

Research Article

Anxiety Levels and Related Factors in People Who Want To Quit Smoking

Sigarayı Bırakmak İsteyenlerde Anksiyete Düzeyleri ve İlişkili Faktörler

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Abstract

In this study, we aimed to determine anxiety in people seeking treatment to stop smoking and investigate the relationships between anxiety with addiction levels and socio-demographic factors. The study was designed to be prospective, cross-sectional and two-centered. Smokers aged 18 and over, who visited smoking-cessation outpatient polyclinics at the Family Medicine Department between 01/06/2015 and 30/07/2015, were included in the study. Socio-demographic data, health status and smoking history were recorded, while the Fagerstrom Test for Nicotine Dependence (FTND), Beck Anxiety Inventory (BAI), and State and Trait-Anxiety Inventory (STAI) were applied, for each patient. The average number of cigarettes smoked per day was 23 ± 11.5 . According to the FTND, 58.4% (n=125) of the participants scored medium for nicotine dependence, whereas 46.7% (n=100) were normal in terms of anxiety, according to the BAI test. No significant correlation was found between the FTND result and the BAI or STAI. This study revealed that nearly half of the participants visiting smoking-cessation outpatient polyclinics had anxiety. Female gender, low levels of education, and being single were determined to be risk factors for anxiety among smokers, which is important when considering the benefit versus risk balance of smoking-cessation treatment. While evaluating people who applied for smoking-cessation therapy, anxiety parameters should be considered, as they can affect the progress and success of treatment.

Keywords

Anxiety • Cigarette • Fagerstrom • Nicotine dependence • Smoking cessation

Öz

Bu çalışmada, sigarayı bırakmak için tedavi arayan kişilerdeki anksiyeteyi saptamayı ve anksiyete ile bağımlılık seviyeleri ve sosyodemografik faktörler arasındaki ilişkiyi belirlemeyi amaçladık. Çalışma prospektif, kesitsel ve iki merkezli olarak tasarlandı. 01/06/2015 - 30/07/2015 tarihleri arasında, Aile Hekimliği Kliniklerine bağlı Sigara Bırakma Polikliniklerine başvuran 18 yaş ve üstündeki sigara içicileri çalışmaya dahil edildi. Her hastanın sosyodemografik verileri, sağlık durumları ve sigara içme öyküleri kaydedilirken Fagerström Nikotin Bağımlılık Testi

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(FNBT), Beck Anksiyete Ölçeği (BAÖ), Durumluk ve Sürekli Kaygı Envanteri (DSKE) uygulandı. Çalışmaya katılan 214 kişinin çoğu erkek idi (%68,2, n=146). Günlük içilen sigara sayısı ortalama $23 \pm 11,5$ idi. FNBT'ne göre katılımcıların %58,4'ü (n=125) orta derecede nikotin bağımlısı iken, BAE'ne göre %46,7'si (n=100) anksiyete bazında normal idi. %53,3'ünde (n=114) herhangi bir seviyede anksiyete mevcuttu. FNBT sonuçları ile BAÖ ve DSKE arasında anlamlı ilişki bulunmadı. Bu çalışma, sigara bırakma polikliniklerine başvuran katılımcıların yaklaşık yarısının anksiyetesi olduğunu ortaya çıkardı. Kadın cinsiyet, düşük eğitim seviyeleri ve bekar olmak sigara içenler arasında anksiyete için risk faktörleri olarak belirlendi. Bu da sigara bırakma tedavisinin yarar zarar dengesi göz önüne alındığında önemlidir. Sigara bırakma tedavisi için başvuran kişileri değerlendirirken tedavinin ilerlemesini ve başarısını etkileyebileceğinden anksiyete parametreleri göz önünde bulundurulmalıdır.

Aanahtar Kelimeler

Anksiyete • Fagerström • Nikotin bağımlılığı • Sigara • Sigara bırakma

Introduction

Smoking is one of the most important public health problems world-wide and the most important cause of preventable and early death and disease in our country (Pekşen, Canbaz, Sünter, & Tunçel, 2005). Approximately 1.1 billion people smoke world-wide and more than 5 million people die every year due to this activity (Mathers & Loncar, 2006). Cigarette smoke contains more than 4000 compounds including nitrosamines, aromatic hydrocarbons, hydrogen cyanide, CO, and nicotine, which are pharmacologically active, antigenic, cytotoxic, and carcinogenic (Behr & Nowak, 2002). However, the compound that is most important, especially for continuity of physical dependence, is nicotine (Malaiyandi, Sellers, & Tynadale, 2005).

