Smoking Cessation Leadership Center

UCSF

University of California San Francisco

The Epidemiology and Treatment of Smoking in People with Mental Illness

Gemma Taylor, PhD, Reader at University of Bath, UK

September 8, 2022

Moderator

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University of California, San Francisco

A National Center of Excellence for Tobacco-Free Recovery

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Disclosures

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Catherine Bonniot Saucedo, Anita Browning, Christine Cheng, Brian Clark, Pamela Ling, MPH, MD, Jennifer Matekuare, Ma Krisanta Pamatmat, MPH, Jessica Safier, MA, Gemma Taylor, PhD, and Aria Yow, MA.

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September: National Recovery Month

https://www.samhsa.gov/recovery-month

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Today's Presenter

Gemma Taylor, PhD

Reader

University of Bath

THE EPIDEMIOLOGY AND TREATMENT OF SMOKING IN PEOPLE WITH MENTAL ILLNESS

DR GEMMA TAYLOR, PHD

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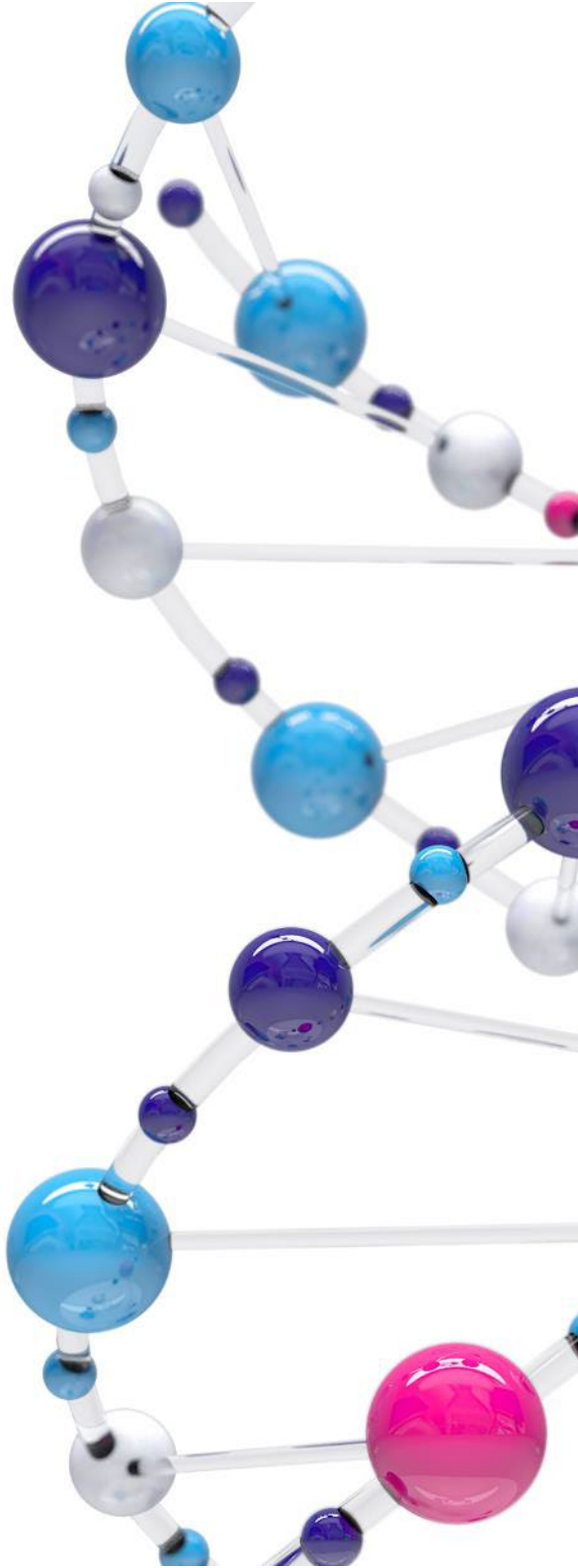

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UNIVERSITY OF BATH

DISCLOSURES AND FUNDING

- This work was partially supported by the National Institute for Health Research (NIHR), via Cochrane Infrastructure funding to the Tobacco Addiction Group.
- I receive funding from a Cancer Research UK Population Researcher Postdoctoral Fellowship award (reference: C56067/A21330) and Cancer Research UK project award (reference: PPRCPJT\100023).
- I report previous funding from Pfizer (GRAND scheme) for an unrelated project.
- I am employed by a scientific consulting company (HEOR) doing work unrelated to this project.

OVERVIEW

1) Why is this an important research area?
2) A Cochrane systematic review about the association between quitting smoking and mental ill-health.
3) The ESCAPE pilot trial – intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety.

QR codes throughout – scan with phone camera!

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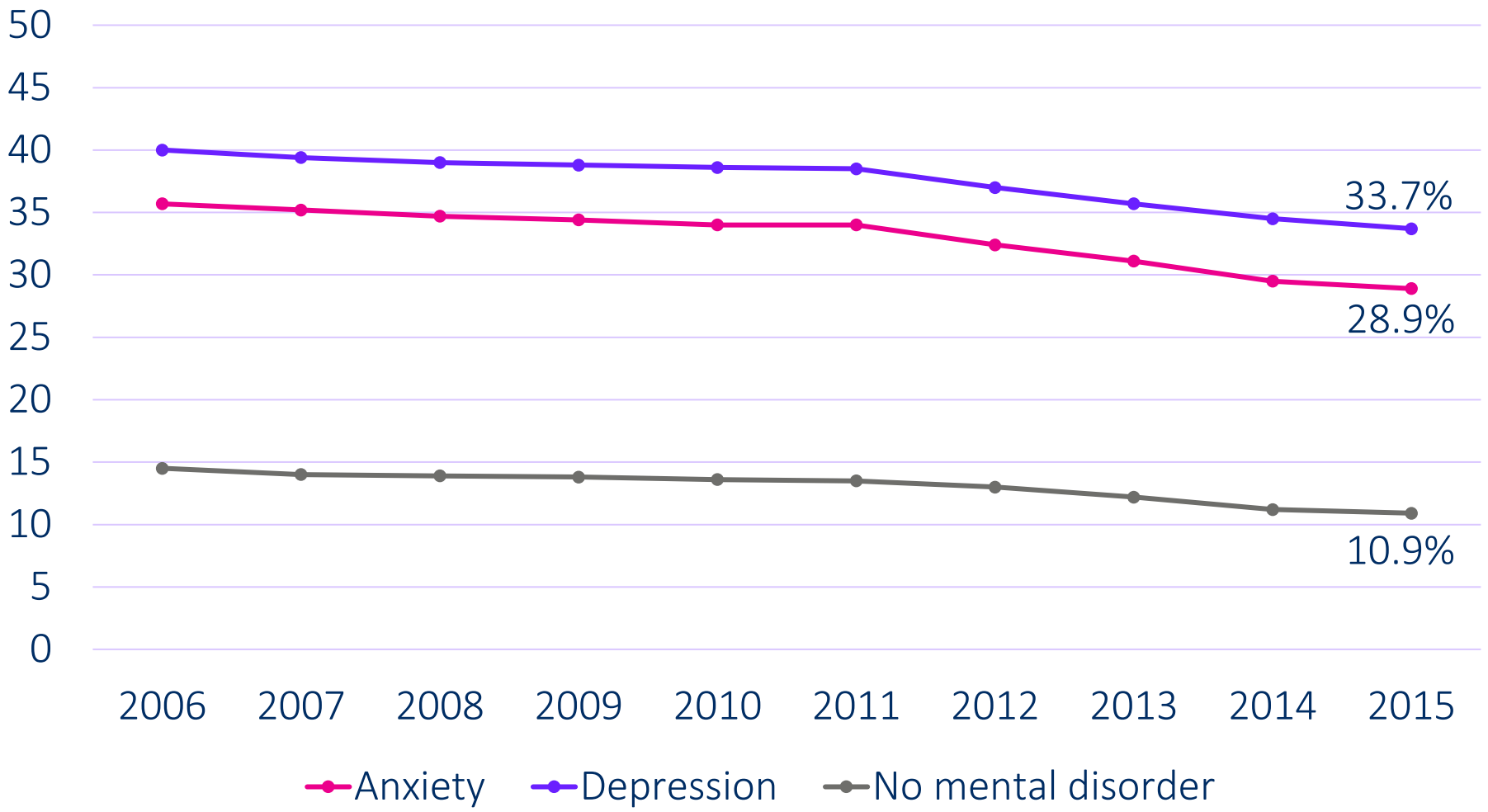
"I was signed off work with depression. I was asked if I smoked and I was encouraged not to try and quit... I was given anti-depressants instead."

