Real world evidence

Jaime Correia de Sousa, MD, PhD

President of the IPCRG

Associate Professor, School of Medicine,
University of Minho, Portugal

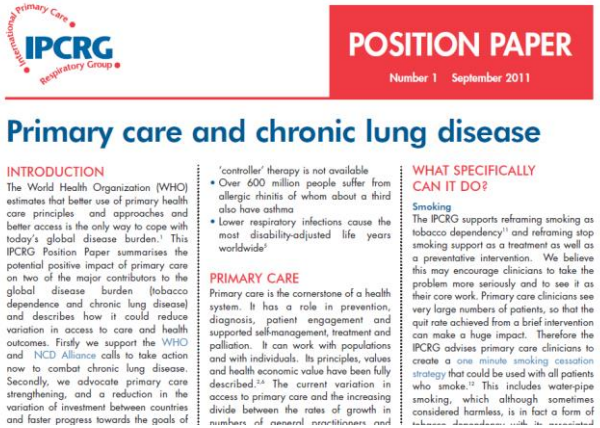
Family Physician in Porto, Portugal

Where can primary care add value?

Primary care is associated with a more equitable distribution of health in populations.

It can deliver cost-effective:

- Care
- Smoking cessation
- Vaccination: flu, pneumococcal
- Maternal health and information about smoke exposure
- Diagnosis and management of multi-morbidity
- Diagnosis and treatment of allergic rhinitis in children and adults
- Diagnosis and treatment of asthma in children and adults, action plans, routine monitoring and referral where appropriate
- Diagnosis and treatment of COPD, including smoking cessation, inhaled medicines, referral for pulmonary rehabilitation and to hospital specialists where necessary



IPCRG

POSITION PAPER

Number 1 September 2011

Primary care and chronic lung disease

INTRODUCTION

The World Health Organization (WHO) estimates that better use of primary health care principles and approaches and better access is the only way to cope with today's global disease burden.[1] This IPCRG Position Paper summarises the potential positive impact of primary care on two of the major contributors to the global disease burden (tobacco dependence and chronic lung disease) and describes how it could reduce variation in access to care and health outcomes. Firstly we support the WHO and NCD Alliance calls to take action now to combat chronic lung disease. Secondly, we advocate primary care strengthening, and a reduction in the variation of investment between countries and faster progress towards the goals of

'controller' therapy is not available

- Over 600 million people suffer from allergic rhinitis of whom about a third also have asthma
- Lower respiratory infections cause the most disability-adjusted life years worldwide[2]

PRIMARY CARE

Primary care is the cornerstone of a health system. It has a role in prevention, diagnosis, patient engagement and supported self-management, treatment and palliation. It can work with populations and with individuals. Its principles, values and health economic value have been fully described.[3,4] The current variation in access to primary care and the increasing divide between the rates of growth in

WHAT SPECIFICALLY CAN IT DO?

Smoking

The IPCRG supports reframing smoking as tobacco dependency[11] and reframing stop smoking support as a treatment as well as a preventative intervention. We believe this may encourage clinicians to take the problem more seriously and to see it as their core work. Primary care clinicians see very large numbers of patients, so that the quit rate achieved from a brief intervention can make a huge impact. Therefore the IPCRG advises primary care clinicians to create a one minute smoking cessation strategy that could be used with all patients who smoke.[12] This includes water-pipe smoking, which although sometimes considered harmless, is in fact a form of

Barbara Starfield

Working locally, collaborating globally to improve respiratory health in primary care

5th Scientific Meeting
International Primary Care Respiratory Group
IPCRG
Ljubljana, Slovenia 17-18 May 2017

Research capability & coordination

Build critical mass & common purpose
Promote research
Research Fellow (Ho Chi Minh-Leiden-Southampton)
National workshops
E-Faculty – small grants programme
Prize-winner support
Abstract review

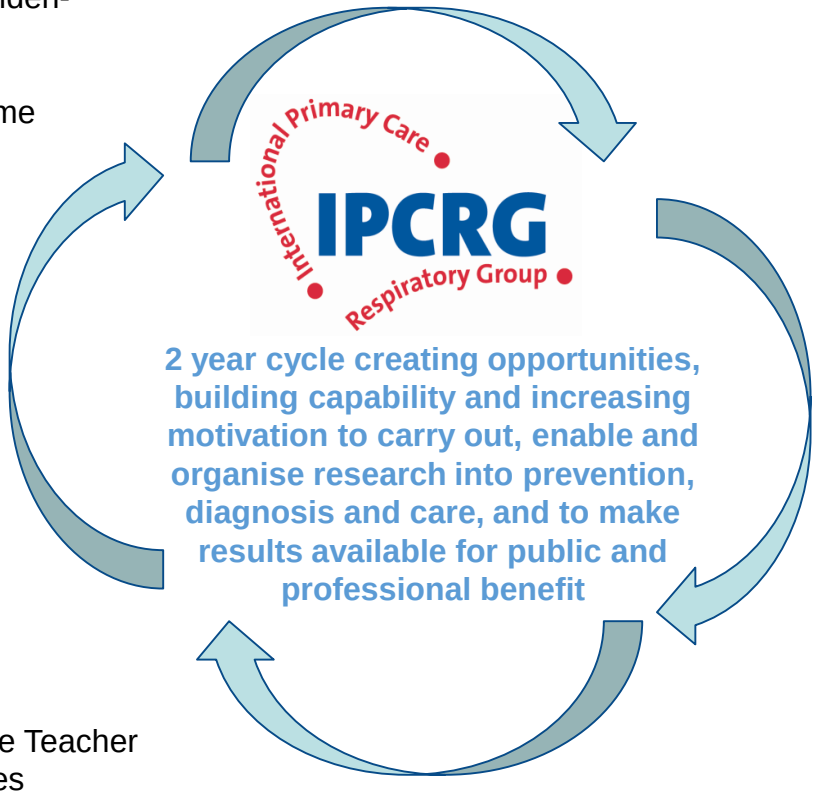
Evidence-generation

Needs led
Multi-national
UNLOCKing primary care data
Implementation eg FRESH AIR

Dissemination of collective intelligence

Publication: peer & lay
Education: International Teach the Teacher
Education: In-country programmes

