How to manage smokers: Drop the word ‘Quit’

Webinar

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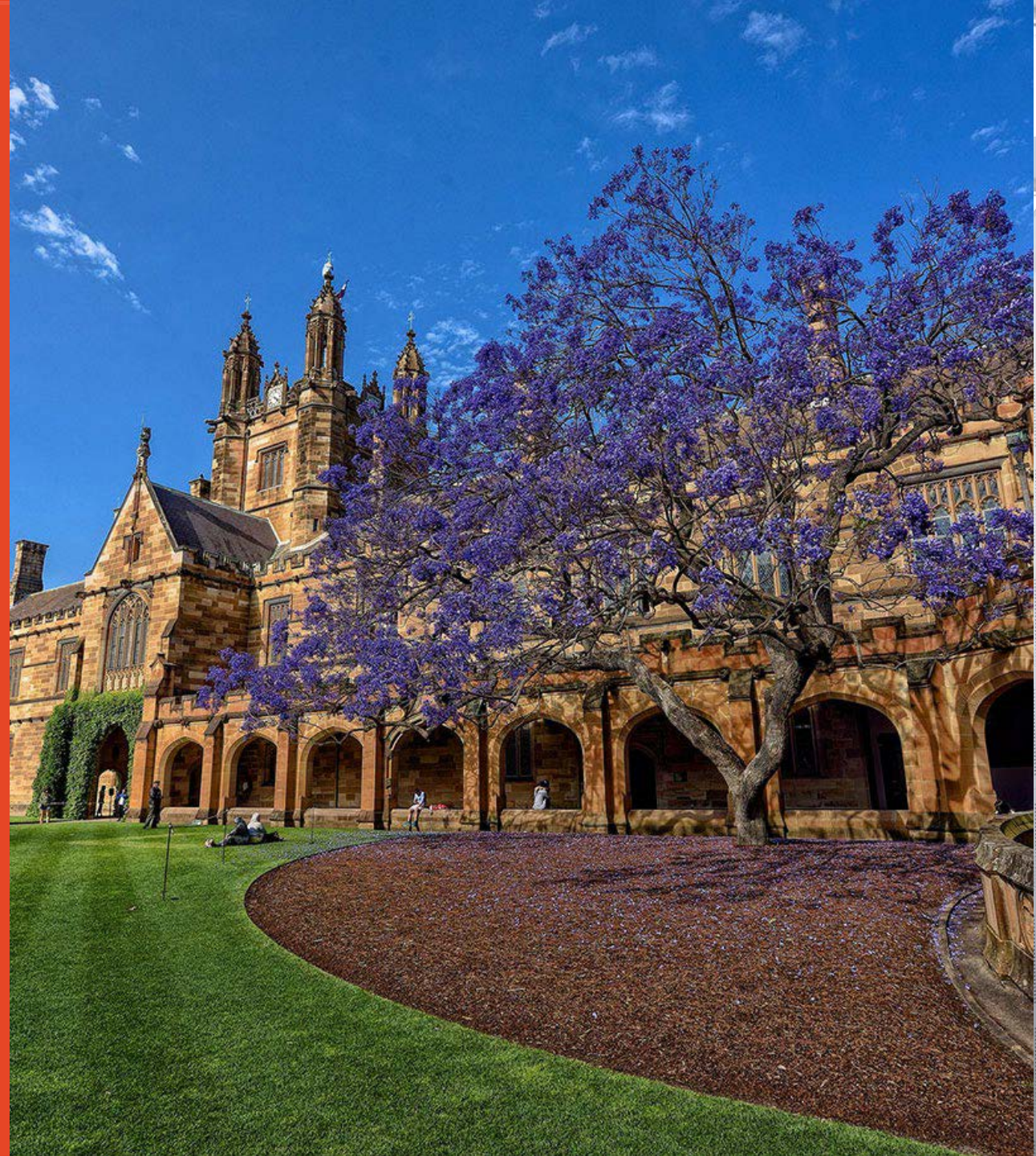

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PART 2.

