



Screening for a Common Cause of Illness and Death: Alcohol

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A 48-year-old male presents for a physical exam. He was last seen in the office two years ago. He reports no significant illness since then. He continues to smoke one half a pack per day and reports "social drinking." He works as an accountant. His blood pressure is 143/89 and his exam is grossly normal. During the visit he casually mentions that he is in danger of losing his job and his wife recently separated from him.

For such a tiny molecular structure, alcohol represents an extremely complex subject for health care providers. The consequences of a glass of red wine can range from modest cardiovascular benefits to chaos and destruction. Alcohol misuse is strongly associated with health problems, disability, accident, injury, social disruption, violence, and death.¹ In the United States, alcohol abuse generates nearly \$185 billion in annual economic costs.¹ It may be surprising to note that Medicare beneficiaries are as likely to be hospitalized for alcohol-related problems as for myocardial infarction; however, as with the 10% to 20% of patients presenting to physicians with some type of alcohol misuse, early recognition and treatment has the potential to derail this deadly disease in all age groups.

As with any behavior related illness, alcohol misuse can be extremely challenging to diagnose. The spectrum of drinking ranges from low risk drinking, to misuse or abuse, which is used synonymously, to alcohol dependence. The DSM IV guidelines for alcohol abuse define it as a maladaptive pattern of alcohol

use leading to clinically significant impairment or distress occurring within a 12-month period. Abuse requires alcohol related disruptions with the law, health, occupation, or social interactions.² The amount of alcohol is irrelevant when any of these problems develops for the patient. Furthermore, misuse often leads to dependence through tolerance and development of withdrawal symptoms, which in most situations should be treated by specialists in a closely monitored setting.

Unfortunately, primary care physicians do not routinely approach the subject of alcohol use with patients.³ The knowledge that most alcohol misuse will not progress to end organ disease is often enough to deter doctors from probing into personal habits. Also, doctors commonly take a patient's initial negative response to screening as a perpetual truth. However, primary care physicians are in a position to make an impact on high risk drinking. A systematic review of 38 studies of screening for alcohol misuse by adults in primary care settings supports the effectiveness of available screening instruments.⁴ For this reason, alcohol misuse screening in adults is recommended by the US Preventive Services Task Force (USPSTF), as well as other organizations.⁵

Screening in the primary care setting does rely on a truthful history from the patient. Screening can range from one simple question such as "How many times this year have you had more than 5 alcoholic beverages in a day?" to more complex surveys. The CAGE (feeling the need to Cut down, Annoyed by criticism, Guilty about drinking, and need for an Eye-opener in the morning) is the most widely used screen for detecting alcohol

Table 1. General Outline for Brief Intervention by the Primary Care Provider

- Ask: "Do you think your drinking is a problem? Safe? Healthy? Does it bother your loved ones? Your work?"
 - Your goal: To get the patient to verbalize his problem. To ensure the patient is not alcohol dependent.
- Advise: "I think you should cut down or quit drinking."
 - Your goal: To clearly state what is medically indicated for the patient.
- Assess: Use the patients previous statements and reactions to determine his willingness to change
 - Your goal: To have a realistic idea of the patient's readiness to change in order to encourage him appropriately and continue to engage him
- Assist: "What do you think is a reasonable drinking goal for you?" "What do you think will be the hardest part and how will you deal with that?"
 - Your goal: Set a specific and reasonable goal for the patient. This may range from drink reduction and safety to abstinence.
- Follow up: "I want to see you in 2 weeks so we can discuss how this is going for you."
 - Your goal: Remain in close contact to keep the patient motivated, answer questions, or refer to a specialist if necessary

abuse; it is also sensitive for alcohol dependence. A longer but more closely studied test is the **Alcohol Use Disorders Identification Test (AUDIT)**. Its ten questions are sensitive for detecting alcohol abuse or dependence, and can be used alone or given with questions about other health related activities. Screening tools are available at the National Institute on Alcohol Abuse and Alcoholism Web site.⁶

A positive screening test should then prompt a primary care physician to perform a brief intervention. Brief interventions have been studied extensively over the last twenty years.⁷ Although the data on these interventions have mixed results on morbidity and mortality of alcoholism, it has been proven to reduce alcohol consumption.^{7,8} In addition, it has not been proven harmful to the patient. In fact, several interventions over time are shown to reduce average alcohol consumption by three to nine drinks per week, with effects lasting up to six to 12 months after the intervention and as far out as four years.⁸

A brief intervention involves a five to 15 minute counseling session consisting of objective feedback, advice, and goal-setting conducted in a non-confrontational environment. Brief interventions work by proposing the idea of abstinence, or if disinterested, to simply educate the patient, with a goal of reducing the harm produced by risky drinking. Ideally, a motivational interviewing technique should be used for these interventions.⁹ This strategy attempts to engage the patient in order to increase awareness of problems and consequences experienced by alcohol use. This awareness may allow the patient to move through the stages of change toward action. These interventions often require a tactful, empathic approach. A suggested format for these interventions is outlined in Table 1.

If screened for alcohol misuse using any validated screening test, a meta-analysis concluded that 3% to 18% of patients would screen positive for alcohol misuse, but less than a third of those patients who screen positive would receive any intervention.¹⁰ A fear many clinicians may have is that screening for such a common malady could bring alcohol abuse to the forefront of many practices, replacing other common illnesses. Currently physicians lack training in addiction medicine and counseling, not to mention the feeling of helplessness that chronic alcoholism can produce for health care providers. However, by creating a safe place for dialogue and using the initial tools for change, primary care physicians can transform high risk behavior and prevent a myriad of negative consequences for their patients.

The patient above answers yes to having more than five drinks several times over the past year. He goes on to say that he often does this once a week, which disturbs his wife. The physician respectfully points out that his drinking is risky and could be causing some of his current problems. Although embarrassed, the patient agrees to the doctor's opinion, but does not want to quit drinking. They negotiate a drinking goal of cutting back to no more than three drinks in one day, and he will return to the office in three weeks.

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