

Alcohol Intervention Helps Hepatitis C Patients

BY JANE SALODOF
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Southwest Bureau

SANTA ANA PUEBLO, N.M. — A hepatitis C virus clinic in Minnesota helped alcoholic patients become eligible for antiviral therapy by integrating alcohol screening and a behavioral intervention into medical care.

Nearly half (47%) of 47 new patients flagged for “severe alcohol use” reduced their drinking after physicians warned that it could make them ineligible for antiviral treatment, according to a poster presented by Dr. Eric W. Dieperink at the annual meeting of the Academy of Psychosomatic Medicine.

Some relapsed after this initial brief intervention, but nearly two-thirds (62%) subsequently reduced their alcohol use by participating in an on-site program with a psychiatric clinical nurse-specialist. And 17 patients (36%) achieved long-term abstinence

and were offered antiviral therapy.

“There was a big effect of just having the [clinic staff] address alcohol use at the initial visit,” Dr. Dieperink, a psychiatrist at the University of Minnesota, said in an interview at the meeting. “It’s a cost-effective way to help people start treatment.”

Standard practice is to refer patients to a substance abuse program and tell them to “come back in 6 months when you are sober,” Dr. Dieperink said. He and his colleagues reasoned that people facing medical consequences would be more likely to respond to an alcohol intervention than would a general population. They decided, therefore, to engage patients medically and psychiatrically at the clinic.

Gastroenterologists at the Veterans Affairs Medical Center in Minneapolis invited psychiatrists into the clinic about 6 years ago, Dr. Dieperink said, citing concerns about depression as a side effect of interferon treatment.

Over time, the collaboration took on other psychiatric disorders in an ongoing attempt to address barriers to treatment.

“Alcohol is considered a barrier to treatment for hepatitis C and also hastens the fibrosis related to liver disease. So there were two reasons to address it,” Dr. Dieperink said.

The intervention began with all patients being screened for psychiatric problems at their initial clinic visit. Instruments included the Alcohol Use Disorders Identification Test-C (AUDIT-C), which the psychiatric clinical nurse-specialist reviewed. The nurse-specialist subsequently met with patients who scored above 4 on the AUDIT-C or were referred by staff members for alcohol problems.

A cornerstone of the program was having gastroenterologists discuss alcohol each time they saw the patients. “At every visit, the hepatology folks continued to address alcohol,” Dr. Dieperink

said. “That was the synergism—constantly attending to the alcohol use at every visit—which we think made a big difference.”

He described the approach as matter of fact. Physicians would compare the patients’ drinking with standards and norms for their age groups, recommend they cut back, and offer to arrange follow-up with the nurse.

The poster described the 47 veterans as 51 years old on average. Of the 47 patients, 32 were diagnosed with alcohol dependence and 15 with alcohol abuse. Most (82%) were hepatitis C genotype 1. Nearly two-thirds had stage II or higher liver fibrosis. The mean score on the AUDIT-C was 6.5. In addition, 24 patients (51%) self-reported use of cannabis, cocaine, or methamphetamine during the previous 6 months.

The patients had consumed alcohol on average 17.3 of the 30 days before they came to the clinic, consuming a mean of 9.5 drinks per day. After the initial

brief intervention, the average number of drinking days per month fell to 10.6 and the average number of drinks consumed per day declined to 5.5.

Ten patients refused referral to the nurse-specialist. Among those who participated in the follow-up program, the average number of drinking days fell to 8.8 after 3-18 months and the number of drinks per day to 3.8 after 5-22 months.

Of 37 patients who participated in the follow-up program with the clinical nurse-specialist and/or a mental health practitioner, only 3 were excluded from antiviral therapy because of continued alcohol use. Seventeen were offered retroviral therapy, and 13 started treatment.

The investigators said the treatment rate, 28% of patients with serious alcohol use, compared favorably with the 21% treatment rate reported for consecutive hepatitis C patients in Veterans Affairs clinics nationwide. ■

Risk of Premature Death Higher With Serious Mental Illness

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — Heart disease and suicide were the leading causes of death in a large study of patients with mental illness in Ohio.

Moreover, these patients died at a mean age of 48 years, which represented 32 years of potential life lost, Dr. Brian J. Miller reported during a poster session at the American Psychiatric Association’s Institute on Psychiatric Services.

