

SECTION FIVE
COUNSELING WOMEN
THROUGH THE
LIFESPAN

Adolescents
Preconceptional & Interconceptional
Pregnancy
Postpartum
Breastfeeding

SECTION FIVE COUNSELING THROUGH THE LIFESPAN

ADOLESCENTS

The majority of first tobacco use has occurred by the time people graduate from high school. Very few people begin to use tobacco as adults. The earlier young people begin using tobacco, the more heavily they are likely to use it as adults, and the longer potential time they have to be users.¹

The Facts

- In North Carolina, during the year 2001, 18.2 percent of all teenage mothers (19 years of age and younger) reported smoking during pregnancy.²
- In the United States, the prevalence of smoking during pregnancy is highest among those who become pregnant in their teenage years.³
- In North Carolina, during the year 2005, 25.7 percent of female high school students (grades 9 - 12) currently smoke cigarettes (within the last 30 days).⁴
- In North Carolina, during the year 2005, 11.8 percent of female middle school students (grades 6 - 8) currently smoke cigarettes (within the last 30 days).⁵
- In North Carolina, during the year 2005, 22.8 percent of female high school students and 7.3 percent of female middle school students report current use of any tobacco product (cigarettes, cigars, smokeless tobacco, pipes, bidis within the last 30 days).⁶
- In the United States, among high school students, current smoking is significantly more likely to be reported by Caucasian and Hispanic females than African American females.⁷
- In North Carolina, during the year 2005, among male and female high school students who currently smoke cigarettes, 23.8 percent are Caucasian, 19.2 percents are Hispanic, and 12.8 percent are African American.⁸
- 24,600 adolescents (under age 18) become new daily smokers each year in North Carolina.⁹
- Female adolescents often view smoking as a way to stay trim; some even start smoking to take off weight and then become addicted for life.
- One Tennessee survey of high school students found that more Caucasian female smokers reported smoking to control their body weight than female African American smokers. Smoking to maintain a lower body weight is believed to contribute to tobacco dependence.¹⁰
- Some teens turn to smokeless tobacco mistakenly viewing it is a "safe" alternative to smoking. 2.3 percent of female high school students (grades 9 - 12) and 1.3 percent of female middle school students (grades 6 - 8) use smokeless tobacco in North Carolina.¹¹

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- 310,000 adolescents are exposed to secondhand smoke at home in North Carolina.¹²
- Teens tend to think that more people smoke than they actually do. In North Carolina, 19.8 percent of adult females (18 years of age and older) smoke.¹³
- Among current smokers in North Carolina, the majority of students reported that they want to quit – 48.7 percent of female high school students and 52.4 percent of female middle school students.¹⁴
- Among current smokers in North Carolina, the majority of students have made at least one attempt to quit in the past year – 54.9 percent of female high school students and 61.2 percent of female middle school students.¹⁵
- Only 14 percent of teenage smokers who saw a physician in the last year were advised to quit.¹⁶
- Nicotine dependence is established rapidly among adolescents. Young people vastly underestimate the addictiveness of nicotine.
- A new study has shown that women who initiated smoking within five years of the onset of menarche (beginning of menstruation) were 70 percent more likely to develop breast cancer before the age of fifty. Human breast tissue is more susceptible to damage caused by carcinogens in tobacco smoke during periods of rapid cell growth when differentiation is incomplete (during puberty).¹⁷

Adolescents Counseling Suggestions

- Provide smoking cessation interventions, that include the 5 A's counseling approach, to adolescents. Please refer to Section II for information on the 5 A's counseling approach.
- Modify the content of smoking cessation interventions (including self-help materials) so that they are developmentally appropriate.
- Provide every adolescent with a clear and strong message to quit, along with information on the harmful effects of smoking and the benefits of quitting on her health and her baby's health (if she is pregnant).
- Provide every adolescent with a clear, strong message to eliminate secondhand smoke exposure. Provide her with information on how secondhand smoke exposure affects her and her baby's health (if she is pregnant) during and after pregnancy. Problem-solve with her on how she can avoid social situations where others are smoking.



