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Objective

To identify and examine important recent advances in addiction medicine in the medical literature that have implications for generalist clinicians.

Methodology

During an initial review, authors reviewed Medline for relevant peer reviewed literature from January 1, 2008 through early 2010

During a secondary review, authors reviewed accessory sources

Through a consensus process, all authors selected prominent articles that had implications for generalist physicians in the care of patients with addictions

Agenda

1) Update in Epidemiology and Prescription Drug Abuse
2) Update in Screening and Brief Interventions
3) Update in Pharmacotherapy for Addictions
4) Wrap-up, Discussion, and Evaluation

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Selected citations that will be discussed -

1) Update in Epidemiology and Prescription Drug Abuse

**Alexander Y. Walley, MD, MSc**


2) Update in Screening and Brief Interventions — Hillary V. Kunins, MD, MPH, MS and Jeanette M. Tetrauld, MD


3) Update in Pharmacotherapy — Darius A. Rastegar, MD


Citations and Abstracts (in alphabetical order)


AIMS: To determine the prevalence of corrected QT interval (QTc) prolongation among patients in opioid maintenance treatment (OMT) and to investigate mortality potentially attributable to QTc prolongation in the Norwegian OMT programme. PARTICIPANTS AND SETTING: Two hundred OMT patients in Oslo were recruited to the QTc assessment study between October 2006 and August 2007. The Norwegian register of all patients receiving OMT in Norway (January 1997-December 2003) and the national death certificate register were used to assess mortality. Mortality records were examined for the 90 deaths that had occurred among 2382 patients with 6450 total years in OMT. DESIGN AND MEASURES: The QTc interval was assessed by electrocardiography (ECG). All ECGs were examined by the same cardiologist, who was blind to patient history and medication. Mortality was calculated by cross-matching the OMT register and the national death certificate register: deaths that were possibly attributable to QTc prolongation were divided by the number of patient-years in OMT. FINDINGS: In the QTc assessment sample (n = 200), 173 patients (86.5%) received methadone and 27 (13.5%) received buprenorphine. In the methadone group, 4.6% (n = 8) had a QTc above 500 milliseconds; 15% (n = 26) had a QTc interval above 470 milliseconds; and 28.9% (n = 50) had a QTc above 450 milliseconds. All patients receiving buprenorphine (n = 27) had QTc results <450 milliseconds. A positive dose-dependent association was identified between QTc length and dose of methadone, and all patients with a QTc above 500 milliseconds were taking methadone doses of 120 mg or more. OMT patient mortality, where QTc prolongation could not be excluded as the cause of death, was 0.06/100 patient-years. Only one death among 3850 OMT initiations occurred within the first month of treatment. CONCLUSION: Of the methadone patients, 4.6% had QTc intervals above 500 milliseconds. The maximum mortality attributable to QTc prolongation was low: 0.06 per 100 patient-years.


BACKGROUND: Despite the availability and demonstrated effectiveness of office-based buprenorphine maintenance treatment (BMT), the systematic examination of physicians’ attitudes towards this new medical practice has been largely neglected. OBJECTIVE: To identify facilitators and barriers to the potential or actual implementation of BMT by office-based medical providers. DESIGN: Qualitative study using individual and group semi-structured interviews. PARTICIPANTS: Twenty-three practicing office-based physicians in New England. APPROACH: Interviews were audiotaped, transcribed, and entered into a qualitative software program. The transcripts were thematically coded using the constant comparative method by a multidisciplinary team. RESULTS: Eighty percent of the physicians were white; 55% were...
women. The mean number of years since graduating medical school was 14 (SD = 10). The primary areas of clinical specialization were internal medicine (50%), infectious disease (20%), and addiction medicine (15%). Physicians identified physician, patient, and logistical factors that would either facilitate or serve as a barrier to their integration of BMT into clinical practice. Physician facilitators included promoting continuity of patient care, positive perceptions of BMT, and viewing BMT as a positive alternative to methadone maintenance. Physician barriers included competing activities, lack of interest, and lack of expertise in addiction treatment. Physicians’ perceptions of patient-related barriers included concerns about confidentiality and cost, and low motivation for treatment. Perceived logistical barriers included lack of remuneration for BMT, limited ancillary support for physicians, not enough time, and a perceived low prevalence of opioid dependence in physicians’ practices. CONCLUSIONS: Addressing physicians’ perceptions of facilitators and barriers to BMT is crucial to supporting the further expansion of BMT into primary care and office-based practices.


