A preoperative smoking intervention decreased postoperative complications in elective knee or hip replacement


QUESTION: In patients having elective knee or hip replacement, is a preoperative smoking intervention more effective than usual care for reducing postoperative morbidity and mortality?

Design
Randomised {allocation concealed*†}, blinded (outcome assessor),* controlled trial with follow up time to discharge.

Setting
3 university affiliated hospitals in Copenhagen, Denmark.

Patients
120 patients who were scheduled for primary elective hip or knee alloplasty and were daily smokers. Patients with a weekly alcohol intake > 35 units were excluded. 108 patients (90%) were included in the analysis (median age 65 y, 57% women).

Outcomes to time of discharge

| Smoking intervention v usual care in elective knee or hip replacement; | | |
|---|---|---|---|
| Intervention | Usual care | RRR (95% CI)§ | NNT (CI) |
| Any postoperative complication | 18% | 52% | 65% (42 to 83) | 3 (2 to 6) |
| Wound related postoperative complication | 5% | 31% | 83% (48 to 95) | 4 (2 to 8) |

§Cl calculated from data in article.

COMMENTARY
Preoperative assessment seeks to reduce postoperative morbidity or mortality. These assessments are typically for patients with increased risk for cardiac and pulmonary complications. Smoking within 8 weeks of surgery increases postoperative pulmonary, cardiovascular, infections, and wound complications.3 Although patients are encouraged to stop smoking before elective surgery, no prospective data exist to validate this advice. The study by Møller et al showed that a formal smoking cessation programme reduced postoperative complications and wound related complications in motivated patients having elective hip or knee replacements.

In this small study population, no deaths occurred before discharge so that no conclusions for effects on mortality could be drawn. The 120 patients who entered the study were those who agreed to participate among the 166 who were eligible, and the study was done in Denmark, so generalisability of the results may be somewhat limited. For example, the median hospital stay in this study was 12 days compared with 5 days in the USA.3 The patients were given an American Society of Anaesthesiology Physical Status Score classification, which is a subjective risk assessment; an objective cardiac or pulmonary risk assessment would have reassured me that the intervention and control groups were similar in overall medical health.

Any intervention that reduces postoperative morbidity warrants attention. The study should be replicated in other settings, and a cost-benefit analysis should be done. Meanwhile, patients who are scheduled for elective surgery and who currently smoke should be encouraged to quit smoking by using whatever formal smoking cessation interventions are available locally.

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2 HCUPnet, Healthcare Cost and Utilization Project, Rockville, MD, Agency for Healthcare Research and Quality (wwwahrqgov/data/hcup/hcupnet.htm).