Welcome to issue 23 of Smoking Cessation Research Review.

An interesting paper in this issue (from New Zealand researchers) suggests that ‘informed choice’ arguments around tobacco smoking are an illusory concept. As the paper states, “young people cannot choose addiction when they do not understand what it will entail any more than they can accept risks they do not believe will affect them”. The authors highlight potential interventions that could denormalise smoking and reduce its perceived acceptability.

Another paper from New Zealand emphasises the role in health promotion and care played by Māori voluntary community health workers (‘Aunties’). These Aunties effectively identify and reach Māori pregnant women who smoke and provide cessation support and referral, in a way that is consistent with traditional Māori knowledge and practices.

The last study in this issue discusses smoking cessation among multiple, defined subpopulations vulnerable to social disadvantage in the Australian context. The paper describes complex issues supporting smoking and sabotaging quitting – the study authors suggest that these issues will have to be taken into consideration by any public health and tobacco control programmes aiming to reduce smoking among disadvantaged groups, if such programmes are to be successful. The paper suggests what measures could be taken.

We hope you enjoy the selection in this issue, and we welcome any comments or feedback.

Kind Regards,

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Independent commentary by Dr Brent Caldwell.

Brent Caldwell was a Senior Research Fellow at Wellington Asthma Research Group, and worked on the Inhale Study. His main research interest is in identifying and testing improved smoking cessation methods, with a particular focus on clinical trials of new smoking cessation pharmacotherapies.

Independent commentary by Honorary Associate Professor Natalie Walker.

Dr Natalie Walker is an epidemiologist and leader of the Addiction Research programme at the National Institute for Health Innovation, University of Auckland. Her primary area of interest is the conduct of phase III, community-based, clinical trials, particularly in the fields of smoking cessation, alcohol consumption, and heart health. FOR FULL BIO CLICK HERE.

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Achieving the tobacco endgame: evidence on the hardening hypothesis from repeated cross-sectional studies in New Zealand 2008–2014

Authors: Edwards R et al.

Summary: This analysis of data sourced from a biennial population-based survey of New Zealand adults (aged ≥15 years) conducted from 2008 to 2014 examined whether there is any support for the hardening hypothesis, which proposes that as smoking prevalence declines the proportion of ‘hardcore’ or ‘hardened’ smokers will increase. This hypothesis was tested across four hardening constructs: reduced motivation to quit, increased levels of addiction, increased levels of disadvantage and reduced quit rates among continuing smokers. During a period of reducing smoking prevalence, there were no statistically significant changes in indicators of hardening including the proportion of smokers who were unmotivated to quit, unable to quit despite repeated attempts or receiving state benefits or on a low income. Quit rates did not change significantly from 2008 to 2014; the OR for recent (within last 1–12 months) quitting was 1.14 (95% CI, 0.53 to 2.46) and for sustained (within previous 13–24 months) quitting was 1.88 (95% CI, 0.78 to 4.54).

Comment (NW): Although an exploratory study requiring further investigation, this study suggests that the NZ government aims to achieve the tobacco endgame: evidence on the hardening hypothesis from repeated cross-sectional studies in New Zealand 2008–2014

Enlisting “Aunties” to support Indigenous pregnant women to stop smoking: feasibility study results

Authors: Glover M et al.

Summary: This feasibility project tested the effectiveness of using Māori voluntary community health workers (“Aunties”) to identify and reach Māori pregnant women who smoke and provide cessation support. The majority of women were Māori, 20–30 years old, had their first cigarette within 30 minutes of waking and 58% had not tried to quit during the current pregnancy. Of the participants who completed a follow-up interview, 33% had stopped smoking while they were pregnant and 57% had cut down. At the follow-up interviews, the number of women who had used cessation support or products was increased from baseline.

Comment (NW): One of the difficulties with supporting pregnant women who smoke to quit is that they are notoriously difficult to find, since they often don’t register with a lead maternity carer until well into their pregnancy, and even then may not disclose their smoking status (due to strong societal pressure). This study, although only a feasibility study, was innovative in its use of Māori community health workers (“Aunties”) to locate pregnant women who smoke, by using their community networks and their trust and linkages with extended family to guide them. I look forward to hearing more about this approach.

A qualitative analysis of Māori and Pacific smokers’ views on informed choice and smoking

Authors: Gifford H et al.

