

20. **Orth M**, Leidag M, Kotterba S, *et al.* [Estimation of accident risk in obstructive sleep apnea syndrome (OSAS) by driving simulation] (In German). *Pneumologie* 2002;**56**:13–18.
21. **Turkington PM**, Sircar M, Saralaya D, *et al.* Time course of changes in driving simulator performance with and without treatment in patients with sleep apnoea hypopnoea syndrome. *Thorax* 2004;**59**:56–9.
22. **Carsten OMJ**, Groeger JA, Blana E, *et al.* *Driver performance in the engineering and physical sciences research council driving simulator: a validation study. Driver Performance in the Engineering and Physical Sciences Research Council Driving Simulator*. Engineering and Physical Sciences Research Council, UK, 1997. Report No. GR/K56162.
23. **Blana E**, Golias J. Differences between vehicle lateral displacement on the road and in a fixed-base simulator. *Hum Factors* 2002;**44**:303–13.
24. **DeLong ER**, DeLong DM, Clarke-Pearson DL. Comparing the areas under two or more correlated receiver operating characteristic curves: a nonparametric approach. *Biometrics* 1988;**44**:837–45.
25. **Jamson S**, Lai F, Jamson H. Driving simulators for robust comparisons: a case study evaluating road safety engineering treatments. *Accid Anal Prev* 2010;**42**:961–71.
26. **Engstrom J**, Aust ML, Vistrom M. Effects of working memory load and repeated scenario exposure on emergency braking performance. *Hum Factors* 2010;**52**:551–9.

Journal club

Chronic disease management for tobacco dependence

This randomised control trial compared the efficacy of utilising chronic disease management principles for tobacco dependence using a tailored intervention with standard care. As tobacco dependence is a chronic relapsing condition, the tailored intervention was chosen to account for possible interim setbacks.

Four hundred and forty-three eligible participants received five telephone-counselling calls and 4 weeks of nicotine replacement therapy. They were randomised to receive continuing counselling and nicotine replacement therapy for 1 year (longitudinal care, LC) or to receive one additional call at 8 weeks (evidence-based usual care, UC). The primary outcome was 6 months of prolonged abstinence, measured at 18 months following initial quit date. Secondary outcomes included abstinence rates before 6 months and smoking reduction.

At 18 months, 30.2% of LC participants reported 6 months of abstinence from smoking, compared with 23.5% in UC. Prior to 6 months, abstinence rates were slightly higher with UC than LC. At all time points, those who did not quit had greater smoking reduction with LC than UC (statistically significant only at 12 months). With LC, quit rates rose throughout the year without reaching a plateau, suggesting that extending treatment further may be beneficial.

One limitation of this study was the difficulty in differentiating between the effects of behavioural and medical treatment. Results were not biochemically confirmed, but the study population was believed to be low-risk for incorrectly reporting smoking status. The LC model allowed counsellors to adjust treatment in response to smokers' experiences of quitting and to positively reinforce the option of interim smoking reduction. Chronic management appears to be a feasible approach to increase long-term abstinence.

► **Joseph AM**, Fu SS, Lindgren B, *et al.* Chronic disease management for tobacco dependence. *Arch Intern Med* 2011;**171**:1894–900.

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