

An intensive smoking intervention for pregnant Aboriginal and Torres Strait Islander women: a randomised controlled trial

TO THE EDITOR: We comment on practical aspects of the approach to maternal Indigenous smoking raised in the study by Eades and colleagues.¹

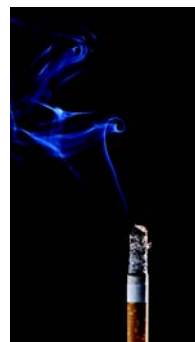
Pregnant smokers face barriers to quitting; however, we believe some additional barriers are systemic,² including excessive caution in prescribing nicotine replacement therapy (NRT). Guidelines for maternal smoking cessation recommend an unassisted attempt before considering NRT.³ There is no agreed definition of a “failed quit attempt”, or for how long a pregnant woman should persist unaided before NRT is tried. In this study, two failed attempts were a prerequisite. In a practice setting, this may be overcautious; intermittent NRT is considered less hazardous than continued smoking in pregnancy.⁴ If a pregnant woman is unable to abstain for 2–3 days, an accelerated option of intermittent NRT should be considered, to keep up momentum with the quit attempt. The attendance rate dropped from 64% at 3–5 days to 35% at 7–10 days — perhaps lost opportunities for initiating pharmacotherapy. The article does not detail the type of NRT (oral or transdermal), dosage, duration of treatment, compliance rates, or the management of side effects. These aspects would be of interest to smoking cessation practitioners.

Although this trial was unsuccessful, it should not discourage health professionals from delivering intensive interventions to pregnant Indigenous smokers. NRT is most effective when prescribed by a cessation specialist or medical practitioner, rather than bought over the counter.⁵ Additionally, behavioural support should ideally be for 4–7 sessions.⁶ Until a trial includes this level of support, intensive approaches should not be discounted.

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IN REPLY: Although our trial¹ did not decrease quit rates with an intensive intervention, health professionals should continue to deliver appropriate intensive smoking interventions to pregnant Indigenous women.² Guidelines advise the exercise of caution with the use of nicotine replacement therapy (NRT) in pregnancy,³ given the lack of trial data supporting its use.⁴ A recent trial of NRT in pregnancy found similar rates of adverse pregnancy and birth outcomes among women who used NRT and those who did not.⁵ Our study recommended NRT after at least two attempts to quit without NRT. NRT gum was prescribed by the treating doctors, with a preference for intermittent doses rather than continuous low doses through the use of NRT patches, in line with current guidelines.³ Women were provided with a week's supply of NRT but, for reasons that were not clear, none

returned for repeat supplies. The frequency with which NRT was prescribed, provided and used by women was not recorded with sufficient accuracy to allow interpretation. No definite conclusions about the efficacy of NRT can be drawn from our study and further research is necessary.

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