MEDICAL PHARMACIES TABLET

Drug information and news for health care providers

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QUIT SMOKING STRATEGIES

ASSESSING THE OPTIONS

For those who smoke, the New Year often rings in a resolution to quit smoking. For most, this is a repeat performance, an average smoker does not quit smoking for good until after the fifth quit attempt.[1] Although many people believe they can quit "cold turkey," studies have shown that using smoking cessation aids such as nicotine replacement therapy (i.e., patch, gum, lozenge, inhaler, mouth spray), bupropion (Zyban®), or varenicline (Champix®) more than doubles quit smoking success rates. The Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-Informed Tobacco Treatment (CAN-ADAPTT) guidelines recommend that efficacious pharmacotherapy should be offered to every patient who smokes ten or more cigarettes daily and is willing to make a quit attempt.[2]

THE MINISTRY OF HEALTH AND LONG-TERM CARE ONTARIO RECOMMENDS THE FOLLOWING STRATEGIES WHEN CONSIDERING QUITTING YOURSELF OR DISCUSSING SMOKING CESSATION WITH A RESIDENT.[3]

- Discuss and document:
  - Tobacco use history
  - Previous quit attempt history and outcome including reasons for relapse (helps to inform strategies that will avoid barriers to remaining smoke-free)
  - Medication-related history
- Think about the personal consequences of smoking as related to the current situation and remind residents about the consequences of smoking with regard to their chronic conditions and risk factors (e.g., smoking and heart disease, smoking and respiratory disease, smoking and risk of cancer).
- Be cognisant of personal smoking triggers and strategies to overcome them and discuss these issues with residents (utilize education gained from previous quit attempts to identify triggers and any strategies that may have been successful).
- Set a quit date (preferably within next two weeks, when the attempt is most likely to be successful).
- Consider pharmacotherapy options based on past quit attempts and preferences.

REDUCE TO QUIT OPTION

Although most quit options suggest that a person stops smoking after the pharmacological aid has been started, the "Reduce to Quit" option as outlined by the CAN-ADAPTT guidelines is another strategy that some may prefer. The protocol for the Reduce to Quit option follows:

Step 1 (0 to 6 weeks): Smoker sets a target for number of cigarettes per day to cut down (at least 50% recommended) and a date to achieve it by. Smoker uses gum to manage cravings.

Step 2 (6 weeks up to 6 months): Smoker continues to cut down cigarettes using gum. Goal should be complete stop by 6 months. Smoker should seek advice from a healthcare professional if smoking has not stopped within 9 months.

Step 3 (within 9 months): Smoker stops all cigarettes and continues to use gum to relieve cravings.

Step 4 (within 12 months): Smoker cuts down the amount of gum used, then stops gum use completely (within 3 months of stopping smoking).*

AVOIDING RELAPSE

If a relapse occurs, don't be judgmental. Use the experience to learn more about the risks to avoid in the next quit attempt, and treat residents the same way. Assure the resident that relapse is not a sign of personal failure, but is consistent with the chronic nature of tobacco dependence.[4]

Relapse prevention needs to be individualized for each individual. Before quitting, taking the time to plan for triggers is an important exercise. Following are some methods that can be used for dealing with circumstances that increase risk for relapse:[4]

- Prepare to deal with social situations, especially those involving alcohol. The highest rate of relapse occurs at social gatherings when inhibitions are lowered due to alcohol consumption. The following five strategies sum up a general approach to coping with high-risk situations for relapse: avoid, leave, distract, delay, use self-talk.
- Avoid circumstances that may trigger relapse. If smoking was a ritual at certain times of day, do something different to create a new ritual. Change your routine. For example, if you normally get up in the morning, light up immediately with a cup of coffee, and then shower, try showering first, then brushing teeth to change the usual morning ritual. Try going for a walk, performing deep-breathing relaxation exercises, or drinking water instead.

- Employ positive self-talk. Continue thinking about the benefits and rewards associated with quitting when an urge to smoke occurs. The craving usually passes within five minutes.
- Reward yourself. Save the money you would have spent on cigarettes for something you really want. Watch the money accumulate until you can achieve your goal.
- Employ stress management techniques. Managing daily stress in an effective manner can ease the quitting process. Stress management strategies include regular relaxation exercises, increasing physical activity, and limiting caffeine intake.
- Plan for weight management. The facts about potential weight gain should be addressed ahead of time and plans made to minimize the impact of this phenomenon on a smoker's ability to remain smoke-free.

