Treating Tobacco Use and Dependence

Practice Guidelines and Principles: Guidelines and principles are intended to be flexible. They serve as training tools, reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Purpose: Tobacco use is cited as the chief avoidable cause of illness and death in the U.S. and is responsible for 440,000 deaths each year. There is a higher mortality rate for tobacco use than for the mortality rates due to alcohol, car crashes, illegal drugs, homicides, suicides and AIDS combined. Efforts to curtail tobacco smoking require a consistent and systematic approach to be effective. The purpose of this document is to assist practitioners by providing a framework for interventions based on the guideline published in 1996, by the Agency for Health Care Policy and Research (AHCPR) and updated in 2000 by the U.S. Public Health Service. In addition, treatments found efficacious since the 2000 guideline were reviewed. A new guideline is expected in 2008.

Tobacco cessation counseling on a regular basis is recommended for all persons who use tobacco products. Pregnant women and parents with children living at home also should be counseled on the potentially harmful effects of smoking on fetal and child health. There are now several different efficacious smoking cessation medications, allowing the practitioner and patient many more treatment options. Anti-tobacco messages are recommended for inclusion in health promotion counseling of children, adolescents, and young adults. USPSTF, 2000.

Any physician/practitioner taking a history who discovers a patient who smokes, should use it as an opportunity to ask if the patient has considered quitting, advise against it and discuss smoking cessation.

Key Messages:
• Practitioners can double patient’s chance of quitting by screening for and discussing smoking cessation.
• Use of pharmacotherapy doubles long-term quit rates compared to placebos.
• Tobacco dependence is a chronic condition that often requires repeated intervention,
• The many dangers of smoking include shortness of breath and increased risk of heart attack, stroke, lung and other cancers. Quitting improves health, allows you to feel better and saves money,
• “Know the 5 A’s” of behavioral counseling: ask, advise, assess, assist, arrange.

Racial and Ethnic Disparities:
Smoking cessation treatments have been shown to be effective across racial and ethnic minorities. Therefore, members of racial and ethnic minorities should be provided treatments shown effective in this guideline.


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Grading Recommendation System

STRENGTH OF RECOMMENDATIONS: The Rochester Community-wide Clinical Guidelines Steering Committee (SC) grades recommendations according to one of five classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms).

A—SC strongly recommends that clinicians provide [the service] to eligible patients. There is good evidence that [the service] improves important health outcomes to conclude that benefits substantially outweigh harms.

B—SC recommends that clinicians provide [this service] to eligible patients. There is at least fair evidence that [the service] improves important health outcomes to conclude that benefits outweigh harms.

C—SC makes no recommendation for or against routine provision of [the service]. There is at least fair evidence that [the service] can improve health outcomes to conclude that the balance of benefits and harms is too close to justify a general recommendation.

D—SC recommends against routinely providing [the service] to asymptomatic patients. There is at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I—SC concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that the [service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

QUALITY OF EVIDENCE: The quality of the overall evidence for a service is on a 3-point scale (good, fair, poor).

Good—Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair—Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor—Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted from the USPSTF grading system.
Approved 05.16.05
FOR EVERY SMOKER 5 “A”

**Ask**
- All patients if they use tobacco
  - Assess the smoking status of every patient while measuring vital signs. [“Do you smoke?” (A)]
  - Clearly identify tobacco use in the chart of active or former smokers (add to problem list, use chart stickers or stamps). (B)
  - Ask former tobacco users if they are still tobacco-free, offer reinforcement and discuss any specific problems they might be having such as weight gain, depression, etc.
  - Recognize previous attempts to quit.
  - Assess patients’ exposure to smoke in the home and at the work place, and discuss second hand smoke and the risks associated.

**Advise**
- All users to quit
  - All smokers to quit in a clear, strong and personalized manner. Mention the impact of smoking on children and others in the household. A clear statement of advice [“As your physician I must advise you to quit smoking now.”] is essential. (A)
  - If unwilling to quit, use motivational interventions such as the “5 R’s” (See below)
  - Patients presenting with a smoking related problem to the office or hospital is a great opportunity for intervention as their perception of risk is highest.

FOR SMOKERS READY TO QUIT

**Assess**
- Patients response to advice
  - Ask every tobacco user if he/she is ready to quit.
    - If unwilling to quit, use motivational interventions such as the “5 R’s”.

