How to manage smokers: Drop the word ‘Quit’

Webinar

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PART 2.

HOW TO MANAGE SMOKERS: DROP THE WORD ‘QUIT’

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NO CONFLICTS OF INTEREST

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

• Enable you to better choose 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
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

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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**
Venous blood concentrations of nicotine over time for various nicotine delivery systems

- Cigarette (nicotine delivery, 1-2 mg)
- Nicotine mouth spray (2mg = 2 puffs)
- Nicotine lozenge, 4mg
- Nicotine gum, 4mg
- Nicabate 21mg (nicotine patch)
- Nicorette 16mg (nicotine patch)

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


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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 = 21 ppm, 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

Prescribe Varenicline (Champix)
- 1st script for 4 weeks
- Do NOT pick a quit date
- "A quit date will pick the person"

Within 4 weeks: Patient stops smoking altogether
- Re-prescribe 2nd script for further 8 weeks

Within 4 weeks: Still smoking but some or all the following are happening:
- Reduced numbers of cigs/day
- Reduced enjoyment of smoking
- Increased time to first cigarette (TTFC)
- Reduced CO reading

If not fully quit within 6-8 weeks
- ADD NRT-21mg patch and/or oral for any breakout smoking

During 4 weeks: NO effect
- Patient still smoking the same amount
- No new script - move on to other pharmacotherapy
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.
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

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

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