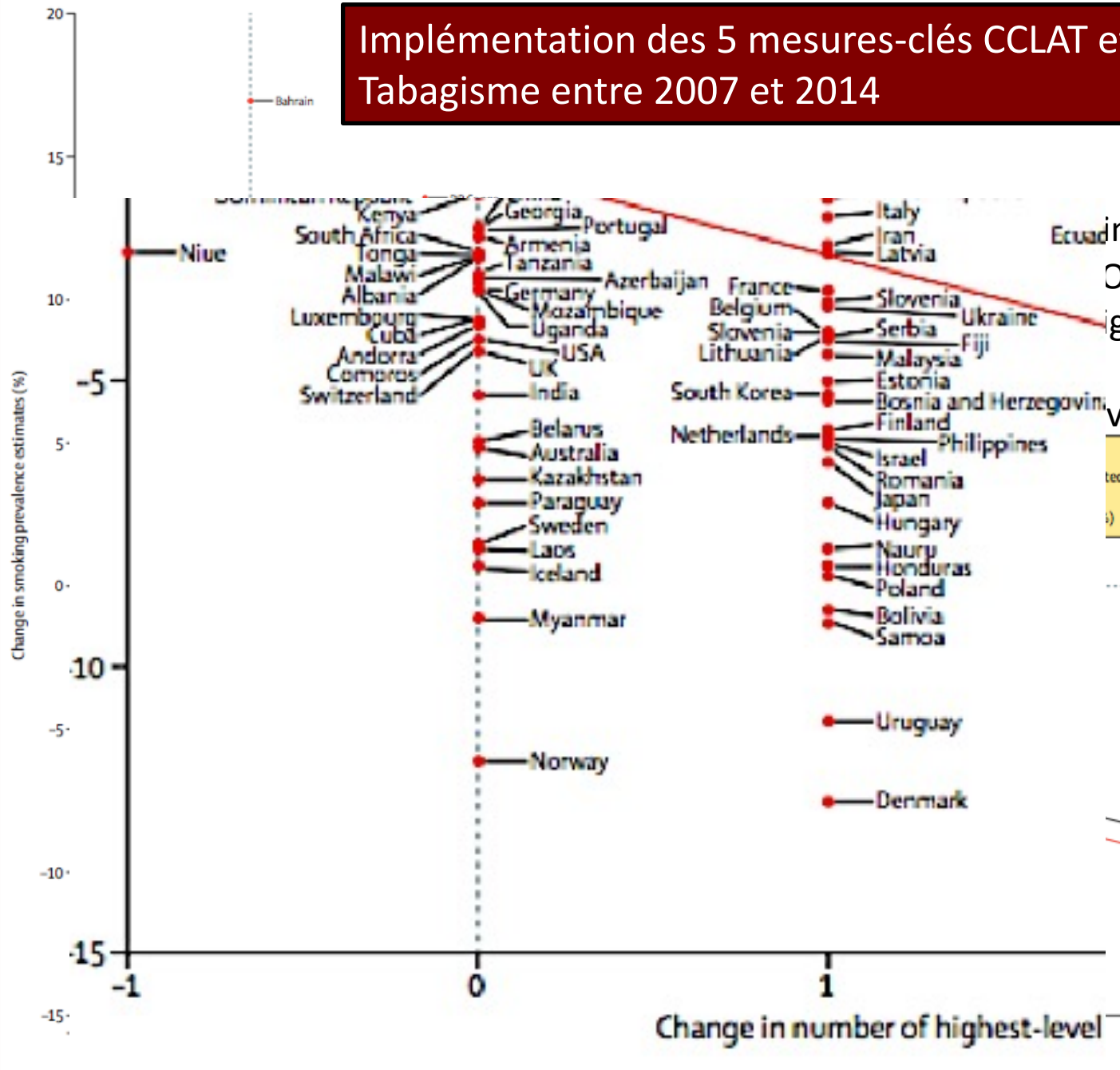


CCLAT :
Convention-cadre de
l'OMS pour la lutte
antitabac

[www.thelancet.com/
public-health](http://www.thelancet.com/public-health)
Vol 2 April 2017