Anxiety is an emotion that features worry or unease, which is different from other types of emotion due to its unpleasant qualities. Its source is largely the anticipation of an unknown danger (Karamustafaoğlu, 2010). Anxiety disorders are the most common psychiatric conditions and are more prevalent in women than men (2:1) (Aydemir & Köroğlu 2017; Reiger, Narrow & Rae, 1990).

There is a close and complicated relationship between nicotine dependence and mental health disorders (Baiardini, Sorino, Marco, & Facchini, 2014) such as anxiety, depression, schizophrenia, attention-deficit hyperactivity disorder, and alcohol abuse (Moylan, Jacka, Pasco, & Berk, 2012). Previous studies have shown that anxiety is commonly found in individuals seeking a treatment to quit smoking. The desire to smoke and nicotine withdrawal occur prominently in people with high levels of anxiety (Piper, Cook, Schlam, Jorenby, & Baker, 2011). Anxiety has been suggested to result in reduced responses to pharmacotherapy and lack of success in attempts to quit smoking. The determination of anxiety in smoking individuals could guide their treatment algorithms and increase the success of treatments (Piper et al., 2011). Moreover, as some mental health problems may occur during the process of stopping smoking and some drugs used in smoking-cessation therapies may cause neu-

ropsychiatric complications, specialists must decide on the most appropriate therapy, considering the benefit and risk balance (Yargıç & Baykan, 2013). This study aimed to evaluate the level of anxiety in individuals visiting outpatient smoking-cessation clinics, according to their nicotine dependency level and socio-demographic factors, and determine whether anxiety levels were altered at follow-up. The second aim of this study was to offer guidance to new projects on smoking cessation.

Method

Study Group

The study was designed to be prospective, cross-sectional, and two-centered. The study population consisted of participants who visited one of three smoking-cessation outpatient polyclinics at two Family Medicine Departments between 01/06/2015 and 30/07/2015. This study was performed with the approval of the Non-Interventional Clinical Research Ethical Committee of Şişli Hamidiye Etfal Training and Research Hospital (Reference number: 990). The study included 214 smokers after confirming the inclusion criteria.

Regardless of dependency on and amount of smoking, people aged 18 and over of both genders, who visited the outpatient clinics and did not have any psychiatric or communication problems, were included in the study. Individuals under the age of 18, who had communication problems such as deafness or blindness, did not accept participation in the study, pregnant women, individuals with any psychiatric disease or using a psychiatric medication during the visit, and people with a history of attempted suicide were excluded from the study.

Data Collection

Socio-Demographic Data

Participants were informed about the aim of the study before they were included. Following the receipt of verbal consent from the participants, details of socio-demographic data, health states, and smoking history were obtained via face-to-face interviews using a questionnaire prepared by the study's authors. Questions about age, gender, marital status, educational status, employment status, cigarette use, alcohol and drug use, presence of chronic disease, history of psychiatric disease, suicide attempts, mental status, and pregnancy status were included in the questionnaire.

In addition data were collected on numbers of cigarettes consumed daily, age at which smoking began, total duration (years of smoking), amount (packs of cigarettes/year), motivating factors to smoke, status of smoking at home and in the office, the reason for quitting smoking, the number of attempts to quit smoking, the duration of smoking cessation, difficulties encountered during the period when the individual quit smoking, previous professional support received, and treatment methods used.

Fagerstrom Test for Nicotine Dependence

One of the most common methods of evaluating nicotine dependence in smokers is the Fagerstrom Test for Nicotine Dependence (FTND), developed by the Swedish physician Dr Karl Fagerstrom in 1978. During this test, six questions were addressed to the smokers. The scoring was as follows: 0–2, low level of dependence; 3–7, medium level of dependence; or 8–10, high level of dependence (Uysal, Kadakal, Karşıdağ, Bayram, Uysal, & Yılmaz, 2004).

