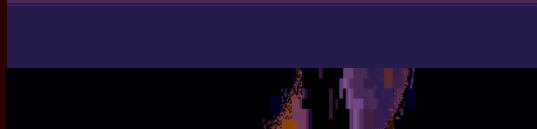
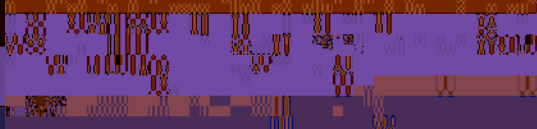
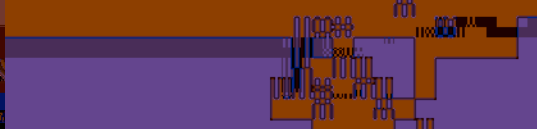
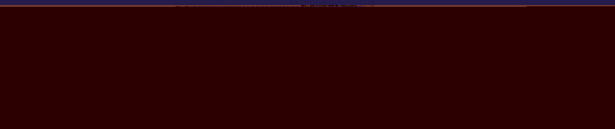
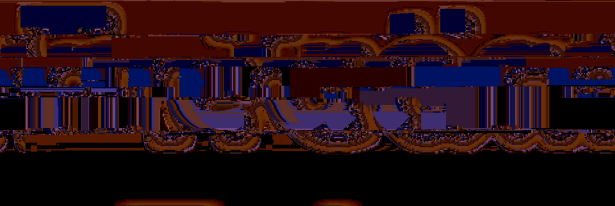


QUICK REFERENCE GUIDE FOR CLINICAL
2008 UPDATE



To All Clinicians

The Public Health Service-sponsored Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update*, on which this Quick Reference Guide for Clinicians is based, was developed by a multidisciplinary, non-Federal panel of experts in collaboration with a consortium of tobacco cessation representatives, consultants, and staff. Panel members, Federal liaisons, and guideline staff were as follows:

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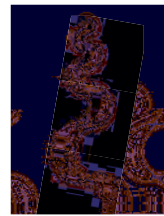
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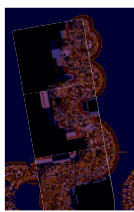
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An explicit science-based methodology was employed along with expert clinical judgment to develop recommendations on treating tobacco use and dependence. Extensive literature searches were conducted and critical reviews and syntheses were used to evaluate empirical evidence and significant outcomes. Peer review was undertaken to evaluate the validity, reliability, and utility of the guideline in clinical practice. See the complete Guideline (available at www.surgeongeneral.gov/tobacco/) for the methods, peer reviewers, references, and financial disclosure information.

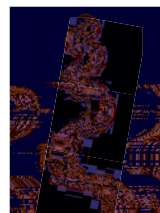
This Quick Reference Guide for Clinicians presents summary points from the Clinical Practice Guideline. The guideline provides a description of the developmental process, through analysis and discussion of the available research, critical evaluation of the assumptions and knowledge of the field, and more complete information for health care decisionmaking. Decisions to adopt particular recommendations from either publication must be made by practitioners in light of available resources and circumstances presented by the individual patient.

As clinicians, you are in the frontline position to help your patients by asking two key questions: “Do you smoke?” and “Do you want to quit?,” followed by use of the recommendations in this Quick Reference Guide for Clinicians.



Treating Tobacco Use and Dependence

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Purpose

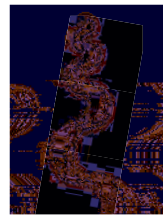
Tobacco is the single greatest cause of disease and premature death in America today, and is responsible for more than 435,000 deaths annually. About 20 percent of adult Americans currently smoke, and 4,000 children and adolescents smoke their first cigarette each day. The societal costs of tobacco-related death and disease approach \$96 billion annually in medical expenses and \$97 billion in lost productivity. However, more than 70 percent of all current smokers have expressed a desire to stop smoking; if they successfully quit, the result will be both immediate and long-term health improvements. Clinicians have a vital role to play in helping smokers quit.

The analyses contained within the Clinical Practice Guideline *Treating Tobacco Use and Dependence: 2008 Update* demonstrated that efficacious treatments for tobacco users exist and should become a part of standard care giving. Research also shows that delivering such treatments is cost-effective. In summary, the treatment of tobacco use and dependence presents the best and most cost-effective opportunity for clinicians to improve the lives of millions of Americans nationwide.

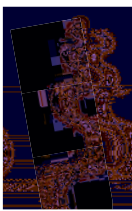
Key Findings

The guideline identified a number of key findings that clinicians should use:

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.
2. It is essential that clinicians and healthcare delivery systems consistently identify and document tobacco use status and treat every tobacco user seen in a healthcare setting.
3. Tobacco dependence treatments are effective across a broad range of populations. Clinicians should encourage every patient willing to make a quit attempt to use the recommended counseling treatments and medications in the Guideline.
4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in the Guideline.



