Tobacco Use and Cessation in Psychiatric Patients

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Professor of Family Medicine
Wake Forest School of Medicine
NCPA, October 2015

Disclosure

* I have no relevant financial relationship with the manufacturers of any commercial products and/or providers of commercial services discussed in this CME activity.
* Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.
* My content will include reference to commercial products; however, generic and alternative products will be discussed whenever possible.
* I do not intend to discuss any unapproved or investigative use of commercial products or devices (discussions will be evidence based).

Objectives

* Discuss prevalence of tobacco use among psychiatric patients and the psychiatric benefits of cessation.
* Enumerate some of the newer tobacco products.
* Explain the risks and benefits of electronic cigarette use.
* List evidence-based tobacco cessation therapies.
* Describe the use of these therapies.

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* Screening:
* 1993-1996: 77%
* 2001-2005: 69%
* 2006-2010: 60%

Rogers et al. American Journal of Public Health104.1(Jan 2014): 90-95
Used National Ambulatory Medical Care Survey Data

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* Counseling:
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* 2001-2005: 11%
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Who?
>50 yo
Obesity
HTN
DM
Rural
Bipolar D/O

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Why is Smoking Cessation Relevant to Psychiatry?

Also….

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* Prevalence of tobacco use is greater in psychiatric patients, and they have harder time quitting
* BUT cessation IS possible with the right approach
* And cessation improves psychiatric outcomes

Diversification as Cig use Declines

Hookah Smoking

* Waterpipe used to smoke flavored tobacco known as shisha
  * Produces a cool, mild smoke
* Often smoked in cafés or hookah bars
  * NC has approximately 20
* Typical hookah session last about 45-60 minutes

Paymon's Mediterranean Café and Lounge, Las Vegas

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* 100-fold increased exposure to tobacco smoke vs cigs

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From: **Smoking and Mental Illness: A Population-Based Prevalence Study**

JAMA. 2000;284(20):2606-2610. doi:10.1001/jama.284.20.2606

Table 3. Smoking Status Among Respondents According to Psychiatric Diagnosis at Any Time in Their Life*

Lifetime Diagnosis	US Population, %	Current Smoker, %	Lifetime Smoker, %	Quit Rate, %
No mental illness	50.7	22.5	39.1	42.5
Social phobia	12.5	35.9†	54.0†	33.4‡
Agoraphobia	5.4	38.4†	58.9†	34.5
Panic disorder	3.4	35.9§	61.3†	41.4
Major depression	16.9	36.6†	59.0†	38.1
Dysthymia	6.8	37.8†	60.0†	37.0
Panic attacks	6.5	38.1†	60.4†	36.9
Simple phobia	11.0	40.3†	57.8†	30.3
Nonaffective psychosis	0.6	49.4§	67.9‡	27.2
Alcohol abuse or dependence	21.5	43.5†	65.9†	34.0‡
Antisocial personality, antisocial behavior, or conduct disorder	14.6	45.1†	62.5†	27.8†
Posttraumatic stress disorder	6.4	45.3†	63.3†	28.4§
Generalized anxiety disorder	4.8	46.0†	68.4†	32.7‖
Drug abuse or dependence	11.4	49.0†	72.2†	32.1§
Biopolar disorder	1.6	68.8†	82.5†	16.6†

*Percentages of the National Comorbidity Study sample of 4411 persons are weighted to approximate the US population as determined from the 1989 US National Health Interview Survey.
†Significantly different from respondents without mental illness, χ^2, $P \leq .0001$.
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Schizophrenia: 68% to 74% outpts current smokers

Can We Do Anything?

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YES!!!!!

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…Individuals with mental illness who received mental health treatment within the previous year were more likely to have quit smoking than those not receiving treatment (P = .005).

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These are patients in your office

Will it Help My Patients?

Research

Change in mental health after smoking cessation: systematic review and meta-analysis

BMJ 2014 ; 348 doi: http://dx.doi.org/10.1136/bmj.g1151 (Published 13 February 2014)
Cite this as: *BMJ* 2014;348:g1151

