Relació alcohol i càncer: el paper de l'Atenció Primària

Barcelona, 11 de març de 2010

[Programa Beveu Menys]

Mercè Marzo

Institut Català de la Salut

semFYC - PAPPS
Programa de actividades preventivas y de promoción de la salud

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Grups de treball

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- La relació dels actuals grups del PAPPS
  - Prevenció de les malalties cardiovasculars.
  - Prevenció de càncer.
  - Prevenció de les malalties infeccioses.
  - Educació sanitària i promoció de la salut.
  - Prevenció dels trastorns de la salut mental.
  - Prevenció i promoció de la salut en la infància i l'adolescència
  - Prevenció en l'ancià
  - Prevenció en la dona
  - Avaluació.

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2009

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Actividades preventivas en el climaterio y menopausia

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Prevención del cáncer

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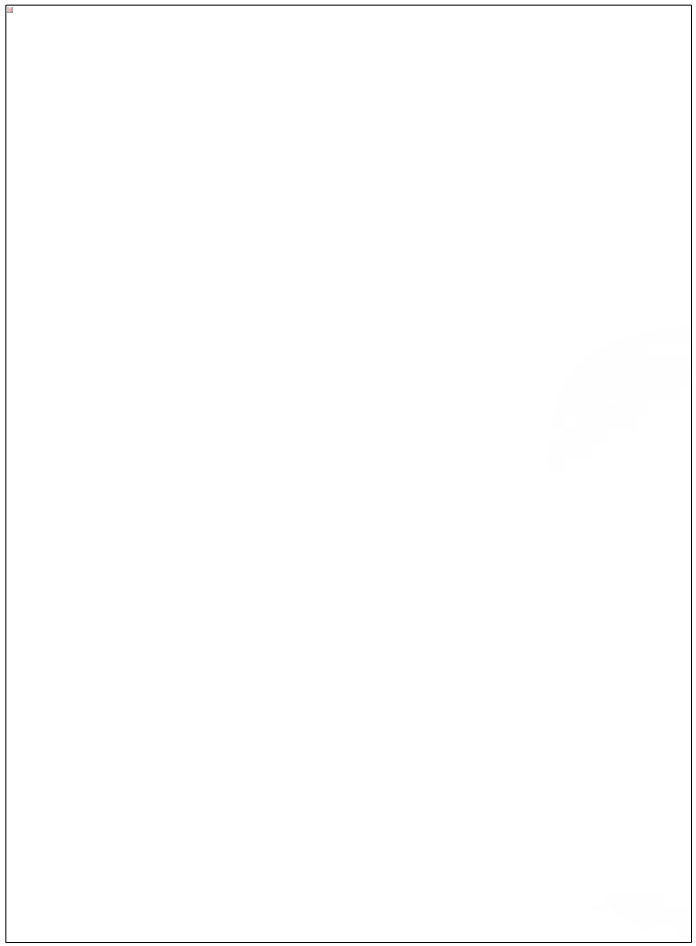
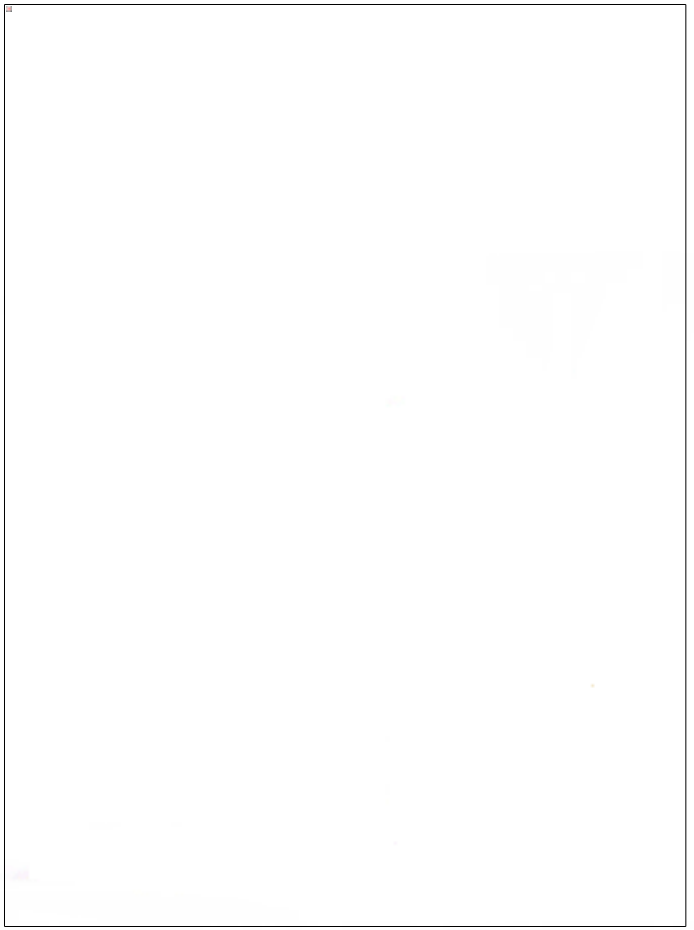
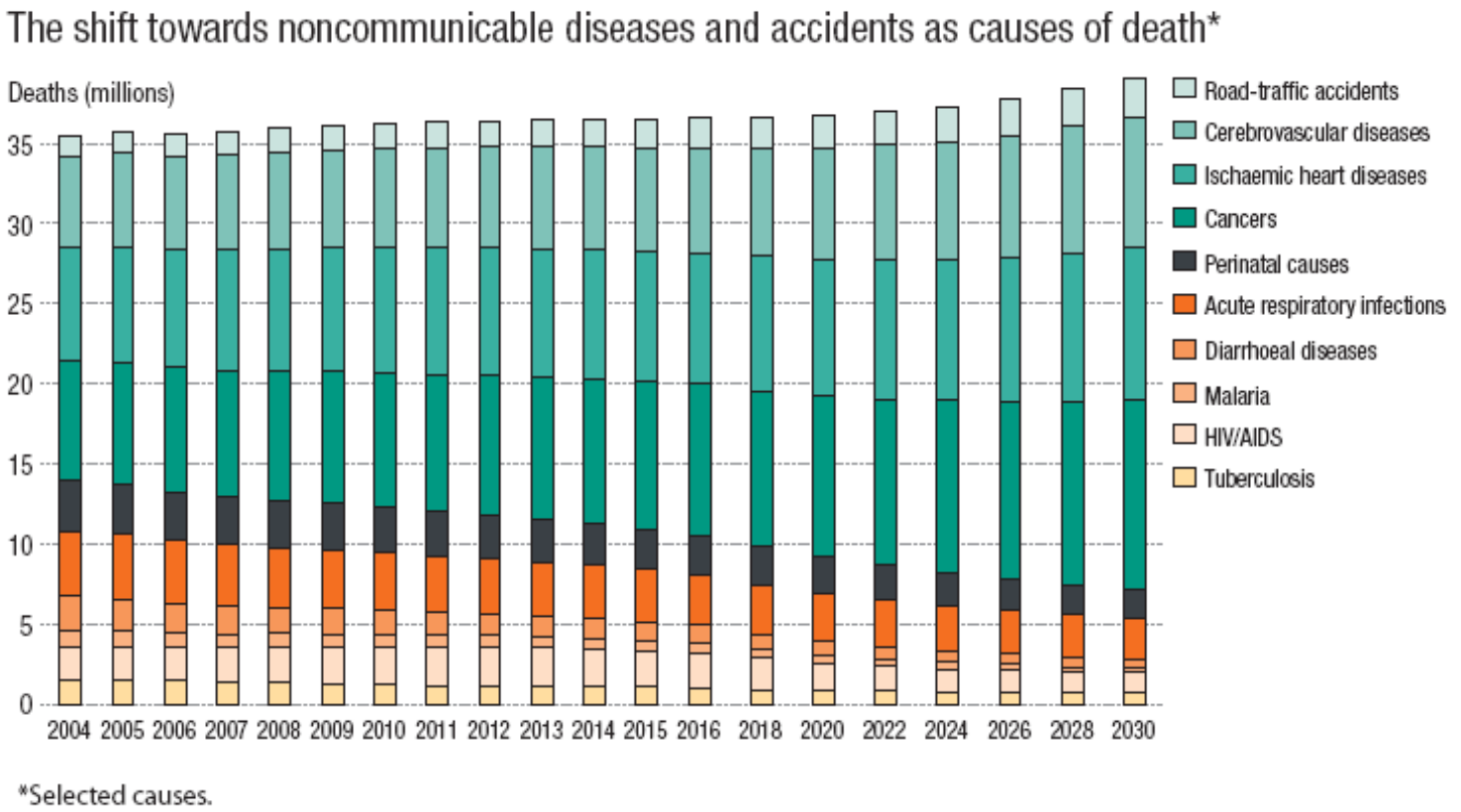
Recomendaciones PAPPS 2009