5. Individual, group and telephone counseling are effective and their effectiveness increases with treatment intensity. Two components of counseling are especially effective and clinicians should use these when counseling patients making a quit attempt:
 - ▶ Practical counseling (problem-solving/skills training)
 - ▶ Social support delivered as part of treatment
6. There are numerous effective medications for tobacco dependence and clinicians should encourage their use by all patients attempting to quit smoking, except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers and adolescents).
 - ▶ Seven first-line medications (5 nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:
 - Bupropion SR
 - Nicotine gum
 - Nicotine inhaler
 - Nicotine lozenge
 - Nicotine nasal spray
 - Nicotine patch
 - Varenicline
 - ▶ Clinicians should also consider the use of certain combinations of medications identified as effective in the Guideline.
7. 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.
8. Telephone quitline counseling is effective with diverse populations and has broad reach. Therefore, clinicians and healthcare delivery systems should both ensure patient access to quitlines and promote quitline use.



9. If a tobacco user is currently unwilling to make a quit attempt, clinicians should use the motivational treatments shown in the Guideline to be effective in increasing future quit attempts.
10. Tobacco dependence treatments are both clinically effective and highly cost-effective relative to interventions for other clinical disorders. Providing coverage for these treatments increases quit rates. Insurers and purchasers should ensure that all insurance plans include the counseling and medication identified as effective in the Guideline as covered benefits.

Tobacco Dependence as a Chronic Health Condition

Tobacco dependence is a chronic health condition that often requires multiple, discrete interventions by a clinician or team of clinicians. The “5 A’s” of treating tobacco dependence (Ask, Advise, Assess, Assist, and Arrange follow-up) is a useful way to understand tobacco dependence treatment and organize the clinical team to deliver that treatment. While a single clinician can provide all 5 A’s, it is often more clinically and cost-effective to have the 5 A’s implemented by a team of clinicians and ancillary staff. However when a team is used, coordination of efforts is essential with a single clinician retaining overall responsibility for the interventions. Clinician extenders such as quit lines, web-based interventions, local quit programs and tailored, self-help materials can often be, and should be, incorporated into the 5 A’s approach. These treatment extenders can make clinical interventions more efficient.

This Quick Reference Guide for Clinicians is organized around the 5 A’s. However, the clinical situation may suggest delivering these components in a different order or format. The following sections address the three main groups of tobacco users: (1) those who are willing to quit, (2) those who are unwilling to quit now, and (3) those who recently quit. This Quick Reference Guide is based on Guideline findings and includes many tables directly from the Guideline.

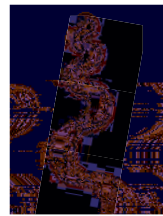
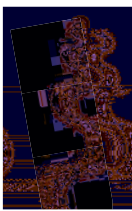
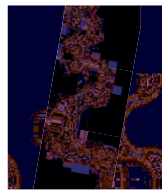


Table 1. The "5 A's" model for treating tobacco use and dependence

<p>Ask about tobacco use</p>	<p>Identify and document tobacco use status of every patient at every visit.</p>
<p>Advice to quit</p>	<p>In a clear, strong and personalized manner urge every tobacco user to quit.</p>
<p>Assess</p>	<p>For current tobacco user, is the tobacco user willing to make a quit attempt at this time?</p> <p>For the ex-tobacco user, how recent did you quit and are there any challenges to remaining abstinent?</p>
<p>Assist</p>	<p>For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment to help the patient quit.</p> <p>For patients unwilling to quit at this time, provide motivational interventions designed to increase future quit attempts.</p> <p>For the recent quitter and any with remaining challenges, provide relapse prevention</p>
<p>Arrange</p>	<p>All those receiving the previous A's should receive followup.</p>





TOBACCO USERS WILLING TO QUIT

The “5 A’s,” Ask, Advise, Assess, Assist, and Arrange, are designed to be used with the smoker who is willing to quit.

Table 2. Ask—systematically identify all tobacco users at every visit

Action	Strategies for implementation
Implement an officewide system that ensures that, for EVERY patient at EVERY clinic visit, tobacco-use status is queried and documented. ^a	Expand the vital signs to include tobacco use or use an alternative universal identification system. ^b
<p>VITAL SIGNS</p> <p>Blood Pressure: _____</p> <p>Pulse: _____ Weight: _____</p> <p>Temperature: _____</p> <p>Respiratory Rate: _____</p> <p>Tobacco Use (circle one): Current Former Never</p>	

^a Repeated assessment is not necessary in the case of the adult who has never used tobacco or has not used tobacco for many years and for whom this information is clearly documented in the medical record.

^b Alternatives to expanding the vital signs include using tobacco use status stickers on all patient charts or indicating tobacco use status via electronic medical records or computerized reminder systems.

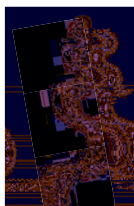


Table 3. Advise—Strongly urge all tobacco users to quit

Action	Strategies for implementation
In a clear, strong, and personalized manner, urge every tobacco user to quit.	Advice should be: <ul style="list-style-type: none">■ Clear—"I think it is important for you to quit smoking (or using chewing tobacco) now, and I can help you." "Cutting down while you are ill is not enough." "Occasional or light smoking is still dangerous."■ Strong—"As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you."■ Personalized—Tie tobacco use to current symptoms and health concerns, and/or its social and economic costs, and/or the impact of tobacco use on children and others in the household. "Continuing to smoke makes your asthma worse, and quitting may dramatically improve your health. Quitting smoking may reduce the number of ear infections your child has."

