Public – To be published on the Trust external website

# Title: Medicines & Smoking

# Ref: PHARM-0000-v9

**Status: Approved**
**Document type: Guidance**
**Overarching policy: Medicines Overarching Framework**

## Contents

# 1. Guidance

To comply with the Trust's Nicotine Management Policy and the NICE guidelines for smoking cessation in secondary care (PH 48, Nov 2013); smokers will need to stop smoking whilst in Trust buildings and grounds during an inpatient admission.

During an in-patient admission a smoker has three options:

## 1.1. Option 1 - Patients but who do not intend to stop smoking (at discharge) but are suffering acute nicotine withdrawal

- Patients suffering acute nicotine withdrawal can be prescribed NRT to help with withdrawal symptoms (which may include agitation, headaches, moodiness, irritability, nervousness, fidgeting, anger, and cigarette craving)
- All inpatients will be given the opportunity for stop smoking support while in the Trust's care.
- No NRT will be given on discharge to patients who do not intend to stop smoking
- The telephone number of the relevant NHS Stop Smoking Service (SSS) will be given on discharge and if contacted will arrange an appointment as soon as possible
- e-cigarettes can also be used - see Nicotine Management Policy

## 1.2. Option 2 - Patients who are motivated to stop smoking and are suffering acute nicotine withdrawal

- Patients will be offered NRT
    - On discharge the patient will be given 7 days' supply of NRT and advised on future support
    - The SSS will be informed, and referral arrangements confirmed
    - The GP practice will be informed of NRT provided at discharge and referral arrangements to SSS
- e-cigarettes can also be used - see Nicotine Management Policy

## 1.3. Option 3 - Patients abstaining from smoking but not suffering acute nicotine withdrawal

- Support should be offered, and withdrawal symptoms monitored
- If withdrawal symptoms occur NRT should be considered

Regardless of which option the patient chooses, every smoker should be offered NRT to manage their tobacco dependence within 30 minutes of arrival to an inpatient unit.

## 2. Smoking and medication

- Tobacco smoke contains polycyclic aromatic hydrocarbons within the tar that increase the activity of certain hepatic enzymes (CYP1A2 in particular).
- Many commonly used medicines are substrates for CYP1A2: theophylline, fluvoxamine, caffeine, coumarins including warfarin and the antipsychotics clozapine and olanzapine.
- Smokers taking a medication that is metabolised by this enzyme may require higher doses than non-smokers.
- When people stop or reduce their smoking, there can be a decrease in enzyme activity with a corresponding increase in drug levels: hence they may require a reduction in the dosage of the interacting medication. Conversely if non-smokers restart smoking, a dose increase should be anticipated to maintain therapeutic levels.
- Not all possible drug-smoking interactions are clinically significant.
- For patients taking clozapine, haloperidol or olanzapine who are intending to stop smoking, advice should be sought from the clozapine clinic staff or consultant psychiatrist who will formulate a plan, to ensure the patient's ongoing safety.
- For a full list of psychotropic drugs affected by smoking cessation see Medication Safety Series 25
- Appendix 1 highlights the impact on physical health medicines.
- Information should be given to service users and carers regarding the likely need to increase the dose of their medication if they start smoking again.

Not all possible drug-smoking interactions are clinically significant. Important factors that determine the clinical significance of an interaction in smokers are:

- The extent to which the medicine is metabolised by the enzyme CYP1A2.
- The therapeutic index of the medicine metabolised (where there is little difference between therapeutic and toxic doses).
- See MSS25 for specific advice relating to medicines including clozapine and olanzapine.

## 3. Stop smoking products including NRT

### 3.1. Nicotine replacement therapy

Several different forms of NRT can be prescribed; the preparation chosen should be safe for the patient and most likely to succeed.

All NRT should be used for 8-12 weeks but may be continued after this time.

