is an important health concern; and offered assistance if they become interested in quitting in the future. Many of those not currently expressing an interest in quitting may nevertheless make an attempt to quit in the subsequent year. For those interested in quitting, a quit date should be negotiated, usually not the day of the visit but within the next few weeks, and a follow-up contact by office staff around the time of the quit date should be provided. There is a relationship between the amount of assistance a patient is willing to accept and the success of the cessation attempt.

There are a variety of nicotine-replacement products, including over-the-counter nicotine patches, gum, and lozenges, as well as nicotine nasal and oral inhalers available by prescription. These products can be used for up to 3–6 months, and some products are formulated to allow a gradual step-down in dosage with increasing duration of abstinence. Antidepressants such as bupropion (300 mg in divided doses for up to 6 months) have also been shown to be effective, as has varenicline, a partial agonist for the nicotinic acetylcholine receptor (initial dose 0.5 mg daily increasing to 1 mg twice daily at day 8; treatment duration up to 6 months). Severe psychiatric symptoms, including suicidal ideation, have been reported with varenicline, resulting in a U.S. Food and Drug Administration–mandated warning and a recommendation for closer therapeutic supervision, but evidence to establish the frequency of these responses and the specificity of their association with varenicline remains unclear. Some evidence supports the combined use of nicotine-replacement therapy (NRT) and antidepressants as well as the use of gum or lozenges for acute cravings in patients using patches. Pretreatment with antidepressants or varenicline is recommended for 1–2 weeks prior to the quit date, and pretreatment with nicotine-replacement products is also being explored, as is longer duration of nicotine replacement as a maintenance therapy for those who are unsuccessful in quitting with a shorter duration of use. NRT is provided in different dosages, with higher doses being recommended for more intense smokers. Clonidine or nortriptyline may be useful for patients who have failed on first-line pharmacologic treatment or who are unable to use other therapies. Antidepressants are more effective in those with a history of depression symptoms.

Current recommendations are to offer pharmacologic treatment, usually with NRT or varenicline, to all who will accept it and to provide counseling and other support as a part of the cessation attempt. There are some data to suggest that longer term use of NRT may enable cessation in some smokers who are unable to quit with shorter duration use and that some individuals are able to achieve abstinence from tobacco through use of NRT chronically. Cessation advice alone by a physician or his or her staff is likely to increase success compared with no intervention; a more comprehensive approach with advice, pharmacologic assistance, and counseling can increase cessation success nearly threefold.

Incorporation of cessation assistance into a practice requires a change of the care delivery infrastructure. Simple changes include (1) adding questions about smoking and interest in cessation on patient-intake questionnaires, (2) asking patients whether they smoke as part of the initial vital sign measurements made by office staff, (3) listing smoking as a problem in the medical record, and (4) automating follow-up contact with the patient on the quit date. These changes are essential to institutionalizing smoking intervention within the practice setting; without this institutionalization, the best intentions of physicians to intervene with their patients who smoke are often lost in the time crush of a busy practice.

PREVENTION

Approximately 85% of individuals who become cigarette smokers initiate the behavior during adolescence. Factors that promote adolescent initiation are parental or older-sibling cigarette smoking, tobacco advertising and promotional activities, the availability of cigarettes, and the social acceptability of smoking. The need for an enhanced self-image and to imitate adult behavior is greatest for those adolescents who have the least external validation of their self-worth, which may explain in part the enormous differences in adolescent smoking prevalence by socioeconomic and school performance strata.

Prevention of smoking initiation must begin early, preferably in the elementary school years. Physicians who treat adolescents should be sensitive to the prevalence of this problem even in the pre-teen population. Physicians should ask all adolescents whether they have experimented with tobacco or currently use tobacco, reinforce the fact that most adolescents and adults do not smoke, and explain that all forms of tobacco are both addictive and harmful.