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¹⁶ North Carolina Youth Tobacco Survey, 1999. Available at
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SECTION FIVE COUNSELING THROUGH THE LIFESPAN

PRECONCEPTIONAL & INTERCONCEPTIONAL WOMEN

SMOKING HARMS EVERY PHASE OF REPRODUCTION.

The Facts

- Smoking is associated with many health risks for women. These health risks include coronary heart disease, lung cancer, stroke, chronic obstructive pulmonary disease (COPD), respiratory disease, hip fractures, and menstrual disorders.¹
- The prevalence of infertility is higher and the time it takes to conceive a baby has been shown to be longer in smokers as opposed to non-smokers.²
- Smoking affects various factors of men's fertility, from sperm motility and volume to damage of the seminiferous tubules which produce sperm, to hormones impacting sexual desire, and to erectile dysfunction.³
- Women who smoked during previous pregnancies and had healthy babies are not guaranteed that their next baby will be healthy if they continue to smoke. **Every pregnancy is different.**
- Women who stop smoking before getting pregnant lower their risk of infertility, miscarriage, ectopic pregnancy, premature birth, placenta previa, placenta abruption, having a low birthweight baby, and other detrimental pregnancy outcomes. Refer to Section V- Pregnancy and Smoking for more information.
- Women who know they are not pregnant may choose to use pharmacotherapy to reduce possible withdrawal symptoms and help them become smoke-free. Refer to Section VII – Pharmacotherapy for more information.
- In the U.S., secondhand smoke exposure causes an estimated 150,000 - 300,000 annual cases of bronchitis and pneumonia in infants and young children and also causes middle ear infections.⁴
- For children between two months and two years of age, exposure to secondhand smoke was found to be responsible for 40-60 percent asthma cases.⁵
- Among children with established asthma, secondhand smoke exposure causes additional episodes and increases the severity of asthma.⁶
- Children are more likely to smoke if their parents are smokers.⁷
- Women who smoke and use oral contraceptives increase their risks of having a stroke or heart attack.⁸

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COUNSELING SUGGESTIONS

- Provide smoking cessation interventions, that include the 5 A's counseling approach, to women during the preconceptional and interconceptional periods.
- Emphasize the benefits of not smoking for both her health and her baby's health. If a woman is thinking about getting pregnant, this is the best time for her to quit smoking. To protect her baby, she should begin her pregnancy as a non-smoker.

- Explain the possible effects of smoking on infertility in males and females. Be sure to clarify, however, that smoking is NOT a method of birth control!
- Explain to her that, even though she may have had healthy babies in the past while smoking, each pregnancy is different and that smoking could affect this baby differently.
- Explain that there is no safe level of smoking and there is no safe cigarette, especially during pregnancy. If she is a light smoker, tell her that it may be easier for her to quit.
- Encourage her to ask for support from significant others (spouse/partner, family members, friends) in her efforts to quit smoking.

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¹ U.S. Department of Health and Human Services. *Women and Smoking: A Report of the Surgeon General*. Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.

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⁸ American Heart Association. "Cigarette Smoking and Cardiovascular Diseases." 2006. <http://www.americanheart.org/presenter.jhtml?identifier=4545>

SECTION FIVE PREGNANCY AND SMOKING

THE FACTS

- During 2005, 11.5 percent of North Carolina mothers reported smoking during pregnancy.¹
- The following are the rates by race/ethnicity for mothers who reported smoking during pregnancy in North Carolina during the year 2006²:

African-Americans	10.5%
American Indians	24.1%
Asian Americans & Pacific Islanders	2.6%
Caucasians/ Whites	15.2%
Hispanics	1.1%

- The following are rates by race/ethnicity for low-income women who reported smoking during pregnancy during the year 2006, the majority of whom participated in North Carolina's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).³

African-Americans	14.2%
American Indians	30.2%
Asian Americans & Pacific Islanders	6.1%
Caucasians/ Whites	34.3%
Hispanics	1.0%

- In most populations, pregnant women who do smoke will deny smoking. For example, if 15 percent report smoking during pregnancy, there are likely to be another 5 – 10 percent who do smoke, but will deny smoking when asked.⁴
- In North Carolina, mothers who smoked during pregnancy had nearly twice the risk of an infant death or low-weight birth as mothers who did not smoke.⁵
- If women quit smoking while pregnant, the overall infant mortality rate would drop an estimated 10 – 20 percent.⁶
- **It's Not Too Late!** Quitting smoking prior to conception or early in the pregnancy is most beneficial, but health benefits result from quitting at any time. Advice and support for smoking cessation should continue throughout the course of pregnancy and beyond.⁷
- About 20 – 40 percent of women stop smoking during pregnancy but the majority start smoking again after the baby is born.⁸
- A woman who quits as late as the second trimester of pregnancy lowers her baby's chances of being born too small, too soon, and/or with health problems.

