# Corrections and Additions to the Public Health Service (PHS) Clinical Practice Guideline

## Treating Tobacco Use and Dependence—2008 Update

*Treating Tobacco Use and Dependence: 2008 Update*, a Public Health Service-sponsored Clinical Practice Guideline, is a product of the Tobacco Use and Dependence Guideline Panel ("the Panel"), consortium representatives, consultants, and staff. These 37 individuals were charged with the responsibility of identifying effective, experimentally validated tobacco dependence treatments and practices.

An impetus for this Guideline update was the expanding literature on tobacco dependence and its treatment. This Corrections and Additions document helps to ensure that the Guideline remains accurate, particularly with regard to any safety issues. Additional postings may occur yearly or as needed.

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### Correction #2 (posted 11-09)

Among the supplemental materials to the PHS-sponsored Clinical Practice Guideline: *Treating Tobacco Use and Dependence: 2008 Update* is the Quick Reference Guide for Clinicians: 2008 Update. Table 16 (page 29) of this document lists specific challenges and potential responses to tobacco users who recently quit. The last challenge listed in Table 16 is "smoking slips." The label and suggested responses are misprinted.

Currently, the text in Table 16 of the printed Quick Reference Guide appears as follows:

| | |
|---|---|
| Smoking slips | • Suggest low-calorie substitutes such as sugarless chewing gum, vegetables, or mints.<br>• Maintain the patient on medication known to delay weight gain (e.g., bupropion SR, NRTs—particularly 4-mg nicotine gum—and lozenge.<br>• Refer the patient to a nutritional counselor or program. |

The corrected text is shown here:

| | |
|---|---|
| Smoking lapses | • Suggest continued use of medications, which can reduce the likelihood that a lapse will lead to a full relapse.<br>• Encourage another quit attempt or a recommitment to total abstinence.<br>• Reassure that quitting may take multiple attempts, and use the lapse as a learning experience.<br>• Provide or refer for intensive counseling. |

This table has been corrected on the electronic version of the Quick Reference Guide, available for downloading on both the AHRQ (http://www.ahrq.gov/clinic/tobacco/tobaqrg.htm) and Surgeon General http://www.surgeongeneral.gov/tobacco/) Web sites. The corrected text also will appear in the next printing of the Quick Reference Guide.

## Correction #1 (posted 7/09)

Table 6.22 (go to top figure, below) was published as Table 6.22 in the 2008 PHS Guideline. The analysis results depicted in that table were intended to contrast the effects of medication + counseling vs. medication alone. However, five study arms were included in the "medication alone" group of studies that should not have been included. The subjects in these study arms actually received one session of counseling in addition to medication. There were, in fact, 8 study arms in the set of studies available to us that received medication + no counseling (Table 6.22 shows 8 arms in the medication alone condition but 13 were actually analyzed). When the proper set of study arms was included in the analysis, the results were essentially the same as those originally reported. The corrected Table 6.22 (the bottom table below) shows that Medication + Counseling produces significantly higher rates of abstinence than does Medication alone (using only study arms with no counseling), and the magnitude of the effect is very similar to that reported in the Table 6.22 that appears in the *Guideline*.

### Table 6.22 as currently printed

| Treatment | Number of arms | Estimated odds ratio (95% C.I.) | Estimated abstinence rate (95% C.I.) |
|---|---|---|---|
| Medication alone | 8 | 1.0 | 21.7 |
| Medication and counseling | 39 | 1.4 (1.2, 1.6) | 27.6 (25.0, 30.3) |

### Corrected table 6.22

| Treatment | Number of arms | Estimated odds ratio (95% C.I.) | Estimated abstinence rate (95% C.I.) |
|---|---|---|---|
| Medication alone | 8 | 1.0 | 21.6 |
| Medication and counseling | 39 | 1.3 (1.1, 1.6) | 27.0 (22.7, 31.4) |

### References for the randomized control trials used in this updated analysis:


Alterman AI, Gariti P, Mulvaney F. Short- and long-term smoking cessation for three levels of intensity of behavioral treatment. Psychol Addict Behav 2001;15:261-4.

Fagerstrom KO. Effects of nicotine chewing gum and follow-up appointments in physician-based smoking cessation. Prev Med 1984;13:517-27.

Fiore MC, McCarthy DE, Jackson TC, et al. Integrating smoking cessation treatment into primary care: an effectiveness study. Prev Med 2004;38:412-20.

Ginsberg D, Hall SM, Rosinski M. Partner support, psychological treatment, and nicotine gum in smoking treatment: an incremental study. Int J Addict 1992;27:503-14.

Hall SM, Humfleet GL, Reus VI, et al. Extended nortriptyline and psychological treatment for cigarette smoking. Am J Psychiatry 2004;161:2100-7.

Hall SM, Humfleet GL, Reus VI, et al. Psychological intervention and antidepressant treatment in smoking cessation. Arch Gen Psychiatry 2002;59:930-6.

Hall SM, Reus VI, Munoz RF, et al. Nortriptyline and cognitive-behavioral therapy in the treatment of

cigarette smoking. Arch Gen Psychiatry 1998;55(8):683-90.

Huber D. Combined and separate treatment effects of nicotine chewing gum and self-control method. Pharmacopsychiatry 1988;21:461-2.

Jorenby DE, Smith SS, Fiore MC, et al. Varying nicotine patch dose and type of smoking cessation counseling. JAMA 1995;274:1347-52.

Lifrak P, Gariti P, Alterman AI, et al. Results of two levels of adjunctive treatment used with the nicotine patch. Am J Addict 1997;6:93-8.

Macleod ZR, Charles MA, Arnaldi VC, et al. Telephone counselling as an adjunct to nicotine patches in smoking cessation: a randomised controlled trial. Med J Aust 2003;179:349-52.

Reid RD, Pipe A, Dafoe WA. Is telephone counselling a useful addition to physician advice and nicotine replacement therapy in helping patients to stop smoking? A randomized controlled trial. Can Med Assoc J 1999;160:1577-81.

Roozen HG, Van Beers SE, Weevers HJ, et al. Effects on smoking cessation: naltrexone combined with a cognitive behavioral treatment based on the community reinforcement approach. Subst Use Misuse 2006;41:45-60.

Simon JA, Carmody TP, Hudes ES, et al. Intensive smoking cessation counseling versus minimal counseling among hospitalized smokers treated with transdermal nicotine replacement: a randomized trial. Am J Med 2003;114:555-62.

Slovinec D'Angelo ME, Reid RD, Hotz S, et al. Is stress management training a useful addition to physician advice and nicotine replacement therapy during smoking cessation in women? Results of a randomized trial. Am J Health Promot 2005;20(2):127-34.

Solomon LJ, Marcy T, Howe KD, et al. Does extended proactive telephone support increase smoking cessation among low-income women using nicotine patches? Prev Med 2005;40:306-13.

Solomon LJ, Scharoun GM, Flynn BS, et al. Free nicotine patches plus proactive telephone peer support to help low-income women stop smoking. Prev Med 2000;31:68-74.

Swan GE, McAfee T, Curry SJ, et al. Effectiveness of bupropion sustained release for smoking cessation in a health care setting: a randomized trial. Arch Intern Med 2003;163:2337-44.

## Addition #1 (posted 7/09)

On July 1, 2009, the Food and Drug Administration (FDA) issued new warnings for both varenicline and bupropion. The manufacturers of these medications are now required to include a boxed warning on the prescribing information for these medications. Clinicians using these medications should consult the FDA Web site for complete information on this warning. The URL is:
http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/DrugSafetyInformationforHeathcareProfessionals/ucm169986.htm

Current as of November 2009