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Special article

Early screening and brief intervention in alcohol misuse to improve the treatment of hypertension in primary care☆

Cribado precoz e intervención breve en el consumo perjudicial de alcohol para mejorar el tratamiento de la hipertensión arterial en atención primaria

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Introduction

The World Health Organization (WHO) has defined an international framework to monitor progress in prevention and control of major noncommunicable diseases (NCDs cardiovascular diseases, cancer, chronic respiratory diseases and diabetes) and their risk factors, such as smoking, physical inactivity, unhealthy diets or alcohol abuse.[1,2] At the Assembly in 2012, WHO set for year 2025 the global goal of reducing NCD-associated mortality by 25%.[3] The voluntary global goals included the relative reduction of at least 10% of alcohol harmful consumption and 25% in hypertension (HT) prevalence.[4]

It is estimated that one third of Spanish adults suffer from hypertension and in 75% of them HT control is inadequate.[5] Moreover, 4.1% of the Spanish adult population (4.5% in men and 3.5% in women) are high-risk drinkers,[6] and less than 15% of the population requiring intervention for alcohol use disorders receive treatment.[7]

The implementation of screening for alcohol use among patients with hypertension in primary care (PC) followed by a brief intervention to address harmful use of alcohol is one of the major strategies that the Spanish Ministry of Health, Social Services and Equality has established to comply with this goal.[8] The joint approach of harmful alcohol use in PC in people with hypertension through a common strategy might also contribute to comply with WHO's goal.

Relationship between alcohol use and hypertension

There exists a significant overlap between alcohol use disorders and hypertension in patients treated in PC (Fig. 1) 20.6% of hypertensive men and 7.2% of hypertensive women aged from 40 to 64 have an alcohol use disorder, and 16.7% of men and 5.8% of women with hypertension are alcohol-dependent. It is also estimated that patients with an alcohol use disorder have, depending on the quantities consumed, 1.5–4 times higher risk of HT.[10] Most studies show a hypertensive effect of chronic alcohol consumption when 60 g are exceeded daily.[11–13]

Also, harmful alcohol use has been proven to be one of the most common causes of reversible hypertension and contributes to the emergence of other cardiovascular diseases.[13] Eventually, alcohol, along with non-adherence to treatment is one of the most common causes of resistant hypertension.[15]

Alcohol and hypertension from a clinical perspective

While hypertension is a risk factor associated primarily with cardiovascular disease, alcohol consumption is linked to over

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◊ The names of the members of the Group for the Study of Hypertension and Alcohol Use Disorder are listed in Appendix.

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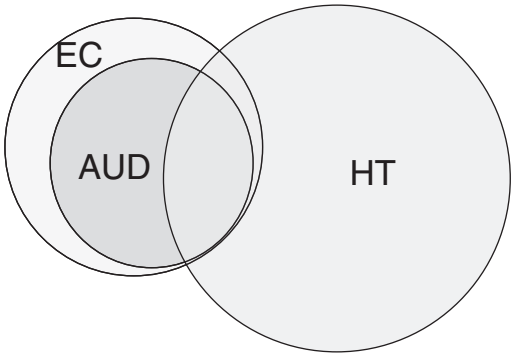

Fig. 1. Overlap between hazardous consumption of alcohol, alcohol use disorder and hypertension in primary care patients (Venn chart based on the data of the APC study).[14]
EC: excessive consumption; HT: hypertension; AUD: alcohol use disorder.

Table 1
Materials and methods for conducting interventions in alcohol use.

	Are they available in Spain?
Materials, methods, screening tools	Yes
Interventions: used and promoted in practice	Yes
Number of service providers that perform interventions in alcohol (governmental/non-governmental)	Yes
Drugs: authorized and available	Yes
Psychological interventions available	Yes
Training of service providers	Yes
Promotion of protocols or tools to perform effective alcohol interventions	Yes
National review of the effectiveness of treatment, or national standards of care published	Yes
Internet interventions	Yes
Professional resources available through Internet	Yes

200 diseases mentioned in the tenth version of the International Classification of Diseases.[16]

The increased use of antihypertensive drugs in the last 10 years in Spain has enabled great advances in the control of blood pressure (BP).[17] However, this control is still far from being the optimal.[18] About one third of the Spanish population aged over 18 suffers from hypertension (BP ≥ 140/90 mmHg) or is currently under treatment with antihypertensive drugs, but only 22.7% have a well controlled BP.[5]

