Primary Care Management of Alcohol Misuse

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KEYWORDS

• Alcohol misuse • Unhealthy alcohol use • Alcohol use disorder • Alcohol abuse
• Alcohol dependence • Alcohol screening • Brief intervention • Alcohol treatment

KEY POINTS

- More than 1 in 4 American adults consume alcohol above the recommended limits. One in 12 have an alcohol use disorder marked by harmful consequences.
- Both types of alcohol misuse contribute to acute injury and chronic disease, making alcohol the third largest cause of preventable death in the United States.
- Alcohol misuse alters the management of common conditions from insomnia to anemia.
- Primary care providers should be proactive, routinely screening adult patients with a tool validated to identify the full spectrum of alcohol misuse.
- A range of effective treatments are available for alcohol misuse, including brief counseling interventions, mutual-help groups, medications, and behavioral therapies.

INTRODUCTION

In the United States, alcohol is responsible for 3.5% of all deaths, the third largest preventable cause of death after tobacco use and being overweight.[1] Annual costs, including lost productivity, health care, legal, and other costs, are estimated at $223 billion per year or $746 per capita.[2] Despite this high prevalence and impact, alcohol-related care is inconsistent. Routine screening and behavioral intervention for alcohol misuse is recommended by the US Preventive Services Task Force (USPSTF)[3] and one of the most cost-effective clinical preventive services,[4,5] but only 16% of adults report ever discussing alcohol use with a health professional.[6] In a study assessing quality of care for 30 conditions across health systems, adherence

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to quality indicators was worst for alcohol dependence.[7] Primary care providers have a critical role in improving identification and management of alcohol misuse.

DEFINITIONS, EPIDEMIOLOGY, AND CONSEQUENCES OF ALCOHOL MISUSE

Definitions

A host of terms are used to describe drinking (**Table 1**). Two concepts underlie the current nomenclature. First, although alcohol-related risks lie on a continuum and for some people any alcohol use poses significant risk (**Box 1**), it is useful to define a threshold below which alcohol use is generally of low risk. This threshold provides clear guidance to patients. Second, alcohol misuse encompasses a spectrum, from patients whose drinking puts them at risk for alcohol-related harm at one end to patients whose lives are overtaken by alcohol-related symptoms at the other. The 2 main types of alcohol misuse, risky drinking and alcohol use disorder (AUD), are defined by excessive consumption and impairment/consequences, respectively.

Alcohol misuse

In the United States, the threshold for risky drinking is defined by the National Institute of Alcoholism and Alcohol Abuse (NIAAA) and includes both daily and weekly limits (see **Table 1**).[8] Most patients who exceed weekly limits also exceed daily limits[8]; but there is heterogeneity, and chronic daily drinkers or binge drinkers may exceed one but not the other. Because of differences in body water/metabolism and clinical outcomes, limits are different for men and women.

Although the NIAAA limits were based primarily on the risk of having or developing an AUD,[8,9] Canadian, British, and Australian guidelines based on mortality and acute harms from alcohol misuse differ in only minor ways.[10–13] In discussing drinking limits with patients, it is critical to clarify the definition of a drink (**Fig. 1**). Whether poured at home or served in a bar, common portions include more, and sometimes much more, than a standard drink.[14,15] Definitions of a standard drink also vary internationally.

Alcohol use disorder

AUD is defined by the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*).[16] The most recent edition, *DSM-5*, replaced the diagnoses alcohol abuse and dependence with the single entity AUD graded mild, moderate, and severe. The revision emphasizes the continuity of use disorders while avoiding confusion around the term *dependence*, the unreliability of the abuse diagnosis, and "diagnostic orphans" meeting 2 dependence but no abuse criteria.[17] The new definition amalgamates criteria for abuse and dependence but replaces recurrent legal problems with the less context-dependent craving (**Table 2**). In the United States, rates of AUD as defined by the *DSM-IV* and *DSM-5* are similar, although there are slight differences in the populations included.[18]

Epidemiology

In US population surveys assessing past year drinking, 29% of adults meet the criteria for risky drinking,[19] of whom 8% to 11% meet the criteria for AUD and about 4% moderate to severe AUD (*DSM-IV* dependence).[18,20] Because of the vastly greater prevalence of risky drinking, most alcohol-related harms result from patients with more mild alcohol misuse, making it clinically important to address the full spectrum of misuse.[21–23]

Prevalence of alcohol misuse varies with age and sex (**Table 3**). Rates of AUD peak around 20 years of age.[20] Many people with AUD in adolescence or young adulthood go on to lives of low-risk use without any formal treatment, although their risk for AUD