Table 4. Assess—Determine willingness to make a quit attempt

Action	Strategies for implementation
Assess every tobacco user's willingness to make a quit attempt at the time.	Assess patient's willingness to quit: "Are you willing to give quitting a try?" <ul style="list-style-type: none">■ If the patient is willing to make a quit attempt, provide assistance.<ul style="list-style-type: none">– If the patient will participate in an intensive treatment, deliver such a treatment or link/refer to an intensive intervention.

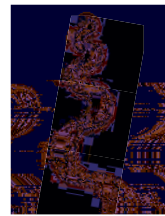


Table 5. Assist—Aid the patient in quitting (provide counseling and medication)

Action	Strategies for implementation
<p>Help the patient with a quit plan.</p>	<p>A patient's preparations for quitting:</p> <ul style="list-style-type: none"> ■ Set a quit date. Ideally, the quit date should be within 2 weeks. ■ Tell family, friends, and coworkers about quitting and request understanding and support. ■ Anticipate challenges to the upcoming quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. ■ Remove tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car). Make your home smoke-free.
<p>Recommend the use of approved medication, except when contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents).</p>	<p>Explain how these medications increase quitting success and reduce withdrawal symptoms. FDA-approved medications include: bupropion SR, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, nicotine patch, and varenicline. There is insufficient evidence to recommend medication for pregnant women, adolescents, smokeless tobacco users, and light smokers (< 10 cigarettes/day).</p>
<p>Provide practical counseling (problem-solving/skills training).</p>	<p><i>Abstinence.</i> Striving for total abstinence is essential. Not even a single puff after the quit date.</p> <p><i>Past quit experience.</i> Identify what helped and what hurt in previous quit attempts. Build on past success.</p> <p><i>Anticipate triggers or challenges in the upcoming attempt.</i> Discuss challenges/triggers and how the patient will successfully overcome them (e.g., avoid triggers, alter routines).G316</p>

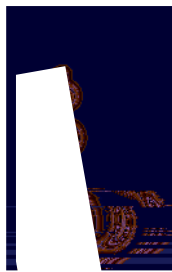
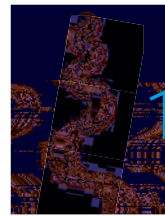


Table 5. Assist—Aid the patient in quitting (provide counseling and medication) (continued)

Action	Strategies for implementation
Provide intratreatment social support.	<p><i>Alcohol.</i> Because alcohol is associated with relapse, the patient should consider limiting/abstaining from alcohol while quitting. (Note that reducing alcohol intake could precipitate withdrawal in alcohol-dependent persons.)</p> <p><i>Other smokers in the household.</i> Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them or to not smoke in their presence.</p> <p>Provide a supportive clinical environment while encouraging the patient in his or her quit attempt. “My office staff and I are available to assist you.” “I’m recommending treatment that can provide ongoing support.”</p>
Provide supplementary materials, including information on quitlines.	<p><i>Sources:</i> Federal agencies, nonprofit agencies, national quitline network (1-800-QUIT-NOW), or local/state/tribal health departments/quitlines.</p> <p><i>Type:</i> Td (att) Td Culourlyraocialy@dunationalynTj0027w0B9d</p>



ASSIST COMPONENT—PROVIDING COUNSELING

Counseling should include teaching practical problem solving skills and providing support and encouragement.

Table 6. Common elements of practical counseling

Practical counseling (problem- Examples

Table 7. Common elements of supportive counseling

Supportive treatment component	Strategies for implementation
Encourage the patient in the quit attempt.	<ul style="list-style-type: none">■ Note that effective tobacco dependence treatments are now available.■ Note that one-half of all people who have

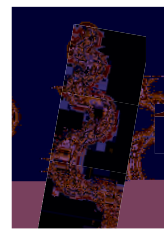
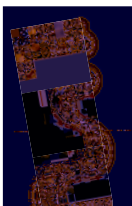


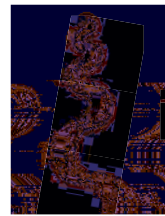
Table 8. Providing Counseling—Frequently Asked Questions

My patient doesn't want counseling, only medication. What should I do?	Point out that counseling plus medication works better than medication alone. Explain that the goal of counseling (or coaching) is to provide the practical skills that increase the likelihood of quitting successfully. Use the motivational interventions designed for tobacco users who do not want to quit (see page 24) to encourage your patient to accept counseling. Emphasize the inconsistency between not using effective counseling for something as important and difficult as quitting tobacco. If the patient still declines counseling, consider providing medication alone because medication alone has been shown to be effective. During followup, continue to provide the key elements of counseling: problem solving, practical skills, and support.
My patient wants to use a method of quitting not known to be effective such as acupuncture, hypnosis, or laser therapy. What do I do?	Ask the patient to consider increasing the success odds of his/her quit attempt by augmenting his/her method of quitting with evidence-based medication and counseling. Do not denigrate any attempt to quit. If the patient declines, support his/her effort, but ask for an agreement that, should it not be successful, the patient will consider evidence-based methods in the future, including medication and counseling.
My patient is concerned about gaining weight.	Recommend that the patient start or increase physical activity. For example, take a walk at break time rather than smoke and/or walk at lunch. Also see medication recommendations for such patients.
My patient is concerned about using NRT because he/she believes nicotine to be one of the harmful ingredients in tobacco products.	Explain that medicinal nicotine by itself is relatively safe. Emphasize that the 4,000 chemicals in cigarette smoke, including about 40 carcinogens, cause the harm from smoking. Also, medicinal nicotine has been proven to greatly reduce withdrawal symptoms in many people.