BACKGROUND: Long-term opioid therapy for chronic noncancer pain is becoming increasingly common in community practice. Concomitant with this change in practice, rates of fatal opioid overdose have increased. The extent to which overdose risks are elevated among patients receiving medically prescribed long-term opioid therapy is unknown. OBJECTIVE: To estimate rates of opioid overdose and their association with an average prescribed daily opioid dose among patients receiving medically prescribed, long-term opioid therapy. DESIGN: Cox proportional hazards models were used to estimate overdose risk as a function of average daily opioid dose (morphine equivalents) received at the time of overdose. SETTING: HMO. PATIENTS: 9940 persons who received 3 or more opioid prescriptions within 90 days for chronic noncancer pain between 1997 and 2005. MEASUREMENTS: Average daily opioid dose over the previous 90 days from automated pharmacy data. Primary outcomes--nonfatal and fatal overdoses--were identified through diagnostic codes from inpatient and outpatient care and death certificates and were confirmed by medical record review. RESULTS: 51 opioid-related overdoses were identified, including 6 deaths. Compared with patients receiving 1 to 20 mg/d of opioids (0.2% annual overdose rate), patients receiving 50 to 99 mg/d had a 3.7-fold increase in overdose risk (95% CI, 1.5 to 9.5) and a 0.7% annual overdose rate. Patients receiving 100 mg/d or more had an 8.9-fold increase in overdose risk (CI, 4.0 to 19.7) and a 1.8% annual overdose rate. LIMITATIONS: Increased overdose risk among patients receiving higher dose regimens may be due to confounding by patient differences and by use of opioids in ways not intended by prescribing physicians. The small number of overdoses in the study cohort is also a limitation. CONCLUSION: Patients receiving higher doses of prescribed opioids are at increased risk for overdose, which underscores the need for close supervision of these patients. PRIMARY FUNDING SOURCE: National Institute of Drug Abuse.

To examine long-term outcomes with primary care office-based buprenorphine/naloxone treatment, we followed 53 opioid-dependent patients who had already demonstrated six months of documented clinical stability for 2-5 years. Primary outcomes were retention, illicit drug use, dose, satisfaction, serum transaminases, and adverse events. Thirty-eight percent of enrolled subjects were retained for two years. Ninety-one percent of urine samples had no evidence of opioid use, and patient satisfaction was high. Serum transaminases remained stable from baseline. No serious adverse events related to treatment occurred. We conclude that select opioid-dependent patients exhibit moderate levels of retention in primary care office-based treatment.


OBJECTIVE: To determine whether varenicline, a recently licensed smoking cessation product, is associated with an increased risk of suicide and suicidal behaviour compared with alternative treatments bupropion and nicotine replacement therapy. DESIGN: Cohort study nested within the General Practice Research Database. SETTING: Primary care in the United Kingdom. PARTICIPANTS: 80,660 men and women aged 18-95 years were prescribed a new course of a smoking cessation product between 1 September 2006 and 31 May 2008; the initial drugs prescribed during follow-up were nicotine replacement products (n=63,265), varenicline (n=10,973), and bupropion (n=6,422). MAIN OUTCOME MEASURES: Primary outcomes were fatal and non-fatal self harm, secondary outcomes were suicidal thoughts and depression, all investigated with Cox’s proportional hazards models. RESULTS: There was no clear evidence that varenicline was associated with an increased risk of fatal (n=2) or non-fatal (n=166) self harm, although a twofold increased risk cannot be ruled out on the basis of the upper limit of the 95% confidence interval. Compared with nicotine replacement products, the hazard ratio for self harm among people prescribed varenicline was 1.12 (95% CI 0.67 to 1.88), and it was 1.17 (0.59 to 2.32) for people prescribed bupropion. There was no evidence that varenicline was associated with an increased risk of depression (n=2,244) (hazard ratio 0.88 (0.77 to 1.00)) or suicidal thoughts (n=37) (1.43 (0.53 to 3.85)). CONCLUSION: Although a twofold increased risk of self harm with varenicline cannot be ruled out, these findings provide some reassurance concerning its association with suicidal behaviour.


