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TCC tobacco cessation center programme how to use effectively in clinical dental practice

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Abstract

These dental clinics provide an opportunity to offer tobacco cessation advice and counselling to the tobacco addicts. Dentistry has long recognized the connection between tobacco use and oral health and the appropriateness for oral health professionals to address tobacco addiction. The regulatory bodies in India urge dentists to assist patients with tobacco cessation. The dental team routinely provides educational and preventive services to patients; the use of dental clinics can be extended to tobacco cessation centres. The dental visit provides a “teachable moment” during which the dental team provide evidence-based brief interventions to patients who use tobacco and assist patients in tobacco cessation.

Keywords: TCC tobacco, clinical dental practice, assist patients

Introduction

Confronting a National Epidemic: Tobacco use is one among the five greatest risk factors for mortality, and also the single most preventable cause of death ^[1,2]. Every third adult in rural areas and every fifth adult in urban areas uses tobacco in some form or the other, revealed the *Global Adult Tobacco Survey, released by the ministry of health and family welfare on 6th June 2018* ^[3]. The survey revealed that 28.6% (266.8 million) of adults aged 15 and above in India currently uses tobacco in some form. Among the adults 24.9% (232.4 million) are daily tobacco users and 3.7% (34.4 million) are occasional users.

The Ministry of health and Family Welfare introduced the National Tobacco Control Programme (NTCP) in the 11th Five Year Plan. It also subsequently launched the National Oral Health Programme (NOHP) in the next Five Year Plan. NOHP and NTCP have joined hands to expand the reach of tobacco cessation services in the country in collaboration with the Dental Council of India.

With the release of operational Guideline named “Establishment of Tobacco Cessation Centers in Dental Institutes. An Integrated Approach in India” ^[4], it is expected that 310 Tobacco cessation Centers will be established in the Dental Colleges across India. This will increase access to tobacco cessation services to tobacco users looking to quit the habit.

The Pivotal Role of Dental Specialist: A Cochrane review of 41 trials, published between 1972 and 2007 covering over 31,000 participants, confirmed that brief advice from physicians is effective in promoting smoking cessation ^[4]. A meta-analysis incorporating 28 trials and over 20,000 participants showed that a brief advice intervention is likely to increase the quit rate by one to three percentage points. *Evidence from some randomized trials suggests that advice from motivated physicians to their smoking patients could be effective in facilitating cessation of smoking* ^[6].

The disease in a community can be compared with an iceberg. The floating tip of the iceberg is what the physician sees in the community, that is formed by the clinical cases.

The big submerged part of iceberg represents the hidden mass of disease, which is formed by in apparent, pre-symptomatic and undiagnosed cases and carriers in the community. Much of the evidence focuses on the cases which represent the tip of the iceberg. At this stage, most of the oral lesions are diagnosed at a very late stage, when not only the treatment becomes more expensive, but also the morbidity and mortality increase.

A similar picture is represented for tobacco-related cases.

A dentist is not only a part of first hand encounter to the patient in dental clinic, hospital or dental institutes but also is the best person among all dental specialties to identify the cases which are not only in the tip of iceberg but also in the submerged portion of iceberg, i.e., tobacco-related oral lesions, smokers, attitude toward tobacco use and the risk groups. Thus, a dentist gets a wide opportunity to sensitize the people and prepare tobacco users for cessation. Counseling is the one of the methods approached for tobacco cessation.

A dentist plays an important role in tobacco cessation and abstinence. His role in tobacco cessation is neither extensively documented nor fully utilized on a larger platform. He can not only assist in early diagnosis with the help of basic clinical skills and academic knowledge, but also offer indispensable care and necessary surgical and behavioral support, make referrals and generate awareness. The initial case history taking is an expansive procedure where reasonable time is spent in assessing and understanding the dental treatment needs of the individual. This could be only achieved by establishing a state of art Tobacco Cessation Centers.

