

LETTERS TO THE EDITOR

SMOKING CESSATION INTERVENTIONS

To the Editor:

In the recent study on family physician smoking cessation interventions by Sesney et al¹ in the June issue of the *Journal*, the authors inaccurately classified "preparation" stage smokers as anyone planning to quit in the next month, and "action" stage as anyone who attempted to quit in the past year. According to the stage of change model, *preparation* stage smokers are those who intend to quit in the next month *and* have also made at least one 24-hour quit attempt in the most recent year, while *action* stage smokers are those currently not smoking and in the first 6 months of quitting.^{2,3} The effect of these inaccuracies is to inflate the percentages of action and preparation stage smokers in their sample, which might alter the study outcome.

Nevertheless, the finding that family physicians are more likely to counsel smokers in the preparation stage than the precontemplator stage agrees with our findings. In our study of smoking status as a vital sign, we found that the odds of a physician addressing smoking were 2.3 times higher among preparation stage smokers.⁴ We agree with the authors that the astute family physician senses the resistance of the precontemplator, and therefore is less likely to give advice to quit. Conversely, smokers in the preparation stage are ready and willing to receive this counseling and may facilitate this counseling if prompted by a regular reminder such as asking about smoking status during the vital signs process. Prior to the

addition of smoking status as a vital sign, only 50% of those smokers in the most ready to quit stage (ie, preparation stage) were counseled to quit smoking by their physician. This increased to 95% after adding smoking status (current, former, or never) to the vital sign routine, a process that takes a nurse several seconds to perform.⁴

The finding by Sesney et al that there is no association between the specific types of smoking intervention and the stages of change suggests that we are missing opportunities with those smokers who are ready to quit. None of their preparation stage smokers and only 10% of the action stage smokers received nicotine replacement therapy despite its proven efficacy.

The great promise of the stage of change model is the development of stage-based interventions that match the patients readiness to change. We need more practice-based research on how to advance precontemplators and contemplators through the stages of change. This model has much to offer the discipline of family medicine; however, it should be accurately applied so that smokers are consistently classified.

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REFERENCES

1. Sesney JW, Kreber NE, Hickner JM, Webb S. Smoking cessation interventions in rural family practices: an UPRNet Study. *J Fam Pract* 1997; 44:578-85.
2. Prochaska JO, DiClemente CC. Stages of change in the modification of prob-

lem behaviors. In: Hersen M, Eisler RM, Miller PM, eds. *Progress in behavior modification*. Sycamore, Ill: Sycamore Publishing, 1992;184:214.

3. Velicer WR, Prochaska JO, Rossi JS, Snow MG. Assessing outcome in smoking cessation studies. *Psychol Bull* 1992; 111:23-41.
4. Robinson MD, Laurent SL, Oittle JM. Including smoking status as a new vital sign: it works! *J Fam Pract* 1995; 40:556-61.

The preceding letter was referred to Drs Sesney and Hickner and Nan Kreher, who respond as follows:

Dr Mark Robinson has reported that we inaccurately classified preparation and action stage smokers in our article. As stated in the article, we used an adaptation of Prochaska's model because of ease of administering the exit questionnaire and our belief that the validity of his model would be maintained.

Dr Robinson is correct in stating that the preparation stage has been defined as smokers who intend to quit in the next month and also have made at least one 24-hour quit attempt in the most recent year. However, we were concerned that this question contained two qualifiers (intention and a behavioral attempt) and that it could create confusion in the responder's choice. For example, they may be planning to quit, but may have not made a previous 24-hour attempt, so how would they respond. Dr Robinson is also correct in his definition of the action stage smokers, which states that these are smokers who are currently not smoking and are in the first 6 months of quitting. We were, however, influenced by Prochaska's statement that "individuals are classified in the action stage if they have successfully altered the addictive behavior for a period of from one day to six months,"¹ and we felt that by asking smokers if they had made a quit attempt in the past year, we would have a more clear delineation between them and preparation stage smokers as we had

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defined them.

It is difficult to say whether this classification inflated the percentages of action or preparation stage smokers in our sample. Based on Dr Robinson's comments, it appears that his findings are quite similar to ours. We agree with him further that the stage of change model holds much promise and should be actively used in smoking patients.

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REFERENCE

1. Prochaska JO, DiClemente, Carlo C, Norcross, JC. In search of how people change. *Am Psychol* 1992; Sept:1102-14.

PANIC STATES AND CHEST PAIN

To the Editor:

I read with interest the article on prevalence of panic states in South Texas Ambulatory Research Network (STARNET) patients presenting with chest pain.¹ However, since mitral valve prolapse is the most common cause of chest pain in women, which constituted 71% of the study participants, and since there is a high prevalence of panic disorders in patients with mitral valve prolapse,² I was surprised that no mention was made of the presence of mitral valve prolapse in any of these patients.