- Smoker with depression, male, aged 37

UK SMOKING PREVALENCE IN PEOPLE WITH AND WITHOUT ANXIETY AND DEPRESSION, 2006-2015

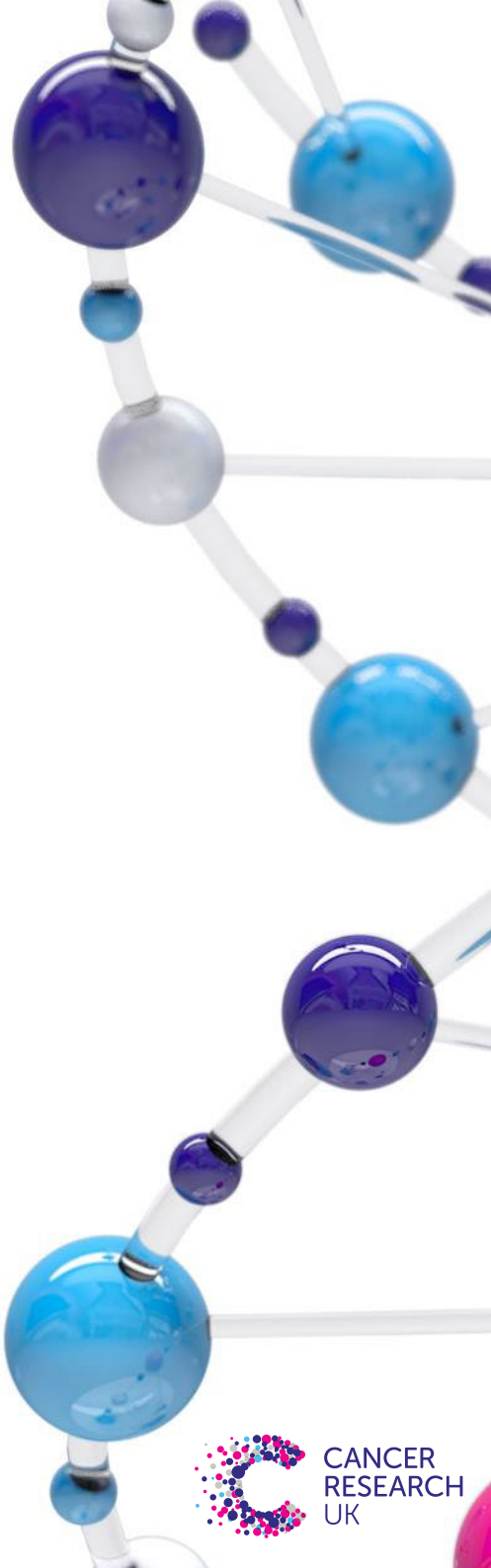


Taylor G., et al (2019). Nicotine & Tobacco Research. ntz072, https://doi.org/10.1093/ntr/ntz072.

RATIONALE

People with mental illness:

- Smoke more, are more heavily addicted, and suffer from worse withdrawal
- Less responsive to standard treatments
- Experience a reduction in life expectancy up to 17.5 years
- They are as motivated to quit as the general population



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RATIONALE

- A common perception that smoking helps people to manage stress and may be a form of 'self-medication'.
- However, there are biologically plausible reasons why smoking may worsen mental health through neuroadaptations arising from chronic smoking, leading to frequent nicotine withdrawal symptoms (e.g., anxiety, low mood, irritability).
- Therefore, quitting smoking may help to improve rather than worsen mental health.

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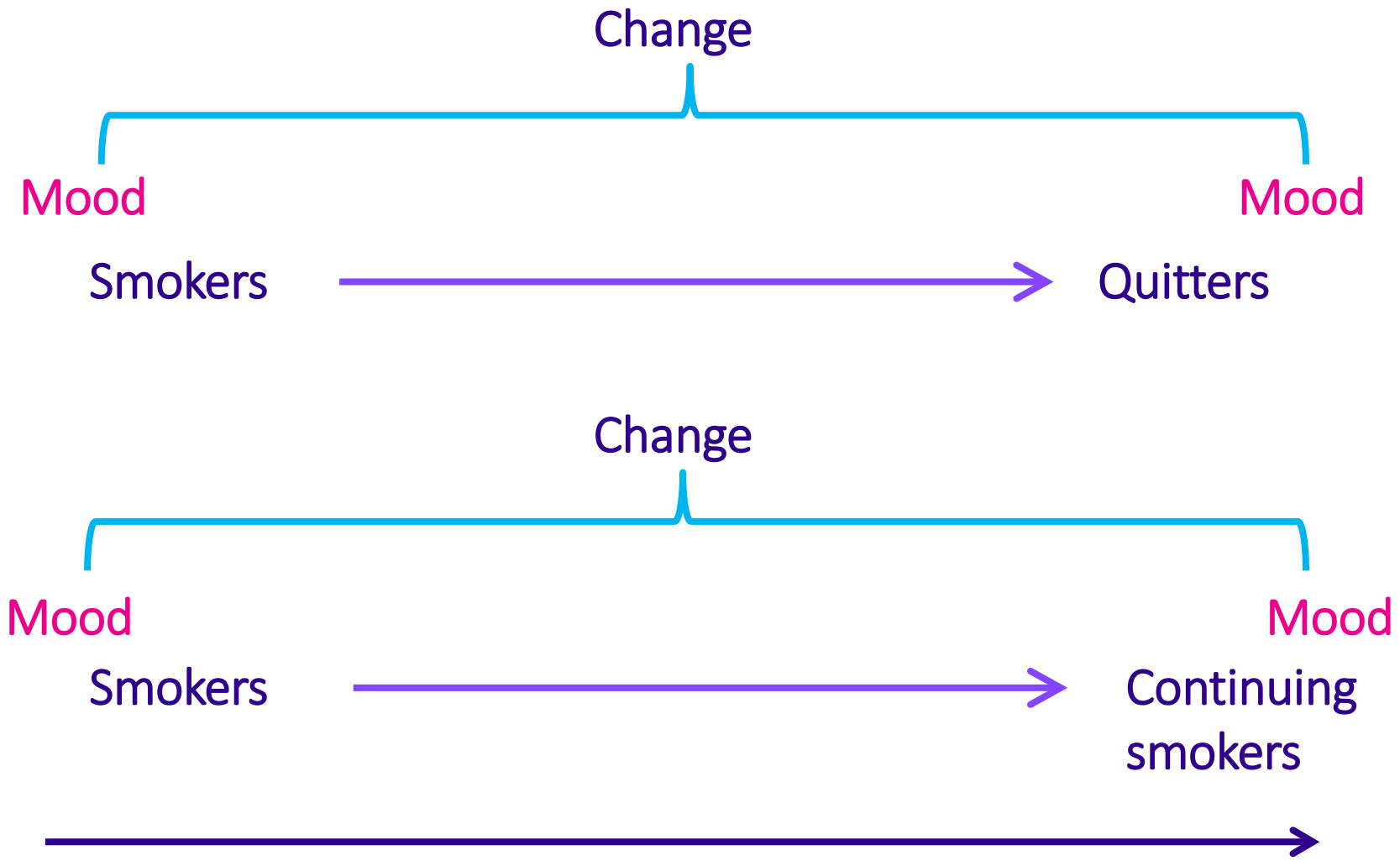
Cochrane Database of Systematic Reviews

Smoking cessation for improving mental health (Review)

Taylor GMJ, Lindson N, Farley A, Leinberger-Jabari A, Sawyer K, te Water Naudé R, Theodoulou A, King N, Burke C, Aveyard P

OBJECTIVES


Change
Mood
Mood
Smokers
Quitters
Change
Mood
Mood
Smokers
Continuing smokers
Baseline to follow-up (6 weeks>)

METHODS

STUDIES:

- Controlled before-after studies
- RCTs analysed by smoking status at follow-up
- Longitudinal cohort studies
- At least 6 weeks follow-up

PARTICIPANTS:

- Adults who smoked tobacco (using studies own definition)
- No restrictions by population type, or comorbidities

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METHODS

EXPOSURE:

- Quitting smoking (any definition, e.g., self report, bio-validated, preference for most stringent definition)

CONTROL:

- Continued smoking

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METHODS - OUTCOMES

CHANGE IN SYMPTOMS OF:

- Anxiety
- Depression
- Stress
- Psychological QOL
- Positive affect
- Mixed anxiety and depression
- Social QOL

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METHODS - SEARCHES

- Updated our previous review, inception to April 12 2012 (Taylor, 2014)
- Searched April 13 2012 to January 7 2020: Cochrane tobacco addiction group register, Cochrane central register of controlled trials, Medline, Embase, PsycInfo, clinicaltrials.gov, International Clinical Trials Registry Platform
- Translated non-English studies

Taylor, G. et al. (2014). Change in mental health after smoking cessation: systematic review and meta-analysis. BMJ; 348:g1151; Taylor, et al. Smoking cessation for improving mental health. Cochrane Database of Systematic Reviews 2021, Issue 3. Art. No.: CD013522.

