Smoking cessation for hospitalised patients: Intensive behavioural counselling started in hospital and continued after discharge increases quit rates; with additional benefit from adding nicotine replacement therapy

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Study type: Systematic review with meta-analysis

Bazian's declarative title: Smoking cessation for hospitalised patients: Intensive behavioural counselling started in hospital and continued after discharge increases quit rates; with additional benefit from adding nicotine replacement therapy

Citation: Rigotti NA, Clair C, Munafò MR, Stead LF. Interventions for smoking cessation in hospitalised patients. Cochrane Database Syst Rev. 2012 May 16;5:CD001837

Commentary
Implications for practice and research
- Hospital initiated smoking cessation intervention, continued post-discharge for at least one month, should become standard practice in all (general) hospital settings.
- A smoking cessation intervention should be initiated with every smoker during a hospital stay.
- An important yet neglected area of research is the effectiveness of smoking cessation interventions initiated within psychiatric hospital settings.

Context
The provision of a smoking cessation intervention in all clinical health care settings has been strongly recommended by expert international reviews. The aim of this review was to determine the effectiveness of smoking cessation interventions initiated in the hospital setting, building on an earlier 2007 review.

Methods
A systematic review was conducted, including randomised and quasi-randomised trials of any intervention (conducted or initiated within hospital settings) to help patients stop smoking. Fifty trials were included, of which 42 incorporated post-discharge support. The review also included sensitivity analyses to explore sub-groupings of interventions, settings and patient diagnoses.

Findings
Results indicated that smoking cessation interventions delivered in the hospital setting with at least one month post-discharge support increased cessation rates by 37% at six to 12 months follow-up. This result was not significantly different for patients with varying diagnoses, or those attending acute versus rehabilitation facilities. No evidence was found for the effectiveness of less intensive interventions, or interventions without post-discharge support. Adding nicotine replacement therapy to a counselling intervention significantly increased cessation rates by 54%; with insufficient evidence found to support the efficacy of adding bupropion or varenicline.

Commentary
This is a comprehensive and timely review with clear clinical implications related to the provision of smoking cessation interventions for hospitalised smokers. Important gaps in research were also identified.

Interestingly, while the authors acknowledge the opportunity afforded by smoke-free hospital settings to provide tobacco dependence treatments for hospitalised smokers, no reference is made to the ‘smoke-free status’ of the hospital settings within the included trials. Some evidence suggests that abstaining from tobacco during a hospital admission can in and of itself significantly improve cessation rates at six month follow up, and that cigarette consumption may reduce post-discharge even for smokers who do not abstain during hospitalisation. It would be valuable if a review such as this included the nature of smoking bans, adherence with them, and the extent to which nicotine dependence treatment was provided to patients as a matter of routine care.

This review excluded psychiatric and substance use facilities; two settings where smoking rates and nicotine dependence levels are disproportionately high, and where the patient populations are especially likely to suffer smoking related morbidity and mortality. While the authors provide no rationale for this, it seems likely that the dearth of research investigating the effectiveness of smoking cessation interventions within such settings necessitated exclusion. It is important that research begins to address the question of the effectiveness of smoking cessation interventions initiated within psychiatric hospital settings; the same sound arguments for the delivery of a smoking cessation intervention to hospitalised smokers generally apply no less to patients hospitalised within psychiatric facilities. As in general hospital settings, high rates of relapse following discharge from a smoke-free psychiatric hospital suggest the need for intensive cessation support to be continued to the community setting. The first rigorous controlled trials of smoking cessation interventions initiated within psychiatric hospital settings are in progress.

Finally, a sensitivity analysis conducted as part of this review excluded trials in which patients were selected on the basis of their motivation to quit. This resulted in no change to the intervention effect relative to the control group. This highlights the importance of offering smoking cessation support to all hospitalised smokers, regardless of their stated or assumed intent to quit at the time.

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References


Competing interests
None