I. PREVALENCE AND IMPACT

**RECOMMENDATION:**
Clinicians should use evidence-based interventions to promote smoking cessation in HIV-infected patients.

Smoking prevalence among both HIV-infected persons and substance users is much higher than in the general population; more than 50% of HIV-infected patients and more than 75% of substance users are estimated to be current smokers. Smoking-related diseases are the leading cause of death in patients previously treated for alcoholism or other non-nicotine drug dependence and also pose unique health risks to HIV-infected patients. These include increased risks of HIV-associated pulmonary infections and oropharyngeal lesions and higher incidences of AIDS-defining and non-AIDS-defining malignancies. Smoking is also an established risk factor for atherosclerosis and has been associated with coronary events in patients receiving PI therapy.

**Key Point:**
Cigarette smoking is highly prevalent among both HIV-infected patients and substance users.

The high prevalence of smoking among HIV-infected substance users and the particular health risks it poses to HIV-infected persons make interventions to promote smoking cessation imperative in this population. Previous studies of smokers seeking treatment for drug or alcohol dependence have found that many are interested in quitting smoking and believe that doing so will not have a negative impact on their sobriety. For HIV-infected substance users, quitting smoking could decrease the risk of HIV-associated infections and malignancies and reduce the incidence of ARV-associated complications. Quitting smoking at any age is associated with improvements in health.

Screening for nicotine addiction is an important part of HIV primary care. The Fagerstrom Test for Nicotine Dependence has been used to assess nicotine addiction and may help guide the patient toward smoking cessation. Heavy smoking often accompanies other drug or alcohol dependence and should prompt the clinician to screen for other addictions.

Smoking cessation interventions delivered during routine visits will reach many smokers who are already receiving care for their HIV infection.
II. ASSESSMENT FOR READINESS TO QUIT

RECOMMENDATIONS:
Clinicians should routinely assess HIV-infected patients’ smoking status and readiness to quit.

Clinicians should identify and discuss barriers to quitting smoking for HIV-infected smokers who are not interested in stopping in the immediate future but may consider it at a later time.

Readiness to quit may be assessed by asking whether the patient is interested in quitting smoking within the next month. Clinicians should offer smoking cessation assistance, including pharmacotherapy, to patients who are ready to quit (see Section III: Smoking Cessation Assistance). For HIV-infected smokers who are not interested in quitting within the next month, clinicians should determine their stage of readiness to change their smoking behavior. For those contemplating change (meaning they are interested in quitting but not in the next month), barriers to quitting should be identified and addressed. These barriers may include nicotine dependence, lack of social support, or depression.

Substance users in recovery may also have concerns about relapse to other substance abuse if they quit smoking. For pre-contemplative smokers (those who are not at all interested in quitting), motivational interviewing techniques should be used to identify ambivalence, elicit pros and cons of smoking cessation, correct misconceptions, and probe resistance to behavior change.

III. SMOKING CESSATION ASSISTANCE

RECOMMENDATIONS:
Clinicians should advise all smokers to quit.

For smokers who are interested in quitting, clinicians should:
- Offer smoking cessation assistance including pharmacotherapy
- Help set a quit date
- Refer to a counseling program
- Educate patients about symptoms of nicotine withdrawal

Assistance with smoking cessation is a cost-effective intervention that is underused by primary care clinicians and inadequately covered by health insurance. For HIV-infected substance users to benefit from recent advances in understanding and promoting smoking cessation, routine medical practice should include effective treatment for tobacco dependence.

Smoking cessation interventions of demonstrated efficacy are now available and easily implemented in healthcare settings. Although these interventions have not been specifically tested in HIV-infected substance users, there is strong agreement about what constitutes effective treatment of tobacco use and dependence.
Patients who are interested in quitting within the next month should be helped to set a quit date, offered pharmacotherapy with nicotine replacement, bupropion, or varenicline, and referred to a counseling program. Because current guidelines regard nicotine replacement and bupropion as roughly equivalent and experience with varenicline is currently limited, the choice of pharmacotherapy should be based on the patient’s preferences and any prior experience (see Appendix VII). Symptoms of nicotine withdrawal (tension, agitation, depression, disturbed sleep) and side effects of nicotine replacement therapy, bupropion, or varenicline should be explained to patients. If the smoker has severe withdrawal symptoms, cravings, or difficulty maintaining abstinence, a general approach is to start with one agent and add a second. Adding pharmacotherapy to in-person or telephone behavioral counseling markedly increases the cessation rate, but counseling is also effective by itself.19

The following are resources for smoking cessation products and programs:

- **New York State Smokers’ Quitline**: Offers free and confidential smoking cessation counseling and resources to New York tobacco users. Clinicians can receive information about the “Fax-to-Quit” patient referral program or request Quitline materials by telephone at 1-866-NY-QUITS (1-866-697-8487) or at the website at [www.nysmokefree.com](http://www.nysmokefree.com)
- **Clinician’s Packet - Treating Tobacco Use and Dependence**: A How-To Guide For Implementing the Public Health Service Clinical Practice Guideline. Available at: [www.surgeongeneral.gov/tobacco/clinpack.html](http://www.surgeongeneral.gov/tobacco/clinpack.html) and [www.ahrq.gov/clinic/tobacco](http://www.ahrq.gov/clinic/tobacco)

### IV. RELAPSE AND RELAPSE PREVENTION

**Recommendations:**

Clinicians should monitor the progress of patients who are trying to quit and discuss relapse prevention.

If patients relapse, clinicians should be nonjudgmental. Relapses should be followed up with discussions of new strategies for the next attempt to quit.

Relapses should not be viewed as failures but rather as opportunities to learn from what happened and to change tactics.
REFERENCES


acetylcholine receptor partial agonist, vs sustained-release bupropion and placebo for smoking cessation: a randomized controlled trial. *JAMA* 2006;296:47-55. [Abstract]