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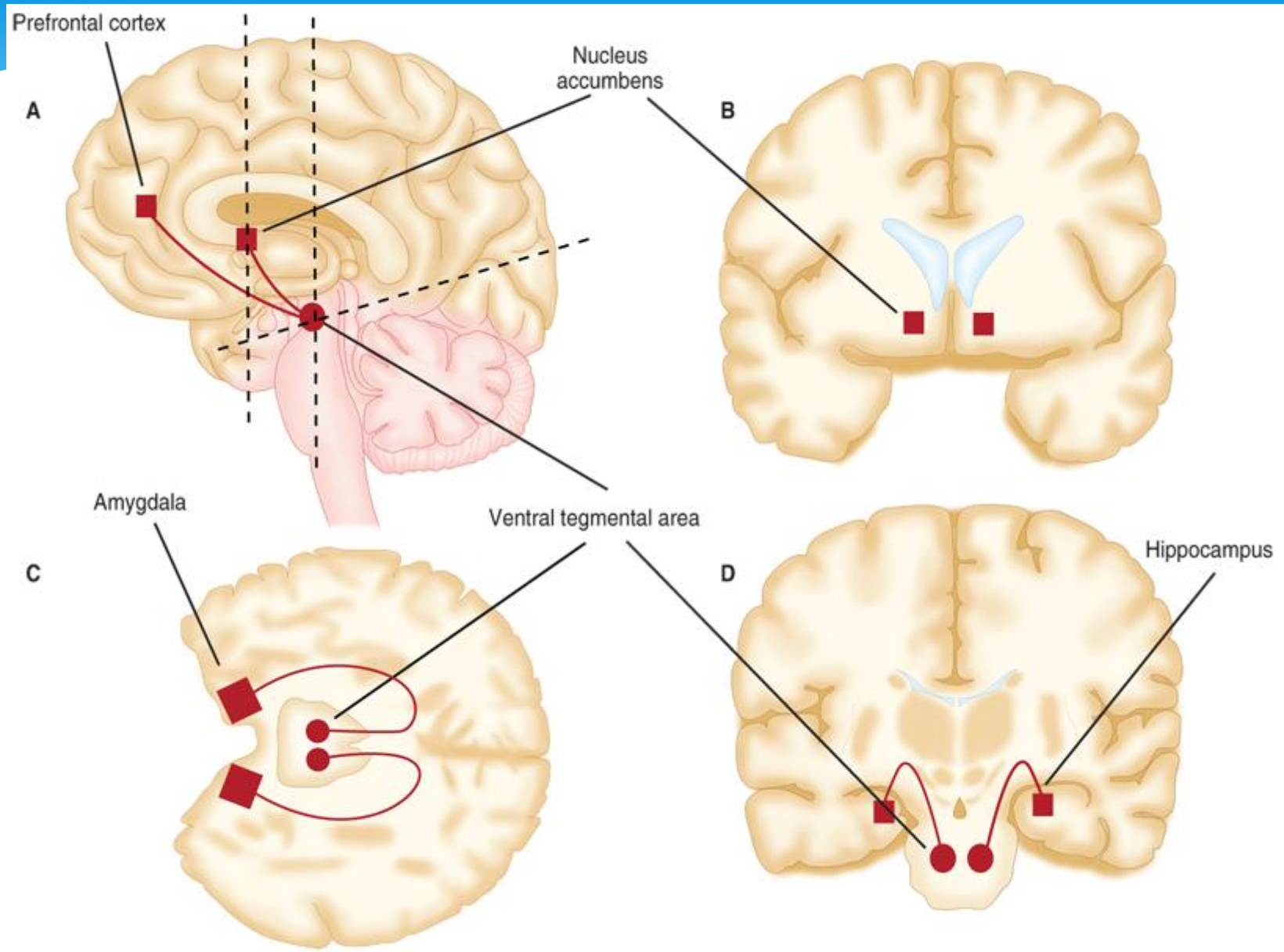
YES!!!!!

Mental Health Improves after Smoking Cessation

Conclusions: Smoking cessation is associated with *reduced* depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The effect size seems as large for those with psychiatric disorders as those without. The *effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders*.

Addiction: Structural/Molecular Targets

* All abused drugs activate the mesolimbic dopamine system; highly "addictive" or "preferred"
* These include:
  * Ventral tegmental area: when drug attaches to dopamine (DA)receptor in VTA, DA released in rapid bursts into:
    * Nucleus accumbens: major target of VTA dopamine projections.
    * Amygdala and prefrontal cortex: also receive dopamine projections.



Source: Bertram G. Katzung, Anthony J. Trevor: Basic & Clinical Pharmacology, 13th Ed.

Dopamine Hypothesis of Addiction?

* Formerly thought that drugs of abuse INCREASE release of DA over time; CONFLICTING evidence
  * Addiction was process of obtaining this high level of dopamine.
* More recently, brain imaging has shown that addiction is actually a "dopamine-impoverished" state
  * Drug use tries to restore pre-addicted DA levels
  * This lasting REDUCTION in DA activity remains even in recovery
  * Restoring "pre-drug" levels of DA might be best approach to "cure" addiction
  * Role for agonist therapy in TOBACCO USE

Marco, D. Front Psychiatry. 2011; 2: 64.

Why Quitting Smoking is Hard!?!

