Notes from a Smoking Cessation Clinic

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The availability of nicotine polacrilex as an adjunct to smoking cessation offers another way for primary care and chest physicians to become involved in one of the most important aspects of preventive medicine in our time. While accompanying package information and literature are helpful, there are many unanswered questions regarding actual practical applications. The following relates my recent experience with use of nicotine polacrilex in a smoking cessation program. New ideas and approaches, especially regarding behavioral modifications and stress management, are continually incorporated into the smoking cessation effort.

New approaches to smoking cessation, such as the use of nicotine gum, garner considerable public interest. This is to be expected since such a high percentage of the population smokes. Unfortunately, much of this interest is coupled with a superficial desire to quit smoking. It is important and helpful to give information on the goals, costs, scope, and limitations of a smoking cessation program when patients ask for information. This serves to discourage impulsive quitting and gives the patient a chance to reflect on his current degree of motivation to quit smoking.

Because the approach to smoking cessation is similar between one patient and another, I have found it convenient to deal with groups of four to five persons. As the people in the group get to know each other, they support each other and, to some extent, provide peer pressure. Small groups also enable me to see more people/week in a smaller period of time.

As my smoking cessation program developed, it became apparent that frequent visits are necessary in the early stages of quitting. Typically, four weekly visits are followed by three to six follow-up visits (or telephone conversations) at two-week intervals. The first four visits are used to introduce use of the nicotine-containing medication and the following visits are for reinforcement of nonsmoking and tapering off the medication (Table 1).

Session One

In my first smoking cessation groups, I had people start chewing nicotine polacrilex during their first visit. However, this proved to be less than optimal, and following the recommendations of my patients, the first session is now an orientation. There is a need for a "breaking-in session," ie, a chance for people to become comfortable with the program, with the idea of quitting, and with each other. The first session now deals with the factors that determine continued smoking, such as psychologic forces and the physiology of nicotine withdrawal. Patients are encouraged to develop the idea that successful quitting is largely self-taught. Finally, reasons to not continue with the program are sought. Is there another major ongoing stress, eg, death in the family, divorce, trouble at work, etc? Is the participation self-induced or the result of pressure from co-workers or a spouse? Is a spouse or other household member a smoker? I now encourage spouses to quit together; the odds of one quitting while the other continues to smoke are not favorable.

At the conclusion of this session, those who choose to enter the program cast their vote of confidence with a check. Those who have decided they are not ready, or that this program will not help them, have the chance to drop out now at no charge.

The introductory session has proven quite useful. Those who genuinely feel they will not benefit from the program drop out, a decision which is better for all concerned. Those who have chosen to stay have shown a marker for motivation. The following week is set as a target quit date. To prepare, I encourage people to identify which cigarettes are "key," those which are the most important to them in their smoking

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<td>1</td>
<td>Session one—orientation</td>
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<td>1)</td>
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<tr>
<td>1)</td>
<td>Reinforce smoking cessation</td>
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<td>Those who continue to smoke are &quot;rejected&quot;</td>
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<td>5</td>
<td>Sessions five through eight—Highly individualized approach. Office visits for some; telephone contact for others. Tapering of medication, usually one piece per week.</td>
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habit. These key cigarettes can be very hard to eliminate even with the use of nicotine polacrilex, and it is reasonable to identify them early. On their return, patients are advised to stop smoking cigarettes three to four hours prior to arrival at the clinic. This means the desire for a cigarette will be strong during the second session when nicotine polacrilex is introduced.

Session Two—Target Quit Date

The patient fills his first prescription of nicotine polacrilex and brings it to clinic. I give a brief discussion on how to chew the medication, how to open the blister packs, and have people start chewing their first piece. After they start, a brief overview of side effects is presented. The sensation of nicotine absorption is discussed. Many patients relate that the nicotine gum is satisfying, and can immediately see how it will suppress their urge to smoke in the coming weeks. It is useful to stress at this point that the medication is not the same as smoking, and should not be thought of as a complete substitute for the cigarette.

The use of nicotine polacrilex requires that the patient determine his own optimal dose. This is quite different from our usual concrete prescribing practice, such as “take one four times daily for ten days.” This can be quite a stumbling block for many smokers who want to have specific directions such as “23 pieces are equivalent to 20 Marlboros.” There is tremendous variability in the dosimetry of nicotine among smokers. Thus, there is no reliable way to equate cigarette usage with number of pieces of nicotine polacrilex. Smoking patterns are as individualized as a fingerprint; some smokers use up to 30 pieces/day the first week, while others use one per day.