Presentation of new clinical or implementation evidence or research ideas for peer review
Mentoring, rehearsal
Early career researcher network



Membership development

Build community:
Associate Corporate members
National country members
Individuals

Dissemination of collective intelligence

Publication – peer & lay
Education: International Teach the Teacher
Education: In-country programmes

Research capability and coordination

Build critical mass & common purpose
Promote research
Research Fellow (Ho Chi Minh-Leiden-Southampton)
National workshops
E-Faculty – small grants programme
Prize-winner support
Abstract review

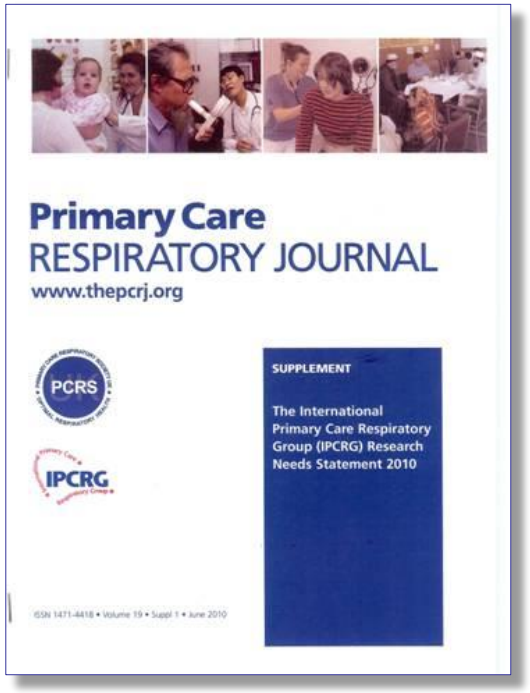
9th IPCRG World Conference
Porto, Portugal
30 May - 2 June 2018

May 2016/2018 world conferences

Presentation of evidence
Abstract peer review
Discussion about best practice
Improve confidence and elevate importance of specific actions
Develop cooperation
Review of need

npj | Primary Care Respiratory Medicine

We generate respiratory questions and evidence in primary care



2010 **145 questions**

Primary Care RESPIRATORY JOURNAL
www.thepcrj.org
Journal of the Primary Care Respiratory Society UK and the International Primary Care Respiratory Group

Home
About the PCRJ
Aims, Scope and History
Editorial Board
Online first
Current Issue
Past Issues
Supplements
Translations
Most popular articles

Volume 21 Issue 1 March 2012
Research Paper

Prioritising the respiratory research needs of primary care: the International Primary Care Respiratory Group (IPCRG) e-Delphi exercise

Pages 19-27

*Hilary Pinnock[a], Anders Østrem[b], Miguel Roman Rodriguez[c], Dermot Ryan[d], Björn Ställberg[e], Mike Thomas[f], Ioanna Tsiligianni[g], Siân Williams[h], Osman Yusuf[i]

March 2012: 62 questions:
80% consensus for 4 or 5 priority score
7 questions achieved 100% agreement:
46% about how to improve diagnosis;
19% practical management strategies

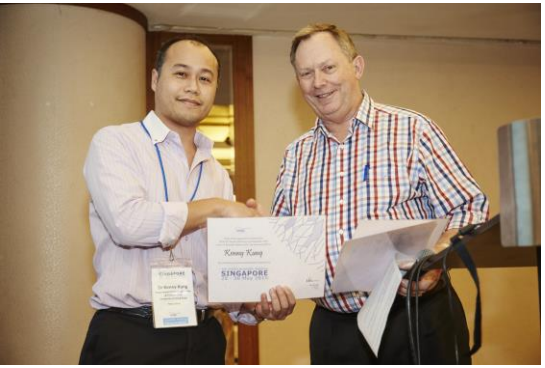
And in new regions

- First scientific meeting in Asia Pacific
- First respiratory research school
- First school prize winner
- First meeting in South Asia last year
- Slovenian meeting: primary care KOLs
- Three IPCRG directors on WHO-GARD
- President attended WHO CRD Technical Meeting including revision of WHO-PEN

We build research capacity E-Faculty, Research Fellow

Vietnam, Romania, Chile

We mentor and support the new generation



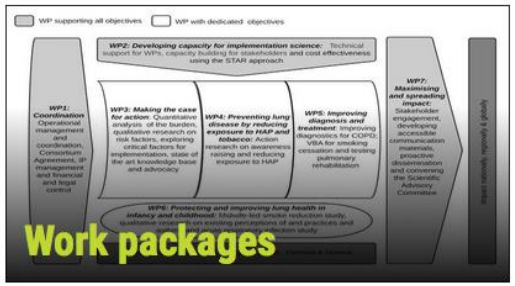
International Primary Care IPCRG Respiratory Group

FRESH AIR
global action for healthy lungs

We started the FRESH AIR movement: now a EU Horizon 2020 implement ation science project in 4 countries, 3 years

The FRESH AIR project

Welcome to the web platform of the Horizon 2020 FRESH AIR project. FRESH AIR (Free Respiratory Evaluation and Smoke-exposure reduction by primary Health Care Integrated Groups) is a three year implementation science research project to improve the prevention, diagnosis and treatment of non-communicable lung diseases in low and middle income countries (LMICs) and other low-resource settings. Read more »