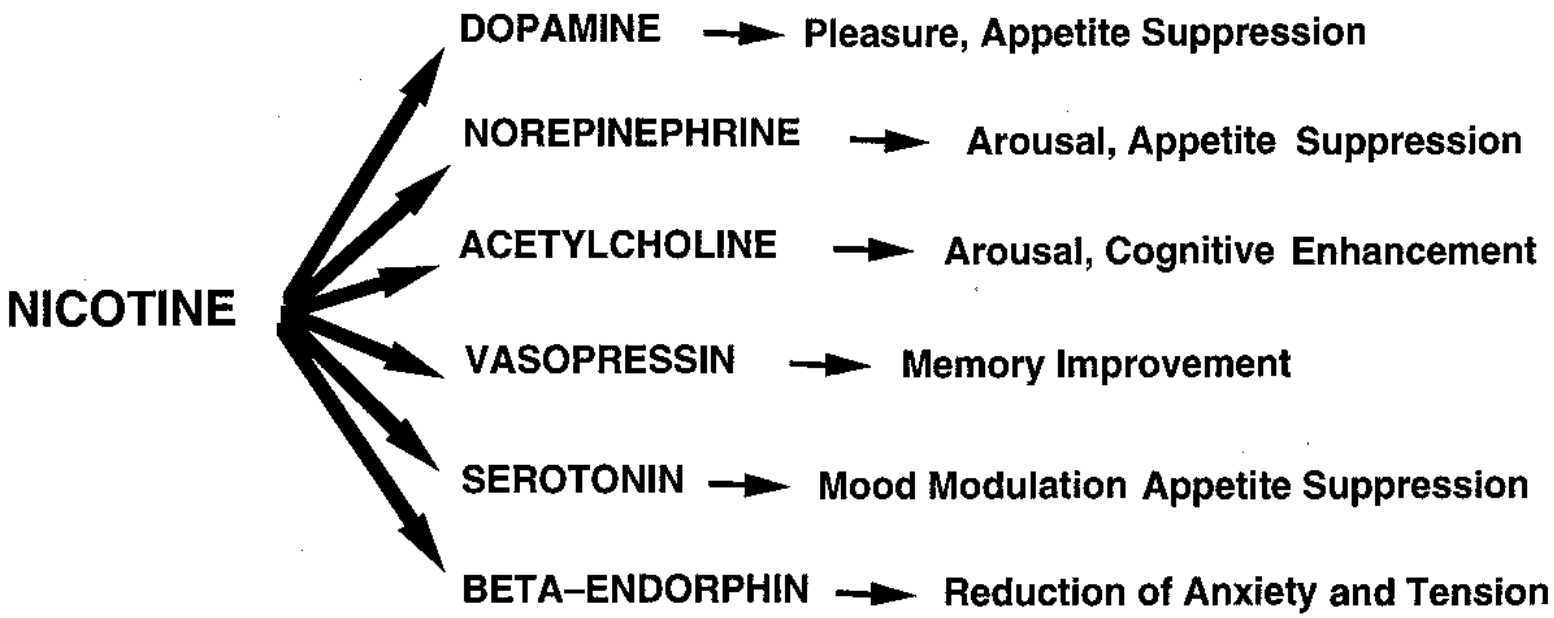
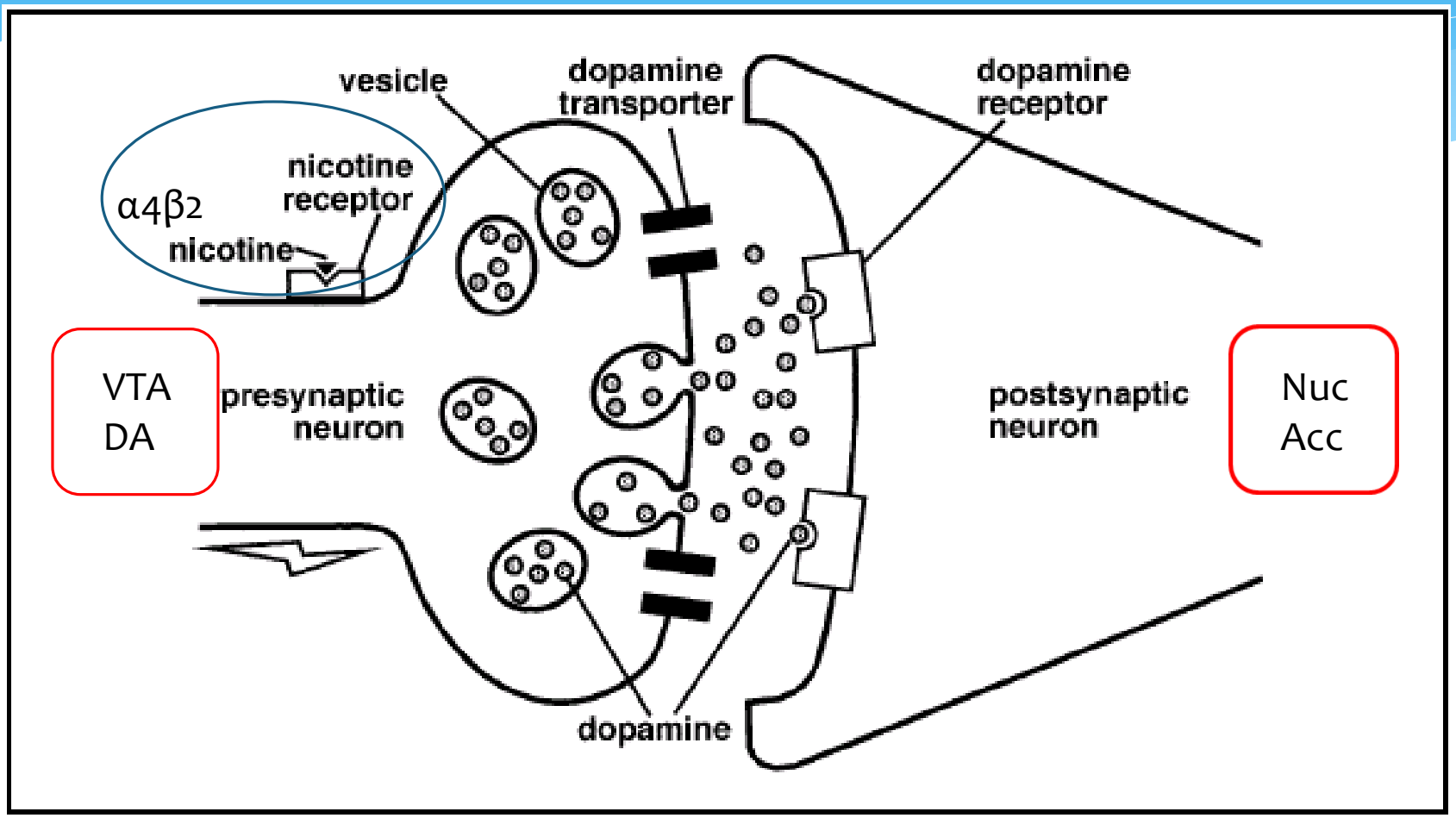


Figure 1. Neurochemical effects of nicotine.

