CORSO RESIDENZIALE: APPROCCIO AL TABAGISMO NEL PAZIENTE HIV-POSITIVO

FIRENZE, VILLA AGAPE

7 • 8 APRILE 2016

Il metodo delle 5A: un intervento breve per la cessazione dell'abitudine al fumo di tabacco nei soggetti con infezione da HIV

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Efficacia degli interventi brevi

- ✓Interventi minimi, che durino meno di 10 minuti, possono raddoppiare il tasso complessivo di astensione dal tabacco
- ✓Interventi che durino più di 30 minuti, possono triplicare il successo di astensione dal tabacco

"Si dovrebbe pertanto offrire un intervento anche minimo a tutti i fumatori, indipendentemente da un successivo intervento intensivo"

Forza dell'evidenza = A

Fiore M et al. "Treating Tobacco Use and Dependence – 2008 Update". U.S. DHHS, 2008

GUIDE FOR
HIV/AIDS
Clinical Care

U.S. Department of Health and Human Services
Health Resources and Services Administration
HIV/AIDS Bureau

April 2014

Smoking Cessation

Jeffery Kwong, MS, MPH, ANP

Background

According to the U.S. Centers for Disease Control and Prevention, smoking prevalence among the general adult population in the United States is approximately 20%. Among HIV-infected persons, the prevalence of cigarette smoking appears to be two to three times greater than in the general population, with estimates ranging from 50% to 70%.

HRSA HAB Performance Measures

Percentage of patients aged 18 years and older who were **screened for tobacco use** one or more times within 24 months AND who **received cessation counseling intervention** if identified as a tobacco user

(Adult and Adolescent measure)

The health effects of cigarette smoking are extensive and have been well documented. There are approximately 400,000 smoking-related deaths annually in the United States. HIV-infected smokers appear to be at higher risk of a variety of tobacco-related conditions than HIV-uninfected smokers. These include lung cancer, head and neck cancers, cervical and anal cancers, oral candidiasis, and oral hairy leukoplakia. HIV-infected smokers who smoke are more likely to develop the conditions listed above, as well as bacterial pneumonia, *Pneumocystis jiroveci* pneumonia, other pulmonary conditions, and cardiovascular disease. Additionally, HIV-infected smokers have been shown to have a decreased immunologic and virologic response to antiretroviral therapy.

Thus, for HIV-infected persons, even more so than for HIV-uninfected persons, clinicians should consider smoking cessation a health care priority. Although many care providers may feel that they can do little to affect the smoking behaviors of patients, evidence suggests that brief interventions by physicians are quite effective. Studies indicate that smoking cessation interventions as brief as 3 minutes in duration, when delivered by a provider, have a positive impact on abstinence rates of current smokers. Furthermore, studies have found that more than half of current HIV-infected smokers have expressed interest in, or have thought about, smoking cessation.

Cigarettes are highly addictive; the U.S. Surgeon General has equated the addictive potential of cigarettes to that of heroin and cocaine. This is in part because nicotine stimulates the release of several neurotransmitters in the brain, including dopamine. Over time, chronic exposure to nicotine causes physiologic changes in the brain that contribute to the addictive potential of cigarettes.

Cigarette smoking involves dependence on more than a single chemical compound, however. It is a multidimensional behavior that has both physiologic and psychological components. Therefore, smoking cessation efforts often require a combined approach to be successful.

Behavioral Model for Smoking Cessation

Several behavioral models present a psychological framework for understanding individuals who are attempting to change behaviors. The transtheoretical model of health behavior change is one of the more frequently cited frameworks for understanding the stages of behavior change of smokers. According to this model, there are five phases of behavior change: precontemplation, contemplation, preparation, action, and maintenance. Using this framework, clinicians can devise

Section 3: Health Maintenance and Disease Prevention

http://hab.hrsa.gov/deliverhivaidscare/2014guide.pdf

EACS
European
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Clinical
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GUIDELINES

Version 8.0
October 2015

English

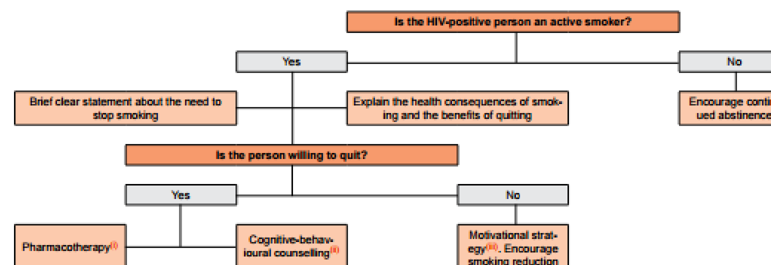
Lifestyle Interventions[i]