Login for our members

Delen 0 Tweet Share Share this on Google+

Tweets by @FRESHAIRTeam

FRESHAIRTeam Retweeted

BTS
@BTSrespiratory

Looking to research in areas related to global #lung health, or working in low income countries? tinyurl.com/zvvtblg #BTSShortCourse

2h

FRESHAIRTeam Retweeted

Euro Lung Foundation
@EuropeanLung

#HealthyLungsFor Life supports training of healthcare professionals in Africa bit.ly/1Sca7MO

14 Apr

FRESHAIRTeam Retweeted

NIHR Research
@OfficialNIHR

Review strengthens evidence that #smoking ban improves

Embed View on Twitter

FRESH AIR

global action for healthy lungs

International Primary Care Respiratory Group IPCRG

An implementation science project to improve prevention, diagnosis and treatment of chronic lung diseases where resources are limited

- Around 90% of deaths from COPD and 80% deaths from asthma occur in low and middle-income countries (LMICs) [WHO]
- In 2010 the IPCRG established the FRESH AIR programme to explore this issue
- The European Commission has awarded Horizon 2020 funding to extend FRESH AIR
- A FRESH AIR Consortium of 14 partners has been set up to undertake research in Uganda, Greece, Vietnam and Kyrgyz Republic
- Over the three years 2016–2018 FRESH AIR will explore why so many people in LMICs are dying from chronic lung diseases and how the burden of disease from birth to death can be reduced
- FRESH AIR will use implementation science to study how to adapt evidence-based interventions in different low resource settings

To receive updates on emerging results from FRESH AIR:
Sign up at www.theipcrg.org/freshair/newsletter

www.theipcrg.org/freshair
@FRESHAIRTeam

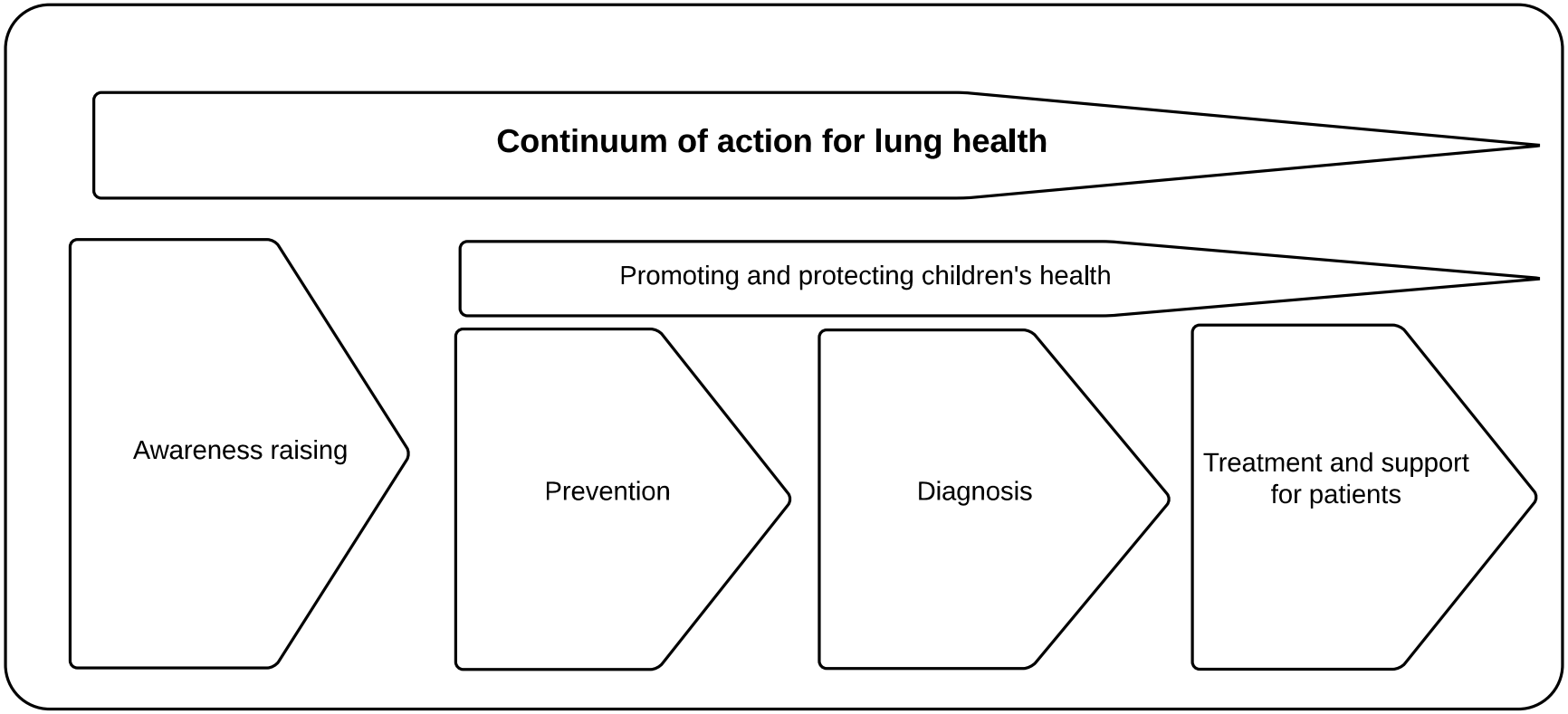
Indoor air pollution from cooking Masindi, Uganda

Smokers – the problem of tobacco dependence Crete

Spirometry testing, Highlands Kyrgyz Republic

Patient asthma and COPD club, Ho Chi Minh City, Viet Nam

The FRESH AIR concept



History

- IPCRG initiated programme
- To improve understanding of the prevalence of chronic respiratory diseases and their risk factors, including all types of smoke
- To develop capacity to implement evidence-based interventions for prevention, diagnosis and treatment of these diseases in low-resource settings