**Table 8. Providing Counseling—Frequently Asked Questions
(continued)**

My patient does not want to use medication because of:	Point out:
- Fear that the medication is addictive	- Medication delivered by mouth or through a patch is not like smoking. Developing a dependency on the medication is uncommon.
- Doubt that the medication will help	- The probability of successful quitting is much higher when medication is used.
- Doubt that recover	- Substance abuse counselors routinely use medication to help people quit.
	- The ultimate goal remains neither smoking nor using



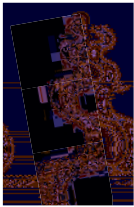


Table 9. Suggestions for the clinical use of medication for tobacco dependence treatment^a

Medication	Cautions/Warnings	Side Effects	Dosage	Use	Availability (check insurance)
Bupropion SR 150	<p>Not for use if you:</p> <ul style="list-style-type: none"> * Currently use monoamine oxidase (MAO) inhibitor * Use bupropion in any other form * Have a history of seizures * Have a history of eating disorders * See FDA package insert warning regarding suicidality and antidepressant drugs when used in children, adolescents, and young adults. 	<ul style="list-style-type: none"> * Insomnia * Dry mouth 	<ul style="list-style-type: none"> * Days 1-3: 150 mg each morning * Days 4-end: twice daily 	<p>Start 1-2 weeks before quit date; use 2 to 6 months</p>	<p>Prescription only</p> <ul style="list-style-type: none"> * Generic * Zyban * Wellbutrin SR
Nicotine Gum (2 mg or 4 mg)	<ul style="list-style-type: none"> * Caution with dentures * Do not eat or drink 15 minutes before or during use 	<ul style="list-style-type: none"> * Mouth soreness * Stomach ache 	<ul style="list-style-type: none"> * 1 piece every 1 to 2 hours * 6-15 pieces per day * If 24 cigs: 2 mg * If 25 cigs/day or chewing tobacco: 4 mg 	<p>Up to 12 weeks or as needed</p>	<p>OTC only:</p> <ul style="list-style-type: none"> * Generic * Nicorette
Nicotine Inhaler	<ul style="list-style-type: none"> * May irritate mouth/throat at first (but improves with use) 	<ul style="list-style-type: none"> * Local irritation of mouth & throat 	<ul style="list-style-type: none"> * 6-16 cartridges/day * Inhale 80 times/cartridge * May save partially-used cartridge for next day 	<p>Up to 6 months; taper at end</p>	<p>Prescription only:</p> <p>Nicotrol inhaler</p>

Table 9. Suggestions for the clinical use of medication for tobacco dependence treatment (continued)^a

Medication	Cautions/Warnings	Side Effects	Dosage	Use	Availability (check insurance)
Nicotine Lozenge (2 mg or 4 mg)	<ul style="list-style-type: none"> * Do not eat or drink 15 minutes before or during use * One lozenge at a time * Limit 20 in 24 hours 	<ul style="list-style-type: none"> * Hiccups * Cough * Heartburn 	<ul style="list-style-type: none"> * If smoke/chew 30 minutes after waking: 2 mg * If smoke/chew 30 minutes after waking: 4 mg * Weeks 1-6: 1 every 1-2 hrs * Wks 7-9: 1 every 2-4 hrs * Wks 10-12: 1 every 4-8 hrs 	3-6 months	OTC only: * Generic * Commit
Nicotine Nasal Spray	<ul style="list-style-type: none"> * Not for patients with asthma * May irritate nose (improves over time) * May cause dependence 	* Nasal irritation	<ul style="list-style-type: none"> * 1 "dose" = 1 squirt per nostril 1 to 2 doses per hour * 8 to 40 doses per day * Do NOT inhale 	3-6 months; taper at end	Prescription only: * Nicotrol NS