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SMOKING AND LOW BIRTHWEIGHT

- Cigarette smoking during pregnancy is the number one preventable risk factor for low birthweight.⁹
- In North Carolina, during the year 1999, the percentage of babies born at a low birthweight was double for mothers who smoked during pregnancy compared to mothers who did not smoke.¹⁰
- Maternal smoking increases the chance of having a low birthweight baby (weighing less than 2500 grams or 5½ pounds at birth). In the United States, studies have shown that maternal smoking accounts for up to 30 percent of infants born at less than 2500 grams.¹¹
- In North Carolina, during the year 2004, 19.9 percent of all infant deaths were associated with premature births and low birthweights.¹²
- It is estimated that there would be a 9 – 25 percent reduction in the incidence of low birthweight if smoking during pregnancy is eliminated.
- Smoking a small number of cigarettes is associated with decreased infant birthweight. While smoking fewer than five cigarettes a day may reduce risk, **quitting is the best thing a woman can do for herself and her baby.**
- The weight of babies born to smoking mothers averages about 250 grams less than that of infants born to nonsmokers.
- Low birthweight can lead to higher use of neonatal intensive care units (NICUs) at delivery, which leads to higher health care costs.



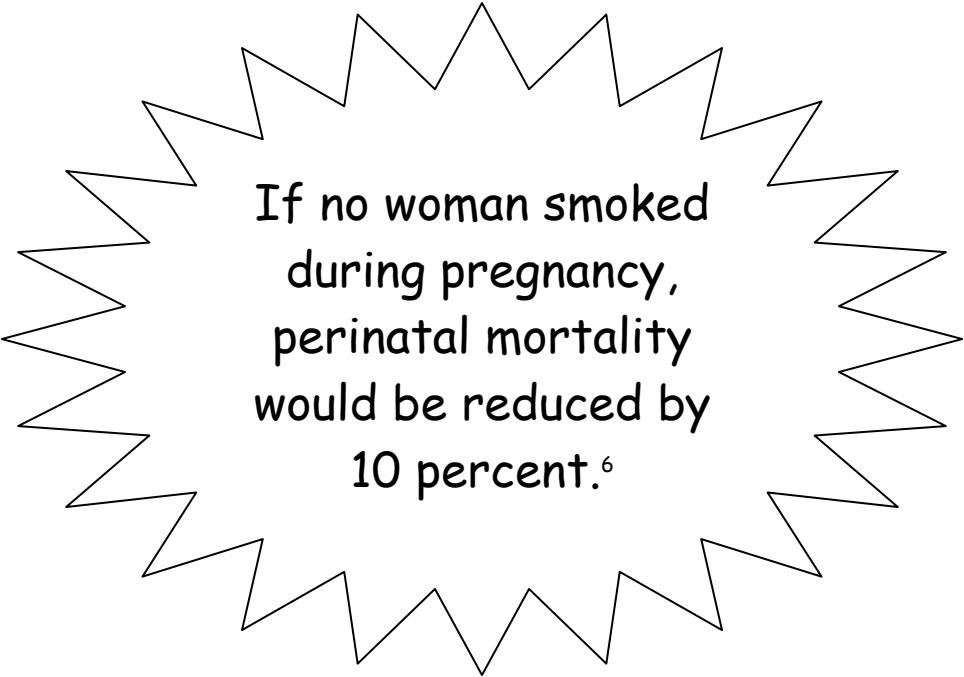
HOW DOES CIGARETTE SMOKING CAUSE LOW BIRTH WEIGHT?