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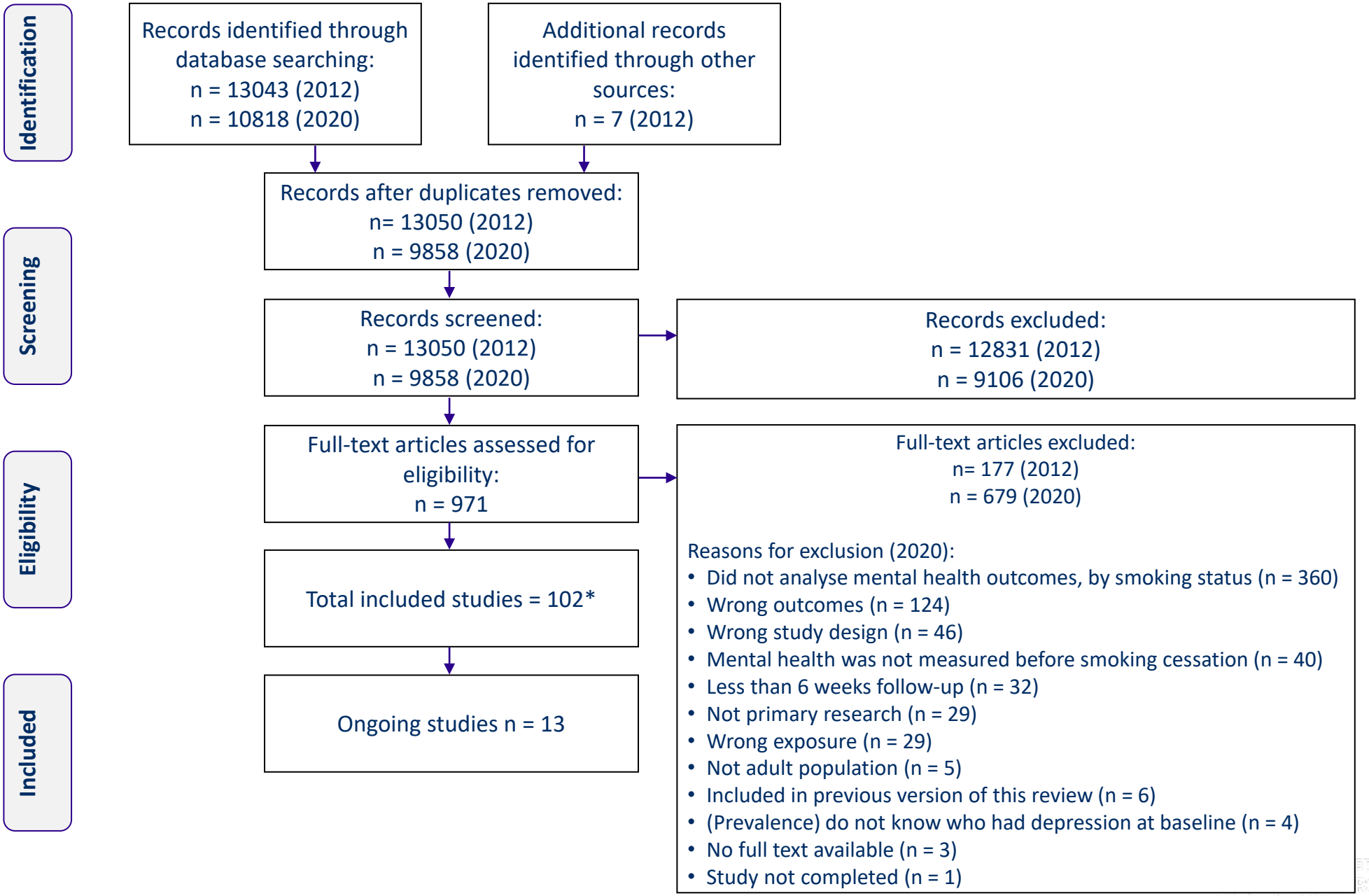
Figure 1. Study Flow Diagram 2020



*40 of these studies were identified through the 2012 literature searches

RESULTS

Search results:

- Screened 22,908 titles and abstracts
- Read 971 full-text studies

Included studies:

- Included 102 studies*
- 73 meta-analysed
- 31 narrative synthesis

Included participants:

- >169,500 participants included**
- >42,000 participants meta-analysed**

*2 studies were included in the meta-analysis and narrative review because they reported data suitable for meta-analysis for one outcome, and data only suitable for narrative synthesis for another outcome)** not possible to give exact Ns as some studies did not report total N analysed.

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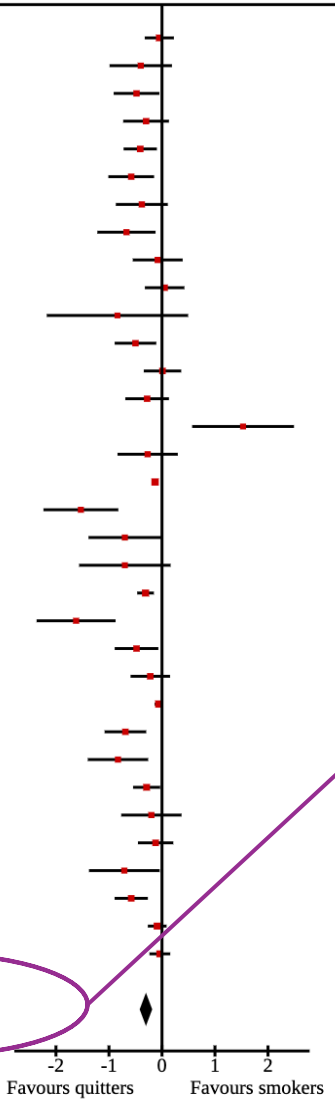
DIFFERENCE IN CHANGE IN DEPRESSION, BETWEEN QUITTERS AND CONTINUING SMOKERS, SMD (95% CI)

Study or Subgroup	SMD	SE	Quitters Total	Smokers Total	Weight	Std. Mean Difference IV, Random, 95% CI
Covey 2015 (1)	-0.05	0.14	99	126	4.2%	-0.05 [-0.32 , 0.22]
Bock 2012	-0.4	0.3	16	39	1.7%	-0.40 [-0.99 , 0.19]
Martínez-Vispo 2016	-0.48	0.22	57	35	2.6%	-0.48 [-0.91 , -0.05]
Berlin 2010	-0.3	0.22	27	106	2.6%	-0.30 [-0.73 , 0.13]
Lubitz 2019	-0.41	0.16	36	143	3.7%	-0.41 [-0.72 , -0.10]
Blalock 2008	-0.58	0.22	9	12	2.6%	-0.58 [-1.01 , -0.15]
Dawkins 2009	-0.38	0.25	33	31	2.2%	-0.38 [-0.87 , 0.11]
Garvey 2012	-0.67	0.28	16	90	1.9%	-0.67 [-1.22 , -0.12]
Tranel 2012	-0.08	0.24	32	38	2.4%	-0.08 [-0.55 , 0.39]
Guimond 2017	0.05	0.19	55	55	3.1%	0.05 [-0.32 , 0.42]
Moadel 2012	-0.84	0.68	16	108	0.4%	-0.84 [-2.17 , 0.49]
Lopez 2015	-0.5	0.2	28	206	3.0%	-0.50 [-0.89 , -0.11]
Solomon 2006	0.01	0.18	45	84	3.3%	0.01 [-0.34 , 0.36]
Kahler 2011	-0.28	0.21	31	82	2.8%	-0.28 [-0.69 , 0.13]
Dedert 2019	1.53	0.49	6	25	0.8%	1.53 [0.57 , 2.49]
Dulger 2019	-0.27	0.29	17	37	1.8%	-0.27 [-0.84 , 0.30]
Krebs 2018	-0.13	0.02	87	490	7.0%	-0.13 [-0.17 , -0.09]
Lechner 2019	-1.53	0.36	16	21	1.3%	-1.53 [-2.24 , -0.82]
Mathew 2013	-0.7	0.35	13	26	1.4%	-0.70 [-1.39 , -0.01]
Schnoll 2016	-0.7	0.44	39	141	0.9%	-0.70 [-1.56 , 0.16]
Zhou 2016	-0.31	0.08	356	334	5.8%	-0.31 [-0.47 , -0.15]
Becoña 2017	-1.62	0.38	52	75	1.2%	-1.62 [-2.36 , -0.88]
Bloom 2015	-0.48	0.21	67	67	2.8%	-0.48 [-0.89 , -0.07]
Busch 2011	-0.22	0.19	43	88	3.1%	-0.22 [-0.59 , 0.15]
Hammett 2019 (2)	-0.06	0.04	111	686	6.7%	-0.06 [-0.14 , 0.02]
Kahler 2002	-0.69	0.2	31	133	3.0%	-0.69 [-1.08 , -0.30]
Rocha 2017	-0.83	0.29	47	18	1.8%	-0.83 [-1.40 , -0.26]
Rodríguez-Cano 2016	-0.29	0.13	91	151	4.5%	-0.29 [-0.54 , -0.04]
Sankaranarayanan 2016	-0.2	0.29	13	108	1.8%	-0.20 [-0.77 , 0.37]
Vázquez 1999	-0.12	0.17	56	104	3.5%	-0.12 [-0.45 , 0.21]
Lee 2019	-0.71	0.34	11	43	1.4%	-0.71 [-1.38 , -0.04]
Martínez-González 2018	-0.58	0.16	53	135	3.7%	-0.58 [-0.89 , -0.27]
Munafò 2008	-0.09	0.09	143	848	5.5%	-0.09 [-0.27 , 0.09]
Vermeulen 2019 (3)	-0.04	0.1	111	608	5.2%	-0.04 [-0.24 , 0.16]
Total (95% CI)			**1863**	**5293**	**100.0%**	**-0.30 [-0.39 , -0.21]**

Heterogeneity: Tau² = 0.03; Chi² = 104.90, df = 33 (P < 0.00001); I² = 69%
Test for overall effect: Z = 6.68 (P < 0.00001)
Test for subgroup differences: Not applicable