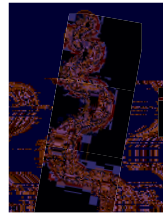
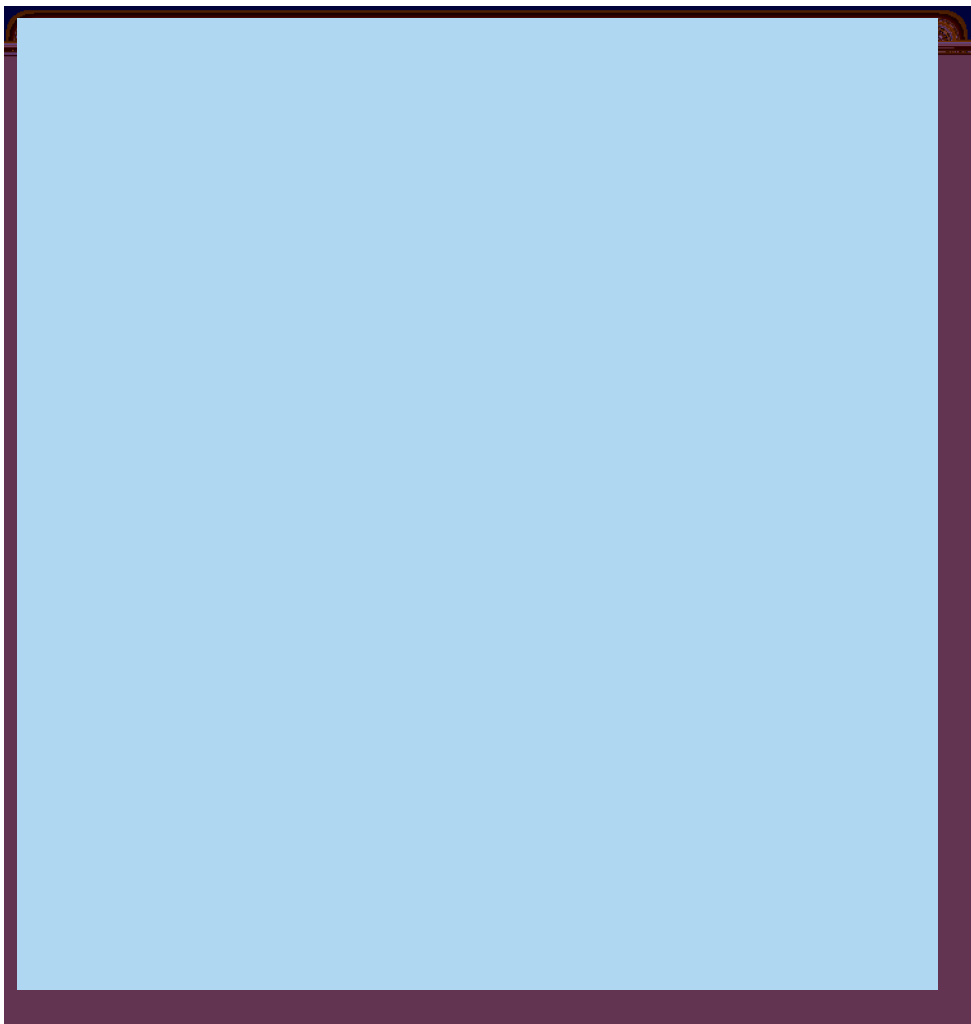


Table 9. Suggestions for the clinical use of medication for tobacco dependence treatment (continued)^a

Medication	Cautions/Warnings	Side Effects	Dosage	Use	Availability (check insurance)
Nicotine Patch	Do not use if you have severe eczema or psoriasis	* Local skin reaction * Insomnia	* One patch per day * If 10 cigs/day: 21 mg 4 wks, 14 mg 2-4 wks, 7 mg 2-4 wks * If <10/day: 14 mg 4 wks, then 7 mg 4 wks	8-12 weeks	OTC or prescription: * Generic * Nicoderm CQ * Nicotrol
Varenicline	Use with caution in patients: * With significant renal impairment * With serious psychiatric illness * Undergoing dialysis * FDA Warning: Varenicline patients have reported depressed mood, agitation, changes in behavior, suicidal ideation, and suicide. * See www.fda.gov for further updates regarding recommended safe use of Varenicline.	* Nausea * Insomnia * Abnormal, vivid, or strange dreams	* Days 1-3: 0.5 mg every morning * Days 4-7: 0.5 mg twice daily * Day 8-end: 1 mg twice daily	Start 1 week before quit date; use 3-6 months	Prescription only: * Chantix
Combinations:	* Only patch + bupropion * Only patch + bupropion + nortriptyline	Individual Individual	Individual Individual	u05076.3wopion islozeng See above	Based on the See above

inhaler

See the FDA Web site for addio507a1 dosing and safety information, including safety protocols



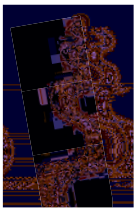
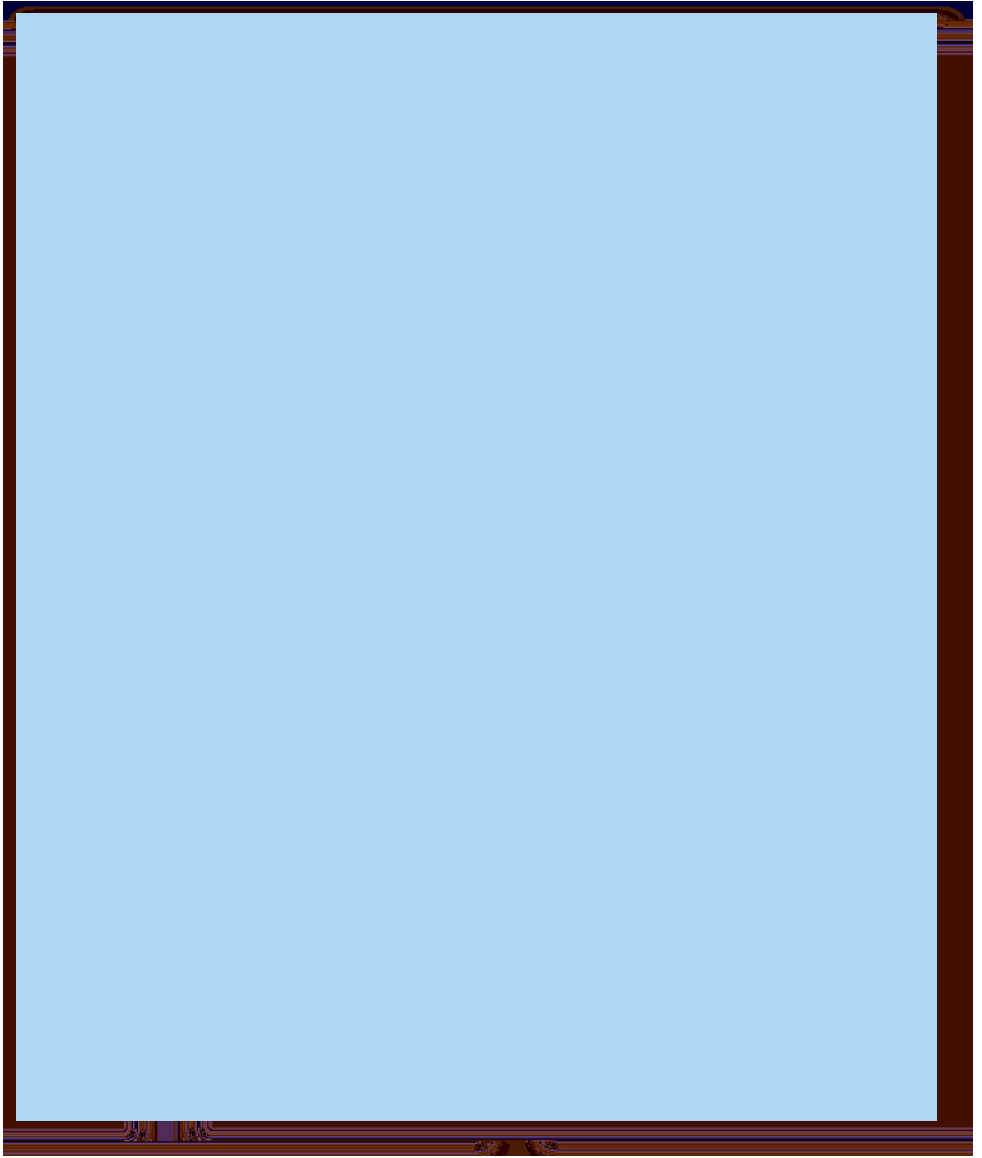