- Nicotine causes blood vessels to constrict, so less blood (with oxygen and nutrients) flows through the placenta to the baby, causing growth restriction and low birthweight.¹³
- Nicotine reaches the baby through the placenta and is concentrated in fetal blood at levels 15% greater than those of the mother. Immediately after the mother smokes a cigarette, the baby's heart rate increases.¹⁴ This causes stress and strain on the unborn baby.
- Carbon monoxide (poisonous gas in cigarette smoke) reduces the amount of oxygen in the bloodstream, which can affect the development and size of the baby.

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WHAT ARE THE OTHER RISKS?

- Smoking during pregnancy is a health risk for both the woman and the baby. It has shown to cause stillbirths, spontaneous abortions, ectopic pregnancy, placenta previa, placental abruption, fetal growth restriction, premature births, sudden infant death syndrome (SIDS), respiratory conditions, and childhood cancers.¹⁵
- In North Carolina, baby's born to mothers who smoked during pregnancy had more than five times the risk for sudden infant death syndrome (SIDS) than baby's born to mothers who did not smoke. In North Carolina, during the year 2004, 9.8% of all infant deaths were caused by SIDS.¹⁶
- Babies born to mothers who smoke have more respiratory infections (pneumonia, bronchitis), recurrent colds, and ear infections during their first year. In the year 2004, 8.6% of all infant deaths were caused by respiratory distress and other respiratory conditions in North Carolina.
- Infants whose mothers smoke during pregnancy have a higher risk of developing asthma and other respiratory illnesses including wheezing and coughing.



If no woman smoked
during pregnancy,
perinatal mortality
would be reduced by
10 percent.⁶

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TEACHABLE MOMENTS DURING PREGNANCY

The best teachable moment is any time a woman brings up the issue of smoking. However, if she does not bring up the issue, **YOU** need to bring it up. Consider these opportunities.

1ST TRIMESTER

Opportunities

- Informing the woman of a positive pregnancy test result
- Discussing ways to decrease morning sickness
- During each prenatal visit
- During an ultrasound test
- During the first visit with the woman's partner and/or family member
- While reviewing her medical and social history (problems she may have experienced in earlier pregnancies may make her more open to counseling)

Points to Reinforce

- It's never too late to quit.
- Quitting completely is best. Even smoking a small number of cigarettes is associated with low birthweight. While smoking fewer than five cigarettes per day may reduce risk, quitting is the best thing she can do for herself and her baby.¹⁷
- Smoking increases the risk of miscarriage.
- Secondhand smoke can harm the baby and her.
- All pregnancies are different. Having a healthy baby or having a baby that appears healthy, despite smoking in the past does not guarantee the same each time.

2ND TRIMESTER

Opportunities

- Hearing the baby's heartbeat for the first time
- During an ultrasound test
- During each prenatal visit and when checking for signs of intrauterine growth
- During nutritional counseling

Points to Reinforce

- It is never too late to quit.
- She may feel better now and can make an effort to quit. If she cuts back earlier due to morning sickness, she may be able to continue to reduce the amount smoked or quit completely.
- Smoking decreases the amount of blood, oxygen, and nutrients flowing to the baby, affecting its growth.
- Secondhand smoke can harm the baby and her.
- Quitting completely is best. Even smoking a small number of cigarettes is associated with low birthweight. While smoking fewer than five cigarettes per day may reduce risk, quitting is the best thing she can do for herself and her baby.

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3RD TRIMESTER

Opportunities

- During each prenatal visit and when checking for signs of intrauterine growth
- Childbirth classes
- Hospital tour (emphasize whether the hospital is tobacco-free)
- Labor and delivery (emphasize whether the hospital is tobacco-free)

Points to Reinforce

- It's never too late to quit. Quitting even right before birth provides more oxygen and nutrients to the baby.
- Rapid growth of baby makes this another beneficial time to quit. The likelihood of her having a low birthweight infant is reduced if she quits.
- The harmful effects of secondhand smoke for the baby are significant (increased risk for SIDS, respiratory and lung problems, ear infections, impaired cognitive abilities, etc.).
- If she was able to quit during pregnancy, she should avoid the temptation to smoke again once the baby is born.