Beck Anxiety Inventory

The Beck Anxiety Inventory (BAI) is a 21-question Likert-type self-report scale developed by Beck, Epstein, Brown, and Steer in 1988 to determine the frequency of anxiety symptoms in individuals. Anxiety-based humor, autonomic hyperactivity, and motor rigidity are among the factors that determine some elements of anxiety. The score interval is 0–63. The total score obtained from the scale reveals the severity of anxiety in the individual. The BAI scores used in the study were evaluated as follows: 8–15, Mild anxiety; 16–25, Moderate anxiety; and 26–63, Severe anxiety (Ulusoy, 1993)

State and Trait-Anxiety Inventory

The State and Trait-Anxiety Inventory (STAI) was developed by Spielberger et al. in 1970. It is a Likert-type scale measuring the levels of state and traits of anxiety separately, with 20 questions for each. The total score obtained from both scales ranges from 20 to 80. High scores indicate a high level of anxiety and low scores indicate a low level of anxiety (Öner & Lecompte, 1985).

Statistical Analysis

Statistical Package for The Social Sciences (SPSS) 20.0 was used for data analysis. Mean, standard deviation, median (minimum and maximum values), frequency, and ratio values were used in the descriptive statistics of the data. The distribution of the variables was measured using the Kolmogorov Smirnov test. The Kruskal–Wallis and Mann–Whitney’s U tests were used in the analysis of quantitative data. The chi-square test was used in the analysis of qualitative data. Spearman correlation analysis was used for correlation analysis. The significance level was evaluated as $p < 0.05$.

Results

Most of the 214 individuals who participated in the study were male (68.2%, $n=146$). The ages of the participants ranged from 18 to 76 years and the mean age was 39.9 ± 11.6 years. Most of the subjects were married (71.5%, $n=153$). Nearly one-third (29.9%, $n=64$) of participants were college graduates. The results of the socio-demographic parameters are shown in Table 1.

Table 1.
Socio-Demographic Characteristics of the Study Group

Socio-demographic Characteristics		n	%
Age	18–40	116	54.2
	41–64	93	43.5
	≥65	5	2.3
Gender	Female	68	31.8
	Male	146	68.2
Educational Status	Primary school	58	27.1
	Middle school	30	14.0
	High school	62	29
	University	64	29.9
Marital Status	Married	153	71.5
	Single	61	28.5
Presence of Chronic Disease	Yes	77	36.0
	No	137	64.0
Drug Use	Yes	48	22.4
	No	166	87.6
Alcohol Use	Yes	79	36.9
	No	135	63.1

Data are presented as mean±standard deviation and median (min:max).

Among all participants in the study, the mean number of cigarettes smoked per day was 23±11.5 and 25.4±16.4 packs were smoked per year. The mean age when smoking began was 17.3±4.0 years. The results of the smoking status parameters are shown in Table 2.

Table 2.
Smoking Status of Participants

Smoking status	min-max	Median	M±S.D.
Cigarettes per day	3–70	20	23.3±11.5
Packs per year	2–100	25	25.4±16.4
Age when began smoking	7–30	17	17.3±4.0
Total years of smoking	2–59	21	22.5±12.2

SD: standard deviation.

The reasons for quitting smoking were divided into five groups and it was found that most participants (90.2%, n=193) wanted to quit smoking for health reasons. The second most common reason was economic factors (13.6%, n=29), followed by ‘requests from family members’ (9.3%, n=20). Distribution of Reasons for Quitting Smoking are shown in Figure 1.

