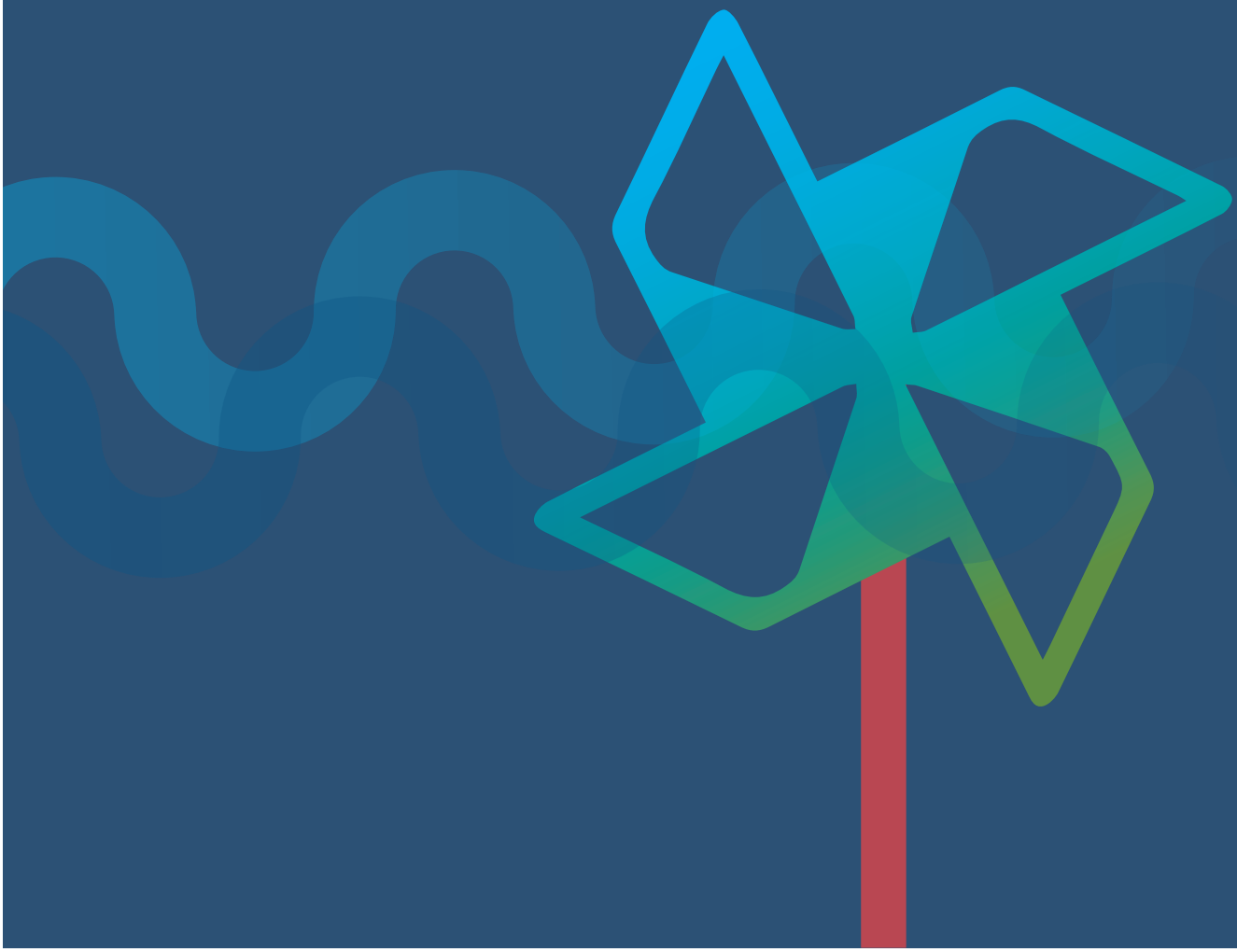
POCKET GUIDE TO SMOKING CESSATION TREATMENT (semFYC)



PAPPS

GAT Grupo de Abordaje del Tabaquismo

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

ESTRATEGIA PROMOCIÓN DE LA SALUD Y PREVENCIÓN EN EL SNS

semFYC
Sociedad Española de Medicina de Familia y Comunitaria

POCKET GUIDE TO SMOKING CESSATION TREATMENT
(semFYC)

PAPPS

GAT Grupo de Abordaje del Tabaquismo

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

ESTRATEGIA PROMOCIÓN DE LA SALUD Y PREVENCIÓN EN EL SNS

semFYC
Sociedad Española de Medicina de Familia y Comunitaria

Authors

Francisco Camarelles Guillem
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.
Grupo de educación sanitaria y promoción de la salud del PAPPS
(Programa de Actividades Preventivas y de Promoción de la Salud).

Vidal Barchilón Cohen
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

Lourdes Clemente Jiménez
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

José Manuel Iglesias Sanmartín
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

Carlos Martín Cantera
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

César Minué Lorenzo
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

Joan Antoni Ribera Osca
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

Emilio Salguero Chávez
Family Physician
Grupo de Abordaje del Tabaquismo (GAT) de la semFYC.

