potential role of gene polymorphisms of vitamin D receptors in asthma and allergies. On the other hand, recent epidemiological data from birth cohort studies have shown beneficial associations between maternal vitamin D intake during pregnancy and early childhood asthma symptoms. In Crete, the basic factor affecting vitamin D is probably exposure to sunlight. Margarite is fortified with vitamin D but is not commonly used among children, and olive oil remains the principal source of fat intake. A randomised clinical trial could provide strong evidence on the effect of fortified margarine intake in childhood allergies. We think, however, that there is an increasing need for more observational studies on this controversial field before embarking on a long term intervention study. We have recently started a mother–child cohort in Crete (Rhea study; http://rhea.med.uoc.gr/) aiming, among other issues, to investigate the role of early life dietary factors on the development of asthma and allergies. We hope to answer some of the questions on the role of vitamin D in the development of allergic disorders.

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REFERENCES

Smoking cessation intervention

We read with interest the article by Aveyard et al on behavioural support as an intervention for smoking cessation in primary care. There is evidence that behavioural support doubles the likelihood of smoking cessation. Aveyard et al conducted a randomised controlled trial and compared basic behavioural support with weekly support as a form of smoking cessation intervention. They have reported a quit rate of 22.4% at 4 weeks for both groups and a quit rate of 7.7% and 6.6% at 52 weeks for basic and weekly support, respectively.

Tobacco smoking is the most common cause of chronic obstructive pulmonary disease (COPD). Smoking cessation is the most significant intervention in patients with COPD as it results in a reduction in lung function decline and improved survival. Behavioural smoking cessation intervention in the group studied by Aveyard et al is important as smoking cessation should be available to smokers in the community who want to give up smoking. We felt, however, that opportunistic smoking cessation should also be offered to patients with COPD who are smokers and who are hospitalised due to exacerbations. Thus, smoking cessation intervention was included in our Hospital at Home (HaH) programme.

We retrospectively analysed 79 patients (59 women) of mean age 65 years (range 51–87) with an exacerbation of COPD who were managed through our HaH programme.4 They had a smoking history of 62.2 pack-years (range 10–228). Smoking cessation intervention was provided by a trained respiratory nurse and included a combination of a verbal 30 min consultation followed by telephone counselling at 1, 3, 6 and 12 months and (in a proportion of patients) nicotine replacement therapy. Our success rates at 4 weeks and 18 months were 51% and 25%, respectively, which was much higher than that reported by Aveyard and colleagues. One of the reasons for this higher success rate in our patients may be related to a possible stronger motivation for smoking cessation resulting from a recent hospital admission. We therefore suggest that smoking cessation intervention is done routinely during an acute exacerbation of COPD as part of the HaH service.

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REFERENCES

Authors’ reply

Kastelik et al describe an excellent example of a smoking cessation intervention for “hospitalised” patients. The recent Cochrane review of interventions for hospitalised patients reports that intensive counselling interventions that began during the hospital stay and continued with supportive contacts for at least 1 month after discharge improved smoking cessation rates after discharge.1 The odds ratio (OR) was 1.65, 95% confidence interval (CI) 1.44 to 1.90. It is therefore likely that the continued behavioural support given by Kastelik et al was an important contributor to the cessation seen. However, the review reports evidence that brief or even intensive interventions that began in hospital and provided less than 1-month follow-up behavioural support were ineffective. The clear message for others wishing to follow this excellent example is that it is important to provide behavioural support following discharge. In the UK this could easily be accomplished by booking the patient an appointment with the NHS Stop Smoking Service clinic after discharge while the patient is still an inpatient.

We would like to make two other suggestions for those emulating Kastelik and colleagues. First, it might be preferable to provide more frequent contacts in the first month after cessation. Relapse is much more likely in the first week or two than later on. This is based on intuitive reasoning rather than trials comparing a weekly visiting schedule with a more spaced visiting schedule. Second, research shows that many interventions are effective at increasing the cessation, meaning more people remain abstinent to the end of treatment, typically 2–3 months after quitting. However, a Cochrane review of trials to prevent relapse shows almost without exception that relapse prevention interventions in those who have been abstinent for a few weeks are ineffective.2 This is another factor that might suggest that behavioural support should be concentrated in the first 2–3 months.

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