Dietary counselling	• Dietary intervention should not interfere with the dietary requirements necessary for appropriate absorption of ART drugs • Keep caloric intake balanced with energy expenditure • Limit intake of saturated fat, cholesterol and refined carbohydrates • Reduce total fat intake to < 30% and dietary cholesterol to < 300 mg/day • Emphasise intake of vegetables, fruit and grain products with fibre • Cut back on beverages and foods with added sugar • Choose and prepare foods with little or no salt. Aim to eat less than 1,500 mg of sodium per day • Emphasise consumption of fish, poultry (without skin) and lean meat • Consider referral to dietician, one-week food and drink diary to discover 'hidden' calories • Avoid binge eating ('yo-yo dieting') • In persons with HIV-related wasting and dyslipidaemia, address wasting first and consider referral to dietician • Persons who are obviously overweight should be motivated to lose weight. Starvation diets are not recommended (immune defence mechanisms potentially decreased). Malnutrition has to be addressed where observed. Normal BMI range: 18.5-24.9; Overweight: 25.0-29.9, Obesity: > 30.0 kg/m²
	• The following questions are helpful to determine average alcohol intake 1. How often do you drink alcohol: never, ≤ 1/month, 2-4x/month, 2-3x/week, > 4x/week 2. If you drink alcohol, how much typically at a time: 1-2, 3-4, 5-6, 7-9, > 10 drinks 3. How many times do you have 6 or more alcoholic drinks at one occasion: never, < 1/month, 1x/month, 1x/week, more or less daily. • Intake of alcohol should be restricted to no more than one drink per day for women and two drinks per day for men (< 20-40 g/day). • In particular, persons with hepatic disease, adherence problems, inadequate CD4 cell increase, tumours, past tuberculosis, diarrhoea and other conditions associated with high alcohol intake should be motivated to decrease or stop alcohol intake.
Exercise promotion	• Promote active lifestyle to prevent and treat obesity, hypertension and diabetes • Encourage self-directed moderate level physical activity (take the stairs, cycle or walk to work, cycling, swimming, hiking etc.) • Emphasise regular moderate-intensity exercise rather than vigorous exercise • Achieve cardiovascular fitness (e.g. 30 minutes brisk walking > 5 days a week) • Maintain muscular strength and joint flexibility

i Based on recommendations by the US Preventive Services Task Force

Smoking cessation

HIV-positive tobacco users should be made aware of the substantial health benefits of smoking cessation which include reducing the risk of tobacco-related diseases, slowing the progression of existing tobacco related disease, and improving life expectancy by an average of 10 years.
Regularly consider the following algorithm with two major questions:



Adapted from [6] and [7]

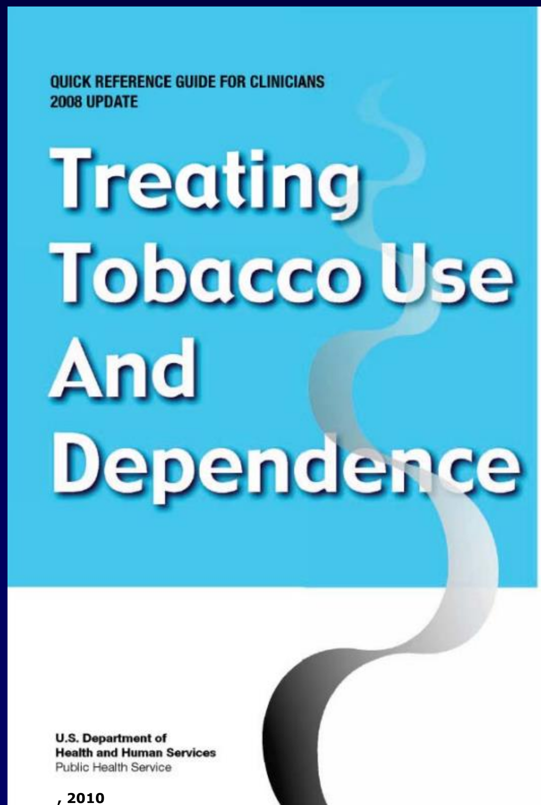
i Pharmacotherapy: Nicotine replacement therapy: Nicotine substitution (patch, chewing gum, spray), varenicline and bupropion are approved by the EMA. Buproprion is contraindicated with epilepsy and varenicline may induce depression. Bupropion may interact with PIs and NNRTIs, see Drug-drug Interactions between ARVs and Non-ARVs

ii Cognitive-behavioral counselling: Use specific available resources. Either individual or group interventions to better suit and satisfy the HIV-positive person. The programme should consist of four or more sessions lasting 30 minutes for 3-4 months.

