

COMMENTS AND RESPONSES

Brief Intervention for Medical Inpatients with Unhealthy Alcohol Use

TO THE EDITOR: In their article, Saitz and colleagues (1) conclude that the brief intervention is inadequate for medical inpatients with unhealthy alcohol use. We fear that their main finding is old wine in new skins: Brief intervention is ineffective in alcohol-dependent individuals.

As the authors discuss, a central issue deals with the representativeness of their sample. Compared with the at-risk drinkers who declined to participate in the study, the 35% of at-risk drinkers who enrolled in the intervention study tended to report higher values on the Alcohol Use Disorders Identification Test (AUDIT) and reported a substantially higher number of drinks per drinking occasion and per week. This indicates a sample bias toward individuals with more severe problems, for whom brief interventions are not effective in outpatient settings (2). In addition, failure to identify intervention effects in nondependent inpatients in the study does not necessarily mean that the intervention was ineffective. It may also reflect problems of statistical power because data were based on only 80 at-risk drinkers without alcohol dependence.

Because brief interventions are assumed to produce small to medium effects (3), detecting differences between the control and the intervention group in this study is unlikely. Most studies on brief interventions in general hospital settings did not systematically diagnose and exclude alcohol-dependent individuals (4); therefore, more research using larger samples of nondependent, at-risk drinkers is needed before we can draw evidence-based conclusions.

There are also remarkable differences compared with findings from intervention studies in outpatient settings. The rates of utilization of formal help among alcohol-dependent patients (44% to 49%) and the reduction in drinking in both groups were much higher than we would expect from the results of studies with outpatients. This finding is in line with results from other studies in general hospital settings (4) and is supported by data indicating a greater motivation to change among alcohol-dependent individuals in general hospitals compared with those in the general population (5). Because remission from alcohol problems is a widespread phenomenon and health problems are an important trigger for unassisted recovery from alcohol dependence (6), data indicate that these processes are more common in inpatients than in outpatients. In addition, hospitalization due to somatic crisis may be a “window of opportunity” for self-initiated change, especially when an extensive assessment has been conducted.

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TO THE EDITOR: Saitz and colleagues described null findings in their recent article on a brief intervention for medical inpatients with unhealthy alcohol use (1). They concluded that the brief intervention “is inadequate” for these patients. We would like to suggest an alternative interpretation of their results.

The authors reported that fewer than 35% of eligible patients agreed to participate in their study. Thus, the sample may have been biased in that it probably comprised individuals who were amenable to discussing their alcohol consumption. Given that addiction is marked by denial and that problem recognition is typically viewed as a first step to recovery, it seems unlikely that this sample is representative of the population of alcohol-abusing hospital inpatients, many of whom reportedly do not view their drinking as problematic. Rather, the sample may have consisted primarily of individuals in the contemplation or preparation stages of change, meaning that they were already thinking about or were preparing to make a change in their drinking (although this information was not reported by the authors).

Assessment and feedback, as well as offering the patient assistance (if desired), are considered key components of brief motivational interventions. Thus, as Saitz and colleagues discussed, the extended assessment and feedback sessions that the control group received may have been an adequate intervention. This assumption is supported by the study finding that almost half of the control sample sought treatment for their alcohol addiction in the months after their hospitalization. The surprising nature of these results is highlighted by the authors’ own a priori hypothesis that only 4% of the participants in the control group would seek help. Rather than viewing the brief intervention as “inadequate,” perhaps it would be more appropriate to view the inpatient assessment and feedback as the single most effective brief intervention for patients who are already considering making a change. For some, it may be a tipping point—enough to tip the balance toward action.

It would be worthwhile to examine the effectiveness of the brief motivational intervention among patients in trauma and emergency departments and inpatients at addiction or psychiatric hospitals who are not interested in making a change (that is, individuals who are in the precontemplation stage). Brief motivational interventions are often successful in helping individuals move from precontemplation to contemplation or preparation, which may make these patients more receptive to offers of assistance.

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Reference

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IN RESPONSE: Drs. Bischof and Freyer-Adam did not correctly characterize the proportion of eligible participants who enrolled in our study. It was 65% (341 of 524 persons), which is remarkably high for an alcohol brief intervention trial. Readiness to change, AUDIT, and many other alcohol severity–related characteristics were similar in those enrolled, those eligible who did not enroll, and those with risky use who were ineligible (1).

Our trial had fewer exclusion criteria than most trials (2), and readiness was not among them. Nonetheless, many of our participants were considering change (as noted in Table 1 of our article). Furthermore, in medical patients, greater readiness is not predictive of less drinking or problems, calling into question approaches that select participants for intervention on the basis of stage of change (3, 4). We find lack of representativeness an unlikely explanation for our findings.