-0.30 (-0.39, -0.21), I^2=69%

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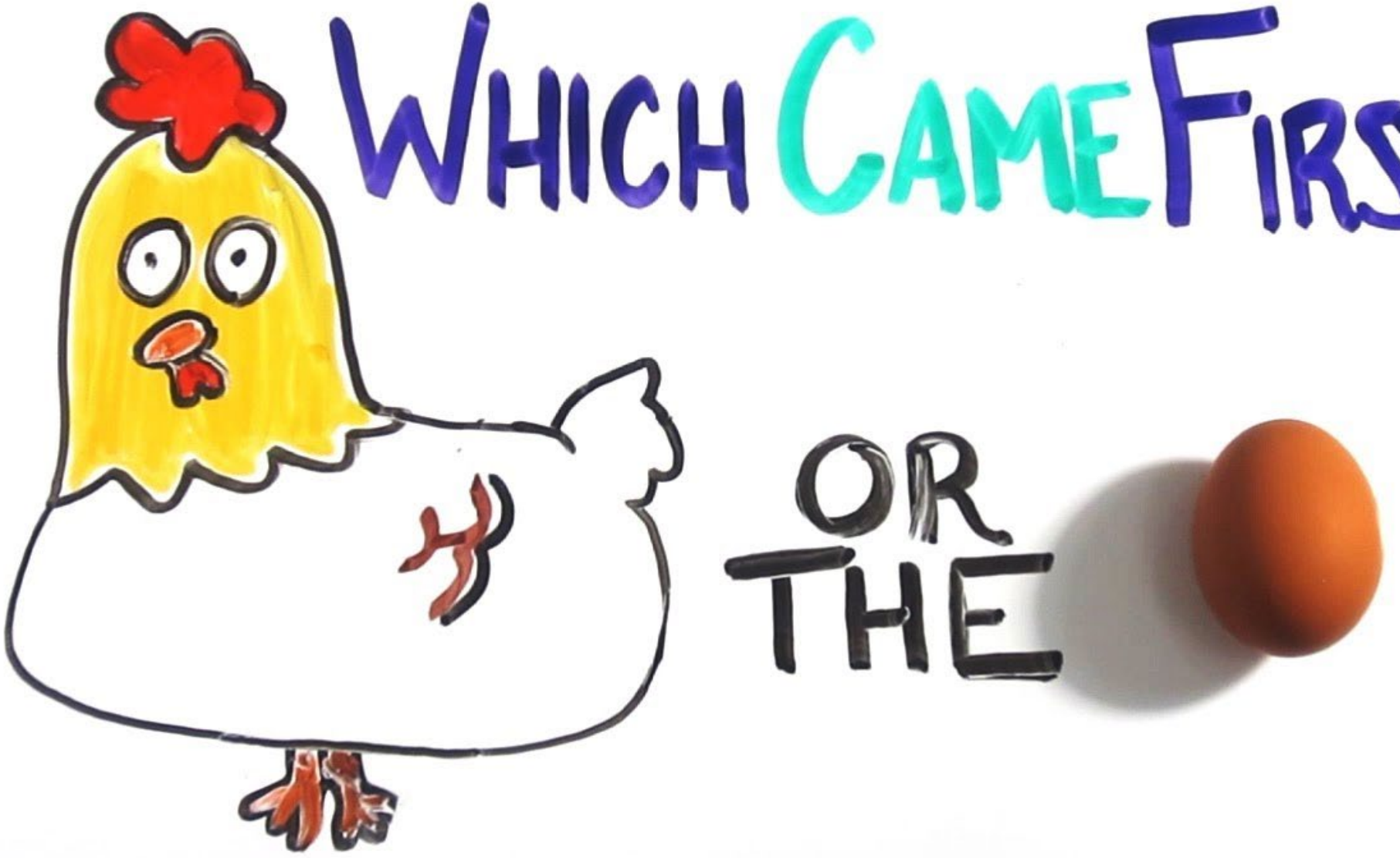

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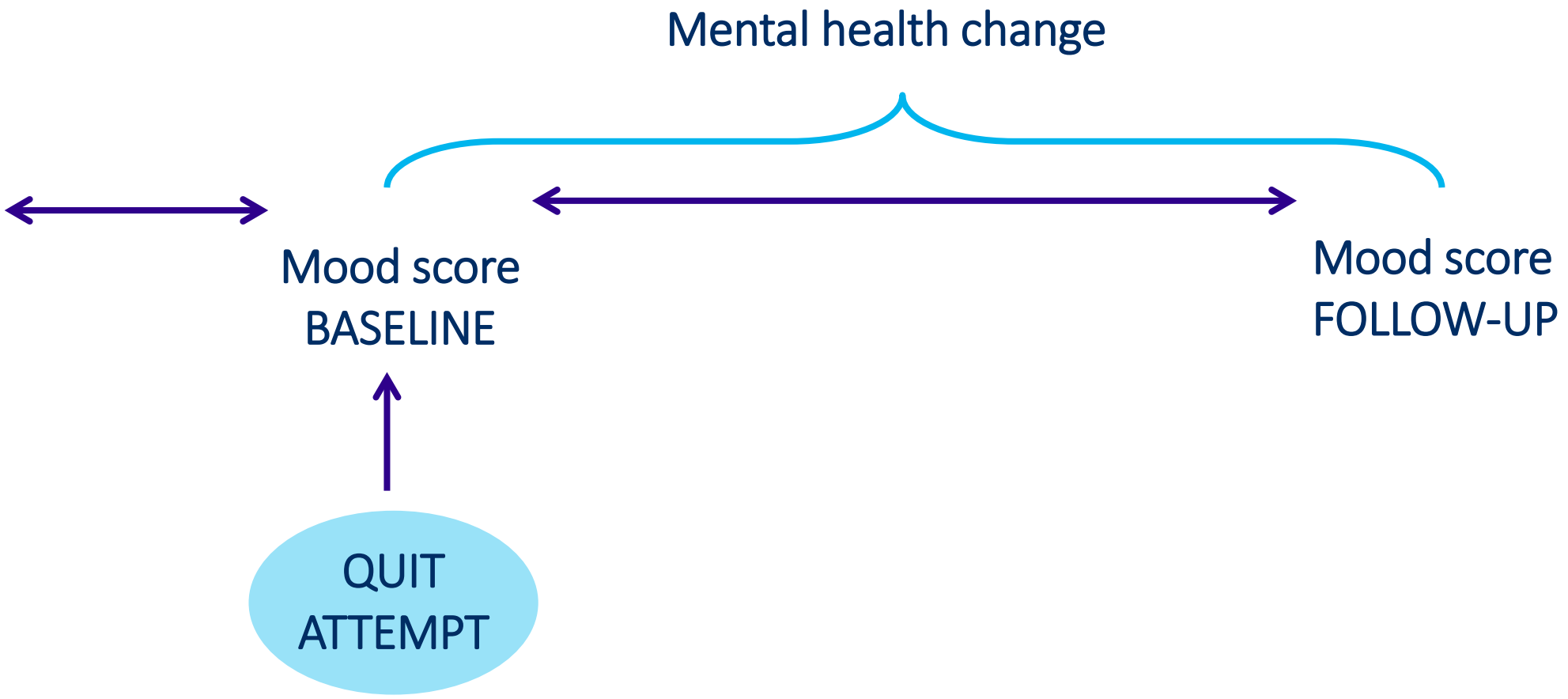
Reverse causality



SUMMARY OF FINDINGS

- Evidence that smoking cessation is associated with improved mental health across 6 different outcomes.
- Strong evidence that mental health does not worsen as a result of quitting smoking.
- Findings robust to multiple sensitivity and subgroup analyses.

