

[MUSIC PLAYING]

ANTOINE All right. So I've worked very closely with Dr. Davis. We're both co-directors of the Tobacco Treatment Service. So
DOUAIHY: I will try my best here to review with you this topic-- the smoking and the hospitalized patient. OK. Let's see here.

So these are Dr. Davis-- no financial conflict of interest. My conflicts of interest are basically in the book, and so--

OK. Well, this has been a big issue for us, trying to really figure out how we can work with the UPMC policies to ensure that patients are not walking out of the units to go out and smoke. And we still see that as a big issue, not just really at Presby or Montefiore, or talk about Shadyside, other hospital.

But I mean, it's kind of a little bit distressing, because obviously it causes a lot of liability for us at the same time. Also, we're seeing patients who leave the units, and for different reasons, obviously, because they want to smoke. They are just having cravings. They are struggling with that. And we're most likely not addressing their struggles. And so it's a more complex issue. And it's not just really one thing here. All right.

So just want to review. This is a case that we put together so to really give you a little bit of a perspective here on what needs to be addressed when we're working with patients who are hospitalized and trying to address their tobacco use.

And Mr. Iheart is just- who presented with a chest pain, and ruling out acute coronary syndrome. A 65-year-old man, current tobacco user of two packs per day for 30 years, history of hypertension, COPD, and hyperlipidemia, and CAD, and was admitted with substernal chest pain. So there were some concerns for an ACS.

All right. So when we think about hospitalization and smoking, or tobacco use, I'm going to really use more of the bigger picture. Obviously, most of people who use tobacco, they smoke it. But obviously, there is different forms of tobacco use.

And first of all, we talk about treatment requires tobacco-free. These are the four things addressing the withdrawal and the cravings. And we know very well that the treatment decreases the risk complications.

This is the-- we're thinking about even the long run when we initially start treatment of the tobacco use. We're not just thinking about that quick hospitalization, that the patient's going to be there for two or three days. But we're thinking about what can we do to initiate a process where they can continue with the smoking cessation, or continue in some sort of a treatment.

And this is really very crucial. So we don't just think about what are we going to need to do at the moment. Particularly, at the moment, is to address the withdrawal and the cravings. But we're really thinking for the long run about how to prevent potential complications as a result of continued smoking.

So we know very well, again, tobacco use disorder is an addictive disorder. Tobacco is the most addictive substance that we know of, even more addictive than heroin, opiates, cannabis, cocaine, methamphetamine, anything you can think of.

And this is really important, our perceptions and our understanding of the issues. That obviously, since it's an addictive disorder, we talk about it's a chronic, relapsing condition. And when we think about treatment, we think about treatment for the long run.

But we know very well, and this is really extremely important, is that 70% of people who smoke in the US, they want to quit. It doesn't mean necessarily all of them are really highly motivated to quit. But they express a desire to quit.

Some of them are really, basically, don't have much of the confidence on how to do it. But they do express at the beginning of this, I have to do it. And 50% have tried to quit at least once. The issue is not really, as you know, the quitting. The issue is how you stay quit after the multiple attempts.

And in fact, we have a lot of people who quit basically on their own, and the risk of obviously going back to using and what we call relapse is really extremely high. But we have what we know of natural recovery. We have people have smoked for 20, 25 years, 30 years. And then one day they wake up and say, well, I'm done with smoking, with no interventions and nothing. So that is what we call like more of a natural recovery process.

And it's kind of very puzzling and interesting, because since we talk about the most addictive-- they've been really hooked on the most addictive drug. And how could they just make that sort of a quick decision and really follow through with it? It is really fascinating. And it kind of explains the fact that when people are committed and determined-- this is what we call the willpower-- even the willpower is the motivation.

Sometimes the willpower is not going to be obviously enough, because you would have to take, obviously, action. It's not going to be enough to be just motivated to wanting to quit. But you're going to have to really follow through how are you going to really do it.

Again-- and this is what we're trying to do very much in on our tobacco treatment service at the Presby and Montefiore and other UPMC facilities, is that this tobacco-- treating the tobacco use is a part of the treatment. It's an integral part of the treatment. We can't just see it as a separate issue that can be addressed by other people or anybody that is not involved in the patient's care.

And again, we're trying to kind of-- when we're working in the tobacco treatment service, we try, obviously, to provide consultations. We work with the team. At the same time, also we can provide our own services, too.

And this is really important, the role of the physician, the practitioner. If you intervene in some sort of a counseling approach, and I'm not talking about the counseling as really telling people what to do-- you should quit, you need to quit, and if you don't quit, this is what's going to happen to you.