Dr. Merlo and colleagues write that our control participants received “assessment and feedback sessions.” However, control participants received no feedback. At least 3 reasons argue against assessment effects as an explanation for our results: 1) mixed-model analyses suggested a lack of effect (similar when including participants with 1 or 2 follow-up assessments), 2) evidence on assessment effects in this population (particularly in those not seeking treatment) is not yet sufficient, and 3) brief intervention studies in other settings have been positive despite assessments.

Brief intervention has efficacy in selected patients with non-dependent, unhealthy alcohol use in primary care. In other settings (such as emergency departments and inpatient medicine services), brief interventions may not have efficacy—as trials are beginning to demonstrate. Moreover, evidence does not support efficacy in non-treatment-seeking adults with alcohol dependence. This is not old news in medical inpatients, and it is relevant now because brief intervention is currently being widely disseminated to these populations. We agree that brief intervention may have efficacy in non-dependent inpatients, but this remains to be proven and will be relevant to only a small proportion of screen-positive inpatients (about 20%). Our study shows that most medical inpatients with unhealthy alcohol use identified by screening are unlikely to benefit from brief intervention alone, and it is not the first negative study in this setting (5).

We do not agree that brief intervention is effective for inpatients who are considering change. Hospitalization may be a time for self-change, but evidence that brief intervention improves on this is limited. Our study and others are the best approaches to providing evidence to direct clinical efforts and for how to improve care where current brief interventions fall short.

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Adjusted-Dose Warfarin versus Aspirin for Preventing Stroke in Patients with Atrial Fibrillation

TO THE EDITOR: The recently published, randomized Birmingham Atrial Fibrillation Treatment of the Aged (BAFTA) Study compared adjusted-dose warfarin (target international normalized ratio, 2.0 to 3.0) with aspirin (75 mg/d) in 973 patients with atrial fibrillation who were 75 years of age or older (mean age, 81.5 years) and were managed by general practitioners in the United Kingdom (1). The study’s important results indicate that the relative efficacy and safety of warfarin for stroke prevention can be extended to very elderly patients who are managed by nonspecialists. Because the BAFTA Study seems likely to be the last large trial comparing adjusted-dose warfarin with aspirin (and its results increase the total number of stroke events available for meta-analysis by 42%), we add the BAFTA results to our updated meta-analysis of antithrombotic trials in patients with atrial fibrillation (2).

Including the BAFTA Study, 9 randomized trials enrolling 4620 participants compared adjusted-dose warfarin with aspirin. By meta-analysis, the relative risk reduction by warfarin over aspirin is 39% (95% CI, 19% to 53%) in these 8 predominantly primary prevention trials and single secondary prevention trial and remained at 39% when 3 comparisons of warfarin with nonaspirin antiplatelet agents were included (1). The meta-analytic estimate for the absolute risk reduction by warfarin over aspirin for primary prevention is about 1% per year (Table).

On the basis of all available randomized data, the relative risk reduction in all strokes by adjusted-dose warfarin versus antiplatelet therapy is about 40%. Despite some variations in results of earlier, smaller trials (Figure [1, 3–12]), this number seems to be stable and is the best available estimate.

Table. Adjusted-Dose Warfarin Compared with Antiplatelet Therapy*

Study	Persons, n	Strokes/Patients/Patient-Years; Warfarin vs. Antiplatelet Therapy, n/n/nt	Relative Risk Reduction (95% CI), %	Annual Absolute Risk Reduction for Primary Prevention, %‡
Adjusted-dose warfarin vs. aspirin				
8 previous trials (2)	3647	91/1803/3740 vs. 142/1844/3730	38 (18–52)	0.7
BAFTA Study, 2007 (1)§	973	35/488/1333 vs. 62/485/1263	47 (19–66)	2.3
9 aspirin trials	4620	126/2291/5073 vs. 204/2329/4993	39 (19–53)	0.9
Adjusted-dose warfarin vs. aspirin or nonaspirin antiplatelet agents				
12 antiplatelet trials	12721	215/6353/10 279 vs. 344/6368/10 209	39 (27–49)	1.0

