

Science **AGAINST** smoking

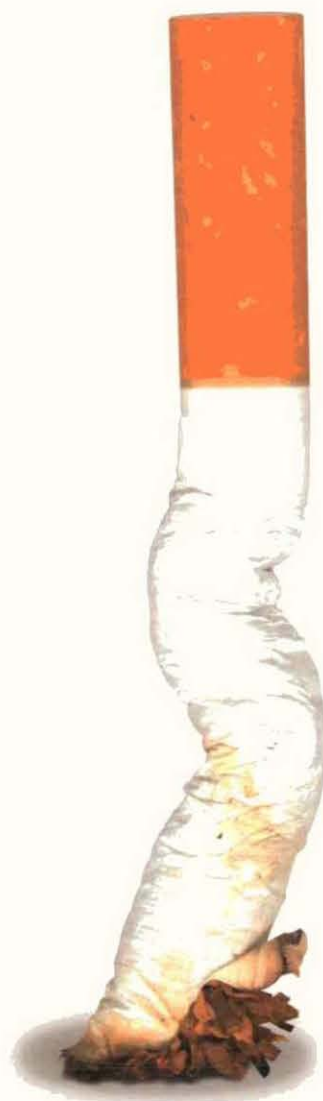
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The challenges for Ireland

*An Irish report from the 3rd
European Tobacco or Health
Conference, Warsaw, Poland*

CONTRIBUTORS

Dr Michael Boland, General Practitioner; Dr Patrick Manning, Consultant Respiratory Physician; Dr Terry Maguire, Community Pharmacist; Anna Magee, Award Winning Health Journalist; Gerry McElwee, Ulster Cancer Foundation.



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References: 1. B&A Survey, 500 smokers, June 1998. 2. Schiffman S *et al.* Comparative efficacy of 24 hour and 16 hour transdermal nicotine patches for relief of morning cravings 18 February 2000

 GlaxoSmithKline

Award winning commentator Anna Magee was struck by the impending health catastrophe which will result from smoking trends worldwide. Patients need help to quit and healthcare professionals are being advised to urgently provide it, she reports

Overview

- ▶ Earlier this year, Europe's first Health Commissioner, our very own David Byrne, along with 24 other EU Representatives, signed the Warsaw Declaration for a tobacco-free Europe. It acknowledged that 'the tobacco epidemic is one of the greatest public health challenges facing the World Health Organisation's European region'. This is a challenge that needs a joint response.

Ambitiously sub-titled 'Solidarity For Health', the 3rd European Conference on Tobacco or Health (or ECTOH) in Warsaw in June sought to mobilize Europeans to action on tobacco control. With it's huge turnout of medics and other health professionals, including some of the biggest names in tobacco control worldwide, the conference represented the nuts and bolts of last February's Declaration – the how, the why and most importantly, the when.

The exigency of the smoking epidemic - particularly among young women, teenagers, and even children - with all it's black-and-white, indeed life-or-death consequences, was repeatedly highlighted, and particularly eloquently by Poland's glamorous First Lady Jolanta Kwanieswska in her welcoming speech to delegates: "It is saddening for me that 10,000 European children start smoking everyday. Especially horrifying, when we realize that at least half of these children will become ill because of smoking."

A consistently recurring concern was the dire need for umbrella European tobacco-control policies and – most importantly – their implementation at grass-roots level. "Since many of us last met in Chicago for the 11th World Conference on Tobacco or Health in August 2000," said Dr Gro Harlem Brundtland, Director General of the World Health Organisation (WHO), "nearly 6 million people have died due to tobacco." In light of this, a day or so into the conference, one could detect a 'throwing-up-of-hands' sub-text in many of the presentations. Implicitly, they seemed to ask, 'What are we doing wrong?' - not surprising given the rise in smoking and smoking related diseases, despite repeated health messages.

"Quite frankly," continued Brundtland, "any delay in implementing effective policies means more deaths." Such forthright language would set the tone for the entire conference. In a word: Urgency!

Dangers and prevalence of smoking

Distinguished Oxford statistician and epidemiologist Sir Richard Peto didn't mince his words in a riveting presentation in which the massive global danger of tobacco was brought home. In the 20th Century tobacco caused about 100 million deaths. If current trends continue tobacco will cause one billion deaths in the 21st Century. Coupled with the statement that half of smokers will die from their tobacco habit, Peto's delivery added up to some pretty alarming stuff.

Still, the Polish example, presented by Conference President Witold Zatonski, is an encouraging one. In the mid-1970s, Poles were amongst the biggest consumers of cigarettes in the world. But over the last ten years a national tobacco control strategy, comprising public awareness campaigns and population based smoking cessation programmes, has reduced smoking frequency in the adult population from 60% to 40% in men and from 30% to 25% in women. But the message is two-fold. Surveys found that those who quit were generally wealthier, better educated than their still-smoking counterparts. Furthermore, the last decade has seen a dramatic difference between levels of tobacco-dependent diseases between better and less educated young adults. The moral of the story? The Polish example is reflected in the results of health campaigns in other countries also and shows that the tobacco control message reaches those better educated far more effectively than it does those less educated. The answer? More targeting of local populations in tobacco and health programs.