Progress so far

- Started with prevalence study in Vietnam
- Moved to Uganda with pilot, then 3-year study
- Won European Lung Foundation grant to commence some public awareness programmes in Kyrgyz Republic
- Won Horizon 2020 grant to work in these + Greece, and to build engagement in additional countries
- Interest in Georgia – developed a protocol, Hungary, Kazakhstan, sub-Saharan Africa including Eritrea, Banglalore slums

Consortium

- Leiden University Medical Centre *(Coordinator)*, Netherlands
- International Primary Care Respiratory Group *(SME),* UK
- Makerere University College of Health Sciences Uganda
- Ministry of Health Kyrgyz Republic, Kyrgyz Republic
- University of Medicine & Pharmacy, Ho Chi Minh City, Vietnam
- University of Crete, Greece
- ARTEG *(SME)*, Netherlands
- European Lung Foundation, UK
- University of Washington, USA
- National Centre for Smoking Cessation and Training *(SME)*, UK
- University of Groningen, Netherlands
- University of Copenhagen, Denmark
- (European COPD Coalition, Belgium)
- Plymouth University, UK

Overview of current H2020-funded programme

Overall aim

To improve health outcomes for people at risk of or suffering from non-communicable lung diseases in low-resource settings by developing capacity for implementation of evidence-based interventions for prevention, diagnosis and treatment in these contexts.

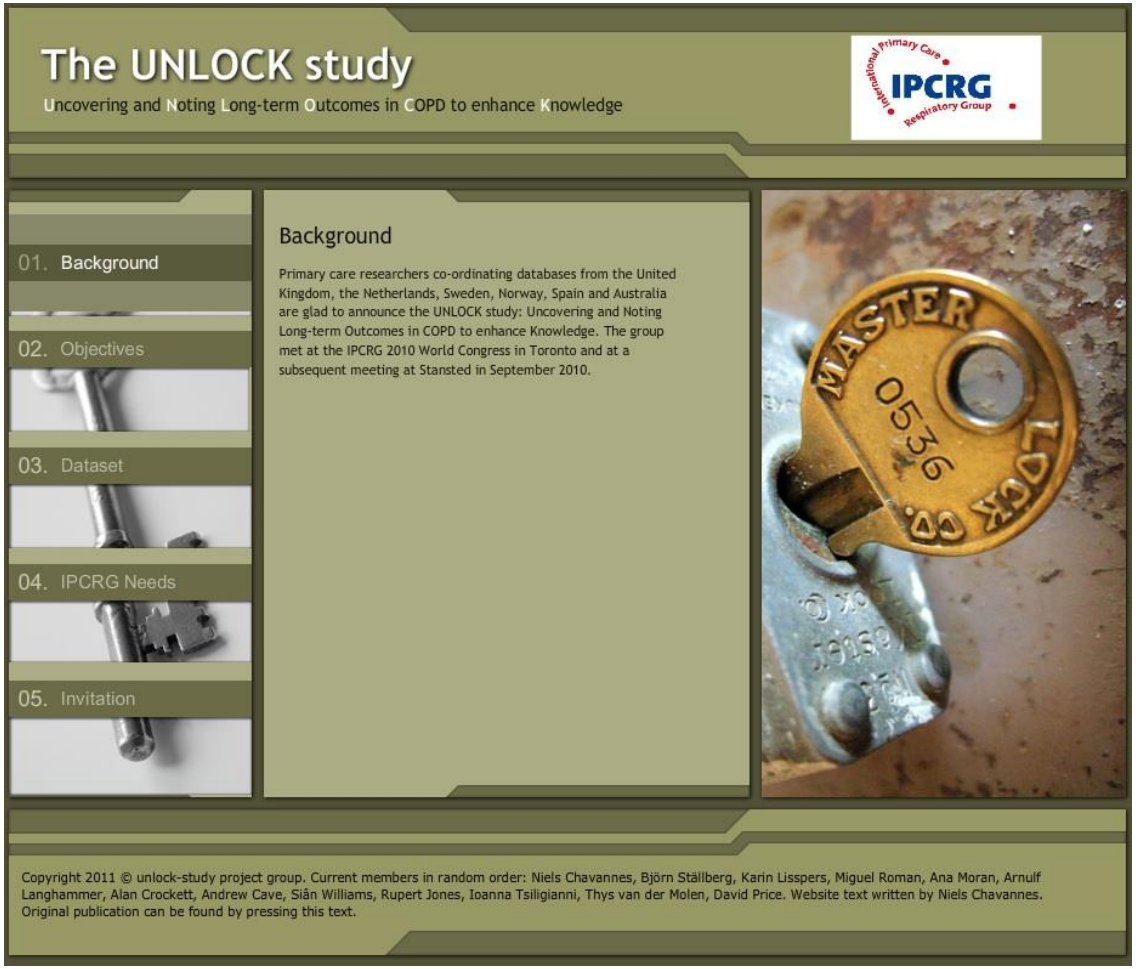
Scope

- Kick off October 2015
- End September 2018
- 7 work packages
- Activities over 36 months
- Budget of €2.99m

There are other IPCRG Projects relateed to FRESHAIR

Two major partnerships with UK centres of academic respiratory excellence

- The University of Birmingham - **BREATHEWELL**.
- The University of Edinburgh - **RESPIRE**
  - to build research capability in respiratory care in LMICs,
  - as part of new global health research initiatives funded by the National Institute for Health Research (NIHR).



We collaborate using routine primary care data: 216k COPD records; 800k asthma; 3.8 million primary care in 15 countries

UNLOCK - Who is involved?