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QUITTING SMOKING COMPARED TO TAKING ANTIDEPRESSANTS

Increased

Psychological quality of life

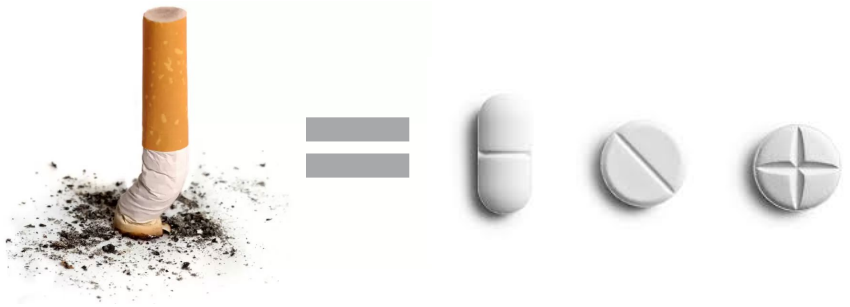
Happiness

Depression

Anxiety

Stress

Decreased



Taylor et al. BMJ 2014; 348:bmj.g1151

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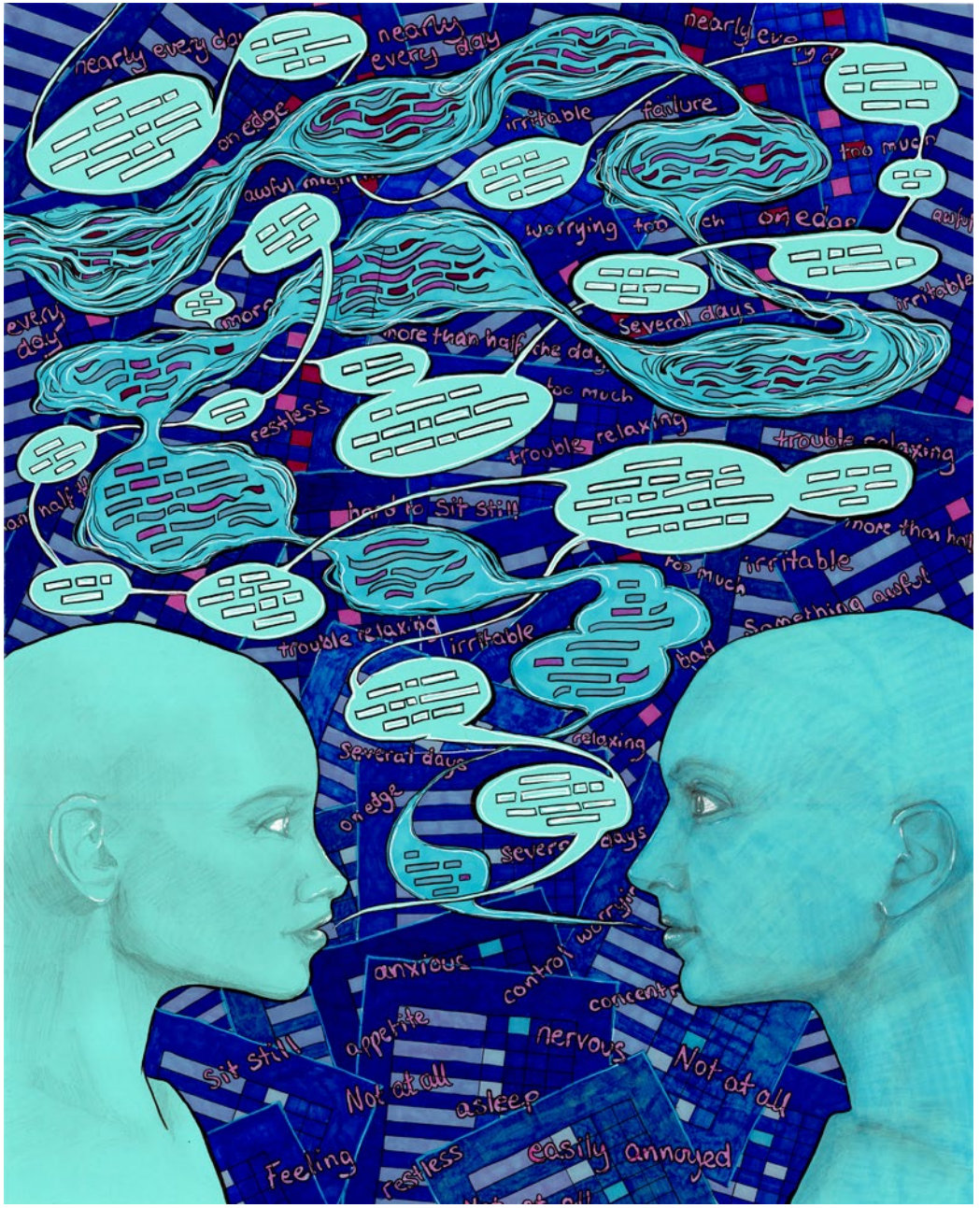

intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety (ESCAPE): a pilot and feasibility trial

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PILOT & FEASIBILITY QUESTIONS

Does offering smoking cessation treatment impact on completing usual care?

Do participants engage with the smoking cessation treatment?

Can we conduct a smoking cessation intervention trial in this setting?

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IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)

- Treat common mental illness (mood, OCD, anxiety)
- Receive 1.5 million referrals each year
- Assess 1 million patients each year
- 50% receive therapy
- Evidence based therapies (CBT)

METHODS

- Pre-registered and published (ISRCTN99531779)
- ESCAPE is a pragmatic randomised and controlled, multicentre, acceptability, feasibility and implementation trial with nested qualitative methods
- Conducted across 4 English regions and included 6 IAPT services

Taylor, G, et al. (2019). intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety (ESCAPE): protocol for a randomised and controlled, multicentre, acceptability, feasibility and implementation trial. Pilot and Feasibility Studies, 5:16.

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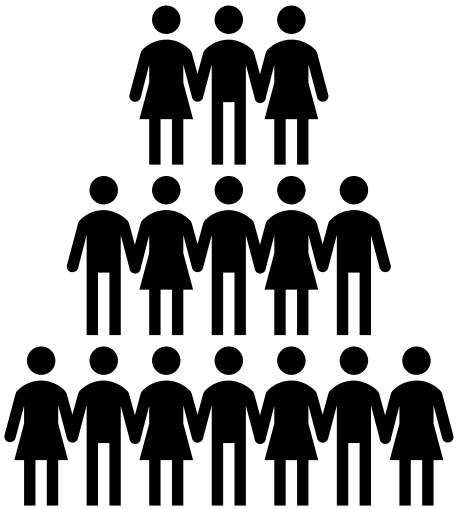
PARTICIPANTS

Inclusion:

- Aged 18+ years
- Depression and/or anxiety (PHQ-9 score of ≥10 and/or GAD-7 score of ≥8)
- Other mental health comorbidities permitted
- Self-reported daily tobacco smokers of ≥1 year

Exclusion:

- Had already started IAPT treatment
- Pregnant/breastfeeding
- Considered “too unwell”



Taylor, G, et al. (2019). intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety (ESCAPE): protocol for a randomised and controlled, multicentre, acceptability, feasibility and implementation trial. Pilot and Feasibility Studies, 5:16.

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INTERVENTION BASIC STRUCTURE

Parallel treatment of smoking and mental health, in IAPT.

Delivered by IAPT therapists during usual therapy sessions during individual sessions.

IAPT service users with depression and/or anxiety, who smoke daily.

5-15 minutes per therapy session, 6+ sessions.

Smoking cessation medication + behavioural support.

TAU + delayed referral to smoking cessation services.

Taylor, G. et al (2020). Addressing concerns about smoking cessation and mental health: theoretical review and practical guide for healthcare professionals. British Journal of Psychiatry. 1, 1

