

# A Perspective of Relative Risk

By Michael Steinberg, MD, MPH

During medical school, one of my mentors said, “If you can only do one thing as a physician to improve the health of your patients, get them to stop smoking...that will have the largest impact.” These words have stayed with me throughout my career.

Recent events in tobacco dependence treatment have me thinking about how we as health professionals and as a society view risk. As a practicing primary care physician who also cares for people in the hospital, I see a great deal of serious illness and disease. I commonly utilize treatments and medications that carry with them some potential risk of side effects or adverse events, and have seen some of these effects firsthand. Treatment is always accompanied by a possible price – hopefully small – and we are in the constant position of determining whether the benefits outweigh the potential risks.

The irony I have seen over the years in terms of tobacco dependence treatment is that, in dealing with the leading cause of preventable death in our society, we are often more fearful of the consequences of our treatments. Don’t get me wrong... I know that a) we need to understand the potential risks of any treatment, b) treating smokers needs to be done with appropriate medical supervision, and c) certain groups are at higher risk of adverse events. However, we need to always keep in mind that the “risk” of not treating is continued smoking—and we know the consequences of that option.

There are certain groups of smokers in which this comes up quite often, and I see a hesitation in treating these smokers with appropriate intensity:

## Smokers with Medical Illness

In my mind, a smoker who has suffered a heart attack or stroke in the past or who has lung disease is precisely the person who we need to treat as aggressively as possible. Continuing to smoke is a matter of life or death for this individual. However, despite evidence to the contrary, we still hear the old misperceptions from physicians and other colleagues of “you can’t use the patch in someone with heart disease.” How is nicotine alone more dangerous than continued smoking?

## Pregnant Women

As per the PHS Guidelines, the optimal way for a pregnant woman to quit smoking is non-pharmacologically. However, the clients we all see are those who may be more dependent, have unsuccessfully tried on their own, already used behavioral and motivational therapies, and are still smoking into their 2<sup>nd</sup> or 3<sup>rd</sup> trimester. The likelihood of these women spontaneously quitting are exceedingly low. In this setting, the use of appropriate pharmacotherapy as an adjunct as part of comprehensive treatment may be the difference between continued smoking throughout pregnancy and successful quitting. Which is more dangerous to fetal development and term delivery – high dose nicotine plus 4000 toxins or lower dose medicinal nicotine as needed? The true choice we are making is not between tobacco dependence treatment medications or nothing; it is medication or smoking.

## Smokers with Mental Illness

Smoking rates among people with mental illness are much higher than those in the general population, and there are data suggesting that some of these smokers are more highly dependent on nicotine and suffer disproportionately higher rates of tobacco-caused disease. However, our willingness to treat these smokers aggressively is not at the level one would expect. There exist concerns about destabilizing mood and causing psychosis if we help these people stop smoking that are largely unfounded. We continue to hear that these smokers “can’t quit” or “don’t want to quit”; statements that are not grounded in data. We fear significant side effects will occur if these people stop using the single worst contributor to overall health and start using medicines to help them quit. With this fear, we need to remember again that using NRT usually equates to lower overall dose of nicotine and elimination of 4000 toxins. We do need to be aware of the metabolic effects of stopping smoking on other medica-



tions (namely antipsychotics) that might necessitate a reduced dose, but isn’t being able to use less medication a good thing? We need to involve and collaborate with behavioral health professionals in treating not only their patients’ mental well-being, but also in keeping their bodies intact.

These points above are only a few examples where we need to remember just how deadly smoking is and how truly safe our treatments have become. I realize that in an era of media-publicized medication adverse events, there is the potential to shift away from therapies that have a proven track-record in clinical trials and in the general public. It is very important that we keep a close eye on potential problems with any new or even established medication in our communities, and this can be best accomplished by maintaining close follow-up with our patients. I simply encourage you to keep the risk/benefit balance in mind when deciding how to approach the treatment of smokers.