

**GENERAL INTERNAL MEDICINE & HEALTH SERVICES RESEARCH CASE
CONFERENCE TEACHING MODULE**

**Preventive Medicine: Smoking Cessation
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Case 1

Chester Field is a 44 yo s/p CABG (at age 38) who complains of frequently feeling anxious as well as dyspneic after walking ¼ block. He is on Medi-Cal and used to drink heavily. One brother died of lung cancer and a sister has emphysema. He has worked as an asbestos installer. His BP is 185/110, his heart rhythm is irregular and he has faint pedal pulses. He has smoked 2 packs/day for 30 years. His girlfriend smokes and chews tobacco. He tried quitting cold turkey many times but each time relapsed. He's not sure it's worth trying to stop again.

1a) What formal approach would you use to help Mr. Field quit smoking?

The 5 A's of smoking cessation is the gold standard of care – Ask about tobacco use status, Advise smokers to quit, Assess readiness to quit, Assist with cessation, and Arrange for follow up (Clinical Practice Guideline, 2008). An abbreviated approach would Ask, Advise, and Arrange either with information about quitlines or internal treatment programs (Schroeder, 2005).

1b) Think of how you would counsel him if he were your patient, realizing that conventional “scare tactics” aren't often successful.

A substantial percentage of smokers continue to smoke even after having had a cardiac event, due to addiction and habituation. Thus, appealing to one's common sense in stopping for long-term health reasons is generally not sufficient alone. Eliciting more practical reasons may be better in this patient, such as being around to enjoy his girlfriend, feeling less dyspneic and having the ability to be more active. Another approach could discuss the financial cost of his cigarette purchases (a two pack a day habit is equal to \$14 a day or over \$5000 a year), and how he could be spending this amount in other ways. Another avenue is to educate about undesired sequelae of smoking, such as erectile dysfunction or secondhand smoke. Asking him to give good reasons for himself to stop may also serve as a discussion point. It is worth pointing out that Medicare reimburses for smoking cessation counseling with a code for counseling between 3-10 minutes and another code for >10 minutes.

2. Is he an appropriate candidate for nicotine replacement or other drugs (what questions would you want to ask to help determine this)? If so, what factors would lead you to recommend gum vs. patches vs. newer pharmacological aids?

He is likely nicotine- as well as psychologically-addicted. Gum may be best for those who have an oral fixation that can't be satisfied with other methods. The downside of gum is that it must be used and chewed in a certain way (“chew and park” instead of constant chewing) to be absorbed properly. Oral and nasal nicotine inhalers are also available. Patches are useful as is sustained-released bupropion (see article). The latter is bid (must be dosed at least 8 hours apart) and cannot be used in anyone with a history of seizures, bulimia or anorexia nervosa. Zyban is just a specially marketed form of bupropion SR which comes with smoker support materials but is not always covered by insurance plans. Varenicline (Chantix) may be more effective; there are concerns about psychiatric effects about both medications (as of July 1, 2009, black box warnings appear for both Zyban and Chantix). One needs to be cautious before prescribing these in anyone with depression or other mood disorders, or serious psychiatric illness. One needs to inform patients of potential changes in mood or behavior and one needs to monitor such patients for said changes (that should just about cover every lawyer's needs). It should be considered for those

failing (or not able or willing to try) other methods, meaning that behavioral counseling and nicotine replacement products still should be considered first-line approaches for cessation assistance.

Behavioral approaches should not be overlooked, and are appropriate for those patients where pharmacotherapy is contraindicated or there is a lack of evidence of efficacy (e.g., pregnant smokers, light and intermittent smokers). Support groups can be found through the American Heart Association, the American Lung Association or other American Cancer Society. Other options include Nicotine Anonymous or the Seventh Day Adventist Churches. There is also UCLA's Freedom From Smoking Program that is run by the pulmonary medicine division, based on the American Lung Association model and costs \$100 for UCLA employees and \$150 for non. There is also the California Smoker's Helpline (1-800-NOBUTTS or 1-800-45NOFUME in Spanish). The California Smoker's Helpline also has many other languages available, including TTY, and also can be reached through the national quitline number (1-800-QUITNOW). Physicians can also order brochures to give out to patients by calling the National Cancer Institutes (1-800-4CANCER) or via www.cancer.gov. A useful website for physicians to get more information is: www.surgeongeneral.gov/tobacco/. There are also web sites patients can search themselves, including www.tobaccofreeca.org and www.cancer.gov/cancertopics/smoking.

3. The patient says he's interested in quitting, but says that he has only tried cold turkey methods because nicotine patches are really expensive.

Medi-Cal patients who enroll with the California Smoker's Helpline or any other behavioral modification program can receive up to ten weeks of free nicotine replacement patches. They need to provide a letter or certificate of enrollment from the program to a pharmacy, and can get two weeks of nicotine patches at a time (http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/drugscdlp2_p00.doc)

Case 2

Marla Burrough is a 35 yo female who sees you as a new patient complaining of fatigue and dyspnea. Her mother recently died of a CVA. She is on oral contraceptives. Her BP is 160/100. She has smoked a half-pack a day for 18 years. She hasn't taken the time to think about stopping smoking due to balancing work with care of her three year old son. In addition, she has had friends who have gained weight after quitting.

1. How would you address her concerns about weight gain?

Most people who gain weight gain only modest amounts (5-8 lbs.), although there is a small subset that gains over 20 lbs. Anticipating this concern is always worthwhile. Encouraging exercise and watching diet are important. Pharmacologic aids appear to mitigate against this problem compared to control groups.

2. What are "teachable moments" in this case?

Teachable moments include, but are not limited to, focusing on her children, smoking related symptoms she is experiencing or increased risk with oral contraceptives. One other tip, especially in younger patients, is quantifying the number of cigarettes a patient will have smoked in the next "X" number of years if they continue: 10 cigarettes a day (a U.S. pack is 20 cigarettes) over the next 10 years adds up to 36,000 cigarettes. Smoking a half-pack a day may not seem to be much, but can be eye-opening when thought of in this way.

3. Can you come up with some patient cases, either that you've seen yourself or that you make up that present teachable moments or challenges to smoking cessation? What approaches might be taken?

Examples of teachable moments might include the young "healthy" smoker who presents with a viral URI

e.g., bronchitis. Or a person concerned about his or her appearance, being told that smoking destroys skin collagen thereby promoting wrinkles. Examples of challenges include the patient with a psychiatric background or the patient who has no desire to quit now (primary goal is to move them from the pre-contemplative stage to the contemplative one). If time, can have housestaff do some role-modeling, with one acting the role of a patient wanting to quit but presenting some obstacle, and another acting the role of physician, trying to counsel.