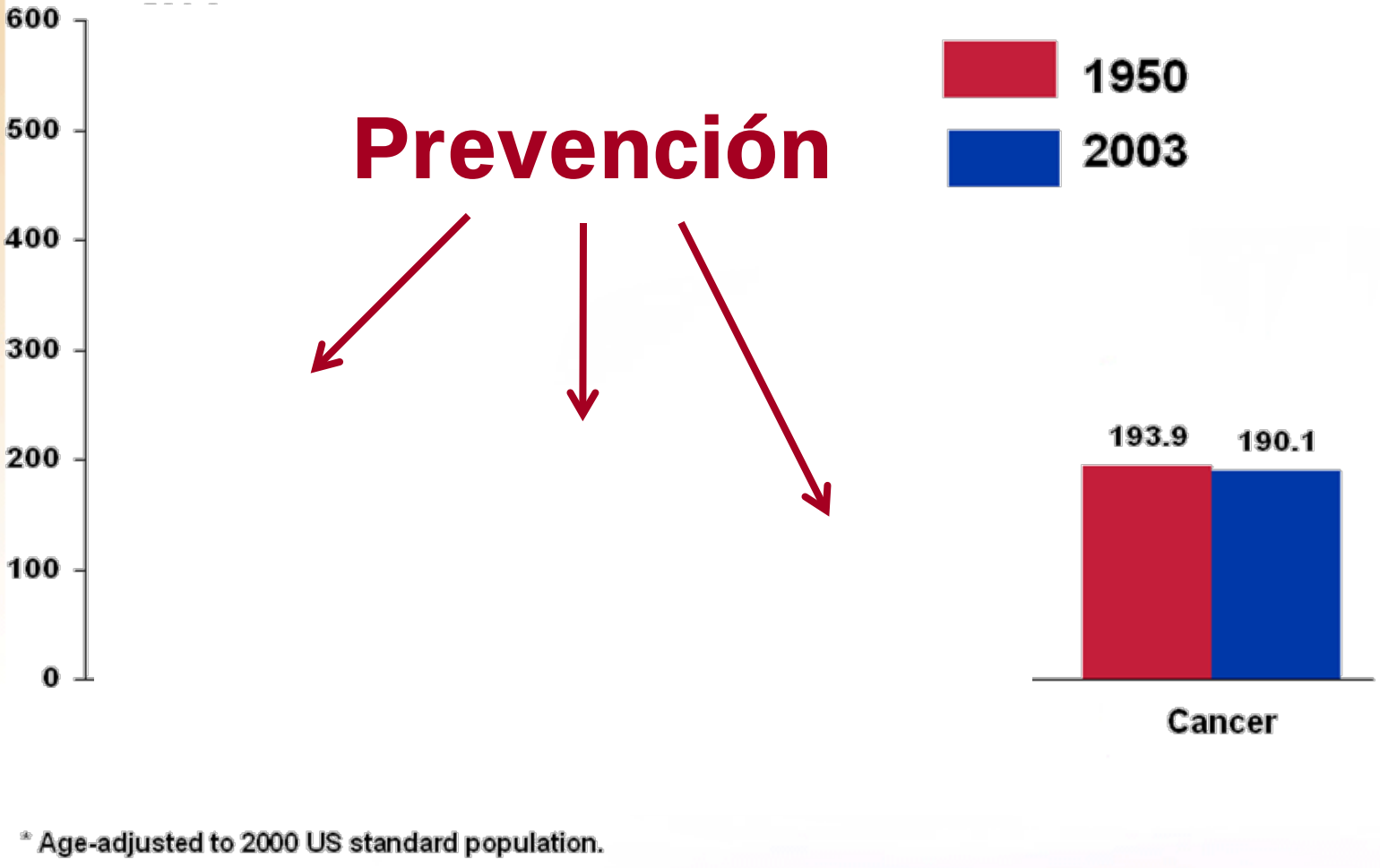


El càncer és un problema sanitari important



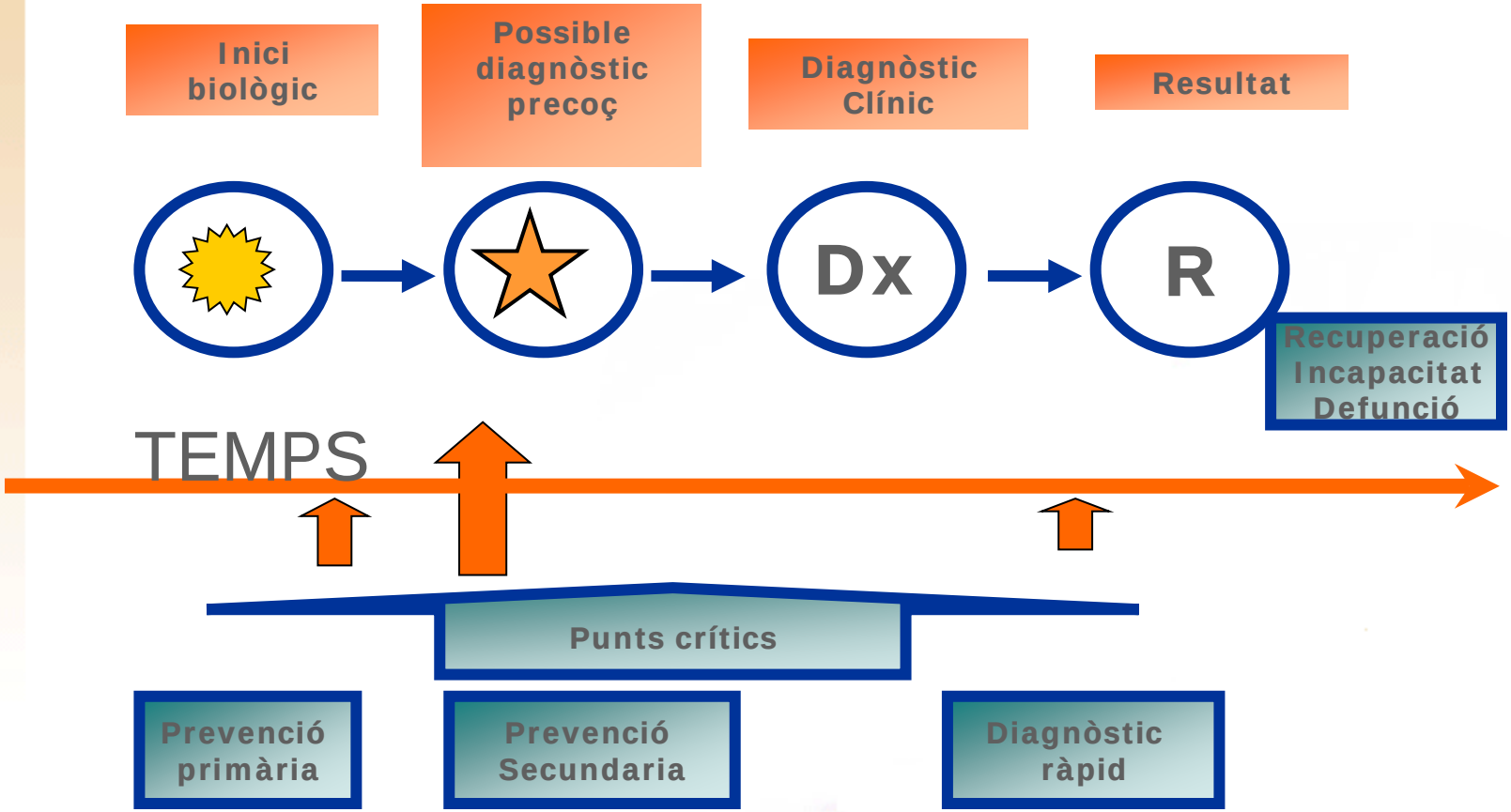
WHO, Health Report 2008

Change in the US Death Rates* by Cause, 1950 & 2003

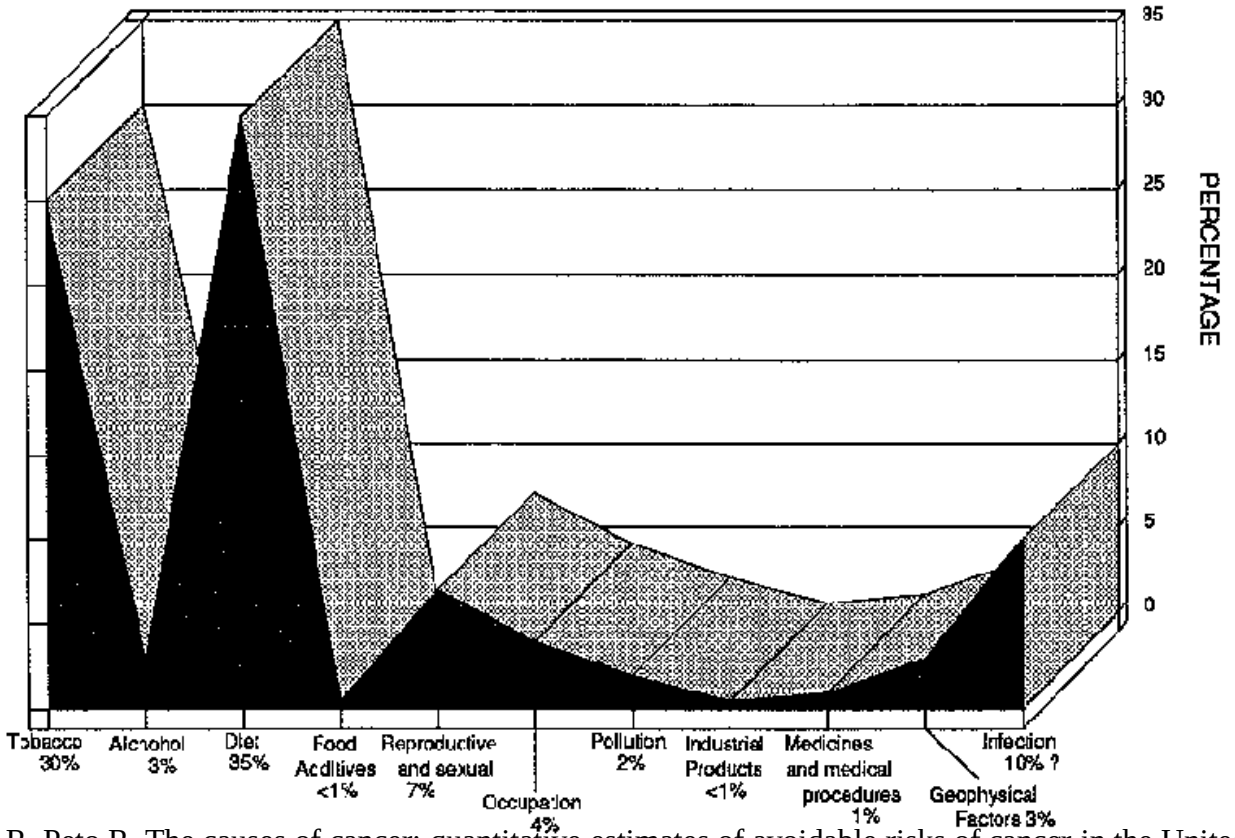


* Age-adjusted to 2000 US standard population.

Història natural de la malaltia



Prevenció Primària. Factors de risc



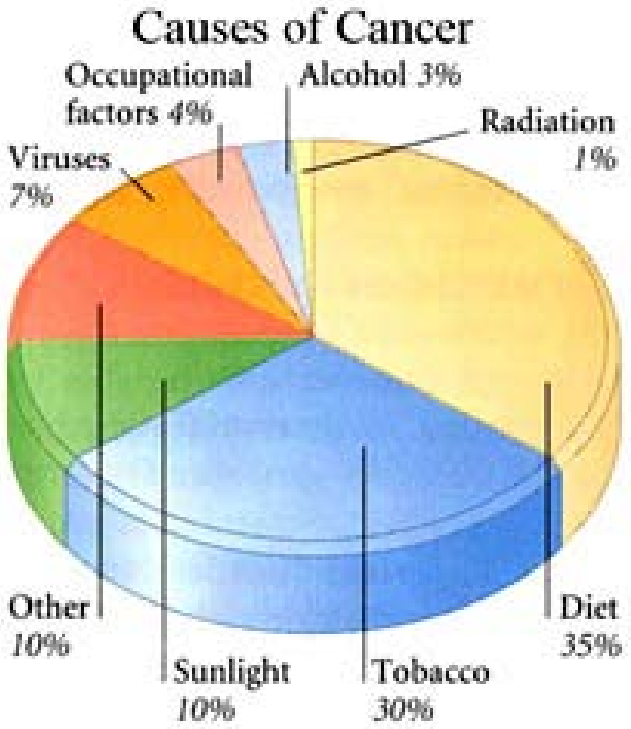
Fuente: Doll R, Peto R. The causes of cancer: quantitative estimates of avoidable risks of cancer in the United States today. J Natl Cancer Inst. 1981; 66:1191-30.

Prevenció Primària. Factors de risc

Table 1a – Proportion of cancer incidence attributable to different avoidable factors in Europe[8,4,16,29,63,69–72]

Factors	Men (%)	Women (%)
Smoking	29–38	2–10
Alcohol	5–9	2–4
Overweight	3	6
Physical activity	2[a]	
Diet	30[b]	
Fruit and vegetable	5–12[c]	
Infection	8	
Sunlight	8–10[d]	
Environmental and occupational exposure	5	

a Based on mortality for colorectum and breast cancer, for incidence it might be higher because these cancers have a much higher incidence rate.
b Also includes other nutritional factors such as fat intake.
c Worldwide estimate, may vary with regions.
d Estimates based on Western populations.



Martin-Moreno, 2008

Prevenció Primària. Factors de risc

Causes of cancer in the world: comparative risk assessment of nine behavioural and environmental risk factors

*Goodarz Danaei, Stephen Vander Hoorn, Alan D Lopez, Christopher J L Murray, Majid Ezzati, and the Comparative Risk Assessment collaborating group (Cancers)**

Lancet 2005; 366: 1784–93

*Members listed at end of paper

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Summary

Introduction With respect to reducing mortality, advances in cancer treatment have not been as effective as those for other chronic diseases; effective screening methods are available for only a few cancers. Primary prevention through lifestyle and environmental interventions remains the main way to reduce the burden of cancers. In this report, we estimate mortality from 12 types of cancer attributable to nine risk factors in seven World Bank regions for 2001.

Methods We analysed data from the Comparative Risk Assessment project and from new sources to assess exposure to risk factors and relative risk by age, sex, and region. We applied population attributable fractions for individual and multiple risk factors to site-specific cancer mortality from WHO.