POSTPARTUM

Opportunities

- At the hospital (after delivery)
- Any telephone contacts and/or home visits
- During the postpartum exam
- Well-baby visits
- Family planning appointments
- Child immunizations
- Parenting classes

Points to Reinforce

If the woman was able to quit during pregnancy:

- Praise her ability to remain smoke-free during pregnancy.
- Stress the importance of staying quit for her baby, other children in the house, and herself.

If she was able to cut down during pregnancy

- Encourage her to stick with it and keep trying to quit completely.
- Pharmacotherapy may be recommended to help her become smoke-free (refer to Section VII - Pharmacotherapy for more information).

If the woman still smokes:

- Continue to provide her with smoking cessation counseling.
- Counsel her not to smoke, or allow others to smoke, around the baby, in the home, the car, while baby-sitting, etc.
- Pharmacotherapy may be recommended to help her become smoke-free (refer to Section VII - Pharmacotherapy for more information)

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¹ Matt Avery. 2006 Smoking During Pregnancy, NC Residents. Special run from the 2006 Birthfile. SCHS. November 2007.

² Ibid.

³ North Carolina Department of Health and Human Services Division of Public Health, Women's and Children's Health Section, Nutrition Services Branch. North Carolina Pregnancy Surveillance system data, 2006.

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¹⁶ Matt Avery. 2005 Smoking During Pregnancy, NC Residents. Special run from the 2005 Birthfile. SCHS. August 2006.

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POSTPARTUM WOMEN

Postpartum relapse is common among women who stop smoking during pregnancy. Following a successful period of tobacco cessation during pregnancy, approximately 50% of all women relapse to smoking during the 6 months after delivery. About 34% of all children are exposed to environmental tobacco smoke due to maternal smoking. Smoking during pregnancy and in postpartum contributes to sudden infant death syndrome (SIDS), and changes in brain and nervous system development.

Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.¹

Secondhand smoke is linked to many illnesses, including between 700,000 and 1.6 million physician office visits for middle ear infections in children each year. It causes and worsens asthma as well as acute respiratory infections such as bronchitis and pneumonia and contributes to 500,000 physician visits by children.²

THE FACTS

- Smoking is associated with many health risks for women. These health risks include coronary heart disease, lung cancer, stroke, chronic obstructive pulmonary disease (COPD), respiratory disease, hip fractures, and menstrual disorders.³
- Many women who quit smoking during pregnancy resume smoking (relapse) after the baby is born. Forty-five percent of women relapse within 3 months after the baby is born.⁴
- Approximately 70 percent of women, who do quit smoking during pregnancy, relapse within one year postpartum.⁵
- African-American women are almost twice as likely as Caucasian women to relapse, during the postpartum period, after successfully quitting during pregnancy.⁶
- Women are more likely to relapse if they chose to formula feed their baby or if there is another smoker in the house.⁷
- Women who quit smoking during pregnancy are less likely to relapse if they breastfeed their baby.⁸
- Smoking affects breastfeeding by reducing the mother's milk supply. The maternal milk production of smokers is more than 250 milliliters per day less than that of nonsmokers.⁹

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- Women who smoke are less likely to breastfeed their infants than women who do not smoke.¹⁰
- Children are more likely to smoke if their parents are smokers.¹¹
- Women who smoke and use oral contraceptives increase their risks of having a stroke or heart attack.¹²