**Assist**
- With a plan to quit
  - Discuss benefits to be gained from quitting and any success patient has had in quitting before.
  - Help set a quit date with the patient – within 2 weeks of the office visit is ideal.
  - Prepare environment by removing cigarettes.
  - Consider prescribing nicotine replacement, Zyban or Chantix for all smokers without contraindications. (A)
  - Offer to fax a referral to the New York State Smokers’ Quitline 1-866-NY-QUITS (1-866-697-8487) for counseling support and a free starter kit of nicotine medications.
  - Encourage adoption of a smoke-free home and car policy (educate about secondhand smoke dangers);
  - If another smoker lives in the home, urge patient to quit with the other smoker
  - Encourage abstinence from tobacco, avoidance of alcohol, reduction in caffeine intake.
  - Discuss triggers and challenges and how patient will successfully overcome them
  - Suggest use of the 4 D’s to fight urges– Drink water, Deep breathes, Don’t smoke, Do something else.
  - Refer patient to a smoking cessation program and provide educational material.
  - Provide tobacco cessation packet. Provide supplementary materials on special topics as appropriate such as smoking and pregnancy, risks of cigars and other tobacco products, weight control, etc.
  - Give congratulations, encouragement and support

**Arrange**
- Arrange follow-up visit within 1-2 weeks after quit date
- Arrange second follow-up visit in 1-2 months
- Assess medication’s help to manage the physical withdrawal symptoms
- Follow up calls from a practitioner or clinic nurse can be helpful
- Remind patients that a lapse can be a learning experience
- Congratulate success and elicit recommitment to total abstinence

FOR SMOKERS NOT READY TO QUIT  5 “R’s”

**Relevance**
- To each patient
  - Encourage patient to indicate why quitting is personally relevant
  - Provide motivational information that is relevant to the patients status, risk, family, social situation, or health concerns

**Risk**
- Of continued smoking
  - Ask patient to identify potential negative consequences of tobacco use that are relevant to the patient
    - Acute-risk: Shortage of breath, harm to pregnancy, impotence, infertility, increased carbon monoxide
    - Long-term risk: Heart attacks and strokes, lung and other cancers, COPD, disability
  - Environmental: Increased risks of lung cancer and heart disease in spouse, higher rates of smoking by children of tobacco users, increased risk for low birth weight, asthma, middle ear and respiratory infections in children of smokers

**Rewards**
- Of quitting
  - Ask patient to identify potential benefits of stopping tobacco use. These include: improved health, saving money, setting a good example for children, feeling better physically, reducing wrinkling/aging of skin, and home, car, clothes and breath smelling better

**Roadblocks**
- Address barriers
  - Ask patient to identify barriers to quitting and target treatment to address barriers
    - Typical barriers might include: Withdrawal symptoms, fear of failure, weight gain, lack of support, depression, enjoyment of smoking

**Repetition**
- At every visit
  - Use motivational interventions such as the “5 R’s” at every visit. Tobacco users who have previously failed in quit attempts should be told most people make repeated attempts before they are successful
**Important Points to Remember for Effective Intervention:**

- You can double your patient’s chance of quitting by screening for and discussing smoking cessation.
- Use of pharmacotherapy doubles long-term quit rates compared to placebo. Combining the nicotine patch with a self-administered form of nicotine therapy (gum, lozenge, nasal spray, or inhaler) is more efficacious than use of single agent for those who are unsuccessful using one agent alone. \(^{(B)}\)
- Being positive and supportive, teach patients to ask for help from friends and family and to plan specific problem solving about how they will live without nicotine will increase likely of quitting for the long-term
- Teach patients to look for irritability, anxiety, difficulty concentrating, and cravings when they stop. These withdrawal symptoms will decrease with pharmacotherapy and over time. Withdrawal symptoms indicate addiction to tobacco.
- There is a strong dose response relationship between the amount of time you counsel your patient and long-term cessation. \(^{(A)}\)
- Advise women that smoking when taking oral contraceptives increases the risk of cardiovascular events.