Nicotine Addiction



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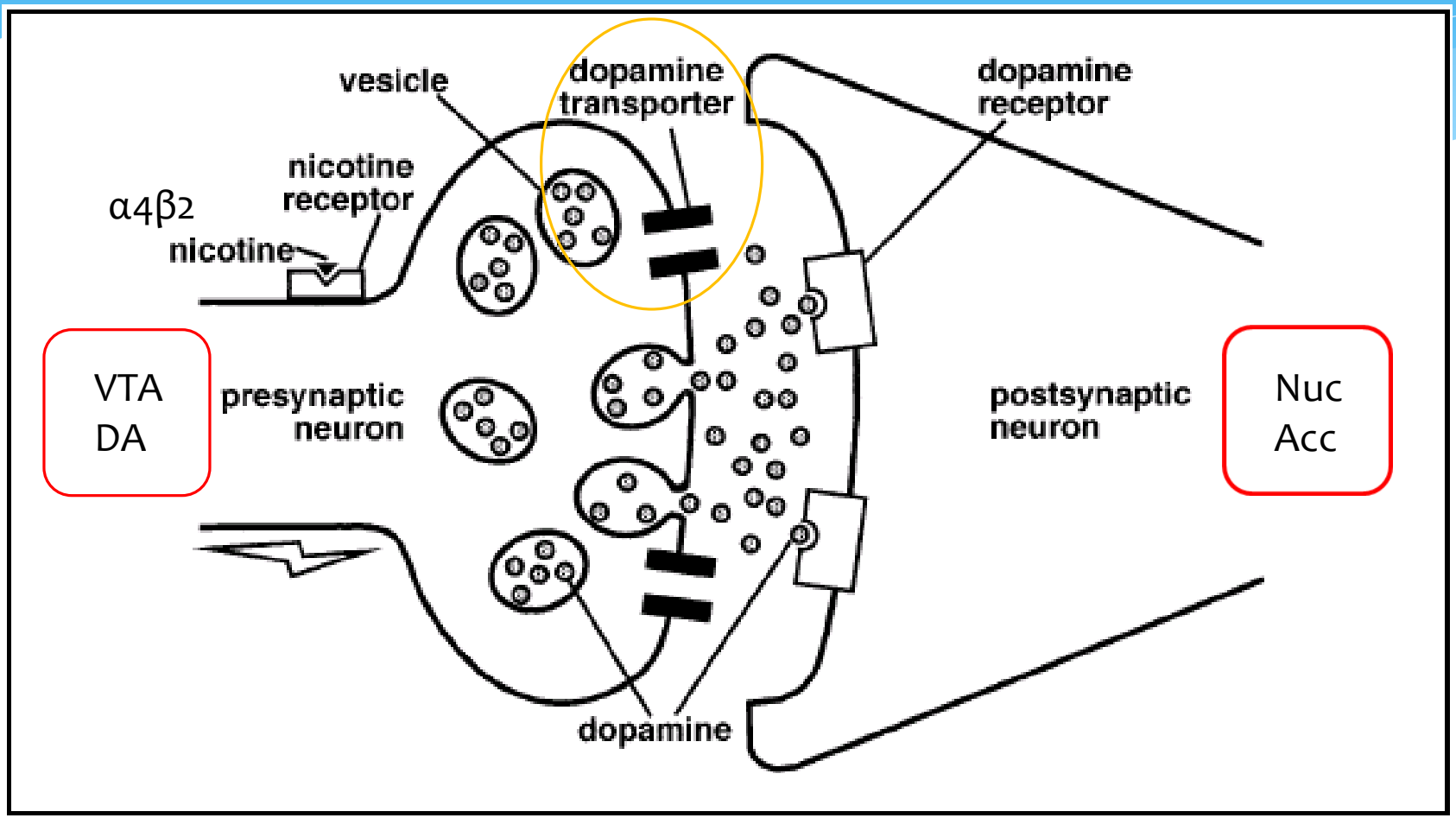