- Initially conceived of as membership conditional on access to a dataset, in practice based on interest
- 27 individuals over 6 years
- Most have combined research/academic and clinical role, some have a research/academic role and some have a clinical role
- 15 countries : Sweden, Spain, Ukraine, Canada, Greece, UK, Netherlands, Norway, Portugal, Germany, India, USA, Australia, Uganda and Chile
- 15 have attended five or more meetings, 21 two or more
- 14 have contributed data to an UNLOCK study

The data available to UNLOCK

- Participants in the UNLOCK Group have access to 14 datasets
- One has become outdated and five have been added
- From 9 countries
- 10 datasets have been used in at least one UNLOCK study
- 3.8m primary care patients, 800,000 patients with asthma and 216,000 patients with COPD
- Variations in dataset size, purpose and variables included
- Some common variables (demographics, diagnosis, medication, smoking status)
- Routine data, cohort studies, pragmatic clinical trials
- Different ownership and governance arrangements

UNLOCK achievements

- 9 studies on the diagnosis and management of COPD, asthma and ACOS in primary care
- 9 publications
- Many presentations at conferences
- Access to data from 3.8 million PC patients across 10 countries
- A sustained network of primary care researchers from 15 very different countries

Challenges and constraints

Time, or lack it!

- Many demands on the time of UNLOCK participants due to their clinical and/or research priorities
- Studies progress as fast as the slowest responder
- Analysis, write-up and submission hugely time consuming
- UNLOCK model requires too much input from very busy people
- Ideas people vs doers

Education needs same academic rigour

MENU Primary Care RESPIRATORY JOURNAL

Altmetric: 1 Views: 190 Citations: 3 More detail

Discussion Paper

Effecting change in primary care management of respiratory conditions: a global scoping exercise and literature review of educational interventions to inform the IPCRG's E-Quality initiative

Juliet McDonnell, Sian Williams, Niels H Chavannes, Correira Jaime de Sousa, H John Fardy, Monica Fletcher, James Stout, Ron Tomlins, Osman M Yusuf & Hilary Pinnock

npj | Primary Care Respiratory Medicine

www.nature.com/npjpcrm

PERSPECTIVE OPEN

Building capacity to improve respiratory care: the education strategy of the International Primary Care Respiratory Group 2014–2020

This article has been corrected since publication and a corrigendum has also been published

Juliet McDonnell[1], Jaime Correia de Sousa[2], Noel Baxter[3], Hilary Pinnock[4], Miguel Román-Rodríguez[5], Thys van der Molen[6] and Sian Williams[1]

Significant attention has been given to the global burden of noncommunicable diseases including respiratory diseases and the potential of primary care to address this challenge. The International Primary Care Respiratory Group (IPCRG) has a potentially significant role to build capacity through research and education in a complex global network with varying degrees of capability. In this paper we outline a comprehensive strategy, which revisits the IPCRG's educational role, our aims, audiences and approach in

TEACH THE TEACHER

Difficult to manage asthma

International Primary Care IPCRG Respiratory Group

DESKTOP HELPER

No. 2 April 2012

Improving the care of adults with difficult to manage asthma: a practical guide for primary healthcare professionals

INTRODUCTION

This guide provides a systematic, practical approach to support primary care and other community healthcare professionals to improve the care of people over the age of 18 years with difficult to manage asthma.

- Difficult to manage asthma is asthma that either the patient or the clinician finds difficult to manage.
- A patient with difficult to manage asthma has daily symptoms and regular exacerbations despite apparently best treatment.

There are two main groups of patients with difficult to manage asthma:

- People whose asthma has been controlled in the past but who have now lost control.
- People whose asthma has never been controlled.

Investigations and management should aim to:

- Identify when asthma control is lost / has never been achieved by prompt and effective monitoring.
- Gain/regain control and then maintain control of asthma with effective, well-tolerated treatment.

How to investigate and improve asthma control in a patient with difficult to manage asthma

Patient has uncontrolled asthma and/or frequent (≥2/yr) asthma exacerbations

↓ YES

Patient has a confirmed diagnosis of asthma — NO → Demonstrate variable airflow limitation (spirometry, methacholine challenge)

↓ YES

Patient is not smoking / exposed to smoke — NO → Offer help to quit, including medication and referral to smoking cessation services

↓ YES

Patient is using inhalers correctly and has received adequate asthma education — NO → Provide training and information and check inhaler technique

↓ YES

Patient is adherent with asthma treatment — NO → Check pharmacy / prescription records, number of inhalations, plasma cortisol or steroid excretion level

↓ YES

Alternative or overlapping diagnosis or primary conditions have been excluded — NO → Exclude alternative diagnosis

↓ YES

Co-morbidities are optimally treated — NO → Address and optimally treat rhinosinusitis, gastric reflux, obesity, depression and anxiety

↓ YES

Exposure to sensitising and non-sensitising substances at home, hobby or work place are excluded / controlled — NO → Check environment exposure at home, hobby or work place

↓ YES

Drugs that may cause bronchoconstriction have been discontinued, wherever possible — NO → Discontinue NSAIDs, beta-blockers, hormone replacement therapy, if possible

↓ YES

Patient has prescription of high-dose inhaled corticosteroid with or without systemic corticosteroid

↓ YES

Add LABA/LTRA/other/increase dose of ICS

↓ YES

Patient has been followed and reassessed for at least 6 months — NO → Review diagnostic steps and reassess patient

↓ YES

Refer to secondary care

HOW TO REVIEW A PATIENT WITH DIFFICULT TO MANAGE ASTHMA

Regular structured review is the key measure to improve the detection and care of patients with difficult to manage asthma.

Patients with difficult to manage asthma should be reviewed every three months until treatment goals are achieved, then annually.

Before the review

Encourage patients to use a quick checklist before each visit to provide key information quickly and plan what they want to discuss with you.

