

# Giving up smoking

Smoking is the most important public health problem in the UK, developed and now the developing world (Royal College of Physicians, 2000). Currently there are 13 million smokers in the UK and 120 000 of these die as a consequence of smoking each year (Jackson et al, 2001). The death rate is therefore approximately 330 smokers per day – equivalent to one jumbo jet crashing each day.

A recent increase in smoking by teenagers (15% of girls, 11% of boys, 25% of 15-year-olds) has fuelled the concern about an epidemic of smoking-related diseases in the near future. The image issues of smoking (peer pressure, a slimmer figure) appear to outweigh the health issues (one in two lifelong smokers die as a result of smoking, smoking-related illnesses lead to 1000 hospitalizations a day in the UK) and passive smoking's deleterious impact on innocent non-smokers and children (17 000 children aged 5 years or less are admitted to hospital each year in the UK with smoking-induced respiratory problems) (Royal College of Physicians, 1992).

The cost consequences of smoking impact adversely on the NHS (£1.7 billion per year), working days lost as a result of smoking-related illnesses (34 million working days/year, cost £328 million), fire caused by smoking (£150 million) and passive damage to children (NHS cost £410 million/year) (Secretary of State for Health et al, 1998). When costs are this high and the numbers this great, even a small percentage reduction in smokers will have a favourable impact.

Any approach to advising on stopping smoking must begin with education not just about the health benefits but about the importance of not starting in the first place. This requires political will – an end to tobacco advertising and sponsorship (covert advertising), adequate funds for anti-smoking publicity and help for the low income unskilled whose smoking rate

is four times that of professionals (Secretary of State for Health et al, 1998). Public places, restaurants and transport should all be smoke-free zones and smoking-related litter should be heavily fined.

## HEALTH BENEFITS

There are substantial and numerous health benefits from quitting smoking (Secretary of State for Health et al, 1998; Jackson et al, 2001). While it is never too late to stop, it is important to emphasize that those who do before the age of 35 years, providing there are no other adverse conditions present such as diabetes, have a life expectancy similar to never smokers (Doll et al, 1994). There are two key messages:

- Do not start (over 50% become dependent in their teens)
  - Quit while you are ahead.
- Emphasizing the health benefits as forcefully as possible is essential – the used car salesman approach to health care is often the only way to get the message across (Secretary of State for Health et al, 1998; Jackson et al, 2001):
- Excess stroke risk reduced to that of non-smokers 5–15 years after stopping
  - Coronary risk halved by 1 year after stopping compared to those who continue smoking
  - Lung cancer risk halved by 10 years after stopping compared to those who continue smoking
  - Mouth, throat and oesophagus cancer risk halved by 5 years after stopping compared to those who continue smoking
  - Chronic lung disease, peptic ulcer risk, bladder and pancreatic cancer and peripheral vascular disease all reduced
  - Reduced erectile dysfunction (often a powerful incentive)
  - Cervical cancer risk reduced
  - Skin ageing less (women respond to this as it implies that they will have fewer wrinkles) (Kadunce et al, 1991).

## HELPING SMOKERS TO STOP

Health-care professionals in primary or secondary care should raise the issue of smoking routinely and at least once a year in primary care (Jackson et al, 2001). Opportunistic advice to stop smoking is successful in 2% – which is cost effective at £200–900 per life-year gained (compared with statins £5 400–13 000 per life-year gained). A careful positive approach is needed as relentless nagging may well be counterproductive.

Patient motivation is important. Direct questions are essential at this point:

- Do you really want to stop smoking?
- Have you tried or thought about stopping?
- Can you commit to stopping in the next 2 weeks?

Once motivation is established it is important to take a brief smoking history (amount smoked, previous attempts to quit, medication tried), a history of previous failures (why?) and whether the patient's partner or family smoke (a non-smoking home and work environment is crucial). A stop date should be set – sponsored if possible for charity (it increases the likelihood of stopping and benefits a good cause at the same time) – and follow up arranged, ideally for 7–10 days. At the quit date, establish with the patient their individual reasons to quit and make sure they are written down to be referred to later at times of reinforcement or crisis.

Support combined with pharmacological treatment can increase the success rate to 10% in primary care and to 20% or greater in dedicated specialist clinics (Jackson et al, 2001). While strategies as a concept are successful, they must be individualized to each patient's personal needs. Specialist clinics provide more intensive support than is available in primary care or secondary care (e.g. as part of cardiac rehabilitation) and their widespread availability working in partnership with primary care achieves the highest success rates.

## PHARMACOTHERAPY

Nicotine is an addictive drug. Pharmacotherapy aimed at reversing dependence doubles the success rate but may be needed for several weeks. Nicotine replacement therapy (NRT) and bupropion hydrochloride sustained release should be used as frontline therapy in well-motivated individuals (Jackson et al, 2001). All smokers attempting to stop should be offered NRT and advised on its use (Anonymous, 2001). Both NRT and bupropion are prescribable on the NHS and NRT is available over the counter in retail outlets.

Bupropion should not be prescribed for anyone with a previous history of seizures or eating disorders. NRT is not contraindicated in cardiac patients. The type and strength of NRT preparations will need to be tailored to the individual and his or her degree of dependence. NRT and bupropion

should only be prescribed if a stop date has been agreed and for 2–4 weeks, being repeated if the smoker has genuinely stopped or reduced the amount smoked significantly. There is no evidence to support the combined use of NRT and bupropion. Patients prescribed bupropion must be fully informed of the contraindications and adverse effects (refer to the *British National Formulary*).

## ALTERNATIVE THERAPIES

Fashionable, but with no evidence base of effectiveness, acupuncture and hypnotherapy are popular. There appears to be no downside, other than cost, providing accredited practitioners are consulted.

## CONCLUSIONS

Smoking increases illnesses and shortens life. Family doctors need to raise the issue of smoking as part of their

routine patient care – they will see 80% of their practice for whatever reason in a year. Opportunistic screening is successful in 2%. Advice and treatment for tobacco dependence should be an essential part of family practice. Secondary care should reinforce the advice of stopping smoking in partnership with primary care. The benefits of quitting smoking will be realized if all treatment modalities are used and support provided. These benefits will extend from the smoker to the innocent bystander whose defensible space is polluted and health jeopardized through no fault of their own. **HM**

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## KEY POINTS

- Nicotine addiction is a serious medical condition.
- Cigarette smoking leads to chronic diseases and shortens life.
- It is never too late to stop – the health benefits are substantial.
- Motivation to quit is essential.
- Primary care, secondary care and specialist smoking cessation clinics need to work as a team.
- Pharmacotherapy increases the success rate.
- Stopping smoking is probably the most cost-effective health-care intervention for the smoker and the innocent victim of passive smoking.
- The medical will must be supported by the political will and enhanced by media education.

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