HOW TO MANAGE SMOKERS: DROP THE WORD 'QUIT'

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Cambridge University Press

NO CONFLICTS OF INTEREST

REVISION

- With a better understanding of the neuropsychsocial determinants regarding tobacco smoking this presentation will review evidence-based interventions for smoking cessation that are based on individual needs.

- Enable you to better chose an appropriate pharmacotherapy if needed, understand that it is not a one-size-fits all treatment, having taken a valid smoking history

- Enable you to develop strategies to address your patients using language to help them "manage" their smoking rather than the intimidatory "you must quit" used in the past.

- You will also be able to advise small but pertinent evidence based behavioural changes that make changes in smoking behaviour possible.

HOW DO WE ASSESS A SMOKER?

Ask about:

- Time to first cigarette (TTFC)
- Quitting history (previous attempts, pharmacological failures)
- Family history (heritability)
- Environment contexts (others smoke at home/or at work)

Also consider:

- Medical history (psychiatric in particular)
- Gender (women metabolise nicotine faster than men)
- Co-morbidities (especially mental health and pregnancy)
- Concomitant medications (caffeine, alcohol, insulin, antipsychotics etc.)
- Daily smoking (number less relevant and type irrelevant)

REVISION: WHO FINDS IT HARDEST TO QUIT?

Characteristics:

- Highly dependant, so smoke within 30 minutes of waking (Time to First Cigarette-TTFC)
- Have multiple short previous attempts to quit, with high severity of withdrawal symptoms
- Smoking or withdrawals in the past while using Nicotine Replacement Therapies (NRT).
- Poor past experiences with quitting
- Likely to be a fast metabolizer of nicotine

Many smokers want to quit – some find it harder than others

TIPS FOR TALKING TO SMOKERS

- Be **non-judgemental** and **don't nag**
- Inform about **biological basis for smoking**
- **Don't use word 'fail'** – use 'don't do well'
- Explain that **smoking is complex** – aim to help you 'manage' your smoking better
- **Motivation and decision-making vacillate** – don't ask; 'Are you interested in quitting?' Can change from day to day
- **Treatment - one size doesn't fit all**

EVIDENCE-BASED TREATMENT

- The most effective treatment is provision of counselling (behavioral treatments) and pharmacotherapy

- **Counselling** – to deal with triggers, habits, emotions related to smoking and provide ongoing motivation and encouragement to quit. Support for family members who smoke is also important.

- **Pharmacotherapy** – to manage cravings and withdrawal symptoms.

- **NSW Quitline** can provide counselling support for patients

Quitline® 13 7848

NO SCIENTIFIC EVIDENCE TO SUPPORT……

- Hypnotherapy
- Acupuncture
- Psychotherapy
- Negative affect counselling
- Self help books
- Self-styled experts selling books / programmes
- Lotions, creams, potions, herbal remedies
- Cutting down rather than quitting – may be worse
- Weaker / mild cigarettes- worse

EVIDENCE-BASED PHARMACOTHERAPIES FOR NICOTINE WITHDRAWALS

1ST Line

- NRT of all types
- Combination NRT (oral + patch)
- Varenicline alone or combined with NRT
- Bupropion alone or combined with NRT

2nd Line

- Nortriptyline, Naltrexone – not registered for use as smoking cessation aid in Australia