PRECONCEPTIONAL & INTERCONCEPTIONAL WOMEN

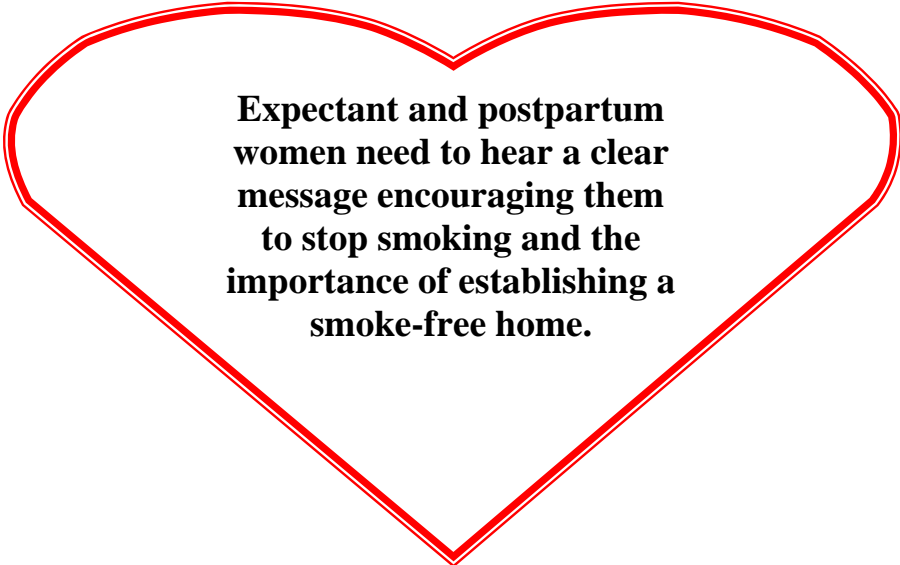
COUNSELING SUGGESTIONS

1. Provide smoking cessation interventions, that include the 5 A's counseling approach, to women who continue to smoke or resume smoking during the postpartum period.¹³ Please refer to Section Two for information on the 5 A's counseling approach.
2. Counsel and support her to stay smoke-free after her baby is born. Many women who quit smoking during pregnancy relapse within three months after their baby is born. She will need to prepare for the added stress that having a new baby can bring (including fatigue, isolation, postpartum blues) in order to avoid a relapse. Help her think of the things she can do and/or the people she can identify to support her during this time. Everyone involved in her care during the postpartum period should make use of every opportunity. Counseling can occur in the hospital room prior to discharge, during postpartum visits, WIC appointments, dental appointments, and at first immunizations and well child care visits.
3. Encourage her to quit smoking now, even if she was not able to quit during pregnancy. Quitting will benefit her health and her baby's health.
4. Encourage her to ask for support from significant others (spouse/partner, family members, friends) in her efforts to quit smoking.
5. Discuss the harmful health effects of secondhand smoke exposure. Counsel her on how to eliminate her baby's exposure and her exposure to secondhand smoke. Encourage the mother to ask people - spouse/partner, family members, friends, baby-sitters, and day-care providers - not to smoke around the baby, including in the home, in cars or on public transportation. Please refer to Section Three - Secondhand Smoke.



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6. Provide her with advice on healthy eating habits and incorporating exercise into her daily routine. Postpartum relapse may be due to her concern about weight gained during pregnancy. She may use smoking as an inappropriate means to control her weight.
7. Remind her that the baby is still developing and that babies are less healthy if they are around smokers.



**Expectant and postpartum
women need to hear a clear
message encouraging them
to stop smoking and the
importance of establishing a
smoke-free home.**

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¹ U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

² <http://www.cdc.gov/communication/tips/shsmoke.htm>

³ U.S. Department of Health and Human Services. *Women and Smoking: A Report of the Surgeon General*. Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.

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⁶ Carmichael SL, Ahluwalia IB. Correlates of postpartum smoking relapse: Results from the pregnancy risk assessment-monitoring system (PRAMS). *American Journal of Preventive Medicine* October 2000; 19(3): 193-196.

⁷ Gantt CJ. The Theory of Planned Behavior and Postpartum Smoking Relapse. *Journal of Nursing Scholarship* Fourth Quarter 2001; 33(4): 337-341.

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¹² Ibid.

¹³ <http://www.cdc.gov/communication/tips/shsmoke.htm>

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BREASTFEEDING WOMEN

The benefits of breastfeeding on the short and long-term health for both the mother and child are profound. Despite public awareness of the benefits of breastfeeding the myth still exists that smokers should not breastfeed because it will hurt the baby. That is simply not true. The breastfed baby, regardless of the mother's smoking status, clearly benefits in numerous ways from breastmilk. The risk for respiratory illness is seven (7) times greater in infants whose mothers smoked and did not breastfeed than for those who smoked and did breastfeed.¹