First line options are NRT patches, lozenges, inhalators, and mouth spray

| **Treatment Choices** | Administration | Dose |
|---|---|---|
| Patch | Record administration on a Patch Chart to ensure site rotation. Apply on waking to dry non-hairy skin on the hip, trunk, or upper arm. Avoid applying to broken, red or irritated skin.<br>Skin sites should not be re-used for at least 7 days. Only one patch should be worn at a time.<br>Exercise may increase absorption of nicotine and therefore side effects.<br>Patients/staff should not try to alter the dose of the patch by cutting it up | Individuals who smoke more than 10 cigarettes a day should apply a high strength patch daily for 6-8 weeks, followed by a medium patch for two weeks, then the low strength patch for the final two weeks.<br>Individuals who smoke fewer than 10 cigarettes a day can start with the medium strength patch for 6-8 weeks followed by a low strength patch for 2 weeks. |
| Lozenges | One lozenge should be placed in the mouth and allowed to dissolve – suck until taste becomes strong, then 'park' at side of the mouth. It should be moved from one side of the mouth to the other until completely dissolved (approximately 20-30 minutes).<br>Do not chew or swallow whole. Use of coffee, acid drinks and soft drinks at the same time may decrease absorption of nicotine and should be avoided for 15 minutes prior to sucking lozenge. | One lozenge should be used every 1-2 hours when the urge to smoke occurs.<br>Individuals smoking less than 20 cigarettes a day should use the lower strength lozenge and those who smoke more than 20 a day should use the higher strength lozenge.<br>Patients should not exceed 15 lozenges a day. |
| Mouth spray | The spray should be released into the mouth holding it as close to the mouth as possible and avoiding the lips.<br>The patient should not inhale whilst spraying and avoid swallowing for a few seconds after use. | One-two sprays in the mouth when the urge to smoke occurs or to prevent cravings.<br>Not more than 2 sprays per episode (up to 4 sprays every hour)<br>Patients should not exceed 64 sprays daily |
| Inhalator | Insert cartridge into the device and draw in air through the mouthpiece. | To be used when the urge to smoke occurs.<br>The maximum of six 15 mg cartridges daily. |

| | | |
|---|---|---|
| (each cartridge) | Each session can last for approximately five minutes.<br>The amount of nicotine from one puff of the cartridge is less than a cigarette, so it may be necessary to inhale more often. | A single 15 mg cartridge lasts approximately 40 minutes of use.<br>Record when the inhalator is given to the patient. |

The detailed guidance on prescribing contained in the current edition of the British National Formulary (BNF) must be followed.

Prescribers must prescribe within their own competencies, comply with current legislation, Trust policies for prescribing and professional guidance.

## 3.2. Bupropion

**Bupropion** is contraindicated in bipolar affective disorder, epilepsy, CNS tumours, alcohol withdrawal, benzodiazepine withdrawal and eating disorders. It should not be prescribed with other drugs that can cause seizures. This includes tricyclic antidepressants and some antipsychotic medicines. **In view of the above bupropion is not approved for smoking cessation within TEWV. Treatment may however be continued if initiated prior to admission.**

Bupropion is not approved for use for smoking cessation in an in-patient setting in TEWV Foundation Trust.

## 3.3. Varenicline

**Varenicline:** has been linked to depression, suicidal ideation, and exacerbation of underlying psychiatric illness. Other side effects include sleep problems and anxiety. **Varenicline has not been approved for use within TEWV. Treatment may however be continued if initiated prior to admission.**

Varenicline is not approved for use to support smoking cessation in an inpatient setting in TEWV Foundation Trust.

Electronic cigarettes are not classified as a medicinal product and cannot be prescribed as an alternative to nicotine replacement therapy (NRT). They should only be used by staff and patients in line with the Trust smoking policy

# 4. Access to NRT during an inpatient admission

To treat nicotine withdrawal symptoms effectively and provide the most comfort to the smoker, the patient should be offered NRT within 30 minutes of arrival on a ward. This requires a prescription of an appropriate NRT product (see above) on EPMA by a prescriber.

The detailed guidance on prescribing contained in the current edition of the British National Formulary (BNF) must be followed.

Prescribers must prescribe within their own competencies, comply with current legislation, Trust policies for prescribing and professional guidance.

# 5. How this guidance will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

## 5.1. Training needs analysis

Identified in the Nicotine Management Policy.

# 6. How the implementation of this guidance will be monitored

Identified in the Nicotine Management Policy.

# 7. Related Documents

The Medicines Overarching Framework defines compliance requirements for prescribing and initiating treatment safely which you must read, understand, and be trained in before carrying out the procedures described in this document.

CORP-0002 Nicotine Management Policy

## 7.1. References

Bazire, S. (2020). Psychotropic Drug Directory.

Bleakley, S. & Taylor, D. (2013). The Clozapine Handbook.

Meyer, J.M & Stahl, S.M (2020). Stahl's handbooks: The Clozapine Handbook.

SPS (July 2020 Update) – What are the clinically significant drug interactions with Tobacco smoking?

Taylor, D et al. (2021). The Maudsley Prescribing Guidelines in Psychiatry (14th Edition)

## 8. Document control (external)

To be recorded on the policy register by Policy Coordinator

| Required information type | Information |
|---|---|
| Date of approval | 28 November 2024 |
| Next review date | 01 December 2027 |
| This document replaces | PHARM-0000-v8 – Stop Smoking Products Guidance |
| This document was approved by | Drug & Therapeutics Committee |
| This document was approved | 28 November 2024 |
| This document was ratified by | n/a |
| This document was ratified | n/a |
| An equality analysis was completed on this policy on | n/a – generic pharmacy EIA applies |
| Document type | Public |
| FOI Clause (Private documents only) | n/a |

