Eight challenges faced by general practitioners caring for patients after an acute coronary syndrome

To the Editor: We would like to comment on some important inaccuracies in Vickery and Thompson’s article on general practitioner management of patients after an acute coronary syndrome.¹

The authors state that unassisted cessation of smoking (quitting without professional support or pharmacotherapy) is the most effective method. In fact, it is the least successful method and produces quit rates of only 3%–5% at 6–12 months.² In comparison, the quit rate from combined counselling and pharmacotherapy ranges from 22% to 32%, depending on the intensity of counselling provided.³

Although many smokers ultimately quit without help, it is usually after numerous failed attempts. Each year that smokers delay quitting after the age of 35 results in a 3-month reduction in life expectancy.⁴ It is therefore vital that smokers stop at the earliest possible opportunity and that every quit attempt has the best possible chance of success.

We advise doctors to follow the Australian¹ and United States.³ smoking cessation guidelines, which recommend the use of pharmacotherapy and counselling for all nicotine-dependent smokers.

The authors have also misinterpreted the Cochrane review data for the efficacy of nicotine replacement therapy (NRT). They state that 50%–70% of people achieve abstinence with NRT. However, the absolute long-term quit rate is only 6%–12% more than for placebo.⁶ The confusion may have arisen because NRT increases the rate of quitting by about 50%–70% compared with placebo.

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In reply: We thank Mendelsohn and Camp for their comments on our article. Their opinion on the best way to quit smoking may be relevant to some smokers, but it is not shared by all ex-smokers, nor by all other quit-smoking authorities.

In contemporary practice, 54% to 69% of Australian ex-smokers had quit unassisted.¹ Reservations about the adequacy of unassisted quitting are at odds with a 2013
Gallup poll in the United States, which showed that only 8% of ex-smokers attributed their success to pharmacotherapy, whereas 48% credited quitting “cold turkey”. Other internationally recognised Australian quit-smoking authorities have expressed the opinion that the impact of unassisted cessation on reducing smoking prevalence is underappreciated, and unassisted quitting should be considered before pharmacotherapy and other methods.

The effect of social media campaigns on smoking cessation, an area in which Australia has considerable international leadership, may also be a major contributor. We note that Mendelsohn and Camp promote pharmacotherapy not only in their letter, but also on Mendelsohn’s “Smokers’ Clinic” website, without acknowledging that many patients successfully quit on their own. This is particularly so when patients have had a health shock such as an acute coronary episode, which was the context of our article. It has been shown that 57% of people who were smokers before an acute coronary syndrome were not smoking 8 months after their coronary event.

We appreciate the correction to our statement on the efficacy of nicotine replacement therapy (NRT). Mendelsohn and Camp are quite right. The correct interpretation of the 2012 Cochrane review is that NRT increases the rate of quitting by 50%–70%, and we acknowledge that long-term cessation success rates remain low.

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