Recommendations on interventions for bacco smoking cessation in adults in Canada – reviewer comments and CTFPHC responses

Reviewer 01 (Stakeholder): Karen Phillips, Prince Edward Island

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	No comments or suggestions	Thank you.

Reviewer 02 (Stakeholder): Chase Simms, BC Centre for Disease Control

Disclosure(s):

- Employed with the BC Centre for Disease Control as a Lead, Prevention of Substance Use Harms
- Previously a Research Officer with the Guidelines and Protocols Advisory Committee (GPAC), a joint committee between the Doctors of BC and the Ministry of Health
- Accepted a contract to complete the GPAC Tobacco Use Disorder clinical practice guideline, which will likely be released Summer 2024

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**No** Somewhat clear, would be helpful to provide definition of tobacco and products included. In BC we are finalizing a clinical practice guideline on Tobacco Use Disorder and it may be beneficial to cite this term as it is noted in the DSM-5.	Thank you for this comment. We have clarified that the guideline pertains to cigarette smoking (including hand-rolled cigarettes). We have also clarified that the guideline does not provide recommendations for other tobacco products (e.g., pouches).
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No** I do not think this is a patient facing document. The way it is currently written is quite complex, catered to practitioner, research and policy audiences. Would suggest creating patient specific resources that supplement this guideline.	Thank you for this comment. We have developed tools to accompany the final guideline, so that users do not need to only rely on the full document.
3. Are the guidelines supported by the evidence?	**Yes** Very strong methodology used and appreciate the extra detail in the appendices.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Would be beneficial to take some time to differentiate between traditional and commercial tobacco use and the importance of culturally safe care being offered. Motivational interviewing should be included in this guideline.	Thank you for this comment. We have discussed in the draft guideline that tobacco use does not apply to ceremonial use (see Scope). While we recognize the importance of culturally safe care being offered, providing guidance on culturally safe approaches it is outside the scope of evidence we examined. However we have noted in the Equity section that interventions delivered in a culturally competent manner

		may help address inequities. Motivational interviewing is not specifically addressed in this guideline as it was excluded from the outset along with other specific types of behavioural counselling techniques. These interventions require specialized training, the amount of which has been shown to vary but can be substantial and may not be readily available for many primary care practitioners.
5. Do you have any comments or suggestions to improve the guideline?	Overall, I think the writing can be tidied up to make it more concise and ensure there is consistent formatting. In addition, there is wording used that can be perceived as stigmatizing and those should be changed throughout e.g., smokers, addiction.	Thank you for this comment. We have revised the guideline text to use people-first language.

Reviewer 03 (Stakeholder): Laurie Schmidt, Saskatchewan Health Authority

Disclosure(s):

- Was a member of the Saskatchewan Coalition for Tobacco Reduction from 2010-2019, representing the former Sun Country Health Region, Health Promotion Department
    - Purpose of coalition's working group was to reduce tobacco related diseases and deaths in Saskatchewan (http://www.sctr.ca/)

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**No** Add an Objectives heading and a statement that clearly outlines the purpose and intent of the document for more clarity	Thank you for this comment. We follow the guideline structure used by CMAJ, which includes a Scope statement following the introduction, which also outlines the objective, which is to provide guidance to primary care professionals, patients, and policymakers on smoking cessation for adults aged 18 years or older who currently smoke tobacco cigarettes. We have also emphasized this objective in the Abstract.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes**	Thank you.

	Adults, age 18 and older who currently smoke commercial tobacco cigarettes– excluding breastfeeding/chestfeeding populations	
3. Are the guidelines supported by the evidence?	**Yes** High level evidence was extracted from systematic reviews (22), RCT's (11) and Cohort (1)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** A graphic summary (flowchart) may be helpful for health care providers to follow	Thank you for this comment. We have included a table in the guideline providing a visual summary of the recommendations. We have also developed an infographic and a decision-tool to help providers and people who smoke.
5. Do you have any comments or suggestions to improve the guideline?	Consider reviewing qualitative evidence as an addition. This may be useful to help support various interventions, particularly in understanding how the various recommendations impact patients directly based on their own lived experience.	Thank you for this comment. We agree that reviewing qualitative evidence would be helpful, but it would be challenging to incorporate additional evidence due to resource and time constraints. In addition, many of the recommendations included are strong. We have developed an infographic and a decision-tool to accompany the guidelines and aid providers and patients identify options that work best for them.

Reviewer 04 (Stakeholder): Suzanne Hamzawi, Canadian Pharmacists Association

Disclosure(s):

- Sister is the current Executive Vice President of the Public Health Agency of Canada

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** Guideline are clear and concise and supported with evidence-based recommendations for practitioners.	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Yes, the patient group is understood from guideline, but it is noted at the end that the patient needs to collaborate with the primary care provider to select the most suitable option for the patient. The group size for the patient engagement assessment was small, but was addressed in guideline.	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** The evidence used is clearly referenced in appendices in addition for inclusion of studies used.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** It is good to see guidelines discussing e-cigarettes as this an evolving topic and expect changes for subsequent guidelines with more emerging research and studies.	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	Please see attached documents for some minor recommendations/changes. [formatting suggestions provided separately]	Thank you for your suggestions about formatting. We have considered all the suggested edits.

Reviewer 05 (Stakeholder): Dr. Heather Carr, Canadian Dental Association

Disclosure(s):

- Currently the Canadian Dental Association's President, where they advocate for smoking cessation initiatives at the federal level

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	Excellent and comprehensive. Page 1 (last paragraph) "…brief advice from a physician…". It may be drawn directly from the reference paper. If not, please note other health professionals including dentists, provide brief advice and other behavioural interventions on a regular basis. The remainder of the guideline refer to health care providers.	Thank you for this comment. We agree that these interventions can be provided by a range of providers, and have edited this sentence to say 'healthcare provider' instead of 'physician.'

Reviewer 06 (Stakeholder): Patrick Luyindula, Institut national de santé publique du Québec

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** Yes, the guidelines do indeed derive from scientific evidences with nuances on the results and the studies' types. We can clearly see the promising interventions both at the level of the general population and the specific clienteles such as patients with mental disorders.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Behavioral interventions based on financial incentives, social support, and physical exercise are missing from the recommendations.	Thank you for this comment. Exercise was included – no analyses of exercise vs no intervention were found. Incentivized cessation was excluded at the systematic review stage (Exclusion reason: "Interventions that cannot feasibly or readily be delivered or referred to by a wide variety of primary care practitioners.")
5. Do you have any comments or suggestions to improve the guideline?	**Yes** The guideline is made for health care professionals but can also be used by other smoking cessation specialists acting outside the framework of clinical care such as those who work in telephone lines, at smoking cessation centers, in prisons, etc. Hence	Thank you for this comment. We have revised the guideline text to use people-first language and have reduced the use of the term 'patients' except where appropriate. We have also noted in the Scope that although this guideline is primarily aimed at primary care providers, there are a broad range of other stakeholders that may find it useful.

	the need to use in future editions perhaps, the term "smokers" instead of "patients". Adding in the final document of the guide, the modalities of the strongly recommended behavioral, pharmacological and combined interventions (duration, intensity, in person or remotely, in groups, strongly recommended types and dosage for pharmacological aids) would have helped users of the guideline to understand and apply the recommendations more easily.	Analyses of behavioural studies included a wide range of different intervention durations and intensities, which limits our ability to recommend these elements with specificity. However, with respect to in person vs remote, and group vs individual, this is clarified in the recommendations and the rationale section which notes that interventions could be in person or remote (e.g., by phone). For pharmacotherapy, the dosage will largely be determined by the product monographs, although the specifics of what was done in included studies is described in the tables found in the Evidence-to-Decision appendix.

Reviewer 07 (Stakeholder): Amit Rotem, Centre for Addiction and Mental Health

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to	**Yes** Tobacco Smoking includes Nicotine Dependence. I recommend highlighting the addictive nature in the introduction, which will better set the stage for the	Thank you for this suggestion. We have highlighted the addictive nature/nicotine dependence underlying tobacco use in the Introduction.

	interpret for primary care practitioners?	treatment recommendations. Here is a quote to consider: "Most smokers use tobacco regularly because they are addicted to nicotine. Addiction is characterized by compulsive drug-seeking and use, even in the face of negative health consequences. The majority of smokers would like to stop smoking, and each year about half try to quit permanently. Yet, only about 6 percent of smokers are able to quit in a given year. Most smokers will need to make multiple attempts before they are able to quit permanently" https://nida.nih.gov/publications/research-reports/tobacco-nicotine-e-cigarettes/nicotine-addictive Most smokers use tobacco regularly because they are addicted to nicotine. Addiction is characterized by compulsive drug-seeking and use, even in the face of negative health consequences. The majority of smokers would like to stop smoking, and each year about half try to quit permanently. Yet, only about 6 percent of smokers are able to quit in a given year.25 Most smokers will need to make multiple attempts before they are able to quit permanently	
5.	Do you have any comments or suggestions to improve the guideline?	1. Please consider presenting the pharmacotherapy in order of the evidence strength, or, explain the order of the current presentation. 2. Please consider highlighting separately, at the beginning of the recommendations and Box 1, the strongly recommended Combination of behavioural and pharmacotherapy approaches.	Thank you for this comment. Interventions in Table 1 are listed in alphabetical order and have emphasized the rationale for this in the text . The Task Force very purposefully approached recommendations with the understanding that patient preference for interventions is a key driver for successful smoking cessation. This was an approach supported by the smoking cessation experts and patients engaged for this guideline. When engaging patients in shared decision-making it is much more important that

		they try something – anything they are willing to try to quit smoking is a good option. This also recognizes that quitting smoking is difficult, and people will often need to try several things before finding what works. Clinically, there is a risk of attempting to rank what would likely be relatively minor differences in effects, which might discourage patients from trying something more consistent with their preferences that could work for them. We have put combined approaches first in both the recommendations section and Box 1, as suggested.