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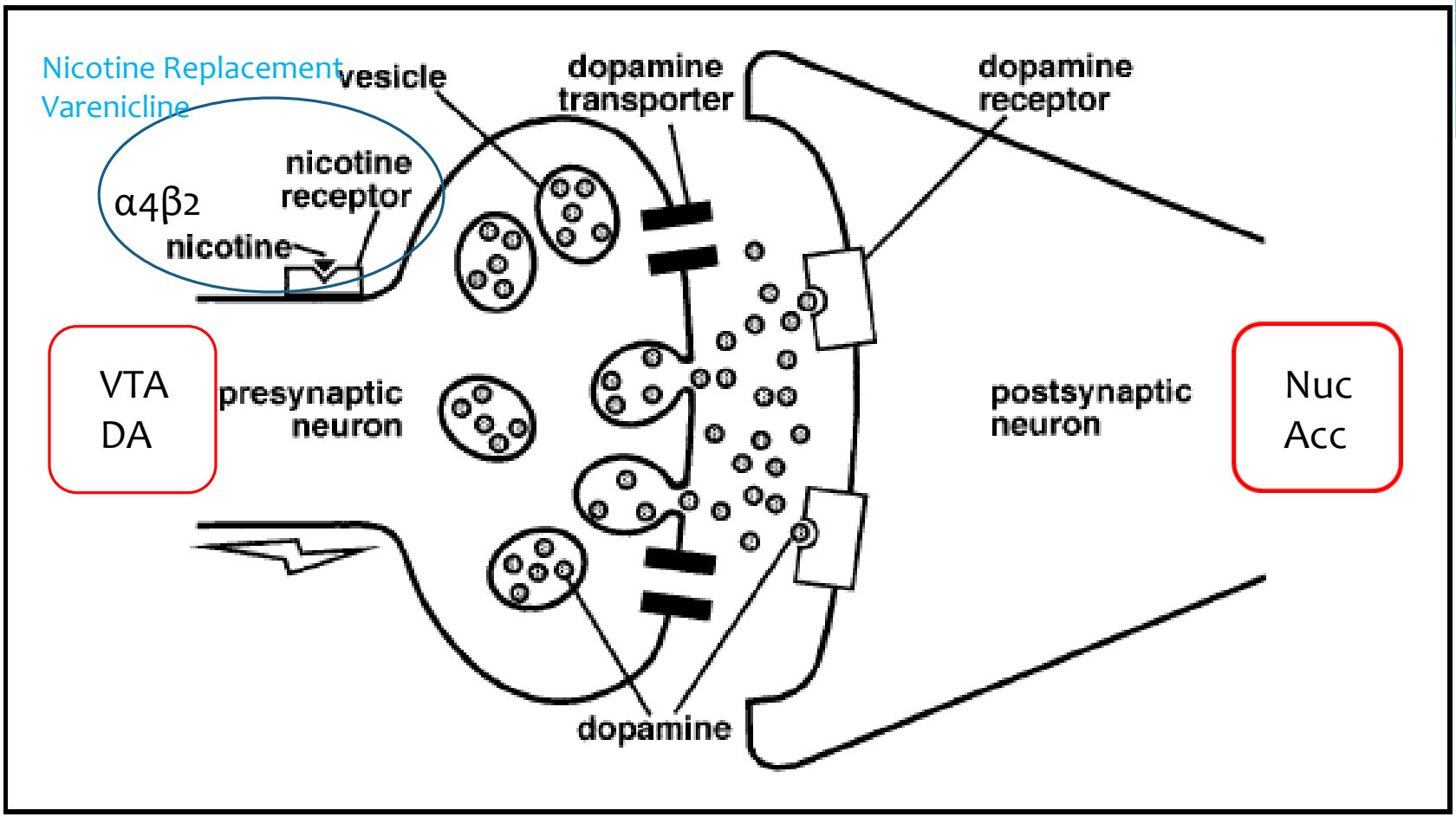
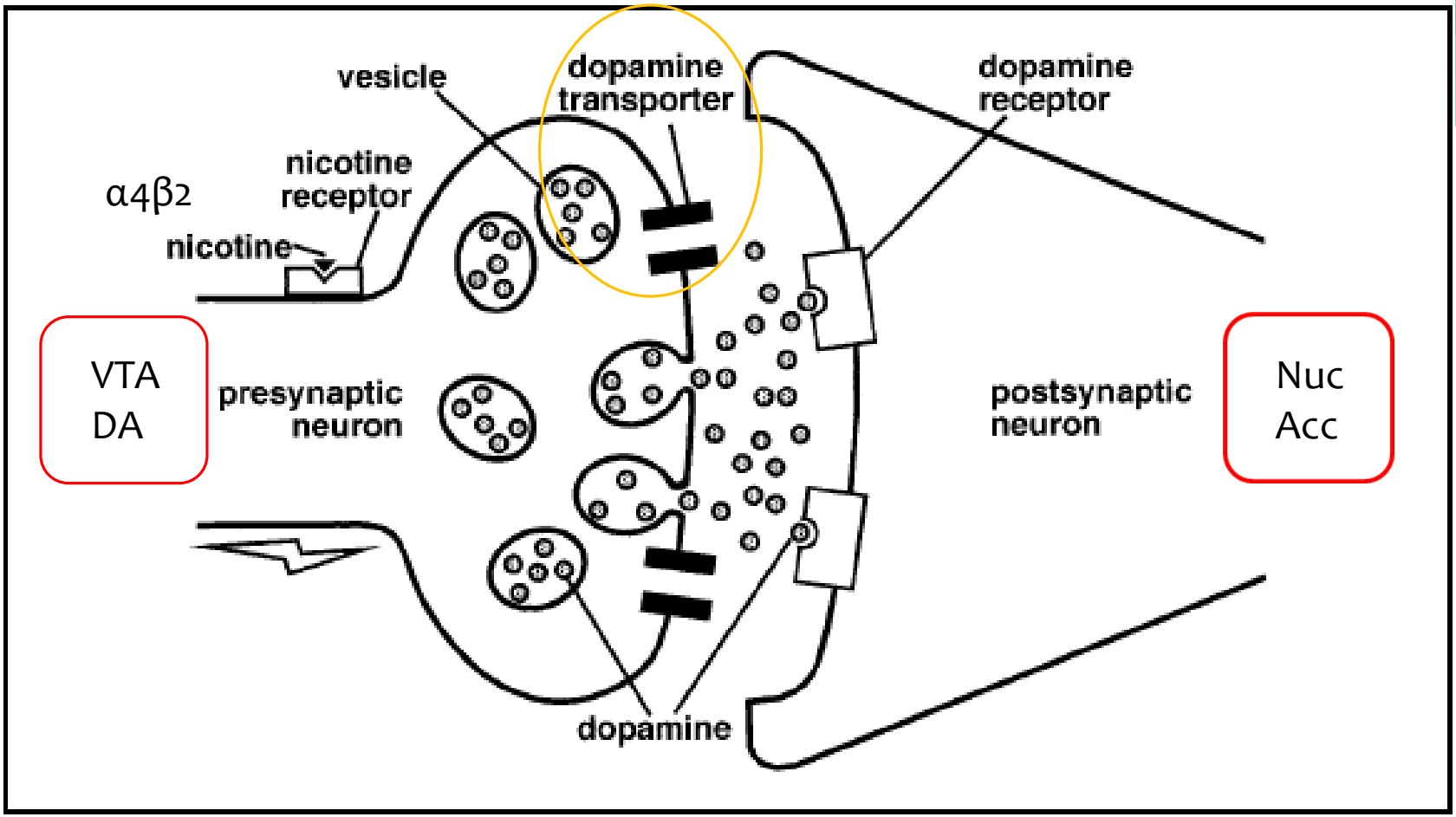
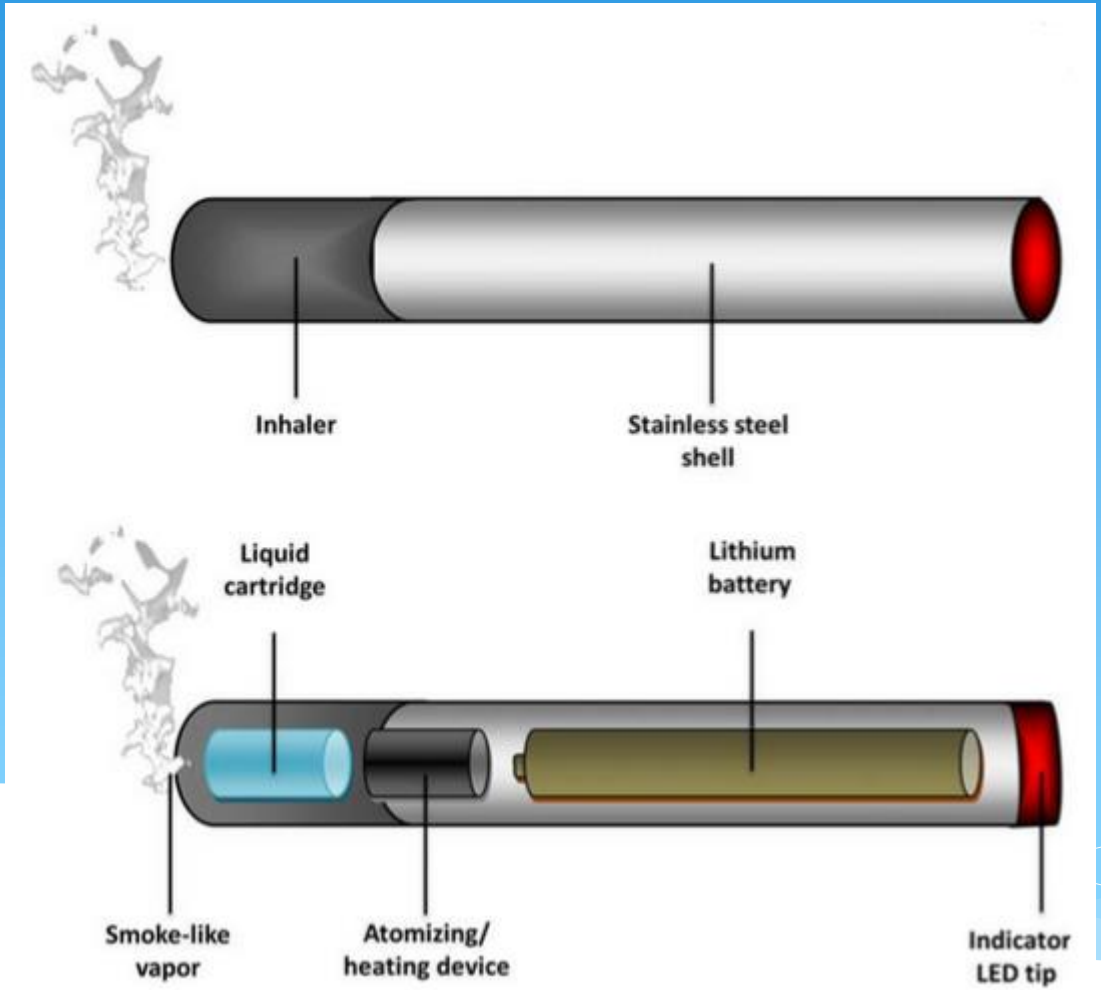


