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Quit to Win

Tobacco Cessation Program

Navy Environmental Health Center, Health Promotion, 620 John Paul Jones Circle STE 1100, Portsmouth VA 23708-2111
voice (757) 953-0959 (DSN 377) Fax: DSN 377-0688; homepage: www-nehc.med.navy.mil/hp/tobacco/index.htm

Women and Tobacco Use: A Terrible Combination

The history of women using tobacco has been a very brief one compared to that of men. It was not until the 1960's that it became "socially acceptable" for women to use tobacco in public with the same degree of freedom and acceptance as men. When the advertising phrase "You've come a long way baby" came into vogue, women were well on their way to using, and ultimately suffering, from tobacco as much as their male counterparts.

What has this equality gotten for women? Well let us look at these facts from the 2001 Surgeon General's Report concerning Women and Tobacco use. (1)

1. The leading cause of cancer death for women is now lung cancer. In the mid-1980's, breast cancer was surpassed by lung cancer as the leading cause of cancer death and this can be directly linked to the increased rates of tobacco use among women. Since 1950, lung cancer mortality rates for women have increased 600%.
2. Nearly one out of every five women uses tobacco, which equates to a 22% national usage rate.
3. Female smokers in the United States will have an average of 14.5 years taken off each of their lives due to their tobacco use. That means that nearly an entire generation of grandchildren will have very little time with the chance to have their grandmothers watch them graduate from high school!
4. This year 178,000 women will die prematurely in the United States because of their tobacco use.
5. According to the 2001 Surgeon General's Report, women now account for 39% of smoking related deaths in the US.
6. Also in the 2001 SG's report, 3 million women have died <u>prematurely</u> since 1980 due to smoking.

The above facts are very disturbing but this is just the "tip" of the iceberg as they learned on the Titanic! There are some additional problems related to women and tobacco use, which we need to discuss. Let us examine some issues surrounding pregnancy and fertility. **(2)**

1. Smoking during pregnancy is directly linked to:
   a. Low birthweight
   b. More problems during the pregnancy
   c. Spontaneous abortion
   d. High risk of Sudden Infant Death Syndrome.
2. Nicotine during pregnancy is a known fetal neurotoxin- a poison of the fetuses developing brain.
3. Women that smoke are less fertile than their non-smoking counterparts.
4. For every $1 spent on prevention of smoking during pregnancy, there will be $6 saved in healthcare costs related to peri- and postpartum complications related to tobacco use during pregnancy. (3)
5. Studies have shown that in certain socio-economic communities, which include the non-college bound population, 54% of the women that report for their first pregnancy visit are still smoking. Studies also show that 16% of women had quit once they learned they were pregnant. That means that 70% of non-college bound women were smoking prior to pregnancy. (3)

Now let us look at the third important aspect of this equality

of tobacco use as it relates to treating nicotine addiction. In all fairness, I should rephrase it to the "inequality" of treating nicotine addiction in women. Clinical experience in helping women quit has led me, as well as other leading nicotine addiction experts, to understand that women often have more problems with quitting than their male counterparts.
Let us look at a few differences that **may** make it more difficult for women to quit.

1. The monthly menstrual cycle

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poses some problems that must be addressed at the beginning of any treatment effort. Many women find that they smoke more during the "PMS" portion of their cycle. The main reason is that nicotine has been shown to have a palliative affect on PMS symptoms. Anyone that does not address this fact will be setting-up the quit attempt for some serious problems. I have always addressed this issue with my female patients and made sure they knew that they might need more nicotine during that part of their cycle. The use of Bupropion, though, seems to have greatly reduced this problem. A possible explanation is related to the fact that Bupropion is an anti-depressant and the b.i.d. dose of the 150mg SR medication may have some level of anxiety relief for the user. It is know that Bupropion is a nor-epinephrine and dopamine re-uptake inhibitor which may also explain some palliative effect.

