Epidemiology

Increased public education measures and public health campaigns in the United States have led to a decrease in smoking by pregnant women and nonpregnant women of reproductive age (1). Pregnancy appears to motivate women to stop smoking; 46% of prepregnancy smokers quit smoking directly before or during pregnancy (1). Although the rate of reported smoking during pregnancy has decreased from 18.4% in 1990 to 13.2% overall in 2006, for some populations, such as adolescent females and less educated non-Hispanic white and American Indian women, the decrease was less dramatic (2, 3).

Smoking during pregnancy is a public health problem because of the many adverse effects associated with it. These include intrauterine growth restriction, placenta previa, abruptio placentae, decreased maternal thyroid function (4, 5), preterm premature rupture of membranes (6, 7), low birth weight, perinatal mortality (4), and ectopic pregnancy (4). An estimated 5–8% of preterm deliveries, 13–19% of term deliveries of infants with low birth weight, 23–34% cases of sudden infant death syndrome (SIDS), and 5–7% of preterm-related infant deaths can be attributed to prenatal maternal smoking (8). The risks of smoking during pregnancy extend beyond pregnancy-related complications. Children born to mothers who smoke during pregnancy are at an increased risk of asthma, infantile colic, and childhood obesity (9–11). Researchers report that infants born to women who use smokeless tobacco during pregnancy have a high level of nicotine exposure, low birth weight, and shortened gestational age as to mothers who smoke during pregnancy (12, 13). Secondhand prenatal exposure to tobacco smoke also increases the risk of having an infant with low birth weight by as much as 20% (14).

Intervention

Cessation of tobacco use, prevention of secondhand smoke exposure and prevention of relapse to smoking are key clinical intervention strategies during pregnancy. Inquiry into tobacco use and smoke exposure should be a routine part of the prenatal visit. The U.S. Preventive Services Task Force (USPSTF) recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke (15). The U.S. Public Health Service recommends that clinicians offer effective tobacco dependence interventions to pregnant smokers at the first prenatal visit as well as throughout the course of pregnancy (16).

Addiction to and dependence on cigarettes is both physiologic and psychologic, and cessation techniques have included counseling, cognitive and behavioral therapy, hypnosis, acupuncture, and pharmacologic therapy. Women who indicate that they are not ready to quit smoking can benefit from consistent motivational approaches by their health care providers as outlined in Committee Opinion No. 423, “Motivational Interviewing.”

Committee on Health Care for Underserved Women
Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Smoking Cessation During Pregnancy

ABSTRACT: Smoking is one of the most important modifiable causes of poor pregnancy outcomes in the United States, and is associated with maternal, fetal, and infant morbidity and mortality. The physical and psychologic addiction to cigarettes is powerful; however, the compassionate intervention of the obstetrician–gynecologist can be the critical element in prenatal smoking cessation. An office-based protocol that systematically identifies pregnant women who smoke and offers treatment or referral has been proved to increase quit rates. A short counseling session with pregnancy-specific educational materials and a referral to the smokers’ quit line is an effective smoking cessation strategy. The 5A’s is an office-based intervention developed to be used under the guidance of trained practitioners to help pregnant women quit smoking. Knowledge of the use of the 5A’s, health care support systems, and pharmacotherapy add to the techniques providers can use to support perinatal smoking cessation.
Committee Opinion No. 471

1. ASK the patient about smoking status at the first prenatal visit and follow-up with her at subsequent visits. The patient should choose the statement that best describes her smoking status:
   A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
   B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
   C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
   D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
   E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum. If the patient is still smoking (D or E), document smoking status in her medical record, and proceed to Advise, Assess, Assist, and Arrange.

2. ADVISE the patient who smokes to stop by providing advice to quit with information about the risks of continued smoking to the woman, fetus, and newborn.

3. ASSESS the patient's willingness to attempt to quit smoking at the time. Quoting advice, assessment, and motivational assistance should be offered at subsequent prenatal care visits.

4. ASSIST the patient who is interested in quitting by providing pregnancy-specific, self-help smoking cessation materials. Support the importance of having smoke-free space at home and seeking out a "quitting buddy," such as a former smoker or nonsmoker. Encourage the patient to talk about the process of quitting. Offer a direct referral to the smoker's quit line (1-800-QUIT NOW) to provide ongoing counseling and support.

5. ARRANGE follow-up visits to track the progress of the patient's attempt to quit smoking. For current and former smokers, smoking status should be monitored and recorded throughout pregnancy, providing opportunities to congratulate and support success, reinforce steps taken towards quitting, and advise those still considering a cessation attempt.

social support systems to remain smoke free in the third trimester and postpartum is encouraged (22).

**Pharmacotherapy**

The U.S. Preventive Services Task Force has concluded that the use of nicotine replacement products or other pharmaceuticals for smoking cessation aids during pregnancy and lactation have not been sufficiently evaluated to determine their efficacy or safety (15). There is conflicting evidence as to whether or not nicotine replacement therapy increases abstinence rates in pregnant smokers, and it does not appear to increase the likelihood of permanent smoking cessation during postpartum follow-up of these patients (23, 24). Trials studying the use of nicotine replacement therapy in pregnancy have been attempted, yet all of those conducted in the United States have been stopped by data and safety monitoring committees for either demonstration of adverse pregnancy effects or failure to demonstrate effectiveness (15, 25, 26). Therefore, the use of nicotine replacement therapy should be undertaken with close supervision and after careful consideration and discussion with the patient of the known risks of continued smoking and the possible risks of nicotine replacement therapy. If nicotine replacement is used, it should be with the clear resolve of the patient to quit smoking.

Alternative smoking cessation agents used in the non-pregnant population include varenicline and bupropion. Varenicline is a drug that acts on brain nicotine receptors, but there is no knowledge as to the safety of varenicline use in pregnancy (27). Bupropion is an antidepressant with only limited data, but there is no known risk of fetal anomalies or adverse pregnancy effects (28). However, both of these medications have recently added product warnings mandated by the U.S. Food and Drug Administration about the risk of psychiatric symptoms and suicide associated with their use (29, 30). Both bupropion and varenicline are transmitted to breast milk. There is insufficient evidence to evaluate the safety and efficacy of these treatments in pregnancy and lactation (16). Furthermore, in a population at risk of depression, medications that can cause an increased risk of psychiatric symptoms and suicide should be used with caution and considered in consultation with experienced prescribers only.

**Coding**

Office visits specifically addressing smoking cessation may be billed, but not all payers reimburse for counseling outside of the global pregnancy care package and some do not cover preventive services at all. Under the health care reform, physicians will be reimbursed for the provision of smoking cessation counseling to pregnant women in Medicaid and in new health plans with no cost sharing for the patient. Health care providers are encouraged to consult coding manuals regarding billing and be aware that reimbursements will vary by insurance carrier.

**Resources**

**The American College of Obstetricians and Gynecologists Resources**

American College of Obstetricians and Gynecologists. Smoking cessation during pregnancy: a clinician’s guide to helping pregnant women quit smoking. Washington, DC: ACOG; 2002. The guide, pocket reminder card, and slide lecture can be ordered by writing to smoking@acog.org.


**Other Resources**


**References**


