The Patient Who Uses Tobacco:
The Role of the Oral Health Team

INSTRUCTIONS: Read and study the narrative. Complete the test and registration form at the end of the narrative and mail along with registration fee to: Continuing Dental Education, 875 Union Avenue, Memphis, TN 38163 or fax completed test, registration form and credit card information to (901) 448-1514. Please direct questions or comments to the Office of Continuing Dental Education, (901) 448-5386 or email *kdonham@utmem.edu*. For more information or a list of continuing education activities, visit our website at ***http://cde.utmem.edu***.

TUITION: $50 per registrant or $40 per registrant for multiple registrants in the same office.

CREDIT: 2 hours **(Registrant must correctly answer 75% of the test questions to receive credit.)**

COURSE OBJECTIVES: At the end of this course the participant will be able to:

1. Discuss three systemic health effects of tobacco use.
2. Discuss three harmful oral health effects of tobacco use.
3. Discuss a practical dental office-based program to help patients stop using tobacco.
4. List and discuss the 5 A's related to helping patients stop using tobacco.
5. Discuss The Transtheoretical Model of Change or Stages of Change Model, in order to better understand how to help patients quit.
6. List and discuss appropriate use of pharmacologic agents used to treat nicotine addiction.

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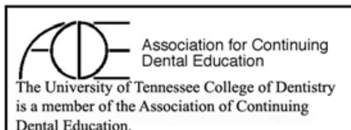

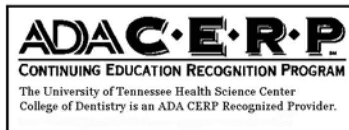

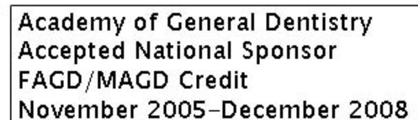

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The Patient Who Uses Tobacco: The Role of the Oral Health Team

Background

Cigarette smoking is a well-known risk factor for head and neck cancers and evidence linking cigarette smoking to periodontal disease and tooth loss continues to mount[1, 2]. Smokeless or spit tobacco use is a risk factor for periodontal disease, dental caries, and oral cancer[3]. Simply stated, there is no safe form of tobacco use.

During the early 1990, dentists, dental hygienists, and assistants began to play a vital role in helping patients become tobacco free. Dental and dental hygiene educational programs began to incorporate tobacco cessation activities into existing curricula and continuing education courses were planned and provided.

The purpose of this continuing education self-study course is to provide an overview of current tobacco intervention techniques that can be readily implemented into the dental clinic setting. This information is based on the U.S. Department of Health and Human Services, Public Health Service, Agency on Healthcare Research and Quality's *Clinical Practice Guideline: Treating Tobacco Use and Dependence*[4] published in June 2000 and the American Dental Hygienists' Association's (ADHA) new tobacco cessation program *Ask.Advise.Refer* (www.askadviserefer.org) that incorporates a national quit line, 1-800-QUIT-NOW, as an essential part of their program[5].

Introduction

For decades, dentists and dental hygienists have taught patients that smoking is a risk factor for oral diseases and conditions ranging from dry socket to oral cancer. Today, teaching patients about all known oral health risks of tobacco use, conducting minimal chair-side interventions and referring heavily addicted users to community-based nicotine dependence program are no longer options and are equally as important as teaching patients dental plaque control and other preventive measures.

According to the American Dental Association's (ADA) and the ADHA's Code of Ethics, failure to teach and intervene with patients concerning risk factors for oral disease is considered unethical behavior. It is well established that failure to inform patients about presence or oral disease risks may result in legal action. Oral health professionals are role models in the community who work diligently to raise the status of their respective professions. Our duties related to tobacco use should include personally becoming and remaining tobacco free, providing minimal chairside interventions on a one-to-one basis in the dental office, including tobacco prevention and cessation information during community oral health education presentations, and becoming a community advocate addressing tobacco control issues such as enforcing penalties for sales to minors and increasing excise taxes on tobacco products.