Findings Of the 7 million deaths from cancer worldwide in 2001, an estimated 2·43 million (35%) were attributable to nine potentially modifiable risk factors. Of these, 0·76 million deaths were in high-income countries and 1·67 million in low-and-middle-income nations. Among low-and-middle-income regions, Europe and Central Asia had the highest proportion (39%) of deaths from cancer attributable to the risk factors studied. 1·6 million of the deaths attributable to these risk factors were in men and 0·83 million in women. Smoking, alcohol use, and low fruit and vegetable intake were the leading risk factors for death from cancer worldwide and in low-and-middle-income countries. In high-income countries, smoking, alcohol use, and overweight and obesity were the most important causes of cancer. Sexual transmission of human papilloma virus is a leading risk factor for cervical cancer in women in low-and-middle-income countries.

Interpretation Reduction of exposure to key behavioural and environmental risk factors would prevent a substantial proportion of deaths from cancer.

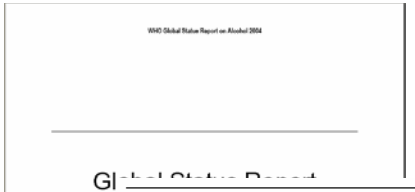
Prevenció Primària. Factors de risc

Table 2 US Cancer deaths that would be avoided by eliminating known risks

Cause	Deaths (%) avoided after removing preceding causes	
	Current smokers*	Non-smokers
Smoking	60	—
Known infections†	2	5
Alcohol‡	0.4	1
Sunlight	0.4	1
Air pollution§	0.4	1
Occupation‖	0.4	1
Lack of exercise¶	0.4	1
Diet#		
Overweight (BMI > 25 kg m^{-2})	4	10
Other dietary factors	4–12?	10–30?
Presently unavoidable★	About a quarter	At least half

Font: Peto J. Cancer epidemiology in the last century and the next decade. Nature 2001;411:390-5.

Consum d'alcohol per càpita (15+), litres d'alcohol pur



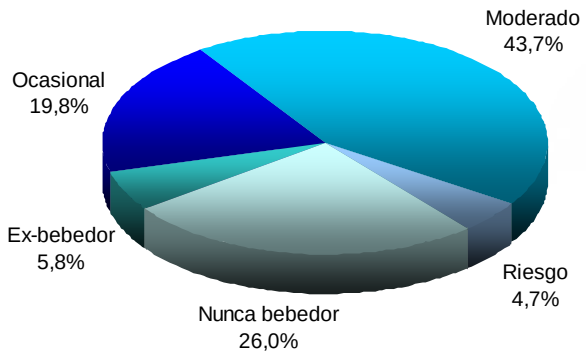
Country	Total	Country	Total	Country	Total
Guyana	5.84	Gabon	7.97	Hungary	11.92
Colombia	5.92	Belarus	8.12	Denmark	11.93
Chile	6.02	Canada	8.26	Spain	12.25
Panama	6.04	Thailand	8.47	Lithuania	12.32
Sao Tome and Principe	6.07	United States of America (the)	8.51	Slovakia	12.41
Dominican Republic (the)	6.11	Argentina	8.55	Portugal	12.49
Haiti	6.51	Bosnia and Herzegovina	8.62	Austria	12.58
Slovenia	6.55	Poland	8.68	Croatia	12.66
Saint Vincent and Grenadines	6.58	Venezuela	8.78	Germany	12.89
Sierra Leone	6.64	Italy	9.14	Bermuda	12.92
Paraguay	6.66	Australia	9.19	Reunion	13.39
Cyprus	6.67	Dominica	9.19	France	13.54
Barbados	6.70	Bahamas (the)	9.21	Republic of Moldova (the)	13.88
Lao People's Democratic Republic (the)	6.72	Greece	9.30	Ireland	14.45
Malta	6.74	Latvia	9.31	Czech Republic (the)	16.21
Rwanda	6.80	Burundi	9.33	Luxembourg	17.54
Sweden	6.86	Swaziland	9.51	Uganda	19.47
Azerbaijan					
Uruguay					
Bulgaria					
Japan					
Grenada					
Saint Kitts and Nevis					
Romania					
French Polynesia					
Republic of Korea (the)					
South Africa					
New Caledonia	7.83	Switzerland	11.53		

Sources: FAO (Food and Agriculture Organization of the United Nations), World Drink Trends 2003

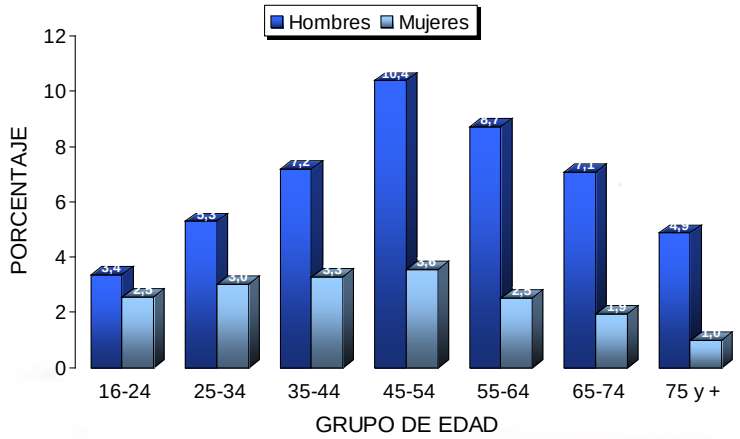
Espanya en l'actualitat ocupa el 15e lloc entre els països del món en quan a consum per càpita d'alcohol, amb 12,22 litres per habitant i any en 2003

Encuesta Nacional de Salud. España 2006

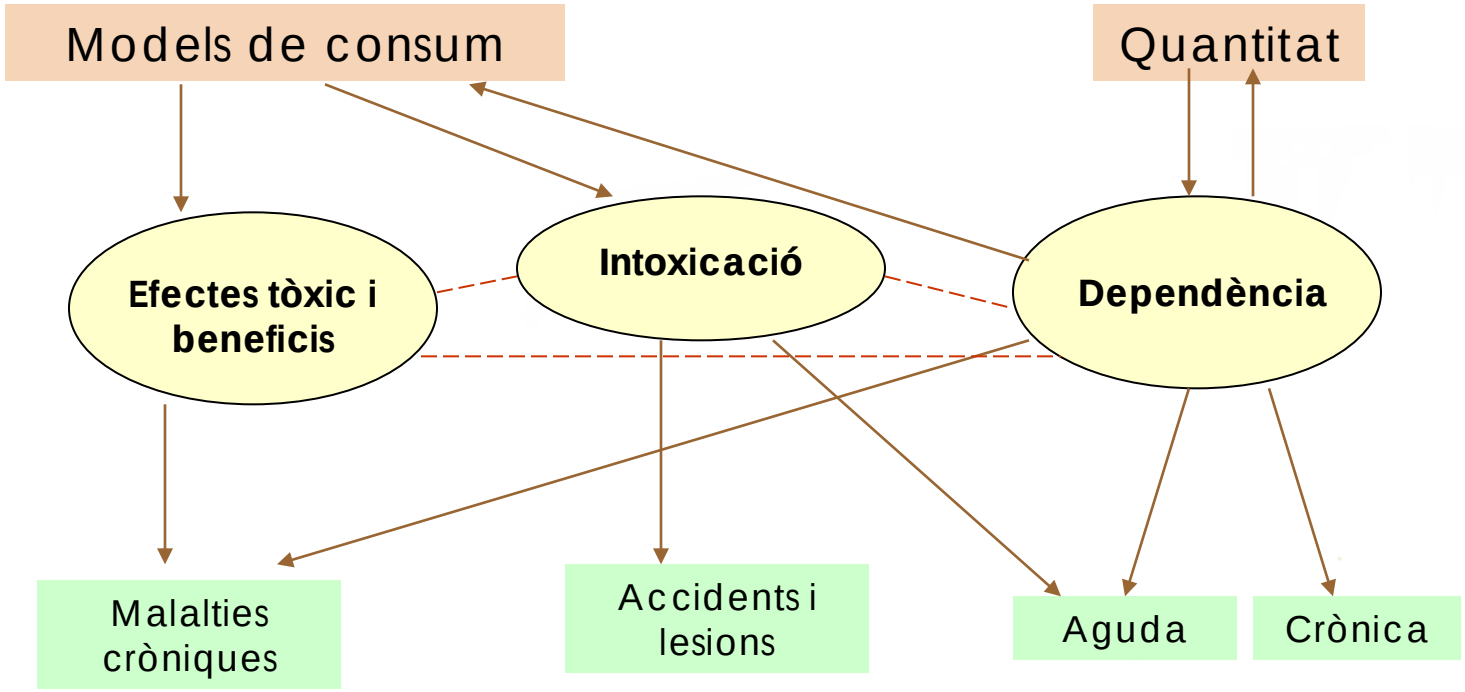
Consumo de alcohol (Población 16 y + años)