iii Motivational strategy: Identify potential health risks of the smoker and to stratify both acute (e.g. exacerbations of COPD) and long-term (e.g. infertility, cancer) risks. Show the HIV-positive person the personal benefits of stopping smoking. Identify the barriers or obstacles that might impede the success of a quit attempt. Smoking cessation interventions should be delivered repeatedly, as long as the HIV-positive person is not willing/ready enough to quit smoking.

http://www.eacsociety.org/files/2015_eacsguidelines_8_0-english_rev-20160124.pdf

A flowchart of the 5 A's model for treating tobacco use and dependence



ASK Do you currently use tobacco?

- YES → **ADVISE** to quit → **ASSESS** Are you willing to quit now?
  - YES → **ASSIST** Provide appropriate tobacco dependence treatments
  - NO → **ASSIST** Intervene to increase motivation to quit
- NO → **ASK** Have you ever used tobacco?
  - YES → **ASSESS** Have you recently quit? Any challenges?
    - YES → **ASSIST** Provide relapse prevention
    - NO → **ASSIST** Encourage continued abstinence
  - NO

ARRANGE FOLLOWUP

Intervento breve: le "5 A"

I. Ask

Annotare nella cartella clinica di ciascun paziente, ad ogni visita medica (al pari dei "segni vitali" o di altri parametri di particolare rilevanza)

- **abitudine al fumo**
  non fumatore, ex-fumatore, fumatore
- **Se "fumatore"**
  - ✓ **età di inizio**
  - ✓ **consumo giornaliero di sigarette**
  - ✓ **dipendenza da nicotina**

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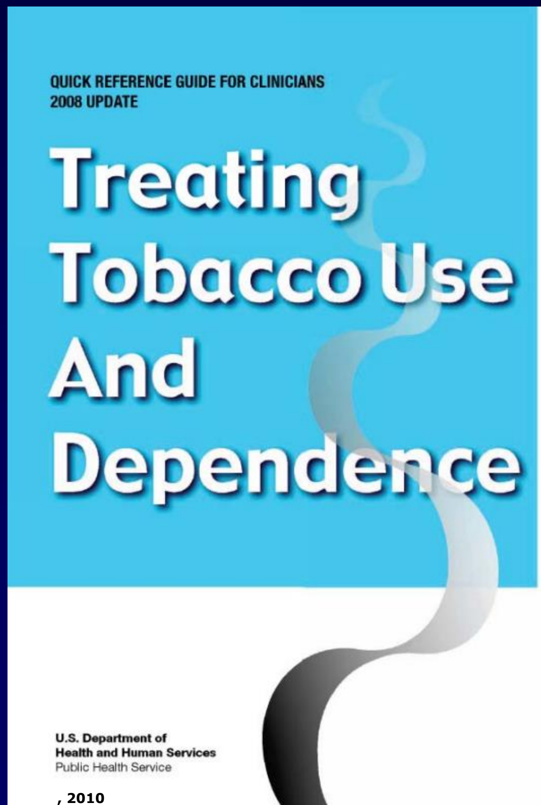

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ARRANGE FOLLOWUP

II. Advice (a)

Raccomandare ad ogni fumatore, in modo chiaro, deciso ed inequivocabile, di smettere di fumare:

"Smettere di fumare è una delle cose più importanti che può fare per la sua salute"

"E' di fondamentale importanza che Lei smetta di fumare"

II. Advice (b)

Personalizzare la raccomandazione

- **migliore risposta alla ART**
- **riduzione del rischio di malattie correlate al fumo**

"Ora che ha l'infezione da HIV, fumare può essere un serio rischio per il suo cuore ed i suoi polmoni"

"L'efficacia delle cure per l'HIV viene ridotta dal fumo"

"Ha da poco avuto una polmonite, il rischio di averne un'altra è più alto se continua a fumare"

"Per la sua salute, è più rischioso continuare a fumare che avere l'infezione da HIV"

II. Advice (b)

Personalizzare la raccomandazione

- ✓ migliorare respirazione, olfatto e gusto
- ✓ migliorare l’aspetto fisico
- ✓ dare un esempio positivo ai figli
- ✓ evitare l’esposizione al fumo passivo per familiari
- ✓ eliminare le spese dovute al fumo di sigaretta
- ✓ liberare abiti, casa e auto dallo sgradevole odore di fumo e dalla cenere
- ✓ migliorare le prestazioni sportive

III. Assess

- Accertare se il fumatore vuole fare un tentativo per smettere di fumare nel prossimo mese
- Comunicare che si è in grado di fornirgli supporto / informazioni utili