Nicotine Addiction

Bupropion



Do Electronic Cigarettes Help with Quitting?



Cochrane Database 2014

"There is evidence from two trials that ECs help smokers to stop smoking long-term compared with placebo ECs. However, the small number of trials, low event rates and wide confidence intervals around the estimates mean that our confidence in the result is rated 'low'."

Most Recent Data

http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0122544

Conclusions:

* Meta-analyses included 1,242 participants who had complete data on smoking cessation.
* Nicotine ecigs more effective for cessation than those without nicotine (pooled Risk Ratio 2.29, 95%CI 1.05-4.97).
  * 224 (18%) reported smoking cessation (minimum period of six months).
  * Use also associated with a reduction in the number of cigarettes used.

Yes, but…

* Ecig use among youth/young adults associated with alcohol and other substance use
* Youth gateway to leaf tobacco use?
* Nicotine = Harm to developing brain
* Toxicants contained in ecigs have not been fully disclosed
* Not regulated by FDA
* Accidental child ingestion of liquid nicotine
* Dual use/maintaining use of cigs (if no intention to quit).

Yes, but…

* Toxic compounds found
  * formaldehyde,
  * acetaldehyde, and
  * Acrolein
  * toluene
  * carcinogenic TSNAs
  * heavy metals (cadmium, nickel, and lead) higher than in conventional cigarettes
    * levels of toxins 9- to 450-fold lower than conventional cigs

Yes, but…

* Increase in impedance, peripheral airway flow resistance, and oxidative stress among healthy smokers
* Long-term effects unknown (propylene glycol)
* Some positive health effects?
  * including reduced carboxy-hemoglobin
  * increased oxygen saturation

Other Therapies for Smoking Cessation

Therapies	Evidence that it helps?
Varenicline, nicotine replacement, bupropion, clonidine, nortriptyline	
Anxiolytics	
Antidepressants (besides bup and nortrip)	
Doctor's, nurse's or pharmacist's advice	
Psychosocial mood management (e.g., CBT for anxiety and depression)	
Naltrexone	
Accupuncture or hypnosis	
Proactive Telephone Quitlines	
Exercise	
Individual OR group therapy	

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Exercise	Maybe
Individual OR group therapy	Yes (for both)

Tobacco Counseling is Effective!