No. I'm not talking about the scare tactics or that quick kind of a sentence that you say to the patient. I'm talking about an approach to really-- which is brief-- brief-- five, seven, eight minutes-- is to really provide that sort of a counseling and done in an empathic way, to really discuss with them about their smoking, and what they really want to do in terms of changes they want to make. And we know very well it does increase the quit rates by 16% to 18%, which is really still significant.

This is a study we did. We looked at basically the hospitalist's role in improving the use of nicotine replacement therapy, which is really fascinating. When you add the hospitalist to the service that we provide, we see more prescribing of nicotine replacement.

And the reason why this is extremely important, because if you prescribe at the beginning more, you're really initiating the process of quitting for the patients. So obviously, we want to increase the rates of initiating smoking cessation interventions, particularly nicotine replacement therapy, so we can help the patients in the early process of quitting, which is going to be really fundamental for the long run.

So going back to the case that I mentioned. Obviously, we're going to talk about the treatment plan. We'll talk about assessing a treatment, treating the withdrawal, which is very significant, very important initially, and then discussing tobacco cessation. And then the harm reduction, the long run-- over the long run, what are the strategies that we could use.

Again, I don't want to go into a lot of details here. But the bottom line is when we talk about nicotine withdrawal, it's extremely uncomfortable. And it can really be manifested in a lot of symptoms, whether people can become anxious, have a hard time sleeping, they have a lot of urges. And it is really-- and in fact, this is one of the biggest reasons why people want to continue smoking.

And in fact, when you see people who have the chain smoking, the reason is not that because they are anxious, they continue smoking-- because they are in that perpetual cycle of smoking, going through withdrawal, and smoking to reduce the withdrawal, and smoking and withdrawal, and smoking and withdrawal. So it's really kind of very much of a painful process. And that ends up getting people totally hijacked, which is exactly what explains what the addictive disorder is.

Very quick, the Fagerstrom test for the nicotine use disorder, nicotine dependence. Do you have a cigarette within five minutes of waking in the morning? This is very much indicative of the addictive-- the severity of the addiction to. Do you have more than 10 cigarettes per day, and smoke within the first 30 minutes of waking?

So these two questions can give you a quick sense of how the person is really-- how much the person is really addicted to nicotine.

These are the nicotine replacement therapies. I believe most of you are familiar with, particularly the patch, gum, and lozenges. Nasal spray, nasal inhaler, not used as much. And they immediately limits the craving and the withdrawal symptoms.

And so we'll talk about nicotine replacement therapy. We'll talk about two other medications that have been used as a first-line treatment. bupropion, which is really the-- we'll talk about the Wellbutrin. And that is really used. Also, the Wellbutrin SR. And the varenicline, which is the Chantix, usually used one to two weeks before the quit date. And this is over for the long run.

This is key issue here. And unfortunately, this is where a lot of practitioners, or even any kind of a staff, are not aware of some things that are extremely important when we're talking about a key points for the nicotine replacement.

And the one point I want to mention is the number three, which is the instruct on the proper use. Talk about, particularly, with the gums. And so we need to look at also what is the dose that is appropriate to address the withdrawal.

If you have a patient who has been smoking two or three packs a day, and you're going to use just one patch of a small dose, clearly, this is not going to do much for the cravings. So again, it's very important to keep these five things, and six things, in fact, in mind.

And particularly, combining medications. The combination medication has been proven to really work better. Combining a patch, for example, with the gum, or patch with the lozenge, or a combination of basically the patch and even sometimes varenicline or the bupropion. So there are different kind of combinations that could really work.

One of the things I want to mention here is that we need to really remove the patch for the MRI. And the patch can be used at night, for particularly reduce the AM cravings. Unfortunately, sometimes patients can get overstimulated with the patch that is kept overnight. You might have to remove it.

But this is really an important slide that really helps us understand that why sometimes patients, when they take any sort of a nicotine replacement, they don't feel the quick relief. If you see here, it depends on the nicotine levels, the plasma nicotine level, which really depends on the source.

If you look at, for example, the patch, how it goes up very gradually. And how, if you see the cigarette, obviously, that it goes down very quickly. But look at the gum, the course of the gum. And how sometimes when the onset of action-- and this is really extremely important. So we need to keep that in mind.

Because if we need to use more medications, we have to be really very much generous. If patients continue to report that they are having cravings, we shouldn't be saying, oh, you know, but you already had, like, three gums or three lozenges. We're not going to give you any more. I think we need to really be cognizant of the withdrawal symptoms that can remain, even after patients use any sort of a nicotine replacement, so that the-- it has to be-- the withdrawal has to be treated very aggressively.