Establishing State of Art TCC (Tobacco Cessation Center) [4] and the roadmap for effective implementation Tobacco Cessation Programme

The Tobacco Cessation Centers helps patients who want to stop using tobacco or patients interested in learning more about tobacco cessation. Certified tobacco cessation counselors provide one-on-one counseling for all patients interested in quitting tobacco. Complimentary materials and cessation tools, such as nicotine patches, lozenges, and/or gum are provided to qualifying patients at no cost.

Tobacco Cessation Centers in Institute

A Tobacco Cessation Center is *defined as* fixed premises where qualified health care professional/counselor provides tobacco (smoke and smokeless forms) cessation therapy to help patients in their attempts to quit the habit. The therapy involves individual or group counseling and may include the dispensing of pharmacological aids, *if the center is registered and equipped to do so.*

To start with the very first step is to register the center, as currently no authorized government organization is providing the registration exclusively for TCC, *the best way to start with registering the centers from local CMO, IDA and IAOMR.* The infrastructure for a state of art TCC requires a good team and very effective patient follow up programme. The equipment and instruments required for TCC as per Dental Council of India are,

1. Printed patient records along with files and stationary items
2. Computer with printer and speaker
3. Clinical diagnostic instruments
4. Carbon Monoxide monitor
5. TV with DVD player
6. Portable Audio system with cordless microphone
7. Printed material in local languages

Contents of the toolkit for tobacco cessation brief intervention

This toolkit [7] is a package of printed or printable material and electronic (soft) material. This protocol and guidelines in the following pages are the principal part of this toolkit. This package also contains non- printable material such as videos. The soft copies can be printed and shared on computers used

by clinicians and primary health care professionals.

5A's [8, 9]: Tobacco cessation brief intervention protocol Flowchart for mounting on wall of all doctors' desks and in TCC

Successful intervention begins with identifying users and appropriate interventions based upon the patient's willingness to quit. The five major steps to intervention are the "5 A's": Ask, Advise, Assess, Assist, and Arrange.

1. **Ask:** Identify and document tobacco use status for every patient at every visit.
2. **Advise:** In a clear, strong, and personalized manner, urge every tobacco user to quit.
3. **Assess:** Is the tobacco user willing to make a quit attempt at this time?
4. **Assist:** For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit.
5. **Arrange:** Schedule follow-up contact, in person or by telephone, preferably within the first week after the quit date.

5R's [8, 9]: Tobacco cessation brief intervention protocol Flowchart for mounting on wall of all doctors' desks and in TCC

1. **Relevance:** Explain to patients why cessation is personally relevant (e.g., comorbidities, cost).
2. **Risks:** Ask patients to explain their perceived potential risks of smoking; discuss these risks with them (e.g., sexual dysfunction, infertility, fetal harm, CV and pulmonary disease, malignancies, secondhand smoke).
3. **Rewards:** Ask patients to explain what they might gain from cessation (e.g., breath smells better, stained teeth get whiter, bad odor of clothes goes away, food tastes better, sense of smell returns to normal, everyday activities do not result in shortness of breath, skin tone gets better, health improves, worries about secondhand smoke lessen, respiratory symptoms improve, lung function improves).
4. **Roadblocks:** Ask patients to identify barriers to quitting (e.g., fear of failure, weight gain, and depression) and offer options to address those barriers.
5. **Repetition:** Discuss these issues with patients at each visit.

Other additional material should be kept in TCC for patients

1. Quit tobacco tips card
2. Quit smoking tips poster
3. 2 videos that can be used for patient education
4. Quitting Smoking Timeline
5. Training slides set that can be used additionally for reference and training sessions.

Stepwise technique for patient Follow-up:

- **1st Visit:** Conduct tobacco use assessment, conduct Oral Health Assessment and disseminate printed material for cessation technique. If there is any potentially malignant lesion identified through screening procedures like toluidine blue staining, biopsy should be done. Reports obtained and necessary pharmacological or surgical intervention planned and followed up.
- **2nd Visit:** 7-10 days from 1st follow up. Behavioral and Pharmacological approach follow up along with dental treatment.
- **3rd Visit:** 10-14 days from 2st follow up. Behavioral and

Pharmacological approach follow up along with dental treatment.

