NATIONAL GUIDELINES

For

TOBACCO CESSATION

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1. INTRODUCTION

This learning module is designed to empower clinicians, health educators and counselors to provide the best behavioral modification strategy / Pharmacotherapy for tobacco cessations

Tobacco use is leading cause of preventable deaths all over the world. According to WHO there are 1100 million smokers worldwide, which constitutes one-third of global population aged 15 years and above. 73% (800 million) of these are in developing countries and 27% (300 million) in developed countries. Tobacco use is responsible for 3 million deaths globally every year, two-third of these occur in developed nations. It has been estimated that without urgent interventions mortality due to tobacco use will rise to 10 million every year over the next 30-40 years, 70% of which will occur in developing nations.

In view of mortality and morbidity burden due to tobacco use it has become imperative to take urgent steps to curb the growing menace of tobacco. Decrease in prevalence of tobacco can be effectively done through two-pronged approach: large scale promotions to educate the people about the harmful effects of tobacco use and benefits of quitting along with providing adequate facilities to those who want to quit. Various methods that are available for quitting should also be publicized as most people who want to quit are not aware of means available to them. Tobacco cessation measures should be regular part of healthcare delivery system.

Health care providers are very effective change agents for tobacco using subjects. A fifteen minute, one-on-one tobacco/cessation session is accepted better by patients than most other methods of non-pharmaceutical cessation methods. Specific programs increase tobacco cessation rates, which benefit the subject's health and are cost effective.

Tobacco use is one of the leading preventable causes of illness and death. The most powerful predictor of adult tobacco use is smoking during adolescence. Tobacco use is growing fastest in low-income countries, due to steady population growth coupled with tobacco industry targeting, ensuring that millions of people become fatally addicted each year. More than 80% of the world's tobacco-related deaths will be in low- and middle-income countries by 2030.

TOBACCO IN INDIA

Tobacco cultivation started about 8000 years back. The Portuguese introduced tobacco in India during 1566.Tobacco became the valuable commodity and the use spread like a wild fire.Tobacco is one of the major causes of deaths and disease in India, accounting for over eight lakh deaths every year. The variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist and they account for about 35 percent of the total tobacco consumption.

According to the National Family Health Survey-2 conducted by International Institute of Population Sciences in 1998-99, the prevalence rate among males for chewing tobacco was 28.3% and for smoking tobacco, 29.4%. For females, the corresponding prevalence rates were 12.4 and 2.5 percent respectively. Based on the National Family Health Survey-2 age specific data, it is estimated that in the thirty plus age group, smoking prevalence among men is 41.2%. Further, 35.4% of men and 18.2% of females use chewing tobacco in this age group.

The prevalence of tobacco use among the youth has been surveyed by the Global Youth Tobacco Survey (GYTS) supported by CDC and WHO. GYTS is a tobacco specific survey to track the prevalence of tobacco use among 13-15 year age group school going students. GYTS has been conducted in different states of India in the period 2000-2004. As per this survey, 17.5% of 13-15 year old students are using tobacco in some form.

The prevalence of tobacco use among the Indian Dental Students has also been surveyed by the GHPS (Global Health Personnel Survey) supported by CDC, Canadian Public Health Association and WHO. The results of the Global Health Professional Survey done in India among dental students reported that 9.6% currently smoke cigarettes comprising 14.9% males and 2.4% females respectively.

National Family Health Survey (NFHS) is household based survey, conducted on the pattern of the DHS survey. In 1998-99, National Family Health Survey provided information on the prevalence in the use of Tobacco and Tobacco products by asking questions to the household head. However, in 2005-06 (NFHS-

3), questions on Tobacco use were asked to individual women and men in the sample, in the age group 15-49 and 15-54 respectively.

About NFHS-3 (2005-06)

National family health survey (2005-06) is the third in the series, first being conducted in 1992-93, and the second one conducted in 1998-99.
It covered all the 29 states, covering around 109,041 households, 124,385 women in the age 15-49 and 74,369 men age 15-54.

Fact Sheet:

Any Tobacco Use-Prevalence:

- 57% men
- 10.8% women

Currently Smoke Cigarette or Bidi

- 32.7% men
- 1.4% women

Currently chew pan masala, gutkha or other tobacco

- 36.5% men
- 8.4% women

Maternity Status

- 8.5% of pregnant women use any kind of tobacco
- 10.8% of women who are breastfeeding their children use any king of tobacco

Daily frequency of smoking

- 43% of male smokers and 26% of women smokers reported they smoked 10 or more cigarettes or bidis in the previous 24 hours.

Smoking and Level of Education

- Tobacco use is more prevalent among both men and women with no education. 78% of men and 18% of women with no education use tobacco. Compared to no education, 38% of men and 1% of women with 12 or more years of education use tobacco.
- Smoking increases with age – About 44% of men in age group 35-49 years smoked cigarette or bidi compared to 33% in the age group 20-34 and 12% in the age group 15-19.

Tobacco use is more prevalent among rural population:

- 35% of rural men smoke cigarettes or bidis compared with 29% of urban men.
- About 4 out of every 10 men living in rural areas chew tobacco compared too 3 out of 10 urban men.
- One in every 10 women in rural areas chews tobacco.

High Rates of Tobacco Use

- In 17 out of 29 states, tobacco use prevalence is more than 60%
- More than 7 in every 10 men in Mizoram consume some from of tobacco, followed closely by Tripura (76%) and Assam (72.4%).

Higher prevalence among Poor and Vulnerable section

- Based on the economic status of households, disparities in tobacco use between lowest and the highest quintile for men and women is ground 35 and 18 % points receptively.

TOBACCO HABITS

In India tobacco is used in variety of forms, mainly- smoking, chewing, applying, sucking, gargling etc. The type of use of tobacco by the individual is dependent on many factors. Beedi smoking is the most popular form of tobacco smoking followed by cigarette smoking. Oral use of smokeless tobacco is widely prevalent.

The types of tobacco used are described below:

Type of tobacco use	Smokeless forms
• Bidis • Cigarettes • Cigars • Cheroots • Chuttas • Reverse chutta smoking • Dhumti • Pipe • Hooklis • Chillum • Hookah	• Paan (betal quid) • Paan masala • Tobacco, areca nut ad slaked lime preparations • Mainpuri tobacco • Mawa • Tobacco and slaked *(lime Khaini)* • Chewing tobacco • Snus

Tobacco products for application

- Mishri
- Gul
- Bajjar
- Lal Dantmanjan
- Gudhaku
- Creamy snuff
- Tobacco water
- Nicotine chewing gum

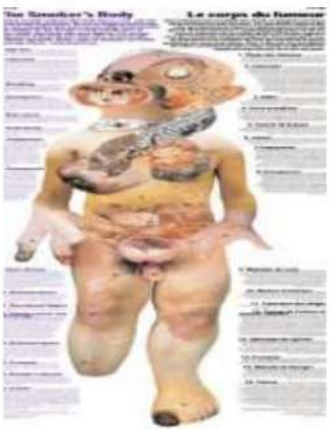
Areca nut preparations

- Areca nut
- Supari
- Meetha mawa

Smoking	***Chewing***	***Snuff***	***Application***
cigarette	pan masala	Fine powder	powder
beedi	zarda		paste
hookah	gutkha		
dhumti	khaini		
chuta	paan		
cigars			

ALL THE TOBACCO PRODUCTS ARE HARMFULL AND ASSOCIATED WITH CANCER

2. TOBACCO AND HEALTH



Tobacco smoke contains over 4000 chemical compounds including tar, carbon monoxide, nicotine, hydrogen cyanide, acetone, ammonia, arsenic, phenol, naphthalene, cadmium and polyvinyl chloride. Many of these agents are toxic and at least 43 can cause cancer (www.treatobacco.net). Examples of these are nitrosamines and benzopyrines. Smokeless tobacco is major concern in India and known to cause oral cancer. There are evidence that it causes some other cancer as well.

Tobacco is a known or probable cause of many diseases. .

Table : Health effects of Tobacco use

Eyes	:	macular degeneration
Hair	:	Hair loss
Skin	:	ageing, wrinkles, wound infection
Brain	:	stroke
Mouth & pharynx	:	cancer, gum disease
Lungs	:	cancer, emphysema, pneumonia
Heart	:	coronary artery disease
Stomach	:	cancer, ulcer
Pancreas	:	Cancer
Bladder	:	Cancer
Women	:	cervical cancer, early menopause, irregular and painful periods

NOT A SINGLE PART OF BODY IS SPARED FROM HARMFUL EFFECT OF TOBACCO

3. NICOTINE ADDICTION

Nicotine is an alkaloid found in the nightshade family of plants (*Solanaceae*) which constitutes approximately 0.6–3.0% of dry weight of tobacco, with biosynthesis taking place in the roots, and accumulating in the leaves. According to the American Heart Association, the "nicotine addiction has historically been one of the hardest addictions to break." The pharmacological and behavioral characteristics that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine. Nicotine content in cigarettes has actually slowly increased over the years.

Why is it so hard to quit?

Nicotine :It is hard to quit because nicotine, a drug found naturally in tobacco, is highly addictive. In fact, it is as addictive as heroin or cocaine. Over time, users become physically and psychologically dependent on nicotine. Studies have shown that they must deal with both of these dependencies to quit and stay quit.

Where nicotine goes and how long it stays: Nicotine enters the bloodstream from the mouth and is carried throughout the body. It affects many parts of the body, including your heart and blood vessels, your hormones, your metabolism, and your brain. During pregnancy, nicotine freely crosses the placenta. Nicotine has been found in amniotic fluid and the umbilical cord blood of newborn infants.

Assessing nicotine dependence

Nicotine acts as an agonist at ganglionic cholinergic receptors inboth the peripheral and central nervous system and causes the release of a number of neuro-transmittors including dopanine, noradrenaline, acetylcholine and serotonin.

Nicotine affects the:

- Central nervous system – a range of short term effects including pleasure, arousal, improved short term memory, improved concentration and decreased anxiety
- Cardiovascular system – increased heart rate and blood pressure and peripheral vasoconstriction

- Endocrine system – increased circulating catecholamines such as adrenaline and noradrenalin and increased cortisol levels
- Metabolic system – increased basal metabolic rate
- Gastrointestinal system – decreased appetite, nausea
- Skeletal muscle – decreased tone.

Nicotine is readily absorbed from the respiratrory tract, buccal mucosa and skin. There is minimal absorption through the gastrointestinal tract when administered orally. Cigarettes are highly efecgti ve mechanism for delivering nicotine. Inhaled nicotine takes about 10-19 seconds to reach the brain when administered through the pulmonary circulation.

