

SMOKING Cessation ROUNDS

SEPTEMBER 2007
VOLUME 1, ISSUE 7

A PHYSICIAN LEARNING RESOURCE FROM THE MINTO PREVENTION AND REHABILITATION CENTRE, UNIVERSITY OF OTTAWA HEART INSTITUTE AND THE ADDICTION MEDICINE SERVICE, CENTRE FOR ADDICTION AND MENTAL HEALTH, UNIVERSITY OF TORONTO

Smoking Cessation and Youth: *It's never too early to help patients quit!*

BY JANE BROWNRIGG, RN, BScN, AND ANDREW PIPE, CM, MD

Cigarette smoking is often described as a rite of passage for teens, since it involves the illusion of looking “cool” and a rebellion against authority. Hollywood has reinforced the association between youth, cigarettes, and sex appeal. For example, in the 1970s film, *Grease*, Sandy parts with her innocent school-girl image by wearing black leather and lighting up a cigarette to attract bad-boy Danny. The tobacco industry promotes such associations by paying for prominent product placement, as well as scenes in films with people smoking. Due to the advent of sponsorship and advertising bans in Canada, the tobacco industry has been forced to seek other product placement opportunities in this country. However, tobacco advertisements persist at point-of-sale, on the internet, in spurious “lifestyle” publications, and in Hollywood movies. Research has demonstrated that there is a correlation between youth smoking rates and celebrity smoking, leading some to argue for R-ratings for movies that contain smoking.¹ In Canada, a contrasting and realistic anti-tobacco message was provided by Barb Tarbox, a woman from Alberta, who spoke to thousands of Canadian students about how she became addicted to tobacco as a teenager and how she was paying the ultimate price; Ms. Tarbox died of lung cancer in 2003 at the age of 41.

The magnitude of the problem

In 2002, 22% of Canadian teens aged 15 to 19 years were smokers, down from 28% in 1999; while in 2006, there was evidence of a further decline in youth smoking: 15% of adolescents were smokers and 9% were daily smokers (Figure 1).² The 2005 Ontario Student Drug Use Survey (OSDUS) revealed that the prevalence of student smoking is at its lowest rate since 1977 (14%).³ Clearly, we are doing some things well in Canada.

Smoking initiation

Most life-long smokers started smoking in their teens and only about 10% of new smokers start after the age of 18. It is, therefore, important to examine and understand tobacco addiction in its early stages. The earlier smoking starts, the more likely an individual becomes a regular and heavier smoker, with a much higher risk of morbidity and mortality as their consumption increases. A British study of male physicians revealed that mortality in 50% to 66% of persistent smokers was due to tobacco. Data also confirm that death rates climb dramatically in association with an earlier age of smoking initiation.⁴ Those who start smoking before the age of 15 double their risk of premature death.⁴

Sadly, smoking initiation is occurring at ever younger ages, resulting in the well-deserved description of tobacco use as a “pediatric disease.” In the 1950s and 1960s, many Canadian smokers started smoking during young adulthood. Currently, however, half of the 12-year-olds in Canada are experimenting with cigarettes. Young smokers



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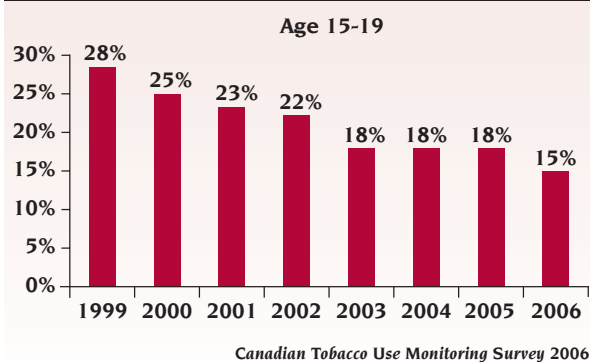
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The editorial content of *Smoking Cessation Rounds* is determined solely by the Minto Prevention and Rehabilitation Centre, University of Ottawa Heart Institute and the Addiction Medicine Service, Centre for Addiction and Mental Health, University of Toronto.

Available on the Internet at www.smokingcessationrounds.ca

Figure 1. Youth smoking rates in Canada²



quickly begin to experience health consequences, including an increased frequency of respiratory illness, asthma, bronchitis, and colds; shortness of breath; compromised maximal lung function; a reduced healing capacity; and, of course, a dramatically increased likelihood of addiction. Fifty percent of teens who smoke will continue to smoke for 16-20 years!

