Treat Tobacco Dependence as a Chronic Disease

BY MARY ELLEN SCHNEIDER

BOSTON — Physicians can go a long way toward helping their patients successfully quit smoking by thinking about tobacco dependence as a chronic disease, according to Dr. Donald J. Brideau Jr., a family physician in Alexandria, Va.

Tobacco dependence, just like diabetes or hypertension, is a chronic problem that requires follow-up and education to prevent relapse, so physicians can use the same types of strategies and patient education techniques that they use for other chronic illnesses, said Dr. Brideau, chief medical officer at Inova Mount Vernon Hospital in Alexandria.

Tobacco dependence, just like diabetes or hypertension, is a chronic problem that requires follow-up and education to prevent relapse, so physicians can use the same strategies.

Dr. Brideau offered this and other tips culled from the clinical practice guidelines on smoking cessation at the annual meeting of the American Academy of Family Physicians.

Another important way to increase success in quitting smoking is to offer every tobacco user some form of therapy, whether it's a pure behavioral approach or medication. This, however, requires physicians or their staffs to systematically identify every smoker or former smoker at every visit. It doesn't matter who does it or how it is done, but it should be done at every visit, he said. Practices can use stickers on charts or make smoking a fifth vital sign.

Once the smokers have been identified, it is important to assess their readiness to quit. The amount of time spent counseling them depends on where they are on the quitting spectrum. If patients say they are not ready to quit, keep the discussion brief. Let them know that you will be there when they are ready and that you will continue to ask them about it, Dr. Brideau said.

In contrast, if patients say they want to quit and could be ready to do so in the next 30 days, they will need information on pharmacologic therapy and advice on other ways they can prepare for their quit date.

When it comes to actually quitting, the literature supports the use of counseling, pharmacologic treatments, and the combination of the two, said Dr. Brideau, who disclosed a financial relationship with Pfizer and the Candela Corp.

In terms of counseling, the evidence shows that the duration and number of sessions is important to increasing success rates. Dr. Brideau tries to get his patients to commit to coming to four office visits over 3-4 months to discuss their progress.

For most patients, pharmacologic intervention should be a part of the approach. Patients will have the greatest chance for success if they receive a combination of medication and counseling. That could mean coupling medication with a 15-minute office visit that is devoted exclusively to discussing smoking cessation.

Another effective approach is use of telephone quit lines. Multiple randomized controlled trials support the use of these hotlines in increasing success rates. It's no surprise that the quit lines are successful, because they offer individualized counseling to patients, he said.

When patients are unwilling to quit, don't give up. Instead, consider using motivational interviewing techniques. When talking to a patient about quitting, for example, focus on their feelings and why they don't want to set a quit date. Try to figure out what rewards they get from smoking and what the roadblocks are to making a cessation attempt, Dr. Brideau advised. ■

Nicotine Craving Greater in Alcohol-Dependent Smokers

VITALS

Major Finding: Negative affect declined more precipitously for control than for alcohol-dependent smokers ($P = .005$).

Data Source: Substance-abuse program participants without Axis I disorders: 39 alcohol-dependent but alcohol-abstinent smokers and 19 control smokers.

Disclosures: The National Institute on Alcohol Abuse and Alcoholism and the Department of Veterans Affairs Research Service supported the study with grants.

BY DOUG BRUNK

SAN DIEGO — During short-term abstinence from nicotine, alcohol-dependent cigarette smokers experience greater negative affect-related craving to smoke and more persistent negative affect, compared with cigarette smokers who are not alcohol dependent.

"Our [preliminary] findings suggest the experience of nicotine withdrawal and associated urge to smoke may be different for smokers with alcohol dependence even when severity of nicotine dependence is taken into account," researchers led by Jaimee L. Heffner, Ph.D., noted at a poster session at the annual scientific conference of the Research Society on Alcoholism."Negative reinforcement motives for smoking may be a critical factor [in designing] intervention strategies for smokers with alcohol dependence."

