A nicotine patch plus nicotine nasal spray was more effective than a nicotine patch alone for smoking cessation


Question
Is a nicotine patch plus nicotine nasal spray more effective than a nicotine patch alone for smoking cessation?

Design
Randomised, double blind, placebo controlled trial with 6 years follow up.

Setting
Reykjavik, Iceland.

Participants
239 people aged 22–66 years (mean age 42 y, 67% women) who had smoked ≥1 cigarette/day for ≥3 years. Exclusion criteria were recent myocardial infarction, severe nasal allergy, skin disease, use of smokeless tobacco, current misuse of alcohol, pregnancy, or lactation. Follow up was 98%.

Intervention
Participants were allocated to 5 months of nicotine patches at daily dosages of 15 mg for 3 months, 10 mg for the fourth month, and 5 mg for the fifth month, plus 1 year of either a nicotine nasal spray, 0.5 mg/dose (n = 120), or a placebo spray (n = 119). Group support meetings and individual follow up were provided.

Main outcome measures
Duration and rate of sustained abstinence from smoking were measured from day 1 of smoking cessation. Abstinence was defined as not taking a single puff of a cigarette, not using other forms of tobacco or nicotine drugs, or a carbon monoxide concentration < 10 ppm.

Follow up  Patch and nicotine spray  Patch and placebo spray  RBI (95% CI)  NNT (CI)
15 days  70%  52%  35% (10 to 67)  5 (3 to 17)
6 weeks  51%  34%  48% (9 to 101)  6 (4 to 26)
5 months  37%  25%  48% (11 to 119)  8 (4 to 593)
6 months  31%  16%  96% (21 to 221)  6 (4 to 22)
1 year  27%  11%  148% (40 to 348)  6 (4 to 16)
6 years  16%  8%  92% (−5 to 291) Not significant

*Abbreviations defined in glossary; RBI, NNT, and CI calculated from data in article.

Conclusions
Use of a nicotine patch for 5 months plus nicotine nasal spray for 1 year was more effective than a nicotine patch alone for smoking cessation. Definite differences in sustained abstinence rates at 1 year persisted as a trend at 6 years.

Commentary
Despite higher cigarette prices, tougher anti-smoking laws, and attempts to hold tobacco companies responsible for smoking related medical costs, smoking cessation remains a huge public health challenge. Blondal et al point out that nicotine patch treatment alone gives an abstinence rate of only 11% after 1 year. Such results have prompted the search for better nicotine or a brief effect on concentration of the spray delivery system. The spray provides a “quick” dose of nicotine that may relieve temporary cravings associated with relapse of smoking.

Nicotine replacement therapy is one approach to smoking cessation management. Mood is closely related to nicotine consumption. The antidepressant, bupropion, has been shown to be an effective smoking cessation aid.1 In their well designed, double blind, controlled trial, Jorenby et al showed that bupropion, used either alone or in combination with the nicotine patch, was more effective than the patch alone or placebo for smoking cessation. A direct comparison of the 1 year continuous abstinence rates across the 2 studies shows interesting results: the rate for the patch spray combination in the study by Blondal et al was 27%, which is similar to that for bupropion alone (18.4%) or the bupropion patch combination (22.5%) in the study by Jorenby et al. Unlike Blondal et al, Jorenby et al followed up patients for 1 year. The continuous abstinence rate beyond 1 year still needs to be studied. The fact that such high intermediate term continuous abstinence rates can be achieved, however, should prompt physicians to consider bupropion in addition

(continued on page 74)

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Bupropion alone or with a nicotine patch increased smoking cessation rates


Question
What is the relative effectiveness of bupropion, a nicotine patch, placebo, and bupropion plus a nicotine patch for smoking cessation?

Design
Randomised, double blind, placebo controlled trial with 1 year follow up.

Setting
4 centres in the US.

Participants
893 people ≥ 18 years of age (mean age 43 y, 52% women) who weighed ≥ 100 lb (≥ 45.4 kg), were motivated to stop smoking, and who smoked ≥ 15 cigarettes/day. Exclusion criteria included serious physical or psychiatric illness, pregnancy, lactation, and previous nicotine replacement therapy. Follow up was 80%.

