Smoking Cessation

The highest-value intervention in general medicine · combine a drug with behavioral support, and treat relapse as data

Both together *beat either alone*

THE FRAMEWORK *brief, repeatable, and effective even in a few minutes*

ASK AND ADVISE

Ask every patient at every visit and record it. **Advise clearly and personally**: "the most important thing you can do for your health is stop smoking", linked to *their* current problem. **Brief advice from a clinician measurably increases quit rates**, so it is worth doing even when time is short.

ASSESS AND ASSIST

Ask whether they are willing to try **now**. If yes, set a quit date, **offer pharmacotherapy** and arrange behavioral support. If not, **do not lecture**: state your availability, address the specific barrier, and ask again next time. Readiness changes.

ARRANGE FOLLOW-UP

Contact in the first week and again in the first month, which is when most relapse happens. Refer to a **quitline** or counseling: combining medication with behavioral support is **substantially more effective than either alone**, and this combination is the single most important message on this sheet.

PHARMACOTHERAPY *offer it to everyone who is willing, not just heavy smokers*

Option	How to use it	Notes
Varenicline most effective single agent	**Start 1 week before the quit date** and titrate up over the first week, continuing for at least 12 weeks. A flexible quit date within the first month is also acceptable	Nausea is the commonest side effect: **take it with food and a full glass of water**, and it usually settles. Also vivid dreams and insomnia. **The neuropsychiatric boxed warning was removed** after a large safety trial found no significant excess of serious neuropsychiatric events, so do not withhold it on that basis
Combination NRT preferred over single NRT	**A patch for the steady background PLUS a short-acting form** (gum, lozenge, inhaler or nasal spray) for cravings. Match the patch strength to how much they smoke	**Combination beats a patch alone.** Common failure: **under-dosing and incorrect technique**. Gum is chewed then parked against the cheek, not chewed continuously, and **acidic drinks reduce absorption**, so avoid coffee and soda just before
Bupropion SR	Start **1 to 2 weeks before** the quit date, continuing for 7 to 12 weeks	**Contraindicated with a seizure disorder, an eating disorder, or abrupt alcohol or benzodiazepine withdrawal**, and with MAO inhibitors. Useful when depression coexists, and it is **less likely to cause weight gain**, which matters to many patients
Combinations	Varenicline plus NRT, or bupropion plus NRT	Reasonable in heavy dependence or after a previous failure on monotherapy
E-cigarettes	Not an FDA-approved cessation treatment	Some evidence of benefit versus NRT in trials, but **they are not a licensed therapy, long-term safety is not established, and dual use is common**. Offer approved treatments first, and if a patient has already switched completely, the goal becomes stopping the e-cigarette too

SPECIAL SITUATIONS *where the usual answer changes*

Situation	What to do
Hospitalized patients	**The single best teachable moment there is**, and the environment is already smoke-free. **Offer NRT for withdrawal on admission** rather than leaving the patient agitated and assumed to be delirious. **Cessation support started in hospital and continued for at least a month after discharge is what works**, so arrange the follow-up before they leave
Before surgery	Quitting reduces wound infection and respiratory complications. **Longer is better, but even short-term cessation helps**, so there is no point at which it is too late to raise it
Pregnancy	**Behavioral intervention is first-line.** Pharmacotherapy data are more limited, so it is an individualized discussion weighing continued smoking against drug exposure. Provide intensive support and follow up closely
Psychiatric illness and other substance use	Smoking prevalence is far higher and these patients want to quit at similar rates. **Do not defer cessation on the assumption it will destabilize them**: treat concurrently, and note that **quitting can raise levels of drugs metabolized by CYP1A2**, including **clozapine, olanzapine and theophylline**, since it is the tobacco smoke rather than the nicotine that induces the enzyme. Doses may need reducing after quitting
Also screen for lung cancer	Annual low-dose CT for eligible patients aged 50 to 80 with a 20 pack-year history who smoke now or quit within 15 years. **Screening and cessation belong in the same conversation**, since cessation delivers more benefit than the scan

WHAT TO TELL THE PATIENT *concrete benefits beat general warnings*

THE BENEFITS START FAST

Circulation and lung function begin improving within weeks, cough and breathlessness improve over months, and **cardiovascular risk falls substantially within the first year or two. Excess lung cancer risk falls steadily over years but never returns fully to baseline**, which is the honest framing and the argument for quitting sooner.

IT HELPS AT ANY AGE

Quitting benefits patients even in their 60s, 70s and beyond, and even after a diagnosis of cancer or heart disease, where it improves treatment outcomes and survival. **"It is too late for me" is the belief to challenge directly**, because it is both common and wrong.

WITHDRAWAL IS TIME-LIMITED

Irritability, poor concentration, restlessness, low mood and increased appetite peak in the first week and largely settle within 2 to 4 weeks. Telling patients this in advance makes them far more likely to push through, and **adequate pharmacotherapy blunts it**.

PEARLS & PITFALLS

- **Relapse is the norm, not failure.** Most people need several attempts. **Frame a relapse as information**: what triggered it, what was the medication dose, was there behavioral support. Then re-treat, because a previous failed attempt predicts nothing about the next one.
- **Under-treatment is the commonest prescribing error.** A single low-dose patch in a heavy smoker will fail. **Match the dose to the dependence**, and ask how soon after waking they smoke, since within 30 minutes indicates high dependence.
- **Address weight gain before it becomes the reason for relapse.** Some gain is usual and is **vastly outweighed** by the benefit of quitting. Raise it proactively, offer activity and dietary support, and note bupropion and NRT blunt it somewhat.
- **Cutting down is a legitimate step, not a failure to commit**, and reduction with NRT support increases the chance of eventually quitting. **Do not dismiss the patient who will not set a quit date today**, since the strongest predictor of future success is continuing to be asked.

References: US Public Health Service and USPSTF guidance on tobacco cessation interventions in adults · the EAGLES safety trial of varenicline and bupropion and the subsequent FDA boxed warning removal · published evidence on combination NRT and on hospital-initiated cessation.

Educational aid; verify against current guidance, local formulary and patient factors.

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