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Letter

Vapes on our drug charts

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Vaping is something that seems ubiquitous, even inevitable, on our psychiatric wards. The transformation of the vape user from cigarette-quitting pariah to Average Joe has happened incredibly quickly – so quickly, in fact, that it feels that there has not been time to fully consider how we should be managing it.[1]

I recently completed an audit looking at nicotine replacement therapy in in-patient wards in Mid-Essex. Although the main focus of my work found that uptake of dual nicotine replacement was non-existent, it also revealed that finding information on who was vaping was nigh on impossible. Time and time again, it was documented that patients declined short-acting nicotine replacement or did not use nicotine – but a cursory glance at nursing review notes revealed that patients were vaping multiple times a day.

I do not think this is the fault of any individual or even any organisation. This has all happened so quickly that electronic systems and their forms and inputs simply have not yet been updated to provide a place for us to document vape use. However, is there a simpler solution? We already have a place to document this, namely, the drug chart. Nicotine, a drug, is prescribed to patients apart from when they use it in vapes. So it seems logical that we should be looking to prescribe vapes, too.

This is, of course, fraught with issues. How often should we be issuing a vape? What strength should we be using? How many puffs should be allowed per 'dose'? Will the vape need to be issued by a nurse and kept with the patient's drugs? Furthermore, vape juices can be different strengths, and patients may use different vapes at different times. However, we cannot ignore it because of its complexity.

The argument is that vaping is superior to smoking in terms of health benefits. Guidance from Public Health England states that it should be encouraged as a smoking cessation tool within our mental health units.[2] However, the number of adults vaping who have never smoked is increasing exponentially.[1] Recent studies suggest an association among e-cigarettes, depression and drug use.[3] Furthermore, although e-cigarettes help in terms of increasing the quit rate, and it is right that Public Health England are encouraging their use, many users did not need to quit cigarettes in the first place. We have all seen the patient who starts to vape upon admission.

If we are to encourage our patients to quit smoking – which we rightly should do – it needs to be done via the guidelines. We need to be aware of our patients' vape use so that we can manage their nicotine replacement as needed and intervene when a non-user is using. We are, indeed, their doctor. We need to be aware that we are going against National Institute of Health and Care Excellence guidelines by prescribing short-acting nicotine for the vaping patient. Unfortunately, we also need to recognise the likely possibility that in-patient units encourage vape use, and intervene.

Ultimately, nicotine is a drug and should be treated as such. If we need to prescribe paracetamol, which is regularly obtainable from shops, then we should be prescribing vapes too. I recognise that this will probably come with logistical nightmares; however, by having little idea of the nicotine usage of our patients, we are doing them a disservice. Furthermore, the jury is still out on the long-term use of vapes.

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Declaration of interest

None.

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