The Eastern Bloc countries show an alarmingly high prevalence of smoking, primarily, it seems, because of misconceptions about smoking's impact and danger and because of the hand-in-hand nature it takes with social and economic inequality – rampant in the current climate. One paper from Armenia found that 80% of smokers believed smoking bettered one's intellectual potential and a massive 78% of smokers believed that they could and would abandon smoking if their own social, economic and financial conditions were bettered.

Women and smoking – curbing the epidemic

Recently the WHO reported a sharp increase in female deaths from cancer of the trachea, bronchus and lung caused by smoking. In fact, in EU countries tobacco-related cancer is rising more rapidly among women than among men.

And while more women in Eastern Europe are taking up the habit – smoking in Russia among women doubled in the last ten years – their Western European counterparts are dying from it in ever-increasing numbers. In the EU, the number of female deaths caused by smoking rose from 10,000 in 1955 to 49,000 in 1975 to 113,000 in 1995.

Fatalities aside, biology means that women suffer even more from tobacco because of it's adverse affects on fertility and pregnancy. Women who use oral contraception and smoke have a far higher risk of circulatory problems and cancers of the reproductive system.

So what's to be done? A mass media campaign in The Netherlands experience suggests that using television programming on a nationwide, regular basis has a greater impact on getting women to quit than men. A series of TV shows created hype around the 'quit for the millennium' idea



Anna Magee

"To support clinicians effort, healthcare systems and guidelines need to include the management of relapse and allow for repeated and long-term interventions,"

– Michael Fiore

- ▶ and aimed to increase social pressure to give up with the motto; "I can do that too (or better)." Not only did more women watch the programmes, but interestingly, after the campaign a significant decline in smoking was reported nationwide – but only among women.

Benefits of treatment

Hearteningly, Sir Richard Peto's presentation wasn't all bad news. "While it matters if children start, it also matters if adults stop. If an adult smoker stops – say by age 35 – it would eliminate most if not all of the risks their smoking had caused to their health," said Peto, emphasising the benefits of quitting – despite age. "Even if someone stops at 50," Peto stressed, "their risks are well reduced."

On a nuts and bolts treatment level, Saul Shiffman from the Smoking Research Group in the University of Pittsburgh had some interesting findings. Firstly, he found that nicotine gum and patches bought over-the-counter were as effective as prescription remedies in helping smokers quit. Encouraging results were also found with the nicotine lozenge. There was significantly greater 28 day abstinence at six weeks and a significant proportion of trial participants remained stopped after a year – the more lozenges used, the better were the treatment effects.

Pharmacotherapy for the prevention of relapse

But only 3-7 per cent of those who try to quit 'cold turkey' are still abstinent one year later. Meanwhile, using bupropion or NRT therapy can increase that quitter's chances by some 25-35 per cent. But that leaves a vast majority who fail. And so amongst the treatment issues addressed, relapse was a prime concern. "To support clinicians effort, healthcare systems and guidelines need to include the management of relapse and allow for repeated and long-term interventions," said Michael Fiore from the University of Wisconsin's Medical School. What that means is the use of long-term pharmacotherapy for the prevention or management of relapse. The issue was also addressed by pioneering Zyban researcher Dr Andrew Johnston, "Recent data also indicate that continued treatment for up to one year with Zyban is efficacious in helping prevent relapse to smoking and fewer patients on Zyban report craving as a cause for relapse. In addition, Zyban is associated with long-term attenuation of the weight gain that accompanies smoking cessation. Lastly, in patients that do relapse following an initial course of treatment with Zyban, re-treatment has been shown to be effective."

Anna Magee is a freelance consumer journalist and winner of the 2002 Irish Medical Media Award

Dr Michael Boland reports from the 3rd European Tobacco or Health Conference on why family doctors should care more about smoking and details the practical steps that can be taken to address addiction among patients

Overview

- ▶ Earlier this year the 3rd European Conference on Tobacco or Health devoted one of its sessions to the topic 'How to engage health providers in tobacco control'. One session in particular considered how tobacco control could be strengthened in the practice of family doctors (GPs).

There are currently one billion smokers worldwide. In the developing world the number of smokers is rising exponentially driven by a global tobacco industry worth \$400 billion dollars a year. Most of their marketing is focused on young teenagers in the certain knowledge that once addicted the majority of them will never be able to stop. The number who die annually of smoking related illnesses will reach 10 million over the next two decades. Seventy per cent of these deaths will be in developing countries. By 2030 smoking will be the leading preventable cause of death in the world.

