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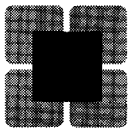

WILLIAM S. WILKE, MD, EDITOR

HIGHLIGHTS FROM MEDICAL GRAND ROUNDS

SMOKING CESSATION: THE PHYSICIAN'S ROLE

WHEN ASKED, most smokers say they would like to quit. Yet approximately 50 million continue to smoke, and more than 1000 people every day die from the long-term consequences of this addiction.

Physicians and other health care professionals have a unique opportunity to intervene: when people come to see them they are concerned about their health, and their minds are quite receptive. It is extremely important to repeatedly remind *all* smoking patients of the multiple dangers of smoking.

WHY PEOPLE START SMOKING

Smoking almost always begins in late childhood or adolescence. Social pressures and imitation of peers or family members who smoke are common contributing factors. Also important is advertising; cigarettes are the most heavily advertised consumer product in the United States. Although people generally have to work to become smokers, they quickly become addicted; nicotine is the primary addicting agent.

WHY PEOPLE CONTINUE SMOKING

Smoking is the most overpracticed addiction in the world: no other addiction entails 20 to 40 "hits" per day for many years. Smoking becomes associated ("linked") to a large, varied array of situations, emotional states, and people, and these links are strengthened through thousands of repetitions. Smokers use nicotine to alternately cause arousal or sedation, and as a way of "dampening" unpleasant emotions. Smoking also develops a number of special psychological meanings for people, which often makes it hard to quit.

HOW PEOPLE QUIT

Nevertheless, an estimated 40 million Americans have quit, and 95% of these people have stopped on their own, without any formal program. Success rates in formal smoking cessation programs tend to be rather low, typically 15% to 20% after 1 year.

To quit, people must be prepared to experience some short-term discomfort in order to achieve immense long-range benefits. No "magic bullet" or "magic pill" will make smoking go away effortlessly. Physical withdrawal symptoms peak in 2 to 4 days and are generally gone in 10 days to 2 weeks. Withdrawal may also include psychological symptoms and disturbances of arousal. After the withdrawal effects are over, people continue to experience periodic urges to smoke in the many situations in which they smoked in the past. This may continue for months and even years; however, the urges rarely last more than a few seconds.

Quitting smoking is a process: people move from precontemplation to contemplation, action, recidivism, and, finally, long-term maintenance. Which stage a smoker is in may determine which interventions are most appropriate. People most likely to be successful at quitting tend know the health risks associated with smoking, believe they can quit, perceive their medical condition as fairly serious, feel themselves to be quite susceptible to a major disease,

■ Highlights from Medical Grand Rounds present take-home points from selected Cleveland Clinic Division of Medicine Grand Rounds lectures.

have been advised by their physician or other health care professional to quit, or have social support for quitting.

AVOIDING RELAPSES

Smoking seems to operate on an "all or none" principle: "slips" are likely to lead to full-blown resumption of the addiction. Relapses are most likely to occur during negative emotional states. Nearly all ex-smokers have "relapse crises" at some time during the first few months. Those who have developed some type of cognitive or behavioral coping skills for dealing with the temptation to smoke are much more likely to survive these crises.

HELPING SMOKERS QUIT

The smoker must select a date to quit. A number of behavioral techniques prepare the person, including reducing overall smoking, not smoking in certain situations, altering the behavior patterns associated with smoking, and beginning to devise a strategy for coping with the desires to smoke. On the day of quitting and for the following 2 weeks the person must discard all cigarettes, spend as much time as possible with nonsmoking people in nonsmoking situations, cope with the desires to smoke without substituting highly caloric food, and use specific techniques for coping with the urges to smoke. In addition, developing or increasing a regular exercise program is quite important.

After 2 weeks the person can return to a normal routine (ie, stop avoiding "high-risk" situations). But vigilance is important, especially in stressful or unusual situations. When the desire to smoke returns—and it will—it is important for the ex-smoker to have one or more coping strategies ready.

Some smokers will require some type of formal smoking cessation program that emphasizes behavioral techniques and provides group interaction and mutual support. Hypnosis may be useful, especially in the early stages of cessation. Nicotine replacement therapies—nicotine chewing gum or the transdermal nicotine patch—may help the heavily addicted smoker. The nicotine patch offers some significant advantages over nicotine gum; it is more pleasant to use, proper dosage is more easily achieved, and it produces fewer side effects. But the nicotine patch is not demonstrably better than placebo unless it is used in a behavior-oriented smoking cessation program.

Perhaps the most important advice one can give the smoker is: "if at first you don't succeed, try, try again!" Many people repeatedly fail before they finally quit, but nearly two thirds of those who repeatedly try eventually succeed. Patients need to be encouraged to learn from their experiences and keep trying and to be told they will eventually succeed. When they finally do, they find it feels good to be rid of an expensive, messy addiction that is more and more scorned and that robs them of vigor, health, and, eventually, life itself.

GARLAND Y. DENELSKY, PHD
Director, Smoking Cessation Program
The Cleveland Clinic Foundation

SUGGESTED READING

DeNelsky GY. Smoking cessation: strategies that work. Cleve Clin J Med 1990; **57**:416–417.

Eraker SA, Becker MH, Strecher VJ, Kirscht JP. Smoking behavior, cessation techniques, and the human decision model. Am J Med 1985; **78**:817–825.

Stone S, Perlmutter KJ. Methods for stopping cigarette smoking. Ann Intern Med 1986; **105**:281–291.

US Department of Health and Human Services. Tobacco and the clinician: interventions for medical and dental practice. NIH Publication No. 94-3693, 1994.

GASTROESOPHAGEAL REFLUX DISEASE: AN OVERLOOKED CAUSE OF ASTHMA

GASTROESOPHAGEAL REFLUX is a frequently overlooked cause of asthma, although Osler noted the association a century ago. It can cause a number of other conditions as well: chronic hoarseness, cough, globus sensation, laryngeal cancer, dental problems (erosions), and noncardiac chest pain.

CAUSES OF AIRWAY OBSTRUCTION: TWO HYPOTHESES

Two hypotheses may account for the airway obstruction: gastric acid regurgitated into the esophagus might either be aspirated in small amounts, or might stimulate a reflex that produces bronchoconstriction. Conversely, asthma can cause or exacerbate reflux via changes in intrathoracic pressure. In addition, drugs used to treat asthma (theophylline, beta-2 agonists) can decrease lower esophageal sphincter pressure.