Consumo de alcohol con riesgo para la salud (Población 16 y + años)



Alcohol: models de consum, conseqüències a curt i a llarg termini



Alcohol i salut

Artritis	Augmenta el risc d'artritis gotosa
Càncer	Augmenta el risc de càncer de fetge, pàncrees, recta, mama, boca, faringe, laringe, esòfag
Síndrome alcohol fetal	Anomalies físiques i de comportament en el fetus
Malalties del cor	En bevedors importants: augment de la pressió arterial, dels lípids en sang, d'ictus i de malalties del cor. Les malalties del cor són menys importants en el bevedors moderats
Hiperglucèmia	Augmenta la glucosa en sang
Hipoglucèmia	Disminució glucosa en sang, especialment en pacients amb diabetis
Malaltia renal	Augment mida dels ronyons, canvia funcions hormonals, i augmenta el risc de fracàs renal
Malalties del fetge	Fetge gras, hepatitis alcohòlica i cirrosis
Malnutrició	Augmenta el risc de desnutrició proteica; disminueix la ingesta de proteïnes, calci, ferro, vitamina A, vitamina C, tiamina, vitamina B6 i riboflavina, i perjudica l'absorció de calci, fòsfor, vitamina D i zinc
Malalties neurològiques	Neuropatia i demència. Perjudica la memòria
Obesitat	Increment energètic, però no és una causa primària d'obesitat.
Malalties psicològiques	Depressió, ansietat y insomni

Accidents de transit, caigudes, etc

Associació d'alcohol i càncer

Cancer Site	Cases	Relative risks		
		25 g day	50 g day	100 g day
Oral cavity and pharynx	7,954	1.8	2.9	6.0
Oesophagus	7,239	1.5	2.2	4.2
Larynx	3,759	1.4	1.9	4.0
Breast	44,033	1.3	1.7	2.7
Liver	2,294	1.2	1.4	1.9
Colon and rectum	11,296	1.1	1.2	1.4
Stomach	4,518	1.1	1.2	1.3
Ovary	1,651	no association	1.2	1.5
Prostate	4,094	no association	1.1	1.2

Fuente: Bagnardi V, Blangiardo M, La Vecchia C, Corrao G. A meta-analysis of alcohol drinking and cancer risk. Br J Cancer 2001;85:1700-5.

Associació d'alcohol i càncer: Pàncrees

Int J Cancer. 2010 Mar 15;126(6):1474-86.

Alcohol drinking and pancreatic cancer risk: a meta-analysis of the dose-risk relation.

Tramacere I, Scotti L, Jenab M, Bagnardi V, Bellocco R, Rota M, Corrao G, Bravi F, Boffetta P, La Vecchia C.

Istituto di Ricerche Farmacologiche Mario Negri, 20156, Milano, Italy. irene.tramacere@marionegri.it

In order to provide a more precise quantification of the association between alcohol consumption and pancreatic cancer risk, we performed a meta-analysis of relevant dose-risk results. We conducted a PubMed search of all case-control (N=21) and cohort (N=11) studies published up to March 2009. We computed summary relative risk (RR) estimates using either fixed- or, in the presence of heterogeneity, random-effects models. The pooled RR was 0.92 (95% confidence interval, 95% CI, 0.86-0.97) for <3 drinks/day and 1.22 (95% CI, 1.12-1.34) for > or = 3 drinks/day. The increased risk for heavy drinking was similar in women and men, but apparently stronger in cohort studies (RR=1.29), in studies with high quality index (RR=1.30), and did not appear to be explained by residual confounding by either history of pancreatitis or tobacco smoking. This meta-analysis provides strong evidence for the absence of a role of moderate drinking in pancreatic carcinogenesis, coupled to an increased risk for heavy alcohol drinking. Given the moderate increase in risk and the low prevalence of heavy drinkers in most populations, alcohol appears to be responsible only for a small fraction of all pancreatic cancers.

Associació d'alcohol i càncer: Pròstata

Mol Nutr Food Res. 2009 Feb;53(2):240-55.

Alcohol use and prostate cancer: a meta-analysis.

Middleton Fillmore K, Chikritzhs T, Stockwell T, Bostrom A, Pascal R.
National Drug Research Institute, Curtin University, Perth, Australia.

Past reviews have concluded that there is no association between alcohol use and prostate cancer incidence. We performed a meta-analysis of existing epidemiological studies finding, in contrast, evidence to suggest that prostate incidence is positively linearly associated with heavier alcohol use. This finding was largely due to the contribution of population case-control studies and those measuring men recruited before age 60. No relationship between alcohol consumption and prostate cancer was found for cohort and hospital case-control studies. Analyses of design effects modestly suggests that population case-control studies were probably better suited to identify potential alcohol-prostate cancer relationships due to the close temporal proximity of the measurement of level of alcohol consumption to diagnosis. Future efforts should be made to exclude all ill subjects from control groups/baseline samples in addition to accounting for changes in consumption with advancing age and the onset of illness. The alcohol-prostate cancer association remained significant despite controlling for the degree to which studies endeavored to eliminate false negatives from their control groups.

Associació d'alcohol i càncer: Cap i coll

Am J Epidemiol. 2009 Oct 15;170(8):937-47. Epub 2009 Sep 10.

Total exposure and exposure rate effects for alcohol and smoking and risk of head and neck cancer: a pooled analysis of case-control studies.

Lubin JH, Purdue M, Kelsey K, Zhang ZF, Winn D, Wei Q, Talamini R, Szeszenia-Dabrowska N, Sturgis EM, Smith E, Shangina O, Schwartz SM, Rudnai P, Neto JE, Muscat J, Morgenstern H, Menezes A, Matos E, Mates IN, Lissowska J, Levi F, Lazarus P, La Vecchia C, Koifman S, Herrero R, Franceschi S, Wünsch-Filho V, Fernandez L, Fabianova E, Daudt AW, Maso LD, Curado MP, Chen C, Castellsague X, Brennan P, Boffetta P, Hashibe M, Hayes RB.

Biostatistics Branch, Division of Cancer Epidemiology and Genetics, National Cancer Institute, NIH, Rockville, MD 20852, USA. lubinj@mail.nih.gov

Although cigarette smoking and alcohol consumption increase risk for head and neck cancers, there have been few attempts to model risks quantitatively and to formally evaluate cancer site-specific risks. The authors pooled data from 15 case-control studies and modeled the excess odds ratio (EOR) to assess risk by total exposure (pack-years and drink-years) and its modification by exposure rate (cigarettes/day and drinks/day). The smoking analysis included 1,761 laryngeal, 2,453 pharyngeal, and 1,990 oral cavity cancers, and the alcohol analysis included 2,551 laryngeal, 3,693 pharyngeal, and 3,116 oval cavity cancers, with over 8,000 controls. Above 15 cigarettes/day, the EOR/pack-year decreased with increasing cigarettes/day, suggesting that greater cigarettes/day for a shorter duration was less deleterious than fewer cigarettes/day for a longer duration. Estimates of EOR/pack-year were homogeneous across sites, while the effects of cigarettes/day varied, indicating that the greater laryngeal cancer risk derived from differential cigarettes/day effects and not pack-years. EOR/drink-year estimates increased through 10 drinks/day, suggesting that greater drinks/day for a shorter duration was more deleterious than fewer drinks/day for a longer duration. Above 10 drinks/day, data were limited. EOR/drink-year estimates varied by site, while drinks/day effects were homogeneous, indicating that the greater pharyngeal/oral cavity cancer risk with alcohol consumption derived from the differential effects of drink-years and not drinks/day.