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INTEGRATED INTERVENTION CBT

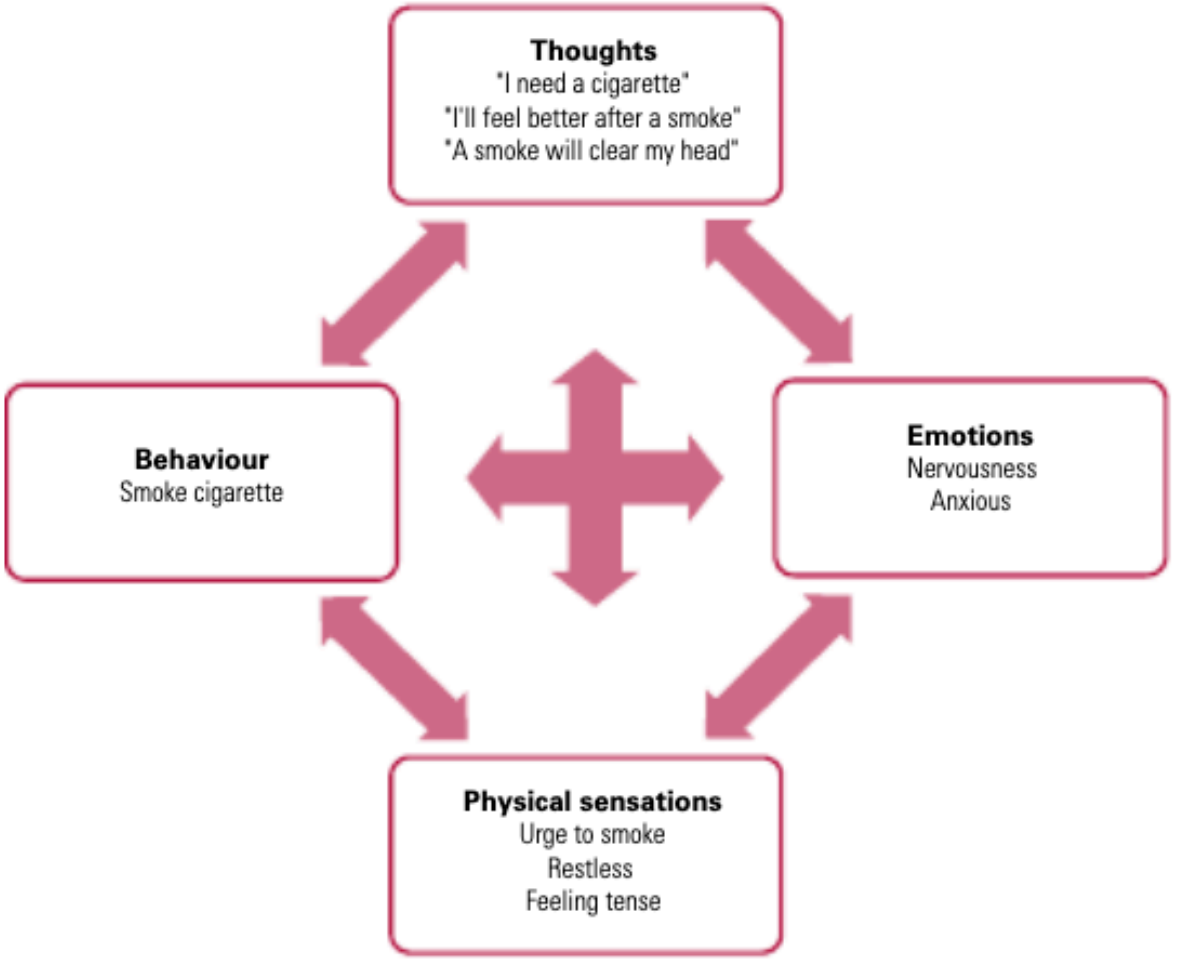
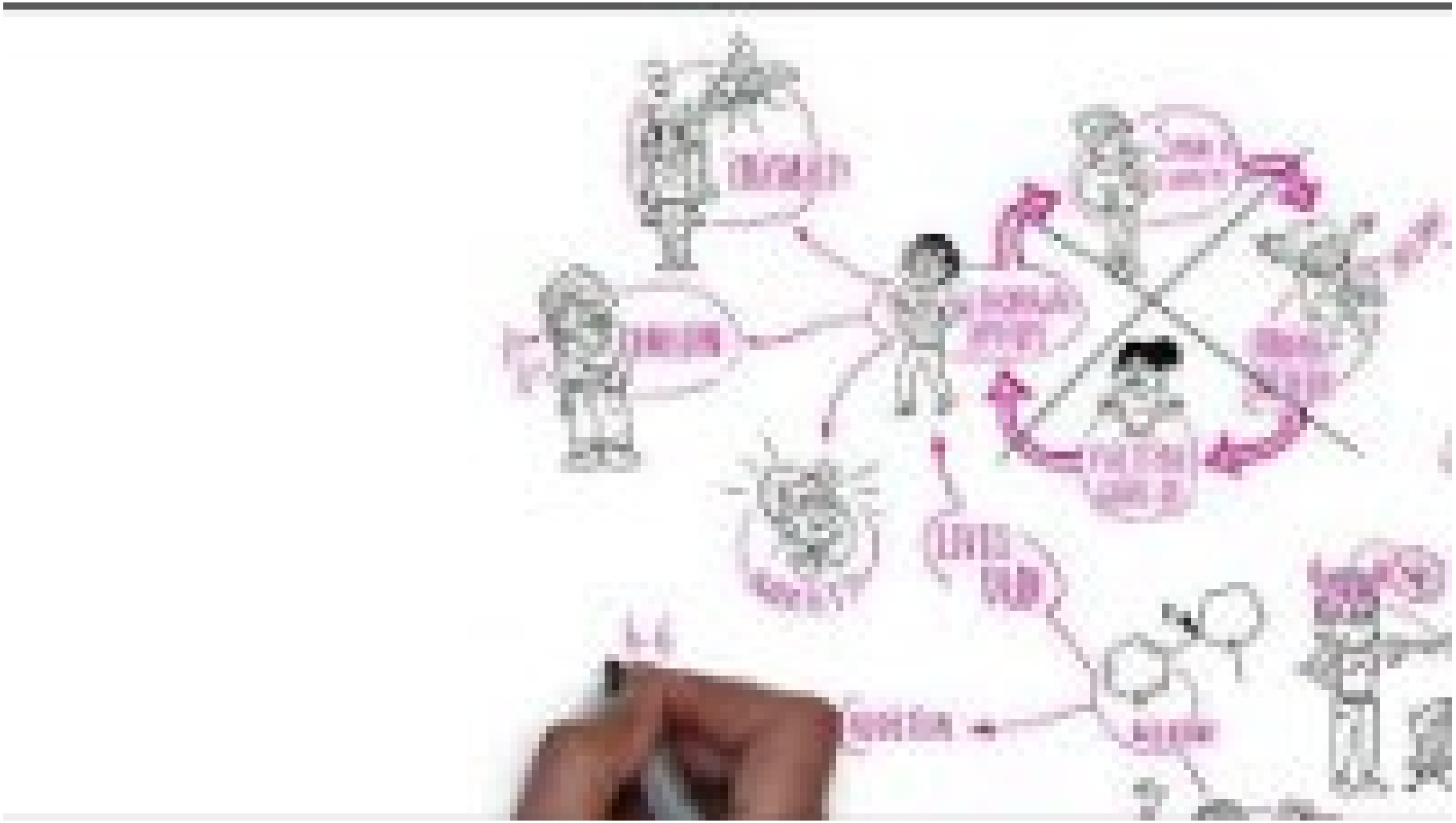


FIG 3 The anxiety cycle in smoking: the trigger is an anxiety-provoking event.

PSYCHOEDUCATIONAL VIDEO



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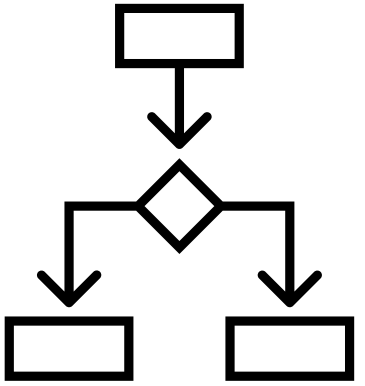
OUTCOMES

- 3- & 6-month follow-up
- IAPT treatment completion
- Quit attempts
- 7-day point prevalence smoking cessation (saliva cotinine or exhaled-CO verified)
- Depression scores (PHQ-9)
- Anxiety scores (GAD-7)
- Treatment satisfaction
- Recruitment rates



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Baseline and pre-clinical* characteristics

		Control N=67	Treatment N=68
Age in years		33.7 (11.9)	37.4 (13.3)
Gender, N (%)	Male	27 (40.3%)	22 (32.4%)
	Female	40 (59.7%)	46 (67.6%)
Ethnicity, N (%)	White	60 (89.6%)	61 (89.7%)
	Mixed	4 (6.0%)	3 (4.4%)
	Indian	1 (1.5%)	1 (1.5%)
	Pakistani	2 (3.0%)	1 (1.5%)
	Bangladeshi	0 (0.0%)	1 (1.5%)
	Other	0 (0.0%)	1 (1.5%)
Highest level of education, N (%)	Some high school	1 (1.6%)	1 (1.5%)
	GCSE/O-grade/equivalent	15 (24.6%)	18 (26.9%)
	A-level equivalent	6 (9.8%)	12 (17.9%)
	Apprenticeship	5 (8.2%)	3 (4.5%)
	Other vocational	13 (21.3%)	14 (20.9%)
	Degree	16 (26.2%)	14 (20.9%)
	Higher degree	5 (8.2%)	5 (7.5%)
IMD		18.1 (12.9)	18.3 (12.4)
PHQ-9*		14.9 (5.8)	14.0 (6.1)
GAD-7*		13.7 (4.7)	12.3 (5.1)
Comorbid anxiety, N (%)*	No	34 (50.7%)	41 (61.2%)
	Yes	33 (49.3%)	26 (38.8%)
Comorbid panic attacks, N (%)*	No	58 (86.6%)	59 (88.1%)
	Yes	9 (13.4%)	8 (11.9%)
Comorbid OCD, N (%)*	No	60 (89.6%)	61 (91.0%)
	Yes	7 (10.4%)	6 (9.0%)
Other comorbid mental health condition, N (%)*	No	55 (82.1%)	55 (82.1%)
	Yes	12 (17.9%)	12 (17.9%)
HIS*		2.1 (1.6)	2.6 (1.6)
CPD*		13.1 (7.8)	15.7 (8.4)
Previous number of quit attempts		5.0 (7.0)	3.7 (6.7)

IMD = Index of Multiple Deprivation score, PHQ-9 = Patient Health Questionnaire, GAD-7 = Generalised Anxiety Disorder Questionnaire, OCD = obsessive-compulsive disorder, HSI = Heaviness of Smoking Index, CPD = Cigarettes per day

MAIN ACCEPTABILITY AND FEASIBILITY OUTCOMES AT 3- AND 6-MONTHS FOLLOW-UP

	3-month follow-up, N (%)		6-month follow-up, N (%)	
	Control	Treatment	Control	Treatment
	N=67	N=68	N=67	N=68
Bio-verified self-reported 7-day smoking abstinence	1 (1.5%)	8 (11.8%)	4 (6.0%)	10 (14.7%)
IAPT treatment completion	13 (19.4%)	11 (16.2%)	21 (31.3%)	16 (23.5%)