Reviewer 08 (Stakeholder): Stephen Lam, BC Cancer Agency

Disclosure(s):

- Serves as an expert advisor to the Canadian Partnership Against Cancer

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** Mostly but not quite. Please see comments in main text and response to Question 5. Introduction: • It seems to me we should omit details because it would raise the question quitting smoking after 50 has no benefit. Suggest	Introduction: • We agree we do not want it to be misinterpreted as meaning no benefit over 50. We have simplified the sentence as suggested. • We have kept 'of a few minutes or less' as this is how it has how 'brief advice' has been defined in existing reviews (versus longer counselling interventions).

	changing to: Quitting smoking increases life expectancy, improves mental health and quality of life with greater benefits by stopping smoking as early as possible (11, 12)
	• Regarding statement: "Behavioural interventions to promote smoking cessation may include brief advice from a physician of a few minutes or less…"
	  ○ Suggest omit ..of a few minutes or less
	  ○ For those who smoke within an hour after waking up, addition of pharmacotherapy has been shown to improve smoking cessation rate
	
	Scope:
	• Regarding statement: "The task force did not specifically evaluate interventions, including safety, for pregnant or breast/chestfeeding populations."
	  ○ Why not?
	
	Recommendation:
	• NRT: should avoid using abbreviation if the document will be read by the public
	• Regarding statement: "We recommend that interactive computer-based or online programs with additional behavioural support may be considered (conditional recommendation)
	  ○ "Behavioural" support is not readily understood especially by the public. How about changing to counselling
		Scope:
		• These were not examined due to feasibility.
		Recommendation:
		• Regarding abbreviations – we have followed the formatting requirements of the CMAJ.
		• We have clarified what is meant by computer-based programs with and without behavioural support to better distinguish these from other interventions. We have not used the suggested wording of 'counselling support' since that level of support offered could have varied across studies and may not have been formal counselling.
		• Regarding the statement that e-cigarettes with nicotine would not address nicotine addiction - it is clear from your comments and those from others that this was not clearly worded. The intention was to indicate that if an individual's goal is to address their addiction or dependence to nicotine, switching from cigarettes to nicotine e-cigarettes does not achieve this as they continue to consume nicotine, despite potentially reducing harms from smoking (particularly if they use the e-cigarette long term). We have revised this sentence to be clearer and have also clarified why this is not a concern with traditional forms of NRT.
		
		Benefits of interventions/Box 1:
		• Interactive computer-based/web-based programs are considered as distinct from self-help materials because of their two-way flow of information between the individual and the program. We have clarified this in the introductory text.
		
		Harms of interventions:

	support? Otherwise, why not list it as self help materials under behavioural instead of endorsing generic "computer based programs" that has little evidence (see Box 1) • Regarding statement: "Patients who decide to use e-cigarettes to quit smoking should be informed of the risks and uncertainties related to e-cigarettes due to the lack of approved products with consistent formulations, the lack of long-term safety data, and that e-cigarettes with nicotine would not address nicotine addiction." ○ Is this correct? Should it be e-cigarettes WITHOUT nicotine? ○ A Cochrane review showed that e-cigarettes with nicotine were more effective for smoking cessation than nicotine-free e-cigarettes. (Hartmann-Boyce J, McRobbie H, Bullen C, Begh R, Stead LF, Hajek P. Electronic cigarettes for smoking cessation. Cochrane Database Syst Rev. 2022 Nov 17;11(11):CD010216. doi: 10.1002/14651858.CD010216.pub7. Update in: Cochrane Database Syst Rev. 2024 Jan 8;1:CD010216. PMID: 36384212; PMCID: PMC9668543. ○ See also: Hajek P, et al. A Randomized Trial of E-Cigarettes versus Nicotine-Replacement Therapy. N Engl J Med. 2019 Feb 14;380(7):629-637. doi:	• We have carried out a search for updates of all Cochrane reviews included in our overview or reviews, and based on these findings, have concluded there could be small harms from bupropion due to a small increase in adverse events. This has been updated in the manuscript, although it has not changed the overall judgment of net benefit nor the strong recommendation in favour. Rationale: • We agree that it may be more than just nicotine content that is uncertain in e-cigarettes on the market, and have added this to the rationale (e.g., other excipients or additives would also be unknown by the provider). External and content expert review: • We've clarified that experts to not provide input or vote on the direction and strength of recommendations specifically. Experts involved in this guideline did review the recommendations and provided input on elements such as wording, implementation, etc. Table 2 • Thank you for sharing the reference to the ATS guidelines. We have restricted the guidelines in the table to generalist organizations such similar to the Task Force or national guidance bodies. Expanding to specialty organization guidelines would greatly expand the table beyond just those of the ATS.

	10.1056/NEJMoa1808779. Epub 2019 Jan 30. PMID: 30699054. ○ The concern is whether e-cigarettes with nicotine would lead to nicotine dependence and other health effects when used long term. Benefits of interventions: • Regarding statement: "Our overview of reviews found that behavioural and pharmacotherapy options that effectively increased cessation included… self-help materials.." ○ Please see comment in Box 1 [regarding interactive computer programs]. Isn't this considered to be self help material at best? Harms of interventions: • Regarding statement: "Our review showed that bupropion may result in little to no harm, although data were of very low certainty of could not be evaluated for certainty because not enough data was provided." ○ This statement is incorrect. Buproprion has definite side effects. This statement appears to say it is safer than NRT or varenicline while the Cochrane review showed this is more likely to cause SAE than the others. Livingstone-Banks J, Fanshawe TR, Thomas KH, Theodoulou A, Hajizadeh A,	

	Hartman L, Lindson N. Nicotine receptor partial agonists for smoking cessation. Cochrane Database Syst Rev. 2023 May 5;5(5):CD006103. doi: 10.1002/14651858.CD006103.pub8. PMID: 37142273; PMCID: PMC10169257. Rationale: • Regarding statement: "The task force judged that internet-based interventions that include effective behavioural support may provide a benefit, and therefore makes a conditional recommendation in favour." o Please see above. How is this different than self-help material? Self-help material can be in the form pamphlets, rack cards, video or other digital media. • Regarding statement: "The harms identified for these interventions were little to none in some cases and small but important in others (e.g., varenicline)." o Bupropion has worse reputation among patients in terms of suicidal or depression side effects. Please see other comments above." • Regarding statement: "Evidence on the effects most of other therapies compared to placebo or sham on smoking cessation was of very low certainty."	

	○ No published evidence. Acupuncturists do not report adverse events. • Regarding statement: "Second, providers cannot direct patients to an approved product with verified formulation, including nicotine concentration, and patients will ultimately use what is available to them on the open market." ○ Nicotine content may be related to addiction but it is likely the diluent/carrier that give long term side effects in the lungs especially the ones with flavour. • Regarding statement: "The task force is concerned about large increases in youth vaping in recent years and the impact that using e-cigarettes for smoking cessation could have on this trend." ○ In relation to this, what about nicotine pouches with 4 mg of nicotine that is popular with young people? Should make a statement. External and content expert review: • Regarding statement: "The task force engaged content who helped to address technical issues and important clinical issues, participated in working group discussions, and reviewed the guideline and key supporting documents. Task force content experts do not provide input into or vote on recommendations."	

	○ Why are content experts excluded to provide input into recommendations?" Box 1: Grading of recommendations Behavioural intervention: • Conditionally recommend - Interactive computer-based or online programs with direct behavioural support ○ If magnitude of benefit is uncertain and certainty is low, why is it conditionally recommended? Is direct behavioural support same as counselling in person or by phone/video conferencing? • Conditionally against - Interactive computer-based or online programs without additional support (fully automated or self-directed) ○ If certainty is very low, why not recommend against? Table 2 • The ATS practice guideline is missing • Leone FT, Zhang Y, Evers-Casey S, Evins AE, Eakin MN, Fathi J, Fennig K, Folan P, Galiatsatos P, Gogineni H, Kantrow S, Kathuria H, Lamphere T, Neptune E, Pacheco MC, Pakhale S, Prezant D, Sachs DPL, Toll B, Upson D, Xiao D, Cruz-Lopes L, Fulone I, Murray RL, O'Brien KK, Pavalagantharajah S, Ross S, Zhang Y, Zhu M, Farber HJ. Initiating Pharmacologic Treatment in Tobacco-Dependent Adults. An Official American Thoracic Society Clinical Practice Guideline.	

	Am J Respir Crit Care Med. 2020 Jul 15;202(2):e5-e31. doi: 10.1164/rccm.202005-1982ST. PMID: 32663106; PMCID: PMC7365361.	
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** A discussion on contemporary issue such as use of nicotine pouch would be useful.	Thank you for this comment. Nicotine pouches or other smokeless tobacco products are currently out of the scope of the guideline. We may consider a discussion on this issue for future updates.
5. Do you have any comments or suggestions to improve the guideline?	1. In the key messages to the public, it seems to me the wording could be improved e.g. in page 1. Details on life expectancy, quality of life, mental health in relation to age of smoking cessation could be omitted because it would give the impression that quitting smoking after 50 has no benefit. Suggest changing to: Quitting smoking increases life expectancy, improves mental health and quality of life with greater benefits by stopping smoking as early as possible (11, 12) 2. It would be worthwhile to include a statement regarding a simple question to assess nicotine dependency to guide the need for pharmacotherapy. This can be readily assessed by asking a simple question on time to first cigarette upon waking (Rojewski AM, Tanner NT, Dai L, et al. Tobacco Dependence Predicts Higher Lung Cancer and Mortality Rates and Lower Rates of Smoking Cessation in the National Lung Screening Trial. Chest. 2018;154(1): 110–118). Pharmacotherapy as an adjunct to counseling is grossly underused.	1. See above. 2. We did not assess evidence for inclusion of an assessment of nicotine addiction to guide use of interventions, so we have not included this at this stage. We have emphasized that the approach used for this guideline recognizes that patients will try many different interventions before finding what works, and patient preference (e.g., desire to avoid medication) will be a major driver of the chosen intervention. We want to ensure providers have access to a menu of interventions that are shown to be effective to help guide this discussion. 3. Reference 17 was a placeholder for the review for this guideline which is now published in Systematic Reviews. We also carried out an additional search for any additional Cochrane reviews published since our last search to ensure the guideline is informed

	e.g. In the NLST, only a minority of smoking participants were offered smoking cessation pharmacotherapy (Thomas NA, Ward R, Tanner NT, et al. Factors Associated With Smoking Cessation Attempts in Lung Cancer Screening: A Secondary Analysis of the National Lung Screening Trial. Chest. 2023 Feb;163(2):433-443). In a Veterans Health Administration study, only 1.1% received the recommended combination of pharmacotherapy and counseling; of those receiving pharmacotherapy, only one in four received one of the most effective medications: varenicline (12.1%) or combination nicotine replacement therapy (14.3%) (Heffner JL, Coggeshall S, Wheat CL, et al. Receipt of Tobacco Treatment and One-Year Smoking Cessation Rates Following Lung Cancer Screening in the Veterans Health Administration. J Gen Intern Med. 2022 May;37(7):1704-1712). 3. "We based recommendations on an overview of Cochrane reviews on smoking cessation interventions (17)" – reference #17 is incomplete. What is JoSR? The following more recent Cochrane reviews are missing : Livingstone-Banks J, Fanshawe TR, Thomas KH, Theodoulou A, Hajizadeh A, Hartman L, Lindson N. Nicotine receptor partial agonists for smoking cessation. Cochrane Database Syst Rev. 2023 May 5;5(5):CD006103. doi:	by the most recent available evidence, and have incorporated this in our findings. See Appendix 2. For a single study in a review to change the direction of a recommendation it would have to be a well conducted RCT with adequate power, a large effect size with clear findings that contradict the summarized body of evidence. In this review, we suspect that the risk of new findings changing the direction of recommendations mostly lie with e-cigarettes where there is greater uncertainty and primary sources were included.

