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Tobacco Use Disorder (TUD)

Draft for External review questionnaire available at:
https://surveymoh.health.gov.bc.ca/public/survey/external-review-questionnaire-tobacco-use-disorder

Effective Date: TBD

Preface: *Tobacco use disorder (TUD) is a chronic disease. The management of TUD may require repeated intervention and multiple attempts to reach patient goals. Examine your own assumptions and biases regarding tobacco use, who uses it, and how they use it. Routine brief intervention and education can increase cessation rates. Evidence-based treatments increase long-term abstinence rates. Treatment plans should be individually and collaboratively tailored.*

Indigenous populations: *Cultural safety and humility are critical when offering care. A First Nations Health Authority (FNHA) report states, "For thousands of years, natural tobacco has been an integral part of Indigenous culture in many parts of British Columbia and Canada. Used in ritual, ceremony and prayer, tobacco was considered a sacred plant with immense healing and spiritual benefits. For these reasons, the tobacco plant should be treated with great respect. Be careful not to confuse traditional tobacco and its sacred uses with commercial tobacco."* [1,2]

Scope

This guideline provides evidence-based recommendations for primary care practitioners on management of TUD. When the term 'tobacco' is used in this guideline, it refers to commercial, smoked tobacco and chew. Vaping is considered in the context of available evidence. The guideline focuses on TUD in patients ages 12 and older. Although the available evidence is derived from adult populations, it is the consensus of the working group that the recommendations may be applied to youth.