Summary: This qualitative study explored how young adult Māori and Pacific smokers interpret ‘informed choice’ in relation to smoking, using data from in-depth interviews conducted with 20 Māori and Pacific young adults aged 18–26 years who smoked. The data were analyzed within an informed-choice framework and overarching themes were identified. Additional themes specific to Māori and Pacific participants were also identified in the transcripts. Few participants considered themselves well informed and none met more than the framework’s initial two criteria. Most reflected on their unthinking uptake and subsequent addiction, and identified environmental factors that had facilitated uptake. Nonetheless, despite this context, most agreed that they had made an informed choice to smoke.

Comment (NW): Although an exploratory study requiring further investigation, this study suggests that the tobacco company mantra that ‘smoking is an informed choice’ is incorrect. The study found that “arguments that smoking is an informed choice overlook young adults’ limited risk knowledge, ignore the social contexts that facilitate initiation and maintain smoking, and take no account of how addiction compromises choice.” Some key strategies are proposed to address the issue, namely increasing the legal age of tobacco purchase to ≥25 years, increasing the price of tobacco, increasing smokefree environments, and the clear need for continued support of and focus on Māori and Pacific people who smoke.

Reference: BMJ Open. 2016;6:e011415

Abstract

Enlisting “Aunties” to support Indigenous pregnant women to stop smoking: feasibility study results


Abstract

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An intervention to reduce the number of convenience stores selling tobacco: feasibility study
Authors: Paynter J et al.
Summary: How willing are New Zealand convenience store owners to stop selling tobacco or sell nicotine replacement therapy (NRT)? These researchers asked convenience store owners in the Auckland metropolitan region of New Zealand to choose one of three actions. The first was to stop selling tobacco for a short period of time; the second was to restrict the hours that they sold tobacco; the third was to display and sell NRT. All participating retailers completed a short interview about selling tobacco. As an incentive to stop selling tobacco, retailers were offered promotion of their stores. Most retailers who participated (93%) were unwilling to stop or restrict tobacco sales and 2 (7%) had already stopped selling tobacco. Tobacco was perceived as a key product for their businesses. When customers were surveyed about NRT and cessation, very few of those who purchased cigarettes noticed NRT or obtained it from convenience stores.

Comment (NW): Although some tobacco retailers have voluntarily stopped selling tobacco, findings from this study suggest that most tobacco retailers are unlikely to make such a move due to concerns about loss of income. To address these concerns, a Tobacco-free Retailers Tool Kit (www.smokefree-shops.co.nz) has been developed with information and templates to assist local health promoters and community members to engage with local tobacco retailers to become tobacco-free. The website this material is housed on also includes a map of all tobacco retailers who have stopped selling tobacco. Such information is collected by word of mouth, as New Zealand does not currently have a licensing programme for tobacco retailers (but clearly needs one). Supporting tobacco retailers to voluntarily opt out of selling tobacco avoids the issue of potential litigation from tobacco companies if there was a government-mandated ban on tobacco.

Abstract

The application of a decision-theoretic model to estimate the public health impact of vaporized nicotine product initiation in the United States
Authors: Levy DT et al.
Summary: Previous models of vaporised nicotine products (VNPs) such as e-cigarettes have failed to estimate tendencies toward smoking amongst youth and young adults initiating VNP use. These researchers provide a decision-theoretic model of VNP use in a young cohort that incorporates tendencies towards smoking. Their model accounts for the public health impact of VNP use in terms of how it alters smoking patterns among those who would have otherwise smoked cigarettes and among those who would not have otherwise smoked cigarettes in the absence of VNPs. The model incorporates transitions from trial to established VNP use, transitions to exclusive VNP and dual use, and the effects of cessation at later ages. Using the 1997 US birth cohort, the model projects a reduction of 21% in smoking-attributable deaths and of 20% in life years lost as a result of VNP use compared to a scenario without VNPs.

Comment (NW): If used instead of smoking, e-cigarettes provide the potential to reduce harm and improve health. However, there is concern that e-cigarettes could act as a gateway to tobacco use in youth. That is, youth who would not have otherwise smoked will become tobacco smokers as a direct consequence of first trying e-cigarettes. When conservative estimates around the plausible positive and negative aspects of e-cigarette use are considered in simulation modelling (based on US data), vaping appears likely to have a net positive public health impact for adolescents and young adults. This paper is therefore key for informing public health policy around the regulation of e-cigarettes. I think similar modelling utilising New Zealand data is currently being undertaken by Otago University researchers.