Figure 2: Relation between change in the number of five key WHO FCTC demand-reduction measures implemented at the highest level between 2007 and 2014 (x-axis) and change in smoking prevalence between 2005 and 2015 (y-axis)

Implémentation des 5 mesures-clés CCLAT et Prévalence du Tabagisme entre 2007 et 2014



implémentation du
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Article 8

Protection from exposure to tobacco smoke

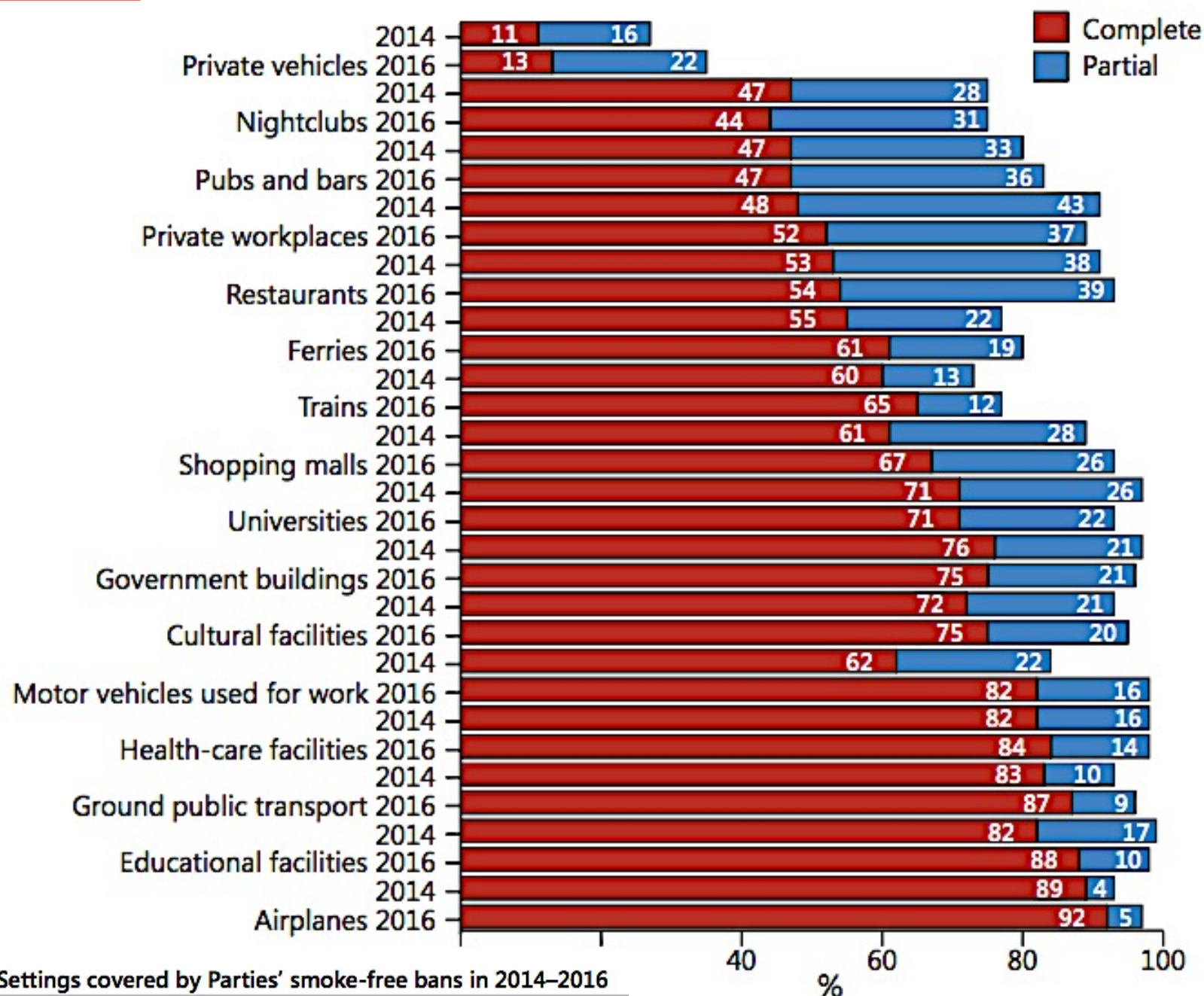
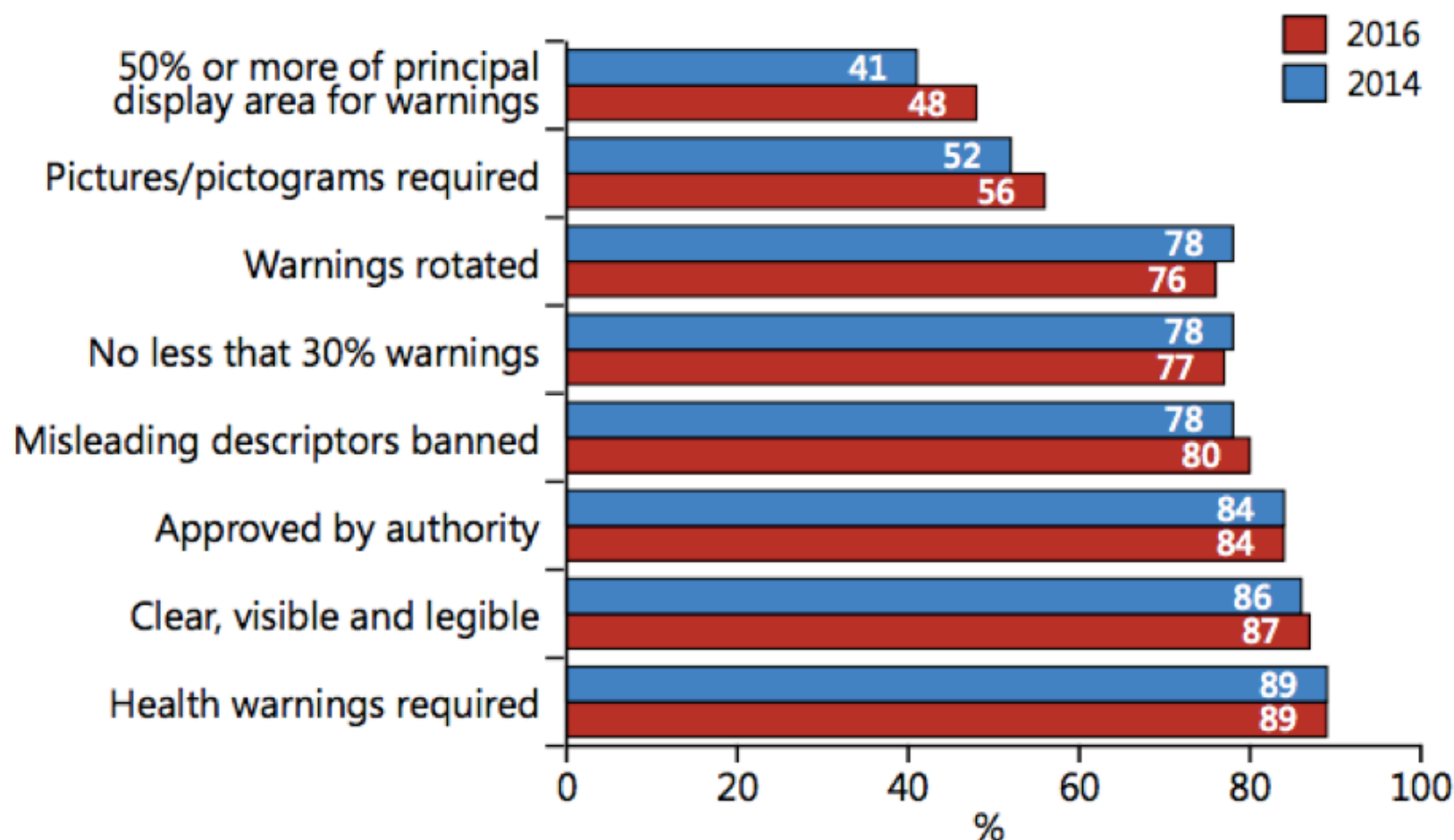


Figure 3.1. Settings covered by Parties' smoke-free bans in 2014–2016

Article 11 *Packaging and labelling of tobacco products*

Figure 3.3. Percentage of Parties implementing time-bound provisions under Article 11 in 2014–2016.