Diputació, 320
08009 Barcelona
www.semfyc.es

Editorial coordination and management:

CONGRESOS Y EDICIONES SEMFYC

Carrer del Pi, 11, 2.ª planta, of. 13
08002 Barcelona
ediciones@semfyc.es

Design: Falcó
Printed in Spain

Contents

	Authors	**4**
1.	**Introduction**	**5**
2.	**Smoking intervention**	**5**
2.1.	The process of stopping smoking	5
2.2.	Intervention in smokers	6
2.2.1.	*Intervention in smokers unwilling to stop smoking*	7
2.2.2.	*Intervention in smokers willing to stop smoking*	11
3.	**References**	**24**

1. Introduction

Smoking presents a rare confluence of circumstances: it is a significant and major threat to health and, despite having effective interventions available to us, there is little engagement among health clinicians to intervene accordingly. It is really hard to identify another determinant of health that presents this combination of deadliness, prevalence and lack of attention. However, smoking intervention is considered the gold standard among preventive interventions, way above other commonly implemented measures.[1]

Smoking is the number one cause of preventable disease and death in Spain, and the aim of this guide is to show the effective interventions available to help smokers that we care for as patients in our clinics to stop smoking.[2]

2. Smoking intervention

Smoking is:
- A physical and psychological addiction
- A learned behaviour
- A social dependence

Stopping smoking entails:
- Overcoming the addiction (psychosocial intervention and medication)
- Unlearning a behaviour (behavioural strategies)
- Changing the influence of the environment

To help a smoker stop smoking, the following considerations need to be taken into account:

2.1. The process of stopping smoking

Stopping smoking entails a behavioural change. It is a process in which smokers go through different stages over time. Smokers will find themselves at one stage or another depending on the lower or higher level of motivation to stop smoking (**Figure 1**).[3] These stages are:

- **Precontemplation:** Smokers are not seriously thinking about the idea of stopping smoking; they do not perceive their smoking behaviour as a problem. This is the case for 25-30% of smokers.

- **Contemplation:** Smokers are seriously thinking about a change in the next six months. Ambivalence or contradictory feelings about smoking are characteristic features at this stage. This is the case for 50-60% of smokers.
- **Preparation:** Smokers are able to set a date and to devise a plan to stop smoking within one month. This is the case for 10-15% of smokers.
- **Action:** At this stage, smokers are trying to stop smoking. They do not smoke for at least six months.
- **Maintenance:** They have stopped smoking for more than six months.
- **Former smokers:** People who have stopped smoking for more than one year.
- **Relapse:** This stage is another part of the process, and it is a frequent step. It may often take three or four attempts to stop smoking permanently. If people slip and start smoking again, it should not to be seen as a stumbling block, but instead as a valuable lesson in working towards the ultimate attempt and to go over the potential mistakes that may have been made. After a relapse, every effort should be made to get patients to recommit to trying to stop smoking, usually after letting some time pass. It is important to assess previous attempts to quit to obtain information that might be useful when trying to prepare patients to have another go.

2.2. Intervention in smokers

It is estimated that 70% of the population goes to see their family doctor at least once a year, and that smokers do so more often than non-smokers. This provides an important opportunity to promote the intention to stop smoking and to give effective help to those who decide to try to do so.

In Spain, smoking cessation assistance is included in the portfolio of Primary Health Care services. El Programa de Actividades Preventivas y Promoción de la Salud (PAPPS)

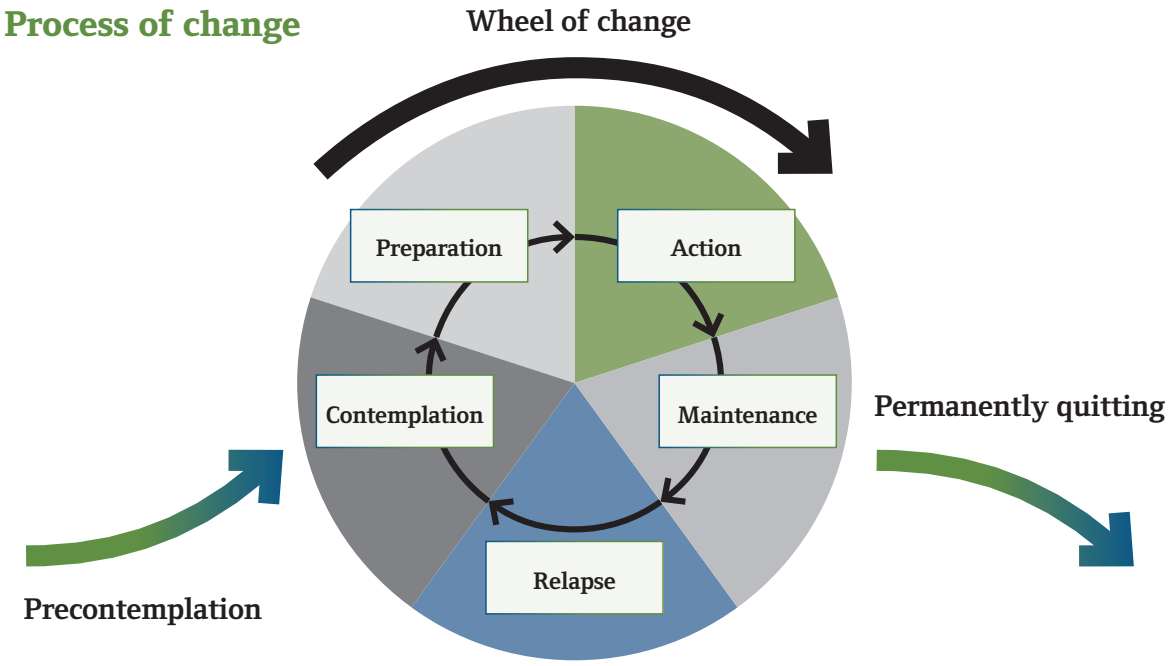


FIGURE 1. TRANSTHEORETICAL MODEL OF THE STAGES OF CHANGE

Source: Programa Atención Primaria Sin Humo
Programas de la Sociedad Española de Medicina de Familia y Comunitaria (semFYC)

[The Preventive Activities and Health Promotion Programme] of the semFYC), recommends asking patients over the age of 10 years about smoking every time they visit the clinic and to record how much they smoke on their health records. The frequency of such enquiry should be every two years. For people aged over 25 years whose health records show that they have never smoked, it is not necessary to ask this question again.[4]

Different interventions are proposed, depending on the individual smoker's predisposition to stopping smoking.[5] They are based on the 5 As of the intervention strategy (Ask, Advise, Assess, Assist and Arrange) to deliver behavioural and advice interventions based on the main risk factors.

2.2.1. Intervention in smokers unwilling to stop smoking

Figure 2 shows the interventions that need to be made in smokers that we care for as patients who are unwilling to stop smoking.

