Internal Medicine and Alcohol

Time to Move Forward

There is no question that the role of internal medicine practice in preventing and treating alcohol use disorders is expanding. Clinical studies show that the prevalence of alcohol abuse and alcoholism is significantly higher among patients visiting a primary care practitioner than among the general population. Therefore, along with other primary care health professionals, the general internist must be proactive in learning about patient alcohol use, determining if that use is causing problems, and following through with an office-based intervention or referral to specialized addiction treatment. As we continue to identify effective pharmacotherapies for the treatment of alcohol abuse and addiction, the management of this therapy is most likely to fall into the realm of the patient's primary physician. This special issue of the *Journal of General Internal Medicine* is an important opportunity to reach many of those who must prepare themselves for this expanded role.

It is important to emphasize the broadening of our view of alcohol problems. If we focus only on individuals who have already progressed to the point where they can be diagnosed as alcohol dependent, we have missed a critical opportunity to intervene earlier, when a brief intervention or prevention message may ameliorate serious consequences. More than 30 studies to date have shown the effectiveness of office-based brief advice delivered by a physician or nurse practitioner in helping at-risk drinkers reduce alcohol use to moderate levels.

Alcohol problems are common in our patients, and yet they are often not identified. According to research conducted by the National Institute on Alcohol Abuse and Alcoholism, almost 20% of those age 18 and older are moderate drinkers who occasionally exceed recommended limits. An additional 3% are moderate drinkers who frequently exceed these limits. These are typically heavy weekend drinkers with increased risk of impaired driving and other acute consequences. Finally, 10% are heavy alcohol consumers, many of whom meet the diagnostic criteria for alcohol abuse or dependence. Research shows that appropriate screening instituted in primary care settings can identify many of these individuals. The primary care physician is in a unique position to help these patients by intervention or referral and long-term follow-up.

In addition to intervening with those patients whose drinking places them at risk for problems, the internist should be prepared to advise patients concerning how alcohol use might affect their medical conditions as well as how alcohol might interact with their medications. Alcohol use is associated with a wide variety of medical conditions including various cancers (for example, esophageal, lip, oral cavity, pharynx, and larynx), acute

and chronic pancreatitis, cirrhosis and chronic hepatitis, pulmonary tuberculosis, hypertension, cerebrovascular disease, diabetes, and pneumonia. At even moderate levels of drinking, patients may be at increased risk for breast cancer, depression, or stroke. Elderly patients can be at risk with relatively small amounts of alcohol, due to interactions with many medications they may be taking for a variety of acute and chronic conditions. Women of childbearing age need to know that if they are pregnant, nursing, or planning a pregnancy, no amount of alcohol is considered safe. Individuals with a first-degree relative who was an alcoholic or heavy drinker are at increased risk for developing alcohol problems.

Are internists and other primary care physicians equipped with the skills necessary to perform these tasks? The paper in this issue presented by Bradley et al.¹ highlights some of the important factors that are coming to light in this area. Alcohol was addressed more often in patients who were the heaviest drinkers and were likely to have more severe alcohol problems. While it is important to intervene with these patients, others perhaps more likely to benefit from an early intervention were missed. When the provider was aware that a patient was an at-risk drinker (exceeding moderate drinking limits), alcohol use was not always discussed during the visit. Finally, and most alarmingly, even though there was an increase in alcohol discussions when physicians were prompted to do so, providers in this study were not often enough forthcoming in giving advice and working with a patient to reduce drinking, in spite of the evidence that these methods are effective.

Bradley et al. aptly point out the need for medical education to increase physician skill in alcohol problems intervention. In addition to meaningful experiences in screening and brief intervention with at-risk patients during undergraduate medical education and residency, continuing medical education that provides effective research-to-practice methods must be made widely available to practicing physicians and other primary health care professionals. These methods include on-site group education by a credible expert educator, the use of opinion leaders, performance feedback, confidential performance reviews relative to peers, and academic detailing.

Research is just beginning to identify the best methods for integrating alcohol problems identification and intervention into busy primary care practice. At some point, we hope that identifying patients with alcohol problems and prescribing appropriate care will be as much a part of our practice as screening for cholesterol or high blood pressure. However, we owe it to our patients

to begin the process based on what we know now. Patients deserve no less. — **RAYMOND A. KINGTON, MD, PhD,** *National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, Bethesda, Md and Johns Hopkins University, Baltimore, Md.*

REFERENCES

1. Bradley KA, Epler AJ, Bush KR, et al. Alcohol-related discussions during general medicine appointments of male VA patients who screen positive for at-risk drinking. *J Gen Intern Med.* 2002;17:315-26.