CME CREDIT

New strategies for detecting and treating problem drinking

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AS MANY AS 20% to 30% of patients seen in a physician's practice have alcohol-related problems, yet only half of them are identified. This failure to recognize and treat the problem can have a profound long-term effect on the health of the patient, as the life expectancy for alcoholic persons is only 58 years.

Only half of patients with alcohol-related problems are identified

Alcohol use is a not an all-or-nothing condition; rather, it is a continuum, with full-blown alcohol dependence representing the end of the spectrum. Moreover, there is no easy test to detect an alcohol problem. Rather, physicians must be alert to subtle signs of alcohol abuse and suspect it when these signs are present.

Despite these challenges, primary care physicians can do a great deal of good, in a short amount of time, by asking a few well-chosen questions about a patient's alcohol use, and by having a short, serious discussion with patients who may have problems in this area.

DOES THIS MAN HAVE AN ALCOHOL PROBLEM?

A 42-year-old firefighter presented to his primary-care physician for a routine physical examination. He had no symptoms except for indigestion, and a negative medical history. When questioned, he stated that he was drinking up to 6 beers several times a week, but it was not interfering with his life in any way. His father was an alcoholic.

Physical examination revealed nothing remarkable, but his blood pressure was 140/100 mm Hg. In addition, his aspartate aminotransferase (AST) level was 168 U/L (normal: 7–40 U/L), his alanine aminotransferase (ALT) level was 101 U/L (normal: 0–30 U/L), and his gamma-glutamyl transferase (GGT) level was 98 U/L (normal: 0–50 U/L).

ALCOHOL USE IS A CONTINUUM

Traditionally, alcohol abuse was a yes-or-no question: Is this patient an alcoholic? If the answer was yes, the primary care physician would refer the patient to a substance-abuse center. But many patients do not fit this paradigm. We now view alcohol use as a continuum, from total abstinence to alcohol dependence. In this new paradigm, there is a role for the primary care physician at every step of the way.

It is useful to think of five categories of alcohol use:

Abstinence. Approximately one third of all adult patients do not use alcohol at all. Some of them may be recovering alcoholics, for whom one should not prescribe any potentially addicting drugs; therefore, it is appropriate to ask why a person does not drink. Although there is some evidence that alcohol use in moderation has some cardiovascular benefit, we would never suggest using alcohol to a person who does not drink.

Low-risk. Approximately 45% of patients are low-risk drinkers. For men, this means two drinks or less per day, and no more than three or four drinks on any one occasion. For women and elderly persons, the threshold is lower—one drink or less per day. (A standard drink is 12 grams of pure alcohol, which is equal to one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits.)

Another criterion is that the person does not drink in risky situations such as before driving or when pregnant.

At-risk. Another 10% of patients are drinking in a way that puts them at risk, although they are not experiencing any problems from it. This means more than 14 drinks per week for men or 7 for women; more than 4 drinks at a time for men or 3 at a time for women; or drinking and driving.

Many young persons such as college students fall into this category due to binge drinking. Most do not go on to become alcoholics, but binge drinking is dangerous because of the cognitive and psychomotor impairment it causes: trauma units and emergency rooms are filled with people who were binge drinking. Many alcoholics have evidence of serious, recurrent problems with alcohol early in adult life. It can be said that if one is not alcoholic by age 25, the odds of ever developing this illness are much reduced.

Problem drinking. Another 5% to 10% of patients experience problems related to drinking, although they may not be actually chemically dependent. First to appear are social problems: trouble at work, fights at home, arrests for drunken driving. The common health consequences such as hypertension, cardiomyopathy, cirrhosis, and pancreatitis usually appear much later, and are not sensitive indicators.

The patient described above is in this category, as he is hypertensive and has liver-enzyme elevations.

Alcohol dependence. Only a minority of patients have obvious signs of true alcohol dependence, with tolerance and withdrawal symptoms.

ASK EVERY PATIENT ABOUT ALCOHOL USE

Because alcohol abuse is so common, it pays to ask every patient if he or she drinks alcohol, including beer, wine, or distilled spirits. If the answer is yes, the next step is to ask the four "CAGE" questions:

Cut down: Have you ever felt that you should cut down on your drinking? A person trying to cut down recognizes that he or she has a problem. The next question is "Tell me more about that."

Annoyed: Have people annoyed you by criticizing your drinking? A yes answer here suggests that people are angry at the patient because he or she is having difficulty meeting obligations—missing work or showing up late, missing family obligations, having interpersonal problems. Find out more.

Guilty: Have you ever felt bad or guilty about your drinking? Here again, find out more.

Eye-opener: Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? This usually indicates alcohol dependency.

If the patient answers yes to any of the above questions, the next step is to establish exactly how much he or she is drinking, and whether the drinking is causing any adverse consequences. Be specific:

- On average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you had on any given occasion during the last month?