OBJECTIVE: Randomized trials examining the effects of brief alcohol interventions by primary
care providers have consistently excluded individuals with alcohol dependence. The purpose of this study was to examine whether a diagnosis of alcohol dependence, according to the criteria in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, predicted differential effectiveness of a brief intervention (BI). METHOD: Retrospective analyses were performed on participants (N = 326) enrolled in a randomized trial designed to examine the impact of interactive voice response following BI. All participants had received a BI from their primary care provider before enrolling in the study. Daily consumption data were collected using the Timeline Followback for the period before the BI (mean = 71 days) and for 6 months following the BI. We compared nondependent and dependent participants on a number of consumption-based outcomes. RESULTS: Dependent participants had significantly higher pre-BI consumption. At the index assessment (median =15 days after BI), both dependent and nondependent participants reported significant reductions in total drinks per week and drinking days per week after BI. Dependent participants significantly reduced their drinks per drinking day. After BI, dependent participants no longer differed significantly from nondependent participants on these measures. Similar decreases from before BI were observed in both groups through 6 months, although dependent participants drank on fewer days and significantly more on days on which they drank than did nondependent participants. Regression analyses showed that baseline consumption was the only significant predictor of post-BI consumption. CONCLUSIONS: We found no evidence that dependent participants realized less benefit on measures of alcohol consumption following a BI than nondependent participants.


CONTEXT: Use and abuse of prescription narcotic analgesics have increased dramatically in the United States since 1990. The effect of this pharmacoepidemic has been most pronounced in rural states, including West Virginia, which experienced the nation’s largest increase in drug overdose mortality rates during 1999-2004. OBJECTIVE: To evaluate the risk characteristics of persons dying of unintentional pharmaceutical overdose in West Virginia, the types of drugs involved, and the role of drug abuse in the deaths. DESIGN, SETTING, AND PARTICIPANTS: Population-based, observational study using data from medical examiner, prescription drug monitoring program, and opiate treatment program records. The study population was all state residents who died of unintentional pharmaceutical overdoses in West Virginia in 2006. MAIN OUTCOME MEASURES: Rates and rate ratios for selected demographic variables. Prevalence of specific drugs among decedents and proportion that had been prescribed to decedents. Associations between demographics and substance abuse indicators and evidence of pharmaceutical diversion, defined as a death involving a prescription drug without a documented prescription and having received prescriptions for controlled substances from 5 or more clinicians during the year prior to death (ie, doctor shopping). RESULTS: Of 295 decedents, 198 (67.1%) were men and 271 (91.9%) were aged 18 through 54 years. Pharmaceutical diversion was associated with 186 (63.1%) deaths, while 63 (21.4%) were accompanied by evidence of doctor shopping. Prevalence of diversion was greatest among decedents aged 18 through 24 years and decreased across each successive age group. Having
prescriptions for a controlled substance from 5 or more clinicians in the year prior to death was more common among women (30 [30.9%]) and decedents aged 35 through 44 years (23 [30.7%]) compared with men (33 [16.7%]) and other age groups (40 [18.2%]). Substance abuse indicators were identified in 279 decedents (94.6%), with nonmedical routes of exposure and illicit contributory drugs particularly prevalent among drug diverters. Multiple contributory substances were implicated in 234 deaths (79.3%). Opioid analgesics were taken by 275 decedents (93.2%), of whom only 122 (44.4%) had ever been prescribed these drugs.

CONCLUSION: The majority of overdose deaths in West Virginia in 2006 were associated with nonmedical use and diversion of pharmaceuticals, primarily opioid analgesics.