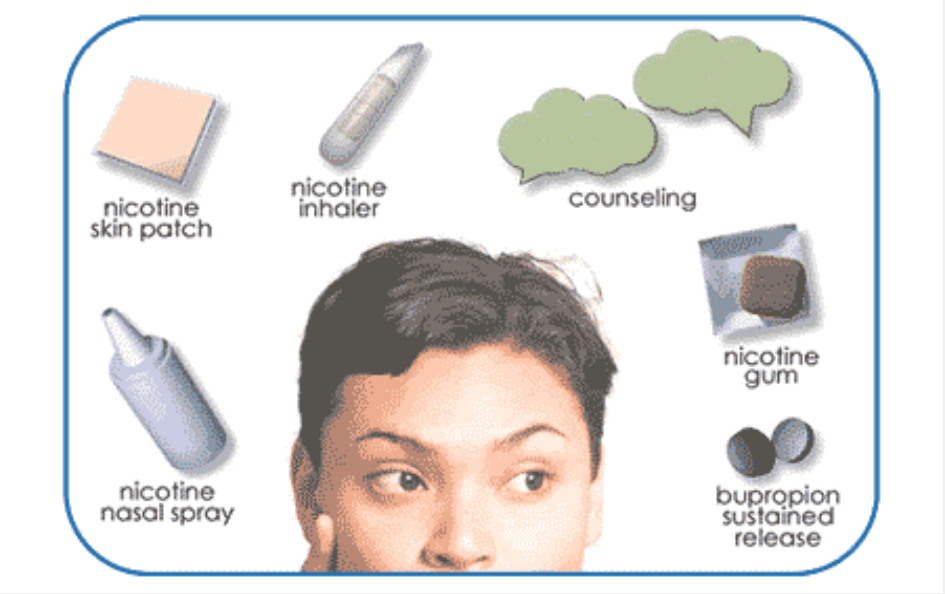
Effectiveness

- Combined use of pharmacotherapy more effective than single use
- Varenicline most effective pharmacotherapy

WHAT'S THE RIGHT PHARMACOTHERAPY FOR MY PATIENT?

Consider:

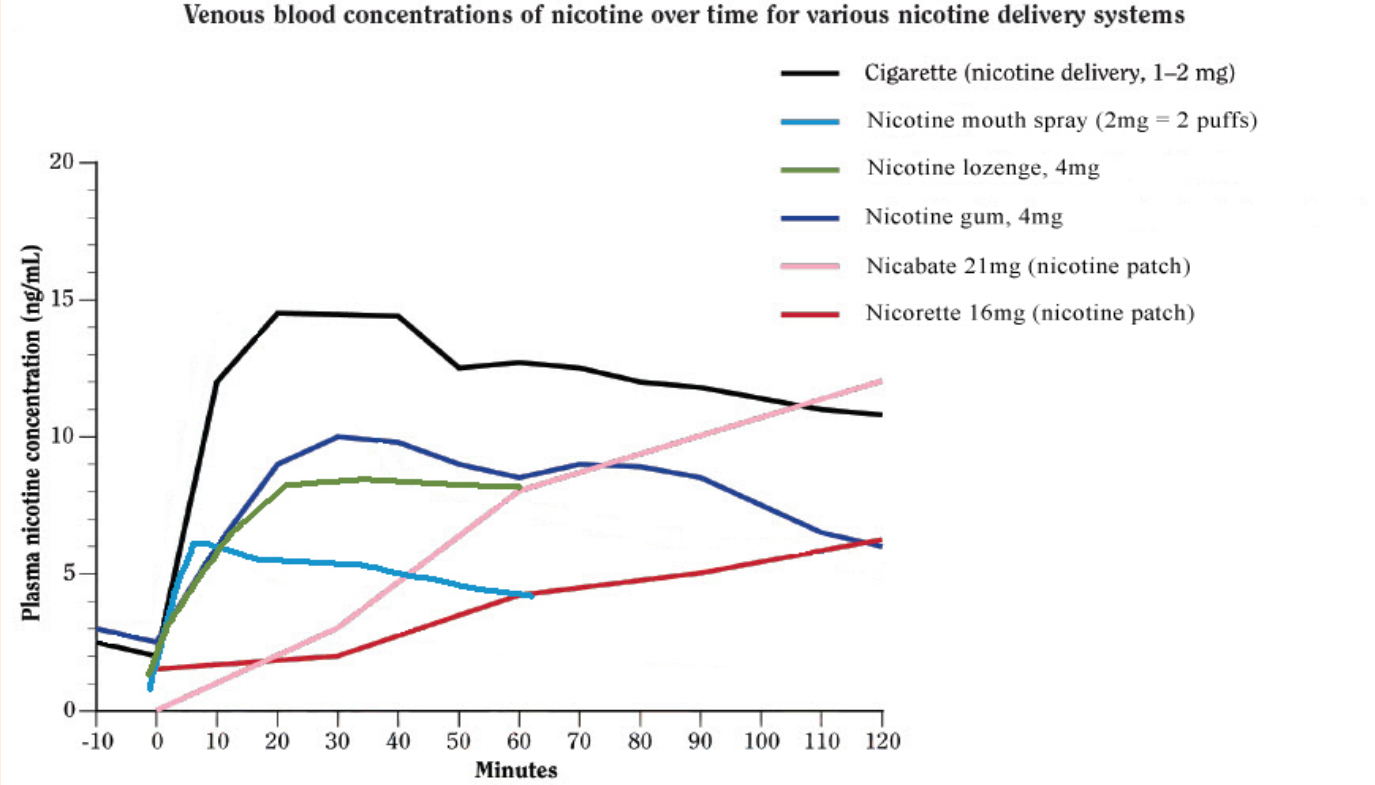
- Past usage - correct usage/dosage
- Past outcomes - success/failures
- Familial traits in success/failures
- Age and gender
- Cost concerns – oral NRT not all on PBS
- Contraindications
- Non-daily smokers – use NRT