Counseling	Odds Ratio	Abstinence Rate (%) Tx/No Tx
None	1.0	10.9
< 3 minutes	1.3	13.4/10.9
3-10 minutes	1.6	16.0/10.9
>10 minutes	2.3	22.1/10.9

http://www.ahrq.gov/clinic/tobacco/slideoverview/brftobaccosl03.htm

Tobacco Cessation Pharmacology

Therapy	Odds	Abstinence Rate (%) Tx/Placebo
Nicotine Patch	1.9	17.7/10.0
Nicotine Gum	1.5	23.7/17.1
Nicotine Inhaler	2.5	22.8/10.5
Nic. Nose Spray	2.7	30.5/13.9
Two NRTs (patch plus gum or spray)	2.2	28.6/12.8

(1 cigarette = 1 mg nicotine)

NON Nicotine Pharmacotherapy

Non-Nicotine Agent	Odds Ratio	Abstinence Rate tx vs placebo
Bupropion	2.1	30.5/17.3
Clonidine 0.1-0.75 mg qd	2.1	25.6/13.9
Nortriptyline 25 mg qd, titrate to 75 mg qd	3.2	30.1/11.7
CHANTIX® (varenicline) 0.5 mg titrate to 1 mg	3.9	44.0/17.7 JAMA. 2006 Jul 5;296(1):47-55

7/1/2009
The FDA is notifying the public that the use of Chantix (varenicline) or Zyban (bupropion hydrochloride), two prescription medicines that are used as part of smoking cessation programs, has been associated with reports of changes in behavior such as hostility, agitation, depressed mood, and suicidal thoughts or actions.

Varenicline use in Mental Illness?

* Smokers have a 2-3 fold increase risk of suicide already
* Confounding with alcohol and substance abuse
* Known high prevalence of psych co-morbidity
* Studies in 2008-2010 showed a signal?

Varenicline use in Mental Illness?

* Post marketing reports of depression, suicide and self-injury
  * Moore et al. PLoS ONE. 2010;5:e15337.
  * Kuehn BM. JAMA. 2012;307:129–130.
  * Harrison-Woolrych, Ashton. Drug Saf. 2011;34:763–772.

Tonstad, Drug Saf. 2010; 33;289

* Pooled analysis of 10 RCT which used varenicline to assess suicide risk
* >5000 patients
* Pts with psychiatric disorders EXCLUDED from original studies (these are NOT your patients)
* No significant increase in psychiatric adverse events "except sleep."??????????????????

Tonstad, Drug Saf. 2010; 33;289

10 pooled studies	Varenicline (n=3091)	Placebo (n=2005)	RR	95% CI
Any Serious Adverse Event (AE)	66	45	0.95	0.65-1.38
Any psychiatric AE	946	418	1.46	1.33-1.62
Only sleep AE	615	224	1.78	1.54-2.05
Any psychiatric AE except sleep	331	194	1.10	0.93-1.31

Note: diagnoses without objective scales; psychiatric patients were excluded.

Garza D. Biol Psychiatry. 2011;69:1075–1082

* 110 pts WITHOUT psychiatric illness
* Authors admit "underpowered"
* Pilot study, "no inferential statistics"
* But….they did use scales:
  * Scales: Depressive symptoms, anxiety, aggression, and irritability (baseline and weekly)
    * Montgomery-Åsberg Depression Rating Scale (MADRS)
    * Hamilton Anxiety Scale (HAM-A)
    * Overt Aggression Scale—Modified (OAS-M)
    * Profile of Mood States (POMS) was administered daily.

Garza D. Biol Psychiatry. 2011;69:1075–1082

	Varenicl. (n=55)	Placebo (n=55)	RR	95% CI
Psych. AE	28	23	1.22	0.81-1.83
None	201	203		

Despite "no inferential statistics", they concluded "no difference" b/t varenicline and placebo (but underpowered to make this statement).

Stapleton et al. Addiction. 2008 Jan;103(1):146-54

* To compare safety and effectiveness in smoking cessation patients with and without mental illness.
* 412 not randomized; consecutive patients. NRT and varenicline pre/post assessment
* Conclusion
  * "No evidence varenicline exacerbated mental illness"
  * "Equally safe and effective as NRT"

Stapleton et al.

	Varenicline (n=208)	Nicotine (n=203)	RR	95% CI
Anxiety/panic	7	1	6.8	0.85-55.0
Low mood/depression	10	2	4.90	1.09-22.1
Any mood change	17	3	5.61	1.67-18.8

There WERE mood changes, despite saying there were not

Stapleton et al.

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Any mood change	17	3	5.61	1.67-18.8

100% rated as mod to severe

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* Cytisine has potential as a safe, effective and affordable treatment.