Session Three

On this return visit, the experience with the medication and attempts at becoming cigarette-free are discussed. The goal is, of course, to completely switch to nicotine polacrilex and participants are reminded of that goal. One problem at this point is that those who do no completely quit smoking may be reluctant to come back. Many of them have told me that they “didn’t want to be the one who spoiled the success of the group.” In my experience to date, only about 50 percent are completely cigarette-free after one week. Early discouragement can be overcome. Those who are cigarette-free are asked to relate how they gave up all cigarettes. These ideas can be quite valuable to those in the group trying to clear the last hurdle. This is as an opportunity to review nicotine pharmacology, and what to expect from this medication. The most common difficulty in this session is failure to use enough medication. Despite careful instructions, patients tend to underdose. The reasons for this have not been studied, but my patients tell me they are afraid of getting hooked. Be aware of the possibility that some will be chewing medication yet still have a terrible craving for cigarettes, somewhat defeating the logic of using nicotine polacrilex as an adjunct to quitting.

This session is most revealing in terms of the roles of pharmacologic vs psychologic addiction to smoking. The medication is a tremendous help, but some find they just “have to smoke” at certain times of the day, or in certain social situations. Recreational and social events involving alcohol leave most quitters too vulnerable to smoking. This is a temporary sacrifice, and in a few short weeks it is easier to attend these functions and resist smoking.

About half of the 50 percent who are still smoking will progress onward to being cigarette-free during the course of the program. Ideas obtained from other members of the group are invaluable. Advice from another smoker seems to have increased validity. Additionally, small groups introduce some “peer pressure,” which can be very advantageous. Session three closes with encouragement for those who need it, and a “pat on the back” for those who are cigarette-free.

Session Four

By this session, the group has subdivided: cigarette-free vs smoking. There is a certain comfort in using nicotine polacrilex to cut down. After all, it seems intuitively obvious that to go from 30 to 40 cigarettes a day to three to five cigarettes plus medication is progress. In many ways it is, particularly in view of the well established dose relationship between smoking and disease. Cutting down is not the goal, though, so for those still smoking, I offer them a second chance at the program, scheduled at their convenience, and at no charge. I do not refill prescriptions of nicotine polacrilex for those who continue to smoke.

For those who have achieved the cigarette-free state, I introduce the concept of tapering the medication. Up until now, its use has been ad lib, but now I suggest concrete numbers. Nicotine polacrilex treatment can be tapered in a fashion similar to that used to taper steroid therapy. Tapering of nicotine polacrilex therapy can be done with either telephone contact or brief office visits and a calendar with numbers of pieces of medication to be used per day with reduction of one piece per week. For example, a patient using eight pieces/day goes to seven per day for a week, then to six, etc. Patients are encouraged to call with progress reports every two weeks, or schedule a five-min visit if they desire.

In the rare instance that a patient just can’t seem to quit the medication, a very slow tapering process may be necessary. Rather than cut down by a full piece, maybe reduce by $\frac{1}{2}$ piece per week. For this type of individual, tapering may take
six months rather than three.

**Does It Work?**

Measurement of success in a program like this is complicated. Undoubtedly, some people quit because of the program. Others quit, but may have quit anyhow. If a patient lapses back into smoking, is this a failure? Maybe. But on the other hand, the educational experience gained from the smoking cessation clinic, the interactions with the interventionist and other patients going through the process of quitting may lead an individual to reformulate his approach into a successful attempt later. While success is easily determined, failure is not so easily defined.

There are limitations to a program of this nature. The real impact on smoking lies in prevention, not cessation. However, for adult patients who smoke and seek the intervention of a physician or health educator, nicotine polacrilex has proven useful. As an internist, my knowledge of behavioral medicine is bolstered by interactions with health educators and behavioral psychologists whose training and experience in behavioral medicine augment my own. With adequate follow-up and support, smoking cessation is an achievable goal.

Smoking cessation intervention can be time-consuming and discouraging, yet there is a special warmth in successfully helping someone quit. Anyone can wear a button with a clever slogan, but to actually make an impact on an individual smoker takes dedication. Ongoing research in behavioral aspects of smoking and development of new pharmacologic approaches will improve our ability to help people quit the usage of cigarettes.