In Reply: Changing the Culture of Tobacco Dependence Treatment Among Not Only Patients, But Also Prescribers

To the Editor: We completely agree with Dr Lang.1 Lingering misperceptions held by patients, physicians, and advanced practice providers continue to inhibit them from using safe and effective pharmacotherapy for tobacco dependence. There is also a misperception that we have conquered the tobacco epidemic. This is also not true, although we have made great progress. In the United States, we continue to have 30 to 35 million adults who use tobacco regularly and tobacco causes tremendous excess mortality beyond the diseases commonly associated with tobacco use such as cancer, cardiovascular disease, and chronic lung disease.2 In addition, the people who are disproportionately affected by tobacco-caused disease often have comorbid serious mental illness.3 Our article shows that these medications can be used safely in patients and with and without underlying mental illness who also use tobacco (ClinicalTrials.gov Identifier: NCT01456936). Appropriate use of pharmacologic therapy for tobacco dependence is an important part of providing effective treatment for every person who uses tobacco whenever they contact the health care and mental health care systems.

Jon O. Ebbert, MD
Mayo Clinic
Rochester, MN
Carlos Jimenez-Ruiz, MD
Smoking Cessation Service
Madrid, Spain
Michael P. Dutro, PharmD
Medical Affairs
Pfizer Inc
New York, NY
Matt Fisher, PharmD
Pfizer Inc
Madison, NJ
Jing Li, PhD
Pfizer Inc
Madison, NJ
J. Taylor Hays, MD
Mayo Clinic
Rochester, MN

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Racial Differences in the Prevalence of Diagnosed Atrial Fibrillation Among Hospitalized Patients

To the Editor: Atrial fibrillation (AF) will affect at least 12 million people in the United States by 2030. Atrial fibrillation is associated with an increased risk for stroke and death and contributes to substantial costs and resource use.3 Considerable efforts are devoted to optimize AF management and mitigate its negative sequelae. However, the literature suggests the presence of racial disparities in the management of AF in the United States. Recent studies showed that direct oral anticoagulant, pulmonary vein isolation, and left atrial appendage closure are less commonly used among patients of non-White race.2 There is a notion that a large proportion of this disparity may be related to the lower prevalence of AF among non-White US individuals.3,4 However, large-scale studies examining race-based differences in the prevalence of AF are lacking.

We used the National-Inpatient-Sample (January 1-December 31, 2018) to identify hospitalization for 6 common conditions using the Clinical Classifications Software Refined. The Clinical Classifications Software Refined collapses diagnosis codes from the International Classification of Diseases, Tenth Revision into major disease categories and has been used in numerous studies.5 To ensure adequate power, we