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* Combination use of NRT is as effective as varenicline, and more effective than single types of NRT.
* Cytisine has potential as a safe, effective and affordable treatment.
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* Safety of varenicline needs to be followed (suicidality, depression)

The 5 As for Treating Tobacco Use & Dependence

Ask about tobacco use. Identify and document tobacco use status for every patient at every visit. (~1 minute)

Advise to quit. In a clear, strong and personalized manner urge every tobacco user to quit. (~1 minute)

Assess willingness to make a quit attempt. Is the tobacco user willing to make a quit attempt at this time? (~1 minute)

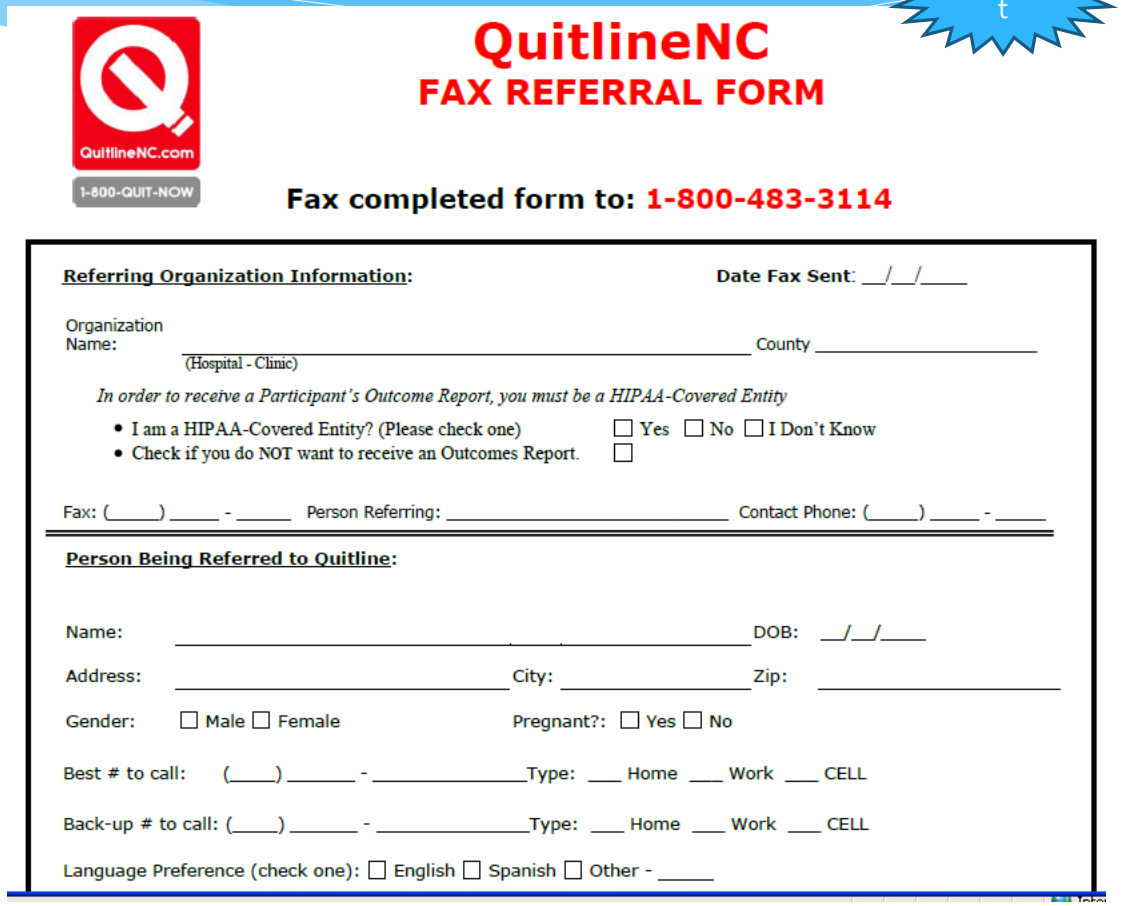
Assist in quit attempt. For the patient willing to make a quit attempt, use counseling or pharmacotherapy to help him or her quit. (~3 minutes)

Arrange followup. Schedule followup contact, preferably within the first week after the quit date. (~1 minute)

Refer to QuitlineNC

- If a patient is ready to quit, inform of NC Quitline services
  - Fax referral
  - Web coach
- Who will send?
  - not clinician; nurse, intake? Upfront staff?

Packet



QuitlineNC.com
1-800-QUIT-NOW

QuitlineNC
FAX REFERRAL FORM

Fax completed form to: 1-800-483-3114

Referring Organization Information: **Date Fax Sent**: __/__/____

Organization Name: _____ County _____
(Hospital - Clinic)

In order to receive a Participant's Outcome Report, you must be a HIPAA-Covered Entity

- I am a HIPAA-Covered Entity? (Please check one) ☐ Yes ☐ No ☐ I Don't Know
- Check if you do NOT want to receive an Outcomes Report. ☐

Fax: (____) ____ - ____ Person Referring: _____ Contact Phone: (____) ____ - ____

Person Being Referred to Quitline:

Name: _____ DOB: __/__/____

Address: _____ City: _____ Zip: _____

Gender: ☐ Male ☐ Female Pregnant?: ☐ Yes ☐ No

Best # to call: (____) _____ - _____ Type: ___ Home ___ Work ___ CELL

Back-up # to call: (____) _____ - _____ Type: ___ Home ___ Work ___ CELL

Language Preference (check one): ☐ English ☐ Spanish ☐ Other - _____

Summary: 5 As & Pharmacotherapy

* If nothing else: Ask, advise, refer
  * Can be very brief (< 1 minute)
  * Every patient at every visit
  * Refer to Quitline
* Urge virtually all regular tobacco users to use nicotine replacement
* For those interested, discuss triggers, negotiate a plan together.
  * Alcohol and stress are common triggers
* Bottom line message: *"There is no safe exposure to tobacco."*

Questions?

Sitting Bull and Custer share the peace nicotine patch.