DESCRIPTION: An independent panel developed cardiac safety recommendations for physicians prescribing methadone. METHODS: Expert panel members reviewed and discussed the following sources regarding methadone: pertinent English-language literature identified from MEDLINE and EMBASE searches (1966 to June 2008), national substance abuse guidelines from the United States and other countries, information from regulatory authorities, and physician awareness of adverse cardiac effects. RECOMMENDATION 1 (DISCLOSURE): Clinicians should inform patients of arrhythmia risk when they prescribe methadone. RECOMMENDATION 2 (CLINICAL HISTORY): Clinicians should ask patients about any history of structural heart disease, arrhythmia, and syncope. RECOMMENDATION 3 (SCREENING): Obtain a pretreatment electrocardiogram for all patients to measure the QTc interval and a follow-up electrocardiogram within 30 days and annually. Additional electrocardiography is recommended if the methadone dosage exceeds 100 mg/d or if patients have unexplained syncope or seizures. RECOMMENDATION 4 (RISK STRATIFICATION): If the QTc interval is greater than 450 ms but less than 500 ms, discuss the potential risks and benefits with patients and monitor them more frequently. If the QTc interval exceeds 500 ms, consider discontinuing or reducing the methadone dose; eliminating contributing factors, such as drugs that promote hypokalemia; or using an alternative therapy. RECOMMENDATION 5 (DRUG INTERACTIONS): Clinicians should be aware of interactions between methadone and other drugs that possess QT interval-prolonging properties or slow the elimination of methadone.


BACKGROUND: Both the 10-item Alcohol Use Disorders Identification Test (AUDIT) and its abbreviated 3-item version (Alcohol Use Disorders Identification Test-Consumption [AUDIT-C]) are considered to detect unhealthy alcohol use accurately. PURPOSE: To examine whether the AUDIT-C is as accurate as the full AUDIT for detecting unhealthy alcohol use in adults. DATA SOURCES: MEDLINE, EMBASE, CINAHL, Web of Science, PsycINFO, and BIOSIS Previews from 1998 to July 2008. STUDY SELECTION: Three independent reviewers selected studies that administered both the AUDIT and the AUDIT-C, applied a valid reference standard, avoided
verification and incorporation bias, and reported relevant data. No language restrictions were applied. DATA EXTRACTION: Two reviewers extracted study characteristics and outcome data, which were cross-checked by a third reviewer. One reviewer assessed methodological quality with a standardized checklist. DATA SYNTHESIS: Fourteen studies were found. Most involved primary care patients in Europe and the United States. Sample sizes ranged between 112 and 13,438 patients, and sex and age distributions varied considerably. No statistically significant differences were found between the overall accuracy of the AUDIT and the AUDIT-C for detecting risky drinking, alcohol use disorders, or unhealthy alcohol use in primary care. Hierarchical summary receiver-operating characteristic curve analysis yielded pooled positive likelihood ratios of 6.62 for the AUDIT and 2.99 for the AUDIT-C, respectively, for detecting risky drinking; 4.03 and 3.82, respectively, for detecting any alcohol use disorder; and 4.82 and 3.91, respectively, for detecting risky drinking or any alcohol use disorder. Findings from a few studies on general population samples and inpatients suggested but did not prove that the AUDIT might be better than the AUDIT-C for identifying severe conditions, such as alcohol dependence. LIMITATION: Studies used different reference standards and had heterogeneous findings. CONCLUSION: Available evidence is inconclusive but suggests that the full AUDIT may be superior to the AUDIT-C for identifying unhealthy alcohol use in adults in some settings.