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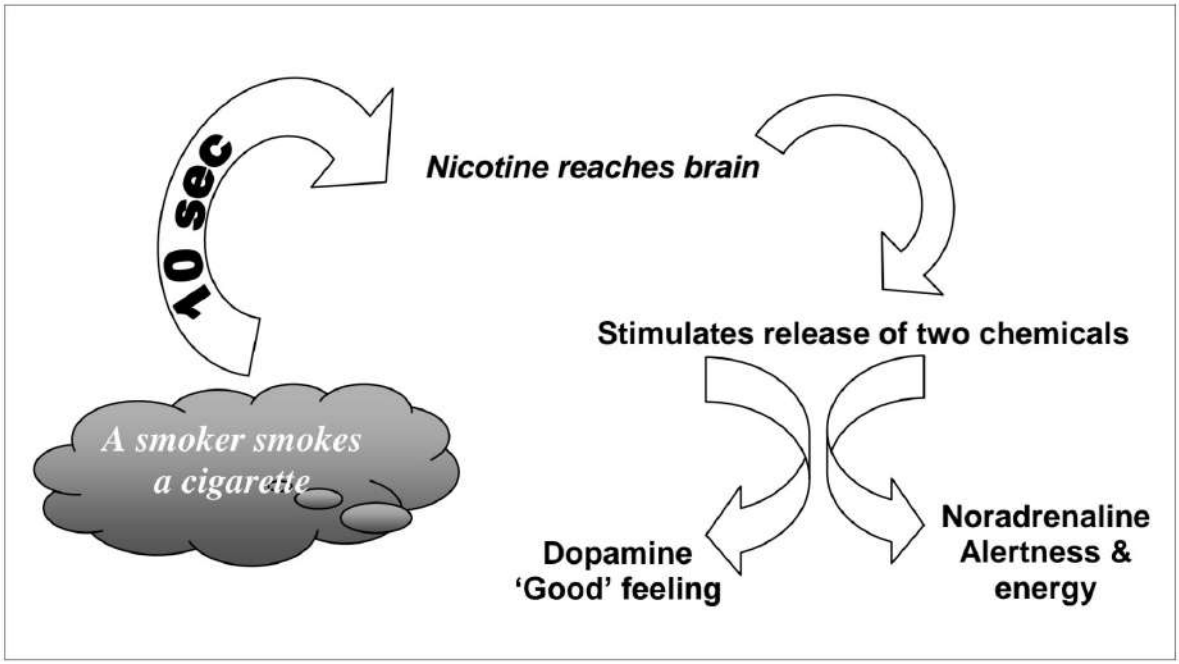
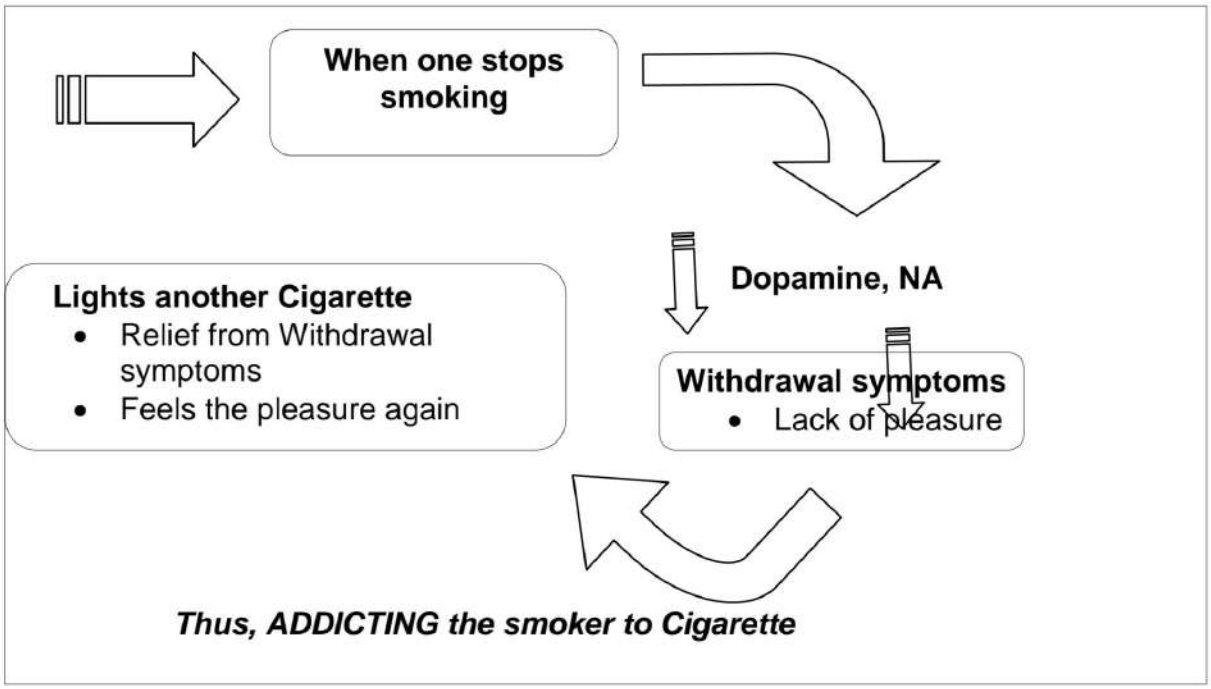
The Vicious Cycle of Smoking

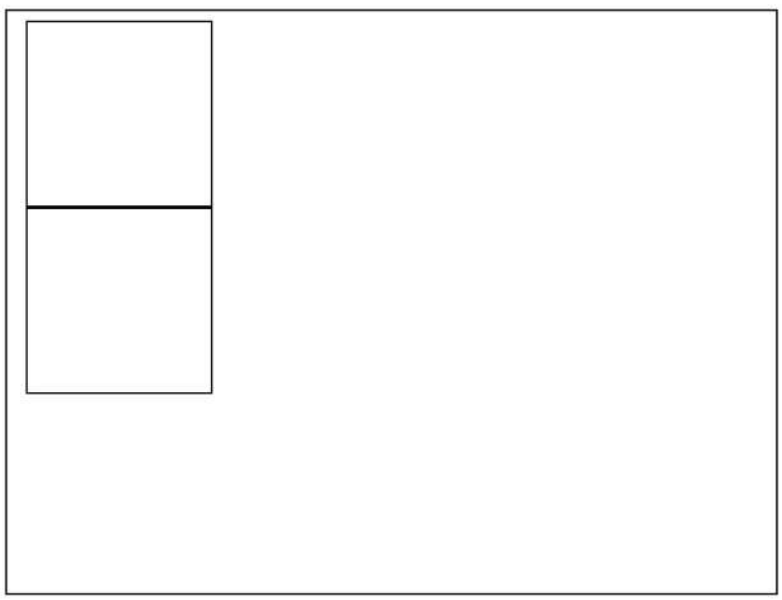


The Vicious Cycle of Smoking



4. TOBACCO CESSATION SERVICES IN INDIA – A OVERVIEW

Until 2002 there was no formal Tobacco Cessation Services available through our India. The first formal tobacco cessation clinics in India were set up in 2002, as a joint initiative of the Ministry of Health and Family Welfare, Government of India and WHO. The initial phase involved the setting up of *tobacco cessation clinics* in India and developing models for cessation. Subsequently these clinics expanded to include training, awareness and advocacy issues and were re-designated as *tobacco cessation centres in 2005.* Presently, it is envisaged to make these tobacco cessation centres nodal to the *National Tobacco Control Programme* (NTCP).



Tobacco Cessation Services in India

The purpose of these clinics was to develop intervention models for tobacco cessation for smoking and smokeless tobacco users, generate experience in the delivery of these interventions, and finally, to study the feasibility of implementing these interventions and their acceptance.

At inception, senior clinicians from these institutions were exposed to a training program on tobacco cessation in Thailand. They initiated the setting up of tobacco cessation clinics (TCCs) in their institutions. The space for the clinics was provided by the respective institutions. All the TCC meets every year to evaluate themselves and formulate the future strategies under direct control of Ministry of Health and WHO .The broad area of the services provided are summarized below

1.Tobacco Cessation Clinic (OPD based and Community based)

TCC services are provided regularly at different parts of the country. The clinic activities include:-

1. Registration and documentation of tobacco use profile in detail
2. Group counselling
3. Individual counseling/Relatives counselling
4. Carbon Monoxide (CO) monitoring
5. Pharmacotherapy
6. Regular follow up with brief counselling at each visit

7. Telephone Counselling for the defaulters
8. Postal letters to people who do not have access to telephone facility
9. Home visits by social workers as and when required
10. Interaction with quitters during Educational programmes
11. Felicitation of quitters/Distribution of certifificates to quitters

2. Research work is also conducted by different TCCs

3. Educational Programmes

4. Preparation and display of educational materials

Group counselling in progress at tobacco cessation clinic

Breath CO monitoring being done in a smoker

Learnings from the TCCs

It is possible to establish tobacco cessation services india
The service model developed by the TCCs can be extended to the community.
People must be educated about the availability and benefits of tobacco cessation programmes
Health care givers must be trained in with behaviour counselling and pharmacotherapy
It is possible and better to have community bases services for India

Towards a National Tobacco Control Programme

The Ministry of Health and Family Welfare, Government of India has set up a National Tobacco Control Programme (NTCP), and the experience gathered by the Tobacco Cessation Centres will be valuable in strengthening to achieve goal of the NTCP.

5. PROCESS OF CESSATION -- INTERVENTIONAL STRAGEGIES- the 5A's

To give individual the best chance at a successful future, it is crucial that subjects quit their tobacco habit before they develop the diseases. However, it is always better that people should not start this deadly habit. If started health care providers must attempt to motivate a change.

The 5A's are the evidence – based framework for structuring tobacco cessation in health case setting.

The Five A's (Ask, Advise, Assess, Assist and Arrange) is a five to fifteen minute research based counseling tool that has proven to be successful.

1. **Ask**	The Five A's for providers to use as a counseling tool: *After the Behavioral Change Model has been assessed to determine a patient's willingness to quit, the health care provider should apply the Five A's to assist his/her client in staying tobacco free.*
2. **Advise**	
3. **Assess**	
4. **Assist**	
5. **Arrange**	

Step 1 : ASK

ASK - Systematically identify all tobacco users at every visit. It should be put into the system that every patient/client at every clinic visit, tobacco-use status is queried and documented.

Step 2 : ADVISE

"Strongly urge all tobacco users to quit"

Advise should be have:

- Clear Message: "I think it is important for you to quit tobacco now and I can help you." "Cutting down while you are ill is not enough".
- Strong message: "As your clinician, I need to advise you that quitting tobacco smoking/smokeless is the most important thing you can do for your health and your baby's health." (Your health now and in future). The clinic staff and I will help you".
- Personalized message: Tie tobacco use to current health /illness, and /or its social and economic cost, motivation level/readiness to quit, and /or the impact of tobacco use on children and others in the house hold.

All tobacco should be firmly advised to quit in a way that is:

- Supportive and non-confrontational

When you are advising a Clint the frequently asked questions are:

1. Why should I quit tobacco use?
2. What is the first thing I need to do once I've decided to quit?
3. What medication would work best for me?
4. How will I feel when I quit tobacco? Will I gain weight?
5. What kinds of activities can I do when I feel the urge to take up tobacco?
6. I like to smoke when I have a drink. Do I have to give up both?
7 I've tried to quit before and it didn't work. What can I do?

It is always better that while you are advising to quite must tell about benefits of quitting.

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BENEFITS OF QUITTING

It is important to tell the client what are benefit of quitting.

From the moment you finish smoking it only takes 20 minutes for your body to start undergoing beneficial changes (This is helpful while giving individual or group counseling)

20 Minutes:

Blood Pressure drops to normal

Pulse rate drops to normal

Temperature of hands and feet increases to normal

8 Hours:

Carbon-Monoxide level in blood drops to normal

Oxygen level in blood increases to normal

24 Hours:

Chance of heart attack decreases

48 Hours:

Nerve endings start re-growing

Ability to smell and taste is enhanced

2 Weeks to 3 Months:

Circulation improves

Lung function increases up to 30%

1- 9 Months:

Coughing, sinus congestion, fatigue and shortness of breath decrease

Cilia re-grow in lings, increasing ability to handle mucus, clean the lungs, reduce infection

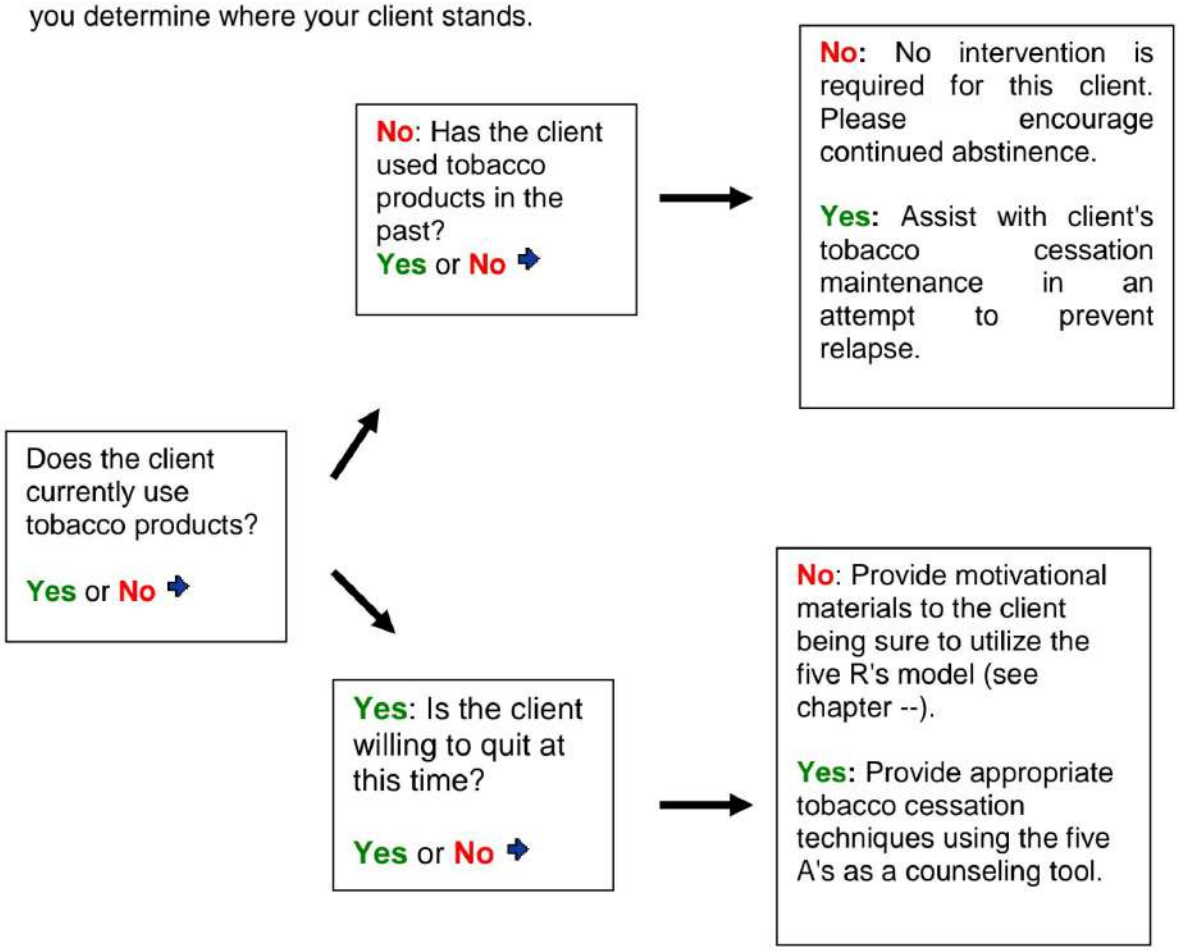
1 Year:

Risk of coronary heart disease is half that of a smoker

Step 3: ASSESS

Assess: Determine willingness to make a quit attempt.