A POLICY PACKAGE TO REVERSE
THE TOBACCO EPIDEMIC

mpower



- M**onitor tobacco use and prevention policies
- P**rotect people from tobacco smoke
- O**ffer help to quit tobacco use
- W**arn about the dangers of tobacco
- E**nforce bans on tobacco advertising, promotion and sponsorship
- R**aise taxes on tobacco

The power of a treaty

According to WHO, about 6 million people die from tobacco use every year, and this is estimated to increase to more than 8 million a year by 2030 without intensified action. Against this predicament, public health is not unarmed. In response to the globalisation of the tobacco epidemic, the WHO Framework Convention on Tobacco Control (WHO FCTC)—the first international treaty negotiated under the auspices of WHO—was adopted in 2003, and entered into force in 2005. For WHO, the Convention represents “a milestone for the promotion of public health and provides new legal dimensions for international health cooperation.” It certainly does. But does it work? A decade later—it is time to assess the power of this treaty.

To answer this question, Shannon Gravely and colleagues examined the association between implementation of key tobacco control measures of the WHO FCTC and smoking prevalence in 126 countries

people’s freedom of choice. Only a fifth of countries had implemented tax measures at the highest level, while raising tobacco taxes to increase prices is the most effective way of reducing tobacco use. Smoking prevalence decreased in 71 countries, but worryingly, did not change in 12 countries and increased in 24 countries. Increases in tobacco prevalence are expected in some parts of the world, in particular in developing countries in Africa.

Tobacco control needs to be firmly anchored in the Sustainable Development Goals (SDGs). It is one of the most effective ways to achieve SDG 3 and its target of a one-third reduction of premature deaths from non-communicable diseases—including cardiovascular disease, cancers, and pulmonary disease, by 2030.

From April, the FCTC 2030 project will support WHO FCTC Parties that are eligible to receive official development assistance to achieve the SDGs by



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See Comment page e158
See Article page e166

For the FCTC 2030 project see
<http://www.who.int/fctc/implementation/fctc2030/en/>

Tobacco control needs to be firmly anchored in the Sustainable Development Goals (SDGs). It is one of the most effective ways to achieve SDG 3 and its target of



