

SECTION FOUR

SMOKELESS TOBACCO

Spit Tobacco
Chew Tobacco

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SMOKELESS TOBACCO – SPIT TOBACCO – CHEW TOBACCO

The two main types of smokeless tobacco in the United States are chewing tobacco and snuff. Chewing tobacco comes in the form of loose leaf, plug, or twist. Snuff is finely ground tobacco that can be dry, moist, or in sachets (tea bag-like pouches). Although some forms of snuff can be used by sniffing or inhaling into the nose, most smokeless tobacco users place the product in their cheek or between their gum and cheek. Users then suck on the tobacco and spit out the tobacco juices, which is why smokeless tobacco is often referred to as spit or spitting tobacco.¹ However, not all smokeless tobacco needs to be spit out during use. Smokeless tobacco, especially spitless chewing tobacco, is used more widely now since smoking in public is frowned upon and prohibited in many places.²

THE FACTS

- Smokeless tobacco is a significant health risk and is NOT a safe alternative to smoking cigarettes!
- Chewing tobacco and snuff contain 28 known carcinogens (cancer-causing agents).
- As with cigarettes, the nicotine in smokeless tobacco is addictive.
- The amount of nicotine absorbed from smokeless tobacco is 3 to 4 times the amount delivered by a cigarette. The nicotine is absorbed more slowly by smokeless tobacco and stays in the bloodstream longer.³
- The average systemic dose of nicotine is 3.6 mg for snuff, 4.6 mg for chewing tobacco, and 1.8 mg for cigarettes.⁴

WARNING: There is no safe tobacco product. The use of any tobacco product—including cigarettes, cigars, pipes, and spit tobacco; mentholated, “low tar,” “naturally grown” or “additive free”—can cause cancer and other adverse health effects.

- Smokeless tobacco users who dip or chew eight to ten times a day may be exposed to the same amount of nicotine as persons who smoke 30 to 40 cigarettes a day.⁵
- In North Carolina, 2.5 percent of women use smokeless tobacco compared to 0.6 percent of women nationally.⁶
- In North Carolina, studies have shown that a significant number of adult American Indian women (18 years of age and older) use smokeless tobacco.⁷
- In North Carolina in 2005, 1.3 percent of female middle school students and 2.3 percent of female high school students reported **current use** of smokeless tobacco.⁸

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- In North Carolina in 2005, 8.3 percent of female middle school students and 10.1 percent of female high school students reported **ever using** smokeless tobacco.⁹
- The use of smokeless tobacco can cause precancerous oral lesions, cancer of the mouth and throat, permanent gum recession, increased hypertension, stomach ulcers, and is a risk factor for cardiovascular diseases.¹⁰

| Health risks of chewing tobacco and other forms of smokeless tobacco | |
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| Addiction | Chewing tobacco, as with cigarettes, contain nicotine, an addictive substance. |
| Cavities | The high amounts of sugar in chewing tobacco and other smokeless tobacco causes tooth decay. |
| Gum disease | The sugar and irritants in chewing tobacco causes the gums to recede which can lead to gingivitis and tooth loss. Gum disease and infection are linked to poor birth outcomes like low birthweight and prematurity. 25 – 30% of spit tobacco users will have gingival recession (periodontal disease) which requires surgery to correct. |
| Heart problems | Smokeless tobacco use increases heart rate and blood pressure. |
| Precancerous mouth sores | The use of smokeless tobacco causes leukoplakia (small white patches) inside the mouth which is precancerous. 5 – 6% of leukoplakia becomes oral cancer. |
| Oral cancer | The use of smokeless tobacco increases the risk of cancers of the mouth, throat, cheek, gums, lips, and tongue. |
| Prematurity | Smokeless tobacco use may also be linked to perinatal morbidity, including low birthweight and prematurity. |

- Studies have shown that smokeless tobacco use significantly increased the risk of breast cancer.¹¹
- Short-term use of smokeless tobacco can cause cracked lips, white spots in the mouth, as well as sores and bleeding.

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COUNSELING SUGGESTIONS¹²

- The same counseling cessation intervention recommended for smokers, that includes the 5 A's counseling approach, should be used to help smokeless tobacco users quit. Refer to Section II for information on the 5 A's counseling approach.
- Dental health clinicians delivering brief counseling interventions to smokeless tobacco users can increase quit rates.
- Provide every woman with a clear, strong message to quit along with information on the harmful effects of smokeless tobacco use on her health and her baby's health, and on the benefits of quitting.
- It is imperative to start educating and counseling kids and adolescents at an early age to prevent them from ever starting smoking or using smokeless tobacco.
- There is little evidence to show that the use of pharmacotherapy increases long-term quit rates among smokeless tobacco users. Physicians should discuss the risk-benefit ratio of nicotine replacement therapy against continued tobacco use with their patients.¹³
- Clinicians can often facilitate the support from family and friends to help the patient during their quit attempt.¹⁴
- Some smokeless tobacco users may want to switch to another tobacco product, like cigarettes, as they attempt to quit. Clinicians should address this during follow-up visits and advise their patients to stop using ALL tobacco products.¹⁵
- Since smokeless tobacco use is an oral habit, oral replacements may help people quit - such as pumpkin or sunflower seeds, sugarless chewing gum, or ground mint leaves.¹⁶

Cigarette smoking and smokeless tobacco use are two methods of self-administering the same addictive substance obtained from different preparations of the same plant. The tobacco industry's marketing strategies for these products are complementary. Hence, the public health response should also show a coordinated approach. **The clear and unambiguous message that should be disseminated to the public is there is no safe form of tobacco.**

http://cancercontrol.cancer.gov/tcrb/monographs/2/m2_8.pdf

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¹ Available at http://www.cdc.gov/tobacco/data_statistics/Factsheets/smokeless_tobacco

² Available at <http://www.mayoclinic.com/health/chewing-tobacco/ca00019>

³ National Cancer Institute Fact Sheet. Smokeless Tobacco and Cancer: Questions and Answers. Available at <http://www.cancer.gov/cancertopics/factsheet/Tobacco/smokeless>

⁴ U.S. Department of Health and Human Services. *Tobacco use Among U.S. Racial/Ethnic Minority Groups – African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. Atlanta, Georgia: USDHHS, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 1998.

⁵ Spangler JG, Smokeless Tobacco Use in North Carolina: Epidemiology and Strategies for Control. *NCMS Doctor to Doctor*. North Carolina Medical Society Tobacco Control Committee November/December 1999.

⁶ Wake Forest University School of Medicine. Use of Smokeless Tobacco May Lead to Breast Cancer, Wake Forest Team Reports. May 9, 2000. Available at <http://www.sciencedaily.com/releases/2000/05/000509003313.htm>

⁷ Ibid.

⁸ Proescholdbell, Scott. NC Youth Tobacco Survey Data. Special Run. August 2006. NC Tobacco Prevention and Control.

⁹ Ibid.

¹⁰ Available at <http://www.cancer.gov/cancertopics/factsheet/Tobacco/smokeless>

¹¹ Article in Science Daily, “Use of Smokeless Tobacco May Lead to Breast Cancer, Wake Forest Reports”, May 9, 2000. Available at <http://www.sciencedaily.com/releases/2000/05/000509003313.htm>

¹² Unless otherwise noted, information in this section was derived from Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Clinical Practice Guideline. Rockville, Maryland: U.S. Department of Health and Human Services. Public Health Service. June 2000.

¹³ Spangler JG, Smokeless Tobacco Use in North Carolina: Epidemiology and Strategies for Control. *NCMS Doctor to Doctor*. North Carolina Medical Society Tobacco Control Committee November/December 1999.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Ibid.