- **4th Visit:** 7-10 days from 3rd follow up. Behavioral and Pharmacological approach follow up along with dental treatment.
- **5th Visit:** Documented Telephonic or center visit and urine cotinine analysis – 1.5 – 3 months and 6 months
- All pharmacological treatment protocols would follow internationally accepted standard guidelines.

Current concepts in pharmacological Management of patients who are willing to quit ^[10,11]:

- NRT: Nicotine Replace Therapies
- Pharmacotherapies

- Psychiatric Counseling

NRT: Nicotine Replace Therapies

The general principle of replacement therapies is to present the patient with a safer and more therapeutically manageable form of the drug that directly alleviates the signs and symptoms of withdrawal and craving. NRT is modeled after those originally developed to treat dependence on heroin and other opiates. A variety of non-tobacco-based delivery systems provide potentially effective means for nicotine replacement.

- Nicotine injection and patches
- Nicotine Gums and lozenges
- NNS: Nicotine Nasal Sprays
- Nicotine aerosols (inhaler)

Table 1: Drugs used and scientifically proved in tobacco cessation

Drug	Doses	Side effects
Varenicline ^[12] : attaches to nicotine receptors partially blocking the reward of effects of nicotine and partially stimulating the nicotine receptors.	Dosing: (TQD). 0.5mg once daily for 3 days, then 0.5mg twice daily for 4 days, then on TQD	Nausea, sleep disturbances (insomnia, abnormal dreams)
Bupropion ^[13] : Originally used as antidepressant. Affects the levels of neurotransmitters reducing the urge to smoke.	Dosing 150mg once daily for 3 days, then 150 mg twice daily for 4 days, then on TQD stop smoking! Continue at 150 mg twice daily for 12 weeks.	Seizures (risk is 1/1,000)

Source: A guide for tobacco users to quit, WHO 2014 ^[11].

Strategies for Emotional and Psychological Connections

You need to help your patient break the connection between smoking or tobacco use and their emotions and beliefs. Look for any such beliefs and misconceptions and clear their misconceptions. Here are some misconceptions what patient think,

1. Low Tar cigarettes are safe to smoke
2. "Rollies" are safe to smoke
3. Cutting down the number of cigarettes can reduce health risks
4. Only old people get ill from smoking

State of art training centers in India and other part of world In India

- a. Shree Krishna hospital and PSM college- Gujarat
- b. National Institute of Mental Health and Neurosciences (NIMHANS)-Karnataka
- c. Jawaharlal Nehru Cancer Hospital & Research Centre- Madhya Pradesh, PGIMER, Chandigarh
- d. Cancer Institute (Adyar Cancer Institute), Tamil Nadu
- e. A.H. Regional Cancer Centre-Orissa
- f. Institute of Human Behavior & Allied Sciences (IHBAS)- Delhi
- g. Vallabhbhai Patel Chest Institute-Delhi
- h. Vaidya Hospital-Goa
- i. Bhagwan Mahaveer Cancer Hospital & Research Center- Rajasthan

Outside India

- a. University of Massachusetts (UMass) Medical School Tobacco Treatment Specialist (TTS) Training Program
- b. King Hussein Cancer Center Tobacco Dependence Treatment Training Amman, Jordan
- c. West Virginia University School of Dentistry Certified Tobacco Treatment Training Program, Morgantown.

Financial aspects of Tobacco Cessation Programmes

As there is significant amount of time spent in individual counselling the consultation fees should be kept and proper

records for each follow-up should be kept in department or clinic. There are number of organization like Bloomberg initiative for tobacco cessation which provide full financial support to the individual interested in training him/herself from John Hopkins University.

The true and greater sense of Image Build of the Dentist

A dentist must be trained in tobacco dependence treatment including behavior counselling and pharmacotherapy. The use of innovative technologies like mobile phones and setting up quit-lines can give a major impetus to the ongoing efforts of the Dentist. Robust high end training post graduates in tobacco cessation will create definite interest for practicing in TCC.