**When to Consider Pharmacological Treatment:**

<table>
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<tr>
<th>Weight Gain</th>
<th>Pregnancy</th>
<th>Mental Health &amp; Alcohol/Chemical Dependency</th>
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<tbody>
<tr>
<td>1. Acknowledge that quitting smoking is often followed by weight gain of ≥10 lbs.</td>
<td>1. Offer effective smoking cessation interventions at the first prenatal visit and throughout the pregnancy. (^{(B)})</td>
<td>1. Buproprion SR and nortriptyline should be considered for the treatment of tobacco dependence in smokers with a history of depression.</td>
</tr>
<tr>
<td>2. Inform the patient that the health risks of weight gain are small in comparison to continued smoking.</td>
<td>2. Offer extended or augmented psychosocial interventions that exceed minimal advice to quit. (^{(A)})</td>
<td>2. Smokers with comorbid psychiatric conditions should be provided smoking cessation treatments and assessed periodically for relapse.</td>
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<tr>
<td>3. Recommend that patients concentrate on smoking cessation, not weight control, until they feel confident that they will not return to smoking.</td>
<td>3. Augmented pregnancy tailored self-help materials are recommended for pregnant smokers.</td>
<td>3. Evidence indicates smoking cessation interventions do not interfere with recovery from chemical dependency.</td>
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<td>4. Recommend physical activity, a healthy diet &amp; limiting alcohol consumption to control weight.</td>
<td>4. Pharmacotherapy has not been sufficiently tested for efficacy and safety in pregnant patients.</td>
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**Helping to Prevent Relapse:**

- Congratulate efforts, acknowledge patient’s struggle, discuss problems patient may encounter while quitting
- Reassure patients that past attempts to quit improve chances of succeeding this time or in the future
- Discuss benefits the patient may derive from cessation
- Encourage the patient to keep trying, encourage continued use of self-help services such as quitline for ongoing support

**Special Issues and Concerns:**

**Children and Teens**

1. Screen pediatric and adolescent patients, and their parents for tobacco use.
2. Counseling and behavioral interventions should be modified to be developmentally appropriate.
3. Offer smoking cessation advice & interventions to parents to reduce second-hand smoke. \(^{(B)}\)
4. Adolescents who use smokeless tobacco are more likely to become cigarette smokers.

**Non-Cigarette Tobacco Products**

1. Smokeless/spit tobacco users should be identified, strongly urged to quit, and treated with the same counseling interventions as smokers. \(^{(B)}\)
2. Clinicians providing dental care services should provide interventions to all cigarette smokers, and individuals using smokeless/spit tobacco. \(^{(A)}\)
3. Users of cigars, pipes, and other forms of tobacco should be identified, strongly urged to quit and offered counseling.
4. Smokeless tobacco use can lead to nicotine addiction and dependence.

**Mental Health & Alcohol/Chemical Dependency**

1. Buproprion SR and nortriptyline should be considered for the treatment of tobacco dependence in smokers with a history of depression.
2. Smokers with comorbid psychiatric conditions should be provided smoking cessation treatments and assessed periodically for relapse.
3. Evidence indicates smoking cessation interventions do not interfere with recovery from chemical dependency.

<table>
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<th>Hospitalized Smokers</th>
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<tr>
<td>1. Provide smoking cessation treatments to hospitalized patients to aid in recovery. (^{(B)})</td>
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<tr>
<td>2. Hospitalized patients may be particularly motivated to quit.</td>
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<tr>
<td>3. Patients in long-term care facilities should also receive tobacco dependence interventions.</td>
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</table>

- Medication selection should be based on factors such as nicotine addiction, contraindications, likelihood of compliance and patient preference.
- Every patient who uses tobacco should be offered treatment. Patients willing to quit should receive a guideline treatment. Those unwilling to quit should be motivated to do so.

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs. Bold italicized letters refer to Rochester Community-wide Clinical Guidelines Grading System, see page 2 for description. Approved Rochester Guideline Committee April 16, 2007. QMC - April 13, 2007. Next scheduled update by April 2009.

Woolf, S. et.al., editors, Health Promotion and Disease Prevention in Clinical Practice; Williams & Wilkins; 1996 pgs. 163-175.


Williams GC, Deci, EL. Activating patients for smoking cessation through physician autonomy support. Medical Care.  2001; 39: 813-823.


Center for Disease Control, National Center for Disease Prevention and Health Promotion. Tobacco Information and Prevention Source. December 2006