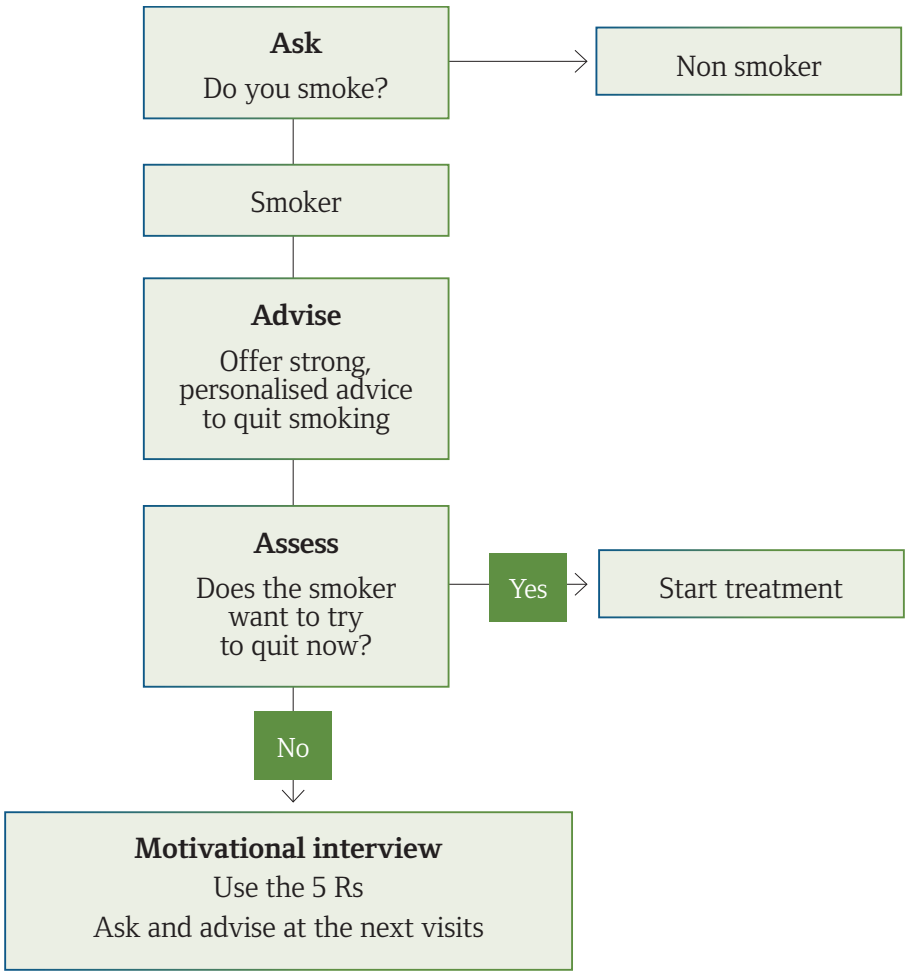


FIGURE 2. INTERVENTIONS IN SMOKERS THAT WE CARE FOR AS PATIENTS WHO ARE UNWILLING TO TRY TO QUIT AT THE TIME OF THE VISIT

Adapted from: Fiore MC[5]

There are two key actions in smokers that we care for as patients who are unwilling to stop smoking:

1. Give health advice to encourage them to stop smoking. The advice should be:

- **Clear:** "It's important for you to stop smoking, and we can help you. We now have effective treatments available to us."
- **Direct:** "As a doctor/nurse, I can assure you that stopping smoking is the most important thing you can do for your current and future health."
- **Personalised:** Link the advice with current health problems, how much it costs to buy cigarettes or other tobacco products, the "slavery" of dependence and the health impact on other people. Focus on those in which the smoker shows greater interest.

2. Use motivational techniques, taking into account the principles thereof[6] (**Table 1**). We can provide information about smoking that places greater emphasis on the benefits of stopping smoking than on the risks of smoking, and use open questions (What benefits would you get if you stopped smoking? How do you think smoking affects your health?"), highlighting the most significant benefits/risks for the patient (**Table 2**). Supplement the intervention with self-help materials (information leaflets, website details, etc.) and always offer to be available to help them stop smoking.

   When it comes to intervening in smokers unwilling to stop smoking, it might be useful to bear in mind that a lower or higher level of predisposition or motivation to stop smoking depends on the IMPORTANCE smokers place on stopping smoking at that time, as well as the CONFIDENCE they have in being able to do so. To assess and increase such importance and confidence, the following strategies can be useful:

- **Importance:** "How important is stopping smoking to you at this time? On a scale from 0 to 10, where 0 means not at all and 10 absolutely, what score would you give?", "Why did you say x and not 1?", "What would need to happen for you to make it a 9?", "How could I help you make it a 9?"
- **Confidence:** "If you decided to stop smoking right now, how confident would you be about being able to do so? On a scale from 0 to 10, where 0 means not at all and 10 absolutely, what score would you give?", "Why did you say x and not 1?", "What would need to happen for you to make it a 9?", "How could I help you make it a 9?"

Express empathy	Being accepting of smokers helps to change behaviour, so mindful, appropriate listening is essential. Smokers' ambivalence about smoking is normal.
Create discrepancy	It is important for smokers to become aware of the consequences of continuing to smoke. We must try to create a discrepancy within them about the consequences of continuing to smoke and the reasons for stopping smoking; it is up to smokers to give their own reasons for quitting smoking.
Avoid arguments	Any arguments between clinicians and smokers are counterproductive. Presenting the arguments against smoking often make smokers defensive and that can lead to resistance. If any resistance emerges, it tells us that we need to change the strategies used previously.
Roll with resistance	Smokers' perceptions of their smoking behaviour can be changed. Clinicians must suggest new viewpoints on smoking behaviour without imposing anything. Smokers are often a valuable source when it comes to finding solutions to problems relating to their own behaviour.
Support self-efficacy	Confidence in the potential to change is an important motivational factor. Smokers are responsible for choosing and making a personal change. If clinicians believe in patients' ability to change, it facilitates that change.