Associació d'alcohol i càncer: Aparell digestiu

Mt Sinai J Med. 2009 Aug;76(4):392-403.

The risk of upper aero digestive tract cancer associated with smoking, with and without concurrent alcohol consumption.

Ansary-Moghaddam A, Huxley RR, Lam TH, Woodward M.

George Institute for International Health, New South Wales, Australia.

BACKGROUND: Smoking and alcohol are major causal factors for upper aerodigestive tract cancer, but reliable quantification of the combined impact of smoking and alcohol on this cancer and its major subtypes has not been performed. METHODS: A meta-analysis of studies that had published quantitative estimates of smoking and upper aerodigestive tract cancer by January 2007 was performed. Pooled estimates of relative risks were obtained. Publication bias was investigated through funnel plots and corrected if found to be present. RESULTS: Overall, 85 studies with information on 53,940 individuals with upper aerodigestive tract cancer were included. The pooled estimate for the association between smoking and the risk of this cancer was 3.47 (95% confidence interval, 3.06-3.92). The risk remained elevated for a decade after smoking cessation but declined thereafter. Individuals who both smoked and consumed alcohol had double the risk of upper aerodigestive tract cancer in comparison with those who only smoked: the relative risk was 6.93 (95% confidence interval, 4.99-9.62) for the former and 2.56 (95% confidence interval, 2.20-2.97) for the latter ($P < 0.001$). CONCLUSIONS: Public health interventions that simultaneously discourage smoking and heavy drinking would have greater benefits than would be expected from those that target only one of these risk factors.

Associació d'alcohol i càncer: Bufeta urinaria

Eur J Cancer Prev. 2009 Feb;18(1):62-8.

Alcohol, coffee, and bladder cancer risk: a review of epidemiological studies.

Pelucchi C, La Vecchia C.

Mario Negri Institute for Pharmacological Research, Milan, Italy. pelucchi@marionegri.it

The objective was to review epidemiological studies that evaluated the association between consumption of coffee and alcohol and urinary bladder cancer. We searched the Medline database for observational studies of bladder neoplasms that included information on coffee or alcohol drinking, and looked for papers quoted as references in reviews of risk factors for bladder cancer and in studies that had been selected for inclusion. Results from epidemiological studies allow excluding a strong association between coffee and bladder cancer. Several studies reported a moderate increase in risk in coffee drinkers as compared with nondrinkers, but no trend with dose has been established. Epidemiological data on alcohol drinking and bladder cancer are suggestive of no association, although findings were not always consistent. For both habits, an explanation of the moderate increase in risk observed in some investigations might be attributed to residual confounding by smoking, or to an association between alcohol, coffee, and yet unidentified risk factors for bladder cancer.

Associació d'alcohol i càncer: Mama

Int J Cancer. 2008 Apr 15;122(8):1832-41.

Alcohol intake and risk of breast cancer defined by estrogen and progesterone receptor status--a meta-analysis of epidemiological studies.

Suzuki R, Orsini N, Mignone L, Saji S, Wolk A.

Division of Nutritional Epidemiology, Institute of Environmental Medicine, Karolinska Institutet, Stockholm, Sweden.

Erratum in:

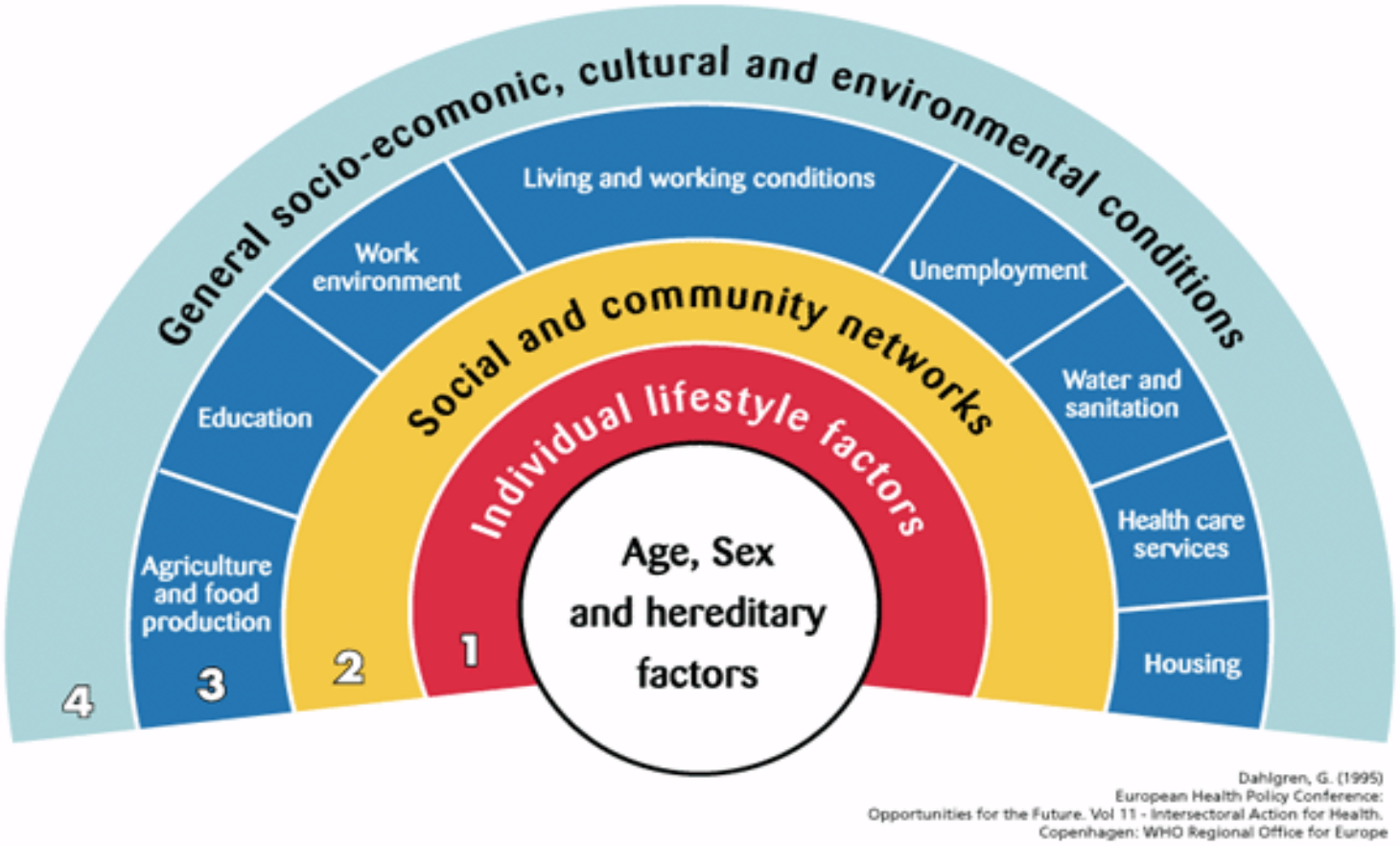
Int J Cancer. 2008 Aug 15;123(4):981.

