

TOBACCO, VAPING & CANNABIS

INFORMATION SERIES



Smokeless Tobacco

Is there new legislation regarding flavoring in tobacco? (i.e., bans)

In Canada, Smokeless Tobacco (ST) products are exempted from some federal laws or regulations that apply to cigarettes (PSFC, 2011). Chapter 27 of Federal Bill C-32 has banned flavoring additives for little cigars, cigarettes and blunt wraps (Statutes of Canada, 2009) however other ST products in Canada, such as water pipe tobacco, cigars not covered by the “little cigar” definition, smokeless (spit) tobacco, roll-your-own tobacco, cigarette papers, pipe tobacco and bidis have not been included in this ban (OTRU, 2013). The Tobacco and Vaping Products Act prohibits additives which add flavouring properties or that enhance flavour to cigarettes, cigars, little cigars and blunt wraps. The Act does not mention smokeless tobacco (Government of Canada, TVPA, 2018).

Chapter T-3.8 of The Tobacco and Smoking Reduction Act (Alberta) section 7.4 (1) states the sale of flavoured products is prohibited.

In this section, ‘flavoured tobacco product’ means a tobacco product that a. has a characterising flavour, b. is represented as being flavoured or c. is designated under the regulations as a flavoured tobacco product. The act also states that (2) No person shall sell or offer for sale a flavoured tobacco product (Statutes of Alberta, 2005).

In October 2018 Health Canada released a document for consultation titled “New Health-Related Labelling for Tobacco Products”. In this document several proposed changes were listed. Proposed changes included implementing several rotating suites of health labelling for all tobacco products. Currently, health messages on tobacco products are not required to rotate after a specified period of time (Health Canada, 2018).

Labelling requirements for tobacco products other than cigarettes and little cigars varies, with minimum size requirements (in cm²) applying only to a small number of package types. Health Canada is considering establishing a minimum size for Health Warnings on tobacco products other than cigarettes and little cigars as well as

considering expanding the 75% Health Warning requirements for cigarettes and little cigars to other tobacco products (Health Canada, 2018).

Changes to the size, colour, and placement of quitline and website information to maximize noticeability is also under consideration. It is proposed that quitline and website information be added to other tobacco products, such as smokeless, heated tobacco, and fine cut tobacco products (Health Canada, 2018).

Is there evidence to suggest that spit tobacco cessation treatment is different to commercial tobacco cessation/treatment approaches?

Pharmacotherapies

The prevention and cessation treatment programs that have been developed for ST are primarily modelled from the programs developed for cigarette smoking and often use the same Nicotine Replacement Therapy (NRT) products (Hatsukami & Severson, 1999).

Nicotine patch: In the case of smokeless tobacco cessation, evidence suggests that the nicotine patch does not offer a significant improvement in long term abstinence rates when compared with placebo (Ebbert J., Elrashidi M., Stead., L, 2015). However, nicotine replacement patches have been found to aid in reducing nicotine withdrawal symptoms, including craving. (Stotts et al, 2003), (Hatsukami & Severson, 1999), (Hatsukami et al, 2000).

Nicotine gum: Research into nicotine gum use in ST users has not shown promising

results for cessation (Ebbert J., Elrashidi M., Stead., L, 2015). This may be due to the standard 2mg nicotine gum dose being less than that of a usual dose of smokeless tobacco. It has been hypothesized that higher dose gum (e.g., 4 mg nicotine gum) may be more effective for cessation. Whilst nicotine gum has the advantage of providing an oral substitute there is criticism that it is too similar to the ST use behaviour (Hatsukami & Severson, 1999). Non-nicotine mint snuff use has not been shown to improve treatment outcomes however the use of this non nicotine snuff did reduce craving and other negative affect withdrawal symptoms (Hatsukami et al, 2000).

Nicotine lozenge: The quality of available nicotine lozenge trials is not sufficient to report on the effectiveness of this therapy (Ebbert J., Elrashidi M., Stead., L, 2015).

Bupropion and Varenicline: A Cochrane review found that two bupropion studies with six months or longer follow up showed no effect on continuous all tobacco abstinence however, confidence intervals do not rule out a small benefit. Two studies in Scandanavian and U.S. populations demonstrated that varenicline increases long term ST abstinence rates by 34% compared to placebo among ST users. In cigarette smokers, however, varenicline increases abstinence rates 131% compared to placebo. (Ebbert J., Elrashidi M., Stead., L, 2015).

Behavioural Interventions

Meta-analyses' demonstrate that behavioural interventions can be effective interventions for ST users, especially those interventions which include an oral examination component (Dale

et al, 2002). Among the behavioral interventions, the use of an oral examination appears to be associated with the greatest odds of ST abstinence (Ebbert et al, 2003).

Five published randomized controlled trials demonstrated that an oral cancer screening with feedback about ST-related oral problems, cessation advice, self-help materials, and brief cessation counselling by a dental hygienist (Oral Screening/ Brief Counseling Model) promotes ST cessation, especially among individuals who are younger or less frequent users (Gansky et al, 2002).

Findings from a further three studies found that of the ST users who received assistance from their dentists or dental hygienists, 71% indicated that the advice received was a significant influence in seriously considering quitting ST use. Based on the results of three studies, there is now clear support for providing brief cessation advice and support to patients who use ST in the context of oral health care (Hatsukami & Severson, 1999).

Intensive group behavioural interventions (such as the AlbertaQuits cessation support group, QuitCore) do offer significantly higher long term abstinence rates than minimal or no contact interventions (Stotts et al, 2003).

In an RCT assessing nicotine patches for treatment of spit tobacco addiction in adolescents, it was found that subjects reported that the two most helpful factors in quitting were seeing photographs of the disfigurement that can be caused by ST use and by having an oral screening that found lesions in subjects' mouths (Stotts et al, 2003).

A Cochrane review highlighted that some behavioural intervention trials showed statistically and clinically significant effect but there were also some with non-significant effects. Telephone counselling is viewed as a potentially useful component of an intervention (Ebbert J., Elrashidi M., Stead., L, 2015).

Is there new evidence around the chemicals present in smokeless tobacco?

In a study which looked at measuring the concentrations of ten common flavour chemicals found in various tobacco products including whole tobacco products such as ST and filler tobacco found that Wintergreen (mint flavoured) snuff varieties manufactured in the USA exhibited high levels of methyl salicylate, (9860 µg/g). Although methyl salicylate is on the "Generally Regarded as Safe" (GRAS) list, toxic doses can easily be ingested, as little as 4 mL of the readily available oil of wintergreen has caused death in children (Lisko et al, 2014).

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