OBJECTIVES: Alcohol screening and brief interventions in medical settings can significantly reduce alcohol use. Corresponding data for illicit drug use is sparse. A Federally funded screening, brief interventions, referral to treatment (SBIRT) service program, the largest of its kind to date, was initiated by the Substance Abuse and Mental Health Services Administration (SAMHSA) in a wide variety of medical settings. We compared illicit drug use at intake and 6 months after drug screening and interventions were administered. DESIGN: SBIRT services were implemented in a range of medical settings across six states. A diverse patient population (Alaska Natives, American Indians, African-Americans, Caucasians, Hispanics), was screened and offered score-based progressive levels of intervention (brief intervention, brief treatment, referral to specialty treatment). In this secondary analysis of the SBIRT service program, drug use data was compared at intake and at a 6-month follow-up, in a sample of a randomly selected population (10%) that screened positive at baseline. RESULTS: Of 459,599 patients screened, 22.7% screened positive for a spectrum of use (risky/problematic, abuse/addiction). The majority were recommended for a brief intervention (15.9%), with a smaller percentage recommended for brief treatment (3.2%) or referral to specialty treatment (3.7%). Among those reporting baseline illicit drug use, rates of drug use at 6-month follow-up (4 of 6 sites), were 67.7% lower (p<0.001) and heavy alcohol use was 38.6% lower (p<0.001), with comparable findings across sites, gender, race/ethnic, age subgroups. Among persons recommended for brief treatment or referral to specialty treatment, self-reported improvements in general health (p<0.001), mental health (p<0.001), employment (p<0.001), housing status (p<0.001), and criminal behavior (p<0.001) were found. CONCLUSIONS: SBIRT was feasible to implement and...
the self-reported patient status at 6 months indicated significant improvements over baseline, for illicit drug use and heavy alcohol use, with functional domains improved, across a range of health care settings and a range of patients.


BACKGROUND: Brief interventions involve a time-limited intervention focusing on changing behaviour. They are often motivational in nature using counselling skills to encourage a reduction in alcohol consumption. OBJECTIVES: To determine whether brief interventions reduce alcohol consumption and improve outcomes for heavy alcohol users admitted to general hospital inpatient units. SEARCH STRATEGY: We searched the Cochrane Drug and Alcohol Group Register of Trials (June 2008) the Cochrane Central Register of Controlled Trials (The Cochrane Library 2, 2008), MEDLINE January 1966-June 2008, CINAHL 1982-June 2008, EMBASE 1980-June 2008 using the search strategy developed by the Cochrane Drug and Alcohol Group. We hand searched relevant journals, conference proceedings and contacted experts in the field. SELECTION CRITERIA: All prospective randomised controlled trials and controlled clinical trials were eligible for inclusion. Participants were adults (16 years or older) admitted to general inpatient hospital care for any reason other than specifically for alcohol treatment and received brief interventions (of up to 3 sessions) compared to no or regular treatment. DATA COLLECTION AND ANALYSIS: Three reviewers independently selected the studies and extracted data. Where appropriate random effects meta-analysis and sensitivity analysis were performed. MAIN RESULTS: Eleven studies involving 2441 participants were included in this review. Three results were non significant and one result was significant mean alcohol consumption per week change scores from baseline (P0.02). AUTHORS' CONCLUSIONS: The evidence for brief interventions delivered to heavy alcohol users admitted to general hospital is still inconclusive. From data extracted from two studies it appears that alcohol consumption could be reduced at one year follow up though further research is recommended. Few studies have been retrieved and the results were difficult to combine because of the different measures used to assess alcohol consumption.


BACKGROUND & AIMS: In the long term, half of patients with their first alcohol-associated acute pancreatitis (AP) develop acute recurrence, alcohol consumption being the main risk factor. None of the recent national or international guidelines for treatment include recommendations aimed to decrease recurrences, possibly because of a lack of studies. This study investigated whether AP recurrences can be reduced. METHODS: One hundred and twenty patients admitted to a university hospital for their first alcohol-associated AP were
randomized either to repeated intervention (n = 59) or initial intervention only (n = 61). The patients in the 2 groups did not differ. A registered nurse performed an intervention in both groups before discharge, after which it was repeated in the study group at 6-month intervals at the gastrointestinal outpatient clinic. Acute recurrences during the next 2 years were monitored. RESULTS: There were 9 recurrent AP episodes in 5 patients in the repeated-intervention group compared with 20 episodes (P = .02) in 13 patients (P = .04) in the control group. The recurrence rates were similar during the first 6 months (4 vs 5 episodes), after which the repeated-intervention group had fewer recurrences than the control group (5 vs 15 episodes; P = .02). CONCLUSIONS: The repeated visits at 6-month intervals at the gastrointestinal outpatient clinic, consisting of an intervention against alcohol consumption, appear to be better than the single standardized intervention alone during hospitalization in reducing the development of recurrent AP during a 2-year period.


