



Smoking cessation for hospitalised inpatients: Butt where do we begin?

The panoply of detrimental health effects directly linked to tobacco smoking cannot be overstated.^[1] A staggering mortality toll, exceeding 5 million deaths annually, is directly attributed to tobacco smoking – a wholly preventable, or at least modifiable, risk factor.^[2] It is a startling fact that new tobacco users, frequently adolescents, may become dependent after as few as four cigarettes.^[3] Furthermore, only ~4% of smokers will achieve sustained abstinence without adequate support.^[3] Despite the known risks of smoking, nicotine withdrawal and the potential for severe symptoms, there is a glaring absence of in-hospital smoking cessation programmes and access to nicotine replacement therapy. These interventions have been proven to significantly enhance cessation rates, highlighting the urgency of addressing this gap in healthcare provision.

In this edition of *AJTCCM*, Soin *et al.*^[4] shed light on the prevalence and consequences of smoking among inpatients at a single tertiary hospital in Cape Town, South Africa (SA). Their findings underscore the urgent need for comprehensive strategies to address tobacco use in healthcare settings. They explore the potential role for smoking cessation measures to be instituted at this critical time point of hospitalisation. Their reported prevalence of smoking may be an under-representation as, like many other studies of hospital inpatients and smoking prevalence, they excluded groups with historically high levels of tobacco use, specifically those admitted for mental health disorders. Nonetheless, the study reveals a startlingly high prevalence of active smokers among hospitalised patients, with nearly a third (32%) of inpatients identified as smokers. This prevalence far surpasses the general population estimates in SA (18%), as well as inpatient hospital prevalences in other countries such as the UK (25%) and Spain (20%), indicating a unique and concerning smoking trend among individuals seeking medical care in our country.^[5,6]

Furthermore, the research highlights disparities in smoking documentation across hospital wards, with some departments significantly lacking in terms of accurately recording patients' smoking status, with a total of 86% of the patients' smoking status being confirmed. Accurate recording was highest at 100% in the maternity unit and lowest in the surgical and critical care wards (70 - 79%). This oversight not only hampers efforts to address tobacco use, but also undermines patient care by neglecting a crucial aspect of their medical history.

No significant difference in smoking prevalence was found across various wards, although numerically the prevalence in the maternity ward was almost half of that found in most other wards. This dramatic difference alludes to the importance of the preventive medicine, counselling and education that form the backbone of most antenatal programmes, which take place at a time when significant changes are happening in the mothers' lives. The article also found that males were almost twice as likely to be smokers, with a prevalence of 43% compared with 22% for females, with an odds ratio of 2.64 (95% confidence interval 1.7 - 4.1). The median age of smokers was 47 years, while alarmingly the mean age of initiation was 16.7 years in a country where the legal minimum age to purchase tobacco products is 18 years.

Once all the smokers were identified, two-thirds of them gave consent to further explore patterns of nicotine use, dependence, withdrawal

symptoms and willingness to quit. In this part of the article, the study exposes the inadequacy of current support systems for smokers in hospitals. As would be expected, many patients reported a pattern of declining tobacco use during the 3 months leading up to admission, which probably reflects overall declining health during this time. In fact, an overwhelming majority of 83 of the 105 smokers interviewed (79%) reported that they had considered quitting during the preceding year and had made more than one quit attempt. Over half of the inpatient smokers expressed current motivation to quit, while ~20% had no interest in quitting. Significant proportions of patients experienced severe dependence, had symptoms of withdrawal and experienced moderate to severe cravings to smoke while admitted, most of which were most common in the surgical wards. Although the risks associated with nicotine withdrawal and the possibility of severe symptoms are recognised, in-hospital smoking cessation programmes and availability of nicotine replacement therapy are conspicuously lacking. There is a dearth of evidence to illustrate the importance and impact of both motivational counselling and pharmacotherapy, even dual pharmacotherapy with nicotine replacement and varenicline, in strengthening sustained abstinence from smoking.^[7-9] This failure to address the needs of hospitalised smokers is not only ethically dubious but also represents a missed opportunity for intervention and improved patient outcomes.

Soin *et al.*^[4] highlight that this same vulnerable group of patients at risk for nicotine withdrawal and complications has increased chances of successful smoking cessation if in-hospital programmes are supported by adequate counselling, nicotine withdrawal treatment and follow-up.^[7] There is much in the literature to support the premise that a 'shotgun' approach to target smoking cessation at a time of major health crisis or change may have increased impact and likelihood of success. Adult smokers with a new diagnosis of stroke, diabetes, cancer, or lung or heart disease were 3.2 times more likely to quit smoking than patients without a new health problem, while cessation was also more likely in patients undergoing surgery, both emergency and elective.^[7,10,11] All quit attempts are strengthened by the provision of at least a month of further counselling and support, as well as pharmacotherapy where applicable.^[7] It goes without saying that the subsequent benefits of smoking cessation on future health risks are unquestionable. Few things in modern medicine rival smoking cessation in its effect on improving overall health status and all-cause mortality. On an individual level, a saving of ZAR13 500 per year would be possible for a pack-a-day smoker, with the average pack costing ZAR38.^[12]

The study findings call for immediate action to prioritise the identification and support of smokers, ensuring that all patients receive appropriate counselling and assistance to quit smoking if they so desire. This should include implementing routine screening for smoking status in all wards, providing access to nicotine replacement therapy for those who medically require it, and offering cessation counselling and interventions based on patients' preferences while they are in contact with the health system. It is simply an opportunity that cannot be squandered. Healthcare professionals must be adequately trained to address smoking cessation effectively, recognising the

complex nature of tobacco addiction. A multidisciplinary approach that integrates smoking cessation support into routine clinical care and empowers patients to make informed decisions about their health should be a unifying goal.

Ultimately, addressing smoking among hospitalised patients is not just a matter of public health, but also a moral imperative. By prioritising the well-being of individuals struggling with tobacco addiction, we can make meaningful strides towards a healthier future for all South Africans. The time has come for hospitals to step up and take decisive action to support smokers in their journey towards better health. The evidence is clear, the need is urgent, and the opportunity for positive change is within reach. Let us seize this chance to make a difference, and blow away the plume of ill health shrouding the lives of those who need our help so much!

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