	10.1002/14651858.CD006103.pub8. PMID: 37142273; PMCID: PMC10169257. Lindson N, Theodoulou A, Ordóñez-Mena JM, Fanshawe TR, Sutton AJ, Livingstone-Banks J, Hajizadeh A, Zhu S, Aveyard P, Freeman SC, Agrawal S, Hartmann-Boyce J. Pharmacological and electronic cigarette interventions for smoking cessation in adults: component network meta-analyses. Cochrane Database Syst Rev. 2023 Sep 12;9(9):CD015226. doi: 10.1002/14651858.CD015226.pub2. PMID: 37696529; PMCID: PMC10495240. Hartmann-Boyce J, McRobbie H, Bullen C, Begh R, Stead LF, Hajek P. Electronic cigarettes for smoking cessation. Cochrane Database Syst Rev. 2022 Nov 17;11(11):CD010216. doi: 10.1002/14651858.CD010216.pub7. Update in: Cochrane Database Syst Rev. 2024 Jan 8;1:CD010216. PMID: 36384212; PMCID: PMC9668543. Since the guideline is unlikely to be updated for several years after it is published, having a literature review cut-off date of September 2020 would make the guideline obsolete already when it is published. It is noted that some of the references cited such as #15, 18 are from 2023. Every attempt should be made to include the latest evidence.	

Reviewer 09 (Stakeholder): Jolyane Blouin Bougie, Institut national d'excellence en santé et en services sociaux

Disclosure(s):

- Current mandate from the Ministère de la Santé des Services sociaux (MSSS) to elaborate a clinical tool to promote optimal use of pharmacological treatments for smoking cessation

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** These guidelines aim to offer general guidance on smoking cessation options for adults. However, the three target audience groups – primary care providers, patients, and policy-makes – have different information needs. For example, it could be useful for patients to know the advantages of getting support to stop smoking and where to find help, and for clinicians to be better informed on when to recommend one or other of the interventions/treatments and to whom. Policy-makers could find it relevant to know which interventions should be available/funded, and for what reasons.	Thank you for this comment. We agree that information needs may differ depending on the audience. We have revised the Scope section to highlight primary care professionals as the main audience, with a note that some other stakeholder may also find the guideline of use (recognizing it may not provide all information needed for all of these audiences). We have also developed knowledge translation tools to accompany the guideline, which will hopefully also help address different information needs.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** It is clear that the recommendations apply to adult current smokers, except pregnant or breastfeeding women. I suggest adding more details in the text (scope) for the sake of clinicians: do the guidelines apply to every type of smoker (daily or regular and occasional smokers; those motivated or not to quit) and to people with mental health disorders? (I	Yes, you are correct that the recommendations apply to all of these groups. This has been clarified in the Scope section.

	assume the recommendations apply to all of the above-mentioned groups given the reviews that informed the recommendations)	
3. Are the guidelines supported by the evidence?	**Yes** Yes, but only the available evidence published up to 2020. This point could be added to the limitations section.	We have carried out an additional search for any additional Cochrane reviews published since our last search to ensure the guideline is informed by the most recent available evidence, and have incorporated this in our findings. See Appendix 2. A search update to January 2025 was also carried out for primary studies on e-cigarettes.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Comments/suggestions on recommendations General comments: 1. It might be interesting to present the results of the reviews (on identified benefits and harms) and the rationale under each recommendation. This would facilitate communication and a shared decision-making process regarding which interventions and/or treatments will be used, and at the same time, would allow presentation of all the arguments that support each of the recommendations. 2. Combined interventions and pharmacotherapy: Even if it is not possible to provide detailed recommendations for each intervention/treatment, such as specific doses or durations of treatment, would it be possible to prioritize them? For instance, taking a position on the greater effectiveness of combined behavioural and pharmacological therapies (vs. only one or the other), or on long- and short-acting NRTs.	1. We appreciate the suggestion to present results and rationale with each recommendation. The arrangement of information in the draft follows the standard formatting for guidelines published in CMAJ which includes some key information as a preamble to the recommendations. We have also summarized information to help improve readability (e.g., for systematic review results). However, we have considered this suggestion in development of knowledge translation tools to accompany the guideline (e.g., decision-aid tool). 2. We did not examine comparative effectiveness of different interventions in order to prioritize them. The menu approach to recommendations was taken with the understanding that patients may have to try many interventions before finding what works for them, and that patient preferences (e.g., wanting to avoid medication) will have a strong influence on what is selected. Clinically, there is a risk of attempting to rank what would likely be relatively minor differences in effects, which might discourage patients from trying something more consistent with their preferences that could work for them. We have emphasized this rationale further in the guideline, and have also added

	3. E-cigarettes: I suggest removing the term "against" in the wording of the recommendation (this is the only recommendation for which "for/against" is mentioned) and making a more direct statement, like the 4th key point (one or the other sentence of this point, since both say almost the same thing). It would be useful to add information on the combination of behavioural intervention and follow-up of people who choose to use e-cigarettes to stop smoking.	references to recent network meta-analyses in the limitations section for those who may want to look more into comparative effectiveness. 3. We feel it is important to keep the word 'against' in the wording of the e-cigarette recommendation to emphasize the importance of considering other interventions first. We feel that removing the word 'against' may cause the recommendation to be interpreted as more positive than as currently written. We have emphasized that combinations of interventions can be considered in the Implementation section.
5. Do you have any comments or suggestions to improve the guideline?	**Yes** 1. Key points: Given that there are two key points made regarding e-cigarettes, I suggest removing the 3rd and replacing it with a message about the recommended interventions/ pharmacotherapies. Moreover, the main message on e-cigarettes, in my opinion, is the 4th key point. It might be simpler to merge the 3rd and 4th key points into a single statement. 2. Key messages for the public: I think that a message destined for the public on how effective the interventions/pharmacotherapies are compared to no intervention/"cold turkey" is important. Most smokers do not seek help to stop smoking and successful smoking cessation rates are low. 3. Recommendations regarding online programs: I suggest to avoid using double negative wording in the recommendations such as in No. 4 on	1. Note that the Key Points section has been replaced with the Abstract, as per CMAJ's guideline structure. We noted that the recommended menu of options includes behavioural and pharmacotherapy options. Comments on other Key Point bullets were also considered in writing the Abstract. 2. We have revised this bullet to note that there are several effective options to help 'increase people's odds of quitting' to make it clear that these interventions improved quitting rates versus no interventions. 3. We have revised the wording of the recommendations for computer-based or online programs to make the wording clearer. We have kept the recommendations for these interventions with and without behavioural support separate given that the data for each of these was examined separately as per our protocol. However, we have considered simplified wording for knowledge translation tools to accompany the final guideline. We have also added additional explanation

	online interactive programs. Such wording can be confusing for some people. In addition, I think that the two conditional recommendations on these programs could be combined into one by adding something like "ONLY with additional behavioural support" to recommendation No. 3. 4. E-cigarettes rationale: I think the challenges and uncertainties surrounding e-cigarettes are well-explained, but I suggest adding a reference or more explanation for the following statement: "Fourth, e-cigarette use may reduce harms from smoking but does not address nicotine addiction." Why is this? E-cigarettes, while not the ideal way to stop smoking, notably because of the inhaled vapours for which long-term harms are still unclear, allow reducing the nicotine concentration gradually (similarly to approved treatments using nicotine to treat nicotine dependence), and seem to be an effective tool to help stop smoking traditional cigarettes (Lindson et al., 2023; Lindson et al. 2024). 5. Box 1: Box 1 summarizes the recommendations to a great extent, as well as the results of the underlying work, but I wonder if removing at least one column (on estimating the magnitude of benefit or on the certainty of the estimated benefit, or even both) might improve the usability of the recommendations and prevent misinterpretation, especially since the target audiences of this document (i.e., patients, PCC,	regarding these interventions, which we hope will make the recommendations clearer. 4. Regarding the statement that e- would not address nicotine addiction - it is clear from your comments and those from others that this was not clearly worded. The intention was to indicate that if an individual's goal is to address their addiction or dependence to nicotine, switching from cigarettes to nicotine e-cigarettes does not achieve this as they continue to consume nicotine, despite potentially reducing harms from smoking (particularly if they use the e-cigarette long term). We have revised this sentence to be clearer. 5. Regarding Box 1 (now Table 1), the interventions are listed in alphabetical order so as not to indicate that there is a particular ranking. We feel that the technical information about the magnitude of benefit will be important to some, so we have left it in the Table 1. However, we agree that different users may have different information needs, and have considered your comment in developing knowledge translation tools to accompany the final guidelines. Lastly, we have clarified that the estimated magnitude of benefit is 'over usual care/no intervention' to emphasize that this is incremental benefit over a 'cold turkey' approach.

	policy-makers) are not researchers nor scientists. For example, people who don't know or are not comfortable with the methodology used (even if it is explained or described, since we cannot assume this section will be read) might conclude from Box 1 that: "Experts recommend providing/getting individual counselling, but the benefit is going to be small, and their level of confidence in this benefit is low. Then, why should I engage in a time-consuming intervention for which experts estimate low certainty and low added value?" I am concerned for patients, because, as previously mentioned, most do not seek any help and counselling services uptake is really low. The last survey of the INSPQ is particularly informative in this regard. As mentioned in the text, it is important not to discourage people from getting help to stop smoking – help is what they need.	