BACKGROUND: The problematic use of prescription drugs (PDs) and related disorders are considerably prevalent but evidence concerning brief intervention for problematic PD users is sparse. A previous analysis of the present study on the effectiveness of brief intervention for problematic PD use in a general hospital revealed a significant reduction in PD use after 3 months. The analyses presented herein provides data from the 12-month follow-up. METHOD: In a randomized controlled trial, 126 proactively recruited general hospital patients were analyzed. The intervention group received two brief Motivational Interviewing (MI) sessions. Two follow-ups (after 3 and 12 months) were conducted. Intervention effects at 12-month follow-up on PD cessation and reduction were analyzed using regression methods and controlling for significant group differences. Subgroups of sedative/hypnotic- and opioid-users were examined. RESULTS: No significant intervention effects were found in the overall sample. Respecting significant differences between the intervention and control groups, we detected no effects of the intervention for the subgroups of sedative/hypnotic- or opioid-users. CONCLUSIONS: In contrast to the short-term effects after 3 months, no long-term effects of brief MI sessions on PD use were found. More intensive interventions, booster-sessions or regular aftercare might help in stabilizing intervention effects on PD use among hospital patients. However, studies using larger samples are needed to allow more powerful and specific analyses. Different samples should be examined. Problems concerning the recruitment of study participants in PD research were discussed and should be considered in further studies.


BACKGROUND: Buprenorphine/naloxone was approved by the FDA for office-based opioid maintenance therapy (OMT), with little long-term follow-up data from actual office-based
practice. 18-Month outcome data on the office-based use of buprenorphine/naloxone (bup/nx) and the impact of socioeconomic status and other patient characteristics on the duration and clinical effects of bup/nx are reported. METHODS: This retrospective chart review and cross-sectional telephone interview provide treatment retention of opioid-dependent patients receiving bup/nx-OMT in an office-based setting. 176 opioid-dependent patients from two different socioeconomic groups (high and low SES) were begun on bup/nx, started intensive outpatient treatment, and followed-up after a minimum of 18 months (18-42 months) by telephone interview to assess treatment outcome. RESULTS: 110 subjects (67%) completed the interview, 77% remained on bup/nx with no difference in retention between high and low SES groups. Those on bup/nx at follow-up were more likely to report abstinence, to be affiliated with 12-step recovery, to be employed and to have improved functional status. CONCLUSIONS: Bup/nx-OMT is a viable treatment option and when coupled with a required abstinence oriented addiction counseling program is effective in promoting abstinence, self-help group attendance, occupational stability, and improved psychosocial outcomes in both low SES and high SES patient populations over an 18-42-month period.


BACKGROUND: Smoking remains the leading cause of preventable mortality in the US. The national clinical guideline recommends an intervention for tobacco use known as the 5-As (Ask, Advise, Assess, Assist, and Arrange). Little is known about the model's effectiveness outside the research setting. OBJECTIVE: To assess the effectiveness of tobacco treatments in HMOs. PARTICIPANTS: Smokers identified from primary care visits in nine nonprofit health plans. DESIGN/METHODS: Smokers were surveyed at baseline and at 12-month follow-up to assess smoking status and tobacco treatments offered by clinicians and used by smokers. RESULTS: Analyses include the 80% of respondents who reported having had a visit in the previous year with their clinician when they were smoking (n = 2,325). Smokers were more often offered Advice (77%) than the more effective Assist treatments-classes/counseling (41%) and pharmacotherapy (33%). One third of smokers reported using pharmacotherapy, but only 16% used classes or counseling. At follow-up, 8.9% were abstinent for >30 days. Smokers who reported being offered pharmacotherapy were more likely to quit than those who did not (adjusted OR = 1.73, CI = 1.22-2.45). Compared with smokers who didn't use classes/counseling or pharmacotherapy, those who did use these services were more likely to quit (adjusted OR = 1.82, CI = 1.16-2.86 and OR = 2.23, CI = 1.56-3.20, respectively). CONCLUSIONS: Smokers were more likely to report quitting if they were offered cessation medications or if they used either medications or counseling. Results are similar to findings from clinical trials and highlight the need for clinicians and health plans to provide more than just advice to quit.