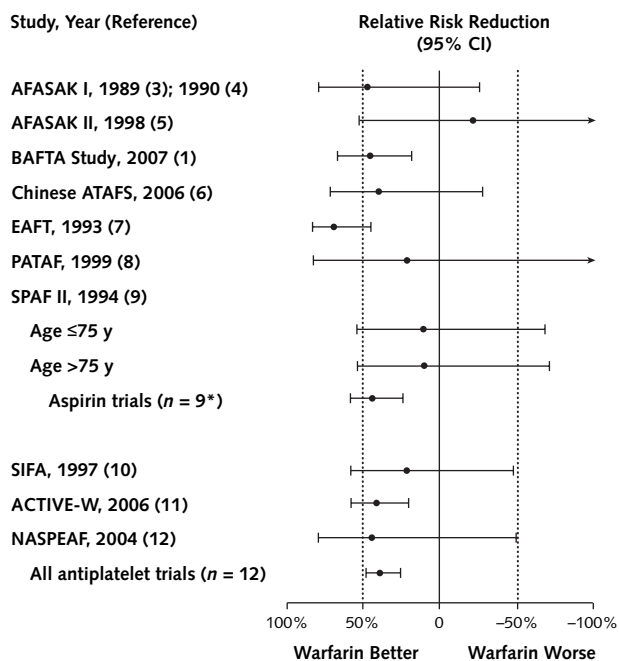
* BAFTA = Birmingham Atrial Fibrillation Treatment of the Aged.

† Strokes include ischemic and hemorrhagic strokes and subdural hematomas.

‡ Primary prevention = patients without previous stroke or transient ischemic attack.

§ Total exposure estimated from reported event rates.

|| Meta-analysis estimates of relative risk reductions ($P > 0.2$ for the 9 aspirin and 12 antiplatelet trials) and absolute risk reductions ($P = 0.11$ for the 9 aspirin trials; $P > 0.2$ for the 12 antiplatelet trials).

Figure. Relative effects of warfarin versus antiplatelet agents on all strokes from randomized trials in patients with atrial fibrillation.

ACTIVE-W = Atrial fibrillation Clopidogrel Trial with Irbesartan for prevention of Vascular Events; AFASAK = Atrial Fibrillation, ASpirin, AntiKoagulation; ATAFS = Antithrombotic Therapy in Atrial Fibrillation Study; BAFTA = Birmingham Atrial Fibrillation Treatment of the Aged; EAFIT = European Atrial Fibrillation Trial; NASPEAF = National Study for Prevention of Embolism in Atrial Fibrillation; PATAF = Prevention of Arterial Thromboembolism in Atrial Fibrillation; SIFA = Studio Italiano Fibrillazione Atriale; SPAF = Stroke Prevention in Atrial Fibrillation. *The Athens Trial (13) and the Warfarin vs. Aspirin for Stroke Prevention in Octogenarians (14) trial are not shown because the 95% CIs spanned beyond the width of the figure, but their results are included in the meta-analyses in the Table.

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Tailoring to the Needs of One's Practice: It's about Time

TO THE EDITOR: Perhaps the most important statement made by Duffy and Holmboe in their editorial on which procedures internists should do was the one about “tailoring procedural skills to the needs of one’s clinical practice setting” (1).

This concept is long overdue. It applies not just to procedural skills, but also to the recertification process—not just for internal medicine, but for family practice as well.

Why? It is almost a truism that the scope of knowledge and skills of practicing, nonacademic generalists, who have been in practice for many years, become narrowed because they limit their practices in some way. Either they use hospitalists for their hospital patients, or they don’t feel comfortable treating certain diseases or because there are many specialists in the community who are better qualified.

The point is: Shouldn’t the recertification process be tailored as well to reflect this? It seems senseless to test any kind of generalist on

the same scope of knowledge he or she possessed when they finished their residencies. Too many physicians waste time and money taking board review examinations in family practice and general internal medicine, memorizing information that they will rarely or never use, just to pass a board examination. Not only is this an unnecessary burden, but it is way out of sync with reality. Most physicians subject themselves to the recertification process to defend against the possibility of being refused admission to a health maintenance organization panel or hospital staff. Neither are good reasons. Worse, some physicians feel that continuing medical education has become a cottage industry that is more intent on financial gain than anything else.

Furthermore, the recertification process should do away with the pass/fail mindset. Physicians already certified, and even those who are “board-eligible,” should be given ongoing opportunities to improve themselves with knowledge tailored to their particular practices. One can argue that those who cram or take Board review courses actually prolong the inadequacy of the test.

The concept of tailoring to the needs of one’s practice needs to be studied for its potential benefits.

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Reference

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CORRECTION

Correction: Cardiopulmonary Resuscitation and Emergency Cardiovascular Care: Review of the Current Guidelines

In the recent narrative review on cardiopulmonary resuscitation and emergency cardiovascular care (1), the first sentence in the “Atropine” section should have read: “Atropine is *an acetylcholine-receptor blocker of the muscarinic type* with a half-life of 2 hours.”

Reference

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