Advantages of Providing Tobacco Cessation Advice

Adding tobacco counseling to routine practice is very rewarding and builds on skills taught to both dentists and hygienists during both their educational and clinical practice experience. By providing tobacco cessation interventions the oral health team shows concern for the overall health of patients, updates patients' knowledge on the link between oral and systemic diseases such as diabetes and cardiovascular disease (both highly correlated to smoking), reduces the time required for the removal of dental stains and calculus thus saving the time and energy, and preventing carpal tunnel syndrome, reduces exposure to second-hand smoke, and advances the status of the profession.

Brief Tobacco Counseling in the Dental Clinic or Setting: What Are Our Barriers?

Why have some dental offices and clinics incorporated smoking cessation into practice while others seem reluctant to offer this service? Could the same roadblocks that prevent patients from quitting keep us from providing this valuable service? The aforementioned publication, *Clinical Practice Guideline: Treating Tobacco Use and Dependence*[4], presents a model entitled "The 5 R's" that will be included in the discussion below. First, however, the oral health team must understand that nicotine is a highly addictive drug.

Nicotine Is Addictive: Nicotine is a psychoactive, addictive drug. It does not cause cancer. According to the National Institute of Drug Abuse (NIDA), "Research has shown that nicotine, like cocaine, heroin, and marijuana, increases the level of the neurotransmitter dopamine, which affects the brain pathways that control reward and pleasure."[6] NIDA, along with other professional healthcare organizations such as the American Psychiatric Association, recognizes nicotine as a highly addictive substance that, unlike alcohol, does not have a safe level of use and any amount of use is considered abuse.

While the oral health team is well prepared and have routinely assisted patients in improving oral behaviors through such practices as dietary counseling and more effective means of dental plaque control, oral health team members must keep in mind that nicotine-addicted patients must eliminate an addiction through the use of behavior modification and pharmacological agents. Team members

should not be discouraged if a patient who uses tobacco is not motivated to set a quit date or is not successful, because while 80% of patients report that they interested in quitting, only about ten percent set a quit date and are successful long-term.

Roadblocks: What are the barriers for the oral health team related to conducting minimal interventions? In order to remove barriers, it is necessary to identify them. The barriers often stated are:

- **Lack of formal training:** Just like any other dental, dental hygiene, or dental assisting skill, practice is required for competency. Classic dental hygiene texts such as the *Clinical Practice of the Dental Hygienist, 9th edition*[7] contain tobacco cessation chapters. Many professional organizations and dental schools, in addition to ADA and ADHA, offer continuing education courses and workshops on this topic.
- **Questioning if this is an appropriate role for the oral health team:** Not only is tobacco cessation appropriate, it is the oral health team's ethical duty. Dentists and dental hygienists have received extensive training related to the prevention and treatment of oral diseases. Emphasizing the relevance of tobacco use and tooth loss, wound healing, and periodontal disease can encourage team members to conduct tobacco counseling. Educating patients about the link between all forms of tobacco use and periodontal and other oral diseases and subsequent treatment outcome can help overcome this barrier. For further information on tobacco's effect on periodontal disease, please visit the American Academy's of Periodontology's website at http://www.perio.org/consumer/smoking_info.htm.
- **Losing patients:** A study of 75 private dental practices in Oregon conducted by Severson and others revealed that loss of patients did not occur nor was it a barrier for delivering or conducting tobacco cessation[8].
- **Receiving criticism from patients:** Patients are not always receptive of our well intended advice related to plaque control practices, replacing existing dental restorations, endodontic therapy, and other well established dental procedures. Dentists and dental hygienists have quickly learned that it is often the approach that is used and not the information improves communication. Always approach tobacco using patients without showing criticism or judgment.
- **Losing practice revenue:** Lack of reimbursement or determining how to charge for this service has always been a first concern by individual dentists and dental organizations. It is true there is little third party reimbursement for nicotine interventions even in the presence of American Dental Associations' treatment code 01320, "Tobacco Counseling for Prevention of Oral Disease." However, dental clinics may offer the service for nominal fees, incorporate charges into existing services, or base fees on the amount of time required for this service. It is also important for dental clinics that provide this service to include the code and fee when filing claims so insurance companies can be made aware that this treatment is indeed being offered.
- **Losing valuable practice time:** Requirements are actually minimal for dentists and hygienists and can be easily incorporated into the dental hygiene visit in a similar fashion as plaque control techniques. (See Tables 1 and 2.)

