Use and Effectiveness of Transdermal Nicotine in Primary Care Settings

I read with great interest the article by Cummings et al. in the August 1994 issue of the ARCHIVES. However, I would like to point out an issue that I believe has a direct impact, not only on the use of nicotine replacement therapy (NRT), but on patient compliance as well. It appears that the authors failed to mention the impact of media advertising on patient requests for NRT.

I have been prescribing NRT since 1990 in private practice. This has afforded me the opportunity to monitor the number of NRT requests as well as compliance with behavior counseling. Based on my experience, it appears that the number of patients requesting NRT goes up proportionately with media advertising. In addition, those who are currently receiving NRT tend to be more compliant with behavior counseling when levels of broadcast advertising are high than when they are low. As a result, I have concluded that a significant number of NRT requests are, in part, based on an impulse for a quick fix rather than an actual desire to change or modify the behavior of nicotine addiction.

I suggest that future studies on the efficacy of NRT score the intensity of media advertising as a confounding variable.

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In reply

Dr White raises an interesting question regarding the impact of media advertising on the use of nicotine skin patches in his letter. In the advertising business, it is often said that, "...without advertising, a terrible thing happens—nothing." When the Food and Drug Administration approved the marketing of prescription nicotine patches in late 1991, patch manufacturers launched a multimillion-dollar advertising campaign to alert consumers to the availability of this new stop-smoking aid. Advertising contributed to the ordering of over 7 million prescriptions for the patch in 1992.

As Dr White suggests, many of those who may have responded to the advertising for the nicotine patch were seeking a quick fix to help them break their addiction to nicotine. Unfortunately, the patch is not a cure for nicotine addiction. While our study of nicotine patch users suggests that the patch can help a person who smokes to quit, the most important factor in stopping smoking still remains the person's desire to give up cigarettes. Perhaps advertising motivates those who may already be contemplating cessation to attempt it.

Patients included in our study were among the first to have access to the nicotine skin patch. This makes this group of patients unique in light of the extensive amount of media advertising that encouraged use of the patch in the first half of 1992. However, even in this group exposed to extensive advertising for the patch, we found that patient compliance with the nicotine patch regimen was good. Media advertising as well as sales of nicotine skin patches have decreased markedly since 1992. During the past year, at stop-smoking clinics at our institution, fewer patients are requesting the nicotine patch. However, among our patients using the patch, we have not noticed a dramatic change in long-term cessation rates or compliance with the patch regimen.

In summary, we agree with Dr White's recommendation that future studies should investigate the impact of advertising on the use and effectiveness of prescription drugs, such as the nicotine patch. Advertising of prescription drug products must be done in a responsible manner. However, in regard to the advertising of NRTs, it is our view that it is better to be promoting patches than Marlboros.

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Screening for Cobalamin Deficiency

Yao et al. are to be commended for their efforts to detect early cobalamin (Cbl) deficiency. It is estimated that disorders of the nervous system will develop in 80% to 90% of untreated Cbl-deficient patients. There appears to be a time window of less than 1 year for effective treatment of Cbl-deficient individuals with cognitive dysfunction and/or spinal cord degeneration. Early detection and treatment will prevent neurologic disability as well as needless expense. For example, caring for an individual with Alzheimer's disease may cost over $213,000, in addition to other medical expenses.

However, screening is better accomplished using the urinary methylmalonic acid (MMA) test by gas chromatography–mass spectrometry (GC-MS). This assay requires only a random spot urine specimen and identifies functional tissue Cbl deficiency. The urinary MMA test by GC-MS is preferred over other Cbl testing procedures for reasons of noninvasiveness, practicality, and sensitivity.