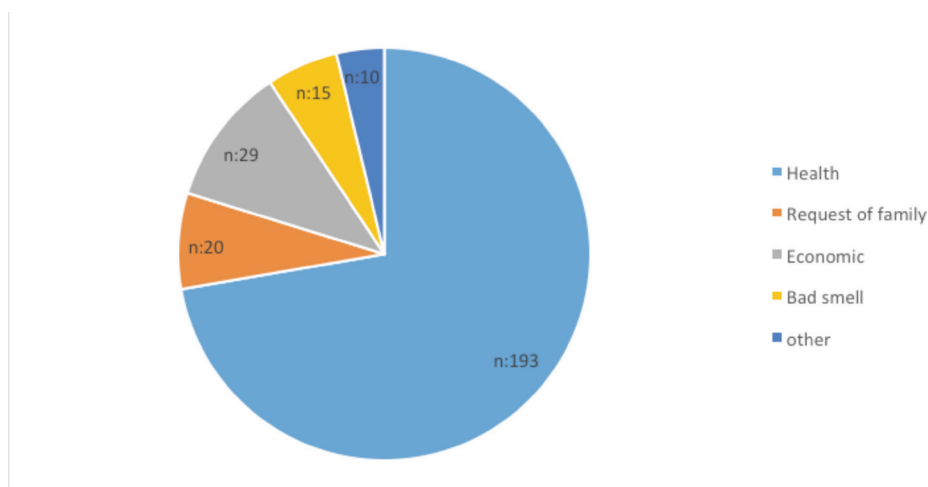


Figure 1. Distribution of Reasons for Quitting Smoking.

Many (69.6%, n=149) of the participants smoked in their offices and 19.2% (n=41) smoked at home. Previously, 70.6% (n=151) of the participants had attempted to quit smoking at least once. The most common problems encountered when individuals quit smoking were the excessive desire to smoke (59.3%, n=127) and short temper (54.2%, n=116). According to the FTND, the level of nicotine dependence was medium in most of the participants (58.4%, n=125). The mean dependence score of the participants in terms of the FTND was 5.8 ± 2.5 . According to the BAI, while 46.7% (n=100) of the subjects had normal levels of anxiety, levels were mild in 29.0% (n=62), moderate in 13.6% (n=29), and severe in 10.7% (n=23). The mean BAI score for the total group was 11.4 ± 10.3 and anxiety was determined in 53.3% (n=114) of the study group. The test scores are shown in Table 3.

Table 3.
Results of the Fagerstrom Test for Nicotine Dependence, Beck Anxiety Inventory, and State-Anxiety Scale and Trait-Anxiety Scale

		n	%
FTND	Low	27	12.6
	Medium	125	58.4
	High	62	29.0
BAI	Normal	100	46.7
	Mild	62	29.0
	Moderate	29	13.6
	Severe	23	10.7
State-Anxiety Scale (M±SD)		37.1±10.3	
Trait-Anxiety Scale (M±SD)		43.1±8.5	

Data are presented as mean±standard deviation, median (min:max), and n (%).

FTND: Fagerstrom Test for Nicotine Dependence; BAI: beck anxiety inventory; M: mean; SD: standard deviation.

There was no significant difference among the mean scores for the FTND, State-Anxiety Scale and Trait-Anxiety Scale in terms of gender ($p>0.05$). However, the BAI scores and the level of anxiety were significantly higher in women than in men ($p<0.001$ and $p<0.001$; Table 4).

Table 4.
Mean Values of Test Scores According to Gender

	Female (n=68)	Male (n=146)	p*
Fagerstrom Test for Nicotine Dependence (M±S.D.)	5.9±2.5	5.8±2.5	0.715
Beck Anxiety Inventory (M±S.D.)	15.5±10.9	9.5±9.5	<0.001
State-Anxiety Scale (M±S.D.)	37.7±10.2	36.9±10.4	0.532
Trait-Anxiety Scale (M±S.D.)	44.0±8.9	42.6±8.3	0.257

*T-test was used.

M: mean; SD: standard deviation.

In terms of the FTND scores (low/medium/high), the distributions were similar in both genders ($p=0.781$). However, anxiety levels were significantly more severe (16%, n=11) and moderate (25%, n=17) in women than men, in which group only 8.2% (n=12) had severe anxiety ($p\leq 0.001$). Anxiety levels were normal in most men (55%, n=81; Table 5).

Table 5.
Dependence and Anxiety Levels According to Gender

		Female (n=68)		Male (n=146)		p*
		n	%	n	%	
Level of Dependence	Low	7	10.3	20	13.7	0.781
	Medium	41	60.3	84	57.5	
	High	20	29.4	42	28.8	
Level of Anxiety	Normal	19	27.9	81	55.5	<0.001
	Mild	21	30.9	41	28.1	
	Moderate	17	25.0	12	8.2	
	Severe	11	16.2	12	8.2	

*T-test was used.