Well informed oral health teams can remove these barriers.

The 5 A's

The *Clinical Practice Guideline: Treating Tobacco Use and Dependence* also suggests use of The 5 A's for clinician interventions. The 5 A's are briefly described below and depicted in Table 3[4.]

1. Ask: The Agency for Healthcare Research and Quality (AHRQ) guidelines state, "Systematically identify all tobacco users at every visit." The American Medical Association has described tobacco use status as the fifth vital sign and should be a part of each office or clinic's health history evaluation and updates. The ADA recommends that two tobacco questions pertaining to use status (1 - Are you a current, former, or never user? How much, how often, type of tobacco product? and 2 - Is the patient interested in quitting?) should be included on the written health history form. The dialogue portion of the health history and data collected from the Tobacco Use Assessment Form (TUAF) will provide further information about tobacco use (Figure 1).

2. Advise: The guideline recommends, "In a clear, strong, and personalized manner, urge all tobacco users to quit." The use of a caring "I" message can be effective (i.e. I am concerned about the extent and severity of pocket depths we have found today); sarcastic or judgmental remarks should not be used.

One of the most important roles for oral health team members involved in tobacco cessation is to motivate patients from never thinking of quitting to setting a quit date in the near future, within two weeks if possible. A brief overview of Prochaska and DiClemente's Stages of Change Theory or the Transtheoretical Model[9] is provided in Table 4.

Motivational strategies should include use of "teachable moments" such as pointing out effects of smoking including supra- and subgingival calculus, extrinsic stains, nicotinic stomatitis, and leukoplakia. If no bleeding during probing is detected, then the vasoconstrictive effects of nicotine and subsequent masking of gingivitis and periodontitis should be discussed with the patient. Esthetic effects of staining, halitosis and the smell of cigarette smoke on clothing and hair can be included. The effects of second-hand smoke on other members of the household and family pets can also be discussed for patient motivational purposes.

3. Assess: Following the AHRQ guidelines, determine willingness to quit by asking every tobacco user if he/she is willing to make a quit attempt within the next two weeks to thirty days. If so, provide assistance (see the 4th A, Assist.) If the patient feels he/she needs more than brief dental clinic based counseling, referral should be made to a more intensive community based treatment program. Dental clinics should maintain a list of programs in their locality. If a patient is unwilling to make a quit attempt this should be documented and motivational advice and literature should be provided for the patient.

4. Assist: Help the patient identify a quit date and develop a quit plan. The use of pharmacological agents used to treat nicotine dependence (PATS) is discussed with the patient by the dental hygienist, and, if required, the dentist writes a prescription. A brief explanation of use is presented in Table 5. Behavioral tips for dealing with withdrawal signs and symptoms should be discussed at this time (Table 6). Remind the patient that cravings are generally brief and pass within five minutes. Aerobic exercise should be strongly encouraged since it will help prevent weight gain and reduce withdrawal symptoms such as irritability and anxiety.

5. Arrange: Follow-up with the patient who attempts to quit must be arranged. Follow-up may be conducted in person, by telephone, or email; however, personal contact is recommended. To help quitters remain abstinent, follow-up should be extensive. To accomplish this within the dental clinic setting, the use of websites and quit lines are encouraged. See "Helpful Articles and Websites" found at the end of this course. Timing and information for follow-up is presented in Table 3.

Appointment Scheduling For Tobacco Users Who Are Ready To Quit

Many dental team members ask how to incorporate tobacco cessation into the practice. Oral health care professionals must understand the 5 A's as well as how to educate patients about the use of pharmacological agents used to treat nicotine dependence. The ADHA's Ask.Advise.Refer protocol will be used for this paper.

Ask during appointment one: During the patient's dental hygiene visit to the clinic, the hygienist should determine the patient's tobacco use status and interest in quitting. If the patient is a tobacco user who is ready to quit, one additional form should be completed by the patient, the Tobacco Use Assessment Form or TUAF (Figure 1).

Completion of this form only takes a few minutes during the visit. If time does now allow, a hardcopy of this form can be given to the patient to answer and fax to the office, or the following internet address can be provided and the patient can download and complete it. This form can be accessed and printed at http://www.thejcdp.com/issue004/index.shtml. The hygienist can review the completed form and make quit suggestions by email, fax or phone when another office visit it not practical during the following two weeks.

