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EDITORIAL COMMENT

Smoking Cessation in Heart Failure: It Is Never Too Late*

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Smoking control efforts have focused recently on primary prevention among teens, rather than adult cessation. This preoccupation with youth has reinforced the feeling that current smokers are a "lost cause." There is also a feeling that once smoking has led to clinical disease, it is too late to intervene in a way that will help the patient. The article by Suskin et al. (1) in this issue of the *Journal* dispels these myths and illustrates that smoking cessation among smokers with heart failure is as effective or more effective at reducing mortality as treatment with beta-blockers or angiotensin-converting enzyme (ACE) inhibitors. Ex-smokers had a

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30% lower mortality compared to current smokers, which was similar to that in never smokers. The benefits of smoking cessation were comparable to treatment with the ACE inhibitor enalapril (19% mortality reduction compared to placebo [2]), the beta-blocker metoprolol (34% mortality reduction [3]) or the aldosterone inhibitor spironolactone (30% mortality reduction [4]). The benefits of smoking cessation accrue rapidly in these patients with heart failure, within one year.

Rather than being preventive care, as many physicians and policy makers consider smoking cessation, the work of Suskin et al. (1) reinforces the message that smoking cessation is really therapy.

Despite this clear clinical benefit to patients, most physicians still do not intervene to treat their patients' tobacco use. Population-based surveys indicate that among smokers who had seen a physician within the last year, less than half (46%) were advised to quit, and only 15% reported being offered cessation therapy (5). Similarly, while a majority of primary care physicians surveyed indicated they ask about smoking status and advise patients to quit, few reported actively assisting patients (35%) or arranged follow-up (8%) as guidelines recommend (6). Physician compliance with smoking cessation advice among those treating people with

heart failure is equally low; in a retrospective review of 522 congestive heart failure patients admitted at seven university hospitals, 72% of "ideal" candidates received ACE inhibitors on discharge but only 9% of smokers had documented advice to quit smoking (7). While the actual level of advice may be higher than is documented in the medical record, it is clearly low.

The findings of Suskin et al. (1) have important implications for both clinical practice and health-care policy. In clinical practice, it is important to determine the smoking status of patients with heart failure, promote smoking cessation and monitor compliance. Some physicians may believe that smoking cessation counseling is not worth the effort because of poor patient compliance stemming from nicotine addiction. In fact, the evidence indicates that compliance with a well designed smoking cessation counseling program is comparable to that of ACE inhibitors for patients with serious cardiovascular disease. A randomized controlled trial of smoking cessation counseling with monthly telephone follow-up for patients with myocardial infarction produced six-month and one-year patient compliance rates of 67% and 55% (8), respectively. Minimal cessation advice, consisting of viewing a smoking cessation video, a 10-min counseling session and referral to smoking cessation programs, resulted in six-month and one-year cessation rates of 43% and 34% (8), respectively. Studies of compliance with ACE inhibitors have found six-month compliance rates of from 46% to 86% in patients with heart failure (9,10).

Given the expense of commonly used medications for heart failure, smoking cessation counseling with follow-up may be more cost effective than pharmaceutical treatment for heart failure to achieve comparable results in terms of mortality. (Of course, one would expect better results from the *combined* effects of smoking cessation and other treatments.) The expected cost of creating a permanent ex-smoker has been estimated to range from \$400 (physician counseling) to \$1,100 (a four to eight week course of nicotine transdermal patch therapy) (11). The annual cost of ACE inhibitors and beta-blockers ranges from \$200 to \$1,500 per year (12-14). The relative cost of smoking cessation therapy is lower than appears from this comparison because the cost of smoking cessation is a one-time investment, while the cost of pharmaceutical therapy continues for the life of the patient. In addition, at an average cost of \$4.50 per pack, an ex-pack-a-day smoker would save \$1,600 a year on cigarettes.

The policy issue is coverage of smoking cessation therapy by health insurance programs. Physicians often complain that smoking cessation therapy is not reimbursed as a separate service. While it would provide a financial incentive to provide this service if it were separately reimbursable, the fact remains that prescribing and supervising the use of beta-blockers and ACE inhibitors is not a separately reim-

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bursed service. Proper prescription and monitoring of these drugs is simply good medical practice and the standard of care for patients with severe cardiovascular disease. There is no reason that proper prescription and monitoring of smoking cessation efforts should not be treated similarly.

It is, however, possible to obtain additional compensation for smoking cessation efforts. Smoking cessation therapy is considered preventive care for tobacco dependence recorded as a primary disease, and is therefore often not covered by fee-for-service insurance policies and is not covered at all by Medicare. However, when tobacco dependence can be documented as a contributing factor to a smoking-related disease, such as heart failure, smoking cessation therapy is often covered. With proper documentation, Medicare will consider coverage on a case-by-case basis. Individual state Medicaid programs and private insurance company policies vary widely. Proper documentation of tobacco dependence as a contributing factor to a primary smoking-related disease is important for justifying coverage.

Health care advocates should also work to make tobacco cessation therapy more widely and easily available for patients with cardiovascular disease, in both fee-for-service and managed care settings. Insurance coverage should be as easily available for smoking cessation therapy as for drug therapy. Drug therapy is widely accepted and the required mechanisms for prescribing and dispensing are in place. The article by Suskin et al. (1) provides compelling evidence that smoking cessation should simply be considered one more clinical intervention in these patients. Unlike the use of powerful drugs, the side effects of smoking cessation—reducing the risks of other diseases—are positive.

When medical professionals and the general public think about smoking, they generally think of cancer, even though heart disease is a major disease end point for tobacco use. Moreover, unlike cancer, the benefits of smoking cessation in terms of reducing risk of cardiovascular disease accrue rapidly. (Other benefits, such as reductions in cancer risk, also accrue, albeit more slowly.) In otherwise healthy individuals, the risk of a heart attack or stroke falls by half within the first year following cessation and is nearly back to that of a nonsmoker in three years (15). Indeed, in California, the short-term savings in direct medical costs associated with these heart attacks and strokes alone amounted to enough money (15) to pay for a major public tobacco control program that has been in place since 1989 (16). Because of the rapid impact on heart disease risk, the California program prevented 33,300 coronary heart disease deaths during its first 7 years (17). These rapid public health benefits in tobacco prevention and cessation do not come from primary prevention of smoking in children, they come from reducing adult smoking rates and the attendant reductions in heart disease.

Suskin et al. (1) show that even in patients with established and serious cardiovascular disease, smoking cessation is an effective measure for the prevention of death and hospitalization. Quitting smoking is as effective as modern

pharmaceutical therapies, and just as fast in manifesting its benefits. It is never too late to quit smoking, even for patients with heart failure and other serious cardiovascular disease. Cardiologists need to incorporate aggressive efforts to promote smoking cessation into practice in the same way that they have incorporated ACE inhibitors and beta-blockers.

To do anything less would be to deny these patients the best care.

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