NICOTINE REPLACEMENT THERAPY (NRT)

- **Works by relieving cravings and withdrawal symptoms**
  - replaces some of the nicotine smokers get from tobacco
- No serious side-effects → mostly due to incorrect use
- Stressors managed better on NRT
- Longer use → better outcome
- Approved by TGA for use in pregnancy
- Some find compliance with patch easier than oral NRT
- No evidence to wean by reducing dose
- Safer than smoking in pregnancy

BLOOD PLASMA LEVELS FOR NRT PRODUCTS VS. CIGARETTES



Source: Adapted from Fant et al. 1999 with permission from Elsevier, ©1999.
Note: **mg** = milligrams; **ng/mL** = nanograms per milliliter.

The Health Consequences of Smoking—50 Years of Progress. A Report of the Surgeon General, 2014

TIPS FOR USING NRT

- **Use Combination NRT** - safe and produces better outcomes
- **Avoid under-dosing** - most need more than single form of NRT
- **Night patching** - Apply patch (24hr 21mg) last thing at night to peak in the morning – will reduce urge to smoke on waking
- **Carbon Monoxide (CO) monitoring** - provides bio-feedback to patient (great motivator) and guides NRT dose requirements
- **Don't stop too early** - recommend continued use for many months while patient learns how to behave without resorting to smoking

NRT CASE STUDY

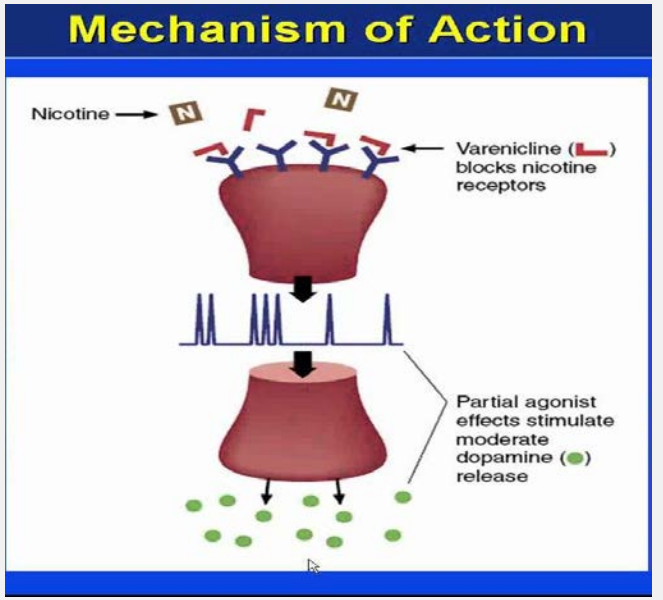
- **Michael – 55 years**
- PHx - significant alcohol abuse, underweight, acute exac. of COPD
- Smokes 50 rollies/day; tried varenicline in the past – no effect -never abstained from smoking; TTFC = 5 mins
- Lives in religious care facility (smoking is allowed outdoors)
- Baseline Expired CO = 30 ppm (normal 2.75+-0.75)
- Commenced on 1x21mg patch/day, applied at night before bed.

