| NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND | |
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| **Section:** Clinical Practice Guideline | **Subject:** Tobacco Cessation for Adults |
| **Effective:** August 17, 2000 | **Updated:** 08/02, 07/04, 05/06, 04/08, 04/10 |

**RATIONALE:**

Tobacco use has been cited as the chief avoidable cause of illness and death in the United States. Smoking is a known cause of cancer, heart disease, stroke, respiratory disease, and complications during pregnancy. Yet, despite these facts, tobacco use remains fairly constant, an estimated 20.8 percent of adult Americans smoke. Smoking prevalence among adolescents has risen dramatically since 1990, with more than 3,000 additional children and adolescents becoming regular users each day.

Tobacco use is not only dangerous to the individual, it also results in staggering societal costs in the form of costly medical care, lost productivity, forfeited earnings due to smoking-related disability, and premature death.

Primary care clinicians, tobacco dependence treatment specialists, health care administrators, and insurers have an unprecedented opportunity to reduce tobacco use rates as the result of an unusual confluence of circumstances: 70 percent of smokers report that they want to quit, and 40 percent try to quit each year; at least 70 percent of smokers visit a health care setting each year, and smokers cite a physician's advice to quit as an important motivator for attempting to stop smoking; and effective treatments now exist.

Tobacco dependence is a chronic disease that often requires repeated interventions and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence

The United States Public Health Service-sponsored Clinical Practice Guideline *Treating Tobacco Use and Dependence* (October 2000) and the *Treating Tobacco Use and Dependence : 2008 Update* provides a comprehensive approach to smoking cessation based on current evidence and developed by a panel of experts. Neighborhood endorses these updated guidelines, which are summarized below.

**PRACTICE GUIDELINE:**

**ASK** About Smoking at Every Visit.

Systematically identify all tobacco users and document tobacco use status at every visit.

Implement an office-wide system that ensures that, for EVERY patient at EVERY visit, tobacco-use status is queried and documented.

**ADVISE** All Smokers to Quit

In a clear, strong, and personalized manner, urge every tobacco user to quit.

**ASSESS** Motivation to Make a Quit Attempt.

If willing to make a quit attempt at this time, offer medication and provide or refer for counseling or additional treatment to help the patient.

Light smokers should be identified, strongly urged to quit and provided counseling treatment interventions.

If clearly states unwilling to make a quit attempt at this time, provide motivational interventions designed to increase future quit attempts.

**ASSIST** Smokers in Quitting.

<u>Ready to Quit Now</u>

Identify reasons for wanting to quit.

Help smoker develop a quit plan:

- Set quit date within 2 weeks.
- Tell family, friends, and coworkers about quitting, request understanding and support.
- Anticipate challenges to planned quit attempt, particularly during critical first few weeks, i.e., nicotine withdrawal symptoms.
- Remove tobacco products from environment. Prior to quitting, avoid smoking in places where a lot of time is spent, i.e., work, home, car.

Provide practical counseling (problem solving/skills training):

- Review previous quit attempts, what helped and what hurt.
- Total abstinence is essential.
- Anticipate triggers or challenges in upcoming quit attempt and discuss how to successfully overcome them.
- Avoid alcohol, since alcohol increases the incidence of relapse.
- Reduce caffeine intake.

- Plan for dealing with other smokers living in the home.

Provide intra-treatment social support:

- Provide supportive clinical environment while encouraging quit attempt as part of treatment.

Help obtain extra-treatment social support:

- Ask spouse/partner, friends, coworkers to support smoker in quit attempt.

**Users of cigars, pipes, and other noncigarette forms of smoking tobacco should be identified, strongly urged to quit, and offered the same counseling interventions recommended for cigarette smokers.**

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone:

- Whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking.

- There is a strong relation between the number of sessions of counseling when it is combined with medication and the likelihood of successful smoking abstinence. Therefore, to the extent possible, clinicians should provide multiple counseling sessions, in addition to medication, to their patients who are trying to quit smoking.

Suggestions for the clinical use of medication for tobacco dependence treatment

- All smokers trying to quit should be offered medication, except when contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, and adolescents).

- All seven of the FDA-approved medications for treating tobacco use are recommended: Bupropion SR, Nicotine Gum, Nicotine Inhaler, Nicotine Lozenge, Nicotine Nasal Spray, Nicotine Patch, and Varenecline.

- Counseling and medication are effective when used by themselves for treating tobacco dependence. However, the combination of counseling and medication is more effective than either alone. Thus, clinicians should encourage all individuals making a quit attempt to use both counseling and medication.

- Although many smokers have quit on their own, the vast majority of unaided quit attempts end in failure. By using the pharmacotherapies found to be effective in this guideline, clinicians can double or triple their patients' chance of abstinence. Pharmacotherapies recommended in this guideline have been used effectively when combined with psychosocial treatments.