In what they believe to be the first study of its kind, the researchers, from the Cincinnati VA Medical Center and Tri-State Tobacco and Alcohol Research Center at the University of Cincinnati, enrolled 39 alcohol-dependent smokers and 19 control smokers who were in a substance abuse treatment program. They were abstinent from alcohol and other non–nicotine drugs for at least 60 days before testing. Those with Axis I disorders were excluded.

During a 6-hour session, each participant underwent the Semi-Structured Assessment for the Genetics of Alcoholism, the Fagerström Test for Nicotine Dependence, the Questionnaire on Smoking Urges–Brief (QSU), and the Profile of Mood States (POMS). To assess smoking urges, the QSU was done at baseline, 150 minutes, and 300 minutes; the POMS was done at baseline, 60 minutes, 180 minutes, and 300 minutes to assess negative affect.

Alcohol-dependent smokers were similar to the control smokers in age (a mean of 40 years vs. 39 years, respectively), gender (56% vs. 53% male), and race (69% vs. 79% white), and in terms of their severity of nicotine dependence (92% vs. 84%) and mean number of cigarettes smoked per day (21 vs. 18). Alcohol-dependent smokers had significantly higher rates of cannabis use (59% vs. 21%) and other drug use disorders (62% vs. 11%).

After controlling for nicotine dependence, alcohol-dependent smokers reported significantly greater craving for negative affect relief, compared with control smokers ($P = .022$), but no group by time interaction was seen.

"The main effect of time was contrary to what had been expected," they wrote. "POMS scores tended to decrease over the course of the testing session. A significant group by time interaction was detected, indicating that negative affect declined more precipitously for control than for alcohol-dependent smokers [$P = .005$]." ■

Varenicline With Counseling Helps in Smoking Cessation

BY KATE JOHNSON

MONTREAL — The first real-world effectiveness trial of varenicline for smoking cessation showed that combining the medication with behavioral counseling results in fairly substantial quit rates at 6 months.

Gary Swan, Ph.D., of SRI International, an independent, nonprofit, research and development organization in Menlo Park, Calif., reported on the findings of a trial in which 1,202 smokers, all taking varenicline 2 mg/day, were randomized to one of three behavioral counseling arms: phone only, Internet only, or a combination of both. The counseling programs were available for up to 12 months. The medication was provided by Pfizer Inc., which manufactures varenicline, and the study was funded by the National Cancer Institute. The trial also included researchers from Group Health Center for Health Studies and Free & Clear Inc., both of Seattle.

All of the subjects received a 5-10 minute orientation phone call at the start of the study and were given access to a toll-free phone line. Behavioral counseling based on Free & Clear's Quit for Life Program was then provided via interactive Web tools or through one-on-one phone counseling, or both, Dr. Swan reported at the annual meeting of the Society of Behavioral Medicine.

The average age of the subjects was 47.3 years; two-thirds were female; and they smoked an average of about 20 cigarettes a day.

At the end of the 12-week treatment period, the subjects in the phone counseling group had the highest abstinence rate (48.5%), followed by the phone/Web group (43%), and then the Web-only group (39%). At the 6-month mark, abstinence rates had fallen overall, and there was no longer any statistical difference between groups (34%, 34%, and 31% respectively).

"For those of us who have been working in the field for many years, these are really quite exciting results when compared with other medications, and our results are consistent with those seen in the pre-approval efficacy trials of varenicline," said Dr. Swan, noting that moderate to severe side effects, including flatulence, altered dreams, altered taste perception, sleep difficulties and changes in appetite, were reported.

He suggested the drop in abstinence after treatment cessation might indicate the need to extend the duration of medication or increase the intensity (frequency of calls) of the behavioral counseling. Phone counseling might improve tolerance to the medication and thus reduce discontinuation because of side effects, he said.

In fact, after 21 days of treatment, a significantly higher percentage of patients in the phone counseling group (87.5%) reported that they were still taking their medication, compared with those in the Web-only group (79%), but not the phone/Web group (83%).

Roughly half of the subjects (48%) reported having made a quit attempt within the preceding year, and the duration of this attempt was a predictor of subsequent success, Dr. Swan noted.

Dr. Swan disclosed that he served as a consultant to Pfizer's National Advisory Board in 2008. ■