



Alcohol consumption in upper aerodigestive tract cancer: Role of head and neck surgeons' recommendations



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ABSTRACT

This study aims to describe the prevalence of alcohol consumption in patients diagnosed with an upper aerodigestive tract cancer (UADTC) and evaluate the clinical impact of head and neck surgeons' recommendations on alcohol intake. An observational, retrospective, and cross-sectional study was conducted. Socio-demographic data, type of cancer, psychiatric history, substance-use history, and DSM–IV–TR criteria for alcohol dependence were recorded. Patients were asked to report their alcohol consumption before UADTC diagnosis and during their follow-up. All patients were asked if they had received from the specialist any recommendation to reduce or stop their alcohol consumption. One hundred ninety-one patients were included. Laryngeal cancer was the most frequent. 85.3% of patients were alcohol consumers before being diagnosed, 39.8% were risky drinkers, and 13.1% had alcohol dependence. The prevalence of alcohol use decreased by 16.7% after the UADTC was diagnosed. The proportion of risky drinkers decreased from 46.6% to 24.5%. Almost half of the patients did not recall having received any recommendation regarding alcohol consumption. Receiving a recommendation was independently associated with a positive response (reduced or stopped alcohol consumption) with an Odds Ratio 3.7; $p < 0.001$. Prevalence of alcohol dependence and risky drinking (39.8%) is high in UADTC patients, compared to the general population. Otorhinolaryngologists and head and neck surgeons frequently provide recommendations about alcohol consumption, which has a relevant impact on the reduction of alcohol intake. Further prospective studies focused on brief advice should be performed in order to demonstrate effectiveness in this population.

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Introduction

Alcohol is the most widely consumed legal drug in Europe, being the third leading risk factor for burden of disease (World Health Organization, 2011). Chronic alcohol consumption is associated with the development of several

medical disorders. More than 200 alcohol-related conditions have been described, including otorhinolaryngological neoplasms (Islami et al., 2010; Rehm et al., 2010; Shield, Parry, & Rehm, 2013).

One million new cases of upper aerodigestive tract cancers (UADTC) are diagnosed worldwide every year, ranking in the top

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ten of the most common cancers, both in men and women (Ansary-Moghaddam, Huxley, Lam, & Woodward, 2009; Guo, Zhang, & Mai, 2012; International Agency for Research on Cancer, 2012). Alcohol and tobacco are the main risk factors and explain 60–85% of UADTC (Anantharaman et al., 2011). Alcohol consumption has been identified as a carcinogenic factor for neoplastic conditions in the oral cavity and pharynx (Righini, Karkas, Morel, Soriano, & Reyt, 2008; Shield et al., 2013). Even though tobacco consumption has been identified as one of the most important factors influencing the development of UADTC, small amounts of alcohol intake over time (e.g., two drinks/day) have been associated with an increased risk for UADTC (Bagnardi, Blangiardo, La Vecchia, & Corrao, 2001a, b; Schütze et al., 2011). Moreover, alcohol-dependent patients have 10 times more risk for mouth and laryngeal cancer, and laryngeal cancer is the most frequent cancer causing mortality in alcohol-dependent patients who reach stable abstinence (Gual, Lligoña, & Colom, 1999).

UADTC mortality is higher in moderate and heavy drinkers (Li et al., 2014), and not decreasing alcohol consumption after a cancer diagnosis may lead to dramatic consequences (e.g., increased risk for surgical complications, cancer recurrence, development of second primary cancer, prolonged admissions to intensive care, increased post-surgery mortality, and decreased overall survival) (Do et al., 2003; Druesne-Pecollo et al., 2014; Miller, Day, & Ravenel, 2006). Approximately 34–57% of patients with UADTC continue using alcohol after diagnosis, stressing the need for better screening techniques and therapeutic maneuvers aimed to modify patients' alcohol consumption in this population (Miller et al., 2006).

In alcohol-related diseases, primary prevention has been centered in Screening, Brief Intervention, and Referral to Treatment (SBIRT) strategies, that have shown efficacy (Jonas et al., 2012; Kaner et al., 2009), effectiveness (O'Donnell et al., 2014), and cost effectiveness (Barbosa, Cowell, Bray, & Aldridge, 2015). Before determining if SBIRT strategies are useful for UADTC patients, it is relevant to define the prevalence of alcohol consumption in this population and the attitudes that otorhinolaryngologists have about alcohol. We hypothesized that the prevalence of risky drinkers in an UADTC outpatient clinic is high compared with the general population, and that the frequency of a recommendation by specialists is low and possibly not enough to decrease the proportion of patients with a risky pattern of alcohol consumption.