Instructed to continue to smoke as needed (family and carers informed).

- **Follow up**.
- - Week One: 1 X 21mg patch: Expired CO = 21ppm, rolling 20/day
- - Week Two: 2x21mg patches: Expired CO = 10ppm, rolling 8/day
- - Week Three: 3x21mg patch: Expired CO = 3ppm, nil cigarettes
- Remains abstinent
- Weened off patches in reverse order: Remain on one patch > 3months

VARENICLINE

- **Best odds ratio of all treatment**
- **No known drug interactions**
- **Mechanism of action**
  - Partial Nicotine Receptor Agonist/Antagonist
- cravings and pleasurable effects of tobacco products
- **Doesn't work for everyone**
  - response genetically determined by brain cell types
  - younger age (< 55) and women do better
  - not best choice for non-daily smoker



- **Longer use = better outcome** - withdrawals may re-appear after cessation of treatment

SAFETY CONCERNS

- Concerns about direct mental health side-effects have been exaggerated. These are typically effects from quitting smoking not side-effects of varenicline. Eagles study (Lancet May 2016)

Position of the TGA and RACGP

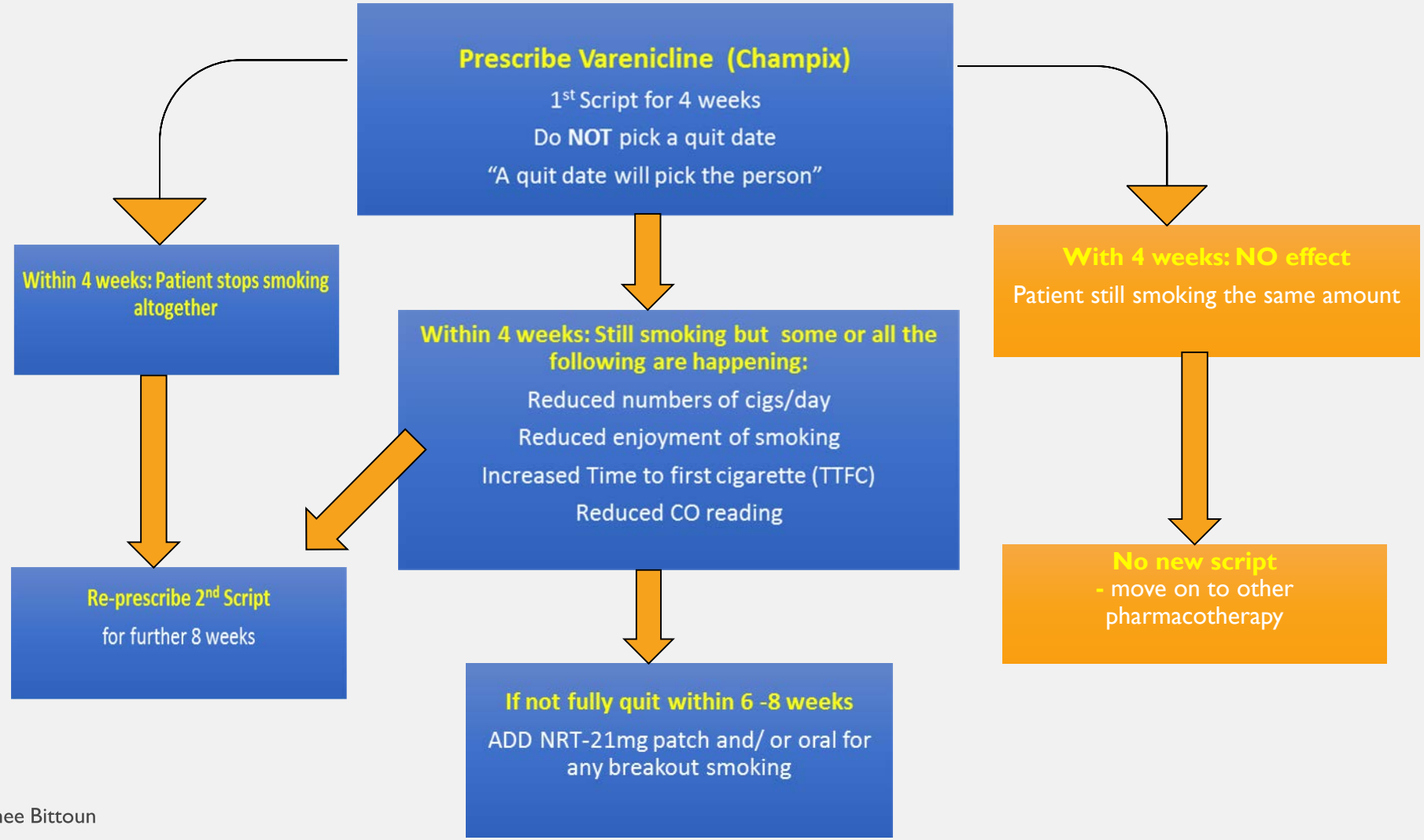
- Trials have not found evidence of higher rates of suicidal events, depression or aggression/agitation attributable to varenicline.
- This applies to those with and without a history of psychiatric disorders.
- However, serious psychiatric symptoms have been reported in some patients taking varenicline.
- **Prescribers should ask patients to report any unusual mood or behavioural changes and suicidal thoughts in everybody quitting smoking**