Reviewer 10 (Stakeholder): Caroline Silverman, Canadian Partnership Against Cancer

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	(Did not select Yes or No) The guidelines are mostly supported by the evidence, but there are some instances where they could be more clear and specific. Pg. 3: Recommendation: "For patients who have unsuccessfully attempted other interventions, are otherwise unwilling to try other interventions, or express a strong preference, practitioners may engage in shared decision-making regarding the possible use of e-cigarettes with or without nicotine." I understand that the evidence isn't strong for the use of e-cigarettes with or without nicotine, but it is stronger for those with nicotine, and this makes sense given that people smoking cigarettes are generally addicted to nicotine. I don't think that e-cigarettes without nicotine should be recommended with the same level of certainty as e-cigarettes with nicotine.	Thank you for your comments. We agree that the assessment of the magnitude of benefit is indeed larger for nicotine e-cigarettes, although the certainty of this evidence is similar due to similar quality issues across studies. We have separated e-cigarettes with nicotine and e-cigarettes without nicotine in Table 1. We have kept the recommendation the same (conditionally against), but separated the tabular data.
4. Is there any information missing from the guideline that would make it easier to	**Yes**	We did not examine comparative effectiveness of different interventions in order to prioritize them. The menu approach to recommendations was taken with the understanding that patients may have to try many

interpret for primary care practitioners?	Pg. 2: "We recommend several behavioural, pharmacotherapy, and combined intervention options (strong recommendation): Bupropion, NRT, Varenicline, Cytisine" • Suggest the recommendations include more information about which pharmacotherapies have been shown to work best and in which combination, based on the systematic reviews. This would be helpful for clinicians. For example, varenicline has been shown to be more effective than bupropion – this information would be important for primary care providers to have at their fingertips (rather than having to look at the appendix).	interventions before finding what works for them, and that patient preferences (e.g., wanting to avoid medication) will have a strong influence on what is selected. Clinically, there is also a risk of attempting to rank what would likely be relatively minor differences in effects, which might discourage patients from trying something more consistent with their preferences that could work for them. We have emphasized this rationale further in the guideline, and have also added references to recent network meta-analyses in the limitations section for those who may want to look more into comparative effectiveness.
5. Do you have any comments or suggestions to improve the guideline?	1. Suggest a copy edit on the document, to improve clarity and reduce the risk of misinterpretation. 2. Suggest changes to some language that is stigmatizing: - "smokers" should be changed to "people who smoke" - "People who have mental or substance use disorders" could instead be "people living with mental health issues or addiction(s)." - "Unskilled workers" could be changed to "workers whose jobs do not require training or education"	1. Thank you, the manuscript will be copy edited prior to publication. 2. Thank you for these suggestions. We have revised the wording throughout.

	3. Wherever the word province or provincial is used, territory or territorial should be added. 4. It would be helpful to see the distinction about commercial versus traditional tobacco on the first page of the document. 5. Pg. 1: "E-cigarettes (also referred to as vaporizers, 'vapes,' or electronic nicotine delivery systems) might also help quit tobacco smoking or reduce harms of smoking (15)" • "Reduce harms of smoking" makes it sound like vaping along with smoking will reduce the harms of smoking. 6. Pg. 2: "This guideline provides a menu of recommendations for evidence-based interventions that can be provided or referred by primary practitioners to help adults choose stop-smoking options that fit best with their values, preferences, and access." • Access isn't typically a choice, so suggest addressing access in a separate sentence. 7. Pg. 3: "…and that e-cigarettes with nicotine would not address nicotine addiction." • I believe this should say "**without** nicotine" 8. Pg. 3: The harms section would benefit from a sentence at the beginning of the paragraph stating that the magnitude of	3. Thank you for this suggestion. We have revised throughout. 4. This distinction is highlighted in the scope, which will appear early in the published version. 5. We have clarified in this sentence that reducing harms of smoking comes from the switch from cigarettes to e-cigarettes. 6. We agree with this point and have revised this sentence to make a distinction between values and preferences, and the interventions to which people may have greatest access. 7. Regarding the statement that e- would not address nicotine addiction - it is clear from your comments and those from others that this was not clearly worded. The intention was to indicate that if an individual's goal is to address their addiction or dependence to nicotine, switching from cigarettes to nicotine e-cigarettes does not achieve this as they continue to consume nicotine, despite potentially reducing harms from smoking (particularly if they use the e-cigarette long term). We have revised this sentence to be clearer.

	harm from behavioural therapies and pharmacotherapies is far less than continued smoking. 9. Pg. 6: "Fourth, e-cigarette use may reduce harms from smoking but does not address nicotine addiction." • This statement doesn't quite seem accurate. Could it say that e-cigarettes **without nicotine** may reduce harms from smoking but do not address nicotine addiction"? 10. Pg. 6. "Fifth, there are uncertain public health and societal impacts of normalizing e-cigarettes as a population approach to cessation; it could, for instance, inadvertently increase youth uptake of vaping and nicotine addiction in the general population." 1. Vaping and nicotine addiction in Canada is already among the highest in the world and should be addressed through regulatory measures. If e-cigarettes with nicotine were regulated as cessation aids by Health Canada, and proper regulations were in place so that they are not appealing or accessible to youth, e-cigarettes could potentially be recommended as a smoking cessation aid without increasing youth uptake.	8. We agree with your comment, but did not specifically examine the harms of interventions versus the harms of continued smoking so have not included this in the Harms section, which focuses on results of our systematic review. However, we have emphasized in the rationale section, that all recommendations and balancing of benefits and harms of interventions took into account the harms of continued smoking, as this factor did impact decision-making around recommendations. 9. See 7 above. 10. This is an interesting suggestion, however as we did not examine evidence around regulatory interventions, we cannot comment on this.

Reviewer 11 (Stakeholder): Nicole Armstrong, Canadian Association for Rural & Remote Nursing

Disclosure(s):

- Shareholder and contractor to Vital Surgical Specialists
- Employee (on medical leave) of Covenant Care
- Served as expert consultant to Atheneum Hub regarding new pharmaceuticals (related to surgery, obesity, and diabetes)
- Served as expert consultant to GLGInsights regarding obesity and diabetes informatics

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** I might quibble a little with the relative pros/cons of pharmacologic options, but agree that the evidence supports the overall strong recommendations for NRT, bupropion, varenicline.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	page 8 "indigenous" should be capitalized. page 9: when discussing culturally competent care and specific populations for future directions, a specific comment about the cultural role of tobacco	Thank you for your comments. We appreciate you highlighting the oversight regarding capitalization of Indigenous, which we have revised throughout.

	in Indigenous communities in Canada would be a helpful comment for primary care providers.	We have ensured that the scope section clearly indicates that this guideline does not apply to cultural or ceremonial uses of tobacco.

Reviewer 12 (Stakeholder): Darrel Melvin, Alberta Health Services

Disclosure(s):

- 2011 to present: Health Promotion Facilitator II with the provincial tobacco, vaping, and cannabis program of Alberta Health Services. Co-lead of Addressing Nicotine as a Standard of Care workstream.
- 2019 to present: Keep Tobacco Sacred Collaboration https://keeptobaccosacred.ca/index.html 2019
- Recipient of the Canadian Respiratory Health Professional National Award of Distinction in recognition of leadership, mentorship, and knowledge translation at a regional and national level.
- 2017 Recipient of the Canadian Network of Respiratory Care Les Matthews Award for outstanding contribution to respiratory care and education locally and/or internationally through their practice and/or research.

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** I appreciate the introduction with the key points for primary care providers and key messages for public. The description of scope clearly defines the focus of the guideline.	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Smoking cessation for adults aged 18 years or older who currently smoke tobacco cigarettes. The identifies the guidelines do not include interventions for pregnant or breastfeeding populations, as well as, only refers to commercial tobacco.	Thank you.

3. Are the guidelines supported by the evidence?	**Yes** Description provided of the systematic review of Cochrane reviews. The task force provides the Grade approach and evidence to decision framework used to generate the recommendations.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** This revised version of the guidelines does a good job of providing a suite of recommendations which aligns with guidance to primary care providers to use shared decision-making to help guide patients to interventions that are effective, most closely fit their values and preferences and are accessible	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	This is an effective set of guidelines for primary care physicians. One small note under implementation: Many patients need to attempt quitting multiple times with different interventions or combinations of interventions before being successful (I suggest adding “encourage patients to reflect on what they learned with each prior quit attempt so they see these as learning opportunities to build on with the next attempt eg. What worked, what didn’t, what will you do differently this time.”)	Thank you for this comment. We’ve made a note in Implementation that individuals may learn from subsequent attempts and change their preferences. This is in line with the menu approach to recommendations which provides a list of those that are effective, rather than comparing interventions and identifying the ‘optimal’ intervention based on cessation rates.