Advise during patient treatment: Prior to patient treatment, team members must become knowledgeable about PATS in order to answer patients' questions and they must also call the quit line to become knowledgeable about the program before recommending it to a patient.

At the beginning of the dental hygiene visit with a tobacco user, the dental hygienist must clearly advise the patient to quit. As the patient is seated and dental hygiene treatment begins, the dental hygienist should assist the user in quitting by reinforcing the user's desire to quit. This can be accomplished by:

- Seizing a teachable moment and relating any intraoral effects of tobacco use.
- Identifying a quit date within two weeks or timely salient date (birthday, vacation, etc).
- Having the patient write down two or three reasons why quitting is important and instructing the patient to keep the reasons with him/her.
- At the end of the appointment (while handing out dental floss, toothbrush, etc), continuing to assist the patient by providing written take home instructions. Information from Tables 5 and 8 can be reproduced as is or adapted for use. It is helpful to have the clinic name, telephone number and email address imprinted. Make individual sheets for each product to increase patient compliance.
- If the dentist and patient decide that the use of bupropion HCl (Zyban) or other prescription PAT is appropriate, insuring that the prescription is written and given to the patient or phoned-in to the patient's pharmacy.
- Documenting all advice related to quitting including the use of PATS. If the patient is referred to a community-based intensive counseling program, include this information in the written documentation in the patient's record.

Refer: At this point the oral health team member should provide the patient with the ADHA telephone quit line 1-800-QUITNOW OR 1-800-784-8669. More information related to this quit line is available at www.smokefree.gov. ADHA provides a plastic card shaped in the same dimensions as a credit card for the patient to use. These cards are available from ADHA at 1-800-243-ADHA or from the local or state dental hygiene association. Each state's ADHA SCI liaison member's name and contact information are available at www.ask.advise.refer.org. While the quit-line does provide personal interactive follow-up information for the patient, any oral health team member is encouraged to contact the patient on their quit date to support the patient's quit attempt.

Follow-up Appointments (Personal, telephone appointment, or email contact): Contact the patient to determine their quit success. If the user has relapsed, review the reasons for quitting, assess appropriate use of PAT's, determine if the quit line is being used and is

helpful to the patient, refer the patient to an intensive nicotine dependence program if necessary, and document notes in the patient's treatment record.

Conclusions

The oral health team has come a long way in recognizing the many harmful oral health effects of tobacco use and why teaching patients about the relationship between oral and systemic disease is essential, but are we reaching every tobacco-using patient? Unfortunately, according to outcome results published in *Healthy People 2000,* we are not reaching every patient, but that does not mean the oral health team is not capable or willing to do so. Even more unfortunate is the fact that a small number of the oral team continues to personally use cigarettes. Young men and women who enter our profession are a target audience for the tobacco industry. Dental and dental hygiene educators should strongly encourage them, as well as fellow practitioners, to quit and provide this service for them.

The focus of this article is to help patients become tobacco free in order to improve both oral health and health in general. Helping the tobacco-using patient become tobacco free is now the most important service that the oral health care team can provide. Today, we do not only save smiles, we have the opportunity to save lives.

Table 1: Appointment Time Required for the RDH Using the Brief Chairside Intervention ADHA Smoking Cessation Model

Never user	½ minute (congratulate patient)
Ex-user	½ minute (congratulate patient)
Not ready user	1 minute (provide motivational literature)
Ready user Appointment one Subsequent contact	 3-15 minutes* 3-5 minutes

*Fifteen (15) minutes is based on the need for an additional appointment when not being seen for nonsurgical periodontal treatment performed by the dental hygienist. Otherwise, smoking cessation information is incorporated into the dental hygiene visit and only a few extra minutes of time are required.

