Given the fact that there was no significant difference in the abstinence rates at 12 months between the two treatments, it calls into question the cost-effectiveness of varenicline as a pharmacotherapy for smoking cessation. The courses of treatment used in the trial cost £163.80 and £76.51 for varenicline and NRT, respectively.4 Clinicians are under pressure at all times to cut costs and be evidence-based, and this trial seems to show that there is currently no compelling reason to use the newer, more expensive agent in the smoking cessation clinic, apart from its apparent benefit in reducing craving and some other non-specific effects in the early phases of treatment.

We think the conclusions of the trial are presented in such a way as to give more emphasis to the efficacy of varenicline compared with NRT. But it seems that what this study really tells us is that there is no significant difference in long-term abstinence when comparing varenicline with NRT in an open-label comparison.

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REFERENCES

Authors’ reply
We recognise the relevance of showing long-term outcomes of smoking cessation therapies. However, many drug trials use end of treatment measures as primary outcomes.1 2 Given the high attrition rates during the follow-up phase, choosing long-term primary outcomes has a high impact on the numbers of subjects needed. It is noteworthy that the study cited by Hillman et al failed to show any significant difference between the efficacy of a nicotine patch and placebo at 6 and 12 months of follow-up.3 We would like to acknowledge that the Russell standard includes six standard criteria.4 One of these criteria is to use an “intent to treat” approach in which all randomised subjects are included in the analyses (unless they have died or moved to an untraceable address). Using an all-randomised population, our long-term quit