Provide supplementary materials, i.e., self-help and referrals:

- Tailored materials, both print and Web-based, appear to be effective in helping people quit. Therefore, clinicians may choose to provide tailored, self-help materials to their patients who want to quit. Culturally/racially/educationally/age appropriate materials are recommended.

Not Ready to Quit Now

Use the 5 Rs to enhance motivation.

- **Relevance**: Provide patient specific information.
- **Risks:** Ask patient to identify negative consequences.
- **Rewards**: Ask patient to identify benefits.
- **Roadblocks:** Ask the patients to identify barriers to quitting and to provide treatment (problem-solving counseling, medication) that could address barriers.
- **Repetition:** Repeat the same message every visit.

Motivational intervention techniques appear to be effective in increasing a patient's likelihood of making a future quit attempt. Therefore, clinicians should use motivational techniques to encourage smokers who are not currently willing to quit to consider making a quit attempt in the future.

Recently Quit

- Assess former tobacco users relapse potential
- Assist former tobacco users with encouragement to stay abstinent

**ARRANGE** Follow-up, either in person or via telephone

If Quit (Relapse Prevention).

Congratulate, encourage maintenance.
Review benefits from cessation.
Review successes during quit period.
Review problems encountered, offer possible solutions.

Anticipate problems or threats to abstinence maintenance such as weight gain, depression, or prolonged withdrawal symptoms.

Timing:
Contact patient soon after the quit date, preferably within the first week.
Second follow-up is recommended within the first month.
Schedule further follow-up contacts as indicated.

<u>If Quit Attempt Unsuccessful</u>
Ask for recommitment to total abstinence.
Remind patient to use lapse as a learning experience.
Review circumstance that caused lapse.
Develop new plan with patient.

Timing: Contact soon after new quit date, preferably during the first week, further contacts person.

**Pharmacotherapies:**

- Bupropion SR (Zyban)
- Nicotine Patch
- Nicotine Gum
- Nicotine Lozenge
- Nicotine Nasal Spray
- Nicotine Inhaler
- Chantix (Varenicline)

**Combination Therapy:**

- Only patch + Bupropion is currently FDA approved
- Other combination therapies are sometimes used off label
- Varenicline is available exclusively as a prescription medication and is not recommended for use in combination with NRT because of its nicotine antagonistic properties.

Because of the lack of sufficient data to rank-order these seven medications, choice of a specific first-line pharmacotherapy must be guided by factors such as clinician familiarity with the medications, contraindications for selected patients, patient preference, previous patient experience with a specific pharmacotherapy (positive or negative), and patient characteristics (e.g., history of depression, concerns about weight gain).

*__Chantix:__ FDA ALERT [2/1/2008]:
FDA is issuing this Alert to highlight important revisions to the WARNINGS and PRECAUTIONS sections of the full prescribing information for Chantix regarding serious neuropsychiatric symptoms.

***Chantix and Bupropion:** FDA ALERT [7/1/2009]:
FDA has required the manufacturers of the smoking cessation aids Varenicline (Chantix) and Bupropion marketed as (Zyban and generics) to add new **Boxed Warnings** and develop patient Medication Guides highlighting the risk of serious neuropsychiatric symptoms in patients using these products. These symptoms include changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide.

**Recommendations and Considerations for Healthcare Professionals**

- It is important to discuss the possibility of serious neuropsychiatric symptoms in the context of benefits of quitting smoking with patients before prescribing these medications. Varenicline and Bupropion are both effective smoking cessation aids and the health benefits of smoking cessation are immediate and substantial.

- Healthcare professionals should monitor all patients taking Varenicline and Bupropion for symptoms of serious neuropsychiatric symptoms. These symptoms include changes in behavior, hostility, agitation, depressed mood, suicidal ideation, suicidal behavior and attempted suicide.

- These symptoms have sometimes occurred in patients without pre-existing psychiatric illness and have worsened in some patients with pre-existing psychiatric illness. In most cases, neuropsychiatric symptoms developed during treatment with Varenicline and Bupropion but in others symptoms developed after stopping drug treatment.

- Patients should be informed that it is not unusual to have symptoms such as irritability, feeling anxious, depressed mood and trouble sleeping when they are withdrawing from nicotine, independent of whether they are taking Varenicline or Bupropion.

- Patients with serious psychiatric illness such as schizophrenia, bipolar disorder, and major depressive disorder, may experience worsening of their pre-existing psychiatric illness while taking Varenicline or Bupropion.

- Patients who discontinue treatment because of neuropsychiatric events should continue to be monitored until symptoms resolve. Although symptoms resolved after treatment was stopped in many cases, there were also some cases where the symptoms persisted.

Interventions identified as effective in this guideline are recommended for all individuals who use tobacco except when medically contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers (< 10 cigarettes/day) and adolescents).

**References**

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7. Clinical Guidelines for Prescribing Pharmacotherapy for Smoking Cessation, Office of the Surgeon General, U.S. Department of Health and Human Services, 1/18/07