Gli stadi del cambiamento

Pre-contemplazione

Contemplazione

Preparazione

Azione

Mantenimento

Ricaduta

Cessazione definitiva

A. Fumatori non intenzionati a smettere

B. Fumatori intenzionati a smettere

A. Fumatori non intenzionati a smettere

- **Effettuare un breve colloquio motivazionale, tenendo in considerazione lo "stadio del cambiamento"**
- **Informare il paziente che nel corso della prossima visita si vorrebbe nuovamente tornare a parlare della sua abitudine al fumo**

Colloquio motivazionale: lo stile

- **Esprimere empatia**
- **Approfondire la frattura interiore**
- **Aggirare le resistenze**
- **Accrescere l'automotivazione e l'autoefficacia**

Colloquio motivazionale: i contenuti

- **Rilevanza** incoraggiare il fumatore ad individuare le ragioni per lui rilevanti per smettere di fumare
- **Rischi** aiutare il fumatore ad individuare le conseguenze negative del fumo sulla sua salute
- **Ricompense** aiutare il fumatore ad individuare i possibili benefici derivanti dalla cessazione del fumo
- **Resistenze** aiutare il fumatore a identificare gli ostacoli al cambiamento di comportamento e le possibili strategie per superarli
- **Riconsiderare** valutare con il soggetto le possibilità di modificare le caratteristiche dell'abitudine al fumo
- **Ripetizione** ripetere il colloquio motivazionale ad ogni visita

B. Fumatori intenzionati a smettere

IV. Assist

Considerare

- grado di dipendenza da nicotina
- pregressi tentativi di cessazione
- presumibili ostacoli
- percezione di autoefficacia
- opzioni preferite dal soggetto

B. Fumatori intenzionati a smettere

IV. Assist

- Fornire indicazioni comportamentali
- Prescrivere terapia farmacologica
- Fornire materiale informativo ("self-help")
- Indirizzare
  - ✓ Medico di Medicina Generale
  - ✓ Centri Anti-fumo territoriali
  - ✓ Telefono Verde I.S.S.
  - ✓ Siti WEB

B. Fumatori intenzionati a smettere

IV. Assist Indicazioni comportamentali

- Stabilire una data precisa per la cessazione
- Buttare sigarette, accendini e posacenere
- Tenere a mente i motivi per cui si vuole smettere di fumare
- Assicurarsi il sostegno di familiari, amici e colleghi di lavoro che non fumano

B. Fumatori intenzionati a smettere

IV. Assist Indicazioni comportamentali

- Evitare i luoghi in cui si è soliti fumare e la compagnia di fumatori
- Evitare le situazioni associate al desiderio di fumare (caffè, TV, giornale)
- Assumere altri stili di vita salutari (dieta, attività fisica, consumo alcolici)
- Gratificarsi

B. Fumatori intenzionati a smettere

IV. Assist Terapie farmacologiche

- **Nicotina**
  - cerotto
  - "inhaler"
  - gomma da masticare
  - compressa sublinguale ("microtab")
- **Vareniclina**
- **Bupropione SR**

B. Fumatori intenzionati a smettere

V. Arrange

Programmare il follow-up (effettuato dal medico o da altro operatore sanitario; di persona, telefonico, internet)

- **controllo entro una settimana**
- **altro controllo entro un mese**
- **ulteriori controlli nei mesi successivi alla cessazione**

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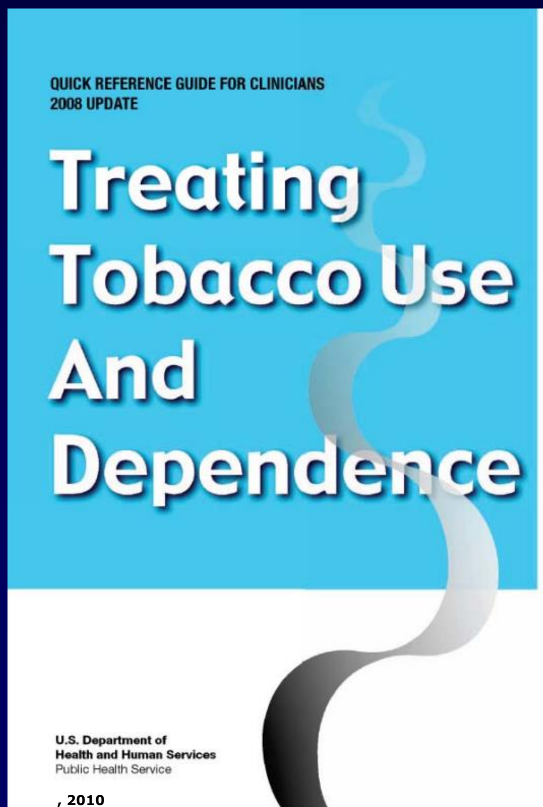

