JFP Journal Club

ALCOHOL SCREENING

TITLE: Opportunities for Alcohol Screening and Counseling in Primary Care
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Background: Evaluation of low-cost, rapid screening procedures that can be used by primary care physicians to identify and begin early treatment of individuals with alcohol-related problems has been recommended.[1] The CAGE questionnaire is a fairly well-known four-item scale which asks patients about cutting down, being annoyed, feeling guilty, and using eye-openers; it has been used to evaluate the presence of an alcohol problem.[2] In addition to identifying individuals with alcohol-related problems, physicians should also be prepared to assess the patient's readiness to reduce his or her alcohol consumption and to offer effective treatment, such as behavior change counseling. Several models for physician intervention emphasize tailoring health-related behavior changes to the individual's perceived benefits and barriers associated with that behavior change.[3]

Clinical questions: 1. How many and what type of primary care patients have positive responses on an alcoholism screening instrument? 2. What proportion of these patients are interested in changing their alcohol consumption behavior? 3. What are the perceived motives for and barriers to that behavior change?

Population studied: Primary care patients aged 18 to 75 years who received regular care from 12 community-based family practice physician groups in North Carolina. Five practices were urban, the other seven included "substantial numbers of rural patients."

Study design and validity: The study design is cross-sectional and descriptive in nature. Eligible patients during July and August 1992 were asked to complete a self-administered questionnaire while waiting to see a health care provider. The questionnaire contained sections on current health behavior status, including alcohol consumption, and sections on the benefits and barriers associated with changing specific current health behaviors. Patients who stated that they drank alcohol at all were assessed for alcohol problems using the CAGE questions, then queried regarding their interest in changing their behavior. The CAGE was modified by limiting the questions to apply to only the previous 12 months. Those with two or more positive responses were considered to have a potential alcohol problem, and their responses were analyzed for interest and plans to cut down as well as their perceived barriers to and motives for making this change.

A limitation of this design is lack of generalizability to other patient populations, since study respondents were all from the same geographic location and only whites and African-Americans were included in the results. Also, nonrespondents tended to be male and older, and often cited acute illness as the reason for not participating. Selection bias could be introduced if this group had a disproportionately high rate of alcohol abuse.

Outcomes measured: The outcomes measured were (1) demographics of patients who drank alcohol as compared with nondrinkers, (2) description of the patients who had two or more positive CAGE responses, and (3) assessment of interest in reducing alcohol consumption and perceived motives for and barriers to reducing consumption among those with two or more positive CAGE responses.

Results: Of 3750 eligible patients, 3000 (80%) agreed to participate, and 2716 (72%) provided questionnaires with no missing data. The results are based on the information provided by these 2716 patients. Fifty-three percent reported drinking at least occasionally. Drinkers were significantly more likely to be male, white, under 40 years of age, and educated beyond the high school level. Of those reporting alcohol use, approximately 9% had two or more positive CAGE responses. These patients were more likely to be male, African-American, and of a lower education level. A majority of patients (82%) with two or more positive CAGE responses expressed interest in reducing their drinking within the next 6 months, and 67% reported planning to cut down within the next 30 days. There was a positive association between the number of positive CAGE responses and the interest in reducing alcohol consumption within the same group. The primary reason given for wanting to reduce alcohol consumption was health improvement, while the most frequently cited barrier was the perception of alcohol as a stress-reducer, although a similar proportion of patients reported that they had no barriers to reducing alcohol consumption.

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Recommendations for clinical practice: Opportunity for physician intervention is encouraged by the large number of patients reporting that improvement in health was a motive for reducing alcohol consumption. While the number of problem drinkers identified in this study (5%) is lower than most estimates in primary care practice populations,[4] the potential benefit of intervention by primary care physicians remains substantial.

The authors demonstrated that a short self-administered questionnaire can be used to screen for problem drinkers, assess their interest in reducing alcohol consumption, and determine their motives for and barriers to reducing consumption. Of particular interest to clinicians is that those most in need of intervention (based on number of positive CAGE responses) were most likely to report interest in changing their behavior. Therefore, primary care physicians can use the CAGE questionnaire to screen for alcoholism and know that those scoring the highest are also the most likely to want to stop drinking.

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NICOTINE PATCH

TITLE: Use of transdermal nicotine in a state-level prescription plan for the elderly—a first look at 'real-world' patch users
AUTHORS: Orleans CT, Resch N, Noll E, Keintz MK, Rimer BK, Brown TV, Snedden TM
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Background: Several randomized double-blind placebo-controlled clinical trials have demonstrated that transdermal nicotine can at least double the quit rate of smokers when combined with a concurrent behavioral smoking cessation treatment.[1–3] However, the experience of "real world" smokers using transdermal nicotine outside of clinical trials has not been well documented.

Clinical questions: 1. Do patients or physicians tend to initiate transdermal nicotine therapy? 2. What type of adjunctive therapy, if any, is used with nicotine patches? 3. Do patients smoke while using the patch? and 4. What is the long-term (6-month) abstinence rate?

Population studied: All noninstitutionalized elderly (aged 65 to 74 years) smokers who qualified for Pennsylvania's state-sponsored pharmaceutical assistance based on low income and who filled a prescription for transdermal nicotine in early 1992.

Study design and validity: Data were gathered using a 10-minute telephone survey of the study population approximately 6 months after initial transdermal nicotine prescription. Simple descriptive statistics were computed. Such a retrospective interview design has several major limitations. For example, patients may not accurately recall smoking-related symptoms or tobacco use and may feel a desire to please the interviewer by reporting that the patch worked successfully. Also, the external validity (generalizability) of the study is limited by the characteristics of the population (older, low-income, and predominantly female), and the brevity of the follow-up period (6 months).

Outcomes measured: Self-reported physician and/or pharmacist advice on transdermal nicotine, use of adjunctive treatment, concomitant smoking, and 6-month abstinence.

Results: 1070 eligible study subjects were invited to take part in the survey, of which 940 were able to be interviewed. Of these participants, 871 actually completed the interview. Nonresponders were demographically similar to participants. The majority of the respondents were white, female and unmarried, and had less than a high school education. The average length of time smoking was 50 years, with most reporting previous quit attempts. Fifty-nine percent of prescriptions were initiated by the respondent. Nicotine patches were used an average of 5 weeks, with few (8%) bothered enough by side effects to quit using the patch. Only 54% reported receiving any initial advice from their physician or pharmacist, and less than 2% took part in formal smoking-cessation counseling. Almost half (47%) reported having smoked while using the patch. At 6 months, 28% of respondents reported tobacco and patch abstinence for 30 days or more. Respondents who received more advice (initial and interim) were significantly more likely to use transdermal nicotine longer, refill their prescription, switch to a lower-dose patch, report abstinence at 6 months, and be less likely to smoke while using the patch.

Recommendations for clinical practice: As the authors observe, there are few, if any, studies of transdermal nicotine use beyond formal clinical trials. Because the results are based on self-reported data, the quit rate may be inflated. However, as stated in the article, even if the false report rate was assumed to be as high as 20% (one of the highest estimates in the literature[4]), the results compare favorably with those of other reports of transdermal nicotine trials and minimal office-based intervention.[1] While the limitations of the study discussed above preclude a blanket recommendation of nicotine patch use in primary care, this study highlights the importance of health providers' advice in encouraging safe and effective use of the nicotine patch. Further work in this area should examine other patient populations in the primary care setting, perhaps using a practice-based research network, and follow these patients prospectively for longer periods.

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