Table 1. Motivational interview principles

Adapted from: Miller W[6]

Adolescents
- Bad breath
- Stained teeth
- Saving money
- Lack of independence (feeling controlled by cigarettes)
- Sore throat
- Cough
- Fatigue, tiredness (may affect doing sport)
- Frequent respiratory infections

Expectant mothers
- Greater risk of miscarriage and foetal death
- Greater risk of child being born underweight

Parents
- Cough and respiratory infections among the children of smokers
- Role model

Recent smokers
- Easier to stop smoking

Asymptomatic adults
- The risk of heart disease is doubled
- The risk of emphysema is six times higher
- The risk of lung cancer is 10 times higher
- Between 5 and 8 years of life are lost
- Saving money
- Cost of time off due to sickness
- Bad breath
- Little social expediency and acceptability
- Skin deterioration

Symptomatic adults
- Upper respiratory tract infections
- Cough
- Sore throat
- Shortness of breath
- Ulcers
- Angina
- Claudication
- Osteoporosis
- Oesophagitis

All smokers
- Saving money
- Feeling better
- Greater ability to exercise
- Longer life to enjoy retirement, grandchildren, etc.

Table 2. Motives for stopping smoking. Try to get smokers to find their own motives

Adapted from: Manley MW, Epps RP, Glynn TJ. The clinician's role in promoting smoking cessation among clinic patients. Med ClinNorth Am.1992;76: 477-94.

The U.S. Public Health Services' 2008 guide recommends the content of areas that should be approached in interviews with smokers, which can be based on the 5 Rs (Relevance, Risks, Rewards, Roadblocks and Repetition)[7] (**Table 3**).

Relevance	Motivational intervention has greater impact if it is relevant to the health/disease status of smokers, their families or social situations (e.g., if there are children at home), if smoking causes them current health concerns (by age, gender and other characteristics of individual smokers).
Risks	The clinician must ask the smoker to identify potential negative consequences of smoking, suggesting and highlighting those problems that seem most relevant to him or her, emphasising that smoking low-nicotine cigarettes or the use of other forms of tobacco (cigars, pipes, chewing tobacco, etc.) does not eliminate the risks. The risks may be acute (e.g., exacerbation of asthma or more respiratory problems), long-term (strokes, heart attacks, different types of cancer, etc.) and environmental (impact on children).
Rewards	The clinician must ask the smoker to identify potential benefits of stopping smoking, suggesting and highlighting those that are most relevant to him or her: improved health, saving money, regaining sense of taste and smell, improved physical fitness, better health for children and other people.
Roadblocks	The clinician must ask the smoker to identify barriers or impediments to stopping smoking and try to provide an appropriate solution. The typical barriers include: withdrawal symptoms, fear of failure, weight gain, lack of support, depression and enjoyment of smoking.
Repetition	The motivational intervention must be repeated every time a smoker who is not motivated to stop smoking visits the clinic, always within an environment of empathy and respect towards him or her. Smokers who have failed in previous attempts to stop smoking should be told that many smokers try several times to quit before they are successful.

TABLE 3. THE 5 RS FOR SMOKERS UNWILLING TO STOP SMOKING
Adapted from: Fiore MC[7]

2.2.2. Intervention in smokers willing to stop smoking

Figure 3 shows the interventions that need to be made in smokers that we care for as patients who are willing to stop smoking.

To help patients who are prepared to make a serious attempt to quit, we have produced a treatment and follow-up plan that includes:

1. **Congratulating the patient on the decision** ("It's the best decision you can take for your health") and clarifying the expectations that the patient has in relation to the therapy for stopping smoking, informing him or her that we are going to provide guidance, help

