

## GUEST EDITORIAL

## Counseling Is Key to Smoking Cessation

BY ALAN  
BLUM, M.D.

If history is any guide, the introduction of Chantix will be a much ballyhooed new addition to the smoking cessation arsenal. In nearly 30 years as a family physician and an active participant in the

effort to curb tobacco use, I have witnessed a parade of much-trumpeted cessation medications, such as Nicorette, Nicotrol, Nicoderm, and Zyban. Such drugs can be useful, in my experience. Yet I vehemently disagree with the recommendation of the Clinical Practice Guideline on Treating Tobacco Use and Dependence that pharmacotherapy should be automatically offered to every patient trying to stop smoking. The guideline is based

on the presumption that tobacco use is synonymous with nicotine addiction, the treatment for which requires nicotine replacement and other medications.

Chantix (varenicline) is likely to be popular over the next year or two, particularly since it is being hailed by the American Cancer Society, the American Lung Association, and others. On the one hand, I am reluctant to discourage patients from trying a new drug if that's what they have their

hearts set on, lest I create a "dysplacebo" effect, whereby a patient's belief that his or her motivation to quit is not enough on its own becomes a self-fulfilling prophecy.

But on the other hand, a number of entities make it harder for a physician to begin cessation treatment non-pharmacologically. The news media, no doubt spurred on by pharmaceutical company news releases, herald every new cessation drug's efficacy. Physicians read nonproduct educational advertisements in medical journals, such as the two-page ads that take note of but downplay the importance of behavior modification. Patients and physicians alike see and hear the manifold TV, radio, and pharmacy point-of-purchase advertisements. And of course, sponsored dinners, detailing, and displays at medical meetings, hospitals, and clinics put the idea of first-line medical treatment for smoking cessation in the physician's mind.

So what should we make of this new arrival? If quitting smoking were as easy as taking a pill, and if such a pill were an affordable option for most patients, that would be a welcome development. But Chantix, like its forebears, shows only limited efficacy. As with all the previous entries in the lucrative smoking cessation market, one of the red flags of the new drug is not that the claimed success rate (44%) is so much higher than most interventions but rather that the success rate of the placebo group is also significantly higher (18%) than that of the nonintervention group (5%). In other words, there seems to be some factor in all drug studies that significantly bumps up the success rate of the placebo group as well.

It is more important than ever to consider the patient's ability to afford a drug we prescribe. I regard pharmacotherapy for smoking as a secondary and adjunctive approach to smoking cessation, not a primary one. Thus my approach is first to spend a few minutes counseling the patient who smokes, using real-world, nonclinical terms and addressing misperceptions. I explain that filters have been shown not to make

*Continued on following page*



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## LETTERS

**Duct Tape and Bic Razor Work on Warts**

I agree with the approaches Dr. Anthony J. Mancini has taken to handle warts and *Molluscum contagiosum* ("Wart and Molluscum Management Made Easy," April 15, 2006, p. 37).

I shall never forget the day when a 14-year-old girl showed up in my office to have a pre-op physical for removal of three palmar and two plantar warts under general anesthesia! No amount of discussion and explanation was enough to dissuade her parents from that drastic decision

about a benign condition. It is crucial for physicians to educate patients and parents about the self-limiting and benign nature of these lesions.

The only different twist I have in my practice is the use of a Bic razor to debride the lesions, especially those on the plantar surface, by the patient or parents following a keratolytic agent such as salicylic acid under duct tape. Since many of the patients do not like duct tape or won't keep duct tape on, I limit application to nighttime. The result has been a number of gratified and satisfied patients as well as parents. I

make less money but it is the least painful approach. The Bic razor provides safety against deeper cuts as well as other injuries, and it is less threatening than a No. 15 blade or any other device. I insist that parents and patients search the Internet for "duct tape treatment warts" to educate themselves on the validity of this approach.

Amar Dave, M.D.  
Ottawa, Ill.

**Pay-for-Performance Puppets**

I'd like to thank Dr. Faith Fitzgerald for the stinging analysis and indictment of the pay-for-performance travesty ("The Perils of Pay for Performance," Guest

Editorial, May 1, 2006, p. 8).

We physicians are fast becoming performing monkeys and puppets paid a pittance—yet we do not know it, having mesmerized ourselves into thinking we are doing our patients a favor. Ironically, every insurance policy makes it twice as hard to obtain legitimate and focused tests and treatments, making us jump through paper hoops and have groveling conversations with the technician watchdogs and the handsomely paid MD desk analysts. I hope many physicians will read Dr. Fitzgerald's message and spread it.

Sydney O. Fernandes, M.D.  
Oregon, Ohio

## LETTERS

Letters in response to articles in FAMILY PRACTICE NEWS and its supplements should include your name and address, affiliation, and conflicts of interest in regard to the topic discussed. Letters may be edited for space and clarity.

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Continued from previous page

cigarettes less harmful but instead help increase the risk of emphysema and heart disease. I note that low tar is not safer than higher tar, since the smoker ends up inhaling more deeply to get the same effect, and that menthol simply anesthetizes the back of the throat and deceives the consumer into believing the smoke is less harsh. I tell the patient that "lights" and "ultralights" are lethal deceptions that may refer only to the flavorings and other chemical additives.

Moreover, I educate the patient about the fact that "just a pack a day" represents 200 inhalations of poisons and more than 70,000 such inhalations a year, and I compare this to breathing in that many puffs of bus exhaust. I also talk to patients about the poison gases (carbon monoxide, ammonia, formaldehyde, and cyanide), making an analogy with each one: Carbon monoxide is what kills people when they leave the car motor on in the garage; ammonia is the same chemical found in urine and household cleaners; formaldehyde is used to preserve bodies and body parts; and cyanide gas is used to execute those convicted of capital offenses. And of course I describe the various diseases that disproportionately strike smokers. At the same time, I try to be upbeat in my encouragement of the patient to stop smoking cigarettes.

Had we been focusing more on consumer education about tobacco products and reinforcing simple behavioral modification approaches rather than finger-wagging solely about the abstract diseases that could develop and dashing off a prescription, we'd have less of a craving for wonder drugs and miracle cures. ■

DR. BLUM is professor of family medicine and director of the Center for the Study of Tobacco and Society at the University of Alabama, Birmingham, and founder of Doctors Ought to Care, a national physician-led health promotion organization.



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