Experts Offer Hot Tips for Helping Smokers Quit

BY DOUG BRUNK
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SAN DIEGO — When it comes to helping patients quit smoking, most primary care physicians could stand to improve their communication and persuasion skills.

A 2007 survey of more than 3,000 physicians conducted by the Association of American Medical Colleges found that 84% asked their patients about smoking and 86% advised their patients to quit, but only 31% recommended nicotine replacement therapy, 17% arranged for follow-up, and just 7% referred patients to smoking cessation help lines, also known as quitlines.

"There's a lot of room for making things better," Dr. Steven A. Schroeder said at the annual meeting of the American Academy of Family Physicians.

Dr. Schroeder, director of the Smoking Cessation Leadership Center at the University of California, San Francisco, maintained that interventions as brief as 30 seconds can have a positive impact on a smoker's decision to quit.

He said he begins his patient encounters by asking if the patient smokes. If the answer is yes, he proceeds with the following script: "Do you know what it does to you? It does a lot of really bad things, including putting you at risk for emphysema, lung cancer, heart disease, and stroke. I'll be glad to talk to you more about that. Would you ever be interested in quitting?"

At that point, he hands the patient a credit card–size American Academy of Family Physicians quitline referral card, which provides the number for the National Network of Tobacco Cessation Quitlines (800-784-8669). The quitlines are staffed by trained smoking cessation experts who tailor a plan and offer advice to each caller. Then he tells the patient to call the number for expert counsel if he or she is ready to quit.

He calls the intervention "take 30 seconds and save a life."

Physicians can also help smokers quit by becoming experts in smoking cessation counseling and treatment or by setting up cessation systems in the clinical facilities where they work, he said.

Dr. Schroeder noted that a study from Group Health Cooperative in Seattle found that 85% of smokers preferred using a quitline to going to a clinic or a physician's office for help with smoking cessation (Am. J. Prev. Med. 1998;14:46-52).

Quitlines are free, convenient, and anonymous. A lot of smokers feel guilty about their smoking.

DR. SCHROEDER

"It's free, it's convenient, and there's anonymity," said Dr. Schroeder, the former president and CEO of the Robert Wood Johnson Foundation. "A lot of smokers feel guilty about their smoking. I've had patients who've missed their follow-up visits because they had made a pledge to quit on a certain date but were unable to do so. In the quitline relationship, you don't have that kind of personal issue."

Another presenter at the meeting, Dr. Carlos Roberto Jaén, a former smoker, discussed specific ways to counsel patients based on the Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence: 2008 Update" (www.surgeongeneral.gov/tobacco).

He noted that patients who express an unwillingness to quit may lack information about the harmful effects of smoking or the benefits of quitting.

"I use humor sometimes," said Dr. Jaén, who chairs the department of family and community medicine at the University of Texas, San Antonio. "I'll say, 'You're not ready to quit? No problem. I'll wait until you have your heart attack or your stroke, then you'll call me very motivated to quit.'" In that example, a form of motivational interviewing, "you are communicating the sense of harmful effects and benefits of quitting."

Another principle of motivational interviewing is to express empathy, an approach recommended in the guideline.

"Help the patient understand you know that quitting smoking is a very difficult thing to do," advised Dr. Jaén, vice chair of the guideline panel. He said he teaches deep-breathing exercises as a way to ward off craving for a cigarette. "I tell them, 'give yourself a minute; the craving goes away.'"

The guideline also recommends point-

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ing out the discrepancy patients may demonstrate between their behavior and their expressed priorities. "If they say they're here to see you about their health, yet they're not ready to quit smoking … say, 'quitting smoking is the one thing you can do that is most effective for your health.'"

If patients resist the notion to quit, "roll with it. It's not for you to try to convince them to change their behavior." But make sure to bring up smoking in their next office visit. "Sometime I tell my patients, 'every time you see my face I want you to think, quit smoking,' " said Dr. Jaén, who is also a member of AAFP's Tobacco Cessation Advisory Committee.

Physicians can support self-efficacy by helping patients identify and build on past successes. Quitting "doesn't have to happen all at once. It can be changing smoking patterns, asking the patient to share his or her ideas about quitting strategies, or calling the quitline. There are multiple ways to get to the point where they are ready to quit," he said.

If patients are keen to quit but aren't ready for intensive interventions, then offer practical counseling interventions such as recommending that they throw away all of their ashtrays and cigarette butts on the day they decide to quit, said Dr. Jaén. Other tips include advising patients not to have cigarettes in their car, to walk instead of sitting down after a meal, and to brush their teeth when they crave a cigarette.

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He emphasized the importance of social support, saying he urges patients to tell family members, friends, and coworkers about their decision to quit. "Call them up, and ask how they're doing," he added.

Dr. Jaén said he also warns patients not to consume alcohol when they're in the early stages of quitting, "because alcohol and nicotine are synergistic. Once people start drinking, it's hard for them to stay off cigarettes, especially early on. If people have conflicted relationships, maybe they should avoid that person for a while, too."

A package of 200 quitline referral cards is available free to AAFP members. The cost for nonmembers is $50 plus shipping. For information, call 800-944-0000 and request item number 966. ■

Antipsychotics Raise Need for Health Checks

BARCELONA — More than 20% of patients taking antipsychotic medications for schizophrenia were at risk for diabetes, more than 30% had undiagnosed hyperlipidemia, and more than 50% had undiagnosed hypertension, a large European epidemiologic study has found.

The findings drive home the need for continuous monitoring of patients taking these drugs, Dr. Marc de Hert and his colleagues wrote in a poster presented at the annual congress of the European College of Neuropsychopharmacology.

The observational study was launched in 2006; it included 2,270 patients with schizophrenia recruited in 12 European countries. Patients made a single clinic visit, during which they underwent a metabolic workup that included measurement of fasting blood glucose, weight, waist, hips, and blood pressure. The patients' median age was 41; 55% were male. Most (76%) had paranoid schizophrenia; the median duration of illness was 11 years.

The most frequently used typical antipsychotics were haloperidol (48%) and zuclopenthixol (20%). The most frequently used atypicals were risperidone (25%), olanzapine (23%), clozapine (19%), amisulpride (17%), and quetiapine (12%).

Only 4% of the patients had a diagnosis of diabetes, yet an additional 24% either had or were at risk of the disorder, wrote Dr. de Hert of the Catholic University Louvain (Belgium). Of these 559 patients, 75 had a fasting blood glucose of at least 126 mg/dL, consistent with diabetes, and 484 presented with an impaired fasting glucose of 100-126 mg/dL. Seven percent (161) previously had been diagnosed with hyperlipidemia. However, an additional 54% of the cohort had undiagnosed hyperlipidemia at the time of the exam.

Hypertension previously had been diagnosed in 248 patients. But at the study visit, an additional 738 patients (32%) had elevated blood pressures; elevations were significantly more likely in those taking a typical than an atypical antipsychotic.

The incidence of metabolic syndrome was similar in both groups (37%).

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—Michele G. Sullivan