Abstract

Gradual versus abrupt smoking cessation: A randomized, controlled noninferiority trial
Authors: Lindson-Hawley N et al.
Summary: This UK investigation recruited 697 adult smokers with tobacco addiction attending primary care clinics in England and randomised them to either an abrupt-cessation intervention (quitting smoking abruptly) or a gradual-cessation intervention (reducing smoking by 75% in the 2 weeks before quitting). Both interventions provided behavioural support from nurses and NRT before and after quit day. At 4 weeks, fewer participants in the gradual-cessation group were abstinent compared with those in the abrupt-cessation group (39.2% vs 49.0%; RR 0.80; 95% CI, 0.66 to 0.93). Corresponding values at 6 months were 15.5% and 22.0%, respectively (RR 0.71; 95% CI, 0.46 to 0.91). Participants who preferred gradual cessation were significantly less likely to be abstinent at 4 weeks than those who preferred abrupt cessation (38.3% vs 52.2%; p=0.007).

Comment (BC): I chose to review this article because I’ve always thought that NRT-assisted pre-cessation smoking reduction was more effective than abrupt quitting. I think that the study has several flaws, so I do not think it definitively negates smoking reduction. Firstly, we are really expected to believe that the abrupt quitting group did not reduce their smoking even though they were wearing a nicotine patch? Secondly, why were subjects in the abrupt quitting group advised to only use one unit of rapid-acting NRT per cigarette that they reduced by, instead of using as much NRT as possible? One piece of gum or squirt of mouthspray is hardly equivalent to the rapid high nicotine dose from a cigarette. The abstinence rate was only superior with abrupt quitting when the Russell Standard was not used (no 2-week grace period). I suspect that one size does not fit all, and we should ask our patients what they prefer, and be aware that the desire to reduce before quitting may be a sign that the person needs more help and support.

Abstract

How are tobacco smokers using e-cigarettes? Patterns of use, reasons for use and places of purchase in New South Wales
Authors: Dunlop S et al.
Summary: Data from the New South Wales Cancer Institute Tobacco Tracking Survey were analysed in this survey of e-cigarette use among 2966 tobacco smokers and recent quitters (in the past 12 months) interviewed by telephone between January 2014 through June 2015. Just 9% of the sample reported they were currently using e-cigarettes; the highest rate (16%) was amongst 18–29-year-olds. Infrequent use (less than weekly; 57%) was more common than frequent use (at least weekly: 43%). Frequent use was more likely among older adults (>55 years vs 18–29 years: adjusted OR 4.43; p=0.002) and less likely among current tobacco smokers (vs recent quitters: adjusted OR 0.38, p=0.020). Among those aged >30 years, e-cigarettes were most commonly used “to help me quit” (42%) and “to cut down” (35%); for younger adults it was “because they are not as bad for your health as cigarettes” (25%). E-cigarettes were commonly purchased from the Internet (29%) and tobacconists (27%).

Comment (BC): Only 9% of New South Wales smokers have used e-cigs. This low number may be due to the Australian ban on advertising e-cigs and ban on sale of e-cig liquids that contain nicotine. In order for any NRT, whether it be an e-cig or gum or inhalator, to compete in the marketplace alongside cigarettes, and attract smokers to use it, the NRT would have to be marketed as a highly attractive product, and gain a reputation as being enjoyable, satisfying, and rapidly quench the desire to smoke. The legal restrictions of Australia prevent e-cigs from fulfilling any of these prerequisites of effectiveness.

Abstract

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New product marketing blurs the line between nicotine replacement therapy and smokeless tobacco products

Authors: Koptyga G et al.

Summary: This article discusses the move by tobacco companies into the marketing of NRT products, such as Zonnic nicotine gum. At the same time, these companies are producing tobacco products such as tobacco chewing gum and lozenges that resemble pharmaceutical nicotine replacement products, including a nicotine pouch product that resembles snus pouches. The article emphasises that this convergence of nicotine and tobacco product marketing has implications for regulation and tobacco cessation.

Comment (BC): I never cease to be amazed by zealots and how misleading they can be. I personally think that all the methods tobacco companies have used to market their NRT products, which the authors of this article criticise, are brilliant and the tobacco companies should be congratulated for (making their NRT attractive, encouraging people who have failed to quit to keep using NRT and trying to reduce to quit). I met Pam Ling, one of the authors of this paper, and talked to her about the Zonnic trial we were doing at the Univ of Otago, funded by the Health Research Council, yet she has stated in this article that our trial was funded by KJ Reynolds. Why be dishonest as the tobacco industry? Why not offer the tobacco companies a way to redeem themselves. They are people too. There go I but for the grace of - ??


Abstract

Flexible, dual-form nicotine replacement therapy or varenicline in comparison with nicotine patch for smoking cessation

Authors: Tulloch HE et al.