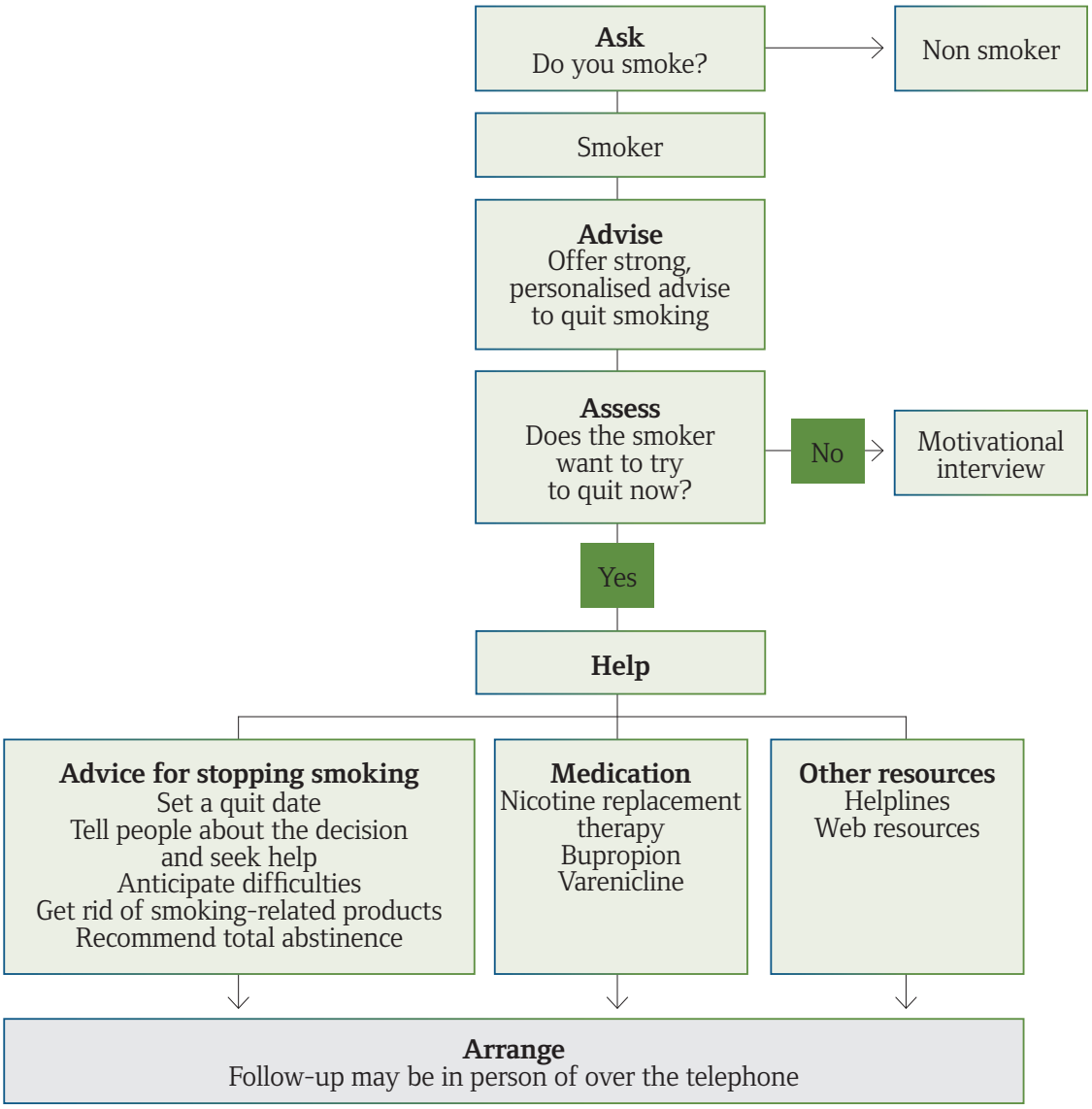


FIGURE 3. INTERVENTIONS IN SMOKERS THAT WE CARE FOR AS PATIENTS WHO ARE WILLING TO TRY TO QUIT SMOKING AT THE TIME OF THE VISIT

Adapted from: Fiore MC[5].

and support, but that his or her efforts are essential for being successful.

2. **Choosing the quit date:** Within one month, choosing the right moment (without stress or social commitments, etc.). Tell family members, friends and/or colleagues to boost the commitment and seek their support and cooperation during the process.
3. **Providing counselling** (Table 4) and offering to explain medication treatment to all smokers, except when contraindicated or there is insufficient evidence of its effectiveness. Medication treatment doubles the chances of stopping smoking within a year[8] (Tables 5a, 5b and 5c).

- **Think about the difficulties** of stopping smoking, particularly in the first few weeks, including withdrawal symptoms.
- Think about and write down the **reasons** for stopping smoking and the reasons why you smoke too.
- **Think about the triggers** of smoking behaviour: Over several days, make a note of all the cigarettes you smoke, the circumstances when you smoke, the importance you place on them and the potential way of dealing with such circumstances without cigarettes. This allows situations when there is a risk of smoking again to be identified.
- **Work out how much money** you spend on smoking and plan to spend it on something that you've been wanting for a while.
- **Make smoking a little more difficult for yourself:** Do not smoke in certain places where you would usually smoke; change the cigarette brand; go out without cigarettes or a lighter; do not accept cigarettes from anyone.
- **Seek support** to stop smoking in your family, work and social environments.
- Learn simple **relaxation techniques** and do some gentle exercise.
- **Advice for D-day:** Think only about the specific day ("Today I'm not going to smoke"); think about your motives for stopping smoking; chew sugar-free chewing gum; hold something in your hands (like a pen); be careful what you eat and drink (for the first few days, do not drink coffee or alcohol; drink natural fruit juice; eat vegetables, fruit and wholemeal bread; avoid snacking, especially on nuts and sweets).
- A **leaflet-guide** containing these and other pieces of practical advice should be given to smokers who are willing to quit. We can download it from: **https://bit.ly/consejosparadejardefumar**

TABLE 4. COUNSELLING: THE AIM IS TO GET THE SMOKER TO BECOME AWARE OF HIS OR HER ADDICTION, TO MODIFY HIS OR HER BEHAVIOUR TOWARDS IT, AND TO DEVELOP SKILLS TO MANAGE ABSTINENCE

Table 6 specifies the psychological treatment techniques that are very useful for helping to stop smoking. It is a good idea to give the patient recommendations about coping with withdrawal symptoms, which peak in the first week and then gradually fade until they are gone (Table 7).

4. **Agreeing a follow-up plan** for all patients making an attempt to quit. Schedule follow-up visits in the clinic or over the telephone. At least one visit a week after and another a month after stopping smoking. At each visit: Congratulate the patient on his or her success and reinforce the advantages (which the patient should verbally express), address any remaining issues (withdrawal symptoms, weight gain, depression, etc.), assess compliance and problems with the medication therapy, confirm that he or she has not smoked and recommend total **abstinence.** The aim of this stage is prevent any relapse. Assess whether a more intensive level of follow-up is required (Table 8).

Medication	Varenicline[9]
Dosage forms and strengths	– 0.5 mg and 1 mg tablets
Dose/ duration	– From day 1 to day 3: 0.5 mg once a day – From day 4 to day 7: 0.5 mg twice daily – From day 8 to the end of the treatment: 1 mg twice daily – Duration of treatment: 12 weeks In the event of adverse effects, a dose of 1 mg per day, either in a single dose or divided into two doses of 0.5 mg, also provides benefits
Instructions	– Start treatment 1-2 weeks before stopping smoking – The tablets should be taken with or after meals – Supplement with psychological support and follow-up
Adverse effects	– Nausea – Headache – Difficulty sleeping and abnormal dreams – Constipation and flatulence – Vomiting – Adverse effects are usually dose-dependent
Contraindications	– Hypersensitivity to the product
Precautions	– Not recommended for use in patients under 18 years of age – Do not use in patients who are pregnant or breastfeeding – There are no clinically significant interactions – In patients with severe renal impairment, reduce the dose to 1 mg per day (start the dose with 0.5 mg once a day for the first 3 days and avoid using Cimetidine during that time) – There is no clinical experience in patients with epilepsy – Caution should be exercised in patients with underlying psychiatric disorders (monitor more frequently) and, in the event of suicidal ideation or behaviour, the treatment must be stopped immediately

Table 5a. Treatment with medication. Unless contraindicated and excluding certain populations (pregnant women, light smokers, adolescents), use in those populations for which there is no firm evidence of its effectiveness

Table 5b. Treatment with medication. Unless contraindicated and excluding certain populations (pregnant women, light smokers, adolescents), use in those populations for which there is no firm evidence of its effectiveness

[a] And there is no evidence that gradual reduction treatment is better than quitting abruptly.