Thus, the aims of this study were: 1) to evaluate the prevalence of alcohol consumption in patients with UADTC followed-up in a specialized outpatient clinic, and 2) to study the impact of giving a recommendation to reduce the proportion of patients with a risky pattern of alcohol consumption.

Methods

Design

This is an observational retrospective study.

Patients and data collection

Patients followed-up in the otorhinolaryngology (ORL) outpatient unit of Hospital Clinic of Barcelona for an oncologic condition, between September 2010 and October 2010, were consecutively evaluated. Inclusion criteria were: 1) age over 17 years old, and 2) diagnosis of UADTC. Exclusion criteria were: 1) refusal to participate, and 2) insufficient knowledge of Spanish, Catalan, or severe neurocognitive impairment (e.g., mental retardation).

Procedures, clinical, psychiatric, and social evaluations

All included patients underwent a survey that contained socio-demographic data (e.g., age, gender, marital status, work status, educational level), oncologic disease history (e.g., type of cancer, time from first symptom to diagnosis, time from diagnosis to ORL unit assessment), psychiatric disease history, and substance-use history. The Hospital Anxiety and Depression Scale (Herrero et al., 2003) and DSM-IV-TR criteria for alcohol dependence (American Psychiatric Association, 2000) were assessed at the patients' visit to the ORL outpatient clinic. Additionally, alcohol consumption was quantified in two time points using a frequency and quantity questionnaire called Systematic Interview of Alcohol Consumption (SIAC) (Gual, Contel, Segura, Ribas, & Colom, 2001). Total alcohol consumption during the week before the diagnosis of the neoplasm and total alcohol consumption during the week before the study assessment was registered (e.g., number of standard drink units during the previous week). A standard drink unit (SDU) was defined as 10 g of pure alcohol, in accordance with Spanish guidelines (Gual, Martos, Lligoña, & Llopis, 1999). All patients were carefully interviewed for the type of alcohol recommendation they received from their otorhinolaryngologist before knowing their prognosis and coded into one of three categories: no recommendation, recommendation to reduce, or recommendation to abstain. Patterns of alcohol consumption (based on SIAC results) were stratified according to the Organization for Economic Co-operation and Development (OECD) and Canadian guideline recommendations (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011; Ministerio de Sanidad Servicios Sociales e Igualdad, 2013; Organisation for Economic Co-operation and Development, 2013). Risky alcohol use was defined as follows: >210 g of pure alcohol (21 SDU) per week for men and >140 g of pure alcohol (14 SDU) per week for women. In order to evaluate the impact of recommendation on alcohol consumption, we defined a positive response as an event in which a risky drinker before diagnosis became a low-risk drinker or abstainer at assessment, and when a low-risk drinker became an abstainer.

The study protocol was approved by Hospital Clinic's Ethics Committee (Code 5973, October/2010), according to the ethical standards given in the Declaration of Helsinki.

Statistical analysis

Continuous variables were described as mean (standard deviation, [SD]). Categorical variables were described by counts and percentages. Comparisons between groups were performed using Student's *t* test or Mann-Whitney *U* test, depending on variable distribution. Differences between categorical variables were assessed by the χ^2 test or Fisher's exact test, when necessary. A *p* value of <0.05 was required for significance. Univariate and multivariate logistic regression (odds ratio [OR]) analyses of clinical and demographic characteristics were performed to identify those factors associated with a positive response on alcohol consumption. Variables were kept in the multivariate analysis if they reached a *p* value ≤ 0.01 . In order to avoid collinearity, those variables used for the same stratification of the patients or including the same measuring variable (e.g., definition of alcohol dependence) were included separately in the multivariate models. To avoid over-fitting of the prognostic model, a pre-defined ratio of candidate prognostic variables to the number of observed events was set at 1:10 or less. In order to correctly evaluate the factors associated with a response in alcohol consumption after a recommendation of the ORL and head and neck surgery staff, we adjusted our multivariate analysis model including time (in months) between the first visit of the

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