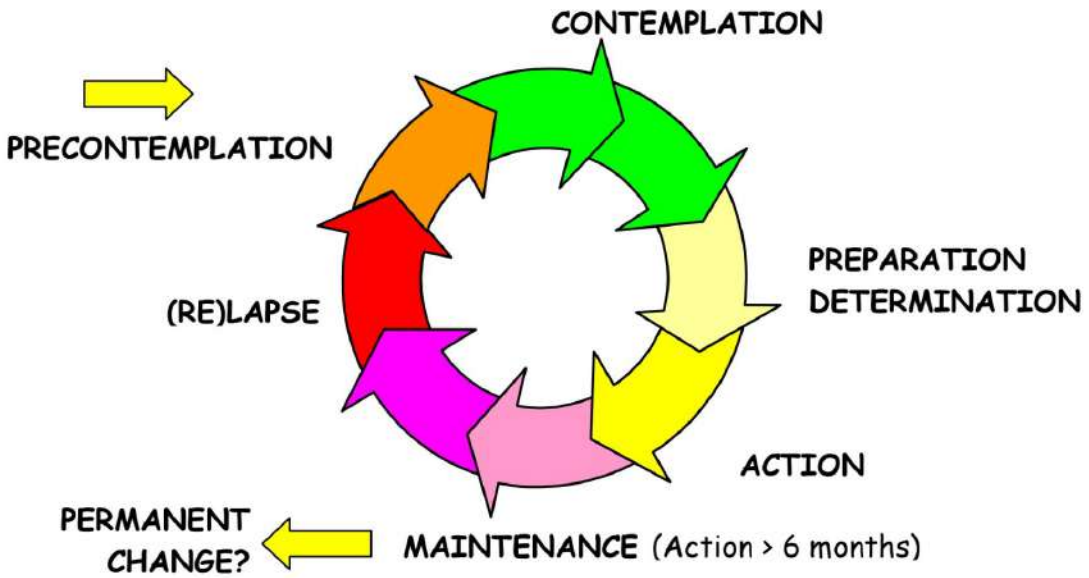
To be able to assist a client with tobacco cessation you need to be able to assess your client's willingness to commit to this change. Ask every tobacco user if he/she is willing to make a quit attempt at this time (eg. within the next 30 days). Here is a flow chart to help you determine where your client stands.



The stages of Readiness to change model is valuable model for assessing a person's readiness to change a variety of behaviors. Cessation is explained as process, rather than a single discrete event and tobacco users through the steps of being ready, quitting and relapsing, an average of three to four times, before achieving long term success. Tobacco users will be in different stages of readiness when the health care provider sees them at different times, so readiness needs to be constantly re-evaluates.

The stages may be i) Not ready (Pre contemplation) ii) Unsure (Contemplation), iii) Ready (Preparation) iv) Action, v) Maintenance

Motivational Interviewing Techniques – Stages Of Readiness to Change Model



Prochaska & DiClemente 1983

In a large studies in the United states involving 18,500 smokers that found 40% of smokers are not Ready, 40% are Unsure, and 20% are in the Ready group (Velicer at al, 1995).

Not ready (Pre contemplation)

These tobacco users are not seriously considering quitting in the next 6 months. They generally see the positive aspects of tobacco and do not like to acknowledge the disadvantages or have been discouraged by failure in past quit attempts. Encourage them to think about his/her tobacco use and invite them for any help. Offer them the written information.

Unsure (Contemplation)

These tobacco user are seriously considering quitting in the next 6 months.. This group is particularly amenable to brief motivational interviewing. Explore relevant health effect of tobacco use and barrier to cessation. Find out other physical mental health issues of

relevance and offer them help from your side. Provide them the written information and tell them about support services.

Ready (Preparation)

These tobacco users are planning to quit in the next 30 days and have usually made a 24-hour quit attempt in the past year. This group is motivated to quit soon and is the group most likely to actually attempt to quit in the near future. This is a window of opportunity, which may only open for a short time, and is the group most likely to ask for help with quitting.

Action

These are former tobacco users who have quit in the last 6 months. This is when the risk of relapse is highest with about 75% of relapse occurring in this stage, most within the first week (National Health Committee, 1999). This is a period where support and strategies to prevent relapse are especially important (see relapse prevention). If relapse does occur it is important that this is not seen as a failure but a learning experience and a not uncommon part of the quitting process.

Maintenance

These are tobacco users who quit over 6 months ago. The non-tobacco use behavior is established and the threat of tobacco use gradually diminishes. The chances of relapse diminish over time- only about 4% of those who quit for more than two years ever go back to tobacco use.

If Client is willing to quit as the Health Care Provider

- Praise him/her for his/her readiness to quit tobacco
- Help him/her set goals to maintain a tobacco free lifestyle
- Discuss an action plan to assist him/her in tobacco cessation
- Inquire about his/her support network
- Respond to his/her specific concerns about quitting tobacco

Cessation Plans or Strategies

- Tapering (cutting) down (1 less cigarette today, 2 less tomorrow, etc.)
- Cold turkey
- Possibly a pharmacological method to assist with cessation

Possible Support Persons

- Close Friends
- Family
- Co-workers

Assessment of Nicotine Dependence-- If Client is in Ready Stage

After assessing willingness to quit, and is in state of Readiness(Preparation) to quit, at the counseling cession, it is important to know the level of Nicotine addiction which can be measured by Fagerstrom Scoring. The tool has been paired to six simple questions. Scoring has also been modified to assist in tailoring nicotine cessation advice to fit individual needs (Annexure--). Scoring is done as followed:

- A high level of addiction will rank between 7 and 10 points.
- A medium level of addiction will rank between 4 and 6 points.
- A low level of addiction will rank between 0 and 3 points.

Breath CO Level Analysis

Although it has been used for verifying quitters (Smoking) of their habit. But in our practice we have used as assessing tool / counseling tool for the client . This also helps us to determine which method of treatment can be given to the subject (IJCD)

Step 4: ASSIST — Aid the client to quit

WILLING TO QUIT

In tobacco users the motivational stage must be utilized properly. When they come for help they must be assisted with care. The strategies to assist these clients is given in the table - 1.

Table 1. Brief Strategies to Assist the Patient Wiling to Quit Tobacco Use

Action	Strategies for implementation
Help the patient with a quit plan.	**A patient's preparations for quitting;** **Set** a quit date; ideally, the quit date should be within 2 weeks. **Tell** family, friends, and coworkers about quitting, and request understanding and support. **Anticipate** challenges to planned quit attempt, particularly during the critical first few weeks. These include nicotine withdrawal symptoms. **Remove** tobacco products from your environment. Prior to quitting, avoid smoking in places where you spend a lot of time (eg, work, home, car). **Abstinence** – Total abstinence is essential, "Not even a single puff after the quit date".
Provide practical counselling (Problem solving/skills training)	**Past quite experience**-Identify what helped and what hurt in previous quit attempts. **Anticipate triggers** or challenges in upcoming attempt – Discuss challenges/triggers and how patient will successfully overcome them. **Alcohol**- Since alcohol can cause relapse, the patient should consider limiting/abstaining from alcohol while quitting. **Other smokers in the household**- Quitting is more difficult when there is another smoker in the household. Patients should encourage housemates to quit with them.

Provide intratreatment social support	**Provide a supportive clinical environment** while encouraging the patient in his/her quit attempt. "My office staff and I are available to assist you".
Help patient obtain extratreatment social support	**Help patient develop social** support for his/her quit attempt in his/her environment outside of treatment."Ask your spouse/partner, friends, and coworkers to support you in your quite attempt."
Recommend the use of approved Pharmacotherapy except in special circumstance	Recommend the use of pharmacotherapies found to be effective. Explain how these medication is increase cessation success and reduce withdrawal symptoms. The firs-line pharmacotherapy medications include; sustained-release buy bupropion hydrochloride, nicotine gum, nicotine inhaler, nicotine nasal spray, nicotine patch and vernicline

A 5 DAY PLAN TO GET READY TO QUIT

- The first step to quitting is to decide to quit. Next make an appointment with your health care provider, or contact TCC to discuss the options for treatment and to get a quit date
- Quit date minus 5
    - list all the reasons to quit
    - Tell your family friends about your Plan
    - Stop buying cartons of bidis/cigarette/smokeless tobacco
- Quite date minus 4
    - Pay attention to why and when to use tobacco
    - Think new ways to relax
    - Think new ways to hold something in mouth and in hand instead of tobacco
    - Think of habits or routine you may want to change
    - Make list of use when you quit.

- Quit day minus 3
    - Make use of things you could do with extra money you save
    - Think whom to reach when you need help

- Quite Day minus 2
    - Clean your clothes to get rid of smell of smoke
- Quite Day minus 1
    - Think of reward you will get yourself after you quit
    - Get you teeth cleaned
    - Throw away all your tobacco products
    - Put away lighters and astrays
- Quit day
    - Keep yourself busy
    - Change your routine when possible
    - Do the things which don't remind you to use tobacco
    - Tell your family, friends that you have quit and ask them to help
    - Avoid alcohol
- Quit day Plus one
    - Congratulate yourself

AFTER QUITTING

- Congratulate yourself
- Stay active
- Drink lots of water
- Do something that does not connect you with tobacco use
- Take deep breath
- Avoid high-risk situations where the urge to smoke is strong
- Avoid coffee and alcohol
- Avoid being around individuals who are smoking

Table-2. Common Elements of Effective Counseling and Behavioral Therapies for Smoking Cessation

Component	Example
Practical Counseling	**(Problem Solving/Skills Training) Treatment**
Identify events, internal states, or activities that increase the risk of smoking or relapse.	Negative affect Being around other smokers Drinking alcohol Experiencing urges Being under time pressure
Identify and practice coping or problem-solving skills. Typically, these skills are intended to cope with dangerous situations.	Learning to anticipate and avoid temptation Learning cognitive strategies that will reduce negative moods Accomplishing lifestyle changes that reduce stress, improve quality of life, or produce pleasure Learning cognitive and behavioral activities to cope with smoking Urges (eg, distracting attention)
Provide basic information about smoking and successful quitting.	The fact that any smoking (even a single puff) increase the likelihood of full replapse Withdrawal typically peaks within 1-3 weeks after quitting Withdrawal symptoms include negative mood, urges to smoke, and difficulty concentrating The addictive nature of smoking
Intratreatment Supportive Interventions	
Encourage the patient in the quite attempt	Note that effective tobacco dependence treatments are now available Note that half of all people who have even smoked have now quit Communicate belief in patient's ability to quit
Communicate caring and concern.	Ask how patient feels about quitting Directly express concern and willingness to help Be open to the patients expression of fears of quitting, difficulties experienced, and ambivalent feelings
Encourage the patient to talk about the quitting process.	Ask about : Reasons the patient wants to quit Concerns or worries about quitting Success the patient has achieved

	Difficulties encountered while quitting.
Extratreatment Supportive Interventions	
Train patient in support-solicitation skills.	Help videotapes that model support skills Practice requesting social support from family, friends, and coworkers Air patient in establishing a smoke-free home
Prompt support seeking	Show patient identify supportive others Call patient to remind him/her to seek support Inform patients of community resources such as hotliness/helplines
Clinician arranges outside support	Mail letters to supportive others Call supportive others Invite others to cessation sessions

Self Help:

- Various self-help intervantions have been developed:
- Pamphlets, videotapes, audiotapes, hotlines/helplines, websites, provide a small increase in quitting vs no intervention

Behavioural and congnitive therapy:

- Behavioral and cognitive therapy is a short-term, focused approach for helping dependent individuals become abstinent from drug use.
    - The most frequently evaluated psychosocial approaches for substance use disorders
    - Have a strong level of empirical support
- Attempts to help people:
    - Recognize
    - Avoid
    - Cope

This therapy is validated and recommended for smoking cessation . Can be used individually or with groups

Cognitive strategies

Cognitive or thinking strategies aim to use the power of logical thought to help overcome the addiction to tobacco. Tobacco user can be encouraged to consider the benefits of quitting and the consequences of starting to smoke again. The perceived benefits of tobacco use can be challenged. Many users strongly believe they cannot cope with their stress without tobacco but in fact when thy stop, they find thy can cope just as well, or even better than when they were using tobacco.