Table 2: Time Required by Dentist for Brief Chairside Interventions[3]

Never user	½ minute (congratulate patient)
Ex-user	½ minute (congratulate patient)
Not ready user	1 minute (reinforce RDH's message)
Ready user	2-3 minutes (reinforce RDH's message)
Ready user + script	4-6 minutes for writing script and answering patient's questions

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Table 3: The 5 A's for Brief Interventions (adapted for dental hygienists from AHRQ's Clinical Practice Guideline: Treating Tobacco Use and Dependence[3])

The 5 A's	Team's Role
Ask	➢ Identify and document tobacco use status for every patient ➢ Congratulate tobacco-free patients
Advise users to quit	➢ In very clear terms, advise users to quit ➢ Determine if they are willing to make a quit attempt
Assess willingness to quit	➢ Tobacco Use Status Form (TUAF)
Assist in quit attempt	➢ Discuss the 4 D's (Table 6) ➢ Identify social support or a friend or buddy to help the patient as they attempt to quit ➢ Discuss PATS ➢ Ask dentist to write a prescription
Arrange for follow-up	➢ Provide the Quit Now quit-line number (1-800-QUIT-NOW) and website information at **www.smokefree.gov** ➢ Contact the patient one day before the quit date to provide support ➢ Provide additional websites such as **www.nicotine-anonymous.org** for support and follow-up

Table 4: Transtheoretical Model of Change[6]

Stage of Change	Description	Team's Role
Precomptemplation	Forty percent of smokers are "precontemplaters." They are not interested in quitting and may construe constructive advice to quit as negative criticism.	Discuss the 5 R's: relevance, risks, rewards, roadblocks, and repetition.
Contemplation	Forty percent of smokers are "thinking about quitting." They are not ready to set a quit date within the next six months.	RDH's skills in motivating patients must be used. Again review the 5 R's with the patient in an attempt to move to the next stage.
Preparation	Twenty percent of smokers are ready to set a quit date within the next 30 days. Be prepared to discuss past failed quit attempts and encourage and provide motivational support.	Provide information related to quit literature, websites and pharmacological adjuncts
Action and Maintenance	Patient has quit.	Provide follow-up support and let the patient know you are ready to answer questions and make referrals to more intensive programs if necessary.
Relapse	A part of change and should be handled as such.	Should the patient relapse, give the patient reasons that led to relapse. Encourage the patient to set another quit date and incorporate this information into next quit attempt.

Table 5: Overview of Pharmacological Agents Used to Treat Nicotine Addiction

Agent	Dosage	Comments
Nicotine Replacement Products (stop tobacco use before using)	Follow manufacturer's instructions	Part of comprehensive behavioral cessation program to relieve withdrawal symptoms.
Nicotine polyacrilex gum	Available in 2 and 4 mg doses. 10 mg in 10-12 pieces of 2 mg; 20 mg in 10-12 pieces of 4 mg.	Gum releases 50% of its nicotine into the mouth. About 1/3 to ½ of the usual daily intake of nicotine (30 cigarettes daily).
Nicotine transdermal patch	Available in 7, 14 and 21 mg doses OTC. Both brand and generic patches are now on the market.	Patches match the mg to the number of cigarettes smoked per day. If a person smokes greater than a pack a day, start with the 21 mg patch. If the user smokes less that a pack a day, begin with the 14 mg patch. Patch doses can be adjusted based on the user's inhalation (i.e. Some users inhale deeply and smoke the entire cigarette while others let the cigarette burn for long periods in the ashtray and are not exposed to as much nicotine.
Nicotine inhaler	Each cartridge contains 4 mg of nicotine and delivers ten 2 mg puffs on an inhaler equal to one puff on a cigarette. 6-16 cartridges per day	Continuous puffing for 20 minutes is advised. Taper down after three months. Requires a prescription.
Nicotine nasal spray	1 dose equals 1 spray in each nostril (1 mg). Start: 1-2 doses per hour Max: 5 doses/hr (40 doses per day). D/C if not quit in four weeks	For greater than a pack a day smokers (more than 20 cigarettes). Metered spray to nasal mucosa. Duration of treatment of 3 months. Requires a prescription.
Non-Nicotine Agent (patient can continue smoking)		
Bupropion HCl	150 mg or one tablet a day upon arising for three days. On fourth day, 150 mg upon arising and then second 150 mg tablet eight hours after first dose.	Take as early as possible. Continue to use for 10-14 days before quit date. Antidepressant therapy that decreases cravings.
Varenicline or Chantix	Now available from Pfizer. Blocks nicotine receptors and cravings.	For more info visit Pfizer.com or www.FDA.gov.