The association between alcohol consumption and an increased risk of breast cancer has been established. It is still unclear however, whether this relationship differs across the estrogen receptor (ER) and progesterone receptor (PR) tumors subtypes. To provide a quantitative assessment of the association between alcohol intake and the risk of ER-/PR-defined breast cancer, we conducted a meta-analysis of cohort and case-control studies. Studies were identified by a literature search of PubMed through April 20, 2007 and by searching the reference lists of relevant articles. Summarized risk estimates (REs) with 95% confidence intervals (CIs) were calculated using random-effects models. The summarized results of the meta-analysis comparing the highest versus the lowest consumption categories showed statistically significant higher risks of developing all ER+ (27%), all ER- (14%), ER+PR+ (22%) and ER+PR- (28%), but not ER-PR- tumors. The dose-response meta-analysis showed that an increase in alcohol consumption of 10 g of ethanol per day was associated with statistically significant increased risks for all ER+ (12%), all ER- (7%), ER+PR+ (11%) and ER+PR- (15%), but not ER-PR-. A statistically significant heterogeneity of the REs across all ER+ versus ER-PR- was observed (p(heterogeneity) = 0.02). The summarized results from studies with adjustment for postmenopausal hormone use, body mass index and family history of breast cancer were higher and statistically significantly different from those without. The observed positive associations with alcohol for ER+PR+ and ER+PR- tumors cannot be explained by estrogen-dependent pathway only. Further studies need to clarify the biological mechanisms.

Codi europeu contra el càncer, 2003
Estils de vida

- ***No fumi*; si fuma, deixi'l com més aviat millor. Si no pot deixar de fumar, mai fumi en presència de no fumadors.**
- **Eviti l'*obesitat*.**
- **Realitzi alguna *activitat física* d'intensitat moderada tots els dies.**
- ***Augmenti el consum de fruites, verdures i hortalisses* variades: mengi almenys 5 racions al dia. *Limiti el consum d'aliments que contenen greixos d'origen animal*.**
- **Si beu *alcohol*, ja sigui vi, cervesa o begudes d'alta graduació, moderi el consum a un màxim de dues consumicions o unitats diàries, si és home, o a una, si és dona.**
- **Eviti *l'exposició excessiva al sol*. És especialment important protegir als nens i adolescents. Les persones que tenen tendència a sofrir cremades han de protegir-se del sol durant tota la vida.**
- **Apliqui estrictament la legislació destinada a prevenir qualsevol exposició a *substàncies carcinogèniques*. Segueixi els consells de salut i de seguretat sobre l'ús d'aquestes substàncies. Respecti les normes de protecció radiològica.**

Els determinants de la salut



Escenaris en la pràctica clínica

- Consell sobre prevenció primària del càncer
- Prevenció secundaria de factors de risc i del càncer: cribratge oportunista
- Persones amb risc elevat de patir un càncer
- Por a tenir un càncer
- Consulta de signes i/o símptomes per sospita de càncer: Diagnòstic ràpid

Mesures de prevenció primària

- A l'hora de transmetre la informació a la població general i dissenyar estratègies preventives de caràcter individual, s'ha de clarificar cap a quins factors de risc cal dirigir els esforços i ca a quin hem de tenir una actitud menys activa **Evitar la disseminació de mesures de escassa eficàcia o ineficàcia provada que saturen a la població.**
- S'ha de distingir un nivell legislatiu i normatiu que afecta al disseny de polítiques sanitàries i general de protecció de la salut i mediambiental i un nivell de disseny d'estratègies per aplicar a diferents grups de ciutadans. **El legislatiu i normatiu ha de ser molt restrictiu i conservador, i les estratègies per la població molt sòlides i avaluades.**

Criteris de definició

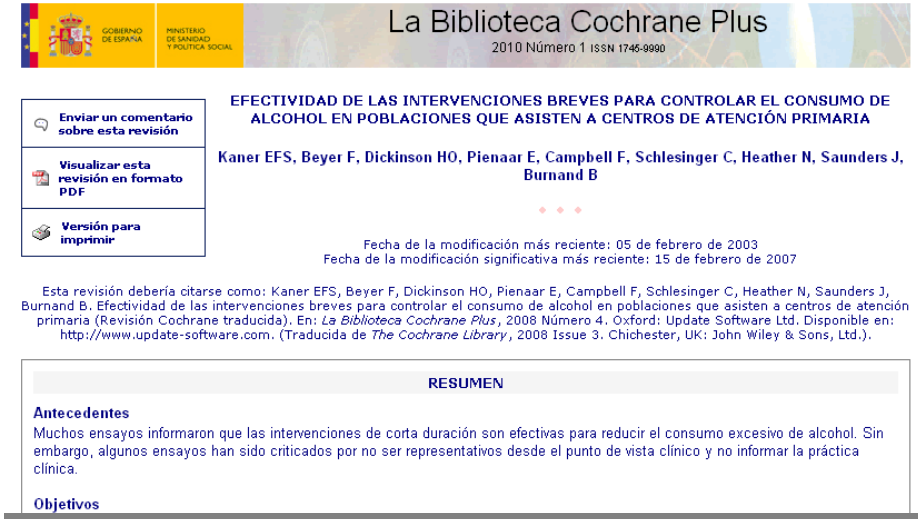
- El consum de risc queda definit com tota pauta de consum que augmenta el risc de sofrir, en el futur, danys físics, psíquics y/o socials, absents en el present.
- A pesar que el grau de risc no està únicament relacionat amb la quantitat d'alcohol ingerit, existeix cert consens en considerar en el nostra mitjà bevedor de risc a un individu que té un consum setmanal d'alcohol per sobre del llindar de risc, es a dir 28 unitats (280 g/setmana) en el home i 17 unitats (170 g/setmana) en la dona.
- A Espanya, una unitat estàndard de beguda (UBE) equival a 10 g d'alcohol pur
- També es considera bevedor de risc, amb independència del nivell d'alcohol ingerit, el individu amb antecedents familiars d'alcoholisme i el que fa ús de l'alcohol en determinades circumstàncies (embaràs, conducció de vehicles de motor, maquinària perillosa)

Recomendaciones PAPPS

semFYC - PAPPS
Programa de actividades preventivas y de promoción de la salud

- **Se recomienda la exploración sistemática del consumo de alcohol, como mínimo cada 2 años, en toda persona de más de 14 años sin límite superior de edad.**
  - Esto debería hacerse al abrir una historia de primer día, al actualizar la historia clínica o ante cualquier indicio de sospecha.
  - Esta actividad puede hacerse indistintamente en la consulta médica o de enfermería.
  - Para esta exploració se recomienda el manejo de una encuesta semiestructurada de cantidad/frecuencia, compuesta por unas preguntas básicas que analizan el consumo en días laborables y festivos.
  - El uso de marcadores biológicos no se recomienda de forma habitual.
- **Debe considerarse consumo peligroso o de riesgo e intervenir cuando la ingesta semanal sea superior a 280 g en el hombre (28 U) o 170 g en la mujer (17 U).**
- **Se considera deseable reducir el consumo por debajo de límites más seguros, como 170 g en el hombre (17 U) y 100 g en la mujer (11 U).**
- **También debe considerarse peligroso consumir 50 g (5 U) en 24 horas, una o más veces al mes. Las mujeres embarazadas, los adolescentes y los usuarios de maquinaria peligrosa o vehículos a motor deben ser persuadidos de abstenerse de tomar bebidas alcohólicas.**

Intervencions a la consulta d'AP



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EFECTIVIDAD DE LAS INTERVENCIONES BREVES PARA CONTROLAR EL CONSUMO DE ALCOHOL EN POBLACIONES QUE ASISTEN A CENTROS DE ATENCIÓN PRIMARIA

Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, Heather N, Saunders J, Burnand B

Fecha de la modificación más reciente: 05 de febrero de 2003
Fecha de la modificación significativa más reciente: 15 de febrero de 2007

Esta revisión debería citarse como: Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, Heather N, Saunders J, Burnand B. Efectividad de las intervenciones breves para controlar el consumo de alcohol en poblaciones que asisten a centros de atención primaria (Revisión Cochrane traducida). En: *La Biblioteca Cochrane Plus*, 2008 Número 4. Oxford: Update Software Ltd. Disponible en: http://www.update-software.com. (Traducida de *The Cochrane Library*, 2008 Issue 3. Chichester, UK: John Wiley & Sons, Ltd.).