Behavioral strategies

A number of behavioral strategies can be suggested to cope with the triggers and high-risk situations. Ideally, the patient should suggest his/her own alternatives and substitute activities. The 4Ds are an easy to remember mnemonic from Quit about behavioral coping strategies:

Delay **:** Acting of the urge to smoke. After five minutes the urge to smoke weakens and your resolve to quit will come back.

Deep breath : Take a ling slow breath in and slowly release it out again .repeat three times.

Drink water : Slowly holding it in your mouth a little longer to savour the taste.

Do something else : To take your mind off smoking. Doing some exercise is a good alternative.

Behavioral and cognitive strategies :

1. Dealing With Cravings – 4 D
    - Delay
    - Deep Breathing
    - Drink Water
    - Distract

2. Remember The Three R's

- Remind
- Rehearse
- Reward

Discuss Past Quit Attempts: What worked?

While assisting the clinical, possessing a clear understanding of the client's past quit attempts can be a helpful tool. This information will assist in determining the skills a client will need to make this a quit attempt successful.

Choose a Cessation Method

Every Tobacco user is unique and one cessation method will not work for everyone!

Common Cessation Aids are:

A. Non-Pharmacological Cessation Strategies: (Remember to let the client chose the method that is most suitable for them)

- Tapering - Cut down the number of cigarettes/bidies smoked (or smokeless tobacco) each day until the client finds they are no longer using it. Tapering involves counting the number of cigarettes/bidies smoked each day and then reducing that amount by a fixed number over a given amount of time. This method involves setting a quit date by which the client will have tapered down to the point that they are no longer using tobacco
- Cold Turkey - Abruptly stopping all smoking. Best for clients who smoke two packs of cigarettes a day or less. Cold turkey is the simplest and, for most people the easiest way to quit.

B. Pharmacological Methods The physician and patient must consider the potential risks of the different pharmacological methods of smoking cessation.

- Nicotine Patch
- Nicotine Gum
- Nicotine Inhaler
- Bupropion
- Verenicline

Withdrawal Symptoms

More than 80% of smokers will experience symptoms of nicotine withdrawal. Cravings for tobacco and irritability are two of the most common symptoms. Withdrawal symptoms may be lessened or prevented by using NRT or bupropion. If people are not using pharmacotherapy then cognitive and behavioral strategies can be used to assist in the early stage of the quit attempt. The worst of the physical symptoms are over within 2-3 days and most have passed after 10-14 days but can last up to 4 weeks.

The DSM-IV criteria for nicotine withdrawal are shown below

Four of the following:

- Depressed mood
- insomnia
- irritability, frustration , anger
- anxiety
- Craving+difficulty in concentration
- restlessness
- decreased heart rate
- increased appetite or weight gain

To meet the diagnostic criteria for nicotine withdrawal the following must also apply: the symptoms cause clinically significant distress, are not due to a general medical condition and are not accounted for by another medical disorder. Withdrawal symptoms of tobacco products should be discussed with the client in advance so that he/she is able to prepare for that. In addition, behavioral coping methods should be taught to the client. The common withdrawal symptoms and coping strategies are described below

Common symptoms and coping strategies are:

Symptom	Coping Strategy
Irritability -	Walk, hot bath, relaxation
Fatigue -	Take naps, exercise
Insomnia -	Avoid caffeine after 6pm
Cough -	Drink plenty of fluids, cough drops
Nasal Drip -	Drink plenty of fluids
Dizziness -	Change positions slowly
Lack of Concentration -	Plan workload, avoid stress
Constipation -	Add fiber to your diet
Gas -	Add fiber to your diet
Hunger -	Low calorie snacks
Craving for cigarette -	Wait out urges, distract yourself, drink water, read, exercise
Headaches -	Drink plenty of fluids, and relaxation, eat a small snack
★Withdrawal symptoms decrease as nicotine leaves the body and most symptoms are short term	

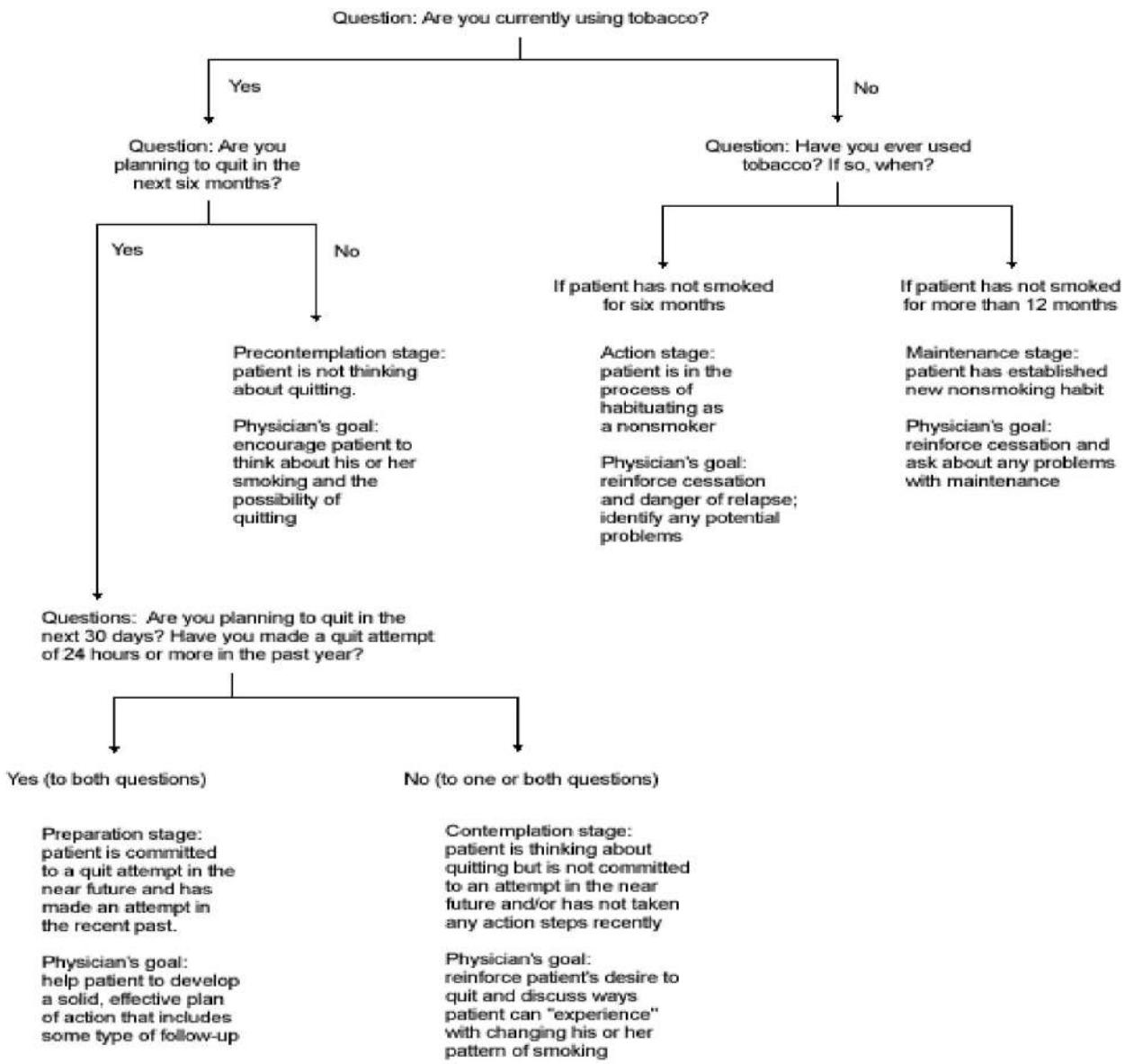
NOT WILLING TO QUIT

For patients not ready to make a quit attempt, the healthcare provider should provide a brief intervention designed to promote the motivation to quit and information about harmful effect of tobacco. The client may have fears concerns about quitting, or may be demoralized because of previous relapse. Such patients may respond to a motivational intervention enter venture designed to educate, reassure and motivate. The components of such motivational intervention build around the 5Rs: Relevance, risk, rewards, roadblocks and repetition (described in detail in table below).

Not willing to quit : 5R's

Relevance	Explain the relevance of quitting to the subject. Motivational counseling is more effective if context is relevant to the smoker, like harm of passive smoking to family members especially younger children
Risks	Clinician should highlight the health hazards that are more relevant to the tobacco uses. Both short term risks like and long term risks should be properly explained.
Rewards	Benefits of quitting all forms of tobacco use should be explained to the tobacco user. Improved health of self and other family members, better physical performance, saving of money and other relevant advantages should be explained to the patient.
Roadblocks	Barriers that the patient may face in his/her quit attempt should be identified. Withdrawal feature, fear and concern associated with quitting, depression, lack of social support, enjoyment of tobacco are some of the barriers that the patient may face in its attempt.
Repetition	Physician should give assurance to the patient that because of chronic nature of tobacco dependence relapses in the initial phases are common and multiple attempts may have to be made before a subject is able to quit tobacco. Repeat motivational counselling should be provided at each contact.

Table : Enhanced motivation to quit in subjects not willing to quit this time[7]



Step 4: ARRANGE

Arrange - Schedule a follow-up contact

Time- Follow up contact should occur soon after the quit date, preferably during the first week. A second follow up contact is recommended within the first month. Schedule further follow up contact as indicated. Follow up visits after advice to quit has been shown to increase the likelihood to successful long term abstinence. Follow up by nurse, community workers, other health workers, doctors can be effective. Letters /Phone calls may be more cost effective than follow up visits at the clinic.

Action during follow up contact:

- Congratulate success
- Review problems and progress
- If tobacco use has occurred, review circumstances and elicit recommitment to total assistance
- Remind patient that a relapse can be use as a learning experience.
- Assess pharmacotherapy use and problems.
- Encourage social support and use of support services.
- Relapse is a normal occurrence.
- Empathies and reframe as learning experience explore reasons for relapse.
- Help build motivation to reach the stage of readiness to try again.

Step 5: Arrange schedule follow-up contact	
Schedule follow-up contact,	
In person or via telephone	Timing-Follow-up contact should occur soon after the quit date, preferably during the first week. A second follow-up contact is recommended within the first month. Schedule further follow-up contacts as indicated.
Action during follow-up contact	Congratulate success. If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence.

While dealing the follow up, the quitters has some common problems and a solution should be given to them. The common problems and solutions are described in table below

Common Problems while quitting and solution

Problems	Responses
Lack of support for cessation	Schedule follow-ups or telephone calls with the patient. Help the patient identify sources of support within her environment (appropriate organization that offers cessation counseling or support).
Negative mood or depression	If significant, provide counseling, prescribe appropriate medications, or refer the patient to a specialist.
Strong or prolonged withdrawal symptoms	If the patient reports prolonged craving or other withdrawal symptoms, consider extending the use of an approved pharmacology or adding/combining pharmacologic medications to reduce strong withdrawal symptoms.
Weight gain	Recommend starting or increasing physical activity after a physician's clearance. Emphasize the importance of a healthy diet. Reassure the patient that weight gain in normal
Flagging motivation/feeling deprived	Reassure the patient that these feelings are common. Recommend rewarding activities. Probe to ensure that the patient is not engaged in periodic tobacco use. Emphasize that beginning to smoke (even a puff) will increase urges and make quitting more difficult.