Interest in treating tobacco-addicted youth has gathered momentum in recent years. Research reveals that addiction in this age group develops after exposure to very few cigarettes and minimal puffs.⁶ It has been demonstrated that inhalation quickly follows a “first puff” and that addiction follows far more rapidly than assumed.⁷ Addiction in adolescent smokers has been described well before actual weekly or daily smoking has been established.⁷ The Nicotine Dependence in Teens (NDIT) study suggests that inhaling the smoke from only 1 or 2 cigarettes is sufficient to induce craving.⁸ Other studies have reported the development of withdrawal symptoms among nondaily smokers and concluded that smokers who start at an early age have more difficulty quitting, even before they have smoked a total of 100 cigarettes.⁸ The Development and Assessment of Nicotine Dependence in Youth (DANDY) study indicated that 50% of adolescents lose autonomy over tobacco by the time they are smoking 7 cigarettes per month, even though they have a mean salivary cotinine (the principal metabolite of nicotine) level of only 5.35 ng/mL, similar to levels in nonsmoking individuals exposed to secondhand smoke.

It appears then that there is no minimum requirement regarding number of cigarettes smoked to establish tobacco addiction in youth. Similarly, it is known that so-called “social smokers” or nondaily smokers also experience cravings.⁸ It may be that the mechanisms of such addiction differ from those present in more “classically-addicted” smokers, who purportedly have a desire to maintain a certain level of nicotine.

Traditionally, the onset of addiction consists of 5 sequential stages: preparation (interest in smoking);

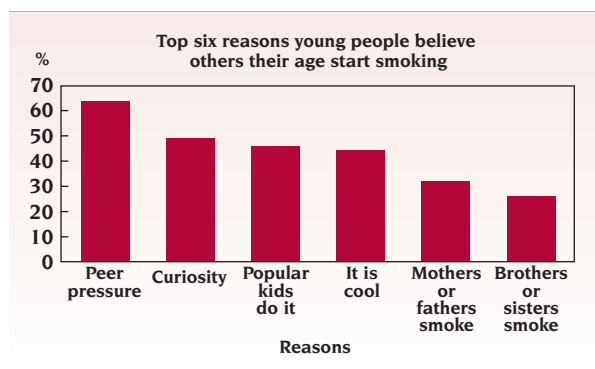
trying; irregular use; regular use; and nicotine-dependent smoking. However, this sequential model may not adequately describe what occurs in a young person. Gervais et al argue for a model that emphasizes the first-time youth experience symptoms of nicotine dependence, regardless of where they are in the process of trying cigarettes.⁷

Youth are, in all likelihood, unaware that they are nicotine-dependent when they are only occasional tobacco users; they may not even view themselves as “real” smokers. Such findings have important clinical implications. One is that it should not be assumed that it is easier for adolescents to stop smoking because of their relatively brief smoking histories. The struggle to shed the addiction to nicotine may be just as challenging for a teenager as it is for those with a long-standing history of smoking. Therefore, clinicians need to provide the same, systematic, best-practice assistance to teens. It is clear that craving, withdrawal symptoms, and other evidence of nicotine dependence are present in cigarette users who smoke only intermittently. What has traditionally been viewed as innocent experimentation may actually be a fundamental step along the pathway towards a 40-year sentence of addiction.

Susceptible youths may experience failed attempts at cessation even prior to the onset of daily smoking.⁹ Achieving abstinence as early as possible is important for long-term health. The lung cancer rate of former smokers who quit by age 30 is still approximately 3 times higher than that for lifelong nonsmokers.¹⁰ Quitting cannot come too early!