No significant correlation was found among the scores of FTND, State-Anxiety Scale, and BAI in terms of educational status ($p>0.05$). The score from the Trait-Anxiety Scale was significantly higher ($p<0.001$) in primary school graduates than in high school and college graduates. While there was a significant negative correlation ($p=0.010$) between the age of starting smoking and FTND score, there was no significant correlation ($p>0.05$) with the scores from the BAI, State-Anxiety Scale, and Trait-Anxiety Scale. There was a significant positive correlation ($p<0.001$) between

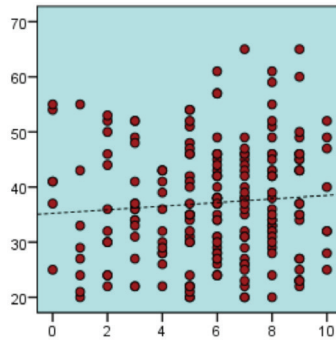


Figure 2. Correlation between State-Anxiety Scale and FTND.
FTND: Fagerstrom Test for Nicotine Dependence.

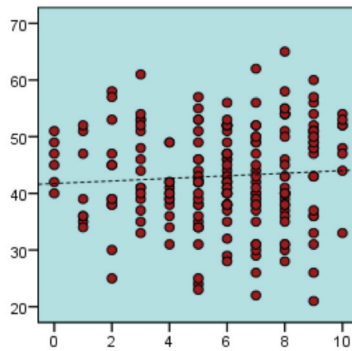


Figure 3. Correlation between Trait-Anxiety Scale and FTND.
FTND: Fagerstrom Test for Nicotine Dependence.

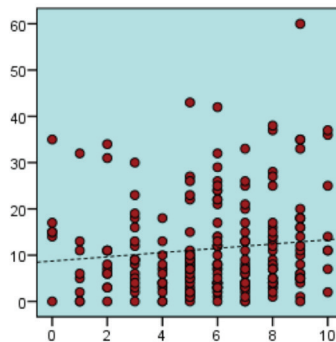


Figure 4. Correlation between BAI and FTND.

BAI: Beck Anxiety Inventory; FTND: Fagerstrom Test for Nicotine Dependence.

the daily number of cigarettes smoked and FTND score but no significant correlation ($p > 0.05$) with the scores from the BAI, State-Anxiety Scale, and Trait-Anxiety Scale. While there was a significant positive correlation between the duration of smoking

and the scores of the FTND ($p=0.007$) and Trait-Anxiety Scale ($p=0.026$), no significant correlation ($p>0.05$) was found between the BAI and State-Anxiety Scale; number of attempts to quit smoking and all the scores.

The Trait-Anxiety Scale scores were significantly higher ($p=0.033$) in married individuals than in an individual.

A significant positive correlation ($p<0.001$, $r=0.396$; $p<0.001$, $r=0.553$) was found between BAI score and the scores of State-Anxiety Scale and Trait-Anxiety Scale. No significant correlation ($p>0.05$) was found between FTND score and the scores of the, State-Anxiety Scale, Trait-Anxiety Scale and BAI (Figure 2-4).

Discussion

Smoking is considered to be a way of coping with stress, especially for women, resulting in relatively low rates of smoking cessation and low numbers of admissions to outpatient smoking-cessation clinics.

When evaluated according to socio-demographic data, the results of this study were consistent with the literature. For example, in a similar study by Abakay et al., 68.6% of 847 patients were male and 31.4% were female, the mean ages of the participating men and women were 45.8 ± 14.2 and 38.7 ± 12.1 years, respectively (Abakay et al, 2014).

In other previous studies, the rate of admissions to clinics of married people ranged from 70.4% to 82.96% and was higher than that for single people (Fidan, Pala, Ünlü, Sezer, & Kara, 2005; Hall et al. 2006; Kaya, Esen, Şakar, & Yorgancıoğlu, 2005). The greater desire to quit smoking in married people can be explained by the motivation provided by their families to quit smoking.

While 43.8% of the participants were higher education graduates in the study by Can et al., 48.5% were higher education graduates in the study by Abakay et al. (Abakay et al., 2014; Çan, Öztuna, Topbaş, & Özlü, 2006). The fact that most of the individuals admitted to outpatient smoking-cessation clinics have higher levels of education may reveal that the awareness of smoking and its hazards escalates as the educational level increases.

In the study by Önsüz et al., 47.1% of the individuals who had attempted to quit smoking previously indicated that their reasons to quit smoking were health problems and 15.7% indicated their reasons to be economic factors (Önsüz, Topuzoğlu, Algan, Soydemir, & Aslan, 2009), which was consistent with our study. These results suggest that people regard quitting smoking as one of the most important steps they will take to live healthily in old-age.