Passive smoking is now recognized as a major problem. For passive smokers the risk of lung cancer is increased by 24%, tobacco specific carcinogens are found in the blood and urine of passive smokers and there is a predictable dose/response relationship to the number of cigarettes. The impact of passive smoking on heart disease and stroke is even more pronounced.

Smoking and the problems for spouses

In addition passive smoking is a particular problem for spouses and colleagues in the workplace. Children don't escape either. Numerous studies have identified tobacco smoke as a trigger to asthma. Its importance in the aetiology of sudden infant death syndrome has been established. It may be a factor in as many as half the cases. Passive smoking increases the chances of pregnancy complications and low birth-weight. As GPs we have a duty to warn patients and their families of the dangers of living, working or socializing in smoky places. Smokers should know that their habit damages not only themselves, but their families, colleagues, and friends as well.

GPs represented only a minority of those attending the conference. Most delegates were fully engaged in what might be described as the tobacco control industry. In their view general practice provided a great opportunity for persuading patients to quit. They were dismayed and frustrated because it appeared to be vastly underused.

As President of the World Organization Family Doctors (Wonca) I was pleased to be able to report that tobacco control had been chosen as one of the two advocacy issues during my term of office.

I reassured them that most GPs were well aware of the devastating effects of smoking on their patients' health. They know from bitter experience that they must expect additional morbidity and mortality amongst smokers.

Reluctance to intervene

So why don't GPs intervene every time? To begin with most patients attending their GP are ill and it may not be appropriate to address other issues. Repeated intervention may antagonize patients. Some GPs may have become disillusioned because they had tried before and failed, because they felt they hadn't the skills, or because they no longer believed in the efficacy of their intervention. In some parts of the world GPs smoke themselves, making them less likely to intervene.

In spite of these limitations most GPs remained committed to tobacco prevention and cessation. This commitment applies at three levels: the first is by the use of brief intervention with individual patients; the second is by the creation of a 'tobacco aware' practice; and the third is by active national advocacy through their professional associations and colleges.

Brief intervention technique starts with simply asking permission to question the patient about smoking habits. This alone has been shown to be effective with 5% of smokers. The next step is to establish where the smoker is on the 'Cycle of Change'. The use of a 'Decision Balance' can be very effective in clarifying the strength of the patient's motivation to quit and the barriers to quitting.

With practice these initial steps can be taken very quickly. If it becomes apparent that the smoker is not contemplating quitting or perceives the barriers to be insurmountable then there is little point in continuing. To do so may simply antagonize the smoker. And the effort is not in vain because even these simple measures may have moved the smoker closer to contemplation. There will be other opportunities at future consultations.

If, however, the brief intervention identifies the smoker is ready and willing to quit then the consultation can be extended and/or follow-up consultations planned. These can be return visits to the GP, longer consultations with a trained Practice Nurse, or by referral to a Health Promotion Officer/Counsellor.

Aids to smoking cessation can double quit rate

Most importantly, a realistic plan for quitting must be made and supported by further review dates. Often nicotine replacement or other aids to smoking cessation will be prescribed and have shown to double the 'quit rate' to 10%. Possible failure at the first attempt should also be discussed. Undertaking extended consultations with all smokers is not only impractical in a busy practice but may be counter-productive because it irritates patients and leaves the doctor with a sense of failure. Therefore the identification of the patients who are ready to quit is essential.

In Ireland, where a GP sees 30 patients a day, on average about



Dr Michael Boland

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– Dr Michael Boland

- ▶ seven will be smokers. Less than one will quit given the right treatment and advice. From the seven a trained GP can identify one or two patients who are seriously contemplating quitting. To do so takes less than two minutes. A longer consultation (15 minutes) is offered to the two patients likely to quit. The total time added to the working day is thus 45 minutes. This is a significant professional commitment which will be made only if it is grounded in a firm conviction that it works and is worthwhile.

Why GPs have a unique role

Yet the GP is uniquely placed to address the problem of smoking. A GP is a chosen and trusted health adviser and usually has an accumulated knowledge of the individual and an understanding of the context of the patient's family, culture, and employment. S/he will have access to a comprehensive medical record which may contain evidence of smoking related problems. Seeing 66 per cent of the population in one year and 95 per cent in five years allows the GP contact with the vast majority of smokers.

In addition to this general screening for smokers who are ready to quit there will be specific opportunities when the subject of smoking may be appropriately raised. During antenatal or postnatal visits, the presentation of the sick infant or about childhood asthma are obvious examples. Discussion of cancer, cardiovascular disease, or a sudden death in family or friends, family planning, sports injuries in teenagers, of the frequent presentation of respiratory illnesses in winter time – all these can lead naturally to a discussion of smoking.