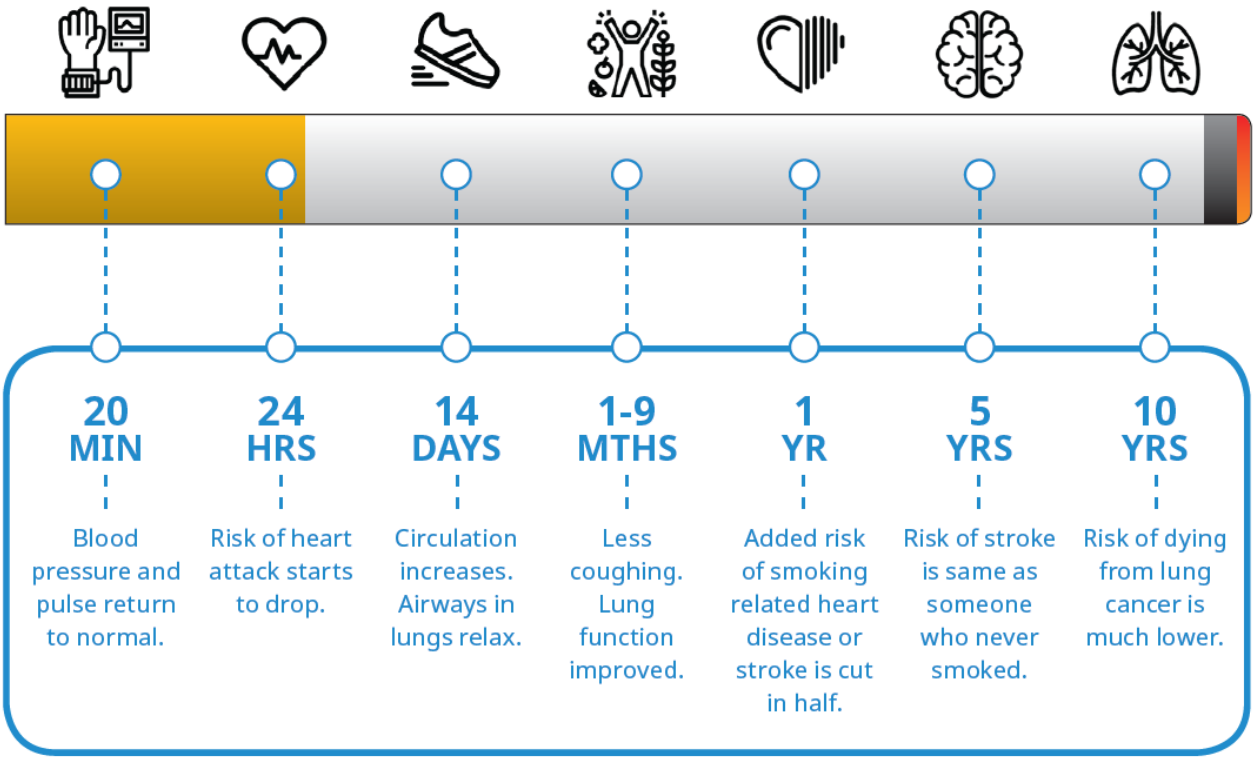
Key Recommendations

1. Ask regularly about smoking status and document tobacco use, including number of repeated cessation attempts. Discuss readiness to stop using the 5 A's approach.[3–9]
2. Acknowledge relapse is common and can be expected. If a patient has resumed tobacco use, offer education and review and adjust their smoking cessation plan.[3,4,7,9,10]
3. Continue to provide brief interventions (BI). Repeated BI is effective.[3,4,7,10,11]
4. Offer both medication and counselling, as this combination is the most effective way to stop smoking.[4–6,9–14]
    a. **Medications:** Encourage first line pharmacotherapy including nicotine replacement therapy (NRT), varenicline, and bupropion (see *Appendix A: Tobacco Use Disorder Medication Tables* for PharmaCare benefits).
    b. **Counselling:** Smoking cessation programs provide support to those who wish to make an attempt to quit smoking. Refer patients to QuitNow.
5. Consider a motivational interviewing (MI) based approach when working with patients, including those who are not ready to stop smoking. See continued learning section for MI information.[3,8,9]

Background

Smoking cessation is associated with positive health outcomes. Compared to patients who continued to smoke, patients who stopped smoking experience greater reductions in anxiety, depression, mixed anxiety and depression, and improvements in stress symptoms, positive feelings and mental wellness.

Figure 1: Benefits of Stopping Smoking[15,16] (refer patients to QuitNow)



Duration of smoking is more important than intensity or compound pack years to identify risks e.g., lung cancer, coronary artery disease, or severity of chronic obstructive pulmonary disease (COPD).[17] In addition, concerning levels of radon are present in many BC communities (refer to *BC Guideline: Suspected Lung Cancer in Primary Care* and the BC Cancer lung screening program), radon exposure acts synergistically with smoking to accentuate lung cancer risk.

Figure 2: Nicotine Use Overview[21] (refer patients to QuitNow)

	Cigarettes	Waterpipe	Smokeless tobacco	Heat-not-burn (HNB)	E-cigarettes/ vaping	Nicotine Replacement Therapy
How it enters the body:	Smoke	Smoke	Chew or snuff	Aerosol	Aerosol	Mouth or skin
What's in it:						
Tobacco	Y	Y	Y	Y	N	N
Nicotine	Y	Y	Y	Y	Y	Y
Does it increase risk or risk factors for...?						
Addiction	Y	Y	Y	Y	Y	N*
Respiratory illness	Y	Y	N	?	Y	N
Cancer	Y	Y	Y	?	?	N
Cardiovascular disease	Y	Y	?	?	Y	N
Reproductive health	Y	Y	?	?	?	?**

*NRT patches are not addictive. However, some patients might experience symptoms of addiction to short acting NRT.
**Safer than smoking and use under the guidance of a healthcare professional.

Many patients falsely believe vaping is harmless. Aerosols from vapes contain chemicals (e.g., acrolein and formaldehyde), and metals (e.g., aluminum, lead, tin and nickel), which may result in damage to the lungs. Patients may become physiologically dependent if their vape contains nicotine, which is one of the reasons why there should be a concern with the significant increase in youth use.[18] For individuals who are already smoking cigarettes, vaping may be a safer option and may assist some individuals in reducing and/or abstaining from tobacco use.[19] Refer to the Controversies in Care section for more information. Cigarette smoking remains the most common form of nicotine use. In 2022, approximately 3.5 million Canadians (15 and older) currently smoke cigarettes.[20] Refer to Health Canada to learn more about different nicotine delivery systems (e.g., smokeless tobacco, cigars, cigarillos and pipe tobacco, pipe tobacco, bidis and hookahs).

Epidemiology

- In Canada one of the most prevalent contributors to premature death is smoking, including second hand smoke exposure,[17,21] with the health issues caused by smoking killing up to 50% of those who smoke.[21,22]
- Tobacco [smoking] is the leading cause of preventable death in British Columbia. Over 6,000 deaths in BC each year are attributed to tobacco smoking, more than deaths due to all other drugs, motor vehicle collisions, murder, suicide, and HIV/AIDS combined. The main causes of smoking-related deaths are cancers, cardiovascular disease, and respiratory diseases.
- The 2021 Canadian Nicotine and Tobacco Survey found that among youth aged 15 to 19, 3.3% currently smoke, while approximately 12% of BC teens have vaped in the past 30 days. A large portion of teens believe there is no or slight risk in the occasional use of vapes with nicotine (44.9%) and without nicotine (60.5%). [23,24]

Screening and Brief Intervention

Screening and initial intervention are within the scope of practice for all primary care practitioners. Primary care providers play an important role in early detection and intervention for TUD. TUD can be quickly and easily identified using simple screening tools (see below) within a few minutes.