[b] On-demand dosage regimen can be offered (in such cases, the patient needs to be warned not to use an insufficient dose).

CVA: Cerebrovascular accident

Medication	Nicotine patches	Nicotine gum	Lozenges	Nicotine mouth spray
Dosage forms and strengths	**24-hour and 16-hour patches**	**2 mg and 4 mg gum**	**1 mg, 1.5 mg, 2 mg and 4 mg lozenges**	**1 mg per application**
Dose/ duration	– One patch per day – If 24-hour patches: 4 weeks, 21 mg 2 weeks, 14 mg 2 weeks, 7 mg – If 16-hour patches: 4 weeks, 15 mg 2 weeks, 10 mg 2 weeks, 5 mg Using for longer than 8 weeks does not increase effectiveness[a]. 16-hour patches produce less difficulty sleeping. For smokers who get up in the night or have variable shifts, 24-hour patches are better.	– Give 2 mg to begin with. – Give 4 mg if: High dependence (≥ 5 in the Fagerström test). Prior relapse with the 2 mg one. – Try a set dosage regimen (1 gum per hour if awake).[b] Do not exceed 25 gums per day of 2 mg, or 15 gums per day of 4 mg. – Gradually reduce after 3 months.	– Try a set dosage regimen (1 lozenge per 1-2 hours).[b] – Usual dose: 8-12 lozenges per day. Do not exceed 30 lozenges per day. – Gradually reduce after 3 months.	*Stage 1: 1-6 weeks (1-2 sprays when there is a craving to smoke a cigarette). *Stage 2: 7-9 week (reduce the number of sprays to achieve 50% of Stage 1 by week 9). *Stage 3: 10-12 weeks (continue reducing sprays to 4 per day by week 12 and then stop completely).

Continuation
Table 5B

Instructions	– Use on healthy, hairless skin between the neck and the waist, on the upper arm or the hip. Women must not apply patches to the chest. – Start using them when you get up on the day you stop smoking and remove the: · 24-hour one the next day. · 16-hour one at night. – Change patch location every day and do not repeat in 7 days.	– Chew the gum until you notice a "tingling" sensation, then put (park) it between your cheek and your gums to allow the nicotine to be absorbed. When the tingling is almost gone, start chewing again and repeat the procedure (changing the place where you park the gum).	– Suck the lozenge slowly until you notice a "tingling" sensation, then put (park) it between your cheek and your gums to allow the nicotine to be absorbed. When the tingling is almost gone, start sucking again and repeat the procedure (changing the place where you park the lozenge).	1. Use your thumb to slide the button down until it can be pressed slightly in. Do not press too hard. 2. Aim the nozzle at your open mouth, as close as possible. 3. Press the upper part of the dispenser firmly to release a spray, trying not to get it on your lips. Do not inhale while applying to prevent the spray from getting into your throat. For the best results, do not swallow for a few seconds after the spray.
		Use each gum or lozenge for 30 minutes. Absorption is limited by drinking coffee, acidic drinks or soft drinks, so you should avoid them at least 15 minutes beforehand. Nicotine is absorbed mainly through the buccal mucosa.		Maximum: 2 sprays per application. Maximum: 4 sprays per hour. Maximum: 64 sprays per day. Do not use for more than 6 months.

Continuation Table 5B

Adverse effects	– Localised skin reactions – Difficulty sleeping and nightmares – Headache	– Muscular pain in the jaw		
		– Gastric: Nausea, vomiting, heartburn, hiccups – Headache – Local: Hypersalivation, irritation and/or minor ulcers in the mouth and/or throat		– Hiccups – Effects at the site of administration of tingling, burning sensation, inflammation, sore throat, or on the lips and changes in flavour perception – Dry mouth or throat or an increase in the amount of saliva – Sensation of dyspepsia (indigestion)
Contraindications	– Generalised dermatitis			
	Acute or unstable cardiovascular disease: Myocardial infarction, unstable angina, serious cardiac arrhythmia, recent CVA.			
Precautions	– In patients who are pregnant or breastfeeding: COMPLETELY quitting smoking without nicotine replacement therapy (NRT) should be recommended. However, if heavily dependent expectant mothers are unable to do so, NRT under medical supervision may be recommended, assessing the risks and benefits at all times. – Not recommended for use in children. It can be used in adolescents (aged 12 to 17 years) under medical supervision. – Use with caution in: uncontrolled hypertension, active peptic ulcer, pheochromocytoma, hyperthyroidism, serious liver or kidney damage. – Chronic heart failure.			
	– Nicotine patches should be combined with nicotine gum, lozenges or spray in smokers who are heavily dependent on nicotine or have a history of major withdrawal symptoms.			