In addition to clinical intervention the GP should ensure that his or her practice is 'Tobacco Aware'. Together the practice staff should agree that they will not smoke themselves and that a non-smoking policy will be enforced throughout the building. Medical records will be designed to prompt staff to inquire about smoking habits and to record the information in a clear standard format. Thus the practice should know the number, age and profile of all their patients who smoke and

should set realistic annual targets for quitting. Posters and leaflets should be available throughout the practice. Staff should be skilled in brief intervention and longer interventions as appropriate. There should be a clear policy on referral.

At the national level through their professional organisations and colleges, GPs have a collective responsibility to demand a government action in relation to smoke. This should include making prebudget submissions on price and the removal of the cost of cigarettes from the consumer price index. They should support calls for a ban on all cigarette advertising including 'product placement' (particularly in films aimed at the teenage market) and 'brand stretching'.

Young people and price increases

It is known that teenagers are particularly sensitive to price increases. A survey of Irish teenagers conducted on behalf of The Office Of Tobacco Control indicated that a 50% price increase would reduce their consumption by a third and a 100% increase would reduce their consumption by almost 50%. Raising price can make smuggling more lucrative. However this can be countered by requiring all product to be batch-numbered by the tobacco manufacturers.

GPs should also support calls for the extension of controls on environmental tobacco smoke. The sale of cigarettes should be controlled by banning pack sizes less than 20, restricting display, banning vending machines, enforcing age limits, and establishing a register of outlets.

Finally GPs should continue to support the government in their commitment to the 'Framework Convention' of the WHO.

Dr Michael Boland MICGP, FRCGP, is Director of the ICGP Postgraduate Centre and President of the World Organisation of Family Doctors (WONCA).

Community Pharmacist Dr Terry Maguire believes it is ironic that NRT products go through the full rigours of drug licensing and have restrictions on their use imposed while tobacco products face no such restrictions

Overview

- ▶ Smoking Cessation is understandably a key aspect of public health policy in most developed countries. The health gain from reducing the prevalence of smoking within the population is clear cut. Half of all smokers who continue to smoke will die from their habit and half of those who die do so before the age of 60. So stopping smoking makes good sense. This year 8,000 people will die in Ireland as a result of smoking related diseases. Smoking related illnesses presents a huge burden to the economy – for example it costs the UK 2.5 billion annually.

Are we really doing enough to reduce the burden of smoking related illnesses?

Getting people to stop smoking is not easy and its even more difficult to get them to stay stopped. Mark Twain's quip, "Its easy to stop smoking – I've done it 50 times", sadly rings true.

Smoking cessation initiatives do bring success. Brief intervention from GPs, for example, has been shown to be effective and greater success is associated with more intense programmes such as those provided by pharmacists and nurses and in smoking cessation clinics.

Nicotine Replacement Therapy (NRT) also works and when used alone or within a smoking cessation programme, doubles the chances of success. So it makes sense to use NRT as widely as possible. There is no good evidence that any particular formulation of NRT is better than any other, therefore it's best to use the product that suits the smoker.

But are we really doing enough to help smokers stop and therefore reduce the burden of smoking related illnesses? When so few smokers are making a stopping attempt each year, and fewer still are staying stopped for more than 12 months, what more could be done?

It seems somewhat ironic that NRT products need to go through the full rigours of drug licensing and, as a consequence, have restrictions on their use imposed, while tobacco products have no such restrictions.

Time to consider harm reduction approach

As healthcare professionals and policy makers we have, perhaps, adopted an extreme and puritanical approach to smoking and the need for all smokers to stop. There is no doubt that cessation is the ideal scenario but this fails to appreciate the complex addiction that is cigarette smoking. Our approach may not serve the needs of many smokers, especially those who cannot or do not wish to stop.

If we really want to do more for smokers, maybe it's time to consider a harm reduction approach towards nicotine use in society to complement our smoking cessation policy. For smokers, the addiction is to nicotine, yet nicotine is not the hazard to health that is presented by other chemicals produced by burning tobacco. The main problem is the means by which nicotine is delivered to the brain.

Cigarettes are nicotine delivery systems. They are similar to the hypodermic syringe in heroin abuse, but in the case of cigarette smoking, the delivery system is a dirty one containing some 4,000 chemicals, many of which are highly toxic. There are other ways of delivering nicotine from tobacco that are associated with less harm.

Is it time for us to consider a harm reduction policy? Harm reduction has been used in other areas with considerable success. The term harm reduction refers to strategies for reducing the physical and social harm associated with risk-taking behaviour. Examples include; needle exchanges, purity standards for alcoholic beverages and safety glass in vehicle windscreens.

When it proves difficult to prevent harmful behaviour it may be possible to reduce the harm done. For those unable or unwilling to stop using nicotine can we offer a product that supports (or does not inhibit) users switching to less harmful forms of nicotine?