Intervention
Patients were allocated to 9 weeks of either sustained release bupropion, 150 mg/day for days 1 to 3 and 300 mg/day for days 4 to 63 (n = 244); nicotine patch, 21 mg/day for weeks 2 to 7, 14 mg/day for week 8, and 7 mg/day for week 9 (n = 244); or bupropion plus a nicotine patch (n = 245); or placebo (n = 160). Patients stopped smoking on day 8 and received counselling for 1 year.

Main outcome measures
Self reported point prevalence rate of abstinence in the previous 7 days and carbon monoxide ≤ 10 ppm, and rate of continuous abstinence (abstinence from quit date and carbon monoxide ≤ 10 ppm); withdrawal symptoms; and weight gain.

Main results
Analysis was by intention to treat. At 1 year, compared with the placebo and nicotine patch alone groups, the bupropion groups had higher point prevalence and continuous abstinence rates (p < 0.001) (table); no difference existed between the 2 bupropion groups (p = 0.22 and p = 0.61, respectively). All 3 active treatments led to less severe withdrawal symptoms than placebo in the first 3 weeks (p < 0.05). Bupropion plus a nicotine patch led to less weight gain than bupropion alone or placebo in the first 7 weeks (p < 0.05).

Conclusion
Compared with placebo or a nicotine patch alone, bupropion alone or with a nicotine patch increased the point prevalence and continuous smoking cessation rates after 1 year.

Comparison of smoking cessation regimens for point prevalence or continuous abstinence at 1 year*

<table>
<thead>
<tr>
<th>Abstinence</th>
<th>Regimen</th>
<th>Intervention</th>
<th>Placebo</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Point prevalence</td>
<td>Bupropion</td>
<td>30%</td>
<td>16%</td>
<td>94% (31 to 193)</td>
<td>7 (4 to 16)</td>
</tr>
<tr>
<td></td>
<td>Combination†</td>
<td>36%</td>
<td>16%</td>
<td>127% (54 to 240)</td>
<td>5 (4 to 9)</td>
</tr>
<tr>
<td>Continuous</td>
<td>Bupropion</td>
<td>18%</td>
<td>6%</td>
<td>228% (69 to 548)</td>
<td>8 (5 to 15)</td>
</tr>
<tr>
<td></td>
<td>Combination†</td>
<td>22%</td>
<td>6%</td>
<td>229% (108 to 681)</td>
<td>6 (4 to 10)</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary; RBI, NNT, and CI calculated from data in article and from data provided by the author. †Combination regimen = bupropion plus a nicotine patch.

Source of funding: Glaxo Wellcome.

For correspondence: Dr D E Jorenby, 1300 University Avenue, Room 7278 MSC, Madison, WI 53705, USA. Fax +1 608 265 3102.

Abstract and modified commentary also published in ACP Journal Club.

Commentary continued from page 73

to or as an alternative to, nicotine replacement therapy.

Patients in both studies were highly motivated and received adjunctive supportive counselling. These circumstances may not apply to a larger population of people who smoke and have some desire to stop. Extensive supportive counselling is time consuming, expensive, and difficult to obtain without access to properly trained professionals. The feasibility and success of these treatments in usual ambulatory care settings needs to be determined.

Another important question that has yet to be addressed is the effectiveness of antidepressants other than bupropion for smoking cessation. With nicotine replacement therapy already available in patch, spray, and gum forms, evidence of the effectiveness of other mood altering drugs will add to the smoking cessation management choices available to patients and physicians.

It was the connection between mood and smoking that led eventually to the trial of the antidepressant bupropion as a cessation aid. People with negative affect are more likely to start smoking and less likely to give up. Affected symptoms are more common among smokers, and their severity is related to the degree of nicotine dependence.1

Although it is unclear how the cessation aids assessed in these 2 studies would perform in a mental health care environment, bupropion could obviously have a dual role among patients with major depression as both an antidepressant and cessation aid. The overall positive effect of cessation aids in the mental healthcare environment may actually be greater than in the general population because smoking is very common among people with psychiatric illness.

Goutham Rao, MD
University of Pittsburgh
Medical Center—St Margaret
Pittsburgh, Pennsylvania, USA

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*Evid Based Mental Health* 1999 2: 73-74
doi: 10.1136/ebmh.2.3.73

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