Cold turkey or gradual approach for smoking cessation?

Lindson-Hawley N, Banting M, West R, et al. Gradual versus abrupt smoking cessation: a randomized, controlled noninferiority trial. *Ann Intern Med*. 2016; 164(9):585–592.

This RCT compared abrupt (n=355) versus gradual (n=342) smoking cessation (75% reduction over 2 weeks prior to complete cessation) in adults recruited from British general practices who smoked at least 15 cigarettes per day, used 12.5 g of loose leaf tobacco daily, or had an end expiratory carbon monoxide concentration of at least 15 ppm and were willing to quit smoking 2 weeks after enrollment.

The primary outcome was Russell Standard abstinence (validated by exhaled CO concentration and salivary cotinine) at 4 weeks, 8 weeks, and 6 months. Participants in both groups were offered and encouraged to use nicotine replacement therapy and received weekly withdrawal-oriented behavioral therapy.

The 4-week abstinence rate for gradual cessation was lower than that for abrupt cessation (39% vs 49%; unadjusted relative risk [RR] 0.80; 90% CI, 0.66–0.93). Abstinence rates were higher for abrupt cessation at 8 weeks (RR 0.8; CI, 0.63–0.95) and 6 months (RR 0.71; CI, 0.46–0.91) as well.

Adverse effects included more salivating and cold sweats in the gradual cessation group in the 2 weeks prior to cessation. No difference was noted in withdrawal symptoms between the 2 groups. More subjects preferred the gradual reduction approach (50.9% vs 32.1%), but among those who had that preference, abstinence rates were lower independent of the group to which they were randomized.

Relevant	Yes	Medical care setting	Yes
Valid	Yes	Implementable	Yes
Change in practice	Yes	Clinically meaningful	Yes

Bottom line: Smokers who stop smoking "cold turkey" have higher abstinence rates at 4 weeks, 8 weeks, and 6 months than those who gradually reduced smoking prior to a quit date. However, because more patients choose gradual smoking reduction, giving patients the choice through shared decision-making may lead to more abstinence overall.

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BMI: A weak predictor of mortality in frail older women

Zaslavsky O, Rillamas-Sun E, LaCroix AZ, et al. Association between anthropometric measures and long-term survival in frail older women: observations from the Women's Health Initiative Study. *J Am Geriatr Soc*. 2016; 64(2):277–284.

This prospective, cohort multicenter study evaluated the health risk associated with body mass index (BMI) in 11,070 frail older women in a subset of the Women's Health Initiative Observational Study. Women were 65 to 84 years old and followed for an average of 11.5 years.

Presence of 3 of 5 parameters defined frailty: muscle weakness, slow walking speed, exhaustion, low physical activity, and unintentional weight loss. BMI was classified as follows: less than 18.5 (underweight); 18.5–24.9 (normal); 25.0–29.9 (overweight); 30.0–34.9 (class I obesity); 35.0–39.9 (class II obesity); and more than 40 (class III obesity). The association of BMI with mortality was examined, adjusted for race, education, income, smoking status, physical activity, cancer, cardiovascular disease, diabetes mellitus, and emphysema. Comparisons were to normal weight as the reference.

Mortality was greater for underweight patients with at least 1 comorbidity (hazard ratio [HR] 2.4; 95% CI, 1.8–3.0), but no association was found when no comorbidity was present (HR 1.2; 95% CI, 0.68–2.0). Mortality was lower for overweight cases (HR 0.80; 95% CI, 0.73–0.88) and class I obesity (HR 0.79; 95% CI, 0.71–0.88), with or without morbidity. Mortality was not different from normal weight cases for class II obesity (HR 0.93; 95% CI, 0.81–1.2) and class III obesity (HR 1.0; 95% CI, 0.85–1.2).

Relevant	Yes	Medical care setting	Yes
Valid	Yes	Implementable	No
Change in practice	No	Clinically meaningful	No

Bottom line: In frail older women, these findings suggest modestly increased mortality rates associated with BMI for underweight, decreased mortality rates for overweight and mildly obese, and no difference among the moderately or severely obese. These small differences in prognosis do not justify any change in clinical approach. EBP

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