RESUMEN

Antecedentes

Muchos ensayos informaron que las intervenciones de corta duración son efectivas para reducir el consumo excesivo de alcohol. Sin embargo, algunos ensayos han sido criticados por no ser representativos desde el punto de vista clínico y no informar la práctica clínica.

Objetivos

Las intervenciones breves produjeron reducciones del consumo de alcohol de forma sistemática. En los casos en que se informaron datos por sexo, se observó que el efecto era claro en los hombres al año de seguimiento, en tanto que no se comprobó en las mujeres. Es probable que una intervención de orientación más prolongada aporte escasos efectos adicionales. La ausencia de diferencias en los resultados entre los ensayos de eficacia y de efectividad indica que la bibliografía actual tuvo una clara relevancia para la atención primaria habitual. Se recomienda que los ensayos futuros se concentren en las mujeres y en delinear los componentes más eficaces de las intervenciones.

Intervencions a la consulta d'AP

Review: brief interventions including information sessions, motivational interviews, and cognitive behavioural therapy reduce excessive alcohol consumption in primary care

Kaner EF, Beyer F, Dickinson HO, *et al*. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev* 2007;(2):CD004148.

Clinical impact ratings GP/FP/Primary care ★★★★★☆☆

Brief intervention (BI) *v* control and extended (EI) *v* BI for alcohol consumption in primary care*

Outcomes at 6 months to 4 years†	Number of trials (n)	Comparisons	Weighted mean difference (95% CI)		
Quantity of alcohol consumed (g/wk)	21 (5638)	BI *v* control	−41 (−57 to −26)		
Frequency of drinking (d/wk)	4 (575)	BI *v* control	−0.1 (−0.6 to 0.4)‡		
	1 (157)	EI *v* BI	−0.7 (−1.3 to −0.1)		
Intensity of drinking (g/drinking d)	4 (1112)	BI *v* control	−3.4 (−13 to 6.2)‡		
			Weighted event rates	**RRR (CI)**	**NNT (CI)**
Heavy drinking§	7 (1792)	BI *v* control	26% *v* 42%	39% (21 to 52)	7 (5 to 10)
Binge drinking	3 (788)	BI *v* control	52% *v* 67%	21% (11 to 30)	7 (5 to 13)

*Abbreviations defined in glossary. Weighted event rates, RRR, NNT, and CI calculated from relative risks and control event rates in article. Analysis based on a random-effects model. †Outcomes are self-reported. ‡Not significant. §>13 to >35 drinks/week.

Solament un 5,5% de les persones amb un trastorn relacionat amb l'alcoholisme que varen contestar han consultat alguna vegada a un professional de la salut en els darrers 12 mesos

Table 7. Alcohol Treatment and Help-Seeking Settings Among Respondents With 12-Month and Lifetime *DSM-IV* Alcohol Use Disorders

	12-Month, % (SE)			Lifetime, % (SE)		
Type of Alcohol Treatment/ Help Seeking	Alcohol Use Disorder	Alcohol Abuse	Alcohol Dependence	Alcohol Use Disorder	Alcohol Abuse	Alcohol Dependence
12-step program	4.46 (0.43)	2.03 (0.39)	7.44 (0.79)	10.84 (0.41)	5.21 (0.38)	18.87 (0.72)
Family/social services	1.47 (0.25)	0.62 (0.19)	2.51 (0.49)	3.18 (0.20)	1.32 (0.17)	5.82 (0.39)
Detoxification	1.98 (0.30)	0.47 (0.14)	3.82 (0.62)	4.84 (0.26)	1.72 (0.19)	9.30 (0.53)
Outpatient clinic	1.78 (0.27)	0.64 (0.22)	3.18 (0.55)	4.11 (0.23)	1.35 (0.16)	8.03 (0.48)
Rehabilitation program	2.34 (0.32)	0.71 (0.23)	4.34 (0.65)	6.58 (0.29)	2.53 (0.24)	12.36 (0.60)
Other inpatient facility	1.35 (0.24)	0.34 (0.14)	2.58 (0.48)	3.45 (0.21)	1.11 (0.15)	6.79 (0.44)
Emergency department	1.35 (0.26)	0.24 (0.12)	2.71 (0.54)	3.77 (0.21)	1.16 (0.14)	7.49 (0.45)
Halfway house	0.29 (0.11)	0.00 (0.00)	0.65 (0.25)	1.21 (0.11)	0.49 (0.09)	2.23 (0.26)
Crisis center	0.16 (0.05)	0.03 (0.03)	0.32 (0.11)	0.53 (0.07)	0.11 (0.04)	1.13 (0.16)
Employee assistance program	0.32 (0.12)	0.04 (0.04)	0.65 (0.27)	1.10 (0.11)	0.44 (0.11)	2.03 (0.23)
Clergy	1.20 (0.22)	0.20 (0.15)	2.42 (0.45)	2.18 (0.16)	1.47 (0.09)	4.61 (0.36)
Physician or other health care professional	3.34 (0.36)	0.56 (0.18)	6.73 (0.77)	5.54 (0.27)	1.62 (0.18)	11.13 (0.56)
Any professional other than AA, EAP, or clergy	5.47 (0.44)	1.85 (0.33)	9.99 (0.88)	11.00 (0.36)	4.50 (0.32)	20.07 (0.68)
Other	0.65 (0.17)	0.53 (0.21)	0.80 (0.27)	1.80 (0.14)	0.74 (0.12)	3.31 (0.30)

Hasin DS, Stinson FS, Ogburn E, et al. Arch Gen Psychiatry 2007;64:830–42.

Elements de reflexió

THE CONSULTATION 1

The exceptional potential in each primary care consultation

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SUMMARY. A four-point framework is described which has been found to be helpful for general practitioners who try to achieve greater breadth in each consultation. The framework has also provided a useful stimulus in undergraduate and postgraduate teaching, because it provides a nomenclature to identify four major components of clinical practice which are particularly relevant to primary care.

Introduction

'COMPREHENSIVE primary care' is an attractive concept with a growing descriptive literature but the principles involved are still difficult to present in a succinct and practical way. Even the students who appear to have understood the principles of comprehensive care often fail to apply them in the consulting room and the five 'areas' described by the Royal College of General Practitioners (1972) in *The Future General Practitioner* provide a conceptual framework of the content of primary care rather than an aid to

We present such a clinical framework which is designed to reveal the practical potential in each doctor/patient contact by highlighting four large areas, each of which embraces many skills which the primary clinician can use to his patient's benefit. The junior undergraduate can be expected to learn the basic outline, which is subsequently elaborated by the acquisition of appropriate knowledge, skills, and maturity.

Postgraduates can also be encouraged to consider the clinical decisions they take in every consultation against the framework because it clarifies the practical implications of many of the concepts and ideas which have been described in *The Future General Practitioner* (RCGP, 1972) and by the Leeuwenhorst Working Party of European Practitioners (1977) in 1974. The objectives of the framework are:

1. To provide a theoretical base from which a practitioner can develop the full potential in any primary care consultation.

2. To highlight some unique features of good primary care.

Figure 1. *The potential in each primary care consultation—an* aide-memoire.

A	B
Management of presenting problems	Modification of help-seeking behaviour

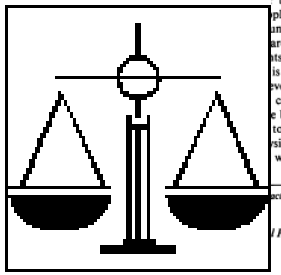

Figure 1. *The potential in each primary care consultation—an* aide-memoire.

A	B
Management of presenting problems	Modification of help-seeking behaviour
C	D
Management of continuing problems	Opportunistic health promotion

Actitut dels professionals