At the review

SIMPLES* provides a useful acronym for the main factors to check:

Smoking

- Ask about current smoking habits and exposure to second-hand smoke. People may be more willing to be honest about their smoking in a written self-completed questionnaire.
- Encourage and support smokers to quit including medication and referral to expert stop smoking services.
- Consider alternative therapy to inhaled corticosteroids (ICS) in patients who cannot quit because smokers respond less well to ICS than nonsmokers.

Inhaler technique

- Does the patient have the best choice of inhaler for their needs?
- Observe the patient using their inhalers to ensure correct technique.
- Recheck inhaler technique on each visit.

Monitoring

Assess asthma control in a systematic way using a simple, validated tool, such as:

RCP 3 questions for assessing asthma control

In the last week/month:

1. Have you had difficulty sleeping because of your symptoms?
2. Have you had any asthma symptoms during the day?
3. Has your asthma interfered with your usual activities?

Yes to any of the above questions = uncontrolled asthma – investigate further

Yes to all three questions = increased risk of hospital admission

Pharmacotherapy

Is the patient being treated at the right step for the severity of their asthma?

- Check for both unintentional and intentional nonadherence by asking the patient about how they take their medication and by checking prescription records for their asthma medication (where this information is available) for the last six months, at every visit.
- Check the patient understands their treatment, tailoring information to their specific needs: what it is, what it is for, how it works, potential side-effects and how to minimise them.

Lifestyle

Ask patients specific questions about their exposure to factors that may worsen their asthma such as exposure to pets or occupational exposure:

- Where do you live?
- Is your house damp – does mould grow on any of the walls?
- Have you noticed anything in the environment (outside or in the home) that makes your asthma worse?
- What hobbies do you take part in?
- Have you noticed a pattern before your asthma gets worse?
- Does your asthma get better or worse at the weekends – or stay the same?

Education

Check patient understands their asthma: what it is, why treatment helps.

Support

Check what support the patient has from their family and involve the family where possible in supporting the patient's understanding of asthma and their adherence to treatment.

For tools, resources and references go to www.theipcrg.org/difficultasthma

International Primary Care Respiratory Group IPCRG

Adapt

DESKTOP HELPER

No. 4 November 2015 2nd edition

Helping patients quit smoking: brief interventions for healthcare professionals

How to help smokers quit: flowchart

Ask all patients about tobacco use (smoking or smokeless tobacco) and reassess at every clinic call/at least once a year. This alone increases quit rates. Use of e-cigarettes identifies ex-smokers at risk of relapse. Document smoking status/stage of motivation/tobacco burden for all.[1]

1. ASK: **Have you used tobacco in the last 12 months?**

No: Congratulate. Reinforce non-use. Patients should be asked about smoking for some years after quitting. People seldom relapse after 5 years' abstinence.

Yes – quit in the last 12 months: Congratulate. Ask if they need help remaining smoke free. Advise them to contact you or to seek other counselling if they have any difficulty (quitline, smoking cessation clinic or other).

Yes – current smoker: Take brief smoking history: number of cigarettes smoked a day; year started smoking; time to first cigarette; presence of smoking-related disease; previous quit attempts and what happened? Use a non-judgemental question such as "How do you feel about your smoking at this moment?" Express concern/interest not criticism.

2. ASSESS: MOTIVATION TO QUIT **On a scale from 1 – 10 how interested are you in trying to quit?**

1	2	3	4	5	6	7	8	9	10

ARE YOU INTERESTED IN QUITTING?[2]

NO, not ready:

ADVISE:
- Focus on motivation, remember motivation can be influenced- CO testing can be useful[3]
- Advise the patient on the benefits of quitting without criticism/confrontation.
- Respect the patient's decision
- Ask if you may tell the patient about the dangers of smoking
- Ask: "Is there anything that might help you consider quitting?" or "Can you imagine any benefits of quitting?"
- Offer help if the patient should change his/her mind

ARRANGE:
- Follow up: – ask patient if you should discuss smoking again at next consultation.

YES, but not yet...unsure:

ADVISE:
- Focus on their ambivalence, help them motivate themselves
- Offer help by asking:
  "What are the things you like and don't like about your smoking?"
  "Have you tried to quit before?"
  "How did you get on when you last quit?"
  "What would have to happen for your motivation score to increase?"
  "How can I help you increase your confidence in quitting? "

ASSIST:
- Explore barriers to cessation
- Offer help quitting
- Refer to quitline or other counselling, refer to smoking cessation unit if patient prefers
- Hand out written material/contact numbers

ARRANGE:
- Follow-up consultation or telephone contact within 6 months or remember to ask when you next see the patient.

YES, ready to quit:

ASSIST:
- Provide assistance in developing a quit plan
- Help patient to set a quit date
- Advise on pharmacotherapy for smoking cessation: nicotine replacement therapy (NRT) or a prescription for varenicline or bupropion when indicated
- Include the following as needed:
  - o Discuss abstinence and suggest coping strategies
  - o Encourage social support
  - o Assist in dealing with barriers such as fear of failure, stress coping, weight gain, social pressure
  - o Give nutritional advice: sleep well, avoid caffeine and alcohol
  - o Physical activity may help
  - o Withdrawal symptoms occur mostly during the first 2 weeks and are less troublesome after 4-7 weeks

ARRANGE:
- Follow-up consultations/phone calls - ideally weekly initially, then monthly.