Reviewer 13 (Stakeholder): Tracy Au-Yeung, Vancouver Coastal Health

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** The objective is covered clearly on p.2 - intended as a guideline/resource for physicians, patients and policy makers. The document is lengthy for patients/public – and summary/fact sheet document would be helpful.	Thank you for this comment. We have also developed tools to accompany the final guideline including a short infographic.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No** Recommend using “people who smoke” instead of “smoker” Recommend defining and using the term “Tobacco Use Disorder” as used in DSM-V P. 1, first para after Key Messages - Last line under prevalence: Insert new sentence here stating Tobacco use is an equity issue and marginalized populations bear a higher burden of tobacco use and associated harm. In the section that talks about these marginalized groups - change wording from “…or have mental or substance abuse disorders” to or have mental health diagnoses or substance use disorders”. Add people who identify as 2SLGBTQ+ to this section.	Thank you for this comment. We have revised the guideline text to use people-first language. We have also clarified that the guideline pertains to cigarette smoking. We have not formally defined tobacco use disorder given that we expect many providers will operationalize this guideline simply by asking if the individual smokes, rather than using a formal definition to guide clinical action. We have revised the wording in paragraph 1 to incorporate your suggestions. Equity issues are also explored in the Equity section.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Suggest inclusion of the CAMH Lower-risk Nicotine Use Guidelines (LRNUG) Lower-Risk Nicotine Use Guidelines (LRNUG) / Lignes directrices sur l'usage de nicotine à moindre risque (LDUNMR) | Nicotine Dependence Services (nicotinedependenceclinic.com) Suggest the inclusion of "Drug Interactions with Tobacco Smoke" NRT_pharmacokinetic_drug_interations_EN_v13 (gov.bc.ca) Suggest using the Best Practices for Health Care Providers Regarding Tobacco Use CAPSA One-Page Info Sheets – to help frame stigma free health focused care. Introduce, distinguish, and emphasize the difference between commercial and traditional tobacco – earlier in the document. P.4 - First statement under "Equity" is confusing: "inequities caused by tobacco use are likely the result of intersecting social determinants …" is this meant to read/mean "the inequity of harm caused by tobacco are likely the result of the SDoH and intersctionality" and/or is it referring to the stigma associated with smoking that causes inequities in access to housing/care etc.? Recommend explaining intersectionaity (the complex, cumulative way in which the effects of	Thank you for these resources. While we have not incorporated these into the guideline as they are not formal smoking cessation guidelines, we have looked to these and other examples to guide discussions around potential tools to accompany the final guideline. We have emphasized the distinction between commercial and traditional tobacco use in the Scope section. You are correct that the first sentence of the Equity section is referring to the inequity of harm from smoking. We have clarified the sentence accordingly. The Equity section of the guideline speaks to the intersectionality. However, we have not examined the specific evidence that would allow us to point to the ways in which the various forms of discrimination might impact individuals of marginalized groups. This specific topic is currently beyond the scope of the guideline. Drivers of smoking behaviour and specific behaviour modification techniques, while interesting suggestions, were not examined in the evidence for this guideline. We therefore do not comment on the specifics of behaviour modification techniques or their theoretical underpinnings, but rather provide an overview of options that providers can use in shared decision-making with individuals who smoke cigarettes, to help improve their likelihood of quitting.

	multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups) and highlighting its relevance to TUD earlier in the document. Recommendation – under recommendation options include and explain the term behavioural modification – understanding why a person smokes (what's triggering the behaviour?) and how a person can change that behaviour?) Behavioural modification tries to break the habit in addition to pharmacotherapy.	
5. Do you have any comments or suggestions to improve the guideline?	P. 1 – prevalence rates - suggest putting statistics into a chart – better visual.	Thank you for this comment. We are limited in the use of figures and tables in the document, so therefore have opted not to put this information in a chart. However, we refer to documents that include such helpful visuals, for those who may want to look into this data further.

Reviewer 14 (Stakeholder): Aaron Ladd, Canadian Network for Respiratory Care

Disclosure(s):

- Have received Honoraria to speak specifically on the topic of Tobacco, Vaping and Cannabis within the past 5 years
- Work in Tobacco control with the AHS Tobacco Vaping and Cannabis Program
- Also the Director to tobacco education programs for the CNRC and sit on the CNRC executive board

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is	**Yes** (No comments provided)	Thank you.

meant to apply clearly described?		
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** Doc 1 page 2: Consider a hierarchy of medication in the list based on efficacy data. Appendix 3. Recommendations on the left hand side do not line up with the content.	Thank you for this comment. We did not examine comparative effectiveness of different interventions in order to prioritize them. The menu approach to recommendations was taken with the understanding that patients may have to try many interventions before finding what works for them, and that patient preferences (e.g., wanting to avoid medication) will have a strong influence on what is selected. We have emphasized this rationale further in the guideline, and have also added references to recent network meta-analyses in the limitations section for those who may want to look more into comparative effectiveness. We have reviewed Appendix 3 to ensure there are no inconsistencies. Please see the text summary within each section for the full explanation of the judgments made in the left column.
5. Do you have any comments or suggestions to improve the guideline?	(No comments provided)	Thank you.

Reviewer 15 (Stakeholder): Cynthia Russell, Canadian Nurses Association

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** It could be helpful for providers to have more guidance on how to have non-judgmental, trauma informed conversations with clients about smoking cessation and how to understand their smoking stories and barriers.	Thank you for this comment. We recognize the importance of having non-judgmental, trauma informed conversations. Specific guidance on how to have those discussions is outside the scope of this guideline, but we agree that it could be helpful.
5. Do you have any comments or suggestions to improve the guideline?	See above. There may be an assumption that all primary care providers are adept and well informed about how to have brief intervention and coaching conversations with clients about how to quit smoking. Perhaps some opening questions and a guide about how to approach this could be helpful.	Thank you for this comment. We agree that a guide on having discussions with patients could be helpful, although outside the scope of the evidence that could be examined for this guideline.

Reviewer 16 (Stakeholder): Iris Mabry-Hernandez, Agency for Healthcare Research and Quality / United States Preventive Services Task Force

Disclosure(s): None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	No. I thought that the guideline was reflective of the evidence.	Thank you.

Reviewer 17 (Stakeholder): Kate Harland, Canadian Nurses Association

Disclosure(s):
- Vice President – Harm Reduction Nurses Association

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.

2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	I would recommend using people first language – instead of smokers, use people who smoke. This is less judgemental and recognizes the person before the behaviour.	Thank you for this comment. We have revised the guideline text to use people-first language.

Reviewer 18 (Stakeholder): Grace Allen, Prince Edward Island

Disclosure(s): None

Question	**Reviewer comments**	**CTFPHC response**
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.

3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	(No comments provided)	Thank you.

Reviewer 19 (Stakeholder): Elizabeth Holmes and Ariana Del Bianco, Canadian Cancer Society

Disclosure(s):

- The Canadian Cancer Society provides information on cancer risk associated with smoking commercial tobacco and offers smoking cessation programs

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	(No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	(No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	(No comments provided)	Thank you.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	(No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	Key Points: 1. What are the differences between the key points and the key messages? Can they be merged? o For example, encourage clearly starting with the menu of effective options (not in key points) before addressing e-cigarettes (found in both key points and key messages) 2. Really great to see plain language key points/key messages 3. Regarding statement: "Primary care providers should ask their patients about smoking status and offer or refer them to effective interventions to help them quit smoking." o Who is included in the primary care provider definition? Doctors/physicians, nurse practitioners, physician assistants and pharmacists all play a role in primary care and smoking cessation. 4. Regarding statement: "The Canadian Task Force on Preventive Health Care recommendations provide a menu of smoking cessation options to use in	1. Apologies if the distinction between key point and key messages was unclear. We have removed the Key Points in favour of the Abstract section as per CMAJ formatting. This leaves the Key Messages for Patients as it's own section, which are plain language, and developed with input from the Task Force Patient Advisors Network (TF-PAN). 2. Thank you. 3. We agree that there are a wide variety of primary care providers that could implement the guideline. We have clarified this in the Scope section. We have also removed reference to physicians or specific types of providers throughout and have used the word primary care provider. 4. We agree that access to healthcare providers could impact the ability of patients to access some of these interventions. We have added this as a consideration to the Feasibility section. We also considered this further when developing knowledge translation tools to accompany the final guideline, which are likely to be used by a wide variety of audiences. 5. We have revised the first sentence of the introduction to note that there is a risk of multiple types of cancers. 6. We agree that counselling is a specific type of intervention often provided by trained specialists.

	shared decision-making with patients to select the most suitable choice." ○ Shared-decision making only works when someone has access to a primary care provider. The emphasis on shared-decision making without acknowledging lack of access for many people in Canada makes the key points/recommendations less applicable to everyone. ○ Options are also available to help patients make an informed decision about smoking cessation. Key Messages for the Public: 5. Regarding statement: "Quitting smoking improves your health and can lead to a longer life. Quitting reduces the risk of serious illnesses like heart disease, stroke, and cancer." ○ Suggestion: "and at least 16 different types of cancer" ○ To recognize that cancer is not one disease. 6. Regarding statement: "Counselling" ○ Concerned about the use of 'counselling' as counsellor is a different profession. Suggest "Specialist support" or "Professional guidance. See also suggestion below on recommendations (page 2)." Recommendation:	We have revised the bullet in key messages for the public to say advice or counselling. 7. See 4 above. 8. The terminology regarding trained cessation counsellor is more specific than cessation specialists, who may do more than counselling. This wording was based on what was used in studies and consultation with content experts. 9. Thank you for this comment. Nicotine pouches or other smokeless tobacco products are currently out of the scope of the guideline. We may consider a discussion on this issue for future updates.

	7. Regarding statement: "We recommend that all patients who smoke be encouraged to stop and engaged in shared decision making about using one or more smoking cessation interventions (strong recommendation)." o See above re: shared-decision making 8. Regarding statement: "Individual or group counselling from a trained tobacco cessation counsellor" o Preferred terminology: trained tobacco cessation specialists 9. Regarding statement: "We recommend that the following interventions not be considered as options (strong recommendation):" o Will nicotine products be included in the next guideline review? Or is there an opportunity to do a mini review on this product to supplement the larger guideline? o We recognize that they were not on the Canadian market when this guideline update would have started, but it is a very timely topic now	

Reviewer 20 (Stakeholder): Cynthia Callard, Physicians for a Smoke-Free Canada

Disclosure(s):

- I am a paid employee of Physicians for a Smoke-Free Canada, which has and continues to take positions on issues related to tobacco use and public policy

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Yes. It is made clear in both the title and the scope that the guidelines are intended to help "adults" and that adults includes individuals over 18 years of age.	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**(Did not select Yes or No)**	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	1. The guideline fails to identify the risks associated with dual use of e-cigarettes and smoking. This is something that is increasingly acknowledged as important by those analyzing the benefits and risks of using e-cigarettes – as reflected in the updated draft Australian recommendations (highlighted below):	1. We did not specifically examine the evidence regarding the harms of dual use (e.g., magnitude of harms for someone who uses e-cigarettes but continues to smoke at varying levels). However, we do know the harms of continued cigarette smoking, and recognize that reductions in smoking may not have major health benefits given harms of even light smoking. Both of these factors were key in

	Current RACGP draft recommendations with respect to e-cigarettes: Recommendation 15 – For people who want to quit but have failed to achieve smoking cessation with first-line therapy (combination of behavioural support and TGA-approved pharmacotherapy), it may be reasonable to recommend NVPs in conjunction with behavioural support. The decision to proceed with this treatment must be part of an evidence-informed shared-decision making process, where the patient is aware of the following. • Due to the lack of available evidence, the long-term health effects of NVPs are unknown. • NVPs are not registered therapeutic goods in Australia and therefore their safety and quality have not been established. • The lack of uniformity in vaping devices and NVPs (e.g. in ingredients and dosage) increases the uncertainties and risks associated with their use. • To maximise possible benefits and minimise risk of harms, dual use (tobacco and e-cigarettes) should be avoided and the duration of NVP use should be minimised. • The importance of the patient returning for regular review and monitoring.	judging the magnitude of net benefit of different interventions and developing recommendations (see Evidence-to-Decision frameworks in appendices). Based on this, we have indicated in the Rationale section, that one of the uncertainties related to e-cigarettes is the potential for dual use, which means the individual is continuing to be harmed by smoking. 2. Thank you for flagging this clarification in the appendices. We have revised the wording accordingly.