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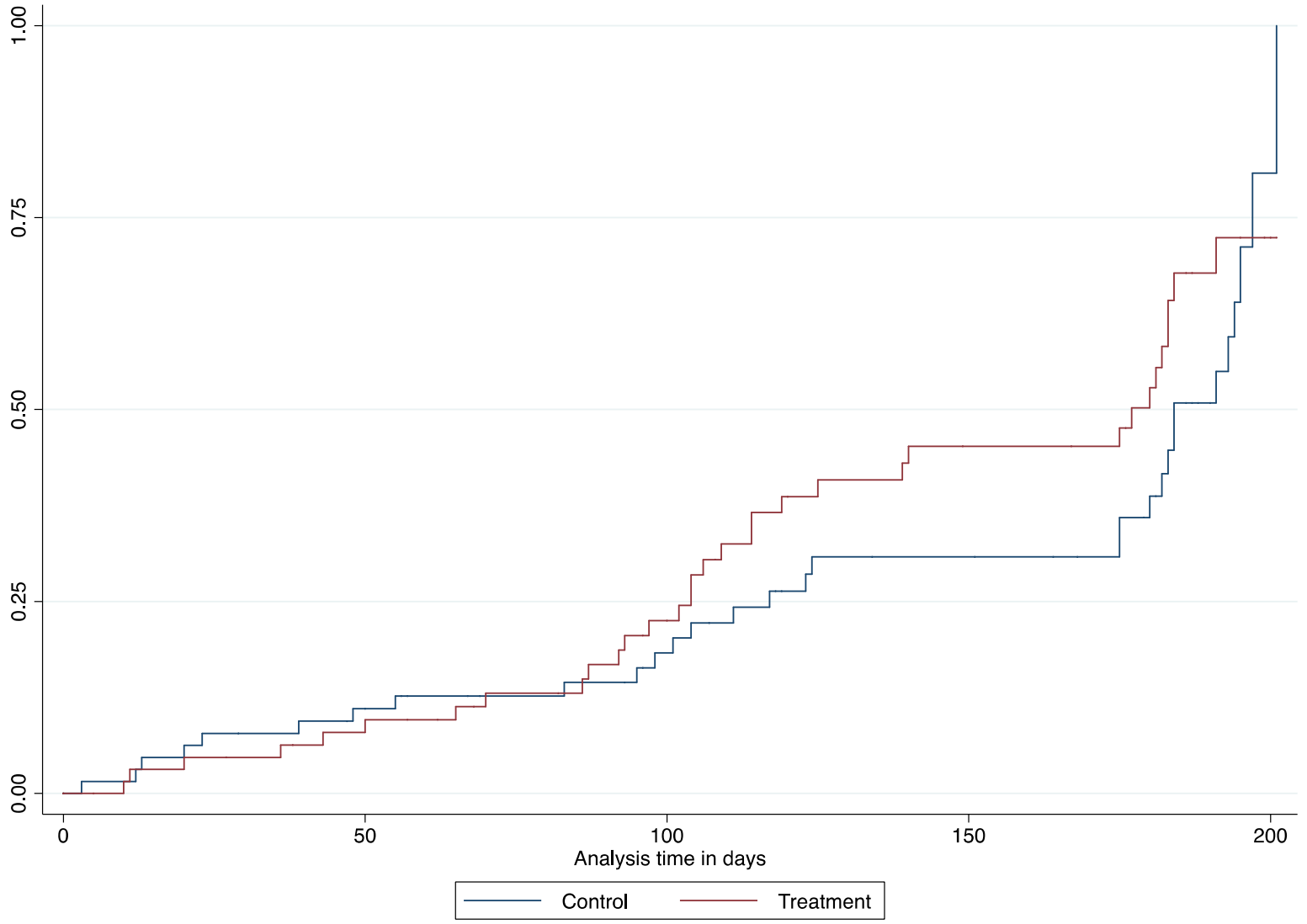
SURVIVAL CURVE: NUMBER OF DAYS TO TREATMENT COMPLETION, BY TRIAL ARM, N=135



LIMITATIONS

- Trial still in progress - data incomplete
- Unable to collect implementation data
- Blinding was unsuccessful in 13-15% of follow-ups
- Predominately recruited white, educated, women in their 30s

Taylor, G, et al. (2019). intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety (ESCAPE): protocol for a randomised and controlled, multicentre, acceptability, feasibility and implementation trial. Pilot and Feasibility Studies, 5:16.

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SUMMARY OF FINDINGS

- We recruited at an acceptable rate across 4 NHS trusts.
- Attrition was what we expected (33%).
- Practitioners and participants reported that they accepted and were satisfied with the intervention.
- Offering smoking cessation treatment did not impact on engagement with the trial, or with usual IAPT treatment.
- Participants engaged with the smoking cessation treatment.
- Evidence of intervention promise for a future smoking cessation trial.

Taylor, G, et al. (2019). intEgrating Smoking Cessation treatment As part of usual Psychological care for dEpression and anxiety (ESCAPE): protocol for a randomised and controlled, multicentre, acceptability, feasibility and implementation trial. Pilot and Feasibility Studies, 5:16.

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How does smoking worsen mental health, and how does quitting improve mental health?

Taylor, G. and Truer, J. (2022). An application of the stress-diathesis model: A review about the association between smoking tobacco, smoking cessation, and mental health. International Journal of Clinical and Health Psychology (In press).

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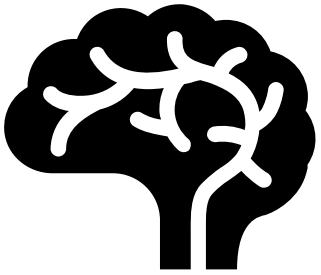
Biological pathways – neurotransmitter systems

- Constant fluctuation in withdrawal-induced psychological symptoms is associated with damage in neurotransmitter pathways, which could increase the risk of mental ill-health.
- After breaking the tobacco withdrawal cycle, through smoking cessation, these systems recover in the same way that other systems damaged by smoking reverse after smoking cessation.
- Smoking damages every organ in the body – so of course it damages the brain.



Taylor, G. and Truer, J. (2022). An application of the stress-diathesis model: A review about the association between smoking tobacco, smoking cessation, and mental health. International Journal of Clinical and Health Psychology (In press).

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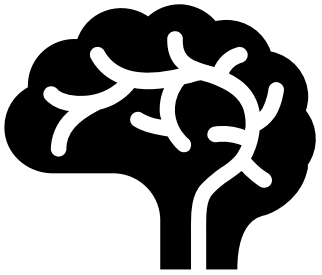
Biological pathways - inflammation and oxidative stress

- Oxidative stress and inflammation underly the progression of depression, anxiety and bipolar disorder
- It is well established that smoking has long-term effects on the oxidative stress burden
- Crucially, the association showed a dose-response pattern, such that higher levels of daily smoking led to higher concentrations of oxidative stress biomarkers
- Evidence that those who had stopped smoking for more than 10 years had similar oxidates stress biomarker levels as never smokers



Taylor, G. and Truer, J. (2022). An application of the stress-diathesis model: A review about the association between smoking tobacco, smoking cessation, and mental health. International Journal of Clinical and Health Psychology (In press).

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FINAL THOUGHTS

- It’s highly likely that smoking damages the brain like it damages other organs in the body.
- There’s consistent evidence that stopping smoking is linked to improvements in mental health.
- People who smoke can be reassured that stopping smoking will not worsen and may improve their mood, by reducing anxiety, depression, and stress.
- Clinicians should be reassured that encouraging and supporting smoking cessation in their patients will not worsen and may improve mood.
- There is no reason to fear that people with psychological disorders will have their condition worsened by smoking cessation.

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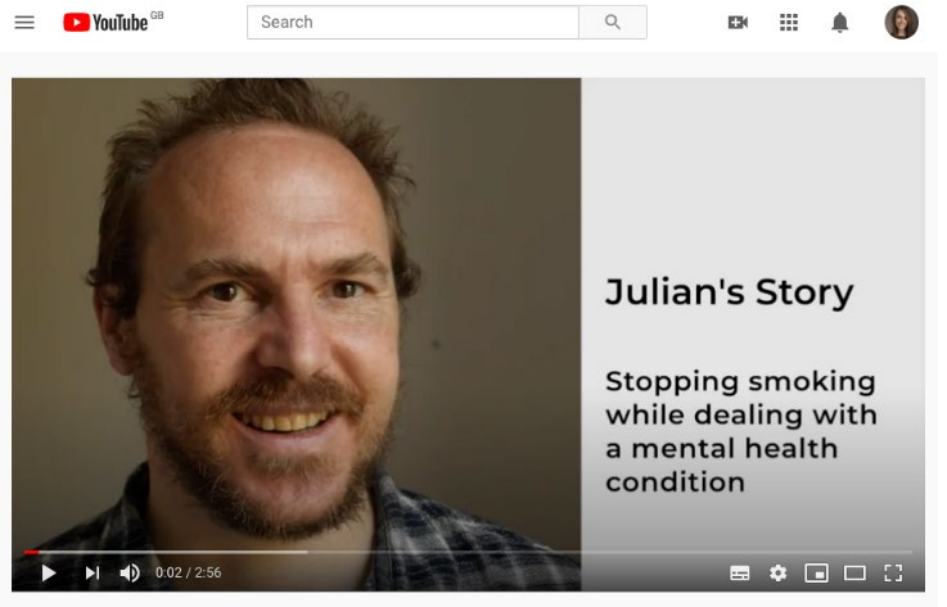
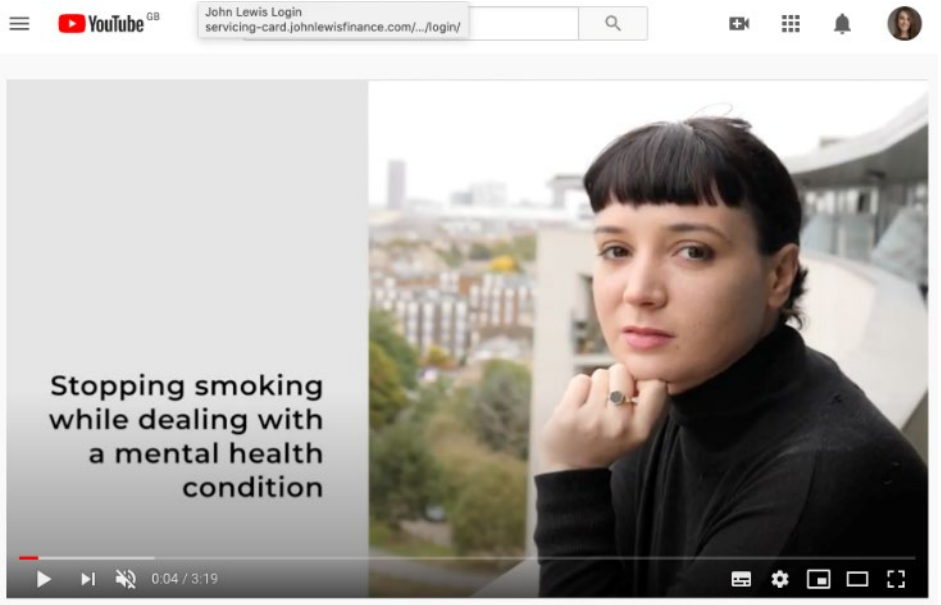
DISSEMINATION