The prevention of tobacco addiction in youth is as important as any discussion of cessation strategies. Physicians should not be deceived by the oft-stated determination of school children that they “will never smoke.” While school children may be able to recite the risks of smoking by heart and are concerned about the welfare of their smoking parents, Figure 2 shows that there are other powerful influences that ultimately determine whether an adolescent will begin to smoke. Youth who smoke are more influenced by behavioural and environmental phenomena than adults.¹² Relying on health messages alone seriously impedes the ability to prevent tobacco addiction. Although such messages are necessary, they are far from sufficient! The health risks associated with smoking have little appeal to youth since they see themselves as being omnipotent, immortal, and inviolable; hence, health risks are not inducements to cessation among young smokers.¹³ As a result, strategies that attempt to “scare” adolescents about the ravages of tobacco-related disease are ineffective because youth feel that these threats are not relevant to them. Young smokers are also convinced that they will not continue to smoke beyond a 5-year time

Figure 2. Statistics Canada: Youth Smoking Survey, 2002¹¹



period; ironically, three-quarters are still smoking 7 to 9 years later.¹⁴

In an effort to reduce youth smoking rates, health professionals have sought to mimic strategies aimed at adult populations with mixed success. Clinicians working with youth, therefore, would do well to educate themselves on successful youth tobacco control initiatives. A number of innovative programmes exist.

Lungs are for Life from the Ontario Physical and Health Education Association (OPHEA), is a curriculum-based program aimed at children in kindergarten to Grade 10. It delivers grade-appropriate tobacco information.

Florida's "Truth" campaign, which earmarked a portion of a 1997 tobacco settlement between Florida and the tobacco industry, created an unconventional, cutting-edge, anti-tobacco counter-marketing effort to reduce youth smoking rates.¹⁵ The program was youth-guided, youth delivered. It relied on messages that "got into the heads" of young people. The campaign used humour, provided facts in a direct manner, delivered affirmative messages, and never used the word "don't." The cigarette was used to represent the tobacco industry's duplicity and intent to manipulate behaviour. The campaign, generously financed with the proceeds of industry settlement awards, focused on one age-group and one issue. Significant, positive changes in anti-tobacco attitudes and tobacco use were noted among Florida youth. Since 1998, the percentage of youth using tobacco in the previous 30 days declined by 7.4% (from 18.5% to 11.1%) in middle school and 4.8% (from 27.4% to 22.6%) in high school.¹⁵

Youth Action Alliances (YAA) in Ontario was recently created under the umbrella of Smoke-Free Ontario. Like the "Truth" campaign, its aim is to engage youth to educate their peers on tobacco industry manipulation and bring anti-industry messages to youth-friendly venues (eg, skateboard parks and shopping malls). Youth create no-holds barred messages at gath-

erings such as "Drop Dead" events, where students portray how many Ontarians die each day from tobacco use by "dropping dead" every few seconds. In Ontario, \$3.8 million in new funding for youth tobacco control was announced in 2006. As a consequence, youth are engaged in tobacco control initiatives in many communities and are highly motivated to educate their peers.

Kick the Nic, developed by the British Columbia Ministry of Health, offers an innovative approach to teen cessation. Group sessions are offered over 10 weeks on a variety of topics such as the consequences of tobacco use, strategies to avoid tobacco, withdrawal coping strategies, and ongoing support strategies (www.tobaccofacts.org).

The particular needs of adolescents

Smoking cessation programs for youth have had short-term success, but no long-term data are available. The use of pharmacotherapy to assist teenagers with cessation has not, until recently, been part of typical clinical practice. There is growing evidence, however, that pharmacotherapy can be of particular assistance in enhancing cessation among young smokers. It is important to realize that the treatment of adolescent nicotine addiction cannot be based solely on the experience of adult research or practice. Adolescence is a time when making any behavioural change may be difficult; it is a developmental stage characterized by changes in many domains: the physical, emotional, cognitive, and social. Adolescents vacillate between parental control and self-regulation¹⁶ and young people are less able than adults to gauge risk accurately, leaving them more vulnerable to addiction. Special consideration needs to be given to their cognitive and developmental levels, experiences, family dynamics, and peers, and the specifics of their smoking behaviour.¹⁷ When working with youth on strategies to address substance abuse issues, like smoking, 3 primary challenges have been noted:

Retention/attrition: Drop-out rates from many programmes are often as high as 50%-60%, making evaluation difficult.

Access: Geographical, cultural, travel, and financial issues make access to many programs difficult for some youth.

Relevance: Treatment approaches need to be designed to encourage youth to be active participants. The more an adolescent feels involved in any treatment strategy and recognizes its relevance to their circumstance, the more likely it is that the treatment will be effective.

When addressing smoking with adolescent patients, it may be particularly important to consider the involvement of their family (which may present a challenge if the youth has not disclosed his/her tobacco

addiction to the family). Parental smoking doubles the risk of youth smoking rates and family involvement does warrant consideration. Parent health benefit plans may cover the cost of nicotine replacement therapy for the child.