	Source: https://www.racgp.org.au/getmedia/2f8ffac1-8751-41aa-906f-f0ec7feca048/RACGP-NVP-and-Vaping-Cessation-Consultation-provisional-draft-Dec2023.pdf.aspx The current draft regulation under discussion proposes the following recommendation for e-cigarettes: For patients who have unsuccessfully attempted other interventions, are otherwise unwilling to try other interventions, or express a strong preference, practitioners may engage in shared decision-making regarding the possible use of e-cigarettes with or without nicotine. Patients who decide to use e-cigarettes to quit smoking should be informed of the risks and uncertainties related to e-cigarettes due to the lack of approved products with consistent formulations, the lack of long-term safety data, and that e-cigarettes with nicotine would not address nicotine addiction. A similar recommendation which acknowledged the risks of dual use could read as follows (amendment highlighted in yellow): For patients who have unsuccessfully attempted other interventions, are otherwise unwilling to try other interventions, or express a strong preference, practitioners may engage in shared decision-making regarding the possible use of e-cigarettes with or without nicotine. Patients who decide to use e-cigarettes to quit smoking should be informed of the	

	risks and uncertainties related to e-cigarettes due to the lack of approved products with consistent formulations, the lack of long-term safety data, that e-cigarettes with nicotine would not address nicotine addiction, and that dual use of e-cigarettes and cigarettes should be avoided. 2. In the Appendices, the statement "The Government of Canada has established a federal Tobacco Strategy with a goal of reducing smoking prevalence to 5% by 2035." Is incorrect. The corrected versions should read "The Government of Canada has established a federal Tobacco Strategy with a goal of reducing tobacco use to less than 5% by 2035."	

Reviewer 21 (Stakeholder): Gillian Pritchard, Trevor Mischki, and Michel Blanchard, Health Canada

Disclosure(s):
Gillian Pritchard

- Author on following publications:
- Lindson N, Pritchard G, Hong B, Fanshawe TR, Pipe A, Papadakis S. Strategies to improve smoking cessation rates in primary care. Cochrane Database of Systematic Reviews 2021, Issue 9. Art. No.: CD011556. DOI: 10.1002/14651858.CD011556.pub2.
- Papadakis, S., Pipe, A., Kelly, S., Pritchard, G., & Wells, G. A. (2015). Strategies to improve the delivery of tobacco use treatment in primary care practice (Protocol). Cochrane Database of Systematic Reviews. doi:10.1002/14651858.cd011556
- Pritchard, G., Gierman, T., Papadakis, S., Chow, H., Hurtubise, R., Aitken, D., Harvey, E. (2015). Integrating cross-sector smoking cessation programs in the Champlain region to improve access, reach and use of evidence based services. Journal of Cardiopulmonary Rehabilitation and Prevention, 35, 372. doi: 10.1097/HCR.0000000000000146
- Reid, R. D., Pritchard, G., Walker, K., Aitken, D., Mullen, K., & Pipe, A. L. (2016). Managing smoking cessation. Canadian Medical Association Journal,188(17-18), E484-E492. doi:10.1503 /cmaj.151510
- Walker, K. L., Noble, S. M., Pritchard, G., Jessup, K., & Mullen, K. (2018). Redemption characteristics and quit rates in a cohort of female inpatients receiving quit cards for smoking cessation - A pilot study. Canadian Journal of Cardiology,34(4). doi:10.1016/j.cjca.2018.01.052

Trevor Mischki: None

Michel Blanchard: None

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**No** The objective of the guideline is not explicitly stated. I presume that it is "to provide guidance to primary care professionals, patients, and policymakers on adult smoking cessation" (based on info provided in the 'Scope' section).	Thank you for this comment. The Scope section does indeed outline the objective of the guideline. This is also included in the Abstract for the guideline which has now been added.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**(Did not select Yes or No)** It can be gleaned from the 'Scope' section that the guideline is meant to apply to "adults aged 18 years or older who currently smoke tobacco cigarettes, and who aren't pregnant or breast/chestfeeding". This is not easy to pull from a quick scan of the document, it took some focussed reading to find it. This information should be incorporated into the key points and key messages for the public.	Thank you for this comment. We have added some text to the Abstract to emphasize the target population.
3. Are the guidelines supported by the evidence?	**No** 1. One thing that is missing is acknowledging where the task force findings differ from Cochrane findings and other smoking cessation guidelines and explaining the rationale for conducting your own reviews and why different conclusions were reached. The guidelines are supported by the two reviews (17,18) that were conducted by the task force, however given the dated nature of the literature review this limits the relevance of the findings particularly for cytisine and e-cigarettes. This should be highlighted as a limitation up front.	1. A comparison of our systematic reviews versus existing reviews is included in the published systematic reviews supporting the guideline, which are now published in Systematic Reviews. We also added a comparison to the benefits section of the guideline. Our conclusions actually align very closely with theirs: they found evidence for a benefit of e-cigarettes for smoking cessation with a similar magnitude as our review, but found that data on harms was limited, with no long-term data on harms, just as we found. Regarding the date of search, we have updated the e-

	• In addition through out the document, the end date of the literature used to support the recommendation/assessment should be included so that readers can evaluate its current relevance. 2. We advise only citing peer reviewed literature, some of the references are opinion / advocacy pieces. 3. We advise to either completely re-run the literature review or remove all citations post the lit cut off date – as of now it appears somewhat arbitrary to include the Banks review but not other more recent pieces.	cigarette search to January 2025, and carried out an additional search for updates to existing Cochrane reviews in June 2024. These new findings were considered by the Task Force and are included in the final guideline, to ensure it reflects the most recent data. 2. Two statements in the Rationale section are supported by references to advocacy groups: a. Many e-cigarette brands are owned by tobacco companies b. and are developed to maximize nicotine delivery, for example via nicotine salts which make high concentrations of nicotine more palatable While we generally agree with the suggestion of citing peer reviewed literature, the first statement is not made any less factual due to the source of the information. The second statement included a reference to a peer-reviewed study and to a piece by an advocacy group. We have removed the latter reference as it was not necessary. 3. As noted above, we have updated the literature informing the guideline. The Banks review is not part of the evidence informing the recommendations, but rather included, in addition to our review, to support the statement that there is no long term data on harms of e-cigarettes, given that they came to this same conclusion, while looking at a wider variety of evidence sources and outcomes beyond those that might be informative for clinical guidelines.

4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** 1. Primary care providers could benefit from guidance on dosage and duration of medications. They could also benefit with some direction on where to find self-help materials and other behavioural supports for their patients. The way the information is currently presented, one could conclude that the recommended interventions are all equally effective. It would be useful for practitioners to know the relative effectiveness of each intervention and combination of interventions. The guideline does not address combining long-acting and short-acting NRT, which does improve quit rates. 2. The 'harms' section could benefit from more elaboration on bupropion, especially since the review finding contradicts Cochrane's finding that: "We are moderately confident that bupropion could rarely cause some serious health effects" 3. The guideline makes reference that primary-care providers and patients can consider e-cigarettes, if the patient has already made an unsuccessful quit attempt using other interventions, therefore it would be clinically useful to define what makes a quit attempt 'unsuccessful' (time period, patient perception, slips, relapse). 4. We suggest a disclaimer at the start of the e-cigarette section highlighting the potential limitations of dated literature as practitioners may make different decisions	1. We did not examine comparative effectiveness of different interventions in order to prioritize them. The menu approach to recommendations was taken with the understanding that patients may have to try many interventions before finding what works for them, and that patient preferences (e.g., wanting to avoid medication) will have a strong influence on what is selected. Clinically, there is a risk of attempting to rank what would likely be relatively minor differences in effects, which might discourage patients from trying something more consistent with their preferences that could work for them. We have emphasized this rationale further in the guideline, and have also added references to recent network meta-analyses in the limitations section for those who may want to look more into comparative effectiveness, which is only available for some comparisons. There is additional information about dosages used in included studies in the Evidence to Decision framework and GRADE tables included with the published systematic review, but we also recognize that this will likely be dictated by product monographs. 2. The most recent Cochrane review on bupropion had 23 RCTs on bupropion serious adverse events and had moderate certainty of 1 more per 1,000 (0 more to 1 more). Based on RR of 1.16 (0.90-1.48). The authors noted that serious adverse rates were low and estimates incorporated the potential of no difference. The Task Force considered update

	based on more recent evidence. We suggest including a link to the CAMH vector project as a current Canadian assessment. https://www.nicotinedependenceclinic.com/en/project-vector	information from Cochrane reviews, and has revised their judgment of harm for bupropion to indicate there may be a small harm due to a small increase in non-serious events. 3. We have concerns regarding the suggestion to define what makes a quit attempt unsuccessful. In practice, this is likely to be driven by what patients tell providers about their quit attempts, which may or may not meet a formal definition. Patient preference will also play in to whether patients wish to switch interventions. There could be a risk to being overly prescriptive about what counts as a quit attempt. 4. We have updated the evidence as noted above.
5. Do you have any comments or suggestions to improve the guideline?	1. Reference 8: should be updated to include new CTNS 2022 data 2. Reference 17, 18: these citations need updating, they are incomplete. 3. The document as a whole does not flow very well (e.g. Findings and Recommendations come before the Methods section). The sections feel choppy and not well connected. Would benefit from some restructuring and/or an introduction that provides context to the document. 4. In the 'Rationale: E-cigarettes' section, argument 4 'e-cigarette use may reduce harms from smoking but does not address nicotine addiction', needs more elaboration, as one could assume this is also an argument against NRT. Argument 5 needs references.	1. Reference 8 has been updated to the 2022 CTNS data as suggested. 2. References 17 and 18 were placeholder references for the systematic reviews, which are now published and referenced accordingly. 3. The structure of the guideline follows the formatting used by CMAJ for published clinical practice guidelines an has been revised in collaboration with CMAJ Editors.