Again, I'm not going to go through this. The point is that obviously, this should be a part of the admission orders. When you are talking about patients, why this smoking shouldn't be a part, since we address sleep and anxiety and whatever all these other PRNs. How about kind of the smoking there, or the tobacco use?

All right. So quickly, the patient goes to cath, and PO before the cath, including smoking. And obviously, you do not need to remove the patch. They can use inhaler or the nasal spray. And the patient gets the PTCA with one stent, and returns to the room from post recovery.

So here, the patient is ready for discharge. You reassess where they are in terms of motivation for change, when it comes to readiness for change in regards to their smoking. And obviously, we have two options here-- either cessation or harm reduction.

So the first scenario is that they are not quite ready to quit. So their motivation for change is at the low level. So they're going to tell you that, look, they are not-- I'm not going to really totally quit smoking, or I'm not going to quit smoking at all.

So in terms of the harm reduction, is that here we can discuss obviously continuing with the NRT. And always reminding the patients-- and this is really important, because there is so much misperception about it, that if patients go back to smoking, they're going to tell you, what is really the point of keeping the patch? Or what if I get too much nicotine? I'm going to get very toxic from nicotine. In fact, we tell patients, you do not need to remove the patch, even if you continue smoking. It can still really be helpful.

And obviously, we know very well also it can decrease also the number of cigarettes that they would be using. And there is no such a thing as a risk of really precipitating a heart attack from keeping the patch, when people are really still smoking.

The issue is that we have to always remind the patients that look, OK. You don't want to quit smoking, and you're not ready. At the same time, the patch or the gums or lozenges, any nicotine replacement therapy, can really help with these residual cravings that you have. And in fact, encouraging them to continue with that. And in fact, if they will continue with that, at some point in time, you never know, they might really change their mind throughout the whole process, and decide to really quit smoking.

So the one thing is that the more likely-- and this is really a fascinating study. Also, really that the more likely to use nicotine replacement at home for the patients if they received it in the hospital. So this whole idea if we're going to discharge them on nicotine replacement, and oh, well, they're not going to use it or something. Most likely, if they are discharged on nicotine replacement, they're going to continue taking it after they leave.

So which means that that could help, obviously, with the withdrawal symptom, but also could help reduce the cravings, and really get them to think a little bit more about, maybe I want to really quit smoking now. And then, continue with the treatment, and discuss it, obviously, with their primary care physician.

So let's say the patient is ready to quit-- highly motivated to change. And in the hospital those three days, doing very well without smoking using nicotine replacement. And very much realizing after this heart attack that he would like to change here, and like to make some changes.

And so what are really the options that we can look at? And here we go again. I kind of freely showed you the three-- lines of the three basically classes of medications that we can use.

When you look at the first line, you can use basically NRT, nicotine replacement, or a combination of nicotine replacement with varenicline. Or the second line, you can use nicotine replacement with bupropion.

And these are-- I'm not going to go through any of this. We don't have much time. But just to give you an idea about, obviously, each medication can be-- usually has some potential side effects. And the one thing that is really essential, unfortunately, we're not using as much. We've noticed that most of the medications that are used in the hospital are nicotine replacement. The varenicline and bupropion are not really used as much.

So this is important, for example, which is we should re-emphasize it over and over again, the [INAUDIBLE] study is just looking at the varenicline for smoking cessation hospitalized with the ACS, is we know that it does improve abstinence. And-- well, just to give you an idea about the percentages, at 24 weeks.

And in terms of the adverse effects, there is not much of a significant difference. I think it's-- unfortunately, the challenge with the varenicline is that a lot of people believe it's kind of complicated to prescribe or to dose. And it's not, in fact.

And obviously, most of the time you would have to get prior authorization, which can be a pain with the insurer. But it's been kind of really more easily accessible. That's really from what I mentioned to you in terms of the varenicline versus placebo.

So the other study that was also very important to mention here is the adverse events, and also looking at-- and this is extremely important. Because early on, the studies came out as that varenicline, you shouldn't be using it in patients who have co-occurrent psychotic disorders, who have severe depression, or can they become very suicidal and all this stuff.

In fact, the study have demonstrated that there is no significant increase in any neuropsychiatric adverse events. And in fact, varenicline is most effective, and again, underutilized.

The patient has a question. Can I use a e-cigarette to quit smoking? Obviously, I don't want to open the can of worms with the e-cigarettes here. But I just very briefly goes through this. Because obviously, that there is a lot of these perceptions about using the e-cigarettes to quit smoking.

At the same time, what we've been seeing more and more, a lot of people using e-cigarettes and smoking at the same time. And so-- which is really-- obviously, we're even seeing it among adolescents, in fact, who do not really smoke. They use e-cigarettes. That's their first entry into the nicotine world, in a sense.