Thus, a dentist should be strongly motivated for the cause of tobacco cessation; only then, the efforts toward cessation will be fruitful. This can be achieved through systematic training on tobacco and its health hazards, identification and clinical diagnosis of tobacco-related lesions and tailored method for tobacco use cessation. This training should be directed to the undergraduate and postgraduate students, and the staff members, with an interdisciplinary approach.

Organization and education, when they interact with each other, they strengthen each other, they are mutually supportive. An organization, no matter how well designed, is only as good as the people who live and work in it. The current awareness regarding tobacco cessation has given opportunity to all of us. We as dentist will strengthen from this opportunity if and only if all of us involve, train, learn and implement strategically themselves in clinics and departments.

Conclusion

Utilization of the expertise and knowledge empowered to a dentist to combat the menace of tobacco will not only help the patient in large but also will help the society to outshine for the efforts for healthcare sector in India. The curriculum equips the dentist with sufficient knowledge to initiate the tailor-made tobacco cessation programs. To equip this situation more effectively, we need to redesign our curriculum

for including tobacco cessation training.

The increasing tobacco awareness and related researches, especially those associated with smokeless forms, provides ample opportunity for a dentist in research and in routine dental practice. *Collaboration is a key part of the success of any organization, executed through a clearly defined vision and mission and based on transparency and constant communication.*

References

1. WHO report on the Global Tobacco Epidemic, 2008. The MPOWER package: www.who.int/tobacco/mpower/en/
2. WHO Tobacco the problem: nmh fact sheet; June 2009: www.who.int/nmh/publications/fact_sheet_tobacco_en.pdf
3. Global adult tobacco survey: India 2016-17 report: <https://mohfw.gov.in/sites/default/files/GlobaltobaccoJune2018.pdf>
4. Establishment of tobacco cessation centers in dental institutes. An integrated approach in India: Operational Guidelines, 2018: http://www.dciindia.gov.in/Rule_Regulation/FinaloperationalguidelinesTCCindentalcolleges.pdf
5. Stead LF, Perera R, Bullen C, Mant D, Lancaster T. Nicotine replacement therapy for smoking cessation. *Cochrane Database Syst Rev.* 2008; 1:CD000146.
6. Venkatesh S, Sinha DN. Involvement of health professionals in tobacco control in the south-east asia region; *Ind J of Can.* 2012; 49(4):327-335
7. Tobacco Dependence Toolkit 2010: American college of chest physicians: (<https://foundation.chestnet.org/wp-content/uploads/2018/08/TobaccoDependenceToolkit2010.pdf>)
8. Jing-guang Luo, Ling Han, Li-wei Chen, Yun Gao, Xiao-jun Ding, Ying LI *et al.* Effect of intensive personalized “5as+5rs” intervention on smoking cessation in hospitalized acute coronary syndrome patients not ready to quit immediately: A randomized controlled trial; *Nicotine & tobacco research.* 2017; 00(00):1-10.
9. Liaisons *et al.* A Clinical Practice Guideline for Treating Tobacco Use and Dependence: 2008 Update. *Am J Prev Med.* 2008; 35(2):158-176.
10. Ashwin A Patkar, Michael J Vergare, Vikas Batra, Stephen P Weinstein, Frank T Leone. Tobacco Smoking: Current Concepts in Etiology and Treatment; *Psychiatry.* 2003; 66(3):183-199
11. WHO A guide for tobacco users to quit 2014: http://apps.who.int/iris/bitstream/10665/112833/1/9789241506939_eng.pdf
12. Burke MV, Hays JT, Ebbert JO. Varenicline for smoking cessation: a narrative review of efficacy, adverse effects, use in at-risk populations, and adherence: *Patient Preference and Adherence.* 2016; 10:435-441.
13. Wilkes S. The use of bupropion SR in cigarette smoking cessation: *Int. J of COPD.* 2008; 3(1):45-53