Tobacco cessation and alcohol reduction

6 months post ACS
only approximately **1 in 3** smokers had quit

Source: Chow CK, Brieger D, Ryan M for the CONCORDANCE Investigators, et al Secondary prevention therapies in acute coronary syndrome and relation to outcomes: observational study *Heart Asia* 2019; **11**: e011122. doi: 10.1136/heartasia-2018-011122

Aims of module

To ensure CR participants who smoke tobacco (or other substances) and/or drink above recommended amounts of alcohol have been:

- Identified and their smoking/alcohol/substance use history ascertained.
- Provided with a brief intervention.
- Supported to take up medications (e.g., nicotine replacement therapies) as appropriate.
- Referred to appropriate services.

Logic

Compared with continued smoking, smoking cessation after a myocardial infarction has been shown to be an effective and cost-effective measure to reduce future myocardial infarctions and death.[1,2]

High-dose alcohol consumption increases risk of death and the development of a range of cardiovascular diseases (e.g., coronary and peripheral artery disease, dilated cardiomyopathy, heart failure, stroke).[3]

Tobacco cessation and alcohol reduction Best Practice Statement 1

Give CR participants who smoke a brief intervention for smoking cessation, using the Ask, Advice and Help model

NHMRC level of evidence: Level I

Example content:

The Ask, Advise and Help model (Figure 1) is an evidence-based framework for structuring cessation support. It involves:

- **Ask:** ask all CR participants if they currently smoke or have smoked in the past. If they have previously smoked, ask how long ago they stopped and whether they need support to continue abstaining. Record information in the medical chart.

- **Advise:** advise all current smokers to quit in a clear, non-confrontational and personalised way such as "the best thing you can do for your health is to stop smoking". Advise smokers that the best way of quitting is with a combination of behavioural support and medications to help stop smoking (e.g., nicotine replacement therapy).
- **Help:** all smokers should be offered help to quit. Offer to arrange a referral to smoking cessation programs or Quitline (referral form: https://www.quit.org.au/referral-form/).

Additionally, the CR clinician may

- **Arrange:** follow-up contacts to increase the likelihood of long term abstinence - especially useful in the first few weeks after quitting.

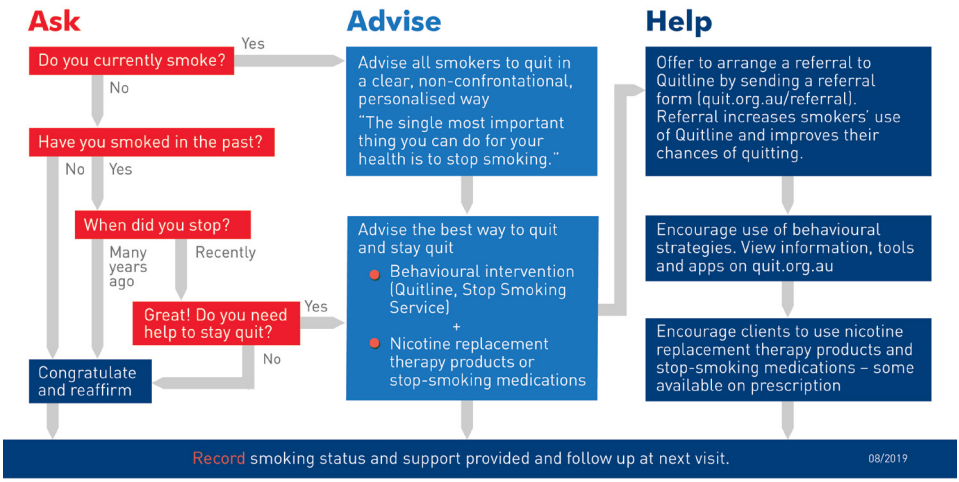

Figure 1. Ask, Advise, Help model. Used with permission from Quit Victoria.

Rationale: Simple smoking cessation advice from health professionals increases the likelihood that someone who smokes will quit.[5,6] Motivation for smoking cessation occurs at the time of diagnosis or (invasive) treatment of CVD. Evidence-based interventions for smoking cessation include prompting a person to try to quit, brief reiteration of cardiovascular and other health hazards, and agreeing on a specific plan with a follow-up arrangement.[1]

In CR services that lack access to specialist resources to provide behavioural support, clinicians should provide brief interventions and refer CR participants to specialist behavioural support services (e.g. Quitline) instead. Quitline is effective and very accessible (available to everyone via telephone irrespective of geographic location or mobility).[6] Quitline also has tailored services for Aboriginal and Torres Strait Islander people, people with mental illness and pregnant women, and translation services for non-English-speaking clients.

Tobacco cessation and alcohol reduction Best Practice Statement 2

Encourage participants who continue to smoke to use a combination of nicotine replacement products (patch plus gum or spray or lozenge or inhalator) and/or to visit their doctor to discuss other 'stop smoking medications' to assist quitting.

NHMRC level of evidence: Level I

Example content:

Pharmacological advice may include:

- Assisting with choice of drugs and ensuring CR participants have a realistic expectation of how medication can aid quit attempts (e.g., by reducing withdrawal symptoms).
- Arranging prescriptions where appropriate or referral to the CR participant's GP to discuss medication options.
- Considering medication cost (some products/medications are available on the PBS).
- Avoiding encouragement of the use of electronic cigarettes; instead referring participants to other evidence-based quit strategies as previously described.

