Reviewer's report

Title: Quitline Referral vs. Self-help Manual for Tobacco Use Cessation in the Emergency Department: A Prospective Pilot Study

Version: Date: 2 30 November 2006

Reviewer: Anne Joseph

Reviewer's report:

General Comments

This manuscript addresses an important and interesting problem: promotion of tobacco dependence treatment to patients seen in the Emergency Department. This question is of a timely nature and well-defined. The manuscript is very clear and well-written (with the exception of some specific suggestions noted below). The biggest problem with the paper is the small sample size, approximately 40 subjects randomized, which unfortunately probably can not be changed. This is important given the relatively low rates of enrollment in treatment, completion, follow-up and abstinence rates. The primary outcome is described as the rate of enrollment in quitline services, but there is no comparison group for this estimate given the study design; it is a descriptive result. It is not really possible to compare abstinence rates of 1/20 and 2/19 at follow-up because of the small numbers.

Major Compulsory Revisions

1. As noted above, the sample size limitation is significant.

Discretionary Revisions – Specific Comments

2. Overall Design: Given that there was interest in the rate of recruitment to the quitline intervention, the entire flowchart data is relevant and should be included in the Results section of the text. It should be clarified that 212 smokers (as opposed to general ED patients) were assessed for eligibility. The most important descriptive result (to this reader) is that so many people were excluded or refused to participate. It would be interesting to know the reasons for refusal in more detail (e.g. did they not want to quit smoking, or participate in research, etc.). The fact that more than 200 patients were screened does not come up in the text until the Discussion.

3. p. 7. Data Analysis. The primary outcome, completion of the QL intervention, is descriptive (i.e. does not use the other treatment group as a comparison). The first secondary outcome, completion rates for outcome calls at 3 and 6 months, is not an obvious one for a tobacco treatment study and would benefit by more explanation and justification. Wouldn’t it have been useful to compare use of services in the control (self-help) group to the QL group, or compare some other process measure rather than completion of follow-up calls?

Minor Essential Revisions

4. It would be helpful to document the efficacy of quitlines, in general, in the Introduction and provide a citation to support this method of treatment, as some readers in this audience may not be familiar with the literature.

5. p. 5. How was “no plans to quit” defined (operationalized) as an exclusion criteria?

6. p. 8. The most remarkable difference between the treatment groups (shown in Table 1) is the higher number of CPD in the QL group compared to the control group (21 vs. 13). This deserves comment as a limitation, although in balance it probably has a conservative effect.

7. p. 8. Recommend qualifying the term “acuity of enrolled patients” as this might be misinterpreted as currently written.

8. p. 9. As noted above, an interesting result (the low enrollment rate) is highlighted for the first time in the Discussion, which seems late.
9. It would be interesting to speculate on a potential relationship between the cause for the ED visit and enrollment in tobacco treatment. For example, perhaps a smoker with a URI would be more interested than a smoker with a UTI.

**What next?:** Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No

**Declaration of competing interests:**

I have no competing interests.