Discuss patient's readiness to stop using the 5 As approach (see more information here).[7]

Interdisciplinary Care (Where Available)

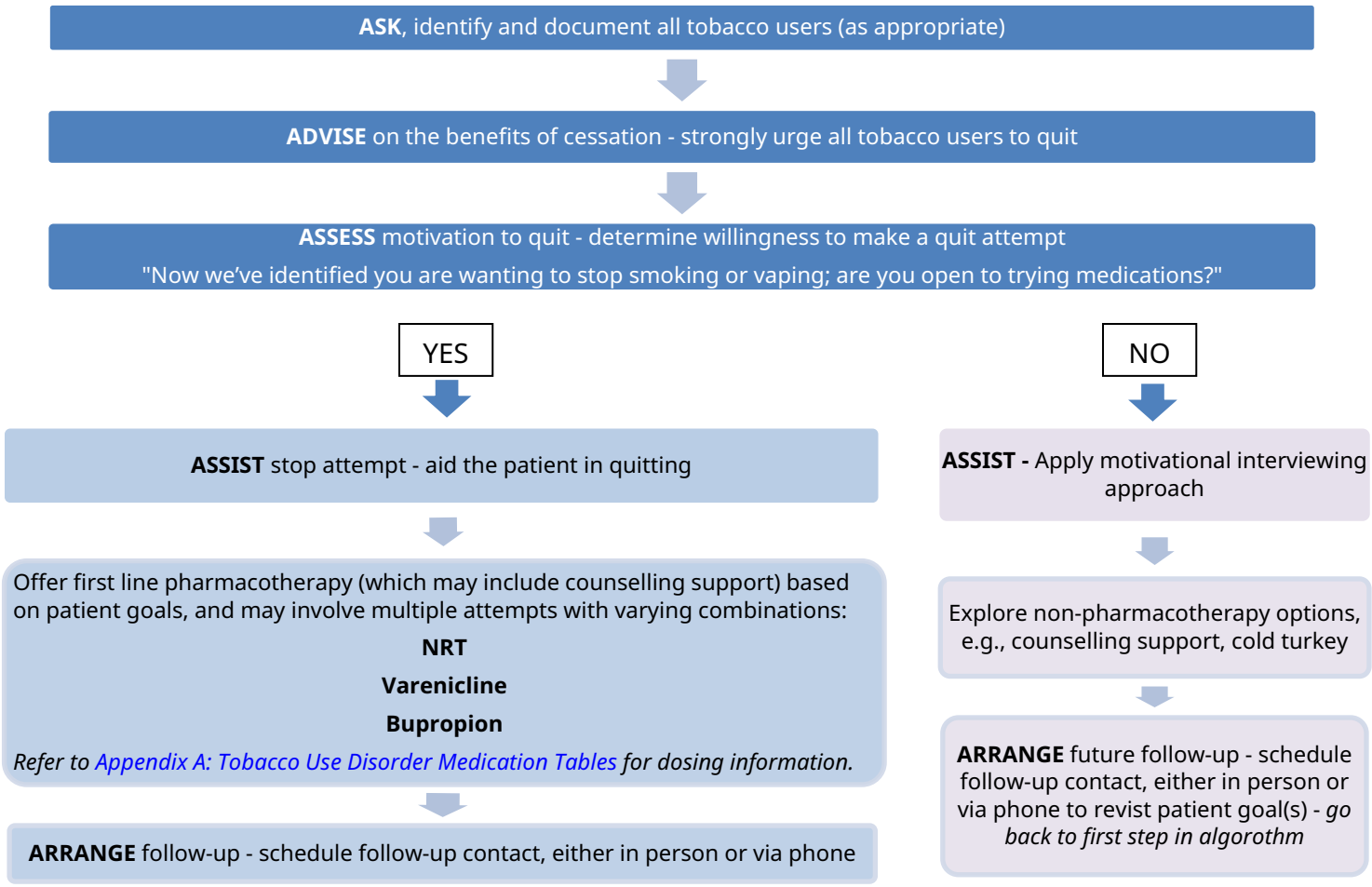
All health professionals, including, nurses, community pharmacists, and medical office assistants can support smoking cessation efforts.[7,25–27]

Pharmacological Management

Relapse following tobacco reduction or cessation is common and can be expected. If a patient presents having relapsed, provide education on how common this is and validate their experience. Recommend reviewing smoking cessation plan to see if there are adjustments that may improve success.

- Provide information about effective stop-smoking medication to everyone who wants help to stop. The approved stop-smoking medication that are available in Canada are: nicotine replacement therapy (NRT), varenicline and bupropion.
- These medication help reduce unpleasant withdrawal symptoms, which makes smoking cessation easier. Even if they do not intend to stop smoking long term, NRT can be used to relieve tobacco withdrawal symptoms in settings where patients cannot smoke (for example, hospitals).
- Check that patients understand how to use their chosen cessation medication.
- Monitor for predictable side effects in all patients using medications for smoking cessation.[12]
- Stopping smoking can affect the metabolism of other drugs (e.g., caffeine, clozapine and warfarin), which may need dose adjustment regardless of the type of stop-smoking medication being used. Refer to the NHS' clinically significant drug interactions document for an overview.