Unethical for healthcare professionals to ignore smoking

A harm reduction policy for tobacco needs to be discussed and debated. The issue must not be ignored – cigarettes cause too much damage to health. The Government needs to consider whether it will sanction such a policy rather than leave it to the tobacco industry to cynically fill this vacuum.

Before this, however, all healthcare professionals need to consider if they are doing enough to motivate, educate and facilitate patients in stopping smoking and staying stopped. Smoking cessation must not be a bolt on to the professional service we provide but must be an implicit part of our practice. It is unethical to ignore smoking, as the patient's condition is unlikely to improve until they stop.

As pharmacists, doctors and nurses committed to patient care we need to consider the smoking status of all our patients when they meet with us.

Smoking is that important and we need to consider if we are doing enough to reduce its affect on public health.

Dr Terry Maguire is a community pharmacist in Belfast. He is Vice-Chairman of the Pharmacy Healthcare Scheme, a UK charity that promotes health and well being to the public through pharmacies. He is also a member of the Committee on Safety of Medicines – the UK body responsible for the regulation of pharmaceutical products.



Dr Terry Maguire

As seasonal patients present at surgeries and clinics, Dr Pat Manning reports on the strong dose-response relationship between the amount of cigarettes smoked and the yearly rate of decline in pulmonary function

Overview

- ▶ Current legislation restricts smoking in public places such as cinemas, buses, and public buildings. These restrictions are usually not taken seriously and are often not enforced. One of the main reasons for this reaction among the population is lack of understanding of the health risks posed by passive smoking. Until non-smokers themselves understand the dangers of passive smoking they are unlikely to demand a clean non-smoking environment or the enforcement of current anti-smoking regulations. Non-smokers do not feel empowered to speak out and demand a smoke free environment, and smokers do not believe that exposure to second hand smoke is dangerous to non-smokers. This is similar to the attitude prevailing among the population about 15 years ago in the State of California, USA where nowadays virtually all indoor public places and workplaces are smoke free. This change of attitude to passive smoking in California was based on strong scientific and medical evidence at the time that second-hand smoke exposure is not just annoying to non-smokers (cigarettes make your clothes and hair smell) but that it is positively dangerous to their health. A passive smoker breathes 'side stream' smoke from the burning tip of the cigarette as well as 'mainstream' smoke that has been exhaled by the smoker. This smoke contains over 4000 chemicals in the form of particles (tar, nicotine, and benzene derivatives) and gases (carbon monoxide, ammonia, amines, formaldehyde, hydrogen cyanide, and acrolein). While some of these substances are known irritants, at least 40 are known to be carcinogens. The Environmental Protection Agency in the United States has classified environmental tobacco smoke as a 'Class A' carcinogen (known to cause cancer in humans) and is in the same class as asbestos, arsenic, hydrogen cyanide and radon gas.

Health effects of smoking

There is no controversy in regard to the health effects of direct smoking. Cigarette smoking is the major known environmental risk factor for the development of many problems, particularly heart, lung and vascular diseases and cancer. Chronic obstructive pulmonary disease (COPD) and the prevalence of and mortality of COPD reflect the smoking history in a given population. In clinical practice, COPD usually presents after the fourth decade of life in smokers but patients may experience symptoms of a chronic cough with phlegm (bronchitis) for many years associated with significant daily cigarette consumption. The risk of developing bronchitis symptoms in adults increases with the number of cigarettes smoked such that, for smokers of one pack per day, the risk for developing bronchitis is 40-50% and, at two packs, the risk is 70-80%. There is also a strong dose-response relationship between the amount of cigarettes smoked and the rate of yearly decline in pulmonary function with smokers, losing 2-3 times the rate of lung function. Teenage regular smokers even those who smoke for as short a period as one year, develop acute and chronic bronchitis at a rate of two and six times that of non-smokers but unfortunately, as in adult smokers,

quitting the habit may not abolish these symptoms completely.

Health effects of passive smoking

One of the strategies of the smoking lobbyists is to create and sustain controversy around the harmful effects of passive smoking with the issue being framed as one of smokers' versus non-smokers' rights. In fact no such controversy exists. Respected researchers and physicians around the world have shown that passive smoking is dangerous to one's health. In terms of mortality, the 1997 Californian Environmental Protection Agency report estimated the annual tobacco-induced death rate from passive smoking in California was of the order of 250 people per million inhabitants per year. If the same annual rate was applied to the European Union this equates to about 70,000 victims per year. The ASH (UK) organisation have calculated that over 600 lung cancer deaths in non-smokers in the United Kingdom can be attributed each year to passive smoking. Workers in restaurants and bars who are routinely exposed to passive smoking can see their risk of lung cancer triple. Non-smokers exposed to regular passive smoking have also a 25% increased risk of heart disease. The majority of asthmatics experience symptoms from chest discomfort to acute asthma attacks triggered by passive smoking. In 1998 the review by the UK government-appointed Scientific Committee on Tobacco and Health (SCOTH) concluded in their report that passive smoking is a cause of lung cancer and ischaemic heart disease in adult non-smokers and a cause of respiratory and middle ear disease and asthmatic attacks in children.