Table 10. Providing Medication—Frequently Asked Questions (continued)

When should second-line agents be used for treating tobacco dependence?

Consider prescribing second-line agents (clonidine and nortriptyline) for patients unable to use first-line medications because of contraindications or for patients for whom the group of first-line medications has not been helpful. Assess patients for the specific contraindications, precautions, other concerns, and side effects of the second-line agents. Please refer to FDA package inserts for this information.

Which medications should be considered with patients particularly concerned about weight gain?

Data show that bupropion SR and nicotine replacement therapies, in particular 4 mg nicotine gum and 4 mg nicotine lozenge, delay, but do not prevent, weight gain.

Are there medications that should be especially considered in patients with a past history of depression?

Bupropion SR and nortriptyline appear to be effective with this population, but nicotine replacement medications also appear to help individuals with a past history of depression.

Should nicotine replacement therapies be avoided in patients with a history of cardiovascular disease?

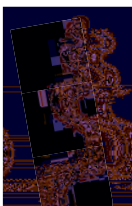
No. The nicotine patch in particular has been demonstrated as safe for cardiovascular patients.

May tobacco dependence medications be used long term (e.g., up to 6 months)?

Yes. This approach may be helpful with smokers who report persistent withdrawal symptoms during the course of medications, who have relapsed in the past after stopping medication, or who desire long-term therapy. A minority of individuals who successfully quit smoking use

Table 10. Providing Medication—Frequently Asked Questions (continued)

Is medication adherence important?	Yes. Patients frequently do not use cessation medications as recommended (e.g., they don't use them at recommended doses or for recommended durations); this may reduce their effectiveness.
May medications ever be combined?	Yes. Among first-line medications, evidence exists that combining the nicotine patch long term (> 14 weeks) with nicotine gum or nicotine nasal spray, the nicotine patch with the nicotine inhaler, or the nicotine patch with bupropion SR, increases long-term abstinence rates relative to placebo treatments.
My patient can't afford medications and doesn't have insurance to cover it. What can I do?	<ul style="list-style-type: none">■ Instruct the patient to set aside all the money they would have spent on tobacco once they quit. After initial use of medication they will be able to afford medication going forward.■ Many clinics that serve people with no health insurance will provide treatment for tobacco dependence, including medication. Check for ones in your area and have them available for staff and patients as a referral source.■ As a clinician, you can call the tobacco quitline and ask about any sources of free or reduced cost medication for your patients. Try 1-800-QUIT-NOW, which works nationwide and seamlessly routes you to the quitline in the State you are calling from.■ If your patient qualifies for Medicaid or Medicare, these programs cover some tobacco dependence treatment medications. Get this information for your State and have available for staff and patients.■ Most pharmaceutical companies have programs to provide medications to those who cannot afford them. Contact the pharmaceutical companies directly or check with Partnership for Prescription Assistance at www.pparx.org or 1-888-4PPA-NOW.

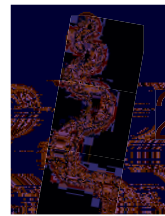


ARRANGE

Tobacco dependence is an addiction. Quitting is very difficult for most tobacco users. It is essential that the patient trying to quit has scheduled followup. This is especially important when the treatment is shared by a team of clinicians and includes treatment extenders such as quitline counseling.