2. Women are much more aware of any discomfort associated with their treatment. Providers, counselors **and facilitators are encouraged** to anticipate problems and listen carefully to **issues and** complaints.
3. The "social image" of a woman may be affected when she gives up her tobacco product. Many social settings use cigarettes as "ice breakers". Many women model their tobacco use to that seen on the big screen, television, and other media sources. I have found that women really enjoy the "feel" of just holding a cigarette. Thus, we must be prepared to provide for the "social crutch" of tobacco use. Fake cigarettes (Smoker's Option- http://www.smokersoption.com), straws, and coffee stirrers are just some examples of cigarette-image substitutes.
4. Even women who smoke a few cigarettes may have a very powerful addiction to nicotine. First let me state that there are **NO light or low tar cigarettes** when it comes to looking at any aspect of health benefit. The tobacco industry started this ploy back in the 70's in order to mislead the public. The only difference in cigarettes of same size and weight is the amount and size of air holes immediately in front of the filter. Supposedly, the bigger and more plentiful the holes, the lighter the tar and nicotine content that the smoker inhales. All studies to this point show this to be very inaccurate. Studies have shown no health benefits to lower tar and nicotine cigarettes. One very simple explanation is seen by the way that women, more so than men, hold the cigarette. Women hold the cigarette just in front of the filter thus blocking the holes and inhaling more of the toxins and nicotine. Another difference is that women wear lipstick and lip-gloss. The residue from these items can get in these holes and cause a greater inhalation of toxins and nicotine.
5. Perhaps the "biggest" difference between men and women in quitting is the fear of weight gain. This fact must be addressed at the onset of treating the nicotine addiction. Young women in high school and college have learned that nicotine is a powerful appetite suppressant and they feel that staying "slim" outweighs the risks of tobacco use. I have found that nicotine gum is a very big help when looking at the medications used in nicotine replacement therapy. The patch works, but I have found that using the gum works even better because people don't eat food when they have gum in their mouth! Another issue is that the 4mg gum is more effective for women than the 2mg gum due mostly to the higher levels of nicotine compensating for the decreased surface absorption area in the woman's oral cavity.

As you can see, there are some very important gender differences in treating the addiction of nicotine. In recent studies, it was shown that 70% of tobacco users wanted to quit their tobacco habit when asked about their habit and offered help in quitting. When you

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broke out gender- 78% of women wanted this help. (4) The women using tobacco want help in quitting and we must be prepared to help them. The VA/ DoD Primary Care Tobacco Use Cessation Guidelines (5) are perfect tools for helping **Medical and Dental** providers help their patients to quit. The Virginia Slims ad slogan of "You've Come a Long Way Baby" has a horribly chilling meaning today and for the future of women worldwide. We must get the message out that tobacco use is not a social acceptable image, but one of misery and death. We must also do more to inform women that we have the tools to help them effectively quit their nicotine addiction.

References

(1) *Women and Smoking: A Report of the Surgeon General- 2001*; http://www.cdc.gov/tobacco/sgr/sgr_forwomen/sgr_women_chapters.htm

(2) *Health Consequence of Tobacco Use Among Women — Fact Sheet*; http://www.cdc.gov/tobacco/sgr/sgr_forwomen/factsheet_consequences.htm

(3) Public Testimony by Ms. Carter-Gaffney representing the National Partnership to Help Pregnant Smokers Quit; presented during the Tobacco Cessation Subcommittee Meeting of the Interagency Committee on Smoking and Health; 24 October, 2002, Washington, D.C.

(4) *Treating Tobacco Use and Dependence*. Quick Reference Guide for Clinicians, October 2000. U.S. Public Health Service. http://www.surgeongeneral.gov/tobacco/tobaqrg.htm

(5) *Tobacco Use Cessation (TUC) Clinical Practice Guideline*, 1999; http://www.oqp.med.va.gov/cpg/TUC/TUC_Base.htm

(6) *Tobacco Use and Women http://www.4woman.gov/editor/nov02/nov02.htm*

Guest Editor

Captain Larry Williams, D.C., USN Military Medical Support Office Great Lakes 847-688-3950 ext 723 DSN 792
e-mail lnwilliams@mmso.med.navy.mil

Conferences

Society for Research on Nicotine and Research annual meeting to be held in New Orleans February 19-22, 2003 For additional information www.srnt.org/meeting/default.html

DoD Health Promotion Conference in San Diego, CA May 12-15, 2003. Featured speakers are Dr. Keith Haddock, UMKC, on the Latest Research on Tobacco Cessation and Dr. Herb Severson of the Oregon Research Institute on Smokeless Tobacco.

World Conference on Tobacco or Health in Helenski, Finland August 3-8, 2003. Contact http://www.wctoh2003.org/main.html

Facilitator Training

Health Promotion at Naval Medical Center Portsmouth offers a basic one day Tobacco facilitator training! Contact agfitzpatrick@mar.med.navy.mil or visit the NEHC HP Tobacco training website for dates www-nehc.med.navy.mil/hp/tobacco/training

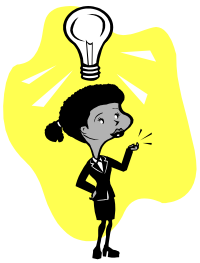
Training

Are you offering a Tobacco facilitator training? Train the Medical/Dental Provider in Tobacco Interventions? Please contact Mark Long to pass the word!

Self Help Resources

Do you recommend the links, programs, and resources on the NEHC Tobacco Page to tobacco users who want to quit ? http://www-nehc.med.navy.mil/hp/tobacco

Do you have any materials that you have developed or found to be helpful? Please contact Mark Long.



Ideas?

Have a question? Idea for an article? Something to contribute to the newsletter? Please contact Mark Long at longm@nehc.med.navy.mil