Despite considerable progress in developing smoke-free environments and regulations concerning the merchandising of tobacco products, the implementation of smoke-free school properties and the social supply of cigarettes to minors remain problematic. “Supply side” strategies (such as restricting youth access to tobacco) are part of any comprehensive tobacco control initiative. Youth smoking rates correlate with the price of tobacco – a 10% increase in the price of a pack of cigarettes reduces the demand for cigarettes by as much as 15% among youth.¹⁸ In 1999, the World Bank concluded, “In reality, the most effective way to deter children from taking up smoking is to increase taxes on tobacco.”¹⁸ This must be coupled with reducing youth access to “cheap smokes” or contraband tobacco. The physician’s role as an advocate in the appropriate regulation of tobacco products is important in this respect.

All successful youth programs recognize the need of youth to identify with a group; peer involvement in cessation activities may prove to be as effective as it has been in the area of tobacco prevention. Web-based interventions have the potential to engage adolescents in a familiar and welcoming format.¹⁹ Adolescents may be living in a household that is very “tobacco friendly” and, thus, experience frequent triggers to smoke. At the same time, young smokers frequently have co-addictions or psychiatric issues that require treatment.¹⁷ Surprisingly, many agencies that address other substance abuse issues in youth have been remarkably inactive in addressing smoking cessation. When? Where? How should treatment strategies be delivered? There are no absolute answers to these questions.

Helping young smokers to quit

Many investigators point to the success of school-based cessation interventions and programs offering increased provider-adolescent contact.¹⁹ It is reasonable to assume that a sensitive, supportive, nonjudgemental approach in any practice setting will be particularly helpful in inducing the consideration of cessation attempts among young patients. Empirical research that might guide best practice for tobacco treatment in youth is lacking. Intuitively, it appears important to pay attention to high-risk, young smokers and those who report “less than daily” smoking.

Health Canada has concluded that adolescence presents a crucial window of opportunity to intervene with smoking cessation and there is demonstrated interest in quitting among this population: 70% of current smokers in Canada aged 15- to 19-years-old report one or more attempts to quit in a previous 12-month period.²⁰ According to the Canadian Tobacco Use Monitoring Survey (CTUMS), 5% of 15- to 19-year-olds are considered “former smokers” (ie, they have not smoked for 1 year).^{2,5}

Ideally, youth cessation programs will become part of comprehensive tobacco control programs in school, home, and work settings. Successful interventions include a combination of cognitive-behavioural strategies (self-management and coping skill training, problem-solving, and specific techniques for dealing with withdrawal).¹⁶

Unfortunately, until recently, pharmacotherapy has not been an element of most youth cessation programs. However, there is growing interest in the use of nicotine replacement therapy (NRT) in adolescent populations²¹ and smoking cessation authorities are increasingly recommending the use of pharmacotherapy for nicotine-dependent adolescent smokers who are trying to quit. A nicotine dependence score, validated for adolescents, can be useful in determining when to consider NRT (Figure 3). Current product labelling of NRT products states that they are not to be sold to anyone <18 years of age. Notwithstanding, it remains as true for youth as it does for adults that continued smoking is far more hazardous than the use of NRT. NRT produces far lower levels of nicotine that are delivered in a slowly rising, steady state via the venous system, rather than the dramatic increase in arterial levels produced by smoking. In addition, NRT delivers none of the thousands of other toxic constituents of tobacco smoke.

A US Clinical Practice Guideline in 2000 suggested that clinicians help adolescents quit smoking utilizing the 5 As (Ask, Advise, Assess, Assist and Arrange).²² The expert panel noted that NRT, in combination with behavioural therapy, is the most effective intervention for individuals who smoke. Some adolescent studies have found that nicotine patches result in a significant reduction in the number of cigarettes smoked daily and may be more effective if they are used in combination with behavioural counselling. None of the adolescent studies to date has found any harm associated with NRT use in adolescent populations.¹² Both US and UK guidelines suggest that NRT be considered for youth who would like to quit

Figure 3. Modified Fagerstrom Tolerance Questionnaire validated for adolescents. A score of 6 or above (out of a possible score of 9) indicates substantial nicotine dependence.¹²