Table 6: The 4 D's for Smokers - Brief Behavioral Advice for Dealing with Cravings

Delay.	Delay use for five minutes even if this means one second at a time. Praise yourself for resisting a craving even if you are only at the one minute mark. Generally, after five minutes, cravings go away.
Do something else.	Do not go to places that you associate with smoking until you are more comfortable as a nonsmoker. If you are in a situation in which friends tempt you to smoke, **do something else**. Leave the party or other situation. Drive your own car. If you have trouble after eating meals, **do something else**. Leave the restaurant immediately after eating. Drive your own car and do not let smoker come along. Remind then that they are your friends and you are trying to manage a difficult addiction.
Drink water.	This both delays and gives you something to do.
Deep breathe.	This relaxation exercise helps you delay and do something else. Close your eyes, inhale deeply through your nose, count to ten and exhale through your mouth. Remind yourself that you can hold your breath for ten seconds – it may not be possible in the future if you continue to smoke.

Table 7: The 5 R's for Enhancing Motivation to Quit (adapted for dental hygienists from *The Clinical Practice Guideline*)

5 R's	RDH Can Discuss with Patient
Relevance	Why is quitting personally relevant? Has the rising costs of cigarettes made it difficult to meet household expenses? Two parents in a household that smoke one pack a day each spend almost $3000 per year on cigarettes alone. If the patient is interested in bleaching his/her teeth, use this strategy.
Risks	Acute risks: hairy tongue and halitosis Chronic risks: more severe periodontal disease, oral cancer, etc. Environmental risks: to children and pets in the household
Rewards	Identify potential benefits for stopping: role model for children, money saved, teeth saved, whiter teeth, better oral health. The patient is in control of this aspect of life.
Roadblocks	Fear of life without smoking, withdrawal, failure, weight gain. Discuss the use of behavioral therapy and PAT. Discuss social support from staff and you, identify "friend or buddy" that patient can contact.
Repetition	Repeat motivational information at future dental hygiene visits and have the dentist support the dental hygienist's advice to quit.

Table 8: Patient Instructions for Using PATs

PAT	Instructions
Patches	Use after tobacco use is discontinued. These are now OTC products – recommend a starter box to the patient. Available in three doses and several brands. **Contraindications**: • Allergy or skin rash at site of patch (patient is allergic to patch adhesive) – use OTC cortisone cream and move patch around from day to day. • Uncontrolled angina or hypertension – get MD consult before use with ASA Status II or greater patients. **Signs of overuse**: dizziness, increase blood pressure, nausea. **Helpful website**: http://committedquitters.quit.com
Polyacrilex gum	Use after tobacco use is discontinued. Nicorette and generic nicotine gum is now available OTC – recommend start box. Four mg generally recommended – patients should use 20-30 pieces per day depending on 2 or 4 mg, respectively; patients should use no less than 10 pieces per day. **Contraindications**: dentures, severe dry mouth, uncontrolled angina or hypertension; get MD consult before use with ASA Status II or greater patients. **Signs of overuse**: hiccups, dizziness, increased blood pressure, nausea. **Helpful website**: http://committedquitters.quit.com
Nicotine lozenge	Use after tobacco is discontinued. *Commit* is the brand name of the nicotine lozenge distributed by GlaxoSmithKlein. OTC product – recommend the starter box. Four mg generally recommended – patients should use 20-30 pieces per day depending on 2 or 4 mg, respectively; patients should use no less than 10 pieces per day. **Advantages** of the lozenge as compared to the gum: denture wearers and patients with severe dry mouth can easily use. **Contraindications**: uncontrolled angina or hypertension, get MD consult before use with ASA Status II or greater patients. **Signs of overuse**: hiccups, dizziness, increased blood pressure, nausea. **Helpful website**: http://committedquitters.quit.com
Nicotine inhalation system (Nicotrol Inhaler)	Use after tobacco is discontinued. **RX**: Nicotrol Inhaler Dispense one starter box 42 cartridges per box; 10 mg per cartridge; .01 mg in a "puff" One cartridge equals 1-3 cigarettes; use between 6-12 cartridges – no more than 12 cartridges daily. Puff on inhaler five minutes at a time. **Contraindications**: uncontrolled angina or hypertension, get MD consult before use with ASA Status II or greater patients. **Helpful website** info includes instructional video at http://www.nicotrol.com
Nicotine nasal spray (Nicotrol Nasal Spray)	For heavy smokers usually at 2 packs or greater pr day and with physician consult. Use after tobacco is discontinued. **RX**: Nicotrol NS Dispense one bottle Each spray contains .5 mg of nicotine or 1 mg per use (.5 mg in both nostrils). Each dose equals one spray in each nostril – do not inhale and do not blow nose for a minute after spraying into nose; breathe normally. One bottle = 100 doses Maximum of five doses per hour or 40 doses per day. **Contraindications**: upper respiratory tract infection, allergies, COPD, uncontrolled angina or hypertension – get MD consult before use by these patients. **Helpful website**: http://www.nicotrol.com
Bupropion HCl (Zyban, GlaxoSmithKlein)	Patient continues to smoke. **RX**: Zyban 150 mg tablets #60 Take one tablet for three days, and then take two tablets beginning on the fourth day. Take table in the morning as early as possible. When using two doses a day, take the second tablet eight hours after the morning dose. One week following the bid regimen, stop use. **Contraindications**: history of anorexia or other eating disorder, history of head trauma, seizure, stroke, etc (this drug lowers the seizure threshold); cannot use if patient is currently taking MAOI; can take with SSRI's but only with physician's advice. **Signs of overuse**: nervousness; however, some patients experience fatigue and difficulty concentrating. Allergies to Wellbutrin SR or Zyban have been reported. **Helpful website**: http://www.quitnet.com/Library/Guides/NRT/bupropion.html or use any search engine and go to GlaxoSmithKlein's website, Zyban will be listed in the prescription drug list as Wellbutrin.

