



PREVENTION OPPORTUNITIES UNDER THE BIG SKY

Use of Both Cigarettes and Smokeless Tobacco is High in Montana

Tobacco use is the single most preventable cause of premature death in the United States.¹ Smoking and exposure to secondhand smoke adversely effect nearly every organ of the body.¹ Smokeless tobacco (SLT) contains 28 known carcinogens and increases the risk of oral and pancreatic cancer. In addition, SLT is associated with an increased risk of fatal heart attack and stroke.²

Nicotine is highly addictive, and both cigarettes and SLT products contain significant amounts of nicotine. The amount of nicotine absorbed by the body varies by tobacco product. Most tobacco users require multiple quit attempts before successfully ending their nicotine addiction.³ Use of more than one tobacco product may create a greater nicotine dependency, and researchers speculate that it may be harder for these users to successfully quit. This issue of *Montana Public Health* presents data from the Behavior Risk Factor Surveillance System to examine the characteristics of current cigarette smokers, current SLT users and the characteristics of cigarette smokers who also use SLT.

Cigarette Smoking In 2009, the smoking prevalence among Montana adults was 17% (Table), the 15th lowest smoking prevalence among the states.⁴

The prevalence of smoking is not statistically different between men and women. Smoking prevalence does vary significantly by age, race, and income level. Smoking was highest among adults aged 18 to 34 years. American Indians had a significantly higher smoking prevalence compared to non-American Indians (43% versus 15%). Low income adults (household income less than or equal to 100% of Federal Poverty Level) also had a greater smoking prevalence than adults with a higher income.

Smokeless Tobacco Use In 2009, the prevalence of SLT use was 7%. Despite a relatively low smoking prevalence, Montana had the 4th highest percentage of SLT users in the United States.⁴

SLT use varied significantly by gender and age. Thirteen percent of men use SLT compared to 2% of women ($p < 0.05$). Adults aged 18 to 34 and 35 to 54 years had a higher prevalence of SLT use than did those aged 55 years or older. SLT use by American Indians and by low income persons was higher, albeit not statistically significant, than by non-American Indians and persons with higher incomes ($p > 0.05$).

Smokeless Tobacco Use among Cigarette Smokers

Approximately 12% of cigarette smokers also use SLT (dual use). Montana had the 2nd highest percentage of smokers who also used SLT.⁴

SLT use among cigarette smokers was significantly higher among men than women ($p < 0.05$; Table). Although dual use among any age group was not statistically different from another, there was a significant trend of decreased use with increasing age (Chi Square test $p < 0.05$).

Table. Prevalence of current smoking, current smokeless tobacco (SLT) use, and percentage of current smokers who also use SLT among adults, Behavioral Risk Factor Surveillance System, 2009

<u>Characteristic</u>	<u>Current Smoker % (95% CI)</u>	<u>Current SLT user % (95% CI)</u>	<u>Current smokers who use SLT % (95% CI)</u>
Total	17 (16-18)	7 (6-9)	12 (9-16)
Gender			
Men	16 (14-19)	13 (12-15)	17 (12-23)
Women	17 (16-19)	2 (1-2)	8 (5-11)
Age group (yrs)			
18-34	23 (19-27)	10 (8-14)	15 (9-24)
35-54	18 (16-20)	9 (8-11)	12 (8-16)
55+	11 (10-12)	3 (3-4)	8 (6-11)
Race			
Am. Indian	43 (36-50)	14 (8-22)	—
Non-Am. Indian	15 (14-17)	7 (6-8)	11 (9-14)
Household Income			
≤ 100% Federal Poverty Level	37 (32-43)	12 (8-18)	—
> 100% Federal Poverty Level	14 (13-16)	7 (6-8)	12 (9-15)

— There were too few respondents to calculate a reliable estimate.

Smokeless Tobacco and Harm Reduction As smoking has become increasingly prohibited in public places, SLT has been marketed to smokers as a means both to fix a nicotine craving and to use in public places. However, using SLT as a strategy to lessen the harm caused by cigarette smoking or to wean smokers off cigarettes is not appropriate. Evidence is lacking to support the contention that SLT is a safe and long-term strategy for smoking cessation.² A recent study found that unsuccessful attempts to quit smoking in the previous 12-months were higher among cigarette smokers who used SLT compared to cigarette smokers who never used SLT.⁵ Smokeless tobacco is not a safe alternative to smoking nor is it a recommended smoking cessation product.

Recommended ways to quit The 2008 Clinical Practice Guideline for Treating Tobacco Use and Dependence recommends that healthcare providers consistently document the tobacco use status of patients.³ The guideline also recommends both cessation counseling and cessation medication. Recommended cessation medications include: over-the-counter Nicotine Replacement Therapy (NRT) (patches, lozenges or gum) and prescription medication such as wellbutrin, bupropion, or varenicline (Chantix®).³ Tobacco users who participate in coaching sessions and receive free or reduced cost medication from the Montana Tobacco Quit Line have experienced great success. Six-month quit rates (seven day point prevalence) for participants who participate in coaching sessions and choose medication are 31% for NRT, and 32% for Chantix®.

Recommendations for healthcare providers of tobacco users

Ask all patients about tobacco use

Advise to quit

Assess willingness to quit

Assist with quitting

Arrange for follow-up

- Consider flagging the charts of patients who use tobacco to prompt the cessation conversation each time they visit the office.
- Refer patients who want to quit to the Montana Tobacco Quit Line (1-800-QUIT-NOW) and use the fax referral system.
- Stock quit line materials and give the materials to patients.

For more information about the Montana Tobacco Quit Line or how your patients can obtain free or reduced cost medication contact Heather Beck at hbeck@mt.gov or (406) 444-7373.

References:

1. U.S. Department of Health and Human Services. *How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General*. Atlanta, GA 2010.
2. Piano MR, Benowitz NL, Fitzgerald GA, et al. Impact of smokeless tobacco products on cardiovascular disease: implications for policy, prevention, and treatment: a policy statement from the American Heart Association. *Circulation*. 2010;122:1520-1544.
3. A clinical practice guideline for treating tobacco use and dependence: 2008 update. A U.S. Public Health Service report. *Am J Prev Med*. 2008;35:158-176.
4. Centers for Disease Control and Prevention. State-specific prevalence of cigarette smoking and smokeless tobacco use among adults --- United States, 2009. *Morb Mortal Wkly Rep*. 2010;59:1400-1406.
5. Tomar SL, Alpert HR, Connolly GN. Patterns of dual use of cigarettes and smokeless tobacco among US males: findings from national surveys. *Tob Control*. 2010;19:104-109.

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