PRACTICAL ISSUES

- 35% of users experience nausea as side-effect
  - important to ingest tablet along with food
- Sleep disturbances / vivid dreams side-effect
  - take tablets (2 in total) eight hours apart (no longer)
- Still having symptoms of withdrawal
  - add NRT (often pulsatile or patch)
- Not tolerating 2 tablets per day
  - halve the dosage – 1 tablet per day
  - if weighs < 45kg - 1 tablet per day

TGA rule change - Patient doesn't need to have quit by 4 weeks for GP to provide a second script

VARENICLINE FLOWCHART



BUPROPION

- Originally an antidepressant (same dose)
- P450 CYP2B6 metabolises bupropion to hydroxybupropion
- This enzyme is genetically determined- similar to varenicline
- Poor metabolisers do not do well
- Contraindications: important seizure threshold – not for use by people with history of epilepsy, fitting, fainting
- Some drug interactions with bupropion
- Not widely used – not as good as varenicline
- If patient doesn't respond to varenicline would try NRT rather than bupropion

E-CIGARETTES

- Not registered in Australia as smoking cessation device
- Limited research/evidence on effectiveness as cessation aid
- Addiction to nicotine remains when using eCigs
- Many users of eCigs continue to smoke tobacco.
- eCigs and e-liquids are often not accurately labelled
  - amount of nicotine being inhaled is unknown.
- Other chemicals in e-liquids may also be unsafe.

- **RACGP and NSW Health position on eCigs at this time**:

E-cigarettes have not been assessed by the TGA for effectiveness and safety, so they should not be considered a safe product, or a suitable quitting aid.

BEHAVIOURAL ADVICE BASED ON EVIDENCE

EVIDENCE-BASED TIPS

- *New house rule* everyone ALWAYS smokes outside --- starts TODAY
- No one smokes in the CAR--- get out to smoke
- Avoid other people's smoke (not them, just the smoke)
- Don't throw away cigarettes (makes you anxious) –-but not too handy

WHAT HELPS WITH AN ACUTE URGE TO SMOKE

- Imagine a scene when you smoke and then imagine that same scene without smoking
- Practice this imagining in all the times and scenes that you would have smoked
- Don't always avoid things that stimulate the need to smoke ie. don't avoid a friend who smokes – just meet up where you can't.
- Break up pairing of smoking with other activities (coffee, phone, newspaper etc.) smoke outside-coffee inside-don't take the coffee outside with it etc
- Short bursts of exercise (one minute) helps with urges
- Use oral NRT a lot

SUMMARY

- GP has a key role in motivating and supporting a quit attempt
- Show empathy and concern and make sure smoker knows the risks of continued smoking and the benefits of quitting
- Ask about smoking in a non-judgemental way
- Dispel myths and misconceptions
- Understand the LIVER interactions with quitting smoking and provide advice around adjustment to usual prescribed drug dosages
- Put smoker in touch with cessation support – eg. Quitline
- Be well informed and proactive about use of pharmacotherapy, where appropriate.