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TOBACCO

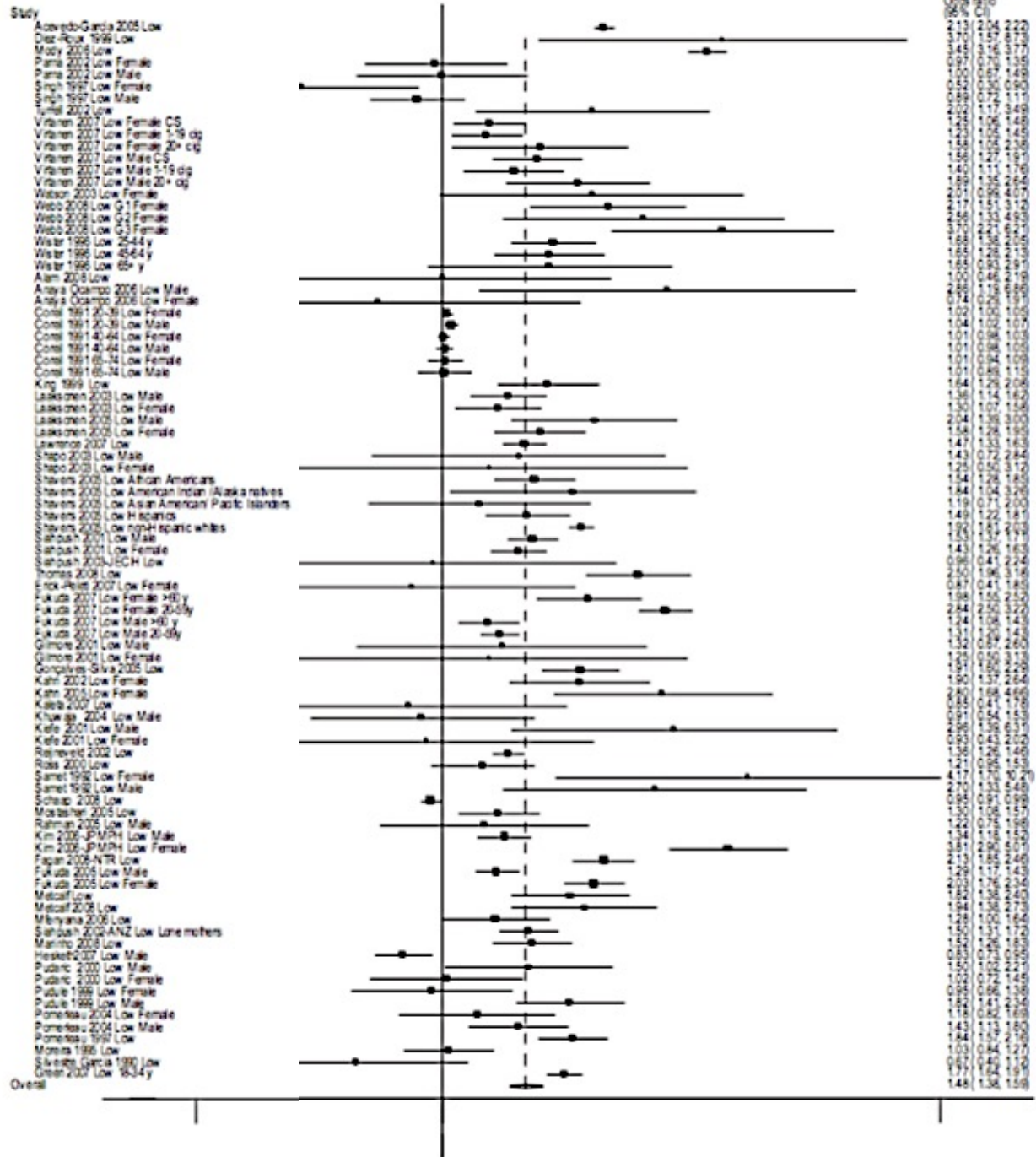
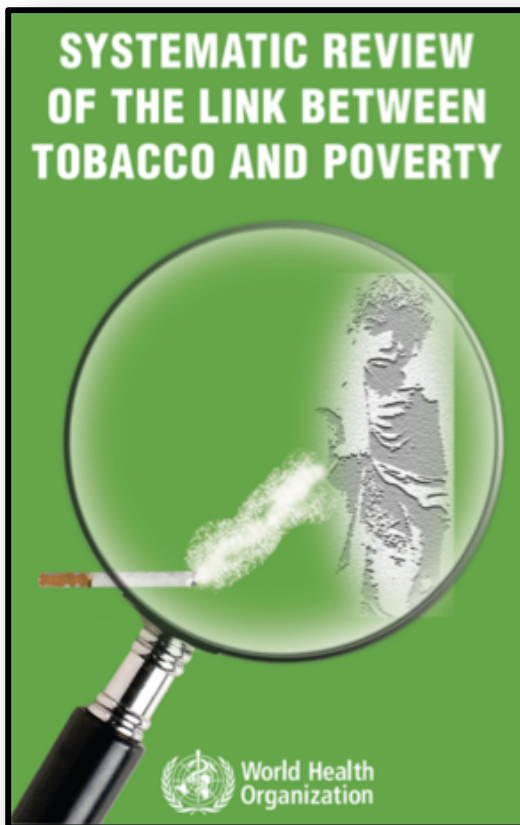
A BARRIER TO SUSTAINABLE DEVELOPMENT



Le tabagisme, un obstacle au développement







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إِنَّ اللَّهَ لَا يُغَيِّرُ مَا بِقَوْمٍ حَتَّى يُغَيِّرُوا مَا بِأَنْفُسِهِمْ

Approche Individuelle :

Les moyens classiques MARCHENT et SANS RISQUE pour QUELQUES

L'e-cigarette:

Aide au sevrage

Aide au Tabagisme des jeunes

Le Tabac Chauffé : Même mesures que pour les Cigarettes

Approche Populationnelle :

Convention-Cadre OMS +++

Pour les pays en développement :

Intégrer la lutte antitabac dans les ODD