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THANK YOU

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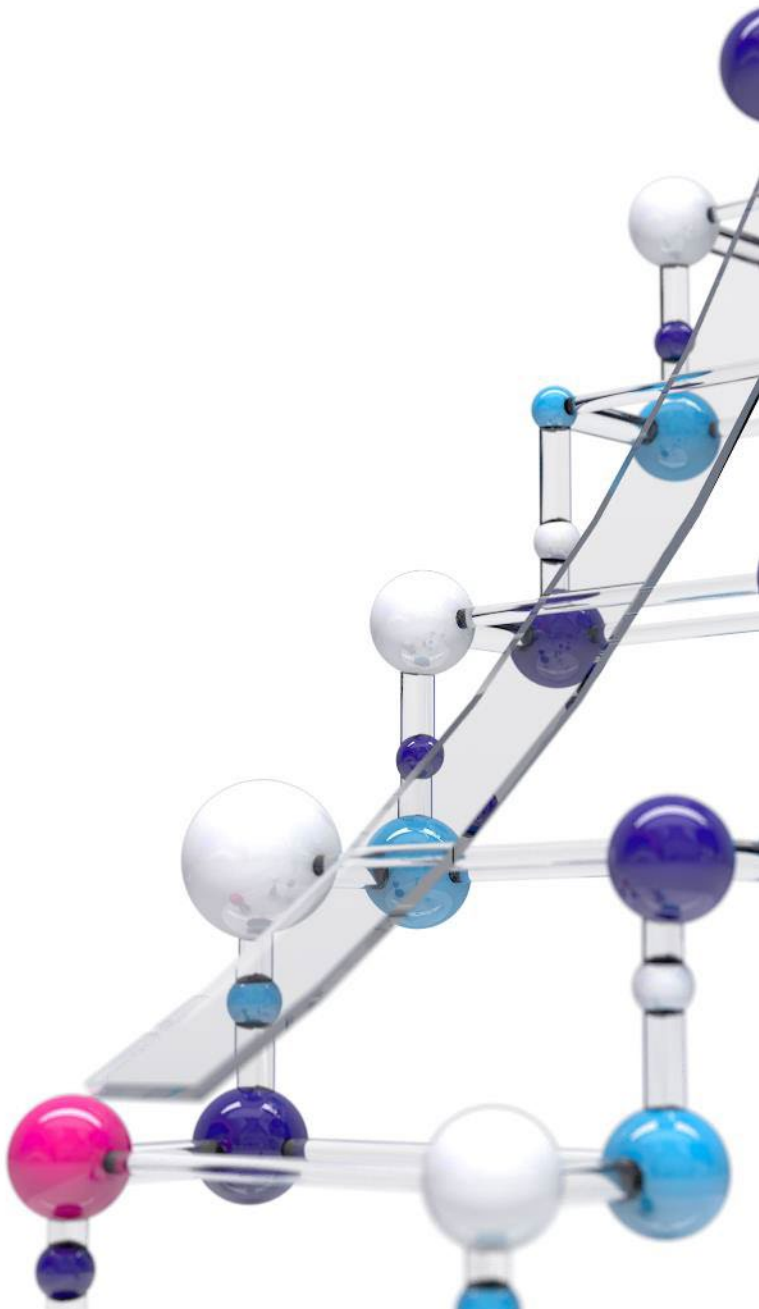

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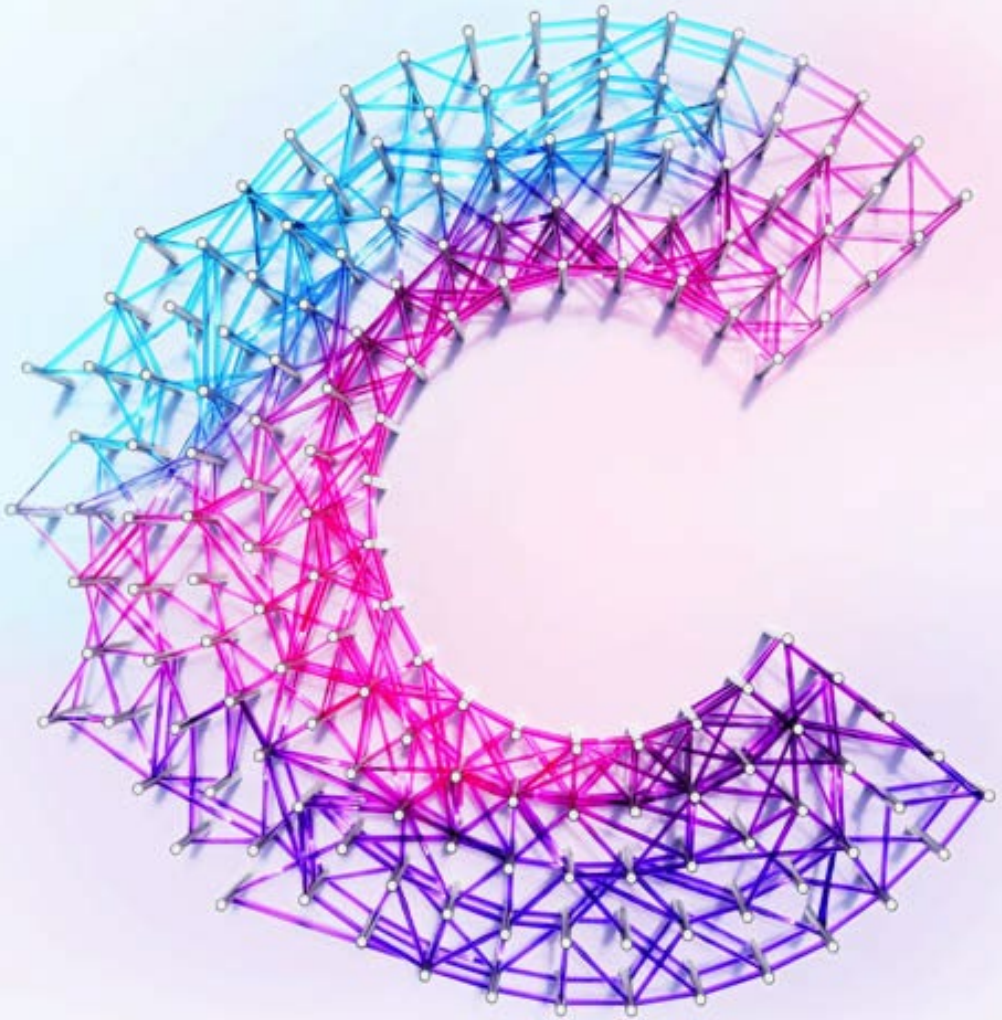

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Q&A

- Submit questions via the **‘Ask a Question’ box**

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Accreditations:
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Free CME/CEUs will be available for all eligible California providers, who joined this live activity thanks to the support of the California Tobacco Control Program (CTCP)

For our California residents, SCLC offers regional trainings, online education opportunities, and technical assistance for behavioral health agencies, providers, and the clients they serve throughout the state of California.

For technical assistance please contact (877) 509-3786 or Jessica.Safier@ucsf.edu.

Visit CABHWI.ucsf.edu for more information

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- You will receive the following in our post webinar email:
  - ✓ Webinar recording
  - ✓ PDF of the presentation slides
  - ✓ Instructions on how to claim FREE CME/CEUs
  - ✓ Information on certificates of attendance
  - ✓ Other resources as needed

➢ All of this information will be posted to our website at https://SmokingCessationLeadership.ucsf.edu

SCLC's next live webinar is co-hosted with the National Behavioral Health Network on Tobacco and Cancer Control (NBHN) entitled, "***Journey to a Tobacco-free Certified Community Behavioral Health Clinic (CCBHC): A Conversation***"

- **Tuesday, September 20, 2022, 12:30 – 1:30 pm EDT**
- Registration will open soon

Contact us for free technical assistance

- **Visit** us online at **smokingcessationleadership.ucsf.edu**
- **Call** us toll-free at **877-509-3786**
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