In general, patients do not come to a doctor seeking treatment for alcohol problems. The signs may be there, but they may be subtle (TABLE 1); you need to suspect that the signs do reflect an alcohol-related problem. For example, if a patient has treatment-resistant hypertension, don't think pheochromocytoma—think alcoholism.There is no test for loss of control over alcohol—you have to infer it. Where there's smoke, there's fire.

In resistant hypertension, don't think pheochromocytoma —think alcoholism

'LET'S HAVE A TALK ABOUT YOUR DRINKING'

In the case of our firefighter patient discussed above, we had a brief discussion with him about the health consequences of drinking, which he knew nothing about, and advised him to cut down. We also sent him a follow-up letter with his laboratory results. He was seen in follow-up three times at 3-month intervals; his blood pressure is down and his liver enzyme levels are normal. He is still drinking, but only 2 drinks per day.

TABLE

Be alert: possible signs of alcohol problems

- Automobile accidents, especially single-vehicle accidents
- Facial scarring (due to accidents, bar fights, falls)
- Family history of alcoholism
- First seizure after age 40
- Job problems
- Jokes or other references to alcohol
- Heavy smoking
- Liver function elevations, especially gamma-glutamyl transferase (GGT) levels > 30 U/L
- Macrocythemia
- Manipulative, drug-seeking behavior ("My doctor in California always gave me Percodan")
- Marriage problems
- Missed appointments
- Nonpayment of bills
- Obvious signs: coarsened skin, plethoric facies, rhinophyma, tremors, alcohol on the breath, slurred speech
- Pattern of repeated incidents: pancreatitis, gastritis, emergency-room visits
- Possible alcohol-related conditions
  - Hypertension
  - Dyspepsia
  - Anxiety
  - Depression
  - Impotence
  - Trauma
  - Insomnia
- Spouse illness due to stress, abuse

For men, at-risk drinking begins at 14 drinks per week, or 4 drinks at one time

Brief interventions can be effective

For patients in the "at-risk," and "problem drinking," categories, a short, serious talk is in order. Remarkably, such a brief intervention can be effective. In a study performed in Sweden by Kristenson and colleagues in approximately 500 patients with elevated GGT levels, such a brief intervention was enough to decrease the 4-year mortality rate and the number of hospital days by half. In a larger study conducted by Fleming and colleagues (mostly family physicians), at 1 year there were significant decreases in binge drinking, number of hospital days, and drinks per week.

State your medical concern

In the discussion, the physician should repeat what the patient has revealed (quantity of drinking, specific problems) and state why he or she is concerned. Then, because alcohol abuse is a sensitive subject, the patient should be allowed the dignity of coming to the conclusion. Ask: "How do you feel about your drinking?" Or: "If I asked you if you had a drinking problem, what would you say?"

Advise to abstain or cut down

Patients should be advised to abstain from alcohol if they have evidence of alcohol dependence, a history of repeated failed attempts to cut down, are pregnant or trying to conceive, or have a medical condition or are taking a medication that makes drinking contraindicated. However, others, such as our firefighter patient, can be advised merely to drink less, which can reduce their risk.

Agree on a plan of action

At this point, ask the patient if he or she is ready to cut down or abstain. If so, agree on a plan: a specific drinking goal, and a follow-up appointment. Written materials such as pamphlets are good to reinforce the reasons for cutting down or abstaining from alcohol. At follow-up visits, for patients who have elevated liver enzyme levels, it is a good idea to obtain GGT levels to check compliance.

'Let's get a professional evaluation'

Brief intervention does not work for all patients. Patients should be referred to a substance-abuse center if they:

- Are alcohol-dependent.
- Have failed to cut down on their drinking after you have urged them to do so.

• Might be alcohol-dependent or noncompliant (but you are not sure).

Because "treatment" implies a commitment that a patient may not be ready to make, it may be easier to persuade the patient to get an "evaluation," and let the expert suggest that the patient undergo treatment.

THE CHALLENGE OF TREATING ALCOHOLIC PATIENTS

Patients with severe alcohol problems can be "difficult" patients. They tend to have an entrenched lifestyle. Because the diagnosis of alcoholism carries a stigma, they often deny having a problem. Often, their defensiveness leads them to avoid or mistrust authority figures (such as doctors), or to conceal important bits of information which could reveal a serious problem.

Alcoholics tend to provoke a judgmental response from physicians. We encourage you to think of these patients as a challenge and become a doctor who is "good" with alcoholics. Use an emphatic, nonconfrontational style. Be persistent, and follow up. Offer your patient some choices about how to change. Emphasize that your patient is responsible for changing his or her behavior. And offer hope: most treatment programs have good success rates.

SUGGESTED READING

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