



LETTERS

DRUGS FOR SMOKING CESSATION

The evidence supports prequit use of nicotine patches

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Hartmann-Boyce and Aveyard state that there is insufficient evidence for starting nicotine replacement therapy (NRT) before quit day (prequit treatment or preloading).¹ While this is true for oral NRT products such as the nicotine gum or lozenge, there is sufficient evidence that starting the nicotine patch two weeks before quit day significantly increases long term success rates.²

A Cochrane review of six studies found that prequit patch use was moderately more effective at long term follow-up than patch use initiated on the quit date itself (relative risk 1.34, 95% CI 1.08 to 1.65).² A meta-analysis also found a benefit for prequit patch use on long term abstinence compared with starting on quit day (1.26, 1.03 to 1.55).³

On the basis of this evidence, both 21 mg/24 h and 25 mg/16 h nicotine patches are licensed in Australia for prequit use, starting two weeks before quit day, and their use is supported in the Australian smoking cessation guidelines.⁴ Smoking while using NRT is safe and is not associated with additional adverse reactions.⁵

The nicotine patch is the most widely used form of NRT but monotherapy is only moderately effective (1.95, 1.61 to 2.36).² Clinicians should be encouraged to optimise the use of NRT

wherever possible to improve outcomes.⁶ Given the increased effectiveness and safety of prequit patch treatment it would be reasonable for this to be the default option, except where immediate cessation is desired.

Competing interests: I have received honorariums for teaching, consulting, and conference expenses from Pfizer Australia, GlaxoSmithKline, and Johnson & Johnson Pacific. I am on Pfizer Australia's Champix advisory board.

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Authors' reply to Mendelsohn

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Mendelsohn highlights an important point.^{1 2} There are valid reasons to think that patches may be more useful prequit than other forms of nicotine replacement therapy (NRT). Research has shown that concurrent use of cigarettes and patches increases blood nicotine concentrations (by 54%), whereas with simultaneous use of cigarettes and shorter acting forms of NRT they remain unchanged.³ It is therefore reasonable to suppose that the steady supply of nicotine provided by patches means that people may not be getting the same reinforcement from a cigarette that they would if they weren't using patches, or even if they were using a short acting form of NRT to replace a cigarette.

Although we agree prequit use of patches may increase abstinence rates, we opted to take a conservative approach on this matter.² This is because the evidence from the meta-analysis cited by Mendelsohn that found a significant difference in favour of prequit use of patches was based on a post hoc subgroup analysis.⁴ The original intention was to conduct a meta-analysis of all forms of NRT, comparing prequit use with starting on quit day. The decision to use the subgroups was made after data were extracted, so we are hesitant to draw conclusions from this analysis (following Cochrane guidance).⁵ More research would clarify this matter, and a large UK trial is under way—we eagerly await its findings.⁶

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