Table 11. Arrange—Ensure followup contact

Action	Strategies for implementation
Arrange for followup contacts, either in person or via telephone.	<p><i>Timing:</i> Followup contact should begin soon after the quit date, preferably during the first week. A second followup contact is recommended within the first month. Schedule further followup contacts as indicated.</p> <p><i>Actions during followup contact:</i> For all patients, identify problems already encountered and anticipate challenges in the immediate future. Assess medication use and problems. Remind patients of quitline support (1-800-QUIT-NOW). Address tobacco use at next clinical visit (treat tobacco use as a chronic disease).</p> <p>For patients who are abstinent, congratulate them on their success.</p>



TOBACCO USERS UNWILLING TO QUIT AT THIS TIME

Ask, Advise, and Assess every tobacco user following the suggestions in Tables 2-4

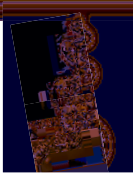
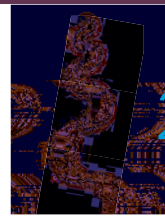


Table 12. Enhancing motivation to quit tobacco—the "5 R's" (continued)

	<ul style="list-style-type: none"> ■ Environmental risks: Increased risk of lung cancer and heart disease in spouses; increased risk for low birth weight, sudden infant death syndrome (SIDS), asthma, middle ear disease, and respiratory infections in children of smokers.
<p>Rewards</p>	<p>The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:</p> <ul style="list-style-type: none"> ■ Improved health. ■ Food will taste better. ■ Improved sense of smell. ■ Saving money. ■ Feeling better about yourself. ■ Home, car, clothing, breath will smell better. ■ Setting a good example for children and decreasing the likelihood that they will smoke. ■ Having healthier babies and children. ■ Feeling better physically. ■ Performing better in physical activities. ■ Improved appearance including reduced wrinkling/aging of skin and whiter teeth.
<p>Roadblocks</p>	<p>The clinician should ask the patient to identify barriers or impediments to quitting and provide treatment (problem-solving counseling, medication) that could address barriers. Typical barriers might include:</p> <ul style="list-style-type: none"> ■ Withdrawal symptoms. ■ Fear of failure. ■ Weight gain. ■ Lack of support. ■ Depression. ■ Enjoyment of tobacco. ■ Being around other tobacco users. ■ Limited knowledge of effective treatment options.
<p>Repetition</p>	<p>The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful and that you will continue to raise their tobacco use with them.</p>



Interventions to increase the likelihood that a tobacco user who does not want to quit will decide to quit can draw upon the principles of motivational interviewing:

Table 13. Motivational interviewing strategies

Express Empathy	<ul style="list-style-type: none">■ Use open-ended questions to explore:<ul style="list-style-type: none">○ The importance of addressing smoking or other tobacco use (e.g., “How important do you think it is for you to quit?”).○ Concerns and benefits of quitting (e.g., “What might happen if you quit?”).■ Use reflective listening to seek shared understanding:<ul style="list-style-type: none">○ Reflect words or meaning (e.g., “So you think smoking helps you to maintain your weight?”).○ Summarize (e.g., “What I have heard so far is that smoking is something you enjoy. On the other hand, your boyfriend hates your smoking and you are worried you might develop a serious disease.”)■ Normalize feelings and concerns (e.g., “Many people worry about managing without cigarettes.”)■ Support the patient’s autonomy and right to choose or reject change (e.g., “I hear you saying you are not ready to quit smoking right now. I’m here to help you when you are ready.”)
Develop Discrepancy	<ul style="list-style-type: none">■ Highlight the discrepancy between the patient’s present behavior and expressed priorities, values, and goals (e.g., “It sounds like you are very devoted to your family. How do you think your smoking is affecting your children and spouse/partner?”).■

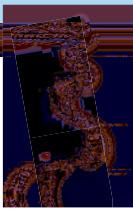
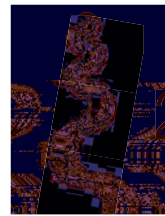


Table 13. Motivational Interviewing Strategies (continued)

Roll with Resistance	<ul style="list-style-type: none">■ Back off and use reflection when the patient expresses resistance.<ul style="list-style-type: none">○ “Sounds like you are feeling pressured about your tobacco use.”■ Express empathy.<ul style="list-style-type: none">○ “You are worried about how you would manage withdrawal symptoms.”■ Ask permission to provide information.<ul style="list-style-type: none">○ “Would you like to hear about some strategies that can help you address that concern when you quit?”
Support Self-Efficacy	<ul style="list-style-type: none">■ Help the patient to identify and build on past successes.<ul style="list-style-type: none">○ “So you were fairly successful the last time you tried to quit.”■ Offer options for achievable, small steps toward change.<ul style="list-style-type: none">○ Call the quitline (1-800-QUIT-NOW) for advice and information.○ Read about quitting benefits and strategies.○ Change smoking patterns (e.g., no smoking in the home).○ Ask the patient to share his or her ideas about quitting strategies.

strategies.