Figure 1: Tobacco Use Assessment Form

Name ____ Date __________________

Do you use tobacco in any form? ☐Yes ☐No
If no, have you ever used tobacco in the past? ☐Yes ☐No
Type of tobacco product(s) used?____
How long did you use? ___years ____months
How long ago did you stop? ___years ____months

Current Users
What type of tobacco do you use? ____
How many per day? ____
Cigarettes smoked per day: ______________________
Spit tobacco/chew - number of dips/chews per day: _________________
Cigars smoked per day: _________________________
Pipes - number of bowls per day: _________________
Bidis - number smoked per day: __________________
Other: Describe use: ___________________________________

How many days a week do you use? ______________________

How soon after you wake up do you use? __________________

Have you ever tried to quit before? ________ How many times? ______________
Latest quit attempt? ___________

Does the person closest to you use tobacco? ☐Yes ☐No

On a 1-10 scale, how interested are you in stopping? ____

On a 1-10 scale, one year from today how confident is you that you will be tobacco free? _____

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9. Prochaska, JO, Diclemente,CC., and Norcross, JC: In search of how people change. *American Psychologist* 1992;47:1102.

HELPFUL ARTICLES AND WEBSITES

The references and helpful articles and websites listed are intended for those individuals who wish to enhance their professional knowledge related to the oral health team's role in preventing or eliminating tobacco use among patients. Due to fast pace that this literature is emerging many websites have been used in the development of this presentation. The list is not meant to be all-inclusive; however, the citations were chosen specifically for the clarity of their text and applicability to clinical practice.

Davis, J (2005). Tobacco Cessation for the Dental Team: A Practical Guide, Part I, Background and Overview. *Journal of Contemporary Dental Practice*, Summer Issue, 2005. http://www.thejcdp.com/issue023/index.htm.

Garg RK and Tandon S (2006). Smoking Habits of Adolescents and the Role of Dentists. *Journal of Contemporary Dental Practice*. Citation Number:Vol.7, No.2, Page 120. http://www.thejcdp.com/issue026/index.htm,

Stafne E. (2000). Tobacco Cessation Intervention: How to Communicate with Tobacco Using Patients. *Journal of Contemporary Dental Practice*, Fall Issue, 2000. http://www.thejcdp.com/issue004/index.shtml.

