EDITORIALS

Increasing Screening for Alcohol Use Disorders

Over the last several years, awareness that alcohol use by the elderly is a common public health problem has been growing. Epidemiologic studies suggest that alcoholism is present in up to 4% of the elderly, and at least one report suggests that the prevalence of alcoholism among older adults is on the rise.^{1,2} Moreover, problem or hazardous drinking is estimated to be even more common among the elderly than alcoholism.^{2,3} Despite these epidemiologic trends, studies like the one by Reid and colleagues in this issue highlight the gap between the presence of alcohol-related problems and the recognition and treatment of these problems.⁴

Reid and colleagues studied the screening practices of primary care physicians and concluded that many older patients have alcohol-use disorders or drinking problems that go undetected by their primary care physician.⁴ Furthermore, they suggest that more age-specific screening methods and educational efforts need to be developed to improve the detection of alcohol use and abuse among the elderly. Perhaps as important was their finding that less than 50% of the physicians who regularly screened their patients used a method known to be sensitive for an alcohol-use disorder. All of the physicians reported collecting information about the quantity and frequency of drinking; however, the quantity and frequency of drinking have been shown to be poor screening measures for alcohol dependence.^{5,6} Moreover, the correlation between the quantity and frequency of drinking and a diagnosis of alcohol dependence is weaker among older adults than among younger adults.⁵

This confusion about the appropriate screening method for alcohol dependence is not surprising because experts in the addiction field have given mixed messages to primary care physicians about screening. Although there appears to be a near-universal consensus that alcohol dependence should be recognized and treated, there is no consensus regarding the risks and benefits of moderate drinking. However, recent efforts have focused on the prevention of alcohol dependence or the prevention of alcohol-related disability. These efforts define hazardous levels of alcohol consumption and recommend reduction in alcohol consumption for patients who meet the criteria. The difference between patients with alcohol dependence and those with hazardous drinking is particularly relevant to the primary care setting as studies have demonstrated that older, alcohol-dependent adults are less likely to visit a primary care physician than are nondependent drinkers.⁷ Moreover, upwards of 12% to 15% of elderly, primary care patients exceed the recommended drinking limits of two drinks per day for men or one drink per day for women,

although most of these patients would not meet the criteria for alcohol dependence.⁸ Therefore, the lack of a consensus about whether we should screen for alcohol dependence or hazardous drinking may explain why different physicians use different screening methods and why there is variability in the perceived prevalence of alcohol problems.

Other considerations also confuse the issue. For example, moderate alcohol consumption has potential benefit, especially with regard to cardiovascular disease.⁹ Conversely, moderate alcohol consumption may be detrimental in an older adult with concurrent medical problems such as obstructive lung disease or diabetes or in someone taking medications. Therefore, in the absence of alcohol dependence, clinicians may be confused about whether they should recommend no change in alcohol consumption or a reduction in consumption. In support of this concept, Conigliaro and colleagues surveyed "problem drinkers" of all age groups who recently had a primary care visit.¹⁰ The majority of these patients remembered having a discussion with their doctor about drinking, but only half remembering being advised to reduce their drinking.

Another consideration that confuses the issue is the level of understanding about treatment. It is reasonable to speculate that a lack of understanding about the benefits of reduced alcohol intake and a belief that treatment for drinking is not assessable or effective also lower a clinician's interest in screening for problem drinking. To address this problem, we need better dissemination of information regarding available treatments for alcoholism and continued development of more effective treatments.

Recent evidence counters the general belief that addiction treatment is futile or of limited benefit and that addiction treatment needs to occur in a highly specialized setting. Remarkable progress has been made during the last decade in the development of effective pharmacologic and nonpharmacologic treatments for addiction. In one of the largest nonpharmacologic treatment studies ever conducted, three treatments were found to be effective in reducing alcohol consumption among younger adults with alcohol dependence.¹¹ Although the treatments had similar effects, they had different purposes: to improve cognitive behavioral coping skills, to enhance motivation, or to facilitate the 12-step program. Naltrexone has been shown in several clinical trials to be safe and efficacious in preventing relapses among alcohol-dependent patients,^{12,13} and in 1995 naltrexone became the first pharmacologic treatment for alcoholism approved by the FDA in more than 50 years. Naltrexone has been found to have similar

efficacy among older adults.¹⁴ Studies are being conducted to test the effectiveness of naltrexone in primary care settings. Recent studies by Fleming and colleagues and Barry and colleagues suggest that therapy in the primary care setting is effective in reducing alcohol consumption for moderate drinkers.^{3,15} The study by Barry is particularly noteworthy because it focused on elderly patients.

Together, these studies indicate that primary care physicians should aim for better screening. Indeed, Adams and colleagues demonstrated that when primary care physicians were helped to recognize alcoholism, the number of their discussions with patients about alcohol use increased significantly.¹⁶ We must decide, however, whether the purpose of screening is to prevent disease or identify disease. In addition, further research is needed to clarify the risks and benefits of hazardous drinking so we can decide whether patients should be evaluated only for alcoholism or for alcoholism and hazardous drinking. Finally, better efforts are also needed to include primary care physicians in the treatment process.—**DAVID OSLIN, MD**, *University of Pennsylvania, Philadelphia, Pa.*

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