Figure 4: Tobacco Cessation Algorithm[3]



NOTE: To prevent relapse, patients should be instructed to taper off NRT by no more than 7mg per week. This helps them adjust to lowering nicotine levels. In the case a patch dose decrease is linked with a burdensome increase in tobacco craving, that dose can be maintained for 3 to 4 weeks before an additional decrease is attempted.[28]

Pharmacotherapy options

- Pharmacological approaches are best used in combination with supportive counselling approach.
- Based on practitioner discussion they may be used for longer periods of time than standard instruction, but they are not as effective if used for a shorter duration.[29,30]

Nicotine replacement therapy (NRT)

- Cravings can be reduced by using NRT, as it delivers nicotine that would have been obtained through tobacco use.[10]
- Long-term abstinence rates can be enhanced by NRT, no matter which product is used.[10]
- For patients who are not ready to stop smoking immediately, NRT can help them reduce their smoking prior to stopping. However, patients who choose to use NRT to support abrupt cessation are more likely to succeed.[10,31]
- Initial NRT dosing is typically based on number of cigarettes consumed per day, but with those who heavily smoke, more than one patch can be recommended for simultaneous use. This can also apply to the combination of two different NRT formats (e.g., patch and gum).[27]
- More than one form of NRT (i.e., combination NRT) can be used concurrently with increased success rates and no increased safety risks.[11] See *Appendix A: Tobacco Use Disorder Medication Tables* for PharmaCare benefits.
- Compared to single form NRT, combining a nicotine patch with a faster-acting NRT (e.g., gum,

lozenge), six- to 12-month abstinence rates increased by 5%.[11]

- When using NRT exercise caution in patients who have had a recent myocardial infarction, unstable angina, severe arrhythmias or recent cerebrovascular events. It is safe for patients with stable cardiovascular disease to use NRT.[11]
  - Compared to placebo, NRT is more effective in assisting smoking cessation for 6 or more months, and are safe for use in patients with cardiovascular disease (CVD).[32]
- NRT is recommended to be used for a minimum of eight weeks. Some individuals may find benefit in using NRT for longer than 12 weeks, although durations beyond 12 weeks are not currently included in Pharmacare coverage.[10]
- NRT can also be used for smoking reduction as a step towards smoking cessation for patients who are unable or not willing to stop smoking abruptly.[10,11]

Varenicline (Also known as Champix, generic brand now available in BC)

- Varenicline is the most effective pharmacotherapy agent. Clinicians may recommend the use of varenicline in combination with NRT, rather than varenicline alone.[11] It can more than double a patient's chance of stopping smoking since it reduces their cravings and the 'reward' they receive from smoking.[10]
- Varenicline should be started a minimum of one week prior to the patient's quit date and used for 12 weeks.[33]
- For some patients who have abstained from smoking after a standard course of varenicline, consider a further course to reduce relapse.[11,34]

Bupropion (Also known as Wellbutrin, Zyban, generic brand now available in BC)

- Bupropion reduces tobacco withdrawal symptom severity and can increase a patient's chance of smoking cessation.[10]
- Bupropion is less effective than varenicline or combination NRT.[11]
- Patients with a history of seizures should not use bupropion.[10]
- Those under the age of 18 years or pregnant or breastfeeding patients must not use bupropion.[10] Refer to PSBC Tobacco Use in the Perinatal Period Guideline (currently being revised) for more information or the American College of Obstetricians and Gynecologists' Committee (ACOG) Opinion on Tobacco and Nicotine Cessation During Pregnancy (2020).
- Bupropion should be started a minimum of one week prior to the patient's quit date and used for at least seven weeks.[10,11]

Figure 3: Supporting Your Patients During Cessation Attempts

Ongoing Support of Your Patient

Resuming use is common. Your approach may look like this:

1.

That's ok, this is something that is quite common when people try something new.

2.

Then ask, "What would you like to do next?"

- If the person wants to make a new plan, follow the steps on the Centre for Collaboration, Motivation and Innovation (CCMI) CCMI Brief Action Planning Flow Chart. Use problem solving and a behavioral menu when needed.
- They may want to talk about what they learned from their action plan. Reinforce learning and adapting the plan.
- If the person does not want to make another action plan at this time, offer to return to action planning in the future.

Controversies in Care

Alternative and Emerging Therapies for Smoking Cessation

Vaping

- For individuals who are already smoking cigarettes, evidence shows that vaping may be a less harmful option and may assist some individuals in reducing and/or abstaining from tobacco use.[35–37] Refer to Quitnow.ca.

However,

- Youth who vape are more likely to transition to smoking.[24]
- There is a possibility that tobacco industry interference in tobacco cessation efforts, includes offering misinformation about the potential benefits of vapes, and targeting youth through the introduction of fruity, menthol or mint flavor cartridges.[38]
- No vaping is without risk. The Canadian Lung Association and the Canadian Thoracic Society feel that vaping presents risks for more nicotine dependency and risks to lung and overall health.[39]
- Currently, the evidence around the harms, efficacy and safety of vaping is emerging. However, multiple organizations[6,11,12,38,40] are still navigating this topic area. as it continues to evolve.

