

CLINICAL GUIDELINES FOR FAMILY PHYSICIANS

Helping Patients Who Drink Too Much

BY NEIL S. SKOLNIK, M.D., AND ANNE T. WIEDEMANN, M.D.

The National Institute on Alcohol Abuse and Alcoholism has released its 2005 Clinician's Guide: "Helping Patients Who Drink Too Much." The NIAAA defines heavy drinking as having more than 5 drinks per day or 15 drinks per week (for men), or as having more than 4 drinks per day or 8 drinks per week (for women).

Based on these definitions, 3 of every 10 Americans drink too much; 25% of these drinkers have an alcohol use disorder, which includes both alcohol abuse and dependence. Primary care physicians are in an ideal position to screen patients for alcohol abuse and initiate treatment.

Guidelines are most useful when they are available at the point of care. A concise yet complete handheld computer version of this guideline is available for download, compliments of FAMILY PRACTICE NEWS, at www.redi-reference.com.

Screening and Diagnosis

All patients should be asked, as part of the routine social history, if they drink alcoholic beverages. The updated NIAAA guidelines recommend that a single question—rather than the conventional four-question alcohol evaluation (CAGE)—be used to screen for alcohol disorders: Ask patients if they ever use alcoholic beverages, and if they do, how many days in the past year they have had four or more drinks in a day.

If the screening is positive, a further evaluation should be performed to assess average weekly drinking and the effect that it has on functioning. An alternative screening method is to give the written questionnaire AUDIT (Alcohol Use Disorders Identification Test) to patients prior to a physical examination.

Patients who are positive on the screening should be questioned about signs of tolerance; withdrawal; inability to stick to drinking limits or to cut down on alcohol intake; the amount of time spent drinking versus doing other activities; and whether they have continued to drink despite physical or psychiatric problems. Anyone who admits to three or more of these behaviors has alcohol dependence.

Interventions

Begin simple interventions when at-risk drinking or an alcohol use disorder is identified. Express concern about the patient's alcohol use and assess his or her readiness to change. If a patient is not ready to quit, express a willingness to help in the future, and plan to reassess the patient at subsequent visits. If a patient expresses a desire to quit, help set realistic goals to cut down on alcohol use and discuss how to handle high-risk situations.

It is important to remind patients that alcoholism is a disease that requires constant surveillance. Relapse is most common during the first 12 months, and—as in other addictions—many drinkers fail multiple times before achieving abstinence.

For many patients who drink alcohol, evaluations by addiction specialists help. Outpatient and inpatient treatment programs and support groups are available. More information can be found at www.findtreatment.samhsa.gov.

Acute Alcohol Withdrawal

Alcohol withdrawal usually begins within a few

hours after a patient's last drink. Signs and symptoms include anxiety, tremors, diaphoresis, hypertension, and tachycardia. If left untreated, withdrawal can lead to alcohol withdrawal delirium, which begins 1-3 days after abstinence.

Alcohol delirium produces hallucinations, changes in both mental status and sleep-wake cycles, and seizures. These patients frequently require hospital admission for management. Treatment includes thiamine and folate replacement, antihypertensive medications as needed, and benzodiazepines.

Medications

Three medications are approved by the Food and Drug Administration for maintaining abstinence.

Disulfiram (Antabuse) produces an unpleasant flushing reaction when a patient drinks. Disulfiram should not be used in patients with coronary artery disease and should be used with caution in patients with a history of psychosis or hepatic or renal impairment.

Naltrexone (ReVia) blocks opiate receptors, resulting in reduced reward response and cravings. Naltrexone is contraindicated in patients who are currently taking opiates. It is also contraindicated in patients with hepatic disease, and should be used with caution in patients with renal impairment or a history of attempted suicide. Studies have shown that naltrexone may have higher response rates in patients with a family history of alcohol dependence.

