Which One is Harder? Give up smoking or keep on this process?

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Introduction

The aim of this case report is to emphasize the importance of informing patients about the aphthous ulcers that may occur after quitting smoking and to demonstrate the effect of nicotine chewing gums on the ulcers. Since tobacco-related diseases are preventable, efforts to promote smoking cessation should be a routine step in primary care.

Case History

A 38-years-old man admitted to seek help for quitting smoking. He has been smoking twenty cigarettes per day for 15 years. He had chronic pharyngitis in physical examination probably caused by smoking. He was prescribed anti-inflammatory and antibacterial drugs. A definitive day was determined for quitting smoking. A week after he had quit smoking, he began suffering from oral ulcers. He did not have similar complaints before. Typical shallow ulcers in the mouth except from hard palate and gingiva were found in physical examination. He was diagnosed as Recurrent Aphthous Stomatitis (RAS) and was informed that the condition was related to quitting smoking. The patient was not willing to keep on being a non-smoker because of the pain during speaking and eating. He was offered nicotine chewing gums although he did not have any nicotine deprivation symptoms. After a week, his lesions showed regression.

Discussion

Asking about smoking behaviour should be a part of routine medical history. Primary care physicians should follow the following strategies to detect, inform and help smokers to quit. United States Public Health Service (USPHS) clinical guidelines for tobacco treatment recommend that health professionals should routinely counsel smokers using a five-step algorithm (5A's):

1. **A**sk about smoking at every opportunity,
2. **A**dvise all smokers to quit,
3. **A**ssess smokers' willingness to quit,
4. **A**ssist smokers' cessation efforts;
5. **A**rrange follow up.

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However, there are some barriers for smokers to keep on smoking cessation decision. In addition to oral aphthous ulcers, withdrawal symptoms such as; feelings of frustration, concentration problems, irritability and increased appetite are other important barriers.[1] Smoking harms other family members due to environmental tobacco smoke (ETS) and family budget as well. A person-centred approach, oriented to individual, family and community would be helpful. Studies have shown that children and adolescents tend to smoke if their close friends, siblings and parents are smokers.[2]

After quitting smoking, 40% of individuals develop mouth ulcers, mostly in the first two weeks. The ulcers resolve within four weeks in 60% of patients. Mouth ulcers are a common result of quitting smoking, affecting two in five.[3]It has been suggested that cigarette smoking prevents aphthous ulcers by causing increased keratinisation of the oral mucosa. Smokeless tobacco and nicotine chewing gums may have the same mechanism.[4] Increases in mouth ulcers following smoking cessation may be related to the absence of the antibacterial effect of smoking. Increases in cold symptoms can be explained by a reduction in salivary immunoglobulin A upon quitting smoking.[5-6] Smokers need to be informed that they will have increased rate of cold symptoms and mouth ulcers on quitting smoking.

Since tobacco-related diseases are preventable, efforts to promote cessation in smokers should be a routine step in primary care. Findings suggest that FPs/GPs who endorse smoking-cessation counselling and referral may provide more treatment recommendations and their patients may have higher quitting rates.[7] It has been shown that having realistic expectations on the consequences of medical interventions increases the chances of positive outcomes. Patients should be reassured that the lesions are result of quitting smoking and not a side-effect of smoking cessation medication.

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