Medication	Bupropion
Dosage forms and strengths	– 150 mg tablets
Dose/ duration	– 150 mg every morning for 6 days; then 150 mg twice daily, with a minimum of 8 hours between doses – Start treatment 1-2 weeks before stopping smoking – Extend treatment for 7 to 9 weeks from the stop smoking day – If a dose is missed, it should not be made up; the patient should wait until the next dose
Instructions	– Set the D-day for stopping smoking 1-2 weeks after starting treatment. – Supplement with support/follow-up
Adverse effects	– Difficulty sleeping – Headache – Dry mouth and alterations in sense of taste – Skin reactions/hypersensitivity – Some side effects are dose-dependent. If they occurwith 150 mg twice daily, 150 mg once daily may be maintained (there are studies to support this)
Contraindications	– Hypersensitivity to the product – Current convulsive disorder or a history of seizures – Central nervous system tumour – Severe hepatic cirrhosis – Acute alcohol or benzodiazepine withdrawal – Current or previous anorexia/bulimia diagnosis – Use of monoamine oxidase inhibitors in the previous 14 days – History of bipolar disorder – Patients who are pregnant or breastfeeding – Children and adolescents
Precautions	– In patients with mild-to-moderate hepatic impairment or renal impairment and the elderly, the recommended dose is 150 mg per day. – If the seizure threshold is lowered (treatment with medication that lowers the seizure threshold, alcohol abuse, a history of head injury, diabetes treated with anti-diabetic drugs or insulin, stimulant or anorectic drug use), it **should not be used unless** there is a justified clinical reason for doing so, where the benefit of stopping smoking outweighs the risk of seizures. In such cases, the dose will be 150 mg per day. – Interactions with other medication.

TABLE 5C. TREATMENT WITH MEDICATION. UNLESS CONTRAINDICATED AND EXCLUDING CERTAIN POPULATIONS (PREGNANT WOMEN, LIGHT SMOKERS, ADOLESCENTS), USE IN THOSE POPULATIONS FOR WHICH THERE IS NO FIRM EVIDENCE OF ITS EFFECTIVENESS

A. Preparation stage	Before D-day
List of motives	– The patient should make a list of personal reasons for stopping smoking, set against a list of reasons for continuing to smoke (decisional balance).
Benefits of stop smoking	– We must tell the patient about the benefits of quitting smoking and the risks of continuing to smoke.
Identification of mistaken ideas	– With the patient, determine mistaken ideas about the process of quitting smoking, and physical and psychological dependence. Provide written materials about how to cope effectively with such problems.
Smoking diaries to identify associated triggers	– The patient should keep a written smoking diary to record the following for each cigarette smoked: the time he or she smoked it, the place where he or she did so, his or her craving to smoke and the activity he or she was doing. Develop alternative behaviours.
B. Quit stage	**In the first few week of abstinence**
Coping with withdrawal symptoms	– Tell the patient about the potential onset of withdrawal symptoms, help him or her identify them while stressing that they will only last for a short period of time and will gradually fade. Point out the risks of a single sporadic puff. Provide recommendations for alleviating withdrawal symptoms.
Verbally expressing the benefits	– It is important for the patient to verbally express the benefits gained thus far and to reinforce them: improved physical activity, regaining breath and taste, elimination of tobacco smell from clothes, etc.
C. Maintenance stage	**Prevention of relapse**
Learning self-control strategies and skills	– Techniques for solving problems, controlling stress and eliminating associated triggers.
Strategies for coping with situations of risk	– These are based on training in abilities or skills to recognise, challenge and overcome situations of risk and, therefore, to increase self-control. – Techniques of distraction, escape, social and assertiveness skills, and cognitive restructuring.

Table 6. Psychological treatment techniques for nicotine addiction

Adapted from: Becoña E[10]

Symptoms	Recommendations
Strong desire to smoke or craving	– Be aware that it goes away within a few minutes and that over time it will become less intense and frequent. – Think about something else, remember your motives for wanting to stop smoking. Take three deep breaths in a row or try other relaxation techniques. If you can, remove yourself from the situation that is causing the need to smoke. Chew sugar-free chewing gum or eat something low in calories.
Difficulty sleeping	– Avoid coffee and caffeinated drinks. – Drink relaxing infusions (lime blossom tea, mint tea, etc.). – Do more exercise. – Try some relaxation techniques.
Headache	– Have a warm shower or bath. – Try some basic relaxation techniques.
Constipation	– Follow a high-fibre diet and drink plenty of water.
Difficulty concentrating	– Do not demand high performance for 1 or 2 weeks. – Avoid alcoholic drinks.
Nervousness	– Walk, do more exercise, have a warm bath, try some relaxation techniques. – Avoid coffee and caffeinated drinks.
Tiredness	– Increase the number of hours you sleep and rest.
Appetite, food anxiety, snacking	– Drink plenty of water, infusions and non-fattening juice. – Watch your intake of refined sugars (cakes, biscuits), fat and other high-calorie food. – Do exercise.

TABLE 7. RECOMMENDATIONS FOR COPING WITH WITHDRAWAL SYMPTOMS (WHICH PEAK IN THE FIRST WEEK AND THEN GRADUALLY FADE UNTIL THEY ARE GONE)

Visit, stage and timetable	Contents
BEFORE D-DAY **1 or 2 visits**	– Complete the history of smoking (age started, number and type of cigarettes smoked, previous attempts to quit, relapses). – Assess previous attempts to quit/relapses. – Explore motives and dependence. – Reinforce motivation. – Assess and offer medication. – Assess family, social and work environment, and seek support. – Take the patient's weight. – **Set D-day.** – Recommendations for alleviating withdrawal symptoms.
EUPHORIA STAGE **3-8 days after D-day**	– Advice about how to cope with difficult situations. – Assess withdrawal symptoms. – Medication review (compliance/adverse effects). – Reinforce the family, social and work environmental support. – Encourage the patient to verbally express the benefits and difficulties of stopping smoking. – If there is a relapse, assess the circumstances. – Tell the patient about the onset of "grief".
GRIEF STAGE **10-15 days after stopping smoking**	– Assess the presence of: feeling of emptiness, increase in appetite and sleep alterations. – Reduction in physical withdrawal symptoms. – Encourage the patient to verbally express the benefits and reinforce them. – Medication review (compliance/adverse effects). – Reinforce environmental support.
NORMALISATION STAGE **15-30 days after stopping smoking**	– Tell the patient about the potential onset of a false sense of security. – Encourage the patient to verbally express the benefits and reinforce them. – Medication review (compliance/adverse effects;regimen change).
CONSOLIDATION STAGE **2-3 months after stopping smoking**	– Assess: monitor unrealistic views. Prevent relapses of a social nature. – Take the patient's weight. – Encourage the patient to verbally express the long-term benefits and reinforce them. – Change/Stop the medication regimen. – Congratulate the patient.
One-year follow-up of the former smoker	– **Congratulate the patient.** – Encourage the patient to verbally express the long-term benefits and reinforce them. – Prevent relapses of a social nature.