*It is important to remember that although nicotine is the addictive component of cigarettes, it is the smoke inhalation that carries the health risks. Therefore, if an individual feels that he/she needs to continue with nicotine replacement therapy for a longer period of time than that recommended, it is far better than beginning to smoke again. MPT

Effectiveness of Quit Smoking Aid Options

Studies have shown that certain combinations of quit smoking drugs (e.g., nicotine patch + nicotine gum or spray, nicotine patch plus bupropion SR) can be more effective than either therapy alone. These combinations can be tried if a single cessation aid has failed. Please note that varenicline is not currently recommended in combination with other therapies, although research is ongoing into effectiveness and side effect profile when used in combination with nicotine replacement therapy. The table below outlines estimated abstinence rates of various therapies based on study outcomes.

Effectiveness of Smoking Cessation Medications on 6-Month Abstinence Rates[4]

Medication	Estimated Percentage Abstinence Rates at 6 Months (95% CI)
Placebo	13.8
Nicotine patch (long term >14 weeks) + ad lib (as required) nicotine gum	36.5 (28.6-45.3)
Varenicline (2mg/day)	33.2 (28.9-37.8)
Nicotine patch + bupropion	28.9 (23.5-35.1)
High dose nicotine patch (>25 mg) (both standard and long-term treatment)	26.5 (21.3-32.5)
Long-term nicotine gum (>14 weeks)	26.1 (19.7-33.6)
Nicotine patch + nicotine inhaler	25.8 (17.4-36.5)
Varenicline (1mg/day)	25.4 (19.6-32.2)
Nicotine inhaler	24.8 (19.1-31.6)
Bupropion SR	24.2 (22.2-26.4)
Nicotine patch (6-14 weeks)	23.4 (21.3-25.8)
Long-term nicotine patch (>14 weeks)	23.7 (21.0-26.6)
Nicotine gum (6-14 weeks)	19.0 (16.5-21.9)

E-Cigarettes: The Debate Continues

E-cigarettes (electronic cigarettes) are plastic or steel tubes that resemble regular cigarettes and are designed to mimic the smoking experience without the actual combustion of the additional chemicals found in tobacco. When smoked (referred to as "vaped"), they emit a vapour, but not smoke.[5] E-cigarettes resemble tobacco cigarettes in the physical and behavioural realms, but do not contain tobacco. Therefore, no combustion takes place and no smoke is emitted. Debate continues about the benefits and risks of these cigarette substitutes.

E-cigarettes are a controversial product, because advocates contend that they are safer than smoking cigarettes, and they are perceived to be helpful in quitting smoking. So far there is no long-term evidence to support either of these claims.[6] Aside from the unknown safety profile, there is a concern that e-cigarettes may become a gateway to tobacco use, potentially due to the behavioural associations of smoking and because they are marketed in a manner similar to how cigarettes were marketed prior to current regulations on advertising.[6] DN

References:

1. Schroeder SA. What to do with a patient who smokes. JAMA 2005;294(4):482-487
2. CAN-ADAPTT. (2011). Canadian Smoking Cessation Clinical Practice Guideline. Toronto, Canada: Canadian Action Network for the Advancement, Dissemination and Adoption of Practice-informed Tobacco Treatment, Centre for Addiction and Mental Health.
3. Ontario Ministry of Health and Long-Term Care. Pharmacy Smoking Cessation Program. First Consultation Meeting. Available at http://www.health.gov.on.ca/en/pro/programs/drugs/smoking/resources.aspx
4. Fiore MC, et al. Clinical Practice Guidelines. Treating Tobacco Use and Dependence: 2008 Update. US Dept of Health and Human Services May 2008
5. Czoli CD, Hammon D, White CM. Electronic cigarettes in Canada: Prevalence of use and perceptions among youth and young adults. Can J Public Health 2014;105:e97-e102
6. Shivo M, Avdalovic MV, Murin S. Electronic nicotine delivery systems for smoking cessation: where are we? Curr Respir Care Rep 2014;3:192-199

This review is not comprehensive. Please refer to specific product monographs for more comprehensive information, including precautions, adverse reactions, and drug interactions.