5 A's of helping smokers quit: ASK ASSESS ADVISE ASSIST ARRANGE

BENEFITS OF QUITTING

- If you quit before the age of 30 your life expectancy returns to be similar to a non smoker's
- Pregnancy: the risk of a low birthweight baby, stillbirth and death of infants in their first 28 days drops to normal if you quit before pregnancy or during your first trimester
- Fertility increases
- Within 72 hours: blood pressure decreases, pulse rate drops, the risk of a heart attack decreases, and the ability to smell and taste increases
- Within two weeks: lung function increases, circulation improves and walking becomes easier
- Within a year: shortness of breath and fatigue improves, coughing decreases and your risk of coronary heart disease is halved
- Within 5 years: risk of ulcers decrease. The risk of cancer of the bladder, kidney, mouth, oesophagus, pancreas and throat decreases
- Within 5-15 years: the risk of having a stroke and the risk of coronary heart disease is reduced to that of a never smoker. The risk of lung cancer is half that of a continuing smoker
- Anxiety and depression decrease. The effect sizes are equal or larger than those of antidepressant treatment for mood and anxiety disorders[4]

MEDICATION

Medication should be offered to every adult patient with nicotine dependence if:
- They smoke more than 10 cigarettes a day
- And smoke within half an hour of wakening

They are particularly likely to suffer from withdrawal symptoms and should be offered pharmacological support once they set a quit date.

Nicotine Replacement therapy (NRT)

Its main effect is to reduce withdrawal symptoms and help the patient through the first two months of craving. Most patients use too low a dose for too short a time. They should use a dose that takes away withdrawal symptoms. Most people need a full dose for 2-3 months, and then they can gradually reduce the use over some months. Added success has been shown if they start NRT 14 days prior to their quit date.

Dosage: It is often wise to combine two different NRTs – a patch to last most of a 24 hour period and gum or other oral forms of NRT for craving situations during daytime.

Patch: The most common dosage forms are 14 mg/24 hours or 10 mg/16 hours for light smokers or 21 mg/24 hours – 15 mg/16 hours for heavier smokers. Some patients need more than one patch a day to control symptoms.

Possible side effects: skin rash, allergy, insomnia, wild dreams

Oral forms such as gum, inhalers, lozenges, sublingual tablets: To be administered every 1-2 hours for relief of symptoms while awake. Since nicotine is absorbed through the mucosa in the mouth it is important to instruct the patient in the use of gum carefully. Chew a few times on the gum then "park" it in the mouth.

Possible side effects: sore dry mouth, dyspepsia, nausea, headache, jaw ache. Often dose dependent.

Contraindication: Pregnancy (some guidelines allow use of some forms if quitting without pharmacotherapy is not possible). Use in children and teenagers under 18 years is unlicensed in many countries.

Varenicline

Varenicline is a nicotinic receptor partial agonist. In addition to blocking the receptor it also stimulates it, thus reducing withdrawal symptoms. In clinical trials varenicline has increased quit rates two to three fold over placebo.

Dosage: Start one week before quit date: 0.5 mg for 3 days, 0.5 mg bid for 4 days, then 1mg bid from quit date for 12 weeks.

Possible side effects: nausea and headache. There is no danger of seizures. Risk of psychiatric side effects is the same, while the risk of cardiovascular side effects is lower compared to other smoking cessation medications.

Contraindication: Pregnancy.[5]

Bupropion

Bupropion was originally developed as an antidepressant. It reduces the urge to smoke as well as symptoms from nicotine withdrawal.

Dosage: Twice daily starting with one tablet a day for a week or two prior to quit date, then regularly 150 mg bid from quit date for 7-12 weeks.

Possible side effects: Insomnia, headache, dry mouth, dizziness, anxiety, elevated blood pressure if combined with NRT.

Contraindications: Seizures, pregnancy, eating disorders and those taking monoamine oxidase inhibitors. Risk of psychiatric side effects is the same compared to other smoking cessation medications.

OTHER MEDICATION

Other drugs have been shown to be effective in smoking cessation but are not licensed for this indication. The cost of these drugs is often low and should be considered if cost is a limiting factor:

Nortriptyline has been shown to be effective, but possible side effects that include sedation, dry mouth, light-headedness and risks of cardiac arrhythmia in patients with CHD limit its application. It should thus be a second line agent.[6]

Cytisine has a mechanism of action like varenicline, binding to the nicotinic receptor. It has been used for smoking cessation in eastern European countries and has received increasing interest due to its low cost. Possible side effects include stomach ache, dry mouth, dyspepsia and nausea.[7]

HARM REDUCTION

Other nicotine products have been suggested as useful to reduce the harm of cigarette smoking. Chewable nicotine, snuff and e-cigarettes are all methods that are less harmful than smoking. However, remember that they still carry a risk for the user. The newest product, e-cigarettes, are heavily marketed with claims that they aid smoking cessation. Their effects – positive and negative – are still not fully known. Their use should, therefore, be restricted to smokers who have tried other methods without success. ●

References
1. Supporting smoking cessation. http://www.racgp.org.au
2. Treating Tobacco Use and Dependence: 2008 Update. http://www.ncbi.nlm.nih.gov
3. Helping Smokers Quit 2014. http://www.londonsenate.nhs.uk
4. Taylor G *et al. BMJ* 2014;**348**:g1151.
5. Kotz D *et al. Lancet Respir Med* 2015;**3**:761-8.
6. Hughes JR *et al. Nicotine Tob Res* 2005;**7**:491-9.
7. West R *et al. N Engl J Med* 2011;**365**:1193-200.

Further reading
Available from www.theipcrg.org desktop helpers

PRACTICAL HINTS FOR PATIENTS

These are suggestions for coping with cravings to smoke and ways to reduce the risk of relapse. Abstinence symptoms are most frequent in the first few days after quitting; they are a sign your body is getting used to living without nicotine. If you use medication to help you quit you will reduce your symptoms of nicotine withdrawal so

Remember to take your medicine and also try the 4 Ds:
- **Delay** acting on the urge to smoke
- **Deep breathe**
- **Drink** water slowly holding it in your mouth a little longer to savour the taste
- **Do** something else to take your mind off smoking. Doing some exercise is a good alternative

Avoid major triggers for smoking early in your quit attempt. Common triggers are alcohol, coffee and smoking friends.