	5. In the 'Scope' section, it states that the guidelines are for primary care providers, patients and policymakers. These are three very distinct audiences. The current document feels like it is written mostly for the primary care/science audience. How will you communicate your findings to policymakers and patients? 6. With respect to recommendations for policy makers, further clarification should be provided to contextualize 'population-level' interventions. As clinical guidance, this could be aligned more with individual level interventions. It is unclear how these guidelines should be interpreted by policy makers for consideration of vaping as a population level intervention - without further context and explanation of the evidence related to a population level approach and dedicated assessment for that context. Public opinion research suggests significant misperceptions exist about/between the harms of combustible tobacco, nicotine, ecigarettes, and the benefits/efficacy of all available quit supports. Clarification around the use of vaping to quit smoking should be considered – considerations around their use should be distinguished and contextualized like in the case of use of NRT – where such are utilized for a specific period, to aid in nicotine withdrawal and ending tobacco use. Messaging on vaping does not implicitly or explicitly address how it should be used to quit smoking, and that quitting vaping will further reduce your risks – and this could also address the concerns of long-term nicotine addiction. 7. For the public facing document, perhaps the scope should be clearly outlined at the onset / top of page 1; before getting into key messages and such.	4. Others found this statement confusing as well, and we have clarified it in the text. We have also clarified the 5th argument against e-cigarettes, noting that it is a concern of the task force, in their judgment. 5. We agree that different audiences may have different information needs. We have revised the Scope section to highlight primary care professionals as the main audience, with a note that some other stakeholder may also find the guideline of use (recognizing it may not provide all information needed for all of these audiences). Knowledge translation tools have also been developed to accompany the final guideline. 6. The Task Force does not make recommendations for policy-makers. However, they may still be an audience for the guideline despite the main audience being primary care providers. For example, many provincial/territorial screening programs use Task Force guidelines as one input to inform screening policies. 7. Thank you for this suggestion. We have outlined the scope in the Abstract of the guideline. We also

	8. Would recommend enhancement/adjustment of messaging around 'shared-decision making' as it pertains to the exploration of cessation options with the client. Recognize some persons with lived experience were consulted in this process, but perhaps opportunity exists to bolster 'person-centred/person first' approach – meeting people where they are at in their quit journey. Quantitative/qualitative research suggests most people have already tried most of the available approved quit aids. Patients should be encouraged to try things again, try things differently, try combination, try something new. Consider referencing/ Centre for Addictions and Mental Health's Lower Risk Nicotine Use Guidelines, as part of key messages for public and practitioner. 9. Would recommend doing a final scan to update any references, sources, particularly scans that are framed as living/systematic reviews to assess possible implications for updated messaging as a result of new information Example: the Cochrane review on Electronic Cigarettes for smoking cessation referenced in the literature review is dated 2020, however this scan is a living source, with updated scan January 2024, including data from July 2023.	considered this input in developing the knowledge translation tools to accompany the guideline. 8. We have added additional information and explanation around shared decision-making in the implementation section. This includes general principles the follow, as we did not examine evidence on specific elements to include in the context of smoking cessation discussions. 9. We have updated the evidence for the guideline as described above.

Reviewer 22 (Peer Reviewer): Mark Eisenberg, McGill University

Disclosure(s):
- Research and publications related to e-cigarettes and smoking cessation
- Grants related to the research mentioned above

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	1. It would be valuable to specify that certain patient groups, particularly those with cardiovascular disorders, may derive greater benefits from smoking cessation and should be offered combined approaches from the start, such as individual counseling paired with pharmacotherapy, as a more effective strategy. 2. The authors could consider replacing the term “smokers” with “individuals who smoke” or “people who smoke” etc. in their	1. While we agree that different population groups might warrant different approaches to smoking cessation, this is outside the scope of the current guideline which aims to provide a menu of evidence-based options to consider with any adult who smokes (and is not pregnant or chestfeeding).

	recommendations, based on the people-first language policy of Tobacco Control. People-first language policy (2023) Tobacco Control. Available at: https://tobaccocontrol.bmj.com/pages/people-first-language-policy (Accessed: 12 April 2024). Hefler M, Durkin SJ, Cohen JE, et al. New policy of people-first language to replace 'smoker', 'vaper' 'tobacco user' and other behaviour-based labels. Tob Control. 2023;32(2):133-134. doi:10.1136/tc-2023-057950 3. Recommendation, page 2: Pharmacotherapy The authors might consider adjusting the order of pharmacological agents for smoking cessation based on their efficacy. The most recent evidence suggests that varenicline is more effective than NRT alone or bupropion. 4. Page 3 The references listed in the recommendations might benefit from a careful review. The document indicates that the data presented are based on an overview of Cochrane reviews on smoking cessation followed by an updated review of primary studies for e-cigarettes, referenced as #17 and #18 on page 16. There appear to be challenges in locating these documents due to potential inaccuracies in the titles and missing publication dates. The only document found is a protocol by Hersi, M. et al. (2019) ("Effectiveness of stop smoking	2. We agree with this suggestions and have changed the wording throughout the guideline. 3. We did not examine comparative effectiveness of different interventions in order to prioritize them. We have therefore listed the interventions in alphabetical order within each group in Table 1. The menu approach to recommendations was taken with the understanding that patients may have to try many interventions before finding what works for them, and that patient preferences (e.g., wanting to avoid medication) will have a strong influence on what is selected. We have emphasized this rationale further in the guideline, and have also added references to recent network meta-analyses in the limitations section for those who may want to look more into comparative effectiveness. 4. References 17 and 18 were placeholder references for the systematic reviews, which are now published and referenced accordingly. Apologies that this was not clear. 5. We have updated the evidence on e-cigarettes to January 2025, and revised the guideline accordingly. The systematic review informing the guideline is also now published in Systematic Reviews and outlines all the included studies. We have also added a comparison with the Cochrane review in the benefits section.

	interventions among adults: Protocol for an overview of systematic reviews and an updated systematic review', Systematic Reviews, 8(1). doi:10.1186/s13643-018-0928-x). 5. Paragraph 2 states, "Our e-cigarette review identified 11 randomised controlled trials (RCTs) and 1 cohort study on the benefits and harms of e-cigarettes for smoking cessation (18)". Does this represent the number of RCTs with follow-ups longer than six months? It may be beneficial to revise this sentence, as the 2024 Cochrane review on e-cigarettes for smoking cessation now includes 47 RCTs. Link: DOI: 10.1002/14651858.CD010216.pub8 6. Paragraph 3. The authors may wish to include the study published in February 2024 in the NEJM, which provides evidence on the efficacy and safety of e-cigarettes for smoking cessation with a six-month follow-up period. Auer, R. et al. (2024) 'Electronic nicotine-delivery systems for Smoking Cessation', New England Journal of Medicine, 390(7), pp. 601–610. doi:10.1056/nejmoa2308815.	6. Thank you for flagging this study published shortly after our last search date, which appears to align with the findings from our other studies. We have made a note about this study in the limitations section.

Reviewer 23 (Peer Reviewer): Milan Khara, Vancouver Coaster Health Addiction Services

Disclosure(s):

- Honoraria from makers of smoking cessation medications (Pfizer and Johnson and Johnson) but not in past 5 years

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** 2 points: increasingly tobacco users are no longer referred to as "smokers" (note: people with schizophrenia v schizophrenics) The point here is that an individual is not defined by their addiction.	Thank you for this comment. We will revise the guideline text to use people-first language.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	1. The 3rd keypoint is not well written. It does not flow and I would argue is poor English. Needs breaking up a bit! 2. I am not sure what "electrostimulation" is…it doesn't refer to transcranial magnetic stimulation does it? This has a growing body of efficacy in smoking cessation	1. Thank you for pointing this out. The Key Points section has been reformatted into an Abstract as per CMAJ's editorial formatting. 2. No, electrostimulation is not referring to transcranial magnetic stimulation but rather electric current applied to the head via surface electrodes or needles. Thank you for highlighting the need to explain what is meant by this intervention, which as

	3. This line: " e-cigarettes with nicotine would not address nicotine addiction" Presumably a typo? Surely "…without nicotine….". 4. Excellent succinct document. Look forward to it's availability.	have done in the recommendation section and Table 1. 3. Regarding the statement that e-cigarettes with nicotine would not address nicotine addiction - it is clear from your comments and those from others that this was not clearly worded. The intention was to indicate that if an individual's goal is to address their addiction or dependence to nicotine, switching from cigarettes to nicotine e-cigarettes does not achieve this as they continue to consume nicotine, despite potentially reducing harms from smoking (particularly if they use the e-cigarette long term). We have revised this sentence to be clearer. 4. Thank you for your comments.

Reviewer 24 (Peer Reviewer): Alice Ordean, St. Joseph's Health Centre

Disclosure(s):
- Honorarium from the Centre for Addiction and Mental Health for webinar
- Salary support for academic work from Department of Family Medicine, St. Joseph's Health Centre, Unity Health Toronto

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** Objectives are not explicitly stated on page 2 – the wording "provides a menu of recommendations for evidence-based interventions" may be revised to "providing a menu for evidence-based interventions" as an example.	We have made the suggested edit to page 2. The objectives will also be included in the abstract for the guideline.

