# 5 Myths of tobacco cessation

**Lee M. Flowers, MD, MPH**

Here are 5 commonly held beliefs about stopping tobacco use, and about your role in helping these patients, that go up in smoke on close inspection.

**Treating nicotine use disorder isn't really a psychiatrist's job.** *False!* Smoking is the leading preventable cause of death, causing 1 in every 5 deaths in the United States and as many as 1 of every 2 deaths among patients with depression, bipolar disorder, or schizophrenia.[1,2] As psychiatrists, our experience with treating addiction positions us to address nicotine use disorder more effectively than deferring exclusively to primary care.

**I can't treat my patients' nicotine dependence until they are ready to quit.** *Not so!* Treatment with varenicline, bupropion, or nicotine replacement therapy is likely to decrease smoking even if the patient has not made a commitment to quit. A smoker treated with pharmacotherapy is more likely to try to quit than one who is not receiving medication.[3,4]

Motivational interviewing is an excellent intervention to facilitate readiness to quit smoking. Many smokers want to quit—but if they don't believe that effective treatments exist or that psychiatrists provide such care, they won't initiate that conversation with you.

**Smokeless tobacco isn't so bad.** *Poppycock!* Chewing and dipping tobacco contains many undesirable chemicals, including abrasives, salts, sweeteners, and carcinogens. Smokeless tobacco is a risk factor for cancer of the mouth and pancreas, as well as tooth decay, periodontal disease, hypertension, hyperlipidemia, myocardial infarction, and fatal stroke.[5]

**Nicotine replacement products are as bad as smoking.** *Claptrap!* You can reassure patients that nicotine is not a carcinogen. If your patients use the same amount of nicotine but replace tobacco in whole or in part with a patch, gum, or an inhaler, they will have better health even if they use nicotine replacement for the rest of their life. Nicotine replacement products are less addictive than cigarettes because they release nicotine more slowly. (Cigarettes bring peak levels of nicotine to the brain even faster than IV administration does.) Nicotine replacement is recommended for at least 3 months after quitting tobacco or for as long the patient needs it.[3]

**Nicotine replacement products are dangerous for current smokers.** *Balderdash!* Many patients are afraid of using nicotine from >1 source. A common myth is that using a nicotine patch while smoking increases the risk of heart attack, which discourages patients from trying a nicotine replacement product before they are sure they will stop smoking. Nicotine replacement is likely to reduce the frequency of their smoking and reduce harm, not add to it.[3]

Dr. Flowers is in private *locum tenens* psychiatric practice and is founder of Aspire Locums LLC, based in Cheyenne, Wyoming.

**Disclosure**
The author reports no financial relationships with any company whose products are mentioned in this article or manufacturers of competing products.

**References**

1. Centers for Disease Control and Prevention. Smoking & tobacco use: tobacco-related mortality. http://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality. Updated August 18, 2015. Accessed December 20, 2015.
2. Callaghan RC, Veldhuizen S, Jeysingh T, et al. Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. J Psychiatr Res. 2014;48(1):102-110.
3. Stead LF, Perera R, Bullen C, et al. Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev. 2012;11:CD000146. doi: 10.1002/14651858.CD000146.pub4.
4. Ebbert JO, Hughes JR, West RJ, et al. Effect of varenicline on smoking cessation through smoking reduction: a randomized clinical trial. JAMA. 2015;313(7):678-694.
5. Piano MR, Benowitz NL, Fitzgerald GA, et al; American Heart Association Council on Cardiovascular Nursing. Impact of smokeless tobacco products on cardiovascular disease: implications for policy, prevention, and treatment: a policy statement from the American Heart Association. Circulation. 2010;122(15):1520-1544.