Preventing Harms from Tobacco Use among People living with HIV:

A brief guide for HIV providers

Comments or questions?
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Tobacco use is common and is a major cause of morbidity and mortality among people living with HIV (PLWH)

- More than 50% of PLWH smoke cigarettes\(^1\)
  - higher prevalence among PLWH with other substance use (men – 90%, women – 70%)\(^1\)
- In PLWH, smoking causes more years of lost life than HIV\(^2\)

\textit{Excess mortality and loss of life years}

- PLWH less likely to be asked, advised or assessed for smoking cessation interventions than other patients\(^3\)
- Immediate benefits with cessation
REFERENCES


The 5 “A”s

- **ASK**
  - ask about tobacco use at every visit
  - identify and document tobacco use
  - consider systematic process

- **ADVISE**
  - to quit tobacco use
  - strong, clear, personalized message

- **ASSESS**
  - willingness to quit
  - not everyone is ready to try to quit
  - if not ready, offer motivational counseling*

- **ASSIST**
  - in quitting
  - set a quit date
  - behavioral changes - alternatives, skills
  - pharmacotherapy
  - support - environment, triggers, 1-800-QUIT-NOW

- **ARRANGE**
  - follow-up
  - in person, telephone, electronic
  - monitor progress, side effects, withdrawal

*Recommended by U.S. Public Health Service Clinical Practice Guideline

*Based on a Cochrane Review of 14 studies, motivational interviewing vs. brief advice or usual care increases quitting (Risk Ratio 1.27 [CI 1.14, 1.42])
## Smoking Cessation Pharmacotherapy

*Greatest benefits seen with dual NRT or varenicline

<table>
<thead>
<tr>
<th>Medication</th>
<th>Mechanisms</th>
<th>Use</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine patches’</td>
<td>Slower delivery than nicotine in cigarettes associated with decreased reward; Lack of toxins in smoke</td>
<td>Start with 21mg if &gt;10 cigarettes per day x 4-6 weeks, then 14mg x 2 weeks, then 7mg if no cravings</td>
<td>Titrate to prevent withdrawal symptoms and cravings; Typical cigarette delivers ~2mg of nicotine thus use of dual therapy is most effective. Can cause rash and impact sleep if worn at night. Advise patient to wear patch even if smoking.</td>
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<td>Bupropion (150 mg/day)</td>
<td>Inhibits serotonin, norepinephrine, and dopamine</td>
<td>Begin 1-2 weeks prior to quit date and continue for 8-12 weeks</td>
<td>Also used as an antidepressant. May cause dry mouth, insomnia, anxiety, headache, rash. Lowers seizure threshold. Interacts with antipsychotics, monoamine oxidase inhibitors and drugs with MAO inhibitor-like activity; may cause elevated BP.</td>
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<td>Varenicline</td>
<td>Partial agonist at α4-β2 nicotinic receptor, leading to dopamine release and decreased craving and less reward with tobacco use</td>
<td>Begin 1 week prior to quit date. May be used up to 24 weeks; studies in general population demonstrate safety up to 1 year.</td>
<td>May cause nausea, sleep disturbances, and gastrointestinal symptoms. Administer with food and water. May need dose adjustment with renal impairment.</td>
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### Notes:
- Long-acting
  - Nicotine gum
    - Chew every 1-2 hours as needed; chew until nicotine taste appears and park until taste disappears then repeat x 30 minutes; 2mg (if <25 cigarettes daily) and 4mg (if >25 cigarettes daily) strength
  - Nicotine inhaler
    - Puff as needed up to 16 cartridges per day; no need to inhale deeply as orally absorbed
  - Nicotine nasal spray
    - 1-2 sprays/hour. Do not sniff/inhale – tilt head back and spray.
  - Nicotine lozenge
    - 2 and 4mg (use 4mg if smoke within 30 minutes of awakening); dissolve in month; do not chew; use 9-15 per day for 6 weeks and then taper.

- Short-acting
  - Nicotine gum
  - Bupropion
  - Varenicline

Notes: greatest benefits seen with combined counseling and pharmacotherapy. 'use with caution post-myocardial infarction, angina and/or recent arrhythmia; systematic review data demonstrate safety in patients with and without CVD.

*RCT data demonstrate similar rates of neuropsychiatric effects with varenicline and buproprion versus nicotine patch and placebo. Pilot study demonstrate safety and efficacy of varenicline in PLWH.