

Pharmacotherapy Urged for 'Hard-Core' Smokers

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN DIEGO — Physicians who have a patient who smokes need to do more than just advise them to quit. Most smokers need much more help than that, Dr. Linda Hyder Ferry said at the annual conference of the American Society of Addiction Medicine.

Specifically, pharmacotherapy tends to be greatly underused, asserted Dr. Ferry, who runs the smoking cessation program in the preventive medicine clinic at the Jerry L. Pettis Memorial Veterans Affairs Medical Center, Loma Linda, Calif.

"Minimal intervention, in my experience, and in looking at the literature, is not what is appropriate and effective for the high-risk, hard-core smoker," she said.

As people have quit over the years, and fewer start, it tends to be the more highly dependent smokers—the high-risk smokers—who remain among the ranks of those who would like to quit, Dr. Ferry said.

And most smokers do want to quit. Currently, 50% of all smokers will attempt to quit in any year. But only 3%-5% of those who try to quit will be successful for a year.

When she encounters a patient who is willing to try quitting, she first gauges the person's level of tobacco dependence, because that helps dictate the amount and kind of assistance the patient needs, Dr. Ferry said.

She assesses dependence with four basic questions and categorizes patients into three levels of dependence: low, moderate, and high. People in the low category tend to be the most successful at quitting on their own. Those with moderate dependence may need some kind of cognitive-behavioral program or counseling. And people who are highly dependent probably need nicotine replacement or medication, in addition to counseling.

The first question Dr. Ferry asks is, "How many cigarettes do you smoke a day?" Fewer than 15 indicates low dependence. More than 25 cigarettes indicates high dependence. Moderate falls in between. The second question is, "How soon do you smoke when you wake up in the morning?" Those who wait at least 30 minutes are likely to have low dependence, and those who

smoke within 10 minutes are highly dependent. The third question is, "How long did your previous quit attempt last?" Those who lasted less than a week have high dependence. Those who lasted 3-6 weeks are going to have a higher likelihood of success in their next attempt, Dr. Ferry said.

Finally, the last question is, "When your last quit attempt failed, what was the reason?" If it was because of withdrawal symptoms, the person will probably need nicotine replacement therapy or medication.

In her program, the cognitive-behavioral component includes four 1-hour group sessions, augmented, when necessary, with individual counseling and telephone follow-up. The success rate at 6 months is approximately 25%-30%, and the rate does not appear to change from year to year. "I've never been able to get it up above about 30%," she said.

On the issue of pharmacotherapy, Dr. Ferry described the following methods:

► **Nicotine replacement therapy.** The choice of replacement type—gum, patch, or nasal spray—is based on susceptibility to side effects, patient preference, and availability, Dr. Ferry said.

The key to nicotine replacement is that patients need a dose that is sufficient to prevent any withdrawal symptoms. The patch, Dr. Ferry noted, comes in three doses, 7 mg, 14 mg, and 21 mg. The 21-mg patch is equivalent to about a pack a day.

Low-dependence smokers may need a patch for only 3-6 weeks to begin eliminating their psychological dependence and their habit patterns. Highly dependent individuals may need to use the patch for 4-6 months. The average time needed in Dr. Ferry's clinic is about 12 weeks, she said.

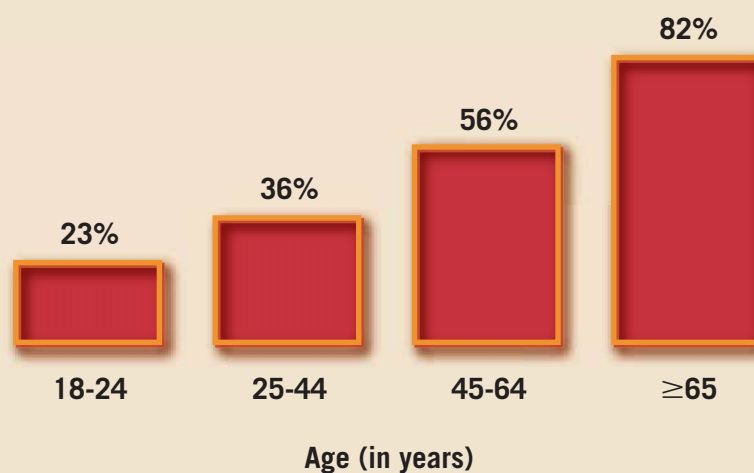
► **Bupropion.** Many have the idea that this drug works best in individuals who are depressed. Bupropion can be used in smokers who are depressed, to address both, but it actually works better for smokers who are not depressed, Dr. Ferry said. Moreover, it works best when combined with nicotine replacement therapy, though there is a need to monitor blood pressure when using both methods.