Passive smoking among Irish teenagers

A major national cross-sectional questionnaire survey of smoking habits of over 3000 Irish secondary school children aged 13-14 years was recently published. The study was undertaken in 1995 and repeated in 1998 by Professor Luke Clancy and I, together with our co-workers from St. James's Hospital in Dublin. In both studies we found that up to 20% of these young teenagers regularly smoke (more girls than boys) and these children had about 2-3 times the rate of bronchitis (cough with phlegm) than non-smokers. We also examined the prevalence of bronchitis symptoms in teenagers who were non-smokers but exposed to second-hand smoking (passive smokers) in the home. 46% of non-smoking children were exposed to passive smoking in the home mainly due to parental smoking. We reported that bronchitis symptoms were increased by up to 80% in these 'passive smokers'. This is not surprising since it has been estimated that the dose of passive tobacco smoke inhaled is equivalent to the children actively smoking 30-80 cigarettes a year.

The finding of excess bronchitis in passive smokers raises the concern for the subsequent development of COPD in these children in the future particularly if tobacco exposure continues. The mechanisms underlying the development of bronchitis with smoking exposure are not clear but decreased mucociliary clearance; goblet cell hypertrophy or hypersecretion of mucous



Dr Patrick Manning

"One sixth of lung cancer cases in non-smoking adults can be attributed to cigarette smoke exposure in childhood and adolescence."

– Dr Patrick Manning

- ▶ may play a role leading to subsequent COPD development. Of more concern however, is the risk of subsequent lung cancer development from passive smoking exposure in childhood. One sixth of lung cancer cases in non-smoking adults can be attributed to cigarette smoke exposure in childhood and adolescence.

Both from a medical, as well as an ethical perspective, children are vulnerable to passive smoking effects. Children have smaller lungs and breathe faster than adults; thus they breathe more tobacco smoke for their weight and size than adults. Children are less likely to be in a position to leave the smoking environment, particularly infants and thus have no choice but to inhale the tobacco smoke. Lung growth and development in children are adversely affected by passive smoking exposure. Passive maternal smoking to baby either in-utero or in infancy can lead to decreased lung function in children of school going age which may persist into adulthood. Parental passive smoking is also associated with higher rates of lower respiratory tract infections, middle ear problems and hospital admission for these problems especially in early childhood.

Conclusion

The finding from our study, showing high levels of smoking in young Irish teenagers, suggests that future national anti-smoking strategies in the young should be focused on primary school children as a preventative measure to combat smoking initiation. Once started, it is difficult to quit even in young teenagers because of the addictive component in the nicotine drug and most adult smokers will have taken up the habit before the age of 20 years. The results from this study of significantly increased levels of bronchitis in young teenage smokers refute the misconception that bronchitis develops many years after commencement of the smoking habit. This high level of bronchitis symptoms in non-smoking children exposed to passive smoking is also of concern and would support the public health advice that no smoke exposure is best. The message is that non-smokers who breathe tobacco smoke may get sick and die like smokers.

Dr Patrick Manning is a Consultant Respiratory Physician at Bon Secours Hospital, Dublin.

References available on request.

The 3rd European Tobacco or Health Conference heard that 75% of smokers want to quit. Gerry McElwee explains how no smoking initiatives can help patients tackle what is, for most, an extremely tough task

Overview

- ▶ Annual No Smoking Day (NSD) aims to help smokers who want to stop by creating a supportive environment and highlighting the many sources of help available. No Smoking Day is coordinated in Northern Ireland by the Ulster Cancer Foundation and supported by a coalition of health education agencies and professional organisations.

Two out of three smokers would like to stop

Two out of three smokers would like to stop. Each year nearly a million try to stop on NSD and many thousands succeed. It is traditionally arranged on the second Wednesday of March, often coinciding with Ash Wednesday, but always capitalising on the seasonal urge for fresh starts.

The campaign is not just about No Smoking Day. Giving up smoking requires much planning, encouragement, support and motivation. Helping others to prepare to give up can be done year round, but the Day provides an excellent focus and motivation for many.

The Day's main messages:

- No Smoking Day is a good opportunity to stop
- Smokers can get help when they want to stop
- There are health and other benefits to stopping smoking

What the Day does:

- Spurs smokers into action – millions take part
- Appeals to smokers of all types – whatever their age, sex or social status
- Publicises and explains the help that smokers can get when they want to quit
- Captures the attention of the media with lots of supportive TV, newspaper and radio coverage

What it doesn't do:

- Try to force smokers to stop
- Harass smokers – it's not about banning smoking, or picking on smokers
- Work in isolation – smokers need support before and after the Day too

Each year's campaign in Northern Ireland is planned by the coordinating group and a wide variety of health professionals are invited to attend a briefing day to plan and disseminate their work at local level.

