Author's response to reviews

Title: How do patients with alcohol problems present in Australian general practice?

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Author’s response to reviews: see over
RESPONSE TO REVIEWERS

We would like to thank the reviewers for their useful comments.

Reviewer 1: Peter Anderson

We note the positive response from this reviewer who requires no changes to this paper.

Reviewer 2: Ulrich John

1-6: We have expanded the method section to give a little more detail, in response to the Reviewer’s comments. The full details of the methods would fill a paper on their own and are already published each year in the annual report of BEACH, which is a book (ISBN 1 74024 337 4; ISSN 1442 3022) and is available on the web for free download under publications at http://www.aihw.gov.au. We have added the URL to the reference list.

7-8: In the methods we had clarified that the GPs do not select the patients for this question, that they ask it of 40 consecutive patients who happen to be seen at the time of completing the 40 forms with questions about alcohol consumption. There is therefore no selection of patients by the GPs for this question. The questions and response categories have now been presented in Box 1 (Page 3).

9. There are no methods by which these responses can be checked. The GPs asking the questions are distributed across the country and ask the patient in the privacy of the normal GP-patient consultation. As suggested by the reviewer, under-statement of alcohol consumption levels by the patient may occur. However, this applies to any survey of alcohol consumption. In fact, the patient may well be more inclined to be more honest with his/her GP since he/she is entrusting his/her medical care to that GP. The number of questions that can be asked are limited by the space available on the form and the GP’s time that can be allocated in a normal consultation. Please note that we did ask 3 questions – this paper concentrates on the third as it is an important indicator of heavy drinking (episodic or regular), and has been proposed as a single-question screen for alcohol problems. We briefly address the other two questions when we divide subjects between regular and episodic heavy drinkers.
10. We agree there is a possible underestimate, due to patient’s being embarrassed to report true consumption levels, so we have added a sentence to that effect in the discussion (Page 9).

11. In this paper we have focused on the management of morbidity at consultations with heavy drinkers (as defined). We do not have a full list of all patient morbidity, only that managed at the single consultation.

12. To our knowledge there is no evidence that ‘the young respondents feel less ashamed about heavy drinking than older patients’, although we cannot exclude this possibility. Alcohol consumption is known to be higher in younger age groups (National Drug Strategy Household Survey).

Minor comments:

1. Table 1 has been changed to provide variable specific rates rather than distributions. Chi square tests have been undertaken for variables in Table 1, and the p values entered (though chi square does not take into account the cluster sample design, whereas the 95% CI calculation does.) One cannot apply the chi square test statistic to rates as reported in Table 2. Statistical significance of differences is judged by non-overlapping confidence intervals.

2. Figure 1 has been removed, since the age and sex specific rates of heavy drinking have now been reported in Table 1.

3. Results section. The prevalence of heavy drinking did not differ by socioeconomic group after adjustment for age and sex and this is an interesting observation. However we have removed a sentence from the demographics section, thus avoiding repetition.

4. The simplification of the paper should now make it more structured; it remains in the traditional IMRD form.

5. The abstract reflects the aim of the paper, which was to describe the conditions that heavy drinkers presented with in general practice. The recruitment of the sample is the subject of another book, as described above.

6. We have changed the title, as suggested by this reviewer at point 9, to reflect the last sentence in paragraph of the introduction.

7. The references for these studies have been provided and we do not think that further elaboration would improve the paper.
8. We feel that this background about the structure of health care in Australia fits better in the introduction section. It is not part of our Method.

9. We have changed the title, as suggested.

10. References: All journal titles are now given in full.

11. Table 1 has been simplified. We believe it important to report both the unadjusted results, which reflect reality, and the age adjusted, to test differences between the groups that are not explained by the age and sex distributions of the two groups.

**Reviewer 3: Katherine A Bradley**

**Major Compulsory Revisions:**

We based the division of heavy and non-heavy drinkers on the NHMRC guidelines; i.e. drinking more than 6 standard drinks on one occasion places men at acute risk of harm from alcohol. The NHMRC states that, for women, drinking more than 4 drinks on any occasion leads to acute risk of harm, but data on drinking 4-5 drinks per occasion is not available from AUDIT-C. Therefore, 6 was used.

**Discretionary Revisions**

1. We believe the unadjusted result is important as it provides the clinician with some idea of the true likelihood of seeing a heavy drinking patient. However we have simplified the body of the results, giving less emphasis to the unadjusted results.

2. Simplification of the paper, with less emphasis to the unadjusted results, we hope will clarify this issue.

3. Smoking status has been added to Table 1 and the result reported in the body of the text. This issue is also now considered in the discussion (Page 8).

4. The rate of counselling is almost exactly the same as that reported in a similar study that compared counselling in hospital inpatients with general practice patients. However, those patients were alcohol-dependent and had sought help. We have added a sentence to that effect in the discussion (Page 8).

5. We have made a slight change to make the paragraph clearer (paragraph 2 in limitations).

6. We have consulted the original papers again and it seems clear that both Gordon and Bush report using AUDIT, AUDIT-C and AUDIT-3 in their studies. Gordon
et al compared AUDIT-C and AUDIT-3 to the full AUDIT for sensitivity, specificity, likelihood ratios and predictive values, while Bush et al used AUROCs to compare AUDIT-C with AUDIT.

**Reviewer 4: Daniel C Vinson**

This reviewer raises many interesting questions, most of which cannot be investigated as part of this study, as the data are not available. He also suggests that we should ‘datamine’ to find patterns of morbidity that may give a GP an indication of likely heavy drinking. While this is an interesting issue, it is not the objective of this paper. It would be better addressed by a study with a detailed interview of alcohol consumption patterns, which would provide a more accurate gold standard against which to compare presentations. This paper concentrates on the prevalence of heavy drinking in patients attending general practice and investigates the relationship between problem managed and the patient’s drinking status. To quote the Reviewer:

‘What your study very appropriately sought were differences between screen-positive and screen-negative patients. Regardless of what a patient’s “true” alcohol status is, it’s worth knowing what patient variables are associated with positive’.

Table 1: The reviewer’s suggestions for changes to Table 1 and the description of the results have been adopted.

**Major compulsory revisions**

None

**Minor essential revisions**

The abstract has been changed to reflect the new Table 1, now reported in the manner suggested.

**Minor discretionary revisions:**

The methods are expanded and the URL of the report added to references.

A sentence has been added to the discussion to comment on the low rate of counselling, considering the GP has identified the alcohol consumption issue through
the questions. We do not have data on whether the GP may have provided counselling on previous occasions or rebooked the patient for a future appointment for counselling.