“That is a strikingly high figure,” said Dr. Miller, a psychiatry resident at the Medical College of Georgia, Augusta. The findings underscore the importance of integrating the delivery of health care services to patients with serious mental illness and targeting interventions that improve their quality of life, such as monitoring blood glucose levels, taking waist circumference measurements, and looking for metabolic syndrome.

The study results “confirm findings of previous reports that patients with serious mental illness are at increased risk of death,” said Dr. Miller, who conducted the research while a medical student at Ohio State University in Columbus. “The cited literature suggests a 1.6- to 2.8-fold increased risk of premature death. We found a 3.2-fold increased risk of premature death.”

He and his associates analyzed Ohio Department of Mental Health records for 20,018 patients discharged from an Ohio public psychiatric hospital between 1998 and 2002, and



matched them against Ohio Department of Health records for the same time period. They identified 608 deaths and calculated leading causes of death, medical comorbidities, age-adjusted mortality, years of potential life lost, and standardized mortality ratios.

Most patients (72%) died within 2 years of discharge from the psychiatric hospital. The leading causes of death were heart disease (21%), suicide (18%), and accidents (14%). The most prevalent medical comorbidities were obesity (24%), hypertension (22%), and diabetes mellitus (12%).

The overall standardized mortality ratio was 3.2, which corresponded to 417 excess deaths.

“What’s interesting is that we found that the leading medical comorbidities—specifically, obesity, hypertension, diabetes, and COPD—are consistent with the risk factors for the observed leading [medical] causes of death: heart disease, COPD, and diabetes,” Dr. Miller said.

In the text of their poster, the investigators acknowledged that the findings may not apply to other populations with serious mental illness. “While our statistical models adjusted for age and gender differences, there are many other demographic, health, and socioeconomic factors that are difficult to adequately and accurately control,” they wrote.

The investigators said that their data came entirely from state mental health inpatient records. The study population was largely male, unmarried, and uneducated—a group for which alcohol and substance abuse were well documented. ■

Suicides in Liver Donors Suggest Need for Psychiatric Assessment

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Postoperative psychiatric complications in a small percentage of liver donors included three completed or attempted suicides, Dr. James F. Trotter reported in a poster at the annual meeting of the American Association for the Study of Liver Diseases.

Data on the right hepatic lobe donors came from the Adult-to-Adult Living Donor Liver Transplant Cohort Study (A2ALL), which followed donors and recipients at nine U.S. transplant centers for at least 5 days and up to nearly 6 years after the surgery.

“Suicide and severe psychiatric complications are of concern in right hepatic lobe donors. We suggest psychiatric assessment and monitoring of liver donors may be helpful to understand and prevent such tragic events,” wrote Dr. Trotter of the University of Colorado Health Sciences Center, Denver, and his associates.

More studies are needed to determine if the psychiatric complications are related to stress from the surgery or to the types of people who choose to donate, or both, he said.

The postoperative psychiatric complications, which occurred in 3% of 390 liver donors, included two completed suicides and one attempted suicide in addition to depression in two donors, substance abuse in two, and the development of worsening

obsessive-compulsive disorder, insomnia, or bipolar disorder in one donor each. Detailed questionnaires were used to profile the three suicide events. The recipients of the right hepatic lobe donations in these three cases were alive and well at the time of the suicide attempts.

A 50-year-old man who donated to his niece was treated with clonazepam for bipolar disorder before and after the donation. He developed physical postoperative complications, including a middle hepatic vein thrombosis, abdominal discomfort, and fatigue. He used a shotgun to the head to kill himself 22 months after the donation.

A 35-year-old man who donated to his brother developed a pleural effusion, ileus, and mild urinary retention after the surgery. Prior to donation, he had been in counseling related to a divorce but had no psychiatric history. A fatal, self-induced drug overdose 23 months after donation was recorded as suicide by the transplant center.

A 23-year-old man who donated to his father had no physical complications. Nine months later he was hospitalized twice in a 2-month period for slashing his wrists in attempted suicides after a breakup with his significant other. He is alive and doing well today, Dr. Trotter wrote.

Besides the two donors who committed suicide, two other donors died—one from postdonation surgical complications and one in a train accident. ■