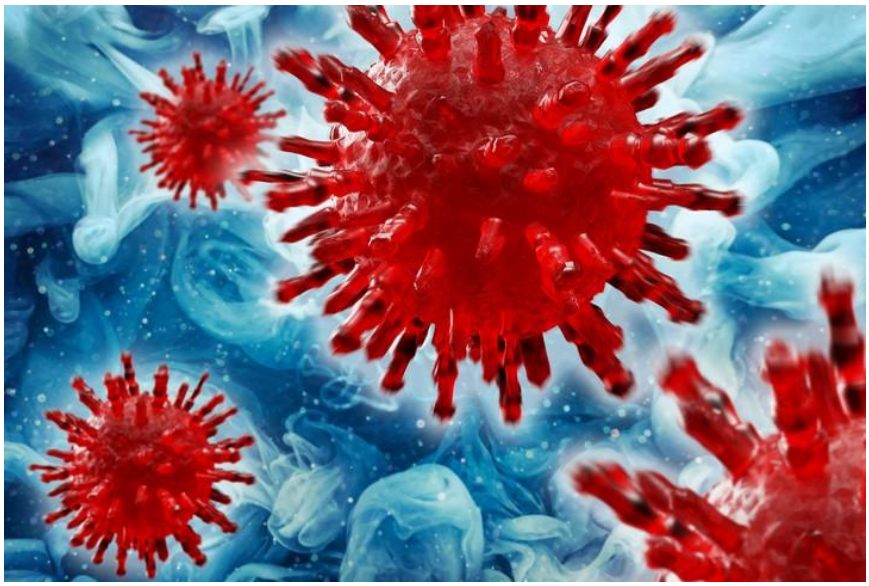
MDQuit NEWSLETTER

SUMMER, 2020



Smoking and COVID-19: Updated Information

As a follow-up to the article in our Spring 2020 e-newsletter -- *"Vaping, Smoking and COVID-19"* -- MDQuit is providing this update to address the continued interest in understanding the relationship between smoking and COVID-19. Currently, no peer-reviewed population-level studies have been conducted to determine the risk of infection associated with smoking.[1] However, because smoking involves contact between fingers and the tobacco product, which then contacts the lips, there may be a higher chance of transmitting the virus from hand to mouth.[2]

There are also no peer-reviewed studies to date that have directly estimated the risk of hospitalization for COVID-19 among smokers, who make up between 1.4% and 18.5% of adults hospitalized for the disease.[1] However, multiple studies have found significant associations between smoking and the severity of COVID-19 outcomes:

- A systematic review of five studies found that compared to non-smokers, ***smokers were 1.4 times more likely to have severe symptoms of COVID-19 and 2.4 times more likely to be admitted to an ICU, require mechanical ventilation, or die.***[3]
- A meta-analysis of nineteen studies found that ***smokers had 1.91 times the odds of COVID-19 progression to more critical conditions or death than those who had never smoked.***[4]

A few studies found the proportion of smokers among COVID-19 patients to be *lower* than in the general population.[5,6] Some researchers hypothesized that these findings suggest that infection with the virus could be altered by nicotine, and proposed its use as a protective agent against COVID-19.[7] While no trial registration record exists currently, a clinical study was announced to test this theory by providing nicotine patches to patients with COVID-19.[1,7]

Others who are wary of this hypothesis point out that the lower proportion of smokers among COVID-19 patients is likely due to sampling error and flaws in study design (e.g., exclusion of the most severe cases), and inadequate screening/documentation of smoking status by healthcare professionals during the crisis.[8,9,10] The lead author's ties to the tobacco industry have also been called into question as a potential conflict of interest, since tobacco companies have tried to promote nicotine-positive messages to downplay associated health risks for years.[11]

The available peer-reviewed evidence showing increased severity of disease and death among COVID-19 patients who smoke reinforces the longstanding recommendation for smoking cessation by researchers, professionals, and other leading health authorities.