Acamprosate (Campral) is thought to work by decreasing the symptoms of withdrawal, including insomnia, anxiety, and restlessness. It works best if it is initiated several days after discontinuing alcohol use. Acamprosate is contraindicated in patients with renal impairment or severe depression. It can cause anxiety, depression, and—in rare cases—renal failure or heart failure. It has not been linked with any drug interactions.

The Bottom Line

Heavy alcohol use is a serious cause of morbidity and mortality and needs to be effectively screened. With brief interventions, one-third of heavy drinkers have been able to maintain abstinence. Constant support and frequent follow-up—as well as the judicious use of formal programs and medications—are key.



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Gender Differences Seen In AA Participants' Beliefs

BY BETSY BATES

Los Angeles Bureau

SANTA BARBARA, CALIF. — Men and women are similarly devoted to long-term participation in Alcoholics Anonymous, progressing at about equal rates through the 12 steps that define the voluntary, nonprofit program for problem drinkers.

But a study presented at the annual meeting of the Research Society on Alcoholism found intriguing gender differences in two areas of Alcoholics Anonymous (AA) participation.

Women just starting out in AA tended to place more emphasis on deferring to a higher power for their recovery than women who had spent more than a year in the program.

For men, the pattern was reversed. Newcomers to the program were much less likely than women to place a high degree of importance on a higher power's role in their recovery. But those who had spent more than a year in the program attributed a great deal of importance to a higher power's role, surpassing women's ratings on this measure.

Men, regardless of how long they had participated in AA, were significantly more likely than women to participate in sister AA 12-step programs such as Narcotics Anonymous.

J. Scott Tonigan, Ph.D., of the center on alcoholism, substance abuse, and addictions at the University of New Mexico, Albuquerque, studied the responses of 99 AA members from five AA groups to a series of questionnaires about the program.

The cohort included 73 men and 26 women. Their average age was 44, and they reported an av-

erage of 69 months of abstinence.

Most had attended AA for more than 1 year, but 35 were newcomers, allowing Dr. Tonigan to capture differences in participants' outlooks based on their longevity in AA.

Regardless of gender, those who had spent more time in the program were significantly more likely to say they were following the central constructs of AA: making amends to others, believing in a higher power, practicing AA behaviors, and completing steps in the program.

"Perhaps ... they had more time to do so relative to the short-term AA members," Dr. Tonigan wrote in his poster.

In this study, just 3 of 26 women but 28 of 73 men said they had attended sister AA programs. Women who had been involved with AA longer placed less emphasis on a higher power than did women who had just started AA, while for men the reverse was true.

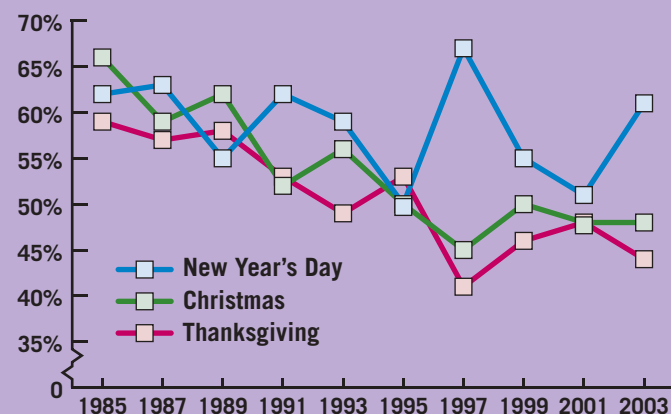
Dr. Tonigan said it is possible that these unexpected findings could be attributable to the cross-sectional nature of the study, to gender differences in substance abuse (with regard to attendance at sister AA program meetings), or to type 1 error, because the number of subjects in the study was small.

He stressed that men and women tend to similarly complete AA steps, read AA literature, and find sponsors—all key elements in the program's proven ability to foster abstinence.

However, he said, a better understanding of what keeps men and women attending AA may help clinicians to assist their patients in benefiting from the mutual-help group. ■

DATA WATCH

Most Vehicle Fatalities During the Holidays Are Alcohol Related



Source: National Highway Traffic Safety Administration