Although there may be generalized wellness benefits of certain interventions, many do not have specific evidence of efficacy in smoking cessation. Encourage patients to utilize evidence-based approaches for the best likelihood of success. There is mixed quality evidence that suggests efficacy for the following:

- **Heated Tobacco Products (HTPs):** Some HTPs use electronic heating elements e.g., capsules containing tobacco, others have a sealed component of the device that heats loose tobacco, sometimes in combination with cannabis.[41] The effectiveness of HTPs for cigarette smoking cessation remains uncertain. Those who use HTP may have lower exposure to toxicants/carcinogens compared to those who smoke.[42]
- **Acupuncture, acupressure, laser therapy and electrical stimulation:** Electrostimulation is not effective for smoking cessation, while acupuncture, acupressure, and laser therapy may offer short term benefits under 6 months.[43]
- **Hypnotherapy:** It is unclear if hypnotherapy is more effective for smoking cessation compared to other forms of behavioural support or unassisted cessation.[44]
- **Mindfulness:** There is no clear benefit of mindfulness-based smoking cessation interventions for increasing smoking cessation rates or changing mental health and well-being.[45]
- **Smoking cessation competitions:** These competitions do not increase long-term cessation rates.[46]

Special Populations

Be aware that certain populations have a higher incidence of smoking and more barriers to quit e.g., socioeconomic status, race/ethnicity, social marginalization, stress, and lack of community empowerment.[47]

- **Pregnant and Breastfeeding Patients:**
  - Refer to PSBC Tobacco Use in the Perinatal Period Guideline (currently being revised) for more information or the American College of Obstetricians and Gynecologists' Committee (ACOG) Opinion on Tobacco and Nicotine Cessation During Pregnancy (2020)
- **Mental Health and Other Substance Use Disorders**:
  - Patients with mental health disorders and those with substance use disorders begin and continue to use tobacco for a variety of reasons, including self-medication, social circumstance, and tobacco industry influence.[48] There are higher smoking rates among these populations and potential contraindications with psychiatric medications.

Quality Improvement (QI)

Smoking cessation interventions at a practice level are well suited to QI work. Talk to a Physician Support Program (PSP) coach regarding Continuing Medical Education (CME) credits and funding for QI project relating to smoking cessation: psp@doctorsofbc.ca

Denominator for following:

- Tobacco use prevalence (includes smoking, vaping nicotine, and chew) - all active patients ages ≥ 12
- Tobacco use prevalence - all active patients ages 12-19 inclusive
- Tobacco use documented in past 2 years – all active patients

Denominator for following: All active patients currently using tobacco

- % patients with tobacco cessation discussion documented
- % patients with dedicated tobacco use cessation consult and/or follow-up (behavioural, pharmacological, both)

Resources

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Abbreviations

BI	Brief intervention
HTP	Heated tobacco products
MI	Motivational interviewing
NRT	Nicotine replacement therapy
SSRI	Serotonin reuptake inhibitors
TUD	Tobacco use disorder

Diagnostic/Billing Codes

Code	Fee Name	Notes	Cost
PG14066	Personal Health Risk Assessment (Prevention)	This fee is payable to the family physician who is most responsible for the majority of the patient's longitudinal primary medical care and who undertakes a Personal Health Risk Assessment with a patient in one of the designated target populations (obese, tobacco use, physically inactive, unhealthy eating). The FP is expected to develop a plan that recommends age and sex specific targeted clinical preventative actions of proven benefit, consistent with the Lifetime Prevention Schedule and GPAC Obesity and Cardiovascular Disease – Primary Prevention Guidelines. The Personal Health Risk Assessment requires a face to face visit with the patient or patient's medical representative. PG14066 is payable only to MRP Family Physicians who have submitted PG14070 or PG14071. More information.	$50.00

Appendices

- Appendix A: Tobacco Use Disorder Medication Tables
- Appendix B: Validating and Invalidating Statements and Curious Questions
- Appendix C: Avoiding Practice Traps

Associated Documents

The following documents accompany this guideline:

- BCGuidelines: *Asthma*
- BCGuidelines: *Cardiovascular Disease - Primary Prevention*
- BCGuidelines: *Chronic Obstructive Pulmonary Disease (COPD): Diagnosis and Management*
- BCGuidelines: *Suspected Lung Cancer in Primary Care*
- Resource List
- Patient handouts –
    - Patient postcard
    - Patient handout (full sheet)
    - Youth vaping handout – Print format
    - Youth vaping handout – Online format
- List of Contributors – TBA

This guideline is based on scientific evidence current as of the effective date.

This guideline was developed by the Guidelines and Protocols Advisory Committee in collaboration with the Provincial Laboratory Medicine Services and adopted under the Medical Services Act and the Laboratory Services Act.

