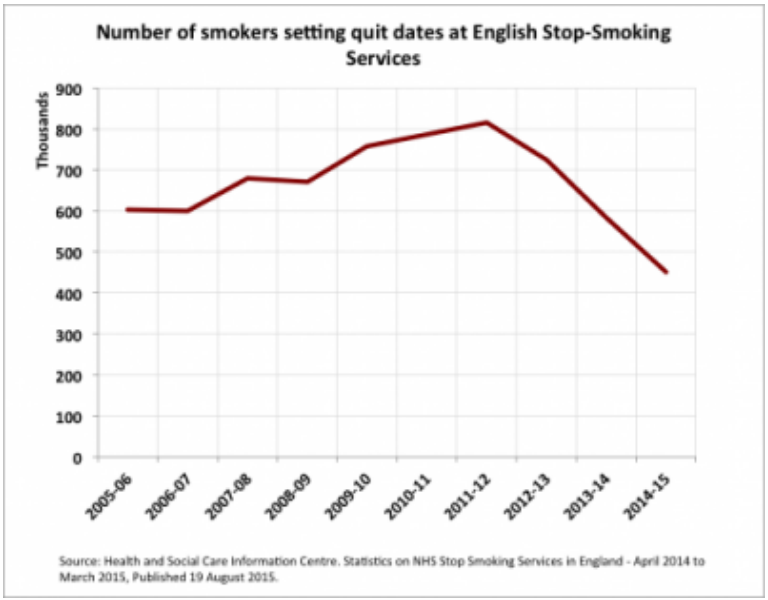
Louise Ross: Scaremongering about e-cigarettes is not in the best interests of patients

written by Clive Bates | 4 November 2015



Falling footfall: are Stop Smoking Services staying relevant and responsive to the changing landscape?

This is a guest posting by Louise Ross, Manager of the Stop Smoking Services for Leicester City Council reproducing her recent article in the Pharmaceutical Journal. The graphic above is mine.

Louise's article starts here:

Scaremongering about e-cigarettes is not in the best interest of patients

The Pharmaceutical Journal 29 October 2015

Louise Ross

Louise Ross is the Stop Smoking Service Manager for Leicester City Council

As evidence continues to emerge about the safety and benefits of e-cigarettes as a displacement tool for smoking, healthcare professionals have a duty to inform, not scare, people about these products.

Pity the poor smoker, trying to do the right thing and quit smoking with the aid of an electronic cigarette, and facing criticism for doing so. Conflicting reports in the media have led to many people viewing e-cigarettes with fear and confusion, and assuming that they have detrimental effects on health. Running the Leicester Stop Smoking Service, operated by Leicester City Council, I spend a lot of time undoing these preconceptions.

In reality, the risks are likely to be at least 95% lower than smoking — a view widely held by experts and recently affirmed by an expert review of evidence for Public Health England (PHE)[1] However, it did not take long before several groups questioned the validity of this evidence with the aim of deterring smokers from trying these products, an approach forcefully rejected by some experts.

For almost two years now, I have both watched and participated in this battle between public health heavyweights, researchers, commentators, media pundits, health professionals, vaping advocates and the general public. Every time there is a ray of hope that evidence and common sense will triumph over prejudice, risk aversion and ideology, another faction will emerge to try to crush it with doubt and suspicion. Indeed, this is exactly what happened, as The Lancet ran an editorial [2] only days after the PHE report, which attempted to discredit the evidence, once more sowing seeds of doubt.

There are a number of victims in this war of words: smokers, who could by now have been encouraged to switch to a safer product to get their nicotine; their families, including their children, who could have benefited from having a smoke-free environment and more money in the household budget; and frontline healthcare professionals who want to know what to say about this rapidly evolving technology when their patients ask them.

E-cigarette friendly

Since No Smoking Day on 12 March 2014, Leicester Stop Smoking Service has welcomed anyone who wants to stop smoking via the use of an e-cigarette, regardless of whether they also want to use nicotine replacement therapy (NRT) or not. Some have started on e-cigarettes and added NRT once they heard from their adviser about new products they had not come across before. Some have gone from NRT to e-cigarettes alone because they got on better with them, and some managed to stop smoking with a combination of both.

In the first quarter of the reporting year (2014–2015), successful quitting with e-cigarettes was 77%, against a typical success rate of 50% using NRT, varenicline, buproprion or no medicine (and falling — we know from national data [3] that the use and success of stop smoking services has fallen for two years running) [see graphic]. However, after the publication of the World Health Organization report on e-cigarettes [4], and the widespread media coverage that picked up the most alarming aspects of the report, confidence among both smokers and healthcare workers dropped like a stone. Even now, some people we speak to believe it is safer to continue smoking regular cigarettes than to switch to a product that produces no tar or carbon monoxide.

Informing patients

So what should healthcare professionals such as pharmacists be telling their patients? Is it reasonable to remain sitting on the fence while the debate rages? Here are a few pointers that could herald an outbreak of common sense.

Vaping might work for smokers wanting to quit. There are now 2.6 million adults in Britain using e-cigarettes. Of these, over one million are now ex-smokers [5]. They have done this because they wanted to stop smoking and, after trying an e-cigarette, they felt that the process was easier than they could have imagined. There are thousands of people visiting pharmacies daily who could do the same, if they were not put off by scare stories, some of which are told by healthcare professionals. We know how easy it is for smokers to talk themselves out of quitting, but that is often because they fear how hard it will be and they dread losing the comfort of smoking. Vaping has the potential to replace that pleasure, without the harm.

