A recent study by the Medical Research Council (MRC) Perinatal Mortality Research Unit at Tygerberg Hospital found that 39% of pregnant women smoked cigarettes. Smoking in pregnancy is clearly recognised in the literature as an important, dose-related, preventable risk factor for poor perinatal outcome. A previous MRC finding that 47% of South African coloured women smoke during pregnancy stands in sharp contrast to the prevalence in developed countries, for example 15.8% in the USA. In a developing country, where poverty in itself increases perinatal mortality and morbidity, this increase in cigarette smoking may have further negative effects on perinatal outcome, despite efforts to optimise antenatal care.

It is, therefore, of concern that despite current knowledge of the harmful effects of smoking in pregnancy, such a large percentage of pregnant women at Tygerberg Hospital are smokers. We wondered to what extent pregnant patients at Tygerberg Hospital are aware of the harmful effects of cigarette smoking during pregnancy and after childbirth.

What was done

The study group consisted of 200 pregnant coloured women attending the high-risk antenatal clinic (HRC) at Tygerberg Hospital. Most of these mothers have had previous pregnancy complications or losses, or suffered from a medical condition that could complicate the pregnancy. For some patients, the HRC served as a secondary clinic because they lived close to the hospital.

Information was gathered over a period of 3 weeks in March 2000 by means of a self-completed questionnaire, which was handed out in the HRC waiting area.

Smokers were asked about their smoking habits and whether they considered altering these habits during pregnancy. Knowledge of smokers was tested with regard to the effects of active maternal smoking and environmental tobacco smoke (ETS) on pregnancy and infants. An enquiry was made into breast-feeding intentions and willingness to expose infants to active maternal smoking. Non-smokers were asked about previous smoking habits, the smoke-free interval, motivation for quitting, and whether they considered resuming smoking after the delivery. There were further questions to non-smokers regarding their knowledge of the effects of active maternal smoking and ETS on pregnancy. An enquiry was made into exposure of non-smokers to ETS.

What was found

Of the 200 respondents, only 57.5% did not smoke and 42.5% smoked. With regard to awareness of the effects of smoking in pregnancy, 8.2% of smokers thought it was harmless and 11.8% indicated knowledge of nonspecific effects. Most smokers (77.6%) knew about one or more of the following specific dangers: disturbed growth parameters (62%), respiratory risk (45%) and a threat to general health (23%). The remaining 2.4% of smokers left the question unanswered.

Sixty-seven per cent of the non-smokers had never smoked previously. Of the 33% of ex-smokers, 34.2% had stopped smoking on falling pregnant, while 60.5% had quit before falling pregnant. The remaining 5.3% of ex-smokers left the question unanswered. Only 20% of non-smokers were not exposed to ETS. The specific knowledge of smokers and non-smokers is shown in Table I.

Recommendations

In the quest for optimal perinatal outcome it is essential to convey current scientific knowledge to the target group of pregnant mothers. This could be achieved effectively at clinic

At the time of the study Dr J E Viljoen was a registrar in the Department of Obstetrics and Gynaecology, Stellenbosch University. Professor H J Odendaal is head of the Department.
or hospital visits and antenatal consultations. Awareness should be raised by means of pamphlets and posters explaining the dangers of smoking in pregnancy, using layman’s terms and illustrations. These could be made freely available in waiting areas and consultation rooms.

On a personal level, the patient should be addressed in a non-judgemental manner, taking into account her psychosocial situation, e.g. social pressures, and the presence of spouse, partner or family members who smoke. The aim should be to enlighten the patient and her family and friends regarding the importance of smoking cessation in pregnancy.

An effective way to persuade smokers to quit in pregnancy during a 5 - 15-minute consultation (Table II) has recently been suggested.3

Table II. Smoking cessation intervention for pregnant patients

<table>
<thead>
<tr>
<th>Consultation scheme</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Ask</td>
<td>Enquiring about smoking status</td>
</tr>
<tr>
<td>2. Advise</td>
<td>Provide strong advice to quit, with personalised messages on benefits of quitting and the impact of smoking on the woman and fetus</td>
</tr>
<tr>
<td>3. Assess</td>
<td>Assess the willingness of the patient to quit within the next 30 days</td>
</tr>
<tr>
<td>4. Assist</td>
<td>Suggest and encourage problem-solving methods</td>
</tr>
<tr>
<td>5. Arrange</td>
<td>Assess status in follow-up visits, encourage cessation if still smoking</td>
</tr>
</tbody>
</table>


Pfizer South Africa announced on 13 April 2005 that the company would suspend the sale of the oral Cox-2 inhibitor Bextra with immediate effect. The suspension is voluntary and at the request of the Medicines Control Council.

This suspension of sales does not stem from any new scientific information, but is a direct result of the request by the Council. While Pfizer respectfully disagrees with the Council decision and believes that Bextra is a valuable treatment alternative for the relief of short-term postoperative pain and primary dysmenorrhoea, it is only indicated for the treatment of acute, mild to moderate postoperative pain and primary dysmenorrhoea, and not for long-term use in rheumatoid or osteoarthritis, as in the USA. Treatment typically runs for 5 days.

To this end, the following advice is offered:

Prescribers are advised not to initiate treatment in new patients and physicians should consider whether patients currently on Bextra should finish their current course of treatment while being monitored or be switched immediately to alternative therapeutic options.

Pharmacists are advised not to dispense further prescriptions for Bextra and to advise patients receiving Bextra to return to their doctors to discuss alternative therapeutic options. In addition, pharmacists are advised that stock will be withdrawn from their sites, through a withdrawal notification procedure.

Patients are advised to make an appointment with their health care providers to discuss their current treatment with Bextra and alternative treatment options.

For further drug-related information, please call Pfizer on 086 073 4937.