Summary: In this study, 737 smokers, including those with medical and psychiatric comorbidities, were randomised into 1 of 3 smoking abstinence arms: standard nicotine patch (NRT), extended use of combined formulations of nicotine replacement therapy (NRT+), or varenicline (VR). The NRT group received 10 weeks of patches (21 mg daily maximum); the NRT+ group received patches (35 mg daily maximum) and gum or inhaler for up to 22 weeks; and the VR group received 1 mg twice daily for up to 24 weeks (22 weeks post-target quit date). All participants also received six standardised 15-minute smoking cessation counselling sessions by nurses experienced in tobacco dependence treatment. Carbon monoxide-confirmed continuous abstinence rates (CARs) for weeks 5–52 were 10.0%, 12.4% and 15.3% in the NRT, NRT+, and VR groups, respectively; there were no between-group differences. In intention-to-treat analyses, higher CARs were observed with VR than with NRT during weeks 5–22 (OR 2.01; 95% CI, 1.20 to 3.36). In 7PP data, both NRT+ (OR 1.72; 95% CI, 1.04 to 2.85) and VR (OR 1.96; 95% CI, 1.20 to 3.23) were more effective than NRT at 22 weeks. Compared with NRT monotherapy, NRT+ and VR produced significant increases in CAR during weeks 5–10 (OR 1.52; 95% CI, 1.00 to 2.30 and OR 1.58; CI, 1.04 to 2.39, respectively); results were similar, but somewhat stronger, when 7PP was used at 10 weeks (OR, 1.57; CI, 1.05–2.41 and OR, 1.79; CI, 1.17–2.73, respectively). All medications were well tolerated, except for the VR group reported more fatigue, gastrointestinal symptoms (e.g. nausea, diarrhoea), and sleep-related concerns (e.g. abnormal dreams, insomnia), but fewer dermatological symptoms than the NRT or NRT+ groups. The frequency of serious adverse events did not differ between groups.

Comment (BC): This study confirms what Cochrane reviews have shown; that combination NRT is more effective than nicotine patch monotherapy, varenicline is more effective than nicotine patch monotherapy, and that varenicline is no more effective than NRT combination therapy (14.6% cf. 11.8%, p= 0.37 by my calculations from the paper). In the present trial, varenicline produced significantly greater digestive, sleep, fatigue and ‘other’ adverse effects, while patches caused significantly greater skin adverse effects. Perhaps the choice between the two most effective treatment options could be guided by which adverse effects smokers are most able/willing to tolerate?


Abstract

Stuck in the catch 22: attitudes towards smoking cessation among populations vulnerable to social disadvantage

Authors: Pateman K et al.

Summary: In Australia, smoking rates are disproportionately high among certain subpopulations, including people experiencing homelessness, substance use issues, unemployment, mental health issues, sole parenting, incarceration and stigmatisation. Previous research has identified unique barriers to quitting among individuals vulnerable to social disadvantage. This investigation explored how smoking and smoking cessation is perceived within the context of disadvantage, using transcripts from 56 participants from nine focus group discussions held at a range of community service organisations in metropolitan and regional Queensland. The focus groups involved a broad cross-section of defined populations vulnerable to social disadvantage, including people living with mental illness, people experiencing or at risk of homelessness (adult and youth populations), people living with HIV, people living in a low-income area and Indigenous Australians. Smoking behaviour, smoking identity and feelings about smoking were reflective of individual circumstances and social and environmental context. Participants described feeling “trapped” by smoking, which they described as a behaviour that was influenced by stressful life circumstances, and yet they also felt that smoking cessation involves personal responsibility. The study researchers consider that public health and tobacco control programmes may not be very successful among disadvantaged groups unless they address the complex interplay of social factors.

Comment (BC): Low socioeconomic status is a risk factor for smoking, so it is important to understand what disadvantaged smokers believe maintains their smoking and obstructs their attempts to quit. Common themes were that smoking helps diffuse stress, and the pressures to continue to smoke are environmental/social, whereas the methods to quit are individualistic, not communal. My research has shown that having a high degree of social/ environmental reasons for smoking is a risk factor for relapse after attempting to quit, and is responsible for why Maori quit rates are lower than for non- Maori. Communal social movements in each of New Zealand’s subcultures are urgently needed.


Abstract

Disclosure Statement: Natalie Walker has provided consultancy to the manufacturers of smoking cessation medications, received honoraria for speaking at a research meeting and received benefits in kind and travel support from a manufacturer of smoking cessation medications. Natalie has undertaken two trials of very low nicotine content cigarettes, which were purchased from two different tobacco companies. The companies concerned had no role in development of the study design, data collection, data analysis, data interpretation, or writing of the trial publications.

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