Smoking cessation: helping patients stick with it until they quit

Peer group discussion based on the article published in BPJ 71, October, 2015

Approximately 5 000 people in New Zealand die each year due to smoking related causes. However, people who smoke can reverse the long-term effects of smoking if they stop early enough. Nicotine addiction should be managed like other long-term health issues and be addressed at every patient contact, unless it is inappropriate to do so.

Ask about and document the smoking status of every patient.

Give **Brief advice** to stop to every patient who smokes.

Strongly encourage every person who smokes to use **Cessation support** and offer help accessing this. A combination of behavioural support and smoking cessation medicine works best.

All patients who accept an offer of cessation support should be referred to a support provider (e.g. Quitline, Aukati KaiPaipa), or be supported in primary care. Throughout a person's quit attempt support from the primary care team is beneficial. This may involve education and correcting mistaken beliefs that make it more difficult for people to stop smoking.

If a patient declines an offer of smoking cessation support this should be documented in their notes, and they should be advised that they will be offered cessation support again at the next consultation. Smoking cessation providers can also contact people who are ambivalent about quitting smoking to discuss their options.

Pharmacological support can be offered to all patients who wish to quit smoking.

Nicotine replacement therapy (NRT) is usually the first-line smoking cessation medicine. Using NRT approximately doubles a person's chances of quitting smoking. Combination NRT (i.e. using patches with gum or lozenges) is recommended for people who smoke more than ten cigarettes a day or who smoke within one hour of waking. Often patients do not use enough NRT. NRT is typically prescribed for 8 – 12 weeks, but may be required for longer to prevent a relapse in smoking. The strength of nicotine patches can be slowly reduced over the patient's course of treatment.

Other pharmacological smoking cessation treatments include bupropion, nortriptyline and varenicline. Bupropion and nortriptyline have a similar effectiveness to NRT, and varenicline is as effective as combination NRT treatment.

Bupropion is an atypical antidepressant that reduces the desire to smoke by increasing the levels of dopamine and noradrenaline in the brain as well as being a nicotinic acetylcholine receptor antagonist. It is started one to two weeks before the patient's quit date and usually continued for seven weeks.

Nortriptyline is a tricyclic antidepressant that increases the levels of noradrenaline in the brain. It is started ten to 28 days before the patient's quit date and may be required for up to six months.

Varenicline is a partial nicotinic agonist which stimulates and blocks nicotinic acetylcholine receptors in the brain. To qualify for subsidised treatment, patients must have already had two quit attempts using NRT or a quit attempt using bupropion or nortriptyline (among other requirements). Varenicline is started one to two weeks before the patient's quit date and used for 12 weeks in total. An additional 12 weeks of treatment may be beneficial, but patients will have to meet the cost of this as extra treatment is not subsidised. Follow up support is important to encourage patients to persist with their varenicline treatment if they initially experience mild to moderate adverse effects.

Peer group discussion points:

1. What strategies do you use to raise the subject of smoking cessation with patients?
2. How do you approach this discussion with patients who do not wish to/are not ready to quit smoking?
3. Do you provide smoking cessation behavioural support in your practice or do you refer patients to smoking cessation providers such as Quitline?
4. What are your experiences with patients trying to quit smoking with NRT? Do you think you prescribe an adequate amount of NRT to patients?
5. What are your experiences with patients trying to quit smoking with either bupropion or nortriptyline? Do you find that one is more effective and/or acceptable than another?
6. What are your experiences with patients trying to quit smoking with varenicline? What are some of the adverse effects patients report and how do you help them to manage these?