Remember: Just one will hurt. Thinking "I can have just one" is the way most people go back to regular smoking.

Original author: **Dr Svein Hoegh Henrichsen** Author of this edition: **Anders Østrem** Contributions from: **Nick Zwar, Onno van Schayck, Noel Baxter, Stephen Brunton, Radost Assenova, Catalina Panaitescu, Vidal Barchilon, Bruce Kirenga, Andy McEwen** Editors: **Hilary Pinnock and Siân Williams**
No conflicts of interest have been declared. Funded by IPCRG.

E-Quality Projects 2013 - 2016

Transition to adult asthma care
Germany - 2016

Antibiotic Prescribing
Macedonia - 2015

Spirometry 360
US/Australia – 2013
(now working in Sri Lanka, Bangladesh

Stop smoking education
Bulgaria - 2016

Evaluating asthma management training
India - 2013

Matrix Support
Brazil - 2014

Developing capacity for spirometry
Sri Lanka - 2015

Matrix Support/Telemedicine
Brazil – 2015

Introducing diagnostic tools to HCP educators in Eritrea – on hold

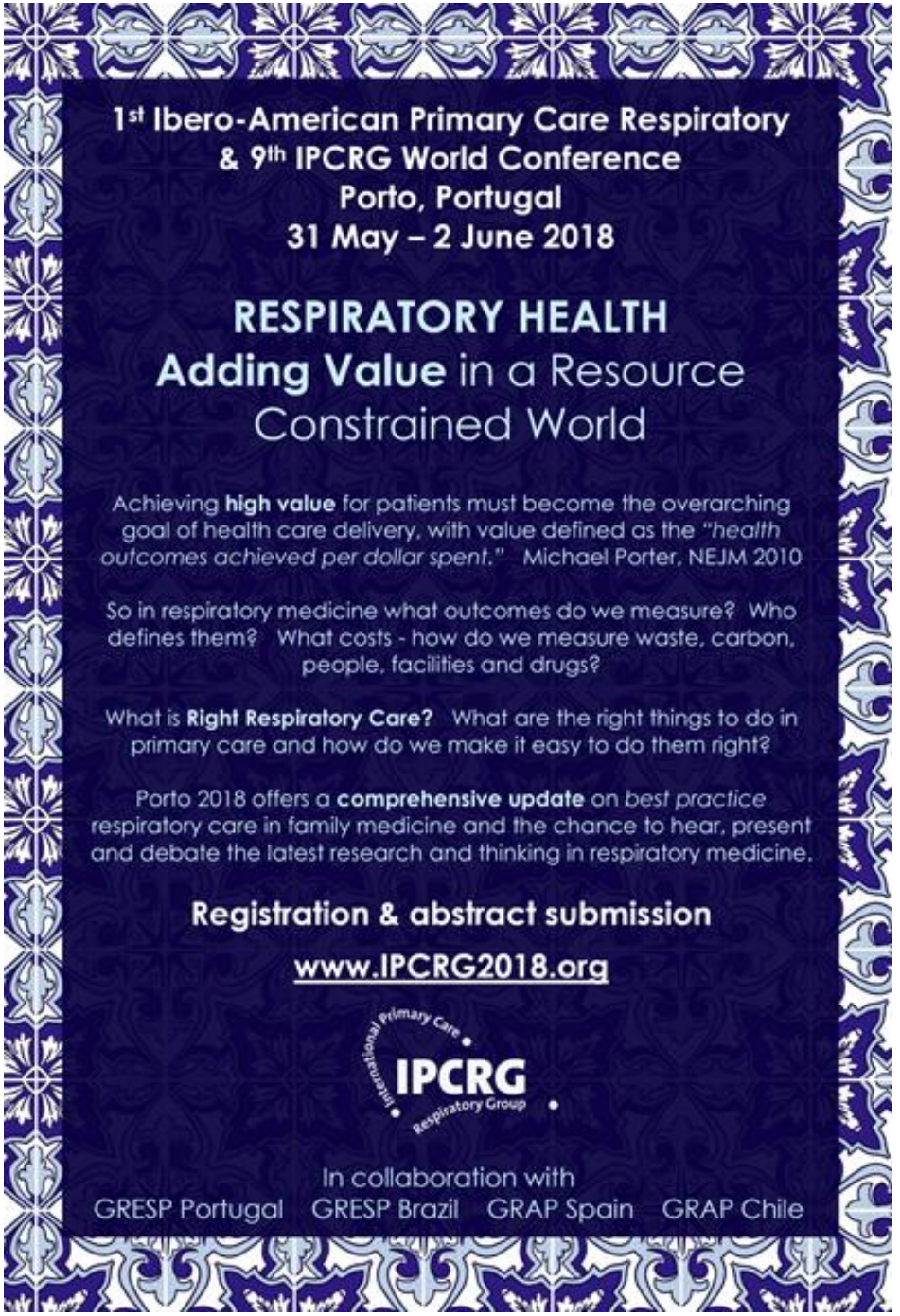
The Asthma Right Care initiative

- The IPCRG is leading an international pilot that is exploring how to use social movement approaches to create a desire for change in the management of asthma
- Our focus, in the first phase, is on the over-reliance on short-acting beta2 agonists (SABAs), and testing how to create a sense of discomfort and dissatisfaction with this amongst all stakeholders.
- We set up a multi-national Delivery Team from four pilot countries, Canada, Portugal, Spain and the UK that includes patients, pharmacists, GPs and nurses.

Respiratory Health: Adding Value in a Resource Constrained World

In collaboration with:

- GRESP Portugal
- GRESP Brazil
- GRAP Spain
- GRAP Chile



Thank you for your attention!