6. RELAPSE PREVENTION

Relapse prevention strategies aim to assist people to avoid or cope with high-risk smoking situations. Such strategies also aim to prevents a lapse form occurring or if it occurs form becoming a full relapse to smoking.

Suggested strategies are:

- Identify high-risk tobacco use situations and important triggers
- Plan coping strategies in advance
- Consider lifestyle changes that may reduce the number of high-risk situations encountered, e.g. stress management, reduction in alcohol consumption
- Encourage patients to have a plan for how to deal with a slip to prevent it becoming a full relapse

Components of *relapse* intervention:
During relapse prevention, a patient might identify a problem that threatens his or her abstinence. Specific problems likely to be reported by patients and potential responses follows:

It is important to remember the reasons you want and need to stop tobacco. The first few days to weeks after quitting will be the hardest. It is important to use self-discipline and your most effective techniques to avoid giving in to the cravings. What some people find helpful when urges come include:

- Take a few deep breaths and let them out slowly.
- Think about the most important reasons why you wanted to stop tobacco.
- Don't let negative thoughts dominate your thinking.
- Use a coping strategy from your action plan.
- Focus you attention away from the urge. Usually peak and subside within 5 to 10 minutes.
- Go to a place where smoking is not permitted.
- Seek support from a non-tobacco user friend.
- Use a low-calorie substitute for oral stimulation.
- Delay your use of tobacco for another hour

Coping tips to stay a non-tobacco user for life

Once you quit tobacco, it's time to focus your energy on avoiding the temptation to have "just one cigarette/bidi". To remain an ex- tobacco, you need to learn specific techniques to help you cope with stress and situations that trigger your cravings for cigarettes.

Try any of these coping responses when faced with a relapse situation:

- Remind yourself how hard it was to quit. Do you want to go through that again?
- Have a nonalcoholic drink. Fruit juice, mineral water, and strongly flavored decaffeinated tea are good choices.
- Take to yourself. Say, "I can beat this," "I can stay tobacco-free for one more day," or "I will not take tobacco"
- Have a crunchy, low-fat snack, popcorn, or carrot sticks.
- Take a short walk.
- Excuse yourself and leave the room if someone lighting a cigarette triggers your craving.
- Run, do stretching exercises or walk the dog.
- Brush your teeth.
- Take several slow, deep breaths and think about how clear you lungs feel.
- Do something with your hands-squeeze a rubber ball, play with a toothpick, coin, or paper clip.
- Remind yourself that smoking makes clothes, and hair smelly, dries skin, causes premature wrinkles and turns teeth yellow.

Type of Smoker/Reasons of Tobacco use and tips to help them

Reasons for smoking	Why smoking affects them	Tips to help them quit
Smokes for energy	Nicotine acts as a stimulant for some people	Get enough sleep, Exercise regularly take a brisk walk instead of smoking Drink lots of water, Avoid getting bored
Likes to touch and handle cigarettes	Oral fixation - nervous: needs to do something with their hands	Pick up a pen or pencil instead of a cigarette and doodle Play with a coin, twist a ring, rub a worry stone, carrot
Smokes for pleasure	Nicotine acts as a depressant Nicotine acts as a stimulant for some people	Educate on the health benefits of quitting Enjoy pleasures of being tobacco-free
Smokes when tense or upset	Nicotine acts as a depressant Many smokers have an underlying depression	Use relaxation techniques when angry or upset Avoid stressful situations Take a hot bath, lie in outside and relax, listen to soothing music
Addicted to nicotine	Some people are genetically or socially predisposed to nicotine addiction. Addiction can be physical or psychosocial. Those physically addicted will have the most challenge during withdrawal.	Be aware of withdrawal symptoms and how to counteract them Need some form of NRT. quitting
Smoking is habit	Smoking has become a part of a routine such as talking on the phone, after dinner, etc. Often lights up a cigarette but let it burn out in the ashtray.	Change smoking routine Keep cigarettes in a different place Don't do anything else while smoking Limit smoking to a certain place Be aware of cigarette smoked Ask self if you really want this cigarette Set a date to quit and stick to it

7. SELF-HELP INTERVENTIONS FOR TOBACCO CESSATION.

Many tobacco users give up on their own, but materials giving advice and information may help them and increase the number who quit successfully.

i. Self help interventions for smoking cessation

Self-help cessation materials are a common component of most tobacco cessation interventions, ranging from brief clinical interventions to community campaigns, but their effectiveness is not often evaluated due to practical difficulties in 'real world settings'

Most commonly, self-help materials are printed leaflets or manuals, although use of audiotapes and videotapes is also well established. The new generation of self-help materials is computer-based on CDs or internet websites or linked to television programs. Other forms of behavioural interventions that are predominantly self-help are client-initiated telephone quit lines and Quit-and-Win competitions. Quit-line services provide a contact point for provision of written self-help materials and may also employ counsellors to assist and support people during cessation attempts. The quit-line number is promoted extensively. The key elements for an effective quit-line are public access, quit tobacco resources and information, counselling, training of counsellors and referral services .

A brief leaflet is sufficient to support pharmacotherapy or smoking cessation advice from a health professional. Therefore, self-help materials should be tailored to the needs and cessation stages of individual smokers and selected population groups

ii. Minimal clinical intervention

Minimal clinical intervention, or brief advice by health professionals could have a great influence on tobacco cessation levels, but has been underused. Australian doctors identify two thirds of their patients who smoke but advise only half of these (34%) to quit.

Minimal clinical intervention consists of brief cessation advice from health care providers delivered opportunistically during routine consultations to tobacco users whether or not they are seeking help with stopping tobacco. Brief opportunistic advice typically involves asking patients about their current tobacco, advising them to stop, offering assistance either by providing further advice, a referral to a specialist service, or recommendation of, or a prescription for, pharmacotherapy, and arranging follow up where appropriate. This approach has been described as the 5As interventions. The duration of each session of minimal intervention is usually three to five minutes, and certainly less than ten minutes .

Barriers to the provision of tobacco cessation advice by all health professionals should be identified and addressed. 'Lack of time' for example is often cited as a barrier to provision of advice, yet the evidence confirms that clients can effectively be encouraged, advised and supported to quit within as little as 3-5 minutes of a health professional's time. Lack of perceived skills or training is another cited barrier, but existing evidence is mixed regarding the added benefit of intensive cessation skills training. Lack of immediate relevance is another barrier for health care providers who do not perceive a direct link between tobacco use and the reason for presentation of their client/patient.

iii. Intensive clinical intervention

Brief advice from a heath care provider is recognized as an important motivator for a quit attempt . However, the 5As approaches to minimal intervention stress the importance of assisting clients to make a cessation attempt. This may include more intensive behavioural therapy .A range of more intensive behavioural methods has been used in clinical settings to support patient attempts at smoking cessation
These include:

a) Individual counselling
b) Supportive group sessions
c) Aversion therapy

a) Individual behavioural counselling

Intensive interventions by health care providers are usually defined as those that take more than ten minutes per session . The distinction between minimal and more intensive

intervention becomes somewhat blurred when the clinician provides continuing support of short duration per session.

Individual counselling was limited to counselling provided by specialist counsellors and not by health care providers during usual care. Counselling was also required to be of at least 10 minutes duration. The counselling interventions typically included the following components:

- Review of the participant's tobacco history and motivation to quit;
- Help in identification of high-risk situations and tobacco cues; and
- Generation of problem-solving strategies to deal with high-risk situations.

Counsellors may also have provided non-specific support and encouragement and as well as written materials, video or audiotapes.

b) Supportive Group Sessions

Group therapy offers individuals the opportunity to learn behavioural techniques for tobacco cessation, and to provide each other with mutual support. Groups may be led by professional facilitators, clinical psychologists, health educators, nurses, doctors, or successful peers. They may be conducted in different settings and may vary in intensity, number and duration of sessions as well as total duration.

Suggested components of a best practice group cessation clinic program include:

- Setting a specific quit date;
- Learning to interrupt the conditioned responses that support tobacco by self-monitoring;
- Making plans for coping with temptations to smoke following cessation; and
- Providing follow-up contact and social support for quitting and continued abstinence).

Other optional components are:

- Instructions for effective use of NRT.

Attendance rates of smokers invited to participate in group cessation programs reviewed by Stead and Lancaster (2000)[33] varied from 8 to 88 per cent. Group therapy can be an effective cessation method that should be available for those who are willing to participate.

c) Aversion therapy

Adding an unpleasant (aversive) stimulus to an attractive behaviour reduces the attractiveness and may extinguish the behaviour . Aversion therapy pairs the pleasurable stimulus of smoking a cigarette with an unpleasant stimulus, with the aim of extinguishing the urge to smoke.

The most frequently examined procedure has been rapid smoking. 'Rapid smoking' usually consists of asking subjects to take a puff every six to 10 seconds for three minutes, or until they consume three cigarettes or feel unable to continue. This is repeated two or three times, and subjects are asked to concentrate on the unpleasant sensations it causes. Explanation and supportive counseling is usually provided with application of the rapid smoking technique. Other aversive techniques include rapid puffing (smoke not inhaled), smoke holding, excessive smoking, paced smoking, self-paced smoking, focused smoking, covert sensitization, symbolic aversion, electric shocks administered by therapist or subject, and behavioural treatments with bitter pills.

8. DEVELOPING A PLAN WITH YOUR CLIENT

Eight steps to assisting your client develop a successful quitting plan

- Discuss reasons to stop smoking
- Determine the type of smoker
- Identify trigger situations
- Identify barriers to quitting
- Discuss past quit attempts
- Chose a cessation method
- Discuss withdraw symptoms
- Reward program –staying tobacco free

9. QUIT TOBACCO FOR BUSY PHYSICIANS

We know the physicians are very much busy and they do not get time to go in details of tobacco cessation although they want to do so.

As physician you must advice--you've made the big decision to quit tobacco! You have made the single best decision for your health. You can quit lots of different ways, but the highest success rates for quitting include combining a tobacco cessation class/counseling with medications. The important thing is to **START**.

S = Set a quit date
T = Tell family, friends, and co-workers that you plan to quit and enlist their support.
A = Anticipate and plan for the challenges you'll face while quitting.
R = Remove cigarettes and other tobacco products from your home, car, and work.
T = Talk to your doctor about getting help to quit.

Why Quit?

Why quit - - - you've done it for years, why stop now?
Very simply, you will greatly improve your health and improve your chances for a long life. There are over 40 carcinogens (chemicals known to cause cancer) in cigarettes/beedis . These greatly increase your odds of developing some type of cancer.

***How* to Quit**

Why is it so hard to quit smoking? Nicotine is the answer. Nicotine stimulates the "pleasure centers" of your brain and may make you feel relaxed, less tense, or happy, and over the years you have learned to associate tobacco with a sense of well-being. You know it's unhealthy to keep using tobacco, so ***let's learn how to quit one step at a time. You will be most successful if you combine medications along with a behavioral modification class or counseling.***

Medication Options to Help You

- Nicotine Replacement Therapy:
- Bupropion
- Verenicline

Behavioral Options to Help You

- **Smoking Cessation Classes:** Studies have shown that the best tobacco cessation program includes individual or group counseling. When considering a program, ask about the following:
    1. *Session length.* It needs to be at least 20 –30 minutes long.
    2. *Number of sessions.* Having at least 4-7 sessions is best.
    3. *Number of weeks.* Attend for at least 4 weeks.
    4. Make sure that your *leader is certified to teach a smoking cessation class/group.*

Symptoms of Recovery

- Take a positive approach and think of "withdrawal symptoms", as your symptoms of recovery! You body is healing and is recovering from an addiction. These feelings or symptoms may not affect you at all or you may have only a few of them, especially if you take medications.

Dealing with Cravings

Once you quit, you may have times when you really want to smoke. Sometimes, you may be "triggered" by a memory or a routine where you used to smoke. These are called cravings. Cravings typically last 4-5 minutes and can be managed several ways. Some medications help a lot with cravings, but there are things you can do to help you get through the rough spots. The ***4 Ds*** can help!