Walsh, MM (2004). Treating Tobacco Dependency. *The Journal of Professional Excellence: Dimensions of Dental Hygiene*, January 2004, pages 23-27 and also at www.dimensionsofdentalhygiene.com.

Nicotine Anonymous- A 12 Step Program offering support to those who want to quit cigarettes and quit smoking and stop other forms of tobacco and nicotine at www.nicotine-anonymous.org.

For more information, about ADHA Smoking Cessation Initiative and the Ask.Advise.Refer program visit www.askadviserefer.org. Dental hygienists or consumers interested in receiving additional information should contact Carol Southard, ADHA SCI project manager, at 312-440-8920 or at carols@adha.net.

Please duplicate and complete one form for each registrant.

Instructions: Answer the questions by choosing the best possible answer. Registrants must correctly answer 75% of the test questions to receive CE credit.

The Patient Who Uses Tobacco: The Role of the Oral Health Team

1. Nicotine is addictive and causes vasoconstriction. It is the psychoactive agent found in all forms of tobacco products.
   A. Both statements are true.
   B. Both are false.
   C. The first is true and the second is false.
   D. The first is false and the second is true.

2. The primary neurotransmitter affected during nicotine metabolism is
   A. Estrogen.
   B. Dopamine.
   C. GABA.
   D. Interleukin-2.

3. The correct order for the 5 A's is
   A. Assess, ask, assist advise arrange.
   B. Arrange, assist, assess, advise, ask.
   C. Ask, advise, assess, assist, arrange.
   D. Ask, assess, advise, assist, arrange.

4. During which step of the 5 A's does the oral heath team member suggest that the user quit?
   A. Arrange
   B. Ask
   C. Assess
   D. Advise

5. How much time is required from the dentist during interaction with a patient who is ready to quit and will also require a prescription or has questions about over-the-counter nicotine replacement products?
   A. 2 minutes
   B. 4-6 minutes
   C. 20 minutes of consult time
   D. One hour

6. Patients who are not ready to quit are termed "contemplaters." The oral health team member should provide strong constructive criticism and insist that this patient should set a quit date within two weeks.
   A. Both statements are true.
   B. Both are false.
   C. The first is true and the second is false.
   D. The first is false and the second is true.

7. Nicotine polyacrilex gum is
   A. Available in 2 mg or 4 mg doses.
   B. Releases 50% of its nicotine into the mouth.
   C. It is not appropriate for denture wearers.
   D. All of the above.

8. Which statement is *false* regarding the nicotine lozenge?
   A. It is the gum reformulated into a lozenge.
   B. It is available over-the-counter.
   C. It is not appropriate for denture wearers.
   D. It is available in a variety of flavors.

9. Zyban or Wellbutrin SR is an antidepressant drug used to help smokers quit. One adverse reaction to this drug is weight gain.
   A. Both statements are true.
   B. Both are false.
   C. The first is true and the second is false.
   D. The first is false and the second is true.

10. Which is true concerning the nicotine inhalation system or nicotine inhaler?
   A. It produces non-harmful smoke during use.
   B. It is available over-the-counter.
   C. It mechanism of action is transmucosal nicotine delivery.
   D. It is only recommended for heavy smokers.

11. The American Dental Hygienists' Association has a tobacco cessation program based on the 5 A's Model. It uses the tobacco quit-line, 1-800-QUIT-NOW for follow-up with smokers attempting to quit.
   A. Both statements are true.
   B. Both are false.
   C. The first is true and the second is false.
   D. The first is false and the second is true.

12. Which form of tobacco use is safe for patients to use and will not harm their health?
   A. Cigarettes
   B. Cigars
   C. Smokeless tobacco
   D. There is no safe form of tobacco

REGISTRATION FORM: Duplicate and complete one registration form for each registrant. Send, along with payment, to the address below.

Name________________________ Last 4 digits of SS#__________ Email__________________

Mailing Address________________________ City, State, Zip________________________

Day Phone__________________ FAX__________________ Charge my (circle one): VISA MasterCard

Card #__________________ Expiration Date________ Signature________________________

Make checks payable to **The University of Tennessee**. Mail completed test, form and payment to:
Continuing Dental Education, 875 Union Avenue, Memphis 38163.
Fax test, form and credit card info to (901) 448-1514 or call (901) 448-5386 to register by phone.