Since DaCosta's original description in 1871,³ clinicians have known that anxiety states are associated with symptoms and signs suggesting cardiovascular involvement including chest pain and panic disorders. Numerous studies, principally in the psychiatric literature,^{4,5} have suggested a significant association between panic disorders and mitral valve prolapse. As a matter of fact, Wooley⁶ one of the world authorities on mitral valve prolapse, suggested in 1976 that mitral valve prolapse and panic disorders were in fact the

same disease state.

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REFERENCES

1. Katerndahl DA, Trammell C. Prevalence and recognition of panic states in STARNET patients presenting with chest pain. *J Fam Pract* 1997; 45:54-63.
2. Barlow JB, Cheng TO. Mitral valve billowing and prolapse. In: Cheng TO, ed. *The international textbook of cardiology*. New York, NY: Pergamon Press, 1987:497-524.
3. Cheng TO. Jacob Mendez DaCosta, DaCosta's syndrome, and mitral valve prolapse. *Am J Surg* 1988; 155:716.
4. Katerndahl DA. Panic and prolapse. Meta-analysis. *J Nerv Ment Dis* 1993; 181:539-44.
5. de Silva RA, Bachman WR. Cardiac consultation in patients with neuropsychiatric problems. *Cardiol Clin* 1995; 13:225-39.
6. Wooley CF. Where are the diseases of yesteryear? DaCosta's syndrome, soldiers heart, the effort syndrome, neurocirculatory asthenia—and the mitral valve prolapse syndrome [editorial]. *Circulation* 1976; 53:749-51.

The preceding letter was referred to Dr Katerndahl, who responds as follows:

We thank Dr Cheng for his thoughtful reading of our article. Because the physician's diagnosis was based on chart audit, we merely reported the physician's impression. In none of the 51 patients did the physician attribute the chest pain to mitral valve prolapse (MVP).

However, whether MVP is a cause of chest pain is unclear. Quill et al¹ suggest that mild MVP overlaps with the normal condition and that MVP may represent an example of medicalization of a normal variant. In the Framingham Study, when patients with MVP were compared with controls, no statistical differences in chest pain, angina, supraventricular tachycardia, or complex ventricular ectopy were found.²

Although it has been suggested that the MVP-panic disorder relationship found in studies may represent selection bias,³ this relationship is generally consistent across studies

and probably does exist.⁴ It may be that MVP-panic disorder relationship that accounts for the previous attribution of chest pain to MVP; the chest pain may be due to the underlying panic disorder.

The importance of MVP in patients with panic disorder has been investigated. MVP itself is not clearly associated with arrhythmias or sudden death. Patients with "silent" MVP are at no increased risk of infective endocarditis. Cerebrovascular accidents are only increased in MVP patients when they are over age 45 or have a thickened mitral valve.⁵ Hence, the presence of MVP in and of itself should not alter patient management. In patients with panic disorder, the presence of MVP is not associated with increased psychiatric comorbidity^{6,7} or decreased treatment response.⁸ For this reason, routine echocardiography is not recommended for patients with panic disorder.

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REFERENCES

1. Quill TE, Lipkin M Jr, Greenland P. Medicalization of normal variants. *J Gen Intern Med* 1988; 3:267-76.
2. Savage DD, Garrison RJ, Devereux RB, et al. Mitral valve prolapse in the general population. *Am Heart J* 1983; 106:571-86.
3. Margraft J, Ehlers A, Rith WT. Mitral Valve prolapse and panic disorder. *Psychosom Med* 1988; 50:93-113.
4. Katerndahl DA. Panic and prolapse. *J Nerv Ment Dis* 1993; 181:539-44.
5. Dager SR, Saal AK, Comess KA, et al. Mitral valve prolapse and the anxiety disorders. *Hosp Comm Psychiatry* 1988; 39:517-23.
6. Mavissakalian M, Salerni R, Thompson ME, et al. Mitral valve prolapse and agoraphobia. *Am J Psychiatry* 1983; 140:1612-4.
7. Dager SR, Cowley DS, Dunner DL. Biological markers in panic states. *Biol Psychiatry* 1987; 22:339-59.
8. Grunhaus L, Gloger S, Birmacher B. Clomipramine treatment for panic attacks in patients with mitral valve prolapse. *J Clin Psychiatry* 1984; 45:25-7.