- **Delay** – Do not act on your urge to smoke. It will pass in a minute or two. Do not give in – use your willpower!
- **Deep breathing** – Take slow, deep breaths to relax you. Breathe in slowly and deeply through your nose and release the breath through your mouth. Keep breathing until you relax and forget about the urge to smoke.
- **Drink water** – Drink water. It helps to flush the toxins from your body and gives you something to do with your hands and mouth.
- **Distract** – Take your mind off smoking. Get up and move around. Take a walk. Call a friend. Listen to music. Start a new hobby. Balance your checkbook. Meditate. Pray. Chew gum. Brush your teeth.

10. SMOKELESS TOBACCO AND HOW TO QUIT

Not a safe alternative

Many terms are used to describe smokeless tobacco products, such as oral, chewing, snuff, spit, and spitless tobacco. All forms of oral tobacco contain chemicals known to cause cancer (carcinogens). These products can cause cancer of the mouth, pancreas, esophagus etc. Oral and smokeless tobacco also cause many other health problems, such as gum disease, destruction of the bone sockets around the teeth, and tooth loss. They cause bad breath and stained teeth, too.

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Smokeless tobacco facts

What is smokeless tobacco?

Smokeless tobacco comes in 2 basic forms, snuff and chewing tobacco. Several other forms of smokeless tobacco are also on the market.

- Snuff is finely ground tobacco packaged in cans or pouches. It is sold in 2 forms: dry and moist. Moist snuff is used by placing a "pinch," "dip," "lipper," or "quid," between the lower lip or cheek and gum. Nicotine is absorbed through the tissues of the mouth. Moist snuff is also available in small, teabag-like pouches or sachets that can be placed between the cheek and gum. These are designed to be both "smoke-free" and "spit-free" and are marketed as a discreet way to use tobacco. Dry snuff is sold in a powdered form and is used by sniffing or inhaling the dry snuff powder up the nose.

- Chewing tobacco comes in the form of long strands of loose leaves, plugs, or twists of tobacco. Portions of this, commonly called "plugs," "wads," or "chew," are chewed or placed between the cheek and gum or teeth. Nicotine is absorbed through the mouth tissues. The user spits out the brown juice – saliva that soaked through the tobacco.

Alternative smokeless tobacco products come in many forms. It is made of air-cured tobacco, water, salt, and flavorings. It has less tobacco-specific nitrosamines than most smokeless products used in the US because the tobacco is not fermented. (Tobacco-specific nitrosamines are chemicals known to cause cancer.) Snus is most commonly

packaged in small pouches, but can also be used like loose moist snuff. The tobacco related powers which are made are Pan Masala.

What are the risks of using smokeless tobacco?

Smokeless tobacco products are not a safe substitute for tobacco smoking. Harmful health effects include:

- oral (mouth) cancer
- pancreatic cancer
- addiction to nicotine
- leukoplakia (white sores in the mouth that can become cancer)
- receding gums (gums slowly shrink away from around the teeth)
- bone loss around the roots of the teeth
- abrasion (scratching and wearing down) of teeth
- tooth loss
- stained teeth
- bad breath

Quitting smokeless tobacco

Surveys show that most people who use snuff or chew would like to quit. In one survey, more than half of those who took part said they would try to quit in the next year.

In many ways, quitting smokeless tobacco is a lot like quitting smoking. Both involve tobacco products that contain nicotine, and both involve the physical, mental, and emotional parts of addiction. Many of the ways to handle the mental hurdles of quitting are the same. But there are 2 parts of quitting that are unique for oral tobacco users:

- There is often a stronger need for oral substitutes (having something in the mouth) to take the place of the chew, snuff, or pouch.
- Mouth sores often slowly go away and gum problems caused by the smokeless tobacco may stop getting worse. This is a benefit of quitting that everyone can see.

Help with psychological addiction

Some people are able to quit on their own, without the help of others or the use of medicines. But for many tobacco users, it can be hard to break the social and emotional ties to chewing or dipping while getting over nicotine withdrawal symptoms at the same

time. The good thing is, there are many sources of support out there – both formal and informal.

Nicotine replacement therapy

Nicotine replacements (nicotine substitutes) give you nicotine without the other harmful ingredients in tobacco. For cigarette smokers, nicotine replacement therapy (NRT) has been proven to help reduce withdrawal symptoms. Together with counseling or other support, it doubles the chances that a smoker will quit. Fewer studies have been done on how much NRT helps smokeless tobacco users quit. Since both smokers and smokeless users are addicted to nicotine, it makes sense to some smokeless tobacco users to try it. These include:

- nicotine gum
- nicotine patch
- nicotine lozenges
- nicotine inhaler
- nicotine nasal spray

Other medicines

- Bupropion
- Varenicline

11. TOBACCO CESSATION IN DENTAL CLINIC

Tobacco use is one of the leading preventable causes of illness and death. The most powerful predictor of adult smoking is smoking during adolescence. While general and pediatric dentists have a positive attitude regarding tobacco cessation counseling, the same is not extrapolated into practice. Several barriers to counseling in the dental clinic have been identified and research into some of these has been conducted. Evidence-based cessation programs are still in the nascent stage, but this should not hinder dental professionals from rendering these services to the child and adolescent populations. Brief interventions, self-help materials, and nicotine replacement therapy for established nicotine dependence form the mainstay of therapy.

Oral precancers

Tobacco use in any form has been shown to have a marked effect upon the soft tissues of the oral cavity. Regular use of substances containing areca nut can cause oral submucous fibrosis(OSF), a painful, debilitating condition in which the mouth tissues gradually lose their elasticity and become tight. The diagnostic criterion is the presence of palpable fibrous bands. In this condition, the ability to open the mouth decreases gradually and can often reach an extend where only a straw can go inside the mouth. This condition is becoming increasingly common, especially in individuals between 15 and 40 years of age, due to the increasing popularity of products containing areca nut and tobacco. The use of these products (gutkha, mawa, paan masala) causes OSF in shorter time than paan use.

Role of the dentist

In the clinic ,dentists have an important role in helping patients quit tobacco and, at the community and national levels, to promote tobacco prevention and control strategies.

Dentists in the clinic

- See the harmful effects of tobacco on the mouth
- Are in an ideal position to counsel patients
- See children and youth as patients and can influence them to adopt a tobacco-free lifestyle

- Treat women of childbearing age and can inform them of the dangers of tobacco use during pregnancy
- Can spend more time with patients by physicians and other caregivers about the dangers of tobacco use and the need to quit
- Can reinforce messages given to patients by physicians and other caregivers about the dangers of tobacco use and the need to quit
- Can build their patients' interest in discontinuing tobacco use by showing them the actual effects in the mouth
- Have a duty to promote oral health and healthy lifestyles among their patients.

Dentists in the community and nation

- Can be role models by not using tobacco or by quitting successfully. Tobacco use by dentists is a significant barrier to tobacco cessation counseling.
- Can speak with authority in the community about the dangers of tobacco use; for example, the need to curb tobacco use in public and educate children about the dangers of tobacco use
- Can be effective advocates for tobacco control in the community.

Just 5 minutes of focused talk during the examination is enough to make the patient aware and conscious of the harms of tobacco use. 5As are same as described earlier.

1. **<u>Ask</u> patients about their use of tobacco at every visit**
    - Look for oral signs of tobacco use

The dentist sees the inside of the mouth and knows if the patient is using tobacco.

ORAL SIGNS OF TOBACCO USE

- Stained teeth
- Foul-smelling breath(halitosis)
- Gum disease
- Loose teeth
- Discoloured patches on the mucosa: White, red, dark-precancerous lesions

Mention your observations to the patient - this will help him or her face facts.

2. **<u>Advise</u> patients**

3. **<u>Assess</u> the patient's readiness to quit**

4. **<u>Assist</u> tobacco users to make a QUIT PLAN**

5. **<u>Arrange</u> for follow-up visits**

Tobacco cessation methods can be broadly classified into

- Cognitive behavioral therapy includes methods such as self-help and brief interventions which can be provided by health professionals,
- Intensive therapy at tobacco cessation centers,
- The pharmacological means including nicotine replacement therapy (NRT) and antidepressants like bupropion.

Brief Intervention: Available evidence suggests that behavioral interventions for tobacco use conducted by oral health professionals incorporating an oral examination component in the dental office and community setting may increase tobacco abstinence rates among smokeless tobacco users. Dental treatment often necessitates frequent contact with patients over an extended period of time, providing a mechanism for long-term contact and reinforcement, coupled with visible changes in the oral cavity in response to counseling.

Brief interventions typically involve an assessment of tobacco use, dependence, and motivation to quit; advice on the benefits and methods of quitting; and assistance with quitting, including referrals to other treatment.

It is important to note that studies report that adolescents consistently rank physical attractiveness, dental concerns, and oral health as greatly important.?
Relating smoking to short-term adverse effects such as staining of teeth, bad breath, loss of taste may be more relevant and meaningful to an adolescent smoker than relating smoking to long-term health effects such as cardiovascular or lung diseases.
Peer influences play a critical role as do role models. Highlighting personalities abstaining from smoking and making the dental clinic adopt a no tobacco policy can be used to guide them away from tobacco use.

Eating healthy foods and exercising is a better way to lose weight than smoking.
The "5 A's" for brief intervention are used in cases where the persons wishes to quit and include.

Anticipatory guidance—the practice of providing counsel regarding potential problems—is a key part of health care for the young, and can be considered an additional and important 'A' of this process. If dentists provide messages about tobacco use that are appropriate to the patient's age and developmental stage, the potential for broad public health impact is great. A congratulatory message positively reinforced can truly enhance the chances of a child desisting from tobacco use in the future.

The 5 R's is recommended in the event that tobacco quitting is not being contemplated:

The self-help, non-interactive approach includes minimal interventions that do not require responses from the adolescent and are delivered through written or audio-visual materials or on a computer, while self-help, computer interactive support approach uses computer technology to assess a person's tobacco use and motivation to quit.

12. TOBACCO CESSATION AT SPECIAL SITUATIONS

Pregnant and lactating women

Pregnant and breast feeding mothers: women who smoke during pregnancy and breast-feeding should strongly advised against smoking. They should be asked to quit without taking help of pharmacological treatment. However if they are unable to quit just by behavior counseling then use of NRT to support smoking cessation in pregnancy and breast-feeding is justifiable in relation to continued smoking as exposure to other toxic ingredients that are present in tobacco smoke does not occur with medicinal nicotine preparations. Pregnant and breast-feeding women who have opted for NRT should be advised to use shorter acting products to minimize overnight fetal exposure to nicotine.

Cardiovascular disease

In stable cardiovascular disease NRT is safe, although caution should be maintained while considering NRT in the patients of unstable angina, myocardial infarction, or stroke as nicotine is vasoconstrictor. However medicinal nicotine is unlikely to be more harmful compared to continued intake of nicotine through tobacco smoke. In these cases rapidly reversible NRT like nicotine gum or nasal spray should be preferable to nicotine patch as with nicotine patch absorption of nicotine may continue through skin even after removal of patch.

People with smoking related disease

This is a group where smoking cessation is of urgent clinical relevance as continued smoking greatly increases their risk of further illness. There is evidence that pharmacotherapy with bupropion can increase cessation rates in unwell chronic smokers and smokers with mild to moderate COPD. People with smoking related disease may benefit form a multidisciplinary care plan. Examples of relevant health professional who could be asked to contribute are diabetes educator, community pharmacist, specialist physician, practice nurse and primary health nurse. In some states Quitline counselors could also be involved.

People with mental illness

People with mental health problems have high rates of smoking (estimated form 50-80%). Mental illness is not a contraindication to stopping smoking but the illness and its treatment need to be monitored carefully during smoking cessation.

People with substance-use disorders

Smoking is common in people with other drug dependencies but there is evidence that in come drug dependence problems (e.g. alcohol dependency), patients can have similar success rates to the general population.

Weight gain apprehensive patients

In smokers who are apprehensive about weight gain associated with quitting should be prescribed bupropion or nicotine gum as these have been shown to delay but not prevent weight gain[7].

Brief Smoking Cessation Counseling for Pregnant Patients

ASK – 1 minute

- Ask patient about smoking status.

A. I have NEVER smoked, or have smoked LESS THAN 100 cigarettes in my lifetime. ☐

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now. ☐

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now. ☐

D. I smoke some now, but I cut down on the number of cigarettes I smoke SINCE I found out I was pregnant. ☐

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant. ☐

If patient responds B or C, reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay quit. If patient responds D or E, document smoking status on her clinic chart, and proceed to ADVISE, ASSESS, ASSIST and ARRANGE.

