

Estimates on severity of alcohol use depend upon methodology

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We thank Dr. Richard Saitz for responding to our finding that at-risk drinkers without alcohol use disorders (AUDs) are the largest group of unhealthy alcohol consumers at general hospitals. The main aim of our study (Bischof et al. 2010) was to present a different picture of the severity of alcohol use among general hospital inpatients than the rather pessimistic one presented by Saitz and colleagues (2006). They found almost all inpatients (77%) with unhealthy alcohol use to be alcohol dependent, and concluded that “Screening on a medicine service largely identifies patients with dependence—a group for whom the efficacy of brief intervention is not well established”. We assume that differences between the studies can largely be explained by