



Smoking Cessation Before and After Pregnancy

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INTRODUCTION

Smoking during pregnancy and postpartum is still a major public health issue. There has been no prior study that has looked at the relationship between risk factors and women's smoking patterns during pregnancy and postpartum. The goal of this study was to report on the methods used to implement a prospective cohort, present baseline participant characteristics, and compare our sample characteristics to pregnant women from national birth record data. The cohort study was designed to look into smoking patterns, variables related to tobacco use and abstinence, and the quality of tobacco treatment from pregnancy to one year postpartum. Current or recently quit smokers were recruited from obstetrics clinics. Women who continue to smoke while pregnant must deal with a number of social determinants of health. Longitudinal data from this cohort provide detailed information for identifying treatment gaps, critical time points, and potential psychosocial variables that require intervention [1].

DESCRIPTION

Pregnancy smoking is a major modifiable risk factor for poor maternal and infant health outcomes. Preterm birth, stillbirth, neonatal mortality, miscarriage, and foetal growth restriction have all been linked to smoking. Furthermore, smoking during pregnancy has been linked to long-term consequences for the child, including stunted growth, delayed development, and weight issues. Children of smokers have a higher risk of developing asthma, behavioural disorders, and performing poorly in school. Despite these issues, one out of every fourteen pregnant women in the United States smokes. Some women stop smoking when they learn they are pregnant, but the majority resume smoking after giving birth [2].

Important variables associated with tobacco use and relapse during pregnancy and postpartum, such as socioeconomic status, depressions, and having a smoking partner, have been

identified in cross-sectional and longitudinal studies. Munaf and colleagues discovered that smoking cessation was associated with a reduction in depressive symptoms from pregnancy to the immediate postnatal period. A more recent study found that while quit attempts increased late in pregnancy, the intention to quit in the next 30 days decreased during the same time period. Furthermore, 3 months after delivery, both quit attempts and intention to quit decreased. In the United States, a prospective longitudinal cohort tracking the number of cigarettes smoked per month from preconception to two months postpartum discovered that most women quit smoking by the third trimester. Because smoking status was assessed in a single evaluation at 3-months postpartum or at only a few timepoints during the first year postpartum, prior pregnancy and postpartum cohorts were unable to determine the precise timing of relapse among quitters. Even in long cohorts that followed mothers for up to 6 years after childbirth, smoking status was assessed at only six timepoints over the entire 6-year period. Another limitation of previous cohort studies is that they assessed only a few potential psychosocial variables related to tobacco use that can be useful in developing interventions.

Similarly, few studies have looked into whether and how smoking cessation treatment is offered during medical visits. According to several studies, health care providers routinely inquire about tobacco use during initial prenatal visits but do not routinely provide other elements of guidelines-based tobacco treatment. In the United Kingdom, nearly 40% of women reported no discussion of quitting with a health care provider throughout the pregnancy, despite the fact that roughly half of the women were interested in receiving help to quit smoking. Many previous studies relied on retrospectively reported tobacco use data for preconception and pregnancy, or did not assess concurrent changes in psychosocial variables related to tobacco use, which can be useful for intervention development [3].

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More than a quarter of women had used e-cigarettes six months before becoming pregnant. E-cigarette use during pregnancy was comparable to a national sample of pregnant smokers recruited, which discovered that 17% of pregnant cigarette smokers used e-cigarettes in the previous 30 days. Current smokers used e-cigarettes more frequently than recent quitters in our study. We did not, however, ask participants if they used e-cigarettes to help them quit smoking. Despite the fact that current guidelines do not recommend e-cigarettes as a quit-smoking aid, pregnant women frequently describe e-cigarettes as safer than regular cigarettes and as a quit-smoking resource.

The majority of smokers in our study were highly addicted to nicotine and had attempted to quit smoking several times. However, prior to completing our baseline survey, seven out of ten women had not received any smoking cessation treatment. Because the majority of our sample completed the baseline assessment around 4.5 months pregnant, it is possible that they received quit smoking assistance later in pregnancy. Our findings, however, are consistent with those of Naughton and colleagues, who discovered that in early pregnancy, less than half of smokers reported speaking to a midwife about quitting smoking, and even fewer had spoken to a general practitioner or nurse. These figures fell even further later in pregnancy, with only 27% of smokers reporting speaking with a midwife about quitting smoking [4,5].

CONCLUSION

The fact that smoking status is self-reported is a limitation of this study and of our cohort. The social stigma associated with smoking during pregnancy may result in under-reporting and, as a result, a response bias. Other research, however, has found a strong link between self-reported smoking and biochemical markers in pregnant women. Furthermore, participants were compensated for their time spent responding to the surveys,

which can lead to social desirability bias. Another limitation of our study is that we recruited more current smokers than quitters, possibly due to the ease of identifying current smokers in the clinical setting versus patients who had already quit smoking. Finally, the small sample size and recruitment from only one region, the United States Midwest, may limit the generalizability of the cohort's findings. A complete and highly diverse study sample was successfully recruited, with few differences when compared to national data. Baseline data revealed that women who continue to smoke during pregnancy are dealing with a number of social determinants of health, all of which are well-known variables associated with tobacco use. The study's findings provide insights into both sociodemographic and time-varying variables related to women's smoking patterns, which may aid in identifying gaps in tobacco treatment and potential time-sensitive intervention targets to support smoking cessation during pregnancy and the first year postpartum.

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