The frequency of similar problems found in studies investigating the symptoms that occur after smoking cessation is noteworthy. These problems include excessive desire to smoke, anxiety, difficulty in concentrating, somatic complaints, insomnia, and weight gain (Çakmak & Saatçioğlu, 2005; Karakulah, 2013). The most common problems experienced by our participants in their previous attempts to quit smoking were excessive desire to smoke and short temper. These results were, therefore, consistent with the literature.

In the study by Uysal et al., the mean FTND score was 5 ± 2.5 (Uysal et al., 2004). In the study by Önsüz et al., the level of dependence according to the FTND was low in 48.0% of subjects, medium in 38.2%, and high in 13.7% (Önsüz et al., 2009). In the present study, nicotine dependence was high in nearly 30% of the participants and low in just over 10%. The facts that individuals with high dependence who seek treatment do not believe enough in themselves and those with a low level of dependence do not attach enough importance to their dependence are considered to result in less willingness to quit smoking.

In terms of mental health disorders, a previous study found that 36.8% of the participants had a mental health disease. The mean BAI score for the individuals who quit smoking was 8.4 ± 7.1 , whereas the score for individuals who could not quit smoking was 14.6 ± 10.3 . They observed that most of the individuals who had a mental health disorder (85.7%) could not quit smoking (Kaya et al., 2005).

In a study performed in Edirne, the BAI score was lower in people who had never smoked than in people who currently smoked (Tunç, 2007). In our study, according to the BAI, 46.7% ($n=100$) of the participants were at normal levels in terms of anxiety and the remainder showed some form of anxiety.

In a study performed in Netherlands, the level of anxiety and the scores of the STAI in people admitted to smoking-cessation centers were higher than in other smokers in general population (Coci, Schruers, Pistelli, & Griez, 2009), whereas in a study carried out in Japan, the risk of smoking did not increase in people who had a high level of trait anxiety and there was no relationship between a high level of trait anxiety and avoiding smoking. People with a high level of trait anxiety displayed more intention to quit smoking, however, the rate of success in these people was low (Takemura, Akanuma, Kikuchi, & Inaba, 1999). In our study, while the mean score obtained from the State-Anxiety Scale was 37.1 ± 10.3 , the mean score from Trait-Anxiety Scale was 43.1 ± 8.5 .

The finding that 53.3% of the study participants demonstrated some level of anxiety supports our hypothesis that the level of anxiety increases in people who seek treatment to quit smoking. Again, consistent with literature, trait anxiety in particular

was higher than state anxiety in smokers, which may be associated with anticipation of the adverse effects of smoking and expectation of success in the attempt to quit smoking. For example, in a Brazilian study, the levels of anxiety and depression increased in individuals who attempted to quit smoking (52% of women and 12.5% of men were depressed, while 27.5% of women and 7.5% of men developed anxiety) (Jesus, Silva, Cordeiro, Kortchmar, Zampier, & Merighi, 2016).

In our study, BAI score and the level of anxiety were significantly higher in female participants than in male participants, which is consistent with literature. It has been reported that depression and anxiety disorders are more common in women in the general population (Kringlen, Torgersen, & Cramer, 2001). It was reported in a study of the Turkey Mental Health profile in our country that the rate of anxiety is two times higher in women than in men. Studies have also revealed that the score of the STAI was higher in women than men in the general population (Dönmez, Aytakin, & Erengin, 1996). Besides, although no significant difference was recorded between genders in terms of the scores of the State-Anxiety and Trait-Anxiety scales, the scores of the Trait-Anxiety Scale were higher than those of State-Anxiety Scale in both genders in our study.

In this study, there was no significant relationship between the age at which smoking begins and the scores from the BAI, State-Anxiety Scale, and Trait-Anxiety Scale. In a previous study, however, a significant relationship between the ages when smoking began was recorded in people with depression and anxiety disorder (Patton, Carlin, Coffey, Wolfe, Hibbert, & Bowes, 1998). A difference was recorded between total duration of smoking and the scores of the BAI and State-Anxiety Scale, while a significant positive correlation with the score of Trait-Anxiety Scale was recorded (Olvera, Bakhshaie, Garey, Jardin, Schmidt, & Zvolensky, 2015). Studies on this subject are limited, however, and further research is required.