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ARRANGE FOLLOWUP

Fumatori che hanno smesso di recente

- Congratularsi per il successo riportato ed esprimere ottimismo per il futuro
- Incoraggiare l'astinenza
  - ✓accertare effetti benefici sulla salute e sul benessere
  - ✓identificare ed affrontare eventuali problemi (ad es., effetti collaterali della terapia, sintomi di astinenza, rapporti familiari o di lavoro con fumatori)

Soggetti che continuano o hanno ripreso a fumare

Aiutare il soggetto

- a non sentirsi "incapace, fallito, sconfitto"
- a ritrovare le motivazioni per un nuovo tentativo di cessazione

HIV Provider

Smoking Cessation

Handbook

U.S. Department of Veterans Affairs

Veterans Health Administration

Clinical Public Health

A Resource for Providers

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

July 2012

MARCH 2014

HIV & TOBACCO USE

PHARMACOLOGIC AND BEHAVIORAL METHODS TO HELP YOUR PATIENTS QUIT

HIV PROVIDER REFERENCE SERIES

A PUBLICATION OF THE MOUNTAIN PLAINS AIDS EDUCATION AND TRAINING CENTER

file:///C:/Users/Admin/Downloads/IB_10-432-HIV_Provider_Smoking_Cessation_Handbook%20(1).pdf

http://www.mpaetc.org/MPAETC/media/MPAETC/Product%20Downloads/tobacco.pdf

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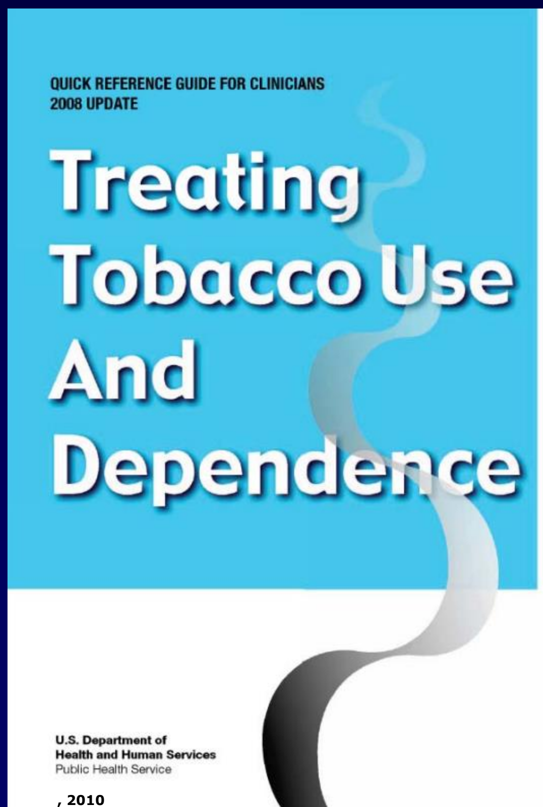

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ARRANGE FOLLOWUP

Infettivologo → **PLWHA fumatore**

La rete per la lotta al tabagismo

Governo
Ministeri

Regioni
ASL
Az. Ospedaliere
Centri anti-fumo

Telefono
verde ISS

Cardiologo
Oncologo
Pneumologo
ORLiatra
Infettivologo
Medico del lavoro
Ginecologo
Internista
Endocrinologo
Pediatra
Chirurgo
Odontoiatra

PLWHA
fumatori

Medico
Medicina
Generale

Infermiere
Ostetrica
Fisioterapista
Altri paramed.
Farmacista

Tobacco Dependence as a Chronic Health Condition

Tobacco dependence is a chronic health condition that often requires multiple, discrete interventions by a clinician or team of clinicians. The "5 A's" of treating tobacco dependence (Ask, Advise, Assess, Assist, and Arrange follow-up) is a useful way to understand tobacco dependence treatment and organize the clinical team to deliver that treatment. While a single clinician can provide all 5 A's, it is often more clinically and cost-effective to have the 5 A's implemented by a team of clinicians and ancillary staff. However when a team is used, coordination of efforts is essential with a single clinician retaining overall responsibility for the interventions. Clinician extenders such as quit lines, web-based interventions, local quit programs and tailored, self-help materials can often be, and should be, incorporated into the 5 A's approach. These treatment extenders can make clinical interventions more efficient.

Fiore MC, Jaén CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. April 2009.