Multiple Strategies Can Aid Smoking Cessation

BY BRUCE JANCIN

ESTES PARK, COLO. — Three major drug classes with diverse mechanisms of action are now approved for smoking cessation, providing an unprecedented array of options in terms of sequential and combination therapies.

Trying different agents, recycling them, combining them, and providing more intensive behavioral support are all important strategies, Dr. Allan Prochazka said at a conference on internal medicine sponsored by the University of Colorado.

Combination drug therapy is usually more effective than monotherapy, particularly for more heavily tobacco-dependent patients, he said. His go-to combinations are nicotine replacement therapy (NRT) plus the antidepressant bupropion (Zyban), or high-dose NRT using a nicotine patch plus nicotine gum or lozenges.

The third class of drugs approved by the Food and Drug Administration for smoking cessation, in addition to NRT and bupropion, is varenicline (Chantix), a nicotine receptor partial agonist and the first designer drug for tobacco dependence.

A Cochrane Review of the pivotal clinical trials leading to varenicline's 2006 marketing approval concluded it had a 52% better quit rate than did long-acting bupropion, and there was a suggestion of moderately greater efficacy than NRT, although there were few trials comparing the two (Cochrane Database Syst. Rev. 2008;doi:10.1002/14651858.CD006103.pub3). And varenicline has a relatively low discontinuation rate. But because of varenicline's psychiatric morbidity and hefty price, Dr. Prochazka reserves it as second-line therapy in patients who have failed NRT and bupropion.

In July, the FDA ordered a black box warning for varenicline and bupropion, urging prescribers to watch for the development of hostility, agitation, depression, and suicidality. For the time being, the best approach to smoking cessation in psychiatric patients remains unclear, said Dr. Prochazka, professor of medicine at the University of Colorado at Denver.

In a generally healthy population of smokers, however, all three FDA-approved types of medication are safe and effective, he stressed. Nearly all smokers will benefit from drug treatment along with brief counseling.

Dr. Prochazka cited a clinical trial of triple combination treatment with bupropion, an NRT patch, and a nicotine inhaler that produced a 35% quit rate at 26 weeks, compared with 19% for the patch alone (Ann. Intern. Med. 2009; 150:447-54).

Varenicline has been combined with bupropion in a 38-patient, open-label, phase II trial. The result was a 58% cessation rate at 6 months (Nicotine Tob. Res. 2009;11:234-9).

Varenicline costs about $370 for 12 weeks' worth of 1-mg tablets. In contrast, 3 months of generic long-acting bupropion runs $210. Transdermal nicotine costs $70-$100 per month; nicotine gum retails for $35-$50 for 108 pieces, with most patients using 5-8 pieces daily; and nicotine inhaler cartridges cost up to $160 for a 2- to 4-week supply. Nicotine lozenges run $30-$40 for a box of 72; the maximum dose is 20 per day. And nasal nicotine spray costs about $47 per 100 doses, with the typical patient using 3-6 doses per day.

The Agency for Healthcare Research and Quality smoking cessation guidelines (www.ahrq.gov/clinic/tobacco) are an excellent resource for primary care physicians, Dr. Prochazka said. Updated in April 2008, the guidelines are based on a review of more than 3,000 studies, nearly all randomized, controlled trials. The guidelines advocate the following "5 As" approach to smoking cessation:

- ► Ask all patients aged 18 and older at each visit about whether they smoke.
- ► Advise the smoker to quit in clear, strong, personalized language.
- ► Assess the smoker's willingness to try to quit now.
- ► Assist the quit attempt with medications, counseling, and other help.
- ► Arrange for follow-up.

A 10%-15% long-term quit rate is realistic for smokers in motivated primary care practices that use the AHRQ guidelines, Dr. Prochazka said. ■