THE GUIDELINES AND PROTOCOLS ADVISORY COMMITTEE

The principles of the Guidelines and Protocols Advisory Committee are to:

- encourage appropriate responses to common medical situations
- recommend actions that are sufficient and efficient, neither excessive nor deficient
- permit exceptions when justified by clinical circumstances

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Disclaimer

The Clinical Practice Guidelines (the guidelines) have been developed by the guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problem. **We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a health care professional.**

Appendix A: Tobacco Use Disorder Medication Tables

Each calendar year, PharmaCare will automatically cover a single continuous course up to 12 consecutive weeks for BC residents of either:

- nicotine replacement therapy (NRT) at 100%
- prescription medication; subject to patient's PharmaCare plan.

The 12-week course starts the day of the first fill and the remaining fills must be dispensed within the 12-week period. Any refills after 12 weeks will not be covered by PharmaCare. For example, if the first fill is on March 10, coverage ends automatically 84 days later on June 2 and resets on January 1 the following year. This policy includes the short acting products (gum and lozenges).
For more details see: Smoking Cessation Program – for prescribers - Province of British Columbia (gov.bc.ca)
Important tips for NRT:

- Patients do not need a prescription for NRT
- Must be filled monthly
- Only specific products
- Only one product at a time; can switch for next fill

Covered NRT products in the BC smoking cessation program.

Product	Strength	Quantities		
		Per box	Per fill	Total per year
Nicorette gum, ultra fresh mint flavour only	2mg; 4mg	105 pieces	315 pieces	945 pieces
Nicorette lozenge, mint flavour only	2mg; 4mg	80 lozenges	240 to 320 lozenges	800 lozenges
Nicoderm patch	7mg, 14mg, 21mg	7 patches	28 patches	84 patches

Important tips for prescription drugs in the program:

- Not 100% coverage for everyone, subject to patient's PharmaCare plan and deductible
- No special authority form required
- Must be filled monthly
- Only Zyban brand for bupropion, and generic for varenicline

Covered prescription drugs in the BC smoking cessation program

Drug	Strength	Approx. Cost per Month[C]	PharmaCare Coverage[B]	Prescription Requirements
Bupropion (Zyban brand only)	150mg SR	Zyban: $70	Regular benefit for smoking cessation. Limited to 12 weeks per calendar year.	Prescriber must include on prescription: • Zyban, no substitutions • for smoking cessation • dispense in 28-day supply
Varenicline (generics only)	0.5mg, 1mg	$55	Regular benefit. Limited to 12 weeks per calendar year.	Prescriber must include on prescription: • no substitutions • for smoking cessation • dispense in 28-day supply

Dosage Form *Trade names* Dosage strengths and pack sizes	Usual Adult Dose	Approx. Cost per Month[A]	PharmaCare Coverage[B]	Adverse Effects	Therapeutic Considerations
NICOTINE REPLACEMENT THERAPIES					
Short acting					
Gum *Nicorette, Thrive, G* 2mg, 4mg 24, 30, 36, 96, 105, 210 pieces Nicorette flavours: mint, cinnamon, fruit Thrive flavours: mint, fruit	~ 1piece/hr PRN Max: 20 pieces/d Individual taper.	$100- $160 based on average of 10-16 pieces per day	Over the counter. Non benefit	Cough, throat irritation (usually mild), hiccups, nausea/dyspepsia (from swallowed nicotine), jaw pain (if incorrect technique)	Bite and Park Strategy: bite gum 1-2 times, then park it between the cheek and the gum x1min; then repeat alternating sides. Use until peppery taste is gone. Use 4mg if history of smoking within 30 minutes of waking. Coffee & acidic beverages (e.g., juice, soda) impair absorption; space by ≥15 minutes.
Nicorette for the program (see table)			Full coverage for 12 weeks		
Lozenge *Nicorette, Thrive, G* 1mg, 2mg, 4mg 20, 36, 80, 108, 160 lozenges Nicorette flavours: mint, fruit Thrive flavours: mint	1 loz. q1-2 hour x6 week, q2-4hr x3wk, q4-8hr x3wk Max:15 lozenges/d Individual taper.	$175- $330 based on average of 8-15 lozenges per day	Over the counter. Non benefit	Mouth irritation, soreness in gums, teeth, & throat, nausea/dyspepsia (from swallowed nicotine)	Move lozenge occasionally from one side of mouth to the other until dissolved (about 20-30 mins). Do not bite, swallow or chew. Note: 2mg lozenge ≈ 4mg gum. Can be used in those with temporomandibular disorders, poor dentition, or dentures. Avoid if phenylketonuria; lozenge contains phenylalanine. Coffee & acidic beverages (e.g., juice, soda) impair absorption; space by ≥15 minutes.
Nicorette for the program (see table)			Full coverage for 12 weeks		
Inhaler *Nicorette* 4mg 42 cartridges	6-16 cartridges/d x12wk Max: 16cartridges/d Individual taper.	$165-$330 based on average of 6-12 cartridges per day	Over the counter. Non benefit	Throat irritation, cough, rhinitis, dyspepsia	Inhale deeply into back of the throat or puff in short breaths. Max absorption with short, continuous, frequent puffing. 1 cartridge delivers 4mg of nicotine (2mg is absorbed), replaces 1-2 cigarettes and lasts up to 20 minutes of continuous frequent puffing. Once punctured, inhaler cartridge viable for 24 hours. Helpful for hand to mouth habit associated with smoking.
Quick Mist *Nicorette* 1mg 150 sprays Flavours: Fresh mint, cool berry	1-2 sprays q 30 mins x 6 wks; reduce # of sprays per day by half x3wks; 2-4 sprays per day x3wks. Max doses: 2 sprays at a time; 4 sprays/hr 64 sprays/d	$200-$250 based on average of 20- 26 sprays per day	Over the counter. Non benefit	Hiccups, throat irritation, nausea	Spray into mouth, avoiding lips. Wait a few seconds before swallowing. Do not inhale spray. Contains small amounts of ethanol, less than 10 mg per spray. Quick delivery convenient for severe cravings (note: still slower absorption than cigarette due to buccal mucosa absorption).