CONCLUSIONS

- Treatment advice no longer "one-size-fits-all"
- Use a medical model of individual treatments
- Smoking is an addiction and as such is chronic and relapsing
- Consider harm-reduction strategies
- Base "tips" on evidence
- Incorporate environmental cues

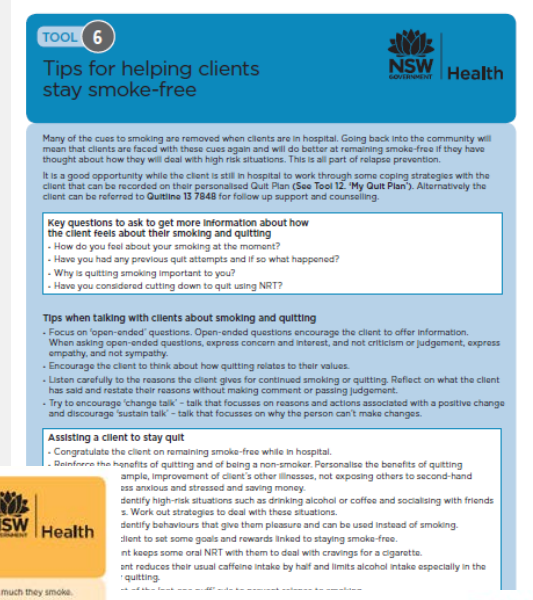
RESOURCES

- NSW Health patient fact sheets

http://www.health.nsw.gov.au/tobacco/Pages/publications-resources.aspx

- NSW Health tools for health professionals
  - Quick guide to NRT
  - Tips for helping clients stay smoke-free
  - Drug interactions with quitting

http://www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx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Tips for helping clients stay smoke-free

NSW Health

Many of the cues to smoking are removed when clients are in hospital. Going back into the community will mean that clients are faced with these cues again and will do better at remaining smoke-free if they have thought about how they will deal with high risk situations. This is all part of relapse prevention.

It is a good opportunity while the client is still in hospital to work through some coping strategies with the client that can be recorded on their personalised Quit Plan (**See Tool 12. 'My Quit Plan'**). Alternatively the client can be referred to **Quitline 13 7848** for follow up support and counselling.

Key questions to ask to get more information about how the client feels about their smoking and quitting

- How do you feel about your smoking at the moment?
- Have you had any previous quit attempts and if so what happened?
- Why is quitting smoking important to you?
- Have you considered cutting down to quit using NRT?

Tips when talking with clients about smoking and quitting

- Focus on 'open-ended' questions. Open-ended questions encourage the client to offer information. When asking open-ended questions, express concern and interest, and not criticism or judgement, express empathy, and not sympathy.
- Encourage the client to think about how quitting relates to their values.
- Listen carefully to the reasons the client gives for continued smoking or quitting. Reflect on what the client has said and restate their reasons without making comment or passing judgement.
- Try to encourage 'change talk' – talk that focusses on reasons and actions associated with a positive change and discourage 'sustain talk' – talk that focusses on why the person can't make changes.

Assisting a client to stay quit

- Congratulate the client on remaining smoke-free while in hospital.
- Reinforce the benefits of quitting and of being a non-smoker. Personalise the benefits of quitting

ample, improvement of client's other illnesses, not exposing others to second-hand

ess anxious and stressed and saving money.

dentify high-risk situations such as drinking alcohol or coffee and socialising with friends

s. Work out strategies to deal with these situations.