There are studies in which the rate of anxiety and depression was higher in those with low educational status among active smokers (Wilkinson, Vatcheva, Pérez, Reininger, McCormick, & Fisher-Hoch, 2014). Although no statistically significance was recorded in our study, the scores obtained from the anxiety scales decreased as the educational level increased. This is considered to be due to the higher level of income better standard of living resulting from a higher level of education.

In a study in which smokers admitted to a center to quit smoking and non-smokers were compared, the risk of anxiety and depression was higher in smokers than in non-smokers. A direct correlation was recorded between the increase in the level of nicotine dependence and increase in the scores of anxiety and depression, a significant relationship between anxiety and high levels of dependence was reported in this meta-analysis (Jiang, Li, Pan, Zhang, & Jia, 2014).

Although differing results appear in the literature, no significant difference has previously been recorded between factors such as previous attempts to quit smoking, number of attempts, professional support status and the distributions of BAI, State-Anxiety Scale and Trait-Anxiety Scale scores. In addition, no significant relationship has been recorded between the levels of nicotine dependence and the scores of the BAI, State-Anxiety Scale and Trait-Anxiety Scale. This is considered to be due to differences in the scales used to measure and comment on anxiety.

A significant positive correlation was recorded between the scores from the BAI and State-Anxiety and Trait-Anxiety Scales. In another study similar to this one, a significant relationship was recorded between state anxiety and trait anxiety (Olvera et al., 2015).

The main limitations of this study are that the anxiety levels of participants were not compared with those of other members of the community. In addition, we used face-to-face self-report questionnaires, which may be subject to individual biases. The strengths of the study are that it reports a prospective study and there are only few similar studies in Turkish society where these data have been examined previously.

Conclusion

In this study, female gender, low level of education, and unmarried status were identified as risk factors for anxiety in smokers. Furthermore, a level of anxiety was found in 53.3% of people seeking treatment to quit smoking by visiting an outpatient smoking-cessation clinic, which is important in terms of the success of the attempt to quit smoking and maintaining smoking cessation, while considering the potential benefit and risk balance of future treatments.

A multidisciplinary approach must be undertaken to evaluate the mental health and anxiety of people who visit outpatient smoking-cessation clinics. Conducting more comprehensive studies on the relationship between anxiety and smoking cessation will play an important role choices made about treatments for smoking cessation.

Ethics Committee Approval: Ethics committee approval was received for this study from the Non-Interventional Clinical Research Ethical Committee of Şişli Hamidiye Etfal Training and Research Hospital (number: 990).

Informed Consent: Verbal informed consent was obtained from patients who participated in this study.

Peer-review: Externally peer-reviewed.

Author Contributions: Concept – S.T.K., D.T.; Design - S.T.K., D.T.; Supervision – D.T.; Resources – S.T.K., Ç.Ş.; Materials – S.T.K., Ç.Ş.; Data Collection and/or Processing - S.T.K., Ç.Ş.; Analysis and/or Interpretation - S.T.K., Ç.Ş., D.T.; Literature Search – S.T.K., Ç.Ş.; Writing Manuscript – S.T.K., Ç.Ş., D.T.; Critical Review – S.T.K., Ç.Ş., D.T.; Other – S.T.K., Ç.Ş., D.T.

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Hasta Onamı: Sözlü hasta onamı bu çalışmaya katılan hastalardan alınmıştır.

Hakem Değerlendirmesi: Dış bağımsız.

Yazar Katkıları: Fikir - S.T.K., D.T.; Tasarım - S.T.K., D.T.; Denetleme – D.T.; Kaynaklar - S.T.K., Ç.Ş.; Malzemeler - S.T.K., Ç.Ş.; Veri Toplanması ve/veya İşlemesi - S.T.K., Ç.Ş.; Analiz ve/veya Yorum - S.T.K., Ç.Ş., D.T.; Literatür Taraması - S.T.K., Ç.Ş.; Yazıyı Yazan - S.T.K., Ç.Ş., D.T.; Eleştirel İnceleme - S.T.K., Ç.Ş., D.T.

Teşekkür: Hastalara ulaşılmadaki yardımları için Okcan Basat ve Sonay Özdemir’e teşekkür ederiz.

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