Dosage Form *Trade names* Dosage strengths and pack sizes	Usual Adult Dose	Approx. Cost per Month[A]	PharmaCare Coverage[B]	Adverse Effects	Therapeutic Considerations
Long acting					
Patches *Nicoderm, Habitrol, G* 7, 14, 21mg/hr 7, 14 patches	If ≥10 cigarettes/day: 21mg/d x 6 wks, then 14mg/d x 2 wks, then 7mg/d x 2 wks If < 10 cigarettes/day: 14mg/d x 6 wks, then 7mg/d x 2 wks	$120- 190	Over the counter. Non benefit	Local irritation to adhesive may occur. Alternate patch site, apply topical corticosteroid cream, or switch to another agent Insomnia. If this occurs, can take off at bedtime and apply another patch in the morning.	Apply new patch to clean, dry, non-hairy area every day in the morning. Rotate sites. Do not cut patch. Consider for people who smoke upon waking. Consider alternative for severe eczema, psoriasis, or other generalized skin disorders. Use until feeling stabilized as a non-smoker. May be continued >12 wks; NRT safer than smoking. Consider NRT for longer period for comorbid psychiatric illness and/or substance use disorders. Off-label: If higher doses than 21mg/d are being considered, shared decision making and a discussion on nicotine toxicity is recommended.
Nicoderm for the program (see table)	Individual taper.		Full coverage for 12 weeks		
Note: new NRT products may be available in Canada that are not listed here (e.g., Sesh+, Zonnic).					
Generic Name *Trade name* Dosage form and strengths	**Usual Adult dose**	**Approx. Cost per Month[C]**	**PharmaCare Coverage[B]**	**Adverse Effects**	**Therapeutic Considerations**
PRESCRIPTION PHARMACOTHERAPIES					
Bupropion *Zyban, G* 150mg SR tablets	150mg SR daily X 3days, then 150mg SR BID X 12 weeks	$35	Generic: -Limited coverage for depression -Non benefit for smoking cessation Zyban: see table above	Insomnia, agitation, tremor, decreased appetite, nausea, dry mouth	Begin ≥ 1 week before cessation of smoking. Longer duration of treatment can be considered, based on previous quit attempts and patient preference. Contraindications: seizure disorder, predisposition to seizure, pre-existing/current eating disorder, past/present excessive use of alcohol or benzodiazepines, on MAO inhibitors within 14 days. Option in concomitant depression.

Generic Name *Trade name* Dosage form and strengths	**Usual Adult dose**	**Approx. Cost per Month**[C]	**PharmaCare Coverage**[B]	**Adverse Effects**	**Therapeutic Considerations**
Varenicline *Champix, G* 0.5mg, 1mg tablets	0.5mg daily X 3 days, then 0.5mg BID X 4 days, then 1mg BID X 12 weeks	$55	Regular benefit for 12 weeks	Nausea (dose dependent, initial titration may reduce), disordered sleep, including insomnia and abnormal (vivid or strange) dreams Early concerns about neuropsychiatric and cardiovascular side effects are not supported by subsequent studies, and varenicline is generally considered safe.	Fixed quit approach: start 1-2 weeks before set quit date. Flexible quit approach: quit smoking between days 8 and 35 of treatment. Gradual quit approach: Reduce smoking gradually (e.g., ≥ 50% reduction by 4 weeks, ≥ 75% by 8 weeks, 100% by 12 weeks). Recommend 24-week course. Precautions: using NRT concomitantly, operating heavy machinery (until reaction to medication is known). If successfully quit at 12 weeks but concern for relapse, may benefit from additional 12 weeks. Dose tapering may minimize discontinuation symptoms (e.g., irritability, urge to smoke, depression). Symptoms observed in up to 3% of patients.