People will buy their own e-cigarettes. They are not a medical product, they are a consumer product. Healthcare professionals do not have to prescribe or dispense them — they do not even have to be an expert in e-cigarettes — they just need to encourage people to do their own research, and talk to a retailer who can explain everything they need to know about devices, flavours and strengths. For comparison, if patients asked for advice about getting fit by taking up cycling, a healthcare professional would suggest they go to a bike shop or tell them to ask other cyclists for advice. What healthcare professionals should offer is good quality information about coping strategies during the quitting process, such as how to avoid a relapse, and so on.

There is no need and no excuse to wait for medicinal licensing of e-cigarettes. There is a fond hope among healthcare workers that everything will be more manageable once there is a product they can prescribe because it will have been tested, quality assured and thus safe to use. But it is important to point out that e-cigarettes are not medicines and most people who use them do not want them to be classed as a medicine. They will continue to buy products they like, rather than use something that is prescribed. This is, of course, assuming that products do get through the arduous licensing process in the first place, something most likely to be achieved by major tobacco companies rather than the small independent makers of e-cigarettes.

If we wait for this long process to happen, people who could switch now will be dying from smoking-related disease and living with disabilities caused by smoking.

Nicotine is not evil

The antipathy towards nicotine needs to stop if we are to help smokers quit. That nicotine can be enjoyed safely is an uncomfortable concept to many, and is arguably at the heart of this debate. Demonised for decades because it was an integral component of a deadly product, combustible cigarettes, nicotine has been likened more recently not to cocaine but to caffeine [6] in terms of its addictive properties. It is understandable that public health professionals will not easily abandon warnings that nicotine is highly addictive, but it is beyond comprehension that the same community will direct their hostility towards new nicotine products in a way that protects the old nicotine products like cigarettes.

Extended nicotine use could prevent relapse to smoking. Advisers at Leicester Stop Smoking Service are often asked how soon people should come off their vaporisers. It could be that, even if users titrate down, they may find that the consistent availability of a nicotine product actually prevents a return to smoking, especially at times of distress, loneliness, boredom, crisis, and all the other causes we hear about so frequently when someone who had successfully quit returns to the Stop Smoking Service after relapsing.

The UK needs data from healthcare professionals. Anyone who runs a stop smoking service in a pharmacy should be welcoming patients who want to quit using e-cigarettes. These devices are mentioned in the National Centre for Smoking Cessation and Training guidance[7] and on the Health and Social Care Information Centre's data monitoring return [8]. Pharmacists will not be breaking any rules, but will be respecting the choices of patients who want to use an unlicensed product to quit. Of course, licensed products should be recommended, too, which can be offered at the same time as e-cigarettes (an overdose of nicotine is unlikely — nausea is the first sign, just like when someone chain-smokes, and is easily remedied by cutting back on one of the sources of nicotine).

Gateway to quitting, not starting

Critics talk about the so-called 'gateway effect' — that e-cigarettes could become a gateway to smoking — but if there is a gateway it looks more like an exit. E-cigarette use is rising and smoking rates are falling. We need to understand whether non-smokers are enticed to start smoking by e-cigarettes [9], but there is evidence that smokers are choosing to end a lifetime of cigarette use by switching to a safer product.

Seeing someone use an e-cigarette could prompt questions among smokers, such as "can I have a look?", "can I try it?", and "where did you get it from?" These could initiate a smoker to begin a journey of quitting cigarettes. The less restricted vaping becomes, the more conversions will happen.

There really are no more excuses for healthcare professionals to be dismissing e-cigarettes outright and scaring people about them unnecessarily. The sooner we embrace this new technology, more smokers will benefit from leaving cigarettes behind.

Louise Ross is Stop Service Manager at Leicester City Council and an associate member of the New Nicotine Alliance, a charity concerned with improving public health through a greater understanding of "new" (risk-reduced) nicotine products and their uses.

References:

1. *Public Health England. E-cigarettes: an evidence update. 2015.*
2. *McNeill A, Brose LS, Calder R et al. E-cigarettes: the need for clear communication on relative risks, The Lancet 2015. doi:10.1016/S0140-6736(15)00079-3*
3. *HSCIC. Numbers using NHS stop smoking services in decline for the second year. 2014.*
4. *World Health Organization. Electronic Nicotine Delivery Systems. 2014.*
5. *Britton J & Bogdanovica I. Electronic cigarettes: a report commissioned by PHE. Public Health England, 2014.*
6. *Hajek P. On e-cigarettes. Queen Mary University of London. YouTube video, 2014.*
7. *National Centre for Smoking Cessation and Training. E-cigarette Briefing. Electronic Cigarettes. 2014.*
8. *Health and Social Care Information Centre. Stop Smoking Services quarterly monitoring 2014–2015.*
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See all Louise's guest blogs here.

Further reading

As well Louise's article, it is worth taking a look at a recent small trial of e-cigarettes in a Stop Smoking Service. The results were encouraging…

Corbin L HP, Spearing E LD. Adding E-Cigarettes to Specialist Stop-Smoking Treatment: City of London Pilot Project. *J Addict Res Ther* 2015;06. [link]

Results: The total of 69 (69%) of smokers accepted EC and 45 (65%) of this group achieved biochemically validated abstinence at 4 weeks. Of smokers not accepting the offer of EC, 14 (45%) were validated abstainers at 4 weeks (X2 =3.53, p =.06). All successful quitters in the EC group reported using EC on most days throughout their quit attempt. Among this group, 31 (45%) smokers did not use or stopped using other stop-smoking medications. Client feedback was highly positive. Among smokers who accepted EC and achieved abstinence, all used EC at the end of treatment. Smokers using varenicline plus EC had a higher success rate (85%) than smokers using EC only (54%; X2=4.99, p=0.03).

Conclusion: Offering EC as an addition to the standard stop-smoking service may increase service appeal, cost effectiveness, and efficacy.

Anyone professionally engaged in helping smokers should know about these products, understand why they are popular, and be alert to the opportunities, not just the risks.