- 1. How many cigarettes a day do you smoke?**
 1. Over 26 cigarettes a day (2)
 2. About 16-25 cigarettes a day (1)
 3. About 1-15 cigarettes a day (0)
 4. Less than 1 a day (0)
- 2. Do you inhale?**
 1. Always (2)
 2. Quite often (1)
 3. Seldom (1)
 4. Never (0)
- 3. How soon after you wake up do you smoke your first cigarette?**
 1. Within the first 30 minutes (1)
 2. More than 30 minutes after waking, but before noon (0)
 3. In the afternoon (0)
 4. In the evening (0)
- 4. Which cigarette would you hate to give up?**
 1. First cigarette in the morning (1)
 2. Any other cigarette before noon (0)
 3. Any other cigarette in the afternoon (0)
 4. Any other cigarette in the evening (0)
- 5. Do you find it difficult to refrain from smoking in places where it is forbidden (church, library, movies, etc.)?**
 1. Yes, very difficult (1)
 2. Yes, somewhat difficult (1)
 3. No, not usually difficult (0)
 4. No, not at all difficult (0)
- 6. Do you smoke if you are so ill that you are in bed most of the day?**
 1. Yes, always (1)
 2. Yes, quite often (1)
 3. No, not usually (0)
 4. No, never (0)
- 7. Do you smoke more during the first 2 hours of the day than during the rest of the day?**
 1. Yes (1)
 2. No (0)

smoking and are nicotine-dependent. This therapy must be considered and explored as part of any intervention with youth who smoke.

A UK study of 98 smoking youth, randomized to nicotine patch treatment or placebo, demonstrated low adherence to therapy: the median duration was 1 week and 63 participants did not attend follow-up. The authors suggested that NRT was unlikely to be effective because of low adherence to therapy in spite of the demonstrated interest in cessation assistance.²³

A clinician's comfort level may play a part when NRT is used in youth. Pediatricians who responded to a mail survey asking if they would use NRT in youth found that, although half thought it to be a safe treatment for youth, 53% did not feel confident in their ability to use it.²² Those who did use NRT with young clients based their decisions on whether the adolescent showed a willingness to quit smoking (78%), if there was a specific request for NRT (72%), and if a health problem that was exacerbated by smoking was present (56%).

The Ontario Medical Association (OMA) states that NRT should be considered for all smokers who need NRT to quit, including those aged <18 years.²⁴ Some simple concepts can guide interventions with young smokers (Figure 4)

The development of new approaches to pharmacotherapy that specifically target the neurophysiological mechanisms underlying the initia-

tion and maintenance of nicotine addiction (eg, varenicline) may, in the future, provide new opportunities for the treatment of young smokers.

Cigarette smoking is often initiated, ironically, as a bid for independence. It quickly becomes a lifelong addiction. Youth who may smoke only a few cigarettes need assistance to both understand and overcome their cravings and withdrawal. Many would argue that preventing smoking initiation in youth would be among the most important of preventive interventions; helping a young smoker to quit would surely rank close behind! Youth smoking remains a critical health issue. Every year, a new generation of children experiment with smoking – the genesis of a new cohort of addicted smokers. The need for activities to prevent the initiation of smoking is paramount. It is equally essential that clinicians become aware

Figure 4. Simple concepts to guide interventions with smoking youth

1. **E**ncourage discussion about smoking at age nine.
2. **A**ccept that many youth are not daily smokers.
3. **S**uggest the use of NRT to addicted young smokers.
4. **Y**outh respond to individualized, innovative approaches.

NRT = nicotine replacement therapy

of opportunities to assist young smokers with cessation. Ontario's Cancer 2020 initiative aspires to reduce youth smoking rates to 2% or less by the year 2020, a laudable goal. Our youth deserve nothing less.

Jane Brownrigg, RN, BScN, a member of the staff at the Minto Prevention and Rehabilitation Centre, has extensive experience in smoking cessation with youth as a member of the exposé smoke-free youth initiative. A member of the Smoke-Free Ottawa Bylaw team, Ms. Brownrigg contributed to the development of the Ontario Smoke-Free Strategy.

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Disclosure Statement: In the past 12 months, Dr. Pipe has received research support, speaking, and consulting fees from Pfizer.

Ms. Jane Brownrigg has no disclosures to announce in association with the contents of this issue.

This publication is made possible by an educational grant from

Pfizer Canada Inc.

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