► **Clonidine.** This drug is used as a second-line agent because it has lots of side effects. However, it appears to work well for highly dependent patients and for women.

► **Varenicline.** This new drug is a nicotine receptor partial agonist with much promise. In one trial, the 1-year quit rates were 20% for the drug and 10% for placebo. In a short-term trial lasting 7 weeks, varenicline was compared with bupropion, as well as with placebo. The quit rates were almost 50% for varenicline, 33% for bupropion, and 16% for placebo, Dr. Ferry said. ■

DATA WATCH

Smoking Quit Rates Go Up With Age



Source: American Lung Association, based on 2003 data from the National Health Interview Survey

ELSEVIER GLOBAL MEDICAL NEWS

Programs Attempt to Treat the Trauma That Underlies Addiction

BY KATE JOHNSON
Montreal Bureau

COLORADO SPRINGS — Trauma therapy should be an integral part of substance abuse recovery programs, because trauma is at the root of most addictions, Dolores J. Walker said at a symposium on addictive disorders sponsored by Psychotherapy Associates.

"Substance abuse comes with a package. If we want to be effective, we have to look beyond substance abuse in our therapy, and the integration of substance abuse and trauma has the best outcome," said Ms. Walker, director of substance abuse services at Cedar Springs Behavioral Health System in Colorado Springs.

Statistics show that up to two-thirds of men and women in treatment for substance abuse report a history of trauma. Among alcoholic women, 90% report sexual abuse or violence as children, and 82% of adolescents in residential care report a history of trauma, she said.

"Clearly, these people are self-medicating. They are numbing out the trauma," she said. "I sit with people every day who are desperate to restore their balance so they can have a life."

Trauma can result from natural disasters, wars, near-death experiences, auto accidents, or acts of violence, but it can also result from seemingly more benign events, such as a significant relationship breakup, a medical procedure, the death of a pet, or being shunned, teased, or bullied, she said.

Addiction treatment programs that are trauma sensitive attempt to help patients address any unresolved issues regarding their traumatic history. It is the unresolved issues that will hamper addiction recovery, Ms. Walker said.

Because of the recognized risk of re-traumatizing the patient, the initial phase of the program focuses on establishing trust and a feeling of safety, she said.

"Our job is to neutralize the memories and restore homeostasis, not to get them to relive the trauma. That only retraumatizes and revictimizes," she said.

It is within this initial stage of establishing safety that patients begin their drug

or alcohol detoxification program. The second stage focuses on trauma recovery, where patients "rewrite" the experience so they see themselves as a survivor rather than a victim.

"You have to enter the trauma area, not through the rational brain but through feeling," Ms. Walker said, stressing that patients must be encouraged not to relive the trauma but to observe it from the safety of the present.

This empowers them to progress beyond victimization to survival of the experience. From this point, patients can then reconnect with the present and address their addiction, she said.

The addictive aftermath of trauma is being seen more frequently among military personnel with posttraumatic stress disorder (PTSD), according to Nancy Harrel, who is director of the Masters and Johnson Trauma-Based Disorders Program at Two Rivers Psychiatric Hospital, Kansas City, Mo.

"I think these guys are going to contin-

ue showing up in our offices, but they won't be saying they've got PTSD from their war experience," she said in a separate presentation at the meeting. "Many ... who I see have come through our dual diagnosis unit because they are using alcohol to cope."

In the case of PTSD, alcohol is particularly effective at blocking flashbacks, she said. This makes the initial detoxification process particularly grueling. "We have to educate them that once they stop drinking, the original trauma behind their addiction will return," Ms. Harrel said, adding that one of the first goals for these patients is to get them sleeping properly again.

Research suggests that military PTSD may be far more common among personnel deployed to Iraq than it is among those deployed to Afghanistan because of the much higher exposure to combat in Iraq, Ms. Walker said.

Up to 17% of those returning from Iraq met criteria for PTSD, compared with 11% of those returning from Afghanistan; and almost 12% of those deployed to Iraq were wounded, compared with 5% of those deployed to Afghanistan, she said at the meeting. ■

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