# Smoking and the Patient With Cardiovascular Disease

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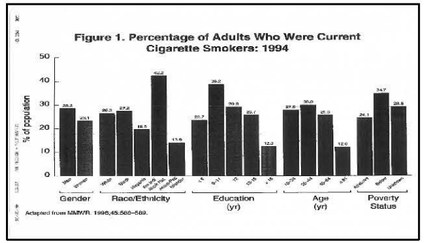
## Introduction

Smoking is the only completely avoidable risk factor for cardiovascular disease; thus, It is critical that family physicians include refreshing approaches to smoking prevention and cessation as important goals in the primary care of our patients.

## Prevalence and Risks

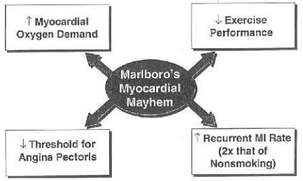
At least a quarter of the adult population in the United States smokes, with the percentage climbing to as high as 40% or more in certain segments of the population (Figure 1)[1]. Furthermore, It is estimated that a third of high-school-age students {34.8%) smoke cigarettes.[2] Those who smoke are at a substantially higher risk for cardiovascular disease, among other serious chronic illnesses. Individuals exposed to passive smoke in the home and workplace are also at increased risk for coronary artery disease.


## Physiologic Effects on the Cardiovascular System

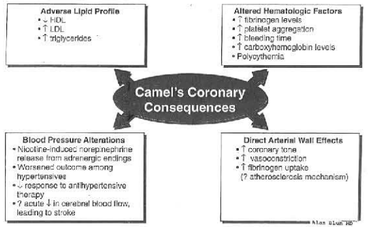
While the precise mechanisms by which smoking increases cardiovascular disease are still being discovered, it has been shown to exert direct myocardial effects, such as increasing myocardial oxygen demand, lowering the threshold for angina, and Impairing exercise performance (Figure 2).

Myocardial Effects of Smoking




Indeed, the rate of CHD deaths among those who smoke is double that of nonsmoking individuals.3 Smoking also appears to accelerate the atherosclerotic process itself by adversely affecting the lipid profile, altering blood pressure and hematologic factors, and exerting direct deleterious effects on arterial walls (Figure 3).

Atherosclerotic Effects of Smoking




## Smoking Prevention and Cessation

Motivating people to stop smoking is a formidable challenge, as is the effort to prevent individuals from starting smoking in the first place. Encouragingly, family physicians can begin to exert a positive influence both by serving as a source of information about the effects of tobacco on health as well as by implementing office-based strategies to promote "anti-smoking" attitudes. Attitudinal approaches should be accompanied by simple behavioral modification techniques (eg, relaxation response, oral substitutes) that move beyond the pharmacologic methods of the conventional nicotine addiction model (ie, the patient as an addict) and toward a consumerist approach-"the thinking patient's technique."


## Consumerist Model

The consumerist model (Table 1) places less emphasis on the physiologic aspects of nicotine addiction and related cessation strategies and more emphasis on a linguistic-based approach In which sociocultural factors are considered and the individual who smokes is encouraged to think in new ways about his or her behavior and how it might be modified.[4,5] The consumerist approach Includes nonthreatening and nonjudgmental questions from the physician that personalize the problem and point out Immediate health and financial implications of the behavior (Table 2).

**Table 1. Smoking Cessation Models**

| Nicotine Addiction Model (Costly) | Consumerist Model |
|---|---|
| • Physiologic-based<br>• Coddling<br>• Medications (patches, gum, nasal spray)<br>• Electroshock<br>• Hypnosis<br>• Acupuncture<br>• Commercial programs, gimmicks<br>• Group therapy | • Low-cost or no cost<br>• Linguistic-based<br>• Mocking the brand name<br>• Attitudinal *and* behavioral modification<br>- consider looks (wrinkled skin, zoo breath)<br>- money (pack/d = $800/yr)<br>- relaxation response (deep breathing)<br>- oral substitutes (atomic fireballs, gum, iced tea) |

**Table 2. Example of Consumerist vs Traditional Approach**

| Traditional Approach | Consumerist Approach |
|---|---|
| • How much do you smoke?<br>• How long have you smoked?<br>(authoritarian, didactic) | • What brand do you buy?<br>• How much do you spend on cigarettes?<br>(nonthreatening, nonjudgmental) |

## Role of the Family Physician

Family physicians will be most successful in helping a patient to stop smoking by individualizing and personalizing the approach. breaking down myths that surround smoking find Its consequences, and by choosing words more carefully (revocabularizing) when discussing cigarettes with the patient (Table 3).

**Table 3. Key Techniques for Family Physicians**

| Individualize | Personalize |
|---|---|
| • Tailor to the individual<br>• Appeal to age, occupation, avocation<br>• Motivate (eg, x-ray, ECG, humor) | • Show that you really care<br>• To teenagers:<br>- "You're 15 and you still smoke? Come on, you're too old for that!"<br>- "Are your teeth that yellow?"<br>- "What smells? Oh, sorry..." |
| **Demythologize** | **Revocabularize** |
| • Dispel the myths:<br>- low tar/filters/lights/menthol cigarettes *ARE NOT* safer<br>- smoking *DOES NOT* keep weight down in most persons<br>- smoking *DOES NOT* relieve stress; just hits the nicotine fix | • Words to avoid:<br>- quit, quitter<br>- low-tar<br>• Helpful one-liners:<br>- "Stop buying that crap."<br>- "Low-tar just means low-poison."<br>- "Menthol is an anesthetic."<br>- "The filter is a fraud." |

## Doctors Ought to Care (DOC)

Since 1977, DOC (Doctors Ought to Care) has been training physicians, medical students, end other health professionals to counteract the promotion of tobacco and other unhealthy products by means of humorous and engaging approaches in the clinic, classroom, and community.



## References

1. CDC. Cigarette smoking among adults – United States, 1994. MMWR, 1996;45:588-589.
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3. Neaton JD, Wentworth D, for the Multiple Risk Factor Intervention Trial Research Group. Serum cholesterol, blood pressure, cigarette smoking, and death from coronary heart disease. Overall findings and differences by age for 316,099 white men. Arch Intern. Med. 1992;152:56-64.
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