Disclosure of interests

PA is an employee of Merck and holds stock/stock options. ■

References

1 Nagpal J, Sachdeva A, Sengupta Dhar R, Bhargava VL, Bhartia A. Widespread non-adherence to evidence-based maternity care guidelines: a population-based cluster randomised household survey. *BJOG* 2014;122:238–47.

2 Spector JM, Agrawal P, Kodkany B, Lipsitz S, Lashoher A, Dziekan G, et al. Improving quality of care for maternal and newborn health: prospective pilot study of the WHO safe childbirth checklist program. *PLoS ONE* 2012;7:e35151.

P Agrawal

MSD for Mothers, Merck, Sharp & Dohme, Kenilworth, NJ, USA

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Authors' reply

Sir,

As investigators for the DELCARE survey we must express our broad agreement with Agrawal's letter, especially with the focus on 'content of care' rather than 'contact of care'. We have observed that a widespread departure from evidence-based guidelines can coexist with acceptable hard outcomes like neonatal and maternal mortality. In our own non-profit hospital, we have had no recorded maternal deaths in the last 8000 deliveries (with 600–1000 deliveries per annum), and have a neonatal mortality rate of eight in 1000. Yet until recently our practice had a high caesarean rate (55%), routine use of oxytocin, and routine episiotomy (80%). Only with a recent focus on standardising care, reducing unwarranted variation, measuring outcomes, and engaging staff have we been successful in improving alignment with evidence-based guidelines.

Checklists produced by global bodies such as the World Health Organization (WHO) have limitations. For example, the WHO safe childbirth checklist suggests that all babies with a respiratory rate >60/min need antibiotics.[1] This is not applicable to settings where facilities allow further differentiation. Hence, healthcare providers and professional societies must carry the onus of defining quality and approaching ideal standards. These standards must also take into account patient-centred measures like quality of life and cost of care.

Practice guidelines should expand beyond medical guidance to aspects such as structure of individual practices, teamwork culture, relevant continuing medical education, patient engagement and outcomes reporting. Medical societies at national and international levels need to take the lead for testing models for improvement like checklists, awareness campaigns on how to choose a good facility, the definition of weekly work hour limits, and the enforcement of outcomes reporting for efficacy and unforeseen consequences. ■

Reference

1 Spector JM, Agrawal P, Kodkany B, Lipsitz S, Lashoher A, Dziekan G, et al. Improving quality of care for maternal and newborn health: prospective pilot study of the WHO Safe childbirth checklist program. *PLoS ONE* 2012;7:e35151.

J Nagpal & A Bhartia

Sitaram Bhartia Institute of Science and Research, New Delhi, India

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Re: Prenatal vitamin C and E supplementation in smokers is associated with reduced placental abruption and preterm birth: a secondary analysis

Reducing placental abruption and preterm birth: deliver adequate smoking cessation first!

Sir,

Although vitamin C/E supplementation reduces placental abruption and preterm birth among smokers,[1] the authors rightly stress that 'smoking cessation remains the most important intervention to prevent these outcomes', but 'unfortunately this is not achieved in a considerable proportion of pregnant women'. This therapeutic pessimism could have devastating consequences, considering the widespread ignorance of pharmacology and the fact that only one-tenth of pregnant smokers are prescribed nicotine replacement therapy.

Combining patches with faster acting forms of nicotine replacement therapy is substantially more effective than patches alone. This 'belt and braces' strategy is also evidence based during pregnancy where it doubles the odds ratio of quitting.[2] Nicotine patches alone and at low dose are ineffective: an 18-mg nicotine patch (16 hours delivery) fails to decrease withdrawal symptoms and craving versus placebo.[3] This is hardly surprising as pregnant women are highly dependent on nicotine because of increased metabolism.[4] Worse still, a 'quit date' was set in this French study, despite hopelessly inadequate treatment.[3] This strategy inevitably leads to a form of programmed failure: addicted people already have low self-confidence, which is worse for pregnant smokers who are aware that they must not smoke for their child's sake, and yet women were not supported through a planned withdrawal.

If healthcare professionals are to truly help pregnant smokers who are motivated to give up, they need better training in pharmacology (dose effects and pharmacokinetics), basic support and cognitive behavioural therapies.

Lastly, adequate coverage for care is a major issue. Belgium is a beacon: since 2005, this very small European kingdom provides both psychological support and pharmacological treatment, not only for pregnant smokers, but also for their smoking spouses. ■

References

1 Abramovici A, Gandley R, Clifton R, Leveno K, Myatt L, Wapner R, et al. Prenatal vitamin C and E supplementation in smokers is

associated with reduced placental abruption and preterm birth: a secondary analysis. *BJOG* 2014; doi:10.1111/1471-0528.13201. [Epub ahead of print]
2 Brose LS, McEwen A, West R. Association between nicotine replacement therapy use in pregnancy and smoking cessation. *Drug Alcohol Depend* 2013;132:660–4.
3 Berlin I, Grangé G, Jacob N, Tanguy ML. Nicotine patches in pregnant smokers: randomised, placebo controlled, multicentre trial of efficacy. *BMJ* 2014;348:g1622.
4 Koren G, Blanchette P, Lubetzky A, Kramer M. Hair nicotine: cotinine metabolic ratio in pregnant women: a new method to study metabolism in late pregnancy. *Ther Drug Monit* 2008;30:246–8.

Alain Braillon[a] & Susan Bewley[b]
[a]*University Hospital, Amiens, France*
[b]*Women's Health Academic Centre, Kings College London, London, UK*

The authors of the article referred to in this letter were invited to respond, but no response was received.

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