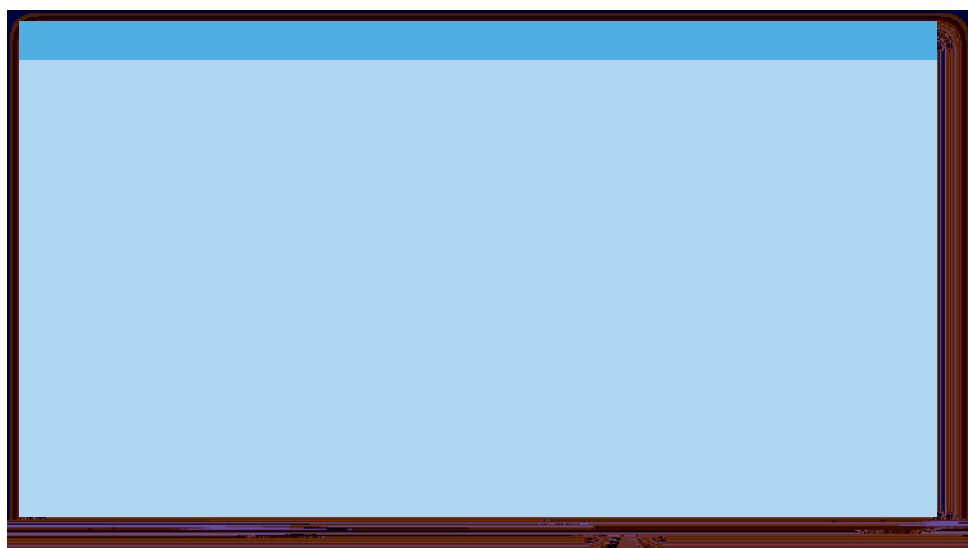
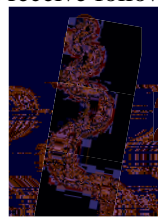


Table 16. Specific challenges and potential responses to the tobacco user who recently quit

Challenges	Responses
Lack of support for cessation	<ul style="list-style-type: none"> • Schedule followup visits or telephone calls with the patient. • Urge the patient to call the quitline (1-800-QUIT-NOW). • Help the patient identify sources of support within his or her environment.
Negative mood or depression	<ul style="list-style-type: none"> • Refer the patient to an appropriate organization that offers counseling or evidence-based support. • If significant, provide counseling, prescribe appropriate medication, or refer the patient to a specialist.
Strong or prolonged withdrawal symptoms	<ul style="list-style-type: none"> • If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved medication or adding/combining medications to reduce strong withdrawal symptoms.
Weight gain	<ul style="list-style-type: none"> • Recommend starting or increasing physical activity. • Reassure the patient that some weight gain after quitting is common and is usually self-limiting. • Emphasize the health benefits of quitting relative to the health risks of modest weight gain. • Emphasize the importance of a healthy diet and active lifestyle. • Suggest low-calorie substitutes such as sugarless chewing gum, vegetables, or mints. • Maintain the patient on medication known to delay weight gain (e.g., bupropion SR, NRTs, particularly 4 mg nicotine gum, and lozenge). • Refer the patient to a nutritional counselor or program.
Smoking lapses	<ul style="list-style-type: none"> • Suggest continued use of medications, which can reduce the likelihood that a lapse will lead to a full relapse. • Encourage another quit attempt or a recommitment to total abstinence. • Reassure that quitting may take multiple attempts, and use the lapse as a learning experience • Provide or refer for intensive counseling.

ARRANGE FOLLOWUP

All patients that have recently quit or still face challenges should receive followup for continued assistance and support.



New Recommendations in the PHS–Sponsored Clinical Practice Guideline—*Treating Tobacco Use and Dependence: 2008 Update*

Most, but not all, of the new recommendations appearing in the 2008 Update of the Guideline resulted from new meta-analyses of the topics chosen by the Guideline panel.

1. Formats of Psychosocial Treatments

Recommendation: 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.

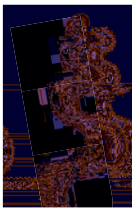
2. Combining Counseling and Medication

Recommendation: The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking.

Recommendation: 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.

3. For Tobacco Users Not Willing To Quit Now

Recommendation: 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.



4. Nicotine Lozenge

Recommendation: The nicotine lozenge is an effective smoking cessation treatment that patients should be encouraged to use.

Note: See the Guideline and FDA Web site (www.fda.gov) for additional information on the safe and effective use of medication.

5. Varenicline

Recommendation: Varenicline is an effective smoking cessation treatment that patients should be encouraged to use.

Note: See the Guideline and the FDA Web site (www.fda.gov) for additional information on the safe and effective use of medication.

6. Specific Populations

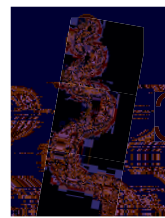
Recommendation: The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline 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 (< 10 cigarettes/day) smokers, and adolescents).

7. Light Smokers

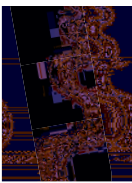
Recommendation: Light smokers should be identified, strongly urged to quit and provided counseling treatment interventions.

Conclusion

Tobacco dependence is a chronic disease that deserves treatment. Effective treatments have now been identified and should be used with every current and former smoker. This Quick Reference Guide for Clinicians provides clinicians with the tools necessary to effectively identify and assess tobacco use and to treat (1) tobacco users willing to quit, (2) those who are unwilling to quit at this time, and (3) former tobacco users. There is no clinical treatment available today that can reduce illness, prevent death, and increase quality of life more than effective tobacco treatment interventions.



Guideline Availability





[REDACTED]

[REDACTED]

[REDACTED]



U.S. Department of Health and Human Services, CEO

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