

LETTER

Pediatric Emergency Department Is a Promising Venue for Adult Tobacco Cessation Interventions

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Received March 8, 2013; accepted March 25, 2013

Rabe et al. (2013) conducted a systematic review and meta-analysis to evaluate the efficacy of emergency department-initiated tobacco control (ETC) trials. The authors should be applauded for their thorough review of adult emergency department (ED)-based cessation interventions. We agree with the authors' exhortation that there is a need for researchers to conduct larger, more methodologically rigorous trials to test the impact of ETC. However, we would like to highlight and address the author's recommendation to evaluate ETC trials that involve family and/or proxies of ED patients such as adult tobacco-using caregivers who present to the pediatric emergency department (PED) with their child, as this is an area of research that remains understudied.

Parental smoking results in adverse health consequences not only to the smoker but also to their children who are involuntarily exposed to secondhand smoke (SHSe; American Academy of Pediatrics, 2009). Annual health care costs associated with adult smoking approach \$97 billion, while those of SHSe are approximately \$5 billion and increasing (Curry, Keller, Orleans, & Fiore, 2008). Parental smoking cessation interventions offer the potential to decrease smoking-related morbidity and costs in both the parent and child. Second- and thirdhand smoke exposure is particularly of concern in the children as it places them at increased risk for asthma, respiratory tract infections, decreased lung growth, and sudden infant death syndrome and results in increased PED visits and hospitalizations (Best, 2009; Oberg, Jaakkola, Woodward, Peruga, & Pruss-Ustun, 2011). Despite the known risks associated with SHSe and although parents are concerned about exposing their children to SHSe, up to 60% of children are exposed to SHSe and this rate remains highest for very young children (Oberg et al., 2011; United States Public Health Service Office of the Surgeon General, 2006). Furthermore, the prevalence of children who present to the PED with SHSe-related illnesses such as asthma or bronchiolitis is high (Mahabee-Gittens, 2002).

One of the first cognitive shifts smokers experience prior to quitting is to view the negative consequences of smoking, such as the realization that their child's illness may be due to SHSe, as salient (American Academy of Pediatrics, 2009; Best,

2009). If the PED visit was used as an opportunity to counsel and activate parents to quit, it might mobilize them to take meaningful steps to stop smoking. Indeed, PED clinicians are uniquely positioned to capitalize on the PED visit to educate parents about SHSe and motivate them to quit. There is ample time for intervention delivery in the PED as the average length of stay is nearly 3 hr with the majority of this time spent idle (Alpern et al., 2006). We have conducted clinical studies demonstrating that brief behavioral cessation interventions can be realistically integrated into the clinical flow of the PED, with encouraging results. This work has demonstrated high prevalence rates of smoking in parents who bring their children to the PED (up to 41%), parental knowledge of the pediatric effects of SHSe, strong interest in quitting, acceptability of receiving interventions in the PED, and the feasibility of conducting PED-based cessation interventions (Mahabee-Gittens, 2002; Mahabee-Gittens & Huang, 2005; Mahabee-Gittens, Gordon, Krugh, Henry, & Leonard, 2008). Moreover, parents typically trust pediatric practitioners and pediatric medical settings and view them as sources of knowledge and expertise (Best, 2009); thus, it is not surprising that parents are receptive to receiving cessation interventions in the PED. All of these characteristics make the PED a particularly promising setting for delivery of smoking cessation interventions.

Our team is currently enrolling low-income parents of children who present to the PED with either a SHSe-related illness or a non-SHSe-related illness. Parents are given brief smoking cessation and child SHSe reduction advice, offered direct connection to the tobacco quitline (QL) to provide immediate counselor support and quitting strategies, and a voucher for a 2-week supply of nicotine replacement therapy (NRT). Thus, far, we have found that 47% of parents are current smokers, and 176 (60%) of these parents have been enrolled. Only 39% of parents believe that quitting smoking would improve their child's health, 40% have a total home smoking ban, and fewer have total car smoking bans. However, parents are motivated to quit, with a mean score on the contemplation ladder at baseline of 7.0 ($SD = 2.2$), representing the response: "I am starting to think about how to reduce the number of cigarettes I smoke a day."

doi:10.1093/ntr/ntt069

Advance Access publication May 24, 2013

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The majority of parents (81%) accepted the voucher for NRT, and 51% accepted a referral to the QL. Parents highly endorsed the intervention, with 94% of parents reporting that they were satisfied with the cessation advice that they were given and 93% reporting that this type of intervention should be given in the PED. Follow-up results at 3 months are encouraging, with 78% of parents reporting a quit attempt, and 10% reporting abstinence (8% biochemically confirmed).

The preliminary results of our study provide additional evidence to support the use of the PED as a valuable channel for intervening with adult smokers. We suggest that the PED should be considered an important venue in which to deliver parental cessation interventions as this practice has the potential to result in significant reductions in parental tobacco use, SHSe-related pediatric illness, and related costs in both parents and in their smoke-exposed children.

FUNDING

This study was funded by a grant to the first author from the National Cancer Institute/National Institutes of Health (K22CA163747).

DECLARATION OF INTERESTS

None declared.

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