[1]WHO. (2020). Smoking and COVID-19 Scientific Brief. [2]WHO. (2020). Q&A: Tobacco and COVID-19. [3](2020). COVID-19 and smoking: A systematic review of the evidence. [4](2020). Smoking Is Associated With COVID-19 Progression: A Meta-analysis. [5](2020). Systematic review of the prevalence of current smoking among hospitalized COVID-19 patients in China: Could nicotine be a therapeutic option? [6](2020). Low rate of daily active tobacco smoking in patients with symptomatic COVID-19. [7](2020). A nicotinic hypothesis for Covid-19 with preventive and therapeutic implications. [8](2020, May 11). Suggestion that smoking protects from COVID-19 may be dangerous to public health. [9](2020, April 27). Review of Controversial Study Related To Smoking and COVID-19. [10](2017). Challenges with Collecting Smoking Status in Electronic Health Records. [11](2020). Flawed Studies Suggest Smoking And Nicotine Protect Against COVID-19 Photo credit: istockphoto 1214860653

MDQuit NEWSLETTER

SPRING, 2020

Special Population: Pregnant Smokers

According to the National Vital Statistics Report, 6.5% of the women who gave birth in 2018 reported smoking at some point during pregnancy.[1] Smoking rates were highest among women aged 20-24 (9.2%), under 20 (7.6%), and 25-29 (7.5%).[1] In terms of race and Hispanic origin, 9.5% of non-Hispanic white, 5.2% of non-Hispanic black, and 1.7% of Hispanic women reported smoking at some point during pregnancy.[1]

Smoking during pregnancy is linked to numerous negative outcomes in infants and children, including:

- Low birthweight[2] and preterm birth[3]
- Stillbirths (fetal death occurring at 20 gestational weeks or later) and perinatal mortality (fetal deaths occurring at 28 weeks or later and early neonatal deaths)[4]
- Various birth defects including cardiovascular/heart, musculoskeletal, eye, facial, and gastrointestinal defects[5]

Up to 85% of women who quit smoking when pregnant continue cessation during the course of their pregnancy.[6] However, up to 45% of women return to smoking by 3 months postpartum, 60-70% by 6 months, and up to 80% by one year.[7] Smoking during and after pregnancy remains a serious health risk, and pregnant women who smoke remain an important smoking cessation intervention target

Although 13% of all U.S. women continue smoking during pregnancy,

between 77% - 99% of substance-using pregnant women continue smoking during pregnancy.[8,9]

Even when women receive treatment for substance use, most continue smoking.[9]

Although best practice guidelines direct healthcare providers to address nicotine dependence among substance-using patients, smoking is often overlooked in treatment.[10] The attitudes and smoking behaviors of staff at treatment facilities play a major role in client smoking. More than 40% of staff smoke and staff who smoke were less likely to view client smoking as a treatment issue.[11] Many also view smoking as a low priority issue compared to the more immediate harms of substance use.[11] Interestingly, however, maternal smoking was found to be the predictive factor for neonatal intensive care unit stay length for infants after controlling for prenatal substance use among substance-dependent pregnant women.[12]

These barriers within an organizational culture in which "smoke breaks" are structured into treatment, maintain an environment amenable to smoking.[11] MDQuit has thus been working with residential treatment facilities for pregnant women and women with children around the state to provide trainings for staff members on addressing smoking cessation with their clients.

The Maryland Tobacco Quitline continues to offer enhanced services for pregnant women (as well as household members who smoke). Pregnant and post-partum women are eligible to receive a series of ten calls with a dedicated team of specially trained Quit Coaches, addressing benefits of quitting for both the mother and the child, effects of secondhand smoke, and relapse after the baby is born. Additionally, by participating in the pregnancy program, callers can receive up to $100 in Target gift cards through completing a series of calls while pregnant and after the baby is born. Enroll by text, phone, or online: (1) Text "READY" to 200-400, (2) Call 1-800-QUIT NOW (1-800-784-8669; TTY 1-877-777-6534) to talk to a live Quit Coach, (3) Visit www.SmokingStopsHere.com**.**

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[1]*Births: Final Data for 2018. (2019).* [2]*Bernstein, I., et al. (2005). Maternal smoking and its association with birth weight.*. [3]*McCowan, L., et al. (2009). Spontaneous preterm birth and small for gestational age infants in women who stop smoking early in pregnancy.* [4]*Cnattingius, S. (2004). The epidemiology of smoking during pregnancy.* [5]*Hackshaw, A., et al. (2011). Maternal smoking in pregnancy and birth defects.* [6]*DiClemente, C. C., et al. (2000). The process of pregnancy smoking cessation.* [7]*Fang, W. L., et al. (2004). Smoking Cessation in Pregnancy.* [8]*Tong, V. T., et al. (2009). Trends in smoking before, during, and after pregnancy-PRAMS.* [9]*Svikis, D., et al. (1997). Tobacco use for identifying pregnant women at risk of substance abuse.* [10]*Treating Tobacco Use and Dependence: 2008 Update*. [11]*Fuller, B., et al. (2007). Attitudes toward the integration of smoking cessation treatment into drug abuse clinics.* [12]*Miles, D., et al. (2006). Smoking and illicit drug use during pregnancy: Impact on neonatal outcome.* *Photo credit: istockphoto 1183657514.*

Maryland's Newsletter for Healthcare Professionals Interested in Tobacco Cessation and Prevention

MARYLAND RESOURCE CENTER FOR QUITTING USE & INITIATION OF TOBACCO

MDQuit NEWSLETTER

FALL 2019

Home of Fax to Assist and BH2

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SAVE THE DATE!