Abbreviations: **bid**: twice daily; **d:** day; **hr**: hours; **kg:** kilogram; **mg**: milligrams; **mins:** minutes; **prn**: as needed; **SR**: sustained release; **q:** every; **wks:** weeks; **y**: years of age.

[A] Drug costs are average retail cost although this fluctuates between retail settings. Current as of Dec 2022.

[B] PharmaCare coverage as of Nov 2022 (subject to revision). Regular Benefit: Eligible for full reimbursement*. Limited Coverage: Requires Special Authority to be eligible for reimbursement*. Non-benefit: Not eligible for reimbursement. *Reimbursement is subject to the rules of a patient's PharmaCare plan, including any deductibles. In all cases, coverage is subject to drug price limits set by PharmaCare. See: www.health.gov.bc.ca/pharmacare/plans/index.html and www.health.gov.bc.ca/pharmacare/policy.html for further information. * Special Authority drug list

[C] Drugs costs are average retail cost of the generic, when available. Current as of Nov 2022 and does not include retail markups or pharmacy fees.

References:

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2. Jobson MD. UpToDate [Internet]. Waltham, MA: UpToDate Inc.; c2019 [Accessed November 18, 2022]
3. Health Canada Drug Product Database Product Monographs. Ottawa, ON: Health Canada; 20194 [Accessed November 18, 2022].
4. Regier L et al. Tobacco Use Disorder/Smoking Cessation. [Internet]. Rx Files. Aug 2021. [Accessed November 24, 2022].

Note: Information on which products PharmaCare covers can be obtained using the B.C. PharmaCare Formulary Search (https://pharmacareformularysearch.gov.bc.ca/).

Appendix B: Validating and Invalidating Statements and Curious Questions

Remember not to focus on what happened; focus on how the patient feels about the situation. To address feelings, you must use emotional language, not rational or judgmental language. Nonverbal cues such as body language, eye contact, and tone of voice are just as important as the words that you say.

Examples of validating statements

"I can see that you are very (upset, sad, frightened, scared)"

"Here's what I'm hearing you say" (*Summarize with fact checking).*

"I can see how hard you are working."

"Wow, that (she/he) must have made you feel really angry/sad, etc."

"I can see this is important to you."

"It makes sense you would be so upset about that."

"I can see you're overwhelmed. Can we talk?"

"It's going to be hard… and I know you will figure it out."

"Tell me what's that like for you?"

Examples of curious questions

"Can I ask some questions?"

"Tell me more."

What are you feeling?

What am I not getting?

Can you give me a stress #? 1 = I'm OK, 10 = I'm drowning!!

Are you safe?

Tell me what worries you.

Examples of invalidating statements

"I hated it when that happened to me." *(Make it about you.)*

"You should feel lucky, thankful…" "What's the big deal?" *(Tell them how they should feel.)*

"What you really should do is…" *(Try to give advice.)*

"Well, life's not fair…" *(Make "life" statements.)*

"What you did was wrong/bad…good/great…" *(Make judgmental statements.)*

"I bet they were just…" *(Rationalize another person's behavior.)*

* Adapted from: www.borderlinepersonalitydisorder.com

Appendix C: Avoiding Practice Traps

Practice Trap*	When you identify the practice trap, change it to:
Fixing and wanting to be helpful to the point of not hearing the patient – thus reproducing abuse dynamics of trauma	Listen with empathy, respect and patience.
Lecturing instead of listening: This is sometimes triggered by time pressures and the perceived necessity to provide ALL of the information. This can make the patient feel disrespected and result in loss of collaboration.	Know when/how to give advice and when to just listen, empathize and give structured choice when appropriate.
Feeling overwhelmed can result from feeling pushed, especially when the patient's situation is so complex that it is hard to know where to start.	Focus on being in the moment. Practice and teach relaxation techniques. • Demonstrating a breathing exercise (e.g., box breathing, or taking a few deep breaths together) at the start of a visit to establish a calm tone and model a simple way to self-soothe. Set boundaries by explaining the length of the visit, choose a priority to work on together, and schedule a follow up. • Use an incremental/longitudinal approach – small steps over time. • Set agendas for more frequent, shorter visits for complex medical issues. • Involve other care providers on the team. Consider reaching out to a colleague for support. • "I need time to think about it/talk to a colleague about it. I will get back to you."
Rigidity: belief that there is only one way for patients to recover.	Flexibility.
Believing that information alone can cause change	Appeal to the emotional instead of the rational (connect to heart). Refer to *Appendix B: Validating and Invalidating Statements and Curious Questions*.
Losing awareness of body language and facial expression can result in expressions of excessive sympathy, dismay, frustration or shock that can have an unintended impact on the conversation.	Register your intention, clarify, and move on.