



MEASURES FOR THE TREATMENT AND PREVENTION OF LEUKOPLAKIA OF THE PALATE IN MILITARY PERSONNEL.

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Abstract. Electronic cigarettes (e-cigarettes) are one of the most common types of electronic nicotine delivery systems. An EC is a device for vaporizing a liquid containing nicotine that enters the user's lungs. In addition to nicotine, the chemical mixture usually contains propylene glycol and other chemicals. Each device contains an electronic evaporation system, batteries, electronic control systems, and liquid cartridges that evaporate.

Key words. Tobacco, oral cavity, smoking, gingivitis, toothpastes.

Cytisine overdose is comparable to nicotine intoxication, which causes nausea, vomiting, pupil dilation, tachycardia, general weakness, clonic seizures, and respiratory paralysis. The appeal of cytisine is that it is currently relatively inexpensive compared to most other pharmacological products for the treatment of nicotine addiction. Cytisine may also be preferable for those people who want to use herbal preparations[5,10].

Any product that contains tobacco is not safe for human health. More than 25 compounds in smokeless tobacco can cause cancer. The most harmful compounds are tobacco nitrosamines, the level of which is directly related to the risk of cancer. Polonium-210– a radioactive decay product of radium-226, enters tobacco leaves by absorption from the soil surface from fertilizers. Nicotine contained in chewing tobacco is also addictive. The danger is formaldehyde, benzopyrene, lead [8].

The harm of smokeless (non-smoking) tobacco is not associated with lung cancer and COPD, as with smoking, but with damage to the mucous membrane of the gastrointestinal tract and the oral region, where tobacco is located for a long time. There are studies showing that the risk of oral cancer from smokeless tobacco is minimal. However, this data is controversial. This is due to the significant difference in the characteristics of the products caused by different methods of processing tobacco leaves and the "formulation" of manufacture [6,8].

The pharmacological action of cytisine is similar to that of varenicline, a partial agonist of the nicotinic acetylcholine receptor. Despite the long history of using the drug, the results of cytisine efficacy studies are not mentioned in the scientific English-language literature, there are only limited data from clinical trials conducted before the principles of good clinical practice (GCP) appeared. To date, a systematic review of the results of studies on the efficacy and safety of cytisine suggests that it has a positive effect on smoking abstinence compared with placebo and is safe enough[4,7].



The dosage regimen. The drug is prescribed for 3 days, 1 tablet 6 times (after 2 hours), while reducing the number of cigarettes smoked. If there is no effect, the drug should be discontinued after 2-3 months. start a new course. If the result is positive, treatment is continued according to the following scheme: from 4 to 12 days – 1 tablet every 2.5 hours – 5 tablets from 13 to 16 days – 1 tablet every 3 hours – 4 tablets from 17 to 20 days – 1 tablet every 5 hours – 3 tablets from 21 to 25 days – 1 tablet every 6-8 hours – 1-2 tablets Smoking should be stopped no later than 5 days after the start of treatment * 7+. Bupropion is also included in the first line of therapy for tobacco addiction. More than 10 years ago, bupropion was approved in most European countries for the treatment of smoking. It belongs to the class of psychoanalytics, selectively inhibits the reuptake of norepinephrine and dopamine, and also blocks nAHP [4].

Aversive therapy drugs (mouthwash drugs that change the taste of cigarette smoke) are currently of very limited use. It should be noted that the methods of tobacco smoking treatment used so far without proven effectiveness, such as acupuncture, hypnosis, normobaric hypoxotherapy, cranial electrical stimulation, phytotherapy, homeopathy, etc. are not recommended for implementation in practical medicine *7,12+. Cognitive Behavioral Therapy (CBT) Behavioral therapy (including brief advice and counseling) and pharmacotherapy are effective in helping people quit smoking [2,6].

The diagnosis of nicotine dependence is one of the important components of any therapeutic strategy. Success in smoking cessation treatment requires a better understanding of the nature of addiction and other factors that prevent smokers from abstaining from tobacco use. The ambiguity regarding the relationship between the severity of nicotine addiction and the ability to quit smoking makes it necessary to look for tools to assess this and determine the prognosis. As we have already pointed out, the so-called Fagerström Test for Nicotine Dependence (FTND) has become almost ubiquitous at the moment [5].

It is recommended in most manuals and methodological manuals for the treatment of tobacco addiction *20+. Its simplicity and brevity allow it to be used effectively by a wide range of medical professionals to assess the degree of tobacco dependence.

A combination of both treatment approaches is recommended wherever possible. Individual counseling increases motivation to quit smoking. During the conversation, the doctor determines the willingness to quit smoking, talks about treatment, discusses with the patient the date of quitting smoking, selects therapy taking into account all factors, informs about possible complications and difficulties, if necessary, gives recommendations on physical activity and nutrition, answers questions and sets a date for a follow-up visit. If possible, it provides information about a working smoking cessation telephone line, an online project, SMS support, or informational materials [5,6].

Anti-relapse treatment The patient is monitored throughout the treatment



period, the frequency of visits is planned taking into account smoking status, concomitant diseases, the severity of motivation to quit smoking and other factors. One of the important follow-up visits is the first one after smoking cessation (2-3 days), to correct therapy, prevent smoking relapse and motivate further abstinence from smoking [2].

Relapse is defined as smoking more than 7 cigarettes per week, while smoking less tobacco is defined as a breakdown. If a breakdown occurs, it is necessary to: increase the frequency and duration of CBT sessions and/ or use combined NRT for a longer period (more than 14 weeks) and/ or extend the use of varenicline from 12 to 24 weeks to prevent relapse and return to remission [10].

It is important to pay attention to concomitant somatic pathology, especially the exacerbation of chronic bronchitis, the clinic of which appears about a week after quitting smoking. Increased cough and difficulty in sputum discharge can serve as a provoking factor for the resumption of smoking, therefore, the patient should be warned about the possible appearance of respiratory symptoms and, if necessary, referred for a clinical examination and assessment of respiratory function in order to detect bronchial hyperreactivity or bronchial obstruction. If signs of chronic bronchitis are detected, it is advisable to prescribe mucolytics (acetylcysteine) and bronchodilators: prolonged-acting beta2-adrenomimetics (formoterol fumarate) and/ or prolonged-acting choline blockers (tiotropium bromide). Treatment of respiratory symptoms improves the patient's well-being and increases the effectiveness of tobacco smoking treatment [4].

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