This briefing day and the campaign itself are supported by GlaxoSmithKline's Niquitin CQ.

A network of local organisers runs events on and around the Day. They include pharmacists, doctors, dentists, health promotion specialists, workplaces, teachers and fitness clubs.

Each year we send local organisers a campaign pack with details

of the new campaign. This gives them ideas for promoting NSD in their area of the country.

Organisers then run activities in their local area (carbon monoxide testing, stalls, displays, competitions, photo shoots, balloon releases, etc) in all manner of places such as schools, swimming pools, company receptions, hospitals, clinics, leisure centres, youth clubs – and anywhere they can think of!

From November we start briefing all sectors of the media about the campaign, and work with organisational partners to create joint activity and publicity programmes.

What your organisation can do

No Smoking Day is an opportunity for smokers to stop – around three quarters of them would like to do so.

Every Health Professional has a role to play in helping them, as there will be smokers among your patients, employees, colleagues, customers, friends, family, contractors, visitors.... and so on.

Many organisations support No Smoking Day by running in-house events on the Day. Others create national-level promotional schemes in partnership with NSD.

What Can Be Done

- Organisations, large and small, are encouraged to publicise the goods or services that are available to smokers to help them quit on No Smoking Day. These can include smoke-free facilities that they can use, or products that can act as a substitute for smoking, or as a reward for abstaining.
- Many organisations offer special promotions or incentives to quitters — assistance is available from local stop smoking services.
- They are encouraged to issue a Press Release to say why their organisation supports the Day
- Many companies have one of their organisation's spokes people write to a newspaper's letters pages supporting the Day.
- Finally, all interested participants are encouraged to talk to NSD HQ about joint activity possibilities

Gerry McElwee is the director of the Ulster Cancer Foundation

In ROI contact:

Norma Cronin, Irish Cancer Society

Tel: 01 6681855

In Northern Ireland contact:

Gerry McElwee, Ulster Cancer Foundation.

Tel: 028 9066 3281



Gerry McElwee



If you wish to receive further information from the 3rd European Tobacco or Health Conference in Warsaw, please contact GlaxoSmithKline on

01 495 5000

Smoking cessation support materials for a range of healthcare professionals are also available.

This publication was financed by an unrestricted grant from GlaxoSmithKline.
The articles contained within do not necessarily represent the views of GlaxoSmithKline.

Abridged Prescribing Information

Zyban 150mg prolonged release tablets (bupropion hydrochloride)

Presentation: Each tablet contains bupropion as bupropion hydrochloride 150mg.

Indication: Zyban tablets are indicated as an aid to smoking cessation in combination with motivational support in nicotine-dependent patients.

Dosage and Administration: Adults only. It is recommended that treatment is started while the patient is still smoking and a "target stop date" set within the first two weeks of treatment with Zyban, preferably in the second week. The initial dose is 150mg to be taken daily for six days, increasing to 150mg twice daily. There should be an interval of at least 8 hours between successive doses. The maximum single dose should not exceed 150mg and the total daily dose should not exceed 300mg. Patients should be treated for 7-9 weeks.

Children: Not recommended.

Pregnancy & Lactation: Not recommended.

Contra-indications: Hypersensitivity, current seizure disorder or any history of seizure, bulimia, anorexia nervosa, recent/current MAOI's, severe hepatic cirrhosis, bipolar disorder, known CNS tumour, abrupt withdrawal from alcohol or benzodiazepines.

Special Precautions: Predisposition to lowered seizure threshold/increased risk of seizures (including previous head injury, use of stimulants or anorectic products, medications which lower seizure threshold, alcohol abuse, diabetes), susceptibility to psychotic episodes. Use 150mg o.d. in renal/hepatic impairment & elderly. Zyban must not be used in patients with predisposing risk factors unless there is a compelling clinical justification for which the potential medical benefit of smoking cessation outweighs the potential increased risk of seizure. All patients should be assessed for predisposing risk factors. If following such assessment, Zyban is prescribed for patients who have predisposing risk factors for seizure, a **maximum dose of 150mg daily** should be considered for the duration of treatment.

Drug Interactions: MAOI's, enzyme inducers/inhibitors, levodopa, orphenadrine, cyclophosphamide, ifosfamide. Use dose at lower end of scale for certain anti-depressants, anti-psychotics, beta-blockers, type IC antiarrhythmics.

Adverse drug reactions: Dry mouth, gastrointestinal upset, abdominal pain, insomnia, tremor, concentration disturbance, headache, dizziness, depression, agitation, anxiety, rash, pruritus, urticaria, sweating, fever, taste disorders.