THE FACTS

- The more women smoke the less likely they are to breastfeed.²
- Smokers who choose to breastfeed were found to be 17% more likely to stop breastfeeding than nonsmokers.³
- Although smokers are less likely to breastfeed and more likely to stop soon after birth, studies show that it is largely due to a lower motivation to breastfeed rather than a physiological effect on their milk.
- Nicotine is readily found in the breastmilk of smokers and can be found in the milk of nonsmokers exposed to secondhand smoke.⁴
- Nicotine concentrations in breastmilk have been found to be 3 times that found in maternal blood. Snuff users had double the amount of nicotine in their milk than smokers.⁵
- The half-life of nicotine in milk was found to be around 95 minutes. The time between breastfeeding and smoking/snuff use influences the concentration of nicotine found in milk.⁶
- Cotinine, the by-product of nicotine, is found in the urine of infants exposed to tobacco. The highest levels of urine cotinine were found in breastfed infants whose mothers smoked and exposed their babies to secondhand smoke.⁷
- Infants of women who choose to use nicotine replacement therapy (NRT) while they quit smoking will benefit from nicotine/cotinine levels up to 70% less than what is found in women who smoke 17 cigarettes a day. The baby's nicotine exposure can be reduced even more if their mothers remove the NRT patch while they sleep.⁸
- Women who continue to smoke and choose to breastfeed their child should be encouraged to wait until just after breastfeeding to smoke and to wait until after the next feeding before smoking again to lessen the nicotine exposure to the infant.
- Mothers should be counseled to never smoke while breastfeeding and to avoid exposing their child to secondhand smoke by smoking outside the home and automobile.

SECTION FIVE COUNSELING THROUGH THE LIFESPAN

BREASTFEEDING WOMEN

COUNSELING SUGGESTIONS

1. Provide smoking cessation interventions that include the 5A's counseling approach to women who continue to smoke or resume smoking during the postpartum period. Please refer to Section II for information on the 5A's counseling approach.



2. Counsel and support her to stay smoke-free after her baby is born. Many women who quit smoking during pregnancy relapse within three months after their baby is born. She will need to prepare for the added stress that having a new baby can bring (including fatigue, isolation, postpartum blues) in order to avoid a relapse. Help her think of the things she can do and/or the people she can identify to support her during this time. Everyone involved in her care during the postpartum period should make use of every opportunity. Counseling can occur in the hospital room prior to discharge, during postpartum visits, during family planning visits, WIC appointments, dental appointments, and at immunizations and well child care visits.
3. Encourage her to quit smoking now, even if she was not able to quit during pregnancy. Quitting will benefit her health and her baby's health.
4. Encourage her to ask for support from significant others (spouse/partner, family members, friends) in her efforts to quit smoking.
5. Discuss the harmful health effects of secondhand smoke exposure. Counsel her on how to eliminate her baby's exposure and her exposure to secondhand smoke. Encourage the mother to ask people - spouse/partner, family members, friends, baby-sitters, and day-care providers - not to smoke around the baby, including in the home, in cars or on public transportation. Refer to Section III - Secondhand Smoke.
6. Remind her that the baby is still developing and that babies are less healthy if they are around smokers.

As health care providers our goal should be a smoke-free mother and environment and a breastfed child.

SECTION FIVE

COUNSELING THROUGH THE LIFESPAN

¹ Becker A, Manfreda J, et al. Breast-feeding and environmental tobacco exposure. *Arch Pediatr Adolesc Med.* 1999; 153:689-691.

² Leung G, Ho L, Lam t. Maternal, paternal and environmental tobacco smoking and breastfeeding. *Paediatr and perinatal Epidemiol.* 2002; 16:236-245.

³ Donath S, Amir L, et al. The relationship between maternal smoking and breastfeeding duration after adjustment for maternal infant feeding intention. *Acta Paediatr.* 2004; 93:1514-1518.

⁴ Dahlstrom A, Ebersjo C, Lundell B. Nicotine exposure in breastfed infants. *Acta Paediatr.* 2004; 93:810-816.

⁵ Ibid.

⁶ Ibid.

⁷ Ilett K, Hale T, et al. Use of nicotine patches in breastfeeding mothers: transfer of nicotine and cotinine into human milk. *Clin Pharma & Therapeu.* 2003; 74:6:516-524.

⁸ Ibid.