Rationale: Pharmacological assistance can support smoking cessation in CVD patients. Pharmacological interventions such as nicotine replacement have not shown any adverse effects in patients with cardiac disease.[1] Combining behavioural support and medication increases the chances of successfully quitting by 70–100%.[6] E-cigarettes containing nicotine are not approved by the Therapeutic Goods Administration Australia, and it is generally unlawful to sell, use and possess them. Exemptions exist, but these are contingent on meeting strict requirements and the relevant drugs and poisons laws in each state and territory.

Tobacco cessation and alcohol reduction Best Practice Statement 3

Offer brief advice/counselling to encourage reduction of excessive alcohol intake in CR participants.

NHMRC level of evidence: Level I

Example content:

- Advise CR participants to consume a low-risk amount of alcohol. Specifically, recommend that CR participants consume no more than two standard drinks per day.
- Provide brief advice or counselling to encourage reduction or moderation of alcohol intake, either during CR or via the CR participant's GP.
- Brief intervention can include feedback on alcohol use and harms, identification of high-risk situations for drinking and coping strategies, increasing motivation to reduce drinking, and the development of a personal plan to reduce drinking.

Rationale: While controversy about the benefits of low levels of alcohol consumption persists, in general "less is better", and CR participants should be encouraged not to drink any more than two standard drinks per day and to have at least two alcohol-free days per week[3,8,9]. In a recent Cochrane review, brief interventions provided by health professionals were shown to lower alcohol consumption for men (evidence is less clear for women).[10]

Tobacco cessation and alcohol reduction Best Practice Statement 4

Consider referring alcohol-dependent CR participants to specialised services and notify their GPs.

NHMRC level of evidence: Expert opinion

Rationale: In CR participants who are alcohol dependent, withdrawal may be complicated and referral to clinics/agencies with expertise in addiction should be considered.[9]

Resources

- QUIT Victoria provides a range of tips and tricks including Quitline (which also offers translation services for non-English speaking clients), how to develop a quit plan, tips to stay on track, or having another go at quitting, https://www.quit.org.au/
- Build a QUIT plan https://www.quit.org.au/make-a-plan/
- Fact sheets for Bupropion; Nicotine chewing gum, inhalator, lozenges, patches, replacement therapy; Varenicline & withdrawals https://www.quit.org.au/resource-order-form/
- Healthy eating and quitting smoking fact brochure https://d1pz9rwztkrv8y.cloudfront.net/media/documents/healthy-eating-guide-for-quitters.pdf
- National Heart Foundation. Alcohol for Heart Health: https://www.heartfoundation.org.au/healthy-eating/food-and-nutrition/drinks/drinking-alcohol

References

1. Piepoli MF, Hoes AW, Agewall S, Albus C, Brotons C, Catapano AL, et al. 2016 European Guidelines on cardiovascular disease prevention in clinical practice The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of 10 societies and by invited experts) Developed with the special contribution of the European Association for Cardiovascular Prevention & Rehabilitation (EACPR). European Heart Journal. 2016 Aug 1;37(29):2315–81.
2. Chow CK, Jolly S, Rao-Melacini P, Fox KAA, Anand SS, Yusuf S. Association of diet, exercise, and smoking modification with risk of early cardiovascular events after acute coronary syndromes. Circulation. 2010 Feb 16;121(6):750–8.
3. Fernandez-Sola J. Cardiovascular risks and benefits of moderate and heavy alcohol consumption. Nature Reviews Cardiology. 2015;12(10):576.
4. Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. Cochrane Database Syst Rev. 2013 May 31;(5):CD000165.
5. The Royal Australian College of General Practitioners. Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice. 2nd edition. (Internet). RACGP; 2015. Available from: https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/SNAP-guideline.pdf

6. Stead LF, Hartmann-Boyce J, Perera R, Lancaster T. Telephone counselling for smoking cessation. Cochrane Database Syst Rev. 2013 Aug 12;(8):CD002850.

7. Stead LF, Koilpillai P, Fanshawe TR, Lancaster T. Combined pharmacotherapy and behavioural interventions for smoking cessation. Cochrane Database Syst Rev. 2016 Mar 24;3:CD008286.

8. Wood AM, Kaptoge S, Butterworth AS, Willeit P, Warnakula S, Bolton T, et al. Risk thresholds for alcohol consumption: combined analysis of individual-participant data for 599 912 current drinkers in 83 prospective studies. The Lancet. 2018;391(10129):1513–1523.

9. Woodruffe S, Neubeck L, Clark RA, Gray K, Ferry C, Finan J, et al. Australian Cardiovascular Health and Rehabilitation Association (ACRA) Core Components of Cardiovascular Disease Secondary Prevention and Cardiac Rehabilitation. Heart, Lung and Circulation. 2014.

10. Kaner EF, Beyer FR, Muirhead C, Campbell F, Pienaar ED, Bertholet N, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews (Internet). 2018 (cited 2019 Jul 19);(2). Available from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD004148.pub4/abstract

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