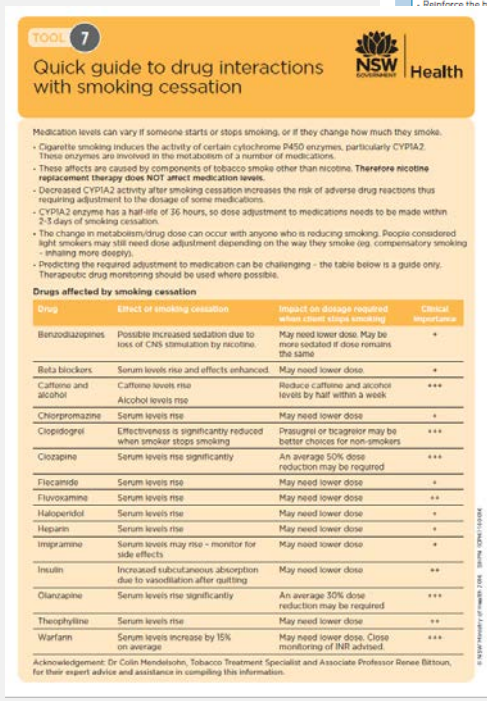
dentify behaviours that give them pleasure and can be used instead of smoking.

lient to set some goals and rewards linked to staying smoke-free.

nt keeps some oral NRT with them to deal with cravings for a cigarette.

nt reduces their usual caffeine intake by half and limits alcohol intake especially in the

quitting.


TOOL 7

Quick guide to drug interactions with smoking cessation

NSW Health

Medication levels can vary if someone starts or stops smoking, or if they change how much they smoke.

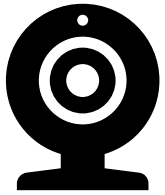
- Cigarette smoking induces the activity of certain cytochrome P450 enzymes, particularly CYP1A2. These enzymes are involved in the metabolism of a number of medications.
- These affects are caused by components of tobacco smoke other than nicotine. **Therefore nicotine replacement therapy does NOT affect medication levels.**
- Decreased CYP1A2 activity after smoking cessation increases the risk of adverse drug reactions thus requiring adjustment to the dosage of some medications.
- CYP1A2 enzyme has a half-life of 36 hours, so dose adjustment to medications needs to be made within 2-3 days of smoking cessation.
- The change in metabolism/drug dose can occur with anyone who is reducing smoking. People considered light smokers may still need dose adjustment depending on the way they smoke (eg. compensatory smoking - inhaling more deeply).
- Predicting the required adjustment to medication can be challenging - the table below is a guide only. Therapeutic drug monitoring should be used where possible.

Drugs affected by smoking cessation

Drug	Effect of smoking cessation	Impact on dosage required when client stops smoking	Clinical importance
Benzodiazepines	Possible increased sedation due to loss of CNS stimulation by nicotine.	May need lower dose. May be more sedated if dose remains the same	+
Beta blockers	Serum levels rise and effects enhanced.	May need lower dose.	+
Caffeine and alcohol	Caffeine levels rise Alcohol levels rise	Reduce caffeine and alcohol levels by half within a week	+++
Chlorpromazine	Serum levels rise	May need lower dose	+
Clopidogrel	Effectiveness is significantly reduced when smoker stops smoking	Prasugrel or ticagreior may be better choices for non-smokers	+++
Clozapine	Serum levels rise significantly	An average 50% dose reduction may be required	+++
Flecainide	Serum levels rise	May need lower dose	+
Fluvoxamine	Serum levels rise	May need lower dose	++
Haloperidol	Serum levels rise	May need lower dose	+
Heparin	Serum levels rise	May need lower dose	+
Imipramine	Serum levels may rise - monitor for side effects	May need lower dose	+
Insulin	Increased subcutaneous absorption due to vasodilation after quitting	May need lower dose	++
Olanzapine	Serum levels rise significantly	An average 30% dose reduction may be required	+++
Theophylline	Serum levels rise	May need lower dose	++
Warfarin	Serum levels increase by 15% on average	May need lower dose. Close monitoring of INR advised.	+++

Acknowledgement: Dr Colin Mendelsohn, Tobacco Treatment Specialist and Associate Professor Renee Bittoun, for their expert advice and assistance in compiling this information.

Further info



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