On the other hand, alcohol is deeply rooted in the Mediterranean culture. Alcohol consumption below 10 g daily (equivalent to a standard drink unit) in women and up to 20 g in men[16] is associated with a reduction in overall mortality, heart disease, diabetes mellitus, congestive heart failure and stroke.[19] However, the line between the beneficial and harmful effects of alcohol consumption is very diffuse,[20] since the risk of causing cardiovascular disease increases depending on the dose. Therefore, above one or two standard drink units per day, each additional beverage increases BP by approximately 1.5 mmHg.[13]

In addition, alcohol misuse may be key to detect an uncontrolled hypertension. Hypertensive patients misusing alcohol (>4 units per day in men or >3 in women) had 1.52 times higher risk of uncontrolled BP compared to abstemious.[21] Furthermore, it has been shown that regular consumption of alcohol increases BP in treated hypertensive patients,[19,22,23] and alcohol-induced hypertension diminishes 2–4 weeks after withdrawal or after significant reduction of consumption.[24,25]

Data from the Spanish Ambulatory Blood Pressure Monitoring Registry reveal that the prevalence of resistant hypertension in treated hypertensive Spanish population is approximately 12–14%.[26] Based on these data, the clinical practice guidelines of the European Society of Hypertension and the European Society of Cardiology recommend that the finding of high BP should always lead your doctor to investigate the causes, including consumption of substances increasing BP, such as alcohol.[15,27]

Barriers to early detection and brief intervention for alcohol misuse in Spain

The prevalence of alcohol use disorders in Spain is 1.4% in men and 0.3% in women, involving 320,112 individuals.[28] The organization of the Spanish health system, with a network of well-trained professionals specializing in the treatment of addictions and with access to information and methods necessary to carry out interventions on alcohol consumption (Table 1) is relatively good. However, it is estimated that less than 15% of patients requiring intervention due to prolonged alcohol consumption are treated.[7] In addition, in the field of BP screening programs, brief intervention and referral of patients with alcohol use disorders to therapy have not been systematically implemented. Even in regions with the highest rates of screening, such as Catalonia, significant disparities have been reported in clinical practice: approximately one third of primary care physicians do not refer their patients to this screening, while 40% screen more than 75% of them (Fig. 2).

For patients it is difficult to admit publicly the need to change their habits of alcohol use. The results of the EUROPREVIEW study showed that approximately 24% of men and 9% of women were high-risk drinkers (defined as those with episodes of heavy consumption [≥5 alcoholic beverages per day] high-risk drinkers [≥20 alcoholic beverages per day per week] or dependent [score on the CAGE questionnaire >1]).[31] It was also noted that one third of men (33%) and more than a quarter of women (28%) had been diagnosed with hypertension. 22% of men and 6% of women suffered from hypertension with alcohol misuse. When asked about the need to change their lifestyle, only 30.5% of high-risk drinkers admitted they had to, as opposed to 64% of smokers, 73.5% of patients with unhealthy eating habits and 73% of sedentary people. High-risk drinkers also stated that their general practitioner talked to them less often about alcohol (42%) than about smoking (63%), eating habits (59%) or physical exercise (55%).[31]

In accordance with the AMPHORA European study–Alliance of Research on Public Health and Alcohol–, the main barriers to screening and treatment of alcohol use disorders involve the lack of time and economic incentives.[7] In Spain, in accordance with the Odhin study, the most important barrier to overcome is primary care physicians, who are more focused on treating the disease than in its prevention.[30] Some of the factors that encourage higher alcohol early intervention are economic incentives and continuing

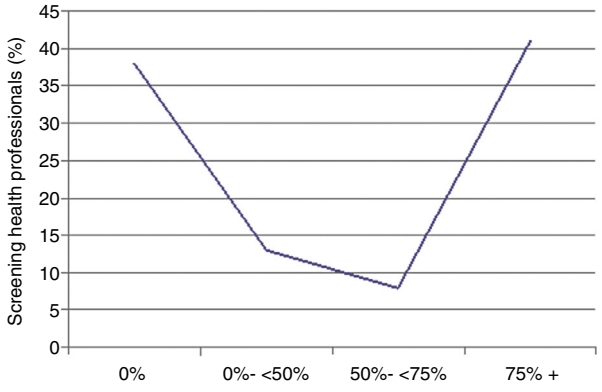

Fig. 2. Baseline data of Catalonia. Distribution of the screening rates of hazardous drinking and harmful drinking and brief advice obtained from ODHIN project.[29]

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