Product Authorisation Number: PA 44/103/1.

Product Authorisation Holder: Glaxo Laboratories Ltd., Stockley Park West, Uxbridge, Middlesex UB11 1BT, UK. Zyban is a trade mark of the GlaxoSmithKline group of companies.

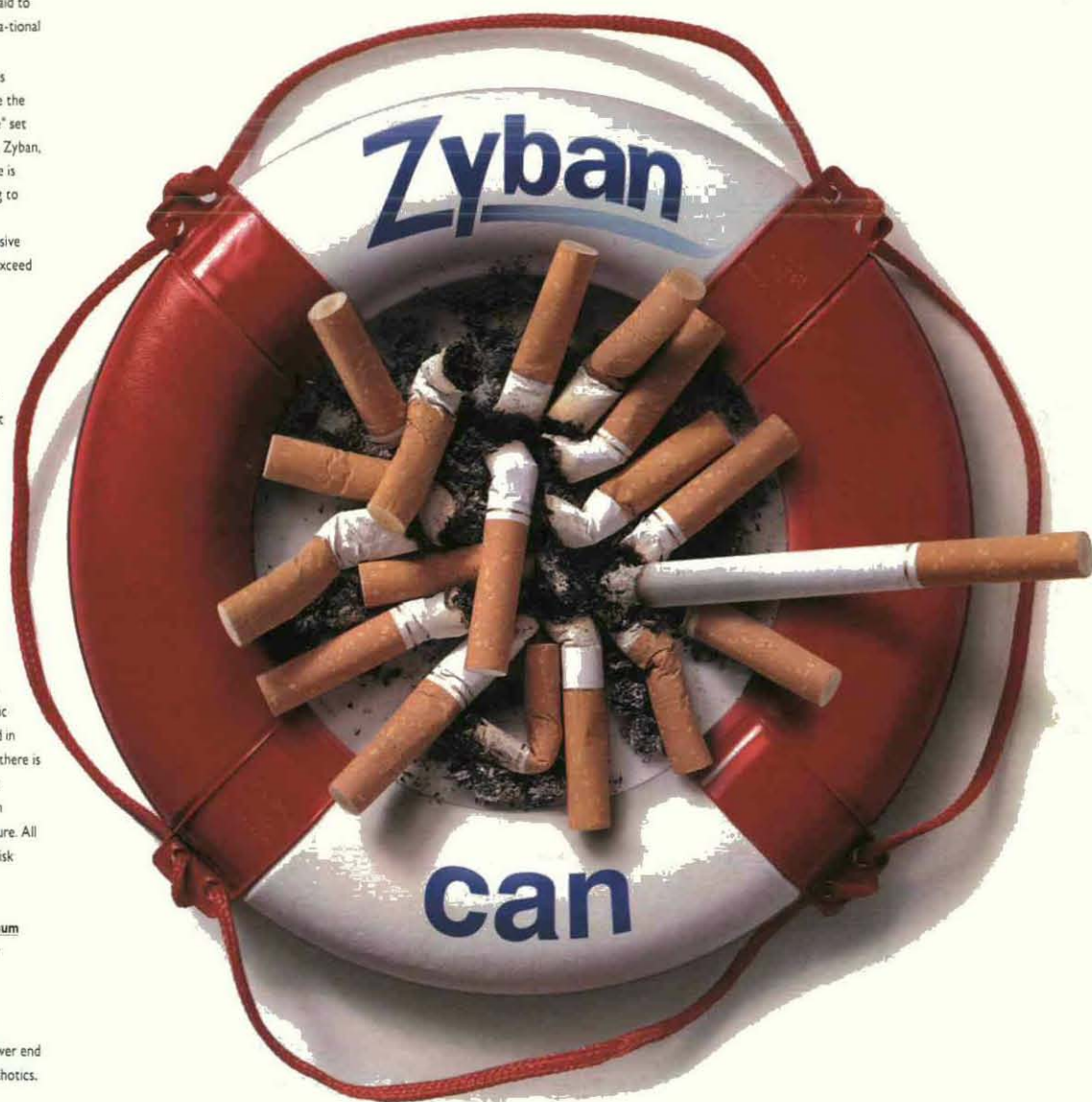
Legal Category: POM.

Date of Preparation: June 2001.

(For further details please see full prescribing information)

Additional information is available on request.

IF THEY CAN'T HELP IT



Rescue your patients
from tobacco addiction
simply and effectively
with Zyban.

Zyban is available now on GMS prescription with budget neutral status.



GlaxoSmithKline

SCIENCE AGAINST SMOKING
GlaxoSmithKline Ltd., Grange Road,
Rathfarnham, Dublin 16.
Tel: (01) 495 5000.

IF THEY CAN'T

Zyban
Bupropion Hydrochloride
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