ADVISE – 1 minute

- Provide clear, strong advice to quit with personalized messages about the impact of smoking on mother and fetus.

ASSESS – 1 minute

- Assess the willingness of the patient to make a quit attempt within the next 30 days.

ASSIST – 3 minutes +

- Suggest and encourage the use of problem-solving methods and skills for cessation.
- Provide social support as part of the treatment.
- Arrange social support in the smoker's environment.
- Provide pregnancy-specific, self-help smoking cessation materials.

ARRANGE – 1 minute +

Periodically assess smoking status and, if she is a continuing smok

13. HOW TO START TOBACCO CESSATION SERVICES

There will be some mandatory and some optional logistics which are needed for the same. In 2002 Govt. of India with the help of WHO started the 13th Tobacco Cessation Clinic. These clinics later on ended to 19 now and with the expances they were called as Tobacco Cessation Centres. The services provided by Tobacco Cessation Centres are in the OPD, Community and related to research activities. It is very important to know how to start the Tobacco Cessation Centres by any one with the help of Govt. of India their own. This Chapter will discuss the logistics of studying the TCC.

Targets

i) Specific targets

- Current smokers
- Current SLT users
- Families of these people

ii) General targets

- All non smokers
- School children
- College children
- Women

Aim is to make current users quit and to keep others from getting into the vicious cycle of tobacco

Plan

- Infrastructure
- Location

- Staff recruitment
- Pre-launch publicity
- Launch
- Post-launch publicity (on continuous basis)

Infrastructure

- One room for OPD services equipped with all necessary furniture and equipments including computer

Staff recruitment

- Doctor
- Counselor
- Social worker
- Computer operator
- Attendant

Location

- TCC Services should be located in a place which is well connected with roads and public transport
- It can be open as a part of an existing government hospital – as that way it is easier for people to approach the Centre.

Pre-launch publicity *(Target identification)*

- Target population should be identified so that appropriate medium could be selected for the clinic publicity
- Efforts should not be confined to just tobacco users, especial emphasis should also be given to those who are not currently using tobacco but are susceptible to take up tobacco in the future
- Focus should also be drawn towards school and college students as these are the ages when a person is more likely to take up tobacco
- Clinic should be appropriately publicized so that those who are the targets of the clinic get to know the presence of such clinic and avail the services

- Publicity should be done in all major newspapers and FM radio channels (as FM channels attract large number of audience) and if economically viable then publicity through the medium of TV can be considered

Launch and Post-launch publicity

- Launch should be preceded by adequate training of the staff recruited for the purpose by the centres who are already providing such services
- Publicity of the clinic should be done on a continuous basis so that it continues to attract people

Equipments/Hand outs

- Hand outs/Educational materials (mandatory)
- Computer with printer and scanner (Optional)
  (For giving multi-media counseling, record keeping, preparation of educational materials and other office works)

- Breath CO analyzer (Mandatory)
  (For measuring the breath CO level in the smokers at each visit- which gives a fairly accurate data on smoking status)
- Telephone connection (Optional)
  (Helpful in contacting the subjects not coming regularly for follow up)
- Kit for measuring saliva and urine cotinine levels (Optional)
  (for measuring the cotinine (by-product of nicotine) in the body)
- Other services to be available in the centre or the nearest government health centre (easier to provide if attached to a big hospital) like– X-ray, ECG, facility for PFT etc. (Optional)

Medicines (Optional) Provision of supply of medicines should be there – as we have experienced in our clinic that most people are not willing to buy medicines for quitting tobacco

- Besides follow up is significantly better in persons getting medicines from our centre
- Quit rate is also better in people getting medicines from the centre itself

Contact with Alcohol de-addiction centers List and complete addresses of all major alcohol de-addiction centers should be available at the clinic so that the people who need these services are referred to the appropriate centers

(this is based on our observation at our tobacco cessation clinic where many smokers are heavy drinkers and they also want to get rid of alcohol)

IMPORTANT

Tobacco Cessation Services be part of other services of Hospital hence there is no need of any extra logistics. Only there is a need of preparing the staff and commencement of Services.

14. PHARMACOTHERAPY

Bupropion: Bupropion is a non-nicotine drug for treating tobacco dependence. It is atypical antidepressant that has both dopaminergic and adrenergic actions[14] . Sustained release preparation is available for smoking cessation. With bupropion the subject does not need to quit smoking from the start of the treatment as in case of NRT where the smoker is advised to abstain from smoking from the day one of starting NRT, instead a quit date is decided preferably within 7 to 14 days of starting treatment with bupropion. This is because steady state plasma concentration of Bupropion and its active metabolites are achieved in approximately 8 days after initiation of therapy[9]. Dosage of prescribing bupropion for smoking cessation is 150mg once a day for the first three days followed by 150mg twice a day for 7 to 12 weeks. Food does not appreciably alter the absorption of Bupropion[9]. Efficacy of bupropion for smoking cessation has been proved in many studies[15, 16].

Nicotine replacement therapy: Mechanism of action of NRT[23-25] is thought to be through stimulation of nicotinic receptors in the ventral segmental area of the brain and consequent release of dopamine in the nucleus of acumens. NRT , however, does not completely eliminate the symptoms of nicotine withdrawal because none of the medicinal nicotine products, which rely on systemic venous absorption and therefore does not achieve rapid levels in arterial system compared to levels of nicotine in the arterial system that is reached following tobacco smoke inhalation. Nicotine through tobacco smoke reaches brain within few seconds compared to medicinal nicotine which take few minutes to hours[23]. Nicotine replacement therapy (NRT) has been shown to double the cessation rates compared with controls[26, 27]. All types of NRTs viz. Nicotine patch, nicotine gum, nicotine inhaler, and nicotine nasal spray have been shown to have similar success rates[28]. NRT is safe [29] and should be recommended for smoking cessation. Choice of NRT should be arrived at after discussing the subject preferences. With NRT subject is advised to abstain from smoking from the day 1 of starting the therapy.

Nicotine patch: Nicotine patch is available in doses of 7mg, 14mg, and 21mg. Recommended prescription dosage schedule[7] is 21mg/24hours for four weeks followed by 14mg/24hours for 2 weeks and 7mg/24hours for another 2 weeks. Other dosage schedule recommendation[28] is to give 21mg/24hours followed by 14mg/24hours and

7mg/24hours for 2 weeks each. In subjects complaining of insomnia patch should be used for 16 hours instead of 24 hours[28].

Nicotine gum: Nicotine gum is available in the doses of 2mg and 4mg. Recommended dosage[7] is 2mg gum (upto 24 pieces per day) for smokers who smoke 1 to 24 cigarettes per day, and for those who smoke≥25 cigarettes per day 4 mg gum (upto 24 pieces per day) is recommended. Treatment is continued for 12 weeks. Subjects are advised to chew the gum till the peppery taste emerges and then to keep it between the cheeks and gum, to be re-chewed when the taste fades. Nicotine gum is associated with mouth soreness and dyspepsia.

Nicotine inhaler: Even though it is called inhaler but the device does not deliver the significant amount of nicotine into the lung, rather it delivers nicotine buccally[30] irrespective of whether the breath is shallow or deep. For the same reason its pharmacokinetics is similar to nicotine gum. Advantage of nicotine is its external resemblance to cigarette[31] because of which it provides psychological fulfillment of cigarette smoking. Nicotine inhaler is shown to double the cessation rates compared to control (placebo)[31].

Nicotine nasal spray: delivery of nicotine through nasal spray is more rapid compared to other NRTs, however it still does not match the swiftness with which the tobacco smoke inhalation delivers the nicotine[32] . Peak levels, which are two-third of what is achieved by cigarette, are reached in 10 minutes. Nicotine nasal spray is shown to be especially helpful in highly dependent smokers[33] in earlier studies but later studies does not show such advantage. In the early phase of treatment nasal spray is associated with nasal and throat irritation, rhinitis, sneezing, coughing and watering of eyes but tolerance to these develop in one week[31]

.***Combination of bupropion and nicotine patch***: bupropion can be used in combination with nicotine patch especially in heavy smokers. Studies have shown combination of bupropion and nicotine patch is associated with higher quit rates compared to when bipropion and nicotine patch are used alone[31].

Verenicline:

is a newer prescription medicine taken as a pill twice a day. It works by interfering with nicotine receptors in the brain. It lessens the physical pleasure from taking in nicotine and

helps lessen the symptoms of nicotine withdrawal. Studies have shown it to work as least as well as bupropion (if not more so) in helping people quit smoking, at least in the short term. Its effects against smokeless tobacco have not been studied.

Second line pharmacotherapies

Clonidine: Clonidine is a post-synaptic alfa-2 agonist that dampens sympathetic activity originating at the locus ceruleus. Clonidine is given in doses of 0.5 mg to 0.75mg per day for 3 to 10 weeks[7]. Treatment with clonidine is associated with dry mouth, sedation and dizziness[7].

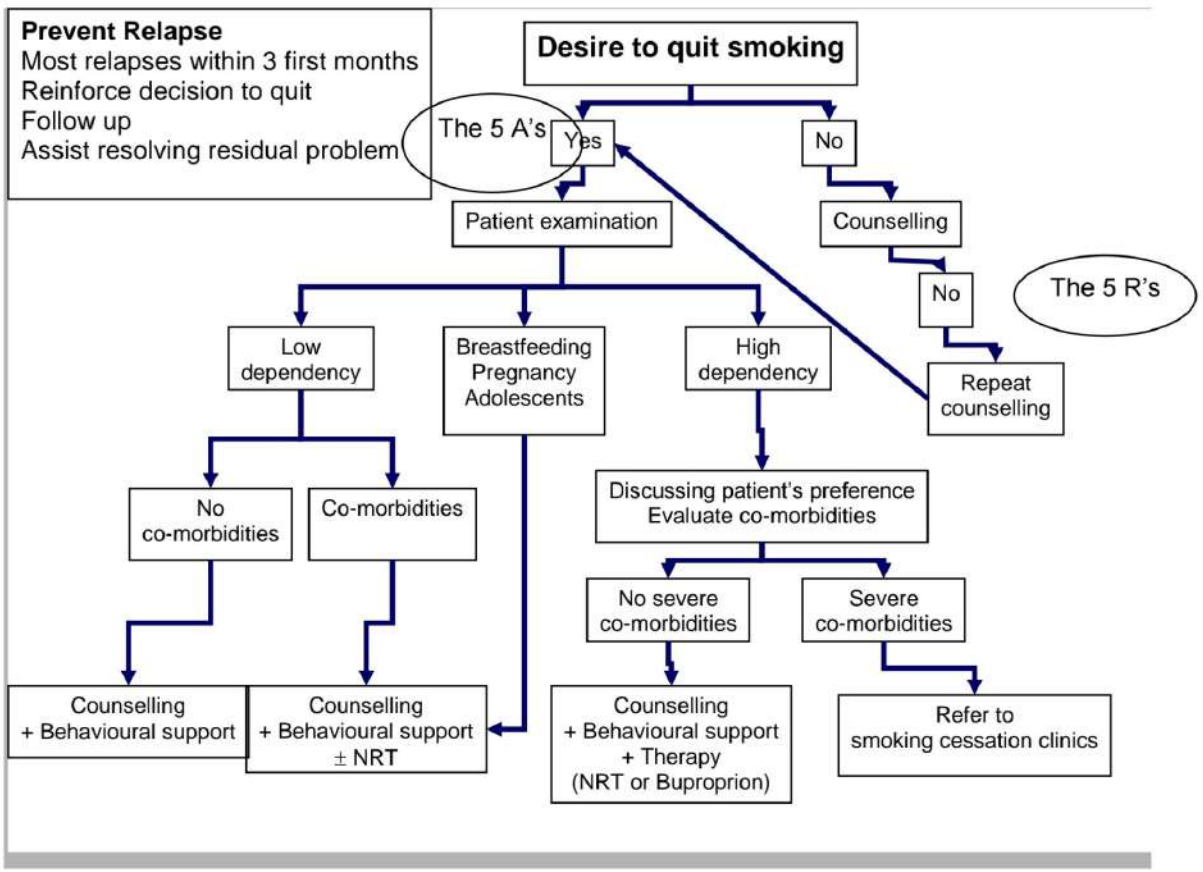
Nortryptyline: It is given in the doses of 75-100mg per day for 12 weeks. It is associated with increased risk of arrhythmias[7].