All right. This is just to show you that obviously, as you know, there is a heating system that is used in the e-cigarettes. And you've heard about recently with the whole issue with the vaping and all this, that has been leading up to all these death related to contamination with some sort of substances-- toxic substances mixed with the cannabis and all this. So that would be a really-- obviously, it's becoming more and more serious.

And unfortunately, there has been, in this understanding and separating the issue of the e-cigarette itself versus what we are doing-- what's been happening with the vaping issue and the contamination with the cannabis. Because obviously, what you have been seeing now more and more, the banning of the flavored e-cigarettes. But the issue is not just the flavor of the e-cigarettes. It's the issue of the contamination that has been happening with the cartridges.

Again, this is really-- I want to mention very briefly, the evidence for the e-cigarettes, obviously, about the question about less harmful. Obviously, they're the combustible tobacco cigarettes. And some studies demonstrating potential reduction in the cravings, some benefits. People are less likely to quit. Even some of the studies-- and so it was just kind of all over the place, in a sense. And in terms of the evidence, it's kind of weak and really conflicting.

Not FDA approved as a quit aid. As I mentioned, the chemicals that are really very problematic in the e-cigarette. And clearly, the issue that we have with the-- with becoming an epidemic, which is really among adolescent and young adults. And which is really very much of a serious public health problem now.

And again, as I mentioned earlier, this whole idea that oh, I'll switch to e-cigarettes, and I won't really smoke as much. Or I'll switch to e-cigarettes and really continue smoking. And so again, we don't also know clearly the long-term risks.

I don't have much time to discuss that. The high costs-- I bet you you've heard about this. And the-- in fact, the FDA, what the FDA did is they permitted its use. It's not necessarily they have not talked about the fact that it is really safe. The safety is not totally there. They just allowed it to be out on the market. And so, again, it's still very much of a controversial issue here.

The one thing is that-- to wrap it up here-- and unfortunately, we have that kind of a sort of a nihilistic attitude towards people who use tobacco or smokers, that they are going to never quit smoking. Or if they're going to quit smoking, they're going to never really stay quit.

And first of all, we have to change our attitude towards that issue, and accept the fact that, or really kind of come to terms with the fact, that patients want to really quit. And most patients would want to quit. Most patients are not motivated enough to quit, or most patients do not have the confidence to be able to do it.

We have to believe in the ability for people to change. Some people are going to be able to change more easily than others. But we would want to remember also that since it is-- tobacco use disorder is one of the most addictive disorder, that this is not going to be an easy process for patients to really quit using tobacco.

And the struggle is that to keep going back and forth. And then motivation is in a sense, very much of a fluid kind of issue, the clinical motivation. So one day that could be very highly motivated to quit. And they come and tell you, look, I'm ready. What should I do? What could I do? And they can come back in a week and tell you, well, I decided to go back to smoking.

So again, we need to be careful about not really confronting the fact that they are really not doing what we told them, or what we want to tell them to do and expect them to do, keeping in mind that it is not an easy kind of issue. And it is very, very challenging for them to make the changes.

So again, being patient and really practicing even with humility, and remembering that any sort of a change, particularly when it comes to tobacco use, is extremely difficult and challenging. And you want to try the best you can to help them through that whole process.

Because they can reach a point to where sometimes they can become very demoralized, because they've tried 10, 15 times. They never succeeded, in a sense.

And it could be one time, when they kind of end up with a particular situation, where they are hospitalized for a major event related to smoking, using that as a more of a window of motivation or opportunity and say, look, OK, well, you know you've struggled before. We can still work together. We can still give-- I'm not saying about necessarily giving people hope. I'm saying evoking the hope from people, particularly if they really believe in wanting to make a change.

So just to finish up here, the case, in a sense, that this is really the potential scenario that can happen, the patient leaving with varenicline or bupropion for two weeks, with nicotine patch or a gum. And refer to the quit line, the PA quitline-- 1-800-QUITNOW-- that patients can do a lot of basically over the phone, can really-- there is a lot of counseling, the skills they could learn.

And in fact, that they provide nicotine replacement for free up to eight weeks, I believe, now. And also, varenicline now has been provided through the quitline. So again, always keeping that in mind, and referring patients to 1-800-QUITNOW. And always following up with their PCP, to make sure whether they need refills on their nicotine replacement, and kind of the follow-up is extremely important.

We have a lot of tobacco treatment resources, and this is our service. We have an in-patient consult and perioperative services, and our counselors there. And we are expanding more and more. And we would be very much happy to help out with any questions or referrals about resources, what services we have. And so please feel free to reach out to us.

These are some of the benefits from the quitline, and other-- that's it. Thank you.