**Change record**

| Version | Date | Amendment details | Status |
|---|---|---|---|
| 6.1 | 26/7/18 | 26/7/18 – page 12 – homely remedy for NRT can be used for up to 7 days in prisons. | Superseded |
| 7.0 | 22/11/18 | Full review – no changes | Superseded |
| 8.0 | 25/5/21 (delayed publication until 13/12/21) | Full review. New template. Medicines and smoking impact added in appendix 1 and referenced in text. | Superseded |
| 9.0 | 28 Nov 2024 | Full review – minor changes to wording of main content<br>Appendix 1 reduced with signposting to MSS25 | Approved |

| | | | |
|---|---|---|---|
| | | Reference and content relating to “homely remedy” supply of NRT removed | |

# Appendix 1: Smoking and the effect on medicines including clozapine.

**The MHRA advised in October 2009 that the most important medicines to consider in those who smoke, or are trying to quit, include THEOPHYLLINE, OLANZAPINE, CLOZAPINE, CAFFEINE and WARFARIN. In 2020, the MHRA issued a reminder to prescribers of the impact of smoking/changes to smoking status on CLOZAPINE.**

**Note: Only tobacco (or cannabis) smoking (including passive smoking) induces hepatic enzymes; cannabis vaping devices may also have an effect. Nicotine replacement, nicotine vaping devices, and electronic cigarettes (which do not contain polycyclic aromatic compounds) have no effect on enzyme activity.**

MSS25 highlights the effects of smoking cessation on psychotropic drugs. However, it is essential to consider the potential effects on all medication prescribed, in particular the following physical health drugs:

- **Warfarin** is partly metabolised via CYP1A2. An interaction with smoking is not clinically relevant in most patients. If a patient taking warfarin **stops smoking**, their INR might increase so monitor the INR more closely. It may take up to a week after stopping smoking to see the full effect on the INR.
- Smoking is associated with poor glycaemic control in patients with diabetes. Smokers may require higher doses of **insulin,** but the mechanism of any interaction is unclear. If a patient with insulin-dependent diabetes stops smoking, their dose of insulin may need to be reduced. Advise the patient to be alert for signs of hypoglycaemia and to test their blood glucose more frequently.
- **Methadone** is metabolised by numerous enzymes within the liver, if a patient taking methadone stops smoking, they should be monitored for signs of methadone toxicity and the methadone dose should be adjusted accordingly.
- Other physical health drugs which may be affected by changes in smoking status include aminophylline/theophylline, erlotinib, riociguat and flecainide.

Advice should be sought from the clozapine clinic team or consultant psychiatrist to formulate a plan for people taking clozapine who wish to stop smoking, to ensure the patient's on-going safety.

# Appendix 2 – Approval Checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

| | Title of document being reviewed: | Yes/No/ Not applicable | Comments |
|---|---|---|---|
| **1.** | **Title** | | |
| | Is the title clear and unambiguous? | Yes | |
| | Is it clear whether the document is a guideline, policy, protocol or standard? | Yes | |
| **2.** | **Rationale** | | |
| | Are reasons for development of the document stated? | Yes | |
| **3.** | **Development Process** | | |
| | Are people involved in the development identified? | Yes | |
| | Has relevant expertise has been sought/used? | Yes | |
| | Is there evidence of consultation with stakeholders and users? | Yes | |
| | Have any related documents or documents that are impacted by this change been identified and updated? | Yes | |
| **4.** | **Content** | | |
| | Is the objective of the document clear? | Yes | |
| | Is the target population clear and unambiguous? | Yes | |
| | Are the intended outcomes described? | Yes | |
| | Are the statements clear and unambiguous? | Yes | |
| **5.** | **Evidence Base** | | |
| | Is the type of evidence to support the document identified explicitly? | Yes | |
| | Are key references cited? | Yes | |

| | Title of document being reviewed: | Yes/No/ Not applicable | Comments |
|---|---|---|---|
| | Are supporting documents referenced? | Yes | |
| **6.** | **Training** | | |
| | Have training needs been considered? | Yes | |
| | Are training needs included in the document? | yes | In Nicotine Management Policy |
| **7.** | **Implementation and monitoring** | | |
| | Does the document identify how it will be implemented and monitored? | Yes | |
| **8.** | **Equality analysis** | | |
| | Has an equality analysis been completed for the document? | Yes | |
| | Have Equality and Diversity reviewed and approved the equality analysis? | Yes | See generic pharmacy EIA |
| **9.** | **Approval** | | |
| | Does the document identify which committee/group will approve it? | Yes | |
| **10.** | **Publication** | | |
| | Has the document been reviewed for harm? | Yes | |
| | Does the document identify whether it is private or public? | Yes | |
| | If private, does the document identify which clause of the Freedom of Information Act 2000 applies? | N/A | |