2. Are the patient groups to whom the guideline is meant to apply clearly described?	**No** Scope of the review was limited to "adults aged 18 years and older who currently smoke tobacco cigarettes". There was no mention in the guideline about the demographic characteristics of participants included in the Cochrane reviews. To determine the applicability of different smoking cessation interventions, It would be important to know if women or different age groups were included in the original studies that shaped the Cochrane reviews.	The Scope and Recommendation statements take into account the populations included in the studies examined for the guideline. This is outlined in the Evidence-to-Decision frameworks accompanying the guideline (i.e., how the Task Force judges that evidence applies to various populations). If evidence examined did not apply to a certain populations, this would be highlighted (as it is for pregnant populations). The systematic reviews informing the guideline are also now published, for those who may want more information.
3. Are the guidelines supported by the evidence?	**Yes** Recommendations for effective interventions are based on the review of the evidence.	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**Yes** There are 2 areas that may need further explanation with respect to implementation of counselling interventions. 1. First, the concept of brief advice by primary care practitioners needs to be explained in more detail. It may be helpful to provide an overview of what components should be part of brief interventions. 2. Second, the concept of shared decision-making should be also described. There are several tools already developed which outline what are key components of shared decision-making eg. AHRQ fact sheet on shared decision-making.	1. Across studies included to provide evidence on brief advice, the interventions varied considerably. Brief advice interventions in most cases were less than 5 minutes in length, and consisted of advice to the patient to quit smoking. This sometimes included outlining risks associated with smoking, importance of quitting, and potential methods, although very few studies provided details about what was included in the advice. More intensive advice interventions generally used similar methods but with additional materials (brochures, guides, etc.) as well as follow-up appointments to track progress and provide additional advice/encouragement. Given this wide variety, we are limited in our ability to specify how advice should be provided. We do however note in the Implementation section that providers should ask patients about smoking, advise

	These additional details either as part of the main document or as separate appendices would enhance advice provided by primary care providers.	them to quit, and use shared decision-making to explore options for other interventions. 2. We have expanded on the concept of shared decision-making in the Implementation section, outlining some of the key principles, with a Canadian reference.
3. Do you have any comments or suggestions to improve the guideline?	There are some additional points of clarification that may be considered in the guideline. 1. In general, the guideline refers to "smoking" which I assumed meant "cigarette smoking" so this may need to be explicitly stated in the introduction, if that is the case. 2. It would be helpful for the target audience for this document to be clearly stated. I am assuming that it includes both patients and health care providers, based on the lay language and vague terminology throughout the document. 3. The term "brief interventions" which has been studied may be more suitable than brief advice by providers. 4. Key Points: It may be helpful to add a bullet about what interventions were found to be effective and should be considered as first options by patients and providers. 5. The last bullet related to e-cigarettes needs clarification around the limited benefit of e-cigarettes based on the current evidence and	1. Yes, that is correct. We have clarified this throughout the guideline. 2. The target audiences are outlined in the Scope section and in the abstract. We have also developed knowledge translation tools to accompany the final guideline to help support users with different information needs. 3. Thank you for this suggestion, but after discussing, we feel that the term brief advice is more specific than 'brief interventions.' 4. We have replaced the Key Points with an Abstract section and have noted that the options recommended includes both behavioural interventions and pharmacotherapy, which are recommended as first options.

	therefore, the recommendation against their use except in some circumstances. 6. Key Messages: Are the interventions listed based on level of evidence? If not, most practitioners transition from counselling and self-help information to pharmacotherapy options and not the other way around. 7. The last bullet contains some confusing language - "there are concerns and unknowns" may need to be clarified to more succinct language. 8. Scope It may be helpful to the reader to state the scope as inclusion criteria and exclusion criteria. 9. Benefits and harms of interventions These two sections contain information with different types of interventions mixed together. It would be more informative to separate the interventions by type – for example, counselling, self-help materials and pharmacological interventions. 10. Harms: Cited harms for NRT such as "increased palpitations or chest pains" are not specific to NRT and actually would related to nicotine use so may cause bias against NRT if mentioned specifically for NRT.	5. As per the rationale section, there may be a small to moderate benefit for cessation with e-cigarettes, however, key to the recommendation is a number of uncertainties, particularly around the harms. The Abstract has been written to reflect these important uncertainties, while noting that they may be effective for some people given the data on benefits. 6. No they are not listed based on level of evidence. Thank you for flagging this. We've rearranged them in alphabetical order to match how we have organized the recommendations and Table 1. 7. We have removed 'and unknowns' for succinctness given that 'concerns' also includes concerns about the lack of information (or unknowns). 8. The inclusion criteria for the evidence review that informed the guideline are included in the Methods section. We now also reference the published evidence reviews for the guideline, for those who wish to examine these in more detail. 9. We agree that some readers may wish to see evidence broken down by intervention, so we have

	11. Since the word "harms" may also include side-effects of interventions especially pharmacotherapies, it is surprising that no side-effects of bupropion were documented in studies. Similarly, St. John's wort and S-adenosyl-L-methionine have well-documented side-effects which were not identified. 12. Resource: It is important to note that NRT products are not covered by the Ontario health care system so only some pharmacotherapies have coverage. 13. Rationale – Behavioural interventions The statement "Data on benefits for computer or internet-based interventions without additional personal support were very uncertain." I am not sure that I understand what "very uncertain" refers to here – is it that there is a lack of data or were the findings not conclusive or conflicting? Further explanation would enhance the reader's understanding of this section.	included detailed results in Appendix 1. In the body of the guideline we have summarized the data at a high level with headers for different types of interventions (with details in an appendix for those who wish to examine in greater detail). 10. The studies that examined harms of NRT compare NRT to placebo or no intervention, and an increase in palpitations/chest pains is above that experienced by the placebo group (who was more likely to continue smoking). Therefore we feel it is important to note this as something that patients may experience when using these interventions. 11. We have updated the data from Cochrane reviews related to bupropion and other interventions, which includes additional data on harms. It is now noted that bupropion may result in a small increase in adverse events. The most recent data from Cochrane reviews on St. John's wort and S-Adenosyl-L-Methionine still did not provide clear evidence on harms for these interventions when used for smoking cessation. 12. We have noted limited coverage for some interventions as a potential barrier in the Feasibility section, and have also noted in Implementation that

		an individual's ability to access to interventions should be considered. 13. This refers to available data being of poor quality. We have clarified this in the sentence to prevent confusion.

Reviewer 25 (Peer Reviewer): Carrie Patnode, Kaiser Permanente Center for Health Research

Disclosure(s):

- Lead investigator for systematic review and presentation on tobacco cessation interventions among adults for the U.S. Preventive Services Task Force

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** Related to my comment under question #4: perhaps just be really clear up front about what behavior you're talking about. Sounds like only those who currently smoke tobacco cigarettes? What about users of other tobacco or nicotine-containing products?	Thank you for this comment. We will clarify that the guideline pertains to cigarette smoking.
3. Are the guidelines supported by the evidence?	**Yes** I was surprised to see Low certainty grades for NRT (hundreds of RCTs) and combined behavioral plus	We understand this as a limitation of our approach. The approach taken to examine Cochrane reviews and pull analyses that restricted to placebo or no intervention controls sometimes limited the available data. This has been

	pharmacotherapy. I'll keep reading – but am curious how you arrived at this. In Appendix 3, the rows for NRT seem to represent very small slivers of evidence. I wonder if this needs another look to compare to your overview of reviews. The Cochrane review concluded high certainty of evidence, although I acknowledge this is when all 133 trials were considered. As I said, just surprised by the Low certainty of evidence here.	highlighted as a limitation in the guideline, as well as in the systematic review which is now published. The task force is aware of other analyses of the evidence included in Cochrane reviews and has indicated in the limitations section that they would not alter the strong recommendation in favour of interventions like NRT.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** You might consider defining "smoking" right up front. Do you only mean conventional combustible cigarettes? Or do you mean "tobacco" use as defined by sources like the FDA, which would include non-pharmaceutical nicotine products like nicotine pouches? Or, e-cigarettes delivering nicotine?	Thank you for this suggestion. We have clarified that we are referring to cigarette smoking, as other tobacco products have not been examined at this time.
5. Do you have any comments or suggestions to improve the guideline?	1. Under Key Points, bullet 3: "There is substantial uncertainty…" – should that sentence include "of e-cigarettes for smoking cessation"? 2. I commend you on the language in the key points and recommendation on the use of e-cigarettes. 3. Under limitations, 2nd paragraph: "did not provide data on all populations who may be disproportionately impacted…". From my knowledge of the evidence base (and Cochrane reviews), most RCTs included in these reviews are among smokers who are ready to quit, intend to quit, or want to quit. We seem to know less and haven't synthesized the evidence very well among patients who may not express a	1. The Key Points section has been replaced by the Abstract as per CMAJ. We've clarified the wording around e-cigarettes in this section. 2. Thank you for this comment. 3. We appreciate your perspective on this. To the extent possible, the overview of reviews separated data on individuals motivated and not motivated to quit separately, although this was not always possible. In the Evidence-to-Decision framework appendices, we have included where the task force made decisions about the generalizability of

	readiness to quit. Just something to consider adding here (or in the overview of reviews itself. FYI – I reviewed that also and might have made the same comment there). 4. Table 2, USPSTF recommendation: should say: "and provide "behavioral interventions and pharmacotherapy" 5. Reference 12 has been updated: https://pubmed.ncbi.nlm.nih.gov/33464342/ and https://www.ncbi.nlm.nih.gov/books/NBK567066/. This is the review that citation #72 (the USPSTF recommendation) is based on. 6. Is Appendix 8 a duplicate of Table 2? Necessary?	findings. While we agree that the populations included are often motivated to quit, the task force judged that the recommendations could apply to a wide variety of individuals who smoke with varying levels of motivation. We've added text to the Scope section to make this clear. 4. Thank you for flagging this. We have updated to wording to better match the USPSTF recommendation statement 5. Thank you for flagging the updated reviews. We have reviewed these more recent citations, however we have not changed the reference in the text, as it accompanies the statement about improvements in mental health and quality of life with quitting, which do not seem to be included in the more recent reports you have provided. 6. We have included Appendix 10 (Details of other guidelines on smoking cessation interventions – previously Appendix 8) for those who wish to review more detailed information about recommendations from other groups, versus the summary in our Table 2. We will consider this comment and work with the journal to determine whether Appendix 10 needs to be included.

Reviewer 26 (Stakeholder): Francois de Wet, Department of Health, Government of Nunavut

Disclosure(s):

- I am part of all negotiations for Health delivery in the Territory (Medevac, Specialist services, and equipment)
- I have access to RFP's issued for the above

Question	Reviewer comments	CTFPHC response
1. Is the objective of the guideline clear?	**Yes** (No comments provided)	Thank you.
2. Are the patient groups to whom the guideline is meant to apply clearly described?	**Yes** (No comments provided)	Thank you.
3. Are the guidelines supported by the evidence?	**Yes** (No comments provided)	Thank you.
4. Is there any information missing from the guideline that would make it easier to interpret for primary care practitioners?	**No** (No comments provided)	Thank you.
5. Do you have any comments or suggestions to improve the guideline?	My only comment would be that I would suggest that this info be compacted into a more "quick read" format. It is a daunting document for a busy family doc to read.	Thank you for this comment. We have developed knowledge translation tools to accompany the final guideline, and considered this suggestion and similar suggestions from others.