BACKGROUND: Unhealthy alcohol use is prevalent but under-diagnosed in primary care settings. OBJECTIVE: To validate, in primary care, a single-item screening test for unhealthy alcohol use recommended by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

DESIGN: Cross-sectional study. PARTICIPANTS: Adult English-speaking patients recruited from primary care waiting rooms. MEASUREMENTS: Participants were asked the single screening question, "How many times in the past year have you had X or more drinks in a day?", where X is 5 for men and 4 for women, and a response of >1 is considered positive. Unhealthy alcohol use was defined as the presence of an alcohol use disorder, as determined by a standardized diagnostic interview, or risky consumption, as determined using a validated 30-day calendar method. MAIN RESULTS: Of 394 eligible primary care patients, 286 (73%) completed the interview. The single-question screen was 81.8% sensitive (95% confidence interval (CI) 72.5% to 88.5%) and 79.3% specific (95% CI 73.1% to 84.4%) for the detection of unhealthy alcohol use. It was slightly more sensitive (87.9%, 95% CI 72.7% to 95.2%) but was less specific (66.8%, 95% CI 60.8% to 72.3%) for the detection of a current alcohol use disorder. Test characteristics were similar to that of a commonly used three-item screen, and were affected very little by subject demographic characteristics. CONCLUSIONS: The single screening question recommended by the NIAAA accurately identified unhealthy alcohol use in this sample of primary care patients. These findings support the use of this brief screen in primary care.


The purposes of this study were to assess outcomes of patients prescribed buprenorphine at a primary care practice and to identify factors associated with favorable outcomes. All 255 patients given at least one prescription for buprenorphine between August 2003 and September 1, 2007, at a primary care practice in Baltimore were included. Data regarding demographics and comorbidities were collected retrospectively. Patients were classified as "opioid-positive" or "opioid-negative" each month based on patient report, urine toxicology, and provider assessment. After 12 months, 145 (56.9%) patients remained in treatment, and 64.7% of their months were opioid-negative. Patients using heroin were less likely to be opioid-negative, whereas those using prescription opioids were more likely to be opioid-negative. Polysubstance use was associated with increased treatment retention. The prescription of buprenorphine for opioid dependence treatment can be incorporated into primary care practice, and many patients, including polysubstance users, benefit from this treatment.


BACKGROUND: The U.S. Preventive Services Task Force (USPSTF) has recommended screening and behavioral counseling interventions in primary care to reduce alcohol misuse. This study was designed to develop a standardized rating for the clinically preventable burden...
and cost effectiveness of complying with that recommendation that would allow comparisons across many recommended services. METHODS: A systematic review of the literature from 1992 through 2004 to identify relevant randomized controlled trials and cost-effectiveness studies was completed in 2005. Clinically preventable burden (CPB) was calculated as the product of effectiveness times the alcohol-attributable fraction of both mortality and morbidity (measured in quality-adjusted life years or QALYs), for all relevant conditions. Cost effectiveness from both the societal perspective and the health-system perspective was estimated. These analyses were completed in 2006. RESULTS: The calculated CPB was 176,000 QALYs saved over the lifetime of a birth cohort of 4,000,000, with a range in sensitivity analysis from -43% to +94% (primarily due to variation in estimates of effectiveness). Screening and brief counseling was cost-saving from the societal perspective and had a cost-effectiveness ratio of $1755/QALY saved from the health-system perspective. Sensitivity analysis indicates that from both perspectives the service is very cost effective and may be cost saving. CONCLUSIONS: These results make alcohol screening and counseling one of the highest-ranking preventive services among the 25 effective services evaluated using standardized methods. Since current levels of delivery are the lowest of comparably ranked services, this service deserves special attention by clinicians and care delivery systems.