Special cases

Table 3: Pharmacotherapy for smoking cessation[7]

Pharmacotherapy	Dosage and duration	Side effects	Contraindications
Bupropion	150mg OD for 3days followed by 150mg BD for 7 to 12 weeks	Dry mouth, Insomnia	Seizure Head trauma Eating disorders
Nicotine patch	21mg/24 hours for 4 weeks then 14mg/24 hours for 2 weeks then 7mg/24 hours for 2 weeks	Local skin reaction, insomnia	
Nicotine gum	For 1-24 cigarettes- 2mg gum (upto 24 pieces/day) for 12 weeks For ≥25 cigarettes – 4mg gum (upto 24 pieces/day) for 12 weeks	Mouth soreness, dyspepsia	
Nicotine inhaler	6-16 cartridges/day for 6 months	Local irritation of mouth and throat	
Nicotine nasal spray	1-2 doses/hour for 3 to 6 months	Nasal irritation	

Clonidine	0.15mg to 0.75mg/day for 3 to 10 weeks	Dry mouth, dizziness drowsiness, sedation	Rebound hypertension
Nortryptyline	75 to 100mg/day for 12 weeks	Sedation, dry mouth	Risk of arrhythmias



14. OTHER FORMS OF THERAPY

Acupuncture

Acupuncture as an aid to smoking cessation has been the subject of a number of controlled studies. Two meta-analyses have reviewed the results of controlled studies (While et al, 1990, Flore et al, 2000). There was no significant difference between 'active' acupuncture of 'inactive' or sham acupuncture procedures.

Hypnotherapy

Hypnoherapy as an aid to smoking cessation has been the subject of a number of studies, including some controlled trials but the Cochrane systematic review (Abbott et al, 2002) concluded that there was such heterogeneity between methods and results that a meta-analysis of the literature was not possible at that time. The review concluded that hypnotherapy does not show a greater effect on six month quit rates than other interventions or no treatment.

Yoga therapy

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(Appendix – I)

Tobacco Cessation Data Collection Form (for understanding)

Ask

Current tobacco user? ☐ Yes ☐ No	If no, recent quitter? ☐ Yes ☐ No	Number of tobacco in household	Tobacco last ? ☐ Yes ☐ No
Amount tobacco per day	Age began tobacco	Number of years tobacco used	Number previous quit attempts

Assess

1. ASSESS readiness to Quit P (Precontemplation) → Not interested in quitting/not ready yet C (Contemplation) → Willing to learn more about quitting R (Preparation) → Ready to Quit Q (Action/maintenance) → Recent Quitter			2. ASSESS Level of Addiction Fagerstrom Questionnaire 3. ASSESS Level of Knowledge 4. ASSESS Barriers Stress, weight gain, withdrawal, family smokers
Readiness stage ☐ P ☐ C ☐ R	Tobacco used within 30 min of waking? ☐ Yes ☐ No	Believes smoking harmful to others ? ☐ Yes ☐ No?	Believes smoking harmful to self? ☐ Yes ☐ No
Barriers		Comments	

Assist

Assist With Education/Quitting Plan

Health Messages: C (effects on child), M (effects on mother), B (benefits of quitting,), N (nicotine addiction)

Education ☐ C ☐ M ☐ B ☐ N	Program materials		
Quit date	Written plan	Quit contract signed ☐ Yes ☐ No	No tobacco support ☐ Yes ☐ No

Arrange/Follow-up

Referred to cessation program ☐ In-house ☐ Outside	Type of intervention ☐ One-to-one ☐ Group	Nicotine Replacement ☐ Patch ☐ Gum ☐ Inhaler ☐ Spray	Other Bupropion Verniciline
Set follow-up date	Type of follow-up ☐ Phone ☐ Letter ☐ Visit	Reduced Tobacco use ☐ Yes ☐ No	Stopped tobacco use ☐ Yes ☐ No

(Appendix – II)

Nicotine addiction questionnaire

Are you addicted to nicotine? Take the test below and see what you rank. After you score is totaled, you will be given tailored advice on what methods or treatments are available to help make your decision to a tobacco free life easier.

1. How soon after you wake up do you smoke your first cigarette?
   ☐ 0-5 min ☐ 6-30 min ☐ 31-60 min ☐ After 60 min

2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., church library, cinema)?
   ☐ Yes ☐ No

3. Which cigarette would you be the most unwilling to give up?
   ☐ First in the morning ☐ Any of the others

4. How many cigarettes per day do you smoke?
   ☐ 10 or less ☐ 11 to 20 ☐ 21 to 30 ☐ 31 or more

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?
   ☐ Yes ☐ No

6. Do you smoke if you are so ill that you are in bed most of the day?
   ☐ Yes ☐ No

Scoring Of Nicotine Addiction Questionnaire

1. How soon after you wake up do you smoke your first cigarette?
   ☐ 0-5 min ☐ 6-30 min ☐ 31-60 min ☐ After 60 min
   (3 points) (2 points) (1 point) (0 points)

2. Do you find it difficult to refrain from smoking in places where it is forbidden (e.g., church library, cinema)?

   ☐ Yes ☐ No

   (1 point) (0 points)

3. Which cigarette would you be the most unwilling to give up?

   ☐ First in the morning ☐ Any of the others

   (1 point) (0 points)

4. How many cigarettes per day do you smoke?

   ☐ 10 or less ☐ 11 to 20 ☐ 21 to 30 ☐ 31 or more

   (0 points) (1 point) (2 points) (3 points)

5. Do you smoke more frequently during the first hours after waking than during the rest of the day?

   ☐ Yes ☐ No

   (1 point) (0 points)

6. Do you smoke if you are so ill that you are in bed most of the day?

   ☐ Yes ☐ No

   (1 point) (0 points)

(APPENDIX – III)

HAND OUTS

(Appendix – IV)

S.NO.	TOBACCO CESSATION CENTRES - CONTACT DETAILS
1.	**Dr. Surendra Shastri,** Principal Investigator Professor & Head of Department of Preventive Oncology Tata Memorial Hospital (TMC) Department of Preventive Oncology Dr Ernest Borges Road, Parel, Mumbai -400012 Phone # 022-24154379 (O) # 0-98201-26744 (M) E-mail: shastri@vsnl.com surendrashastri@hotmail.com
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3.	**Dr. Nimesh G. Desai,** Professor & Head of Department of Psychiatry Institute of Human Behaviour & Allied Sciences (IHBAS) G.T. Road, Dilshad Garden, Post Box No. 9250, Delhi-110095 Phone # 011-22113395 (O) # 98107-97933 (M) E-mail: tcc.ihbas2008@gmail.com Concerned TCC Staff **Ms Shuchi** (Medical Officer) # 9818338963 (M) **Mr. Ved Muni** (Medical Social Worker) # 011-22113395 (O)
4.	**Dr. Girish Mishra** Principal Investigator HM Patel Centre for Medical Care & Education Pramukhswami Medical College & Shree Krishna Hospital Gokal Nagar, Karamsad –388325 , Gujarat # 0-98254-89878 (M) # 02692-223666 (O) E-mail: daxa.girish@yahoo.com Concerned TCC Staff **Mrs Indu Kumar** # 02692-223666 (O # 0-98981-77380 (M)) E-mail: ibrijukumar@yahoo.co.uk

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7.	**Dr. Rama Kant,** Principal Investigator Head of Deptt. of Surgery & Endocrine Surgery Unit) Chhatrapati Shahuji Maharaj Medical University, Lucknow–226003, Uttar Pradesh # 0522-2358230 (O), 0522-3245224 (O) # 0-9415 00 72 99 (M) E-mail: ramakantkgmc@rediffmail.com <u>Concerned TCC Staff</u> **Dr Madhu Pathak** Clinical Psychologist # 09415102280 (M) **Mr. Arohi Srivastava** Programme Assistant # 0522-3245224 (O)
8.	**Dr. R.K. Panday** Principal Investigator (Tobacco Cessation Clinic) Jawaharlal Nehru Cancer Hospital & Research Centre P.O. Box No. 32, Idgah Hills, Bhopal – 462001, Madhya Pradesh 0755-2666374, Extn. 104 # 091-0755-2666611 (O) E-mail: jnchwhotcc@sify.com jncancer@sancharnet.in Concerned Staff: Dr. N. Ganesh (Co-Principal Investigator) Dr. Anita Dash (Medical Officer) Mrs. Kavita Chaube (Clinical Psychologist) Mr. Sanjeev Sharma (Social Worker)

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(Appendix –V)

TOBACCO CESSATION CLINIC- INTAKE AND FOLLOW-UP FORM

Note: This is the minimum required information for the database. Each center is encouraged to maintain a detailed clinical record for each client.

	Centre	Centre code	Client No.
Date			

1. Name : _____
2. Age : _____
3. Gender : Male ☐ Female ☐
4. Address : _____
   _____ Ph. No. _____
5. Education (Numbers of years of formal education) _____
6. Marital Status: Unmarried ☐ Married ☐ Widowed ☐

   Separated or Divorced ☐ Not Applicable ☐
7. Income (Per month): Rs. _____
8. Occupation: Professional and Semiprofessional ☐ Unemployed ☐

   Skilled, Semiskilled & Unskilled worker ☐ Retired ☐

   Housewives ☐ Students ☐ Others/ Not Classified. _____
9. Detail of Tobacco use:

Type	Ate at Starting Tobacco use	Sachet/cigarette years (Numbers of cigs/bidis/sachets of tobacco used per day X No. of years of regular tobacco use)	Average numbers of cigarette/ sachets amount of tobacco chewed per day in the last one month

Smokeless 1. 2. 3.			
Smoking 1. 2. 3.			

11. Expense per month on tobacco (Average month last year) Rs. _____

12. Alcohol use in the last 1 year: Daily Drinking ☐ Regular Drinking (3 or more times a week) ☐

Social Drinking (<3 times/ week) ☐

None ☐

13. Average units per drinking day (30 ml spirit/60ml wine/1/2 mug beer= 1 unit) _____ Units

14. Others Substance use: Yes ☐ No ☐ If Yes specify substance: _____

15. Number of previous attempts at quitting which lasted for at lasted one month _____.

16. Severity of Tobacco use (applicable for the last one Month):

1. How soon after you wake up, do you smoke your first cigarette/ bidi/your first packet? ☐
   3- Within 5 min. 2- 6 to 30 min. 1-31 to 60 min 0- more than 60 min
2. Do you find it difficult to refrain from smoking/chewing in place where it is forbidden? ☐
   (Such as religious places/ classroom/ hospital etc.) 1- Yes 0-No ☐
3. Which cigarette or tobacco would you hate most to give up? ☐
   1- the first one in the morning 0- any other
4. Do your smoke or use tobacco if you are ion bed most of the day? 1- Yes 0- No ☐
5. How many cigarette/ bidis/packers do you use in a day? ☐
   31 or more- 3 21 to 30 -2 11 to 20 -1 10 or less – 0
6. Do you smoke/chew more frequently during the first hours after walking? ☐

   Then during the rest of the day? 1- Yes 0 – No

Severity Score (Sum of items 1 to 6) ____

7. How long do you keep the betel quid / khaini / ghutkha etc in your mouth in a day? (In hours) ☐

17. Tobacco use in first \-degree relatives: Smoking ☐ Smokeless ☐ Both ☐ None ☐

18. History & Symptoms suggestive of: HTN (yes, No) ☐ Diabetes (Yes, No) ☐

Heart Attack (Yes, No) ☐ Stroke (Yes, No) ☐

Asthma/ Bronchitis (Yes, No) ☐ Cancer (Yes, No) ☐

Physical Examination

19. Weight_____ Kgs. 20. Height _____ cms. 21. Pulse_____ 22. BP Systolic_____ ☐ ☐ ☐ ☐
Diastolic____

23 Oral Cavity: Leukoplakia Yes ☐ No ☐ Erythroplakia Yes ☐ No ☐

Sub mucous fibrosis Yes No Dental Caries Yes No

24. Significant current co-morbid disorder: a)_____
b)_____
c) _____

25. Intervention: Behavioural Counselling Behavioural Counselling+ Medication

Behavioural Counselling + NRT ☐☐ Behavioural Counselling+ NRT+ Medications ☐☐

26. Fellow up

	Date	No Change (or<50% reduction from baseline*)	Reduced use (50% or greater reduction from baseline*)	Stopped Use	Lost to fellow up	Continine test (+ve or_ve) or not done
2 weeks						
4 weeks						
6 weeks						
3 months						
6 months						

Any other numbers: