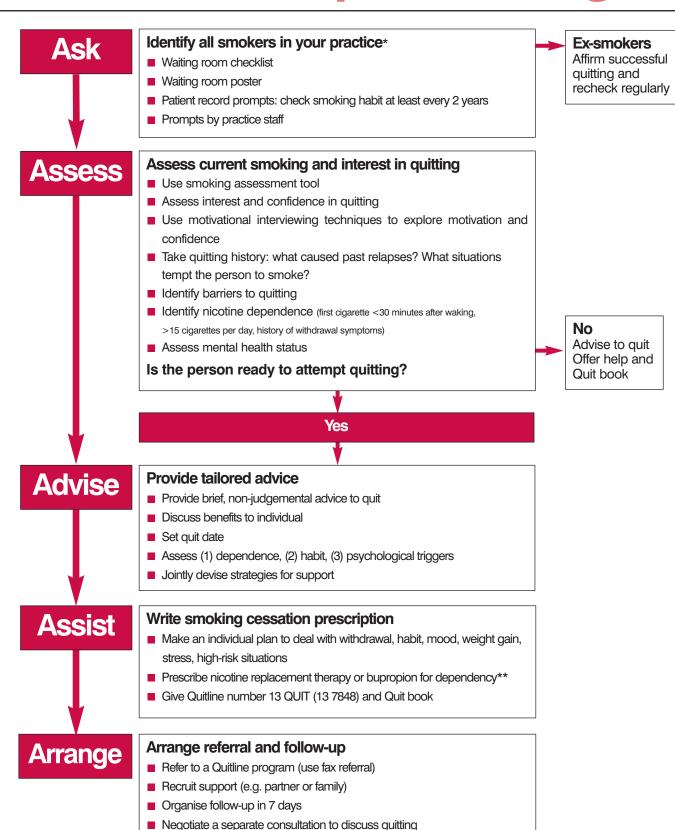
Helping patients quit smoking



- * See national guidelines (reference 9)
- ** Note contraindications, adverse effects and drug interactions



Evidence for the benefits of quitting

Why quit?

Smoking causes more deaths and disease in Australia than any other preventable risk factor, and is responsible for an estimated 19,000 deaths and 142,500 hospital admissions per year.1 Life-long smokers have a 50-60% chance of dying from a tobacco-related disease, and half of these deaths will occur in middle age (25-54 years).^{2,3}

Quitting achieves immediate and long-term benefits. Everyone who smokes can benefit from quitting – the sooner the better. Even when illness is present, quitting smoking is still very worthwhile.

Have you identified all the smokers among your patients?

Approximately 21% of men and 18% of women smoke daily.4 At any time:

- just over half of these are seriously thinking about quitting within the next 6 months⁵
- nearly half have tried to quit during the past 12 months.⁶

Many smokers are pessimistic about their ability to guit and are often reluctant to ask for help. However, the trend towards a smoke-free lifestyle is gaining momentum: the number of Australians who have quit smoking now exceeds the number of smokers.7

Smoking facts

- Tobacco smoke contains about 4000 chemicals, including known carcinogens (e.g. nitrosamines, toluidine, nickel, benzopyrene, cadmium, polonium 210), carbon monoxide, hydrogen cyanide, various nitrogen oxides and tar.
- In developed countries, smoking is estimated to cause: 1,2
 - 87% of all deaths due to lung cancer
 - 82% of all deaths due to emphysema
 - 40% of all deaths due to heart disease in people under 65
 - 21% of all deaths due to heart attack
 - 33% of all cancers
 - 10% of all infant deaths
 - more deaths, hospital admissions and primary care visits than any other single factor.
- In Australia, smoking costs the community an estimated \$21 billion per year (1998–1999 figures),8 offset by only \$5.2 billion in tobacco excise.

Benefits according to time since guitting⁷

Almost all nicotine has been metabolised 24 hours Carbon monoxide levels drop markedly

2 days Cleaner breath and hair

Sense of taste and smell improve 5 days

3 months Cilia begin to recover and lung function improves

1 year Risk of coronary heart disease halved,

compared with smoker

10 years Risk of lung cancer less than half of risk for

continuing smoker, and continues to fall

15 years Risk of coronary heart disease same as for

non-smoker

Can GPs make a difference?

Compared with smokers who attempt to quit without assistance, the chance of successfully quitting is 4-6 times higher in people who receive:

- brief advice on quitting AND
- help dealing with withdrawal and stress AND
- referral to Quitline structured call back program (available in most states)

There is good evidence that GPs can assist smokers to quit. The key components of a primary care-based intervention include:

- brief and clear advice
- assistance in identifying individual barriers to quitting, and strategies to overcome barriers
- help withdrawing from nicotine
- helping patients to understand and strengthen their motivation and confidence to quit
- working in partnership with Quitline.

Recommended reading

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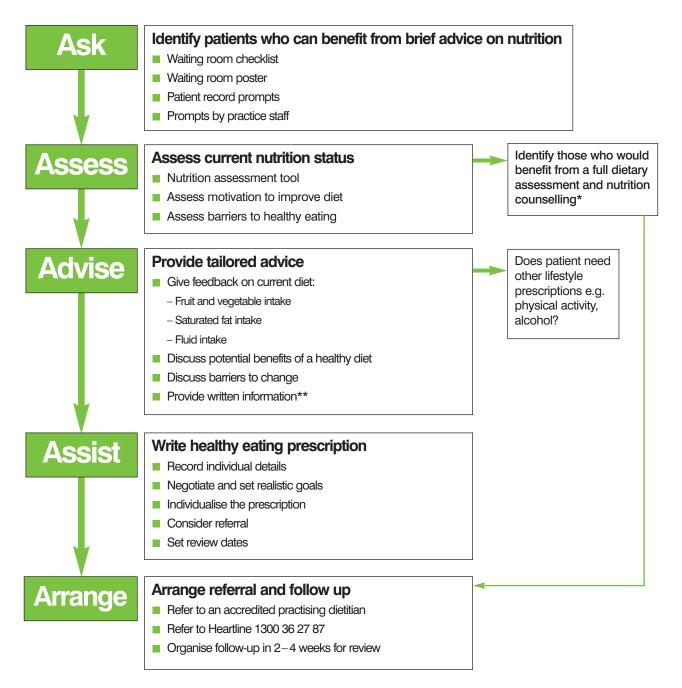
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Helping patients eat well for health



- *Important: A full dietary assessment and nutrition counselling by an accredited practising dietitian may be beneficial for:
- people who have lost weight unintentionally
- pregnant or lactating women
- children
- patients with diabetes mellitus who require insulin
- patients with specific nutrition related diseases.
- people who cannot shop and cook for themselves (e.g. frail elderly, disabled), who may be at risk for malnutrition.
- **Quality information for consumers is available from the following sources:
- The Dietitians Association of Australia (www.daa.asn.au)
- Find an Accredited Practising Dietitian 1800 812 942
- Nutrition Australia (www.nutritionaustralia.org).



Evidence for the benefits of healthy eating

Good nutrition contributes to quality of life and well-being. Both under- and over-nutrition must be managed effectively to prevent nutrition-related disease. Poor nutrition contributes significantly to the burden of chronic disease in Australia; the direct costs of nutrition-related disease have been estimated at \$1.5 billion per year, and indirect costs at \$2.3 billion per year.

Eat plenty of fruit and vegetables

Aim to include 5 serves of vegetables and 2 serves of fruit every day. Epidemiological evidence from around the world indicates that diets rich in vegetables and fruit are associated with lower risk for coronary heart disease, stroke, and several cancers. High vegetable and fruit intake may also be associated with reduced risk of developing type 2 diabetes, hypertension, cataracts and macular degeneration.²

Reduce saturated fat intake

Diets high in saturated fats contribute to insulin resistance and increase the risk for coronary heart disease, type 2 diabetes and several cancers.

Australian dietary guidelines recommend a saturated fat intake of no more than 15–25 g per day (equivalent to 6–8 teaspoons of saturated fat). The average Australian currently consumes more than this recommended intake, mostly from dairy foods, meats and 'hidden' saturated fats in commercially baked cakes, pastries and biscuits.²³

Drink plenty of water

Health authorities generally recommend that adults drink 6–8 glasses of fluid (1.5–2 L) each day.² Adequate water consumption is essential for digestion, absorption and transportation of nutrients, and for efficient waste elimination. Low fluid intake has been reported to increase risk for kidney stones, colon and urinary tract cancers, childhood obesity, mitral valve prolapse, and to impair physical and mental performance.²

Patients should be advised that sugary drinks (soft drinks, cordials, sports drinks, juice and flavoured mineral waters) may contribute to overweight and poor oral hygiene,² and should be replaced with water whenever possible.

Do GPs make a difference?

Dietary advice given in the primary care setting is effective to reduce saturated fat intake, and increase vegetable and fruit intake. The elements of the dietary advice include tailoring the message for the patient, and reinforcing the message.⁴⁵

Further recommended reading

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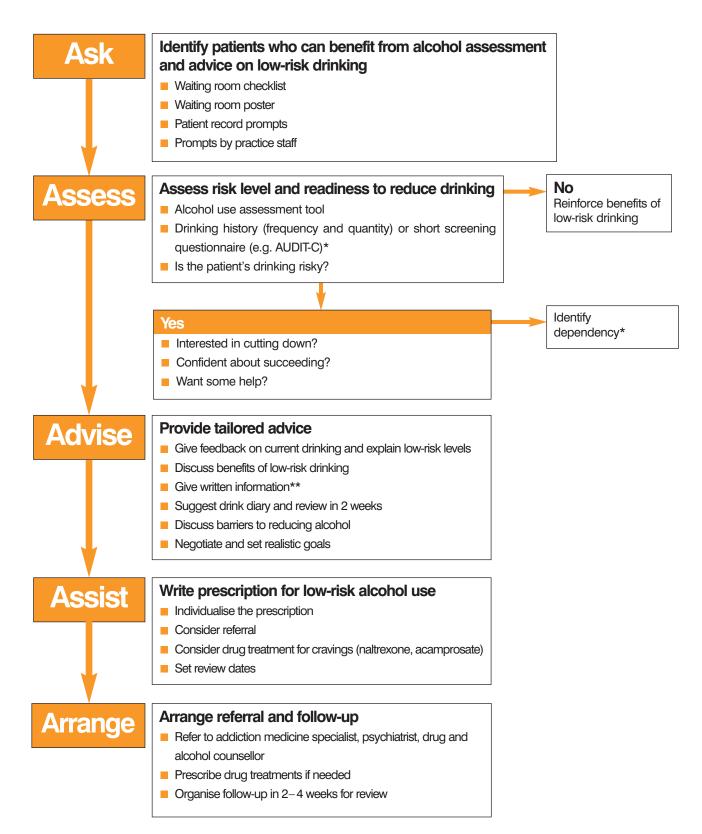
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Helping patients reduce alcohol-related harm



^{*}Use full AUDIT if you suspect alcohol dependency (see reference 1). **See reference 2.



Evidence for the benefits of low-risk alcohol use:

Although moderate alcohol consumption has some health benefits for older adults, excessive drinking harms health and social life.

Drinking problems in Australia

- About 6% have an alcohol use disorder or are alcohol-dependent
- One in 10 engage in risky drinking or binge drinking
- Risky drinking is most prevalent among under 25-year-olds

Australian recommended levels of alcohol consumption³

For men:

- No more than 6 standard drinks on any one day (60 g), for risk of harm in the short term, and
- No more than 4 standard drinks of alcohol per day (40 g), or 28 standard drinks (280 g) per week for risk of harm in the long term.

For women:

- No more than 4 standard drinks on any one day, for risk of harm in the short term, and
- No more than 2 standard drinks of alcohol per day (20 g) or 14 standard drinks (140 g) per week for risk in the long-term.

Risky drinking – early intervention is effective

The most effective strategy to reduce alcohol-related harm is early intervention for people who engage in risky drinking, to prevent them becoming heavy regular or dependent drinkers. Once a person is dependent on alcohol, withdrawal may be difficult or complicated.

Brief advice from a GP can be very effective in correcting risky drinking in non-dependent drinkers, as demonstrated by a substantial body of evidence. Brief intervention achieved a 17% mean reduction in alcohol consumption, and resulted in significant health benefits, in a large international study conducted by the World Health Organization.

Including routine questions about alcohol use in your history will provide opportunities to prevent further harm.

Alcohol dependence – more help needed

It is important for GPs to identify patients who meet criteria for alcohol dependence. If you suspect dependence, use the Alcohol Use Disorders Identification Test (AUDIT).¹

GPs can help people who are alcohol dependent, but effective interventions take more time and the prognosis is worse than for non-dependent risky drinkers. Detoxification in the community, supervised by a GP, can be a safe option. Alcohol abstinence — rather than moderate drinking — is usually the most appropriate goal, as these patients are unable to control their alcohol consumption. You may wish to refer these patients to a clinician with expertise in addiction medicine.

Drug therapies for alcohol problems

Pharmacotherapies can be helpful in reducing alcohol consumption in people who are alcohol dependent. Emerging evidence suggests they may also be effective in people with alcohol problems who are not alcohol dependent, including binge drinking.

- Naltrexone (Revia) and acamprosate (Campral) are generally well tolerated and can be used even if the person continues to drink.
- Disulfiram (Antabuse) causes an unpleasant reaction when alcohol is ingested and is not used as a first-line therapy.

GPs can help problem drinkers

- Most patients who drink too much appreciate a chance to discuss this issue with their doctor.
- If more serious alcohol or other drug problems emerge from the discussion, GPs in most parts of Australia can access expert clinical advice or refer the patient for specialised treatment

Recommended reading

Holmwood C. Alcohol-related problems in Australia: is there a role for general practice? *Med J Aust* 2002; 177: 102–103.

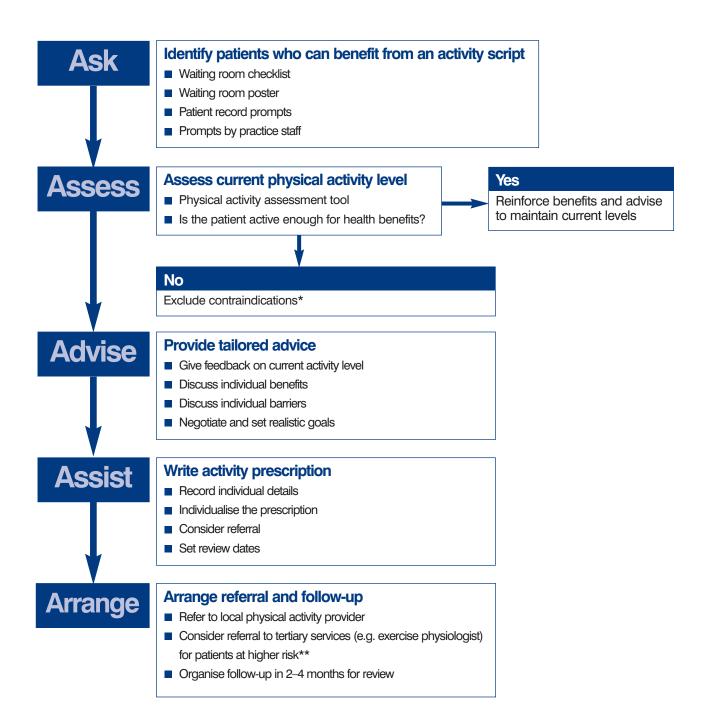
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Helping patients become more active



- *Contraindications to moderate-intensity physical activity
- Unstable angina
- · Chest discomfort or shortness of breath on low-intensity activity
- Uncontrolled heart failure
- Severe aortic stenosis
- Uncontrolled hypertension
- Acute infection or fever
- Resting tachycardia (>100 beats per minute)
- Recent complicated acute myocardial infarction (<3 months)
- Uncontrolled diabetes

**People with multiple risk factors, pre-existing disease, long-standing disabilities and the frail elderly may require referral for supervision or other tertiary services to ensure their activity is safe and provides maximal benefit.



Evidence for the benefits of physical activity

Physical inactivity is a major modifiable risk factor affecting the health of Australians. It accounts for 7% of the total disease burden[†] and is estimated to cost the community at least \$400 million per year in direct health costs. In women, insufficient physical activity is responsible for more premature death and illness than any other modifiable behavioural risk factor, while in men it is second only to tobacco smoking.

Summary of health benefits of physical activity[†]

- All-cause mortality risk reduced by 50%
- Cardiovascular disease risk reduced by up to 50%
- Hypertension prevention and management
- Stroke risk reduced by up to 30%
- Cancer risk (colon, breast) reduced
- Type 2 diabetes prevention (risk reduced by 30–50%) and management
- Osteoarthritis management (pain control, maintenance of muscle strength, joint structure and function)
- Osteoporosis risk reduction
- Falls risk in the elderly reduced by resistance exercises
- Weight management and reduction (when combined with dietary changes)
- Mental illness (anxiety, depression and subjective feelings of stress) prevention and management
- † Comparisons between low activity and moderate activity

Australian physical activity guidelines

Just 30 minutes per day of moderate-intensity physical activity (either continuous or accumulated in bouts of 10 minutes or more) provides health benefits and reduces risk for a range of conditions in all population groups. The preventative benefits of physical activity are best documented for cardiovascular disease, diabetes, stroke, mental illness, prevention of falls and obesity.²

Inactivity in Australia

More than half of the Australian population is not active enough to achieve these documented health benefits. About 54% of adults aged 18-75 could benefit by increasing time and number of sessions involved involved in physical activity. ³

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- Smith B. Promotion of physical activity in primary health care: an update of the evidence on interventions. J Sci Med Sport 2004; 7(Suppl): 67–73.

Can GPs make a difference?

A growing body of evidence – including over 30 primary care studies – demonstrates that GPs and practice nurses can effectively increase patients' physical activity levels through brief clinical interventions that include:⁴

- brief advice
- provision of written information, such as an individualised prescription
- follow-up over subsequent consultations.

Who can benefit from this advice?

All sectors of the population can benefit from regular, moderateintensity physical activity. There is evidence that the greatest benefit can be derived by people who are currently inactive, those with cardiovascular disease, hypertension, depression, anxiety or obesity, and those who are at higher risk of diabetes and osteoporosis.

What has been shown to work?

The '5 As' approach (Ask, Assess, Advise, Assist, Arrange) has proved a powerful tool to assist GPs in structuring advice to patients on physical activity, and has been used successfully by thousands of general practices in Victoria and New South Wales since 1999. Having identified a patient who can benefit from increased physical activity levels and excluded major contraindications to exercise, the GP assesses individual barriers to positive behaviour change and identifies specific activities that are suitable. The patient and GP negotiate realistic goals, and the advice is reinforced by an individually tailored physical activity prescription. GPs can also arrange referral to suitable activity providers within the community, and arrange appropriate follow up to review the patient's progress.

Disease burden is a measure of years of healthy life lost to illness, injury or death, and takes into account the prevalence and amount of disability associated with a disease or risk factor. Source: Australian Institute of Health and Welfare 2004. Australia's Health. Canberra: AIHW.

Recommended reading

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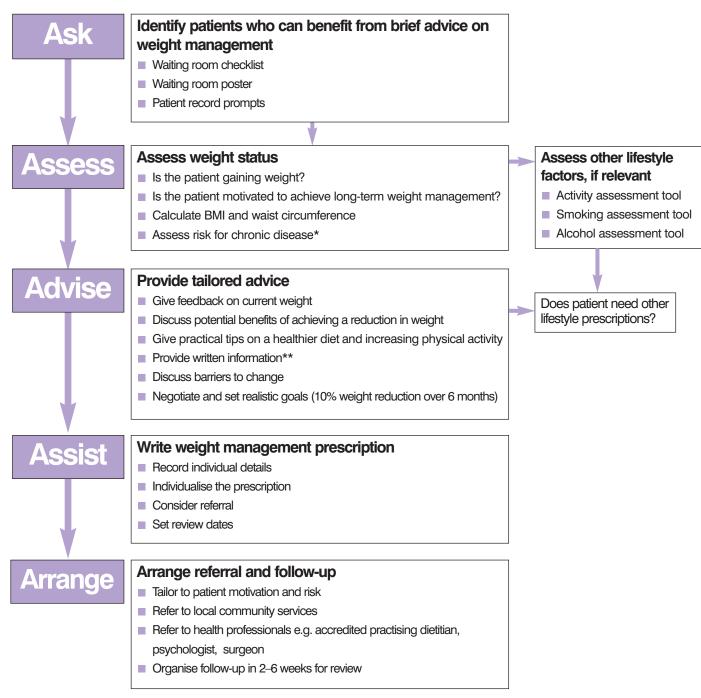
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Helping patients achieve and maintain a healthy weight



*Chronic disease risk

 $\label{eq:moderate_bound} \begin{tabular}{ll} Moderate & BMI > 25 kg/m^2 OR waist circumference > 102 cm (men) or > 88 cm (women) \\ High & BMI 25-35 kg/m^2 + 2 risk factors \\ \end{tabular}$

Very high $BMI \ge 40 \text{ kg/m}^2 \text{ OR BMI} > 35 \text{ kg/m}^2 + 2 \text{ risk factors}$

Risk factors

- Lipid abnormality (high total cholesterol, high LDL or low HDL)
- Hypertension
- Impaired glucose tolerance
- •Type 2 diabetes



^{**}Quality information for consumers is available from: Dietitians Association of Australia (www.daa.asn.au) Find an Accredited Practising Dietitian 1800 812 942 Nutrition Australia (www.nutritionaustralia.org)

The evidence: achieving and maintaining healthy weight

Approximately 67% of Australian males and 52% of females are overweight or obese (1999–2000 statistics). Obesity contributes to approximately 4.3% of the overall burden of disease in Australia. Over 50% of people visiting a GP will have, or be at risk for, medical conditions directly caused by excess body fat.¹²

Development of obesity is influenced by genetics, environmental factors, cultural factors and lifestyle behaviours. Treatment must be multifactorial and long term. It involves changes in diet, physical activity levels and behaviours, and must be tailored to the individual and reviewed regularly. High failure rates are partly due to unrealistic goals and impractical approaches to diet and physical activity that cannot be sustained long term. Moderate weight loss (5–7% of initial weight) that is maintained long term is a successful outcome, and is associated with significant improvements in the risk for chronic disease including type 2 diabetes. Support for weight maintenance is required throughout life.²

Aim to reduce weight by 5-10%

There is high-quality evidence that weight loss of between 5% and 10% of original body weight achieves significant metabolic and cardiovascular health benefits in overweight people, including:

- blood pressure reduction
- improvements in dyslipidaemia and hypertriglyceridaemia
- reduced risk for type 2 diabetes and improved control in those with existing type 2 diabetes
- improvement or resolution of sleep apnoea.

Weight loss of greater than 10% of initial body weight provides further health benefits, but this is a less achievable goal. Current evidence suggests that the short-term goal should be loss of 1–4 kg per month, aiming for 10% of initial weight in the medium term, ²³ but in real-world settings, a slower rate of 0.5–1 kg per month (6–12 kg/year) is more likely to be achieved.

Reduce energy intake (2000–4000 kJ/day)

The main aim of diet therapy in reducing body weight is the establishment of lifelong healthy eating patterns. In the short term, the main requirement is to reduce energy intake. There is good evidence that a reduced-energy diet will be more effective in maintaining weight loss than other more prescriptive diets. Strategies for reducing energy intake include eating smaller servings overall, altering particular components of the diet (reducing fat intake or increasing lean protein) or changing food patterns such as increasing vegetable and fruit consumption.

Reducing energy intake involves behavioural change and may require planning ahead and avoiding high-risk situations for overeating e.g. eating at the dinner table instead of in front of television, using a food journal.³

Reduce fat intake

Weight loss of 0.5–1 kg per week can be achieved by a reduced-fat diet (fat provides 25–30% of total energy intake) or a low-fat diet (fat provides 20–25% of total energy) as part of a reduced-energy diet.³ **Important!** Weight loss will not be achieved by a reduction in dietary fat intake alone, without reducing total energy intake. This means replacing high-fat foods with less energy-dense foods such as vegetables and fruit and reducing serving sizes.³

Current choice	Replace with	Energy reduction
Main Meal • Large steak • Hot chips (10)	Small piece of lean red meat Boiled potato (no added fat)	1500 kJ 1000 kJ
Snacks • Potato crisps (1 pkt) • Chocolate biscuits (2)	Piece of fruit Piece of fruit	700–1000 kJ 1000 kJ
Other Full-cream milk (250 mL) Regular fruit yoghurt (1 tub) Soft drink (600 mL)	Low-fat milk (250 mL) Low-fat yoghurt (1 tub) Diet soft drink or water (600 mL)	300 kJ 600 kJ >1000 kJ

The role of physical activity

Physical activity is a necessary component of weight management. It helps reduce abdominal fat and can help to reduce total body fat (see Lifescripts physical activity materials).

Can the GP make a difference?

Ongoing care is needed for successful weight management.

Long term follow-up is vital to monitor the patient's dietary, physical activity and lifestyle behaviours. Supportive follow-up will help the patient resolve set-backs and reinforce any positive changes that have been achieved.

Recommended reading

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