Jan. 30, 2020

MDQuit's 14th Best Practices Conference

TOBACCO 21: Bridging the Gap for 18-20-Year-Olds

On October 1, 2019, young adults between the ages of 18-20 who were previously allowed to legally purchase tobacco products became ineligible to do so as Maryland joined 13 other states in implementing Tobacco 21 (T21), raising the minimum legal sale age for tobacco products from 18 to 21. Unlike some other states, Maryland's T21 law does not include phase-in periods or grandfathering provisions.

In areas where T21 laws have been implemented, there has been a 39% reduction in the likelihood of both recent smoking and current established smoking among this age group.[1] At the same time, for those already addicted to smoking, the reduction of easy access to tobacco products at retail stores presents them with the challenge of reducing and/or quitting smoking. Since individuals in this age group are often considered adults, other T21 states without phase-in periods or grandfathering provisions have not offered smoking cessation resources tailored to this subgroup, instead promoting their state Quitline and general cessation resources to *all* residents who smoke.

Many young adults are also reluctant to seek assistance for quitting and would prefer to choose an unassisted method for their next quit attempt.[2] However, they were willing to seek assistance if nicotine replacement therapy products were offered without cost, which the Maryland Tobacco Quitline offers.[2] In Maryland, 10.4% of individuals between the ages of 18-24 currently smoke cigarettes, and 5.4% in the same age group smoke e-cigarettes.[3] Of these individuals, 3.6% utilized web services provided through the state Quitline in the past year.[4]

Young adults identified ***loss of a way to handle stress*** and ***trouble with withdrawal*** as *the two most common barriers to quitting*, while ***physical fitness*** and ***cost of tobacco*** were seen as *the most compelling reasons to quit smoking*.[5] Continuing to develop state-wide materials and resources* reflecting this information and targeting this 18-20-year age group would be beneficial in helping them quit smoking, and ultimately in decreasing overall smoking rates. Finally, promoting these resources on college campuses and including information on how to get help with smoking cessation, along with the required T21 signs in stores, may increase the number of 18-20-year-olds who seek these services.[6] In the meantime, free, evidence-based resources for quitting tobacco products, such as the following, can be promoted:[7]

- ***Maryland Tobacco Quitline* (1-800-QUIT-NOW)**: particularly Web Support
- ***This is Quitting (Truth Initiative):*** text support to help teens and young adults quit e-cigarettes
- ***Smoke Free Teen:*** text and app support for teens and young adults to quit tobacco products
- **Local health department programs**

***What materials/resources are *you* currently using for this age group? Email us at info@mdquit.org**

See p. 2 for more info on T21 from Center for Tobacco Prevention and Control at MDH

[1]Friedman, A. S., et al. (2019). Tobacco-21 laws and young adult smoking: Quasi-experimental evidence. Addiction (Abingdon, England), 114(10), 1816–1823. [2]Hines, D. (1996). Young smokers' attitudes about methods for quitting smoking: Barriers and benefits to using assisted methods. Addictive Behaviors, 21(4), 531–535. [3]State Tobacco Activities Tracking and Evaluation (STATE) System State Highlights|OSH|CDC.(n.d.).https://nccd.cdc.gov/STATESystem/rdPage.aspx?rdReport=OSH_STATE.Highlights&rdRequestForwarding=Form [4]Maryland Department of Health. (2018). Quitline Utilization Statistics. [5]Villanti, A. C., et al. (2016). Reasons to quit and barriers to quitting smoking in US young adults. Family Practice, 33(2), 133–139; [6]Tobacco Legal Consortium. (2016). Raising the Minimum Legal Sale Age for Tobacco and Related Products—Tips and Tools. https://www.publichealthlawcenter.org/sites/default/files/resources/phlc-Tobacco-21-Tips-Tools-2016.pdf. [7]Legal Resource Ctr. for Public Health Policy (2019, Sept. 25). Tobacco 21 Enforcement Webinar—Part II [webinar].