function.[8] Fears about treatments are especially important since they may impair self management of both continuing symptoms ("inhaled steroids are bad for you") and acute attacks ("it is dangerous to exceed the stated dose of a bronchodilator"). Confidence in self management is vital if the inevitable anxiety associated with having asthma is to be minimised. Screening questions for excessive anxiety should be non-respiratory (Do you ever feel that something awful is about to happen? How often do worrying thoughts go through your mind?), and we should ask about patients' family and social backgrounds to learn of the predicaments that may cause their anxiety.

Thirdly, for some patients, hyperventilation with symptoms of hypocapnia is part of their experience of asthma. We must explain the similarities and differences between the symptoms of worsening asthma and hypocapnia and the side effects of increased doses of bronchodilators—all of which may be experienced during an attack. The guidance should be: if in doubt, treat for asthma but try also to slow down the breathing rate to avoid hypocapnia. Some patients may find peak flow measurement helpful in distinguishing between bronchospasm and hyperventilation. All need to know that the symptoms of hypocapnia and of higher dose bronchodilators, though unpleasant, are not dangerous.

Thomas et al suggest that breathing therapy is appropriate for some patients. But there is no good evidence that breathing therapy benefits patients with asthma. The studies they describe were carried out among patients without asthma. In 1990 Howell rejected management of behavioural breathlessness by breathing training and recommended sympathetic explanation aimed at giving patients reassurance and insight and at "removing the frightening element of the experience."[9] This approach may still offer the most practical way of helping patients with asthma cope with anxiety. Specialist referral will be appropriate where there are continuing uncertainties over diagnosis or management—ideally to a unit with psychological as well as medical expertise.

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Newly available treatments for nicotine addiction

Smokers wanting help with stopping now have effective treatment options

Nicotine addiction is recognised as a life threatening but treatable disorder[1] and from 17 April, in accordance with the *NHS Plan*, all forms of nicotine replacement therapy were made available on NHS prescription.[2] Britain now has a comprehensive treatment strategy for nicotine addiction, which includes provision of bupropion (Zyban) on prescription[3] and the introduction of specialist smoking cessation services to provide behavioural support to people who want to stop smoking.[4]

In theory therefore, every smoker in the country who wants help with overcoming his or her addiction to nicotine now has access to effective treatments. Many general practitioners, however, are sceptical about the appropriateness of having nicotine replacement therapy or bupropion available on NHS prescription,[5] and many are unaware of the part these can play in helping smokers to stop. The Health Development Agency is distributing a reprint of guidelines on smoking cessation with the general practice edition of this week's *BMJ*,[6] and here we summarise the evidence on the effectiveness of nicotine replacement therapy, bupropion, and behavioural support to guide prescribing and referral decisions.

Nicotine replacement therapy used alone can be effective, but better results are achieved when it is combined with behavioural support and counselling from a trained health professional.[6] More intensive support seems to be more effective.[6] For example, nicotine replacement therapy prescribed after general practitioners' brief advice against smoking can result in up to 10% of smokers stopping,[6] but nicotine replacement therapy together with support from specialist counsellors can result in up to 20% of smokers stopping.[6] Bupropion has not yet been tested without intensive behavioural support, so it is difficult to know whether it can be effective without this. The sustained one year abstinence rates achieved in the published trials of bupropion average about 20%.[7 8] Nicotine replacement therapy is generally well tolerated, and most side effects arise from the irritant effect of nicotine (such as rashes with nicotine patches). Experience from many years' use of bupropion in the United States indicates that, in the dose used for smoking cessation, it causes seizures in about 1 in 1000 users, and figures from initial use in the UK are consistent with this.[9] The most common side effects, however, are relatively minor, with insomnia and dry mouth the commonest.

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How should this evidence translate into clinical practice? Firstly, nicotine replacement therapy and bupropion are suitable only for heavier smokers (10-15 a day or more) who clearly want to stop and are ready to try. Indiscriminate prescribing to unselected smokers is unlikely to be effective. Secondly, smokers who want to try stopping should be offered referral to the newly established specialist services. Thirdly, if for some reason a smoker cannot attend the service it is still worth offering a prescription for nicotine replacement therapy.

Smoking cessation services should now be running in all health authorities. These can provide specialist behavioural support to maximise smokers' chances of stopping and are being geared to meet local needs, so most smokers should have relatively convenient access to them. Once smokers are referred general practitioners should work with the specialist services to ensure that patients receive the medication they need. In addition to treating smokers, services have a brief to train health professionals, so interested primary care teams may be able to obtain training in smoking cessation methods, enabling them to provide some support to smokers within general practices.

The costs of prescribing nicotine replacement therapy or bupropion are likely to remain modest. Currently, in an average general practitioners' list of 2000 patients only around five smokers a year are using the specialist smoking cessation services together with nicotine replacement therapy or bupropion.[10] Additionally, the Department of Health has increased prescribing budgets to allow for more prescriptions of nicotine replacement therapy and bupropion. This money may not be obvious, however, as it has not been ring fenced. Also, from April 2002 the money to fund specialist smoking cessation services will no longer be ring fenced and services will be commissioned from within primary care.[11] It is essential that the government continues to provide adequate funds to sustain services and that health authorities, primary care groups, and primary care trusts liase with their local smoking cessation services to arrange for their continued provision.

The UK has led the world by establishing a national network of smoking cessation services using proved treatments. It would be unpardonable if these were to be lost in the transition between funding arrangements.

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Why Britain needs a nicotine regulation authority

To bring consistency and regulation to tobacco and alternative nicotine products

In the United Kingdom, as in most developed countries, strict laws apply to the production and supply of goods and services to the public. An important function of this legislation is to protect consumers from damage caused by the products they buy, and in many cases this protection extends to levels of risk that are, at an individual level, extremely small. It is therefore an anomaly that cigarettes, which if used as intended kill half of all regular consumers,[1] enjoy remarkable freedom from consumer protection legislation.

Cigarettes are not a food, so are not regulated by the Food Standards Agency, and not medicines, so are not regulated by the Medicines Control Agency. They are a consumer product but are exempt from the Consumer Protection Act 1987 and General Product Safety Regulations 1994. Thus the most dangerous product on general sale in the UK is subject to the least regulatory control.

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Cigarettes kill because they produce nicotine, which is addictive, and tar and other combustion products, which are toxic. Most smokers smoke to relieve or avoid the unpleasant symptoms of nicotine withdrawal[2] and in the process are exposed to harmful components of tobacco smoke. Since pure nicotine at the doses obtained from cigarettes appears to be relatively free from major adverse effects,[2] nicotine addiction itself is not the central problem: it is the use of tobacco combustion products. The tobacco industry has long realised the importance of nicotine addiction to the use of their products and has refined and developed cigarettes to optimise nicotine delivery[3] but has done little to reduce smokers' exposure to toxic tobacco products. That the cigarette companies have failed a moral duty to meet the requirement that the Consumer Protection Act imposes on other manufacturers to minimise the safety hazard of their products is