AIMS: Heavy drinking is associated with hypertension. This study evaluated blood pressure changes occurring during treatment for alcohol dependence. PARTICIPANTS: Subjects included 1383 people participating in the Combining Medications and Behavioral Interventions for Alcoholism (COMBINE) study, a large multi-center treatment study for alcohol dependence. MEASUREMENTS: Methods appropriate for repeated-measures data were used to assess the relationship of percentage of drinking days (PDD) to systolic and diastolic blood pressure over a 16-week treatment period. Modification of these associations by demographic and other variables was assessed. FINDINGS: Blood pressure reduction was evident only in people who were above the median blood pressure at baseline. In this group, systolic blood pressure decreased by an average of 12 mmHg and diastolic blood pressure decreased by an average of 8 mmHg. Blood pressure reduction occurred during the first month of treatment. This effect was similar regardless of age, sex, body mass index, reported history of hypertension and use of anti-hypertensive medications. An observed association between blood pressure and PDD in Caucasians was not evident in African Americans due largely to their lower pre-treatment blood pressure. CONCLUSIONS: Reduction in alcohol consumption has a potent anti-hypertensive effect in alcoholics with higher blood pressure. For hypertensive, alcohol-dependent people, treatment for alcoholism should be considered a major component of anti-hypertensive therapy.

BACKGROUND: Buprenorphine is a safe, effective and underutilized treatment for opioid dependence that requires special credentialing, known as a waiver, to prescribe in the United States. OBJECTIVE: To describe buprenorphine clinical practices and barriers among office-based physicians. DESIGN: Cross-sectional survey. PARTICIPANTS: Two hundred thirty-five office-based physicians waived to prescribe buprenorphine in Massachusetts. MEASUREMENTS: Questionnaires mailed to all waived physicians in Massachusetts in October and November 2005 included questions on medical specialty, practice setting, clinical practices, and barriers to prescribing. Logistic regression analyses were used to identify factors associated with prescribing. RESULTS: Prescribers were 66% of respondents and prescribed to a median of ten patients. Clinical practices included mandatory counseling (79%), drug screening (82%), observed induction (57%), linkage to methadone maintenance (40%), and storing buprenorphine notes separate from other medical records (33%). Most non-prescribers (54%) reported they would prescribe if barriers were reduced. Being a primary care physician compared to a psychiatrist (AOR: 3.02; 95% CI: 1.48-6.18) and solo practice only compared to group practice (AOR: 3.01; 95% CI: 1.23-7.35) were associated with prescribing, while reporting low patient demand (AOR: 0.043, 95% CI: 0.009-0.21) and insufficient institutional support (AOR: 0.37; 95% CI: 0.15-0.89) were associated with not prescribing. CONCLUSIONS: Capacity for increased buprenorphine prescribing exists among physicians who have already obtained a waiver to prescribe. Increased efforts to link waived physicians with opioid-dependent patients and initiatives to improve institutional support may mitigate barriers to buprenorphine treatment. Several guideline-driven practices have been widely adopted, such as adjunctive counseling and monitoring patients with drug screening.


AIMS: Dependence on or problematic use of prescription drugs (PD) is estimated to be between 1 and 2% in the general population. In contrast, the proportion of substance-specific treatment in PD use disorders at 0.5% is comparatively low. With an estimated prevalence of 4.7%, PD-specific disorders are widespread in general hospitals compared to the general population. Brief intervention delivered in general hospitals might be useful to promote discontinuation or reduction of problematic prescription drug use. DESIGN: A randomized, controlled clinical trial. SETTING: Internal, surgical and gynaecological wards of a general and a university hospital. PARTICIPANTS: One hundred and twenty-six patients fulfilling criteria for either regular use of PD (more than 60 days within the last 3 months) or dependence on or abuse of PD, respectively, were allocated randomly to two conditions. INTERVENTION: Subjects received two counselling sessions based on Motivational Interviewing plus an individualized written feedback (intervention group, IG) or a booklet on health behaviour (control group, CG). MEASUREMENTS: The outcome was measured as reduction (>25%) and discontinuation of PD intake in terms of defined daily dosages (DDD). FINDINGS: After 3 months, more participants in the IG reduced their DDD compared to the participants in the CG (51.8% versus 30%; chi(2) = 6.17; P = 0.017). In the IG 17.9%, in the CG 8.6% discontinued use of PD (chi(2) = 2.42; P = 0.17). Conclusions Brief intervention based on Motivational Interviewing is effective in reducing PD intake in non-treatment-seeking patients.