TABLE 8. INTENSIVE ASSISTANCE. PROTOCOL OF 6-7 ASSISTANCE VISITS

Adapted from: Ballvé (2000), from an earlier proposal by Marín and González (1998)

The use of **the three-visit protocol is suggested** to clinically approach smoking[11] (**Figure 4**).

Figure 4. Protocol of three assistance visits. Approaching smoking in real time using the 1-15-30 method

Visit 1

Patient details

How much do you smoke? Cigarettes per day Age started

Quit date (D-day)

Motives for stopping smoking (advantages) **Motives for continuing to smoke (difficulties)**

Environment

Family	☐ Smoking	☐ Non-smoking
Work	☐ Smoking	☐ Non-smoking
Social	☐ Smoking	☐ Non-smoking

Previous attempts to quit smoking Number of times

Did you have any relapses in the first few days? ☐ Yes ☐ No

How long (maximum) did you go without smoking?

What methods did you use?

Why did you start again?

Nicotine dependence: Short Fagerström test

The scores for the two questions are added together and the result is assessed as follows:
5 or 6 = high dependence; 3 or 4 = moderate dependence, and 0 to 2 = low dependence

1. How many cigarettes do you smoke per day?

☐ More than 30 (3 points)
☐ 21 to 30 (2 points)
☐ 11 to 20 (1 point)
☐ Ten or fewer (0 points)

2. After getting up, how much time passes before having your first cigarette?

☐ Up to 5 minutes (3 points)
☐ 6 to 30 minutes (2 points)
☐ 31 to 60 minutes (1 point)
☐ More than 60 minutes (0 points)

Recommend keeping a prior diary of the cigarettes he or she smokes (https://bit.ly/consejosparadejardefumar)

Have you told anyone about your decision to stop smoking?

Potential difficulties for stopping smoking and chosen alternatives?

Advice to make quitting easier (https://bit.ly/consejosparadejardefumar)

Assessment of medication use

Visits	*15 days after visit 1*	*30 days after visit 2*
Ask about smoking. Congratulate the patient if he or she has stopped smoking, and assess the circumstances if he or she has had a relapse.		
Benefits and difficulties of stopping smoking.		
Assess withdrawal symptoms.		
Review medication.		
Recommend total abstinence.		
Do you need more intensive follow-up? Remaining problems?		

Proposed by: Gascó P, Camarelles F (2011), based on Fiore's 2008 American Guide.
Available at: http://goo.gl/lzJR1p.

3. References

1. Camarelles Guillem F, Dalmau González-Gallarza R, Clemente Jiménez L, Díaz-Maroto Muñoz JL, Lozano Polo A, Pinet Ogué MC, Comité Nacional para la Prevención del Tabaquismo (CNPT). Documento de consenso para la atención clínica al tabaquismo en España [Consensus document for clinical assistance with smoking cessation in Spain]. Med Clin (Barc). 2013;140:272.e1-e12. - Issue 140. Article No. 06. Available at: http://goo.gl/vCgbBl.
2. Banegas JR, Díez Ganan L, González Enríquez J, Villar Álvarez F, Rodríguez-Artalejo F. La mortalidad atribuible al tabaquismo comienza a descender en España [Smoking-related mortality is beginning to fall in Spain]. Med Clin (Barc) 2005;124:769-71.
3. Prochaska J, DiClemente C. Stages and process of self-change of smoking: towards an integrative model of change. J Clin Psychol 1983; 3:390-5.
4. Córdoba R, Camarelles F, Muñoz E, Gómez J, Díaz D, Ramírez JI, et al. Recomendaciones sobre el estilo de vida. grupos de expertos del PAPPS [Lifestyle recommendations. PAPPS expert groups]. Aten Primaria. 2014;46(Supl 4):16-23.
5. Fiore MC, Baker TB. Clinical practice. Treating smokers in the health care setting. N Engl J Med. 2011;365:1222-31.
6. Miller W, Rollnick S. Motivational Interviewing, Preparing People for Change. 2a ed. Guilford Press; 2008.
7. Fiore MC, et al. A Clinical Practice guideline for treating tobacco use and dependence: 2008 update. A US Public health Service Report Am J Prev Med. 2008;35(2). Available at: http://goo.gl/xbI3Zr.
8. Cahill K, Stevens S, Perera R, Lancaster T. Pharmacological interventions for smoking cessation: an overview and network meta-analysis. Cochrane Database of Systematic Reviews 2013. Issue 5. Art. No.: CD009329. DOI: 10.1002/14651858.CD009329. Available at: http://goo.gl/UUZvFw.
9. Cahill K, Stead L, Lancaster T. Nicotine receptor partial agonists for smoking cessation. Cochrane Database of Systematic Reviews 2012 Issue 4. Art. No.: CD006103. DOI: 10.1002/14651858.CD006103. Available at: http://goo.gl/U4ytXq.
10. Becoña E. El tratamiento psicológico de la adicción a la nicotina [Psychological treatment of nicotine addiction]. Papeles del Psicólogo. 2003;85:48-69.
11. Gascó P, Camarelles F. Abordaje del tabaquismo en tiempo real (metodología 1-15-30) [Approach to smoking in real time (1-15-30 method)]. AMF. 2011;7(7):402-10.

semFYC
Sociedad Española de Medicina de Familia y Comunitaria

Atención Primaria sin HUMO

PAPPS

GAT Grupo de Abordaje del Tabaquismo

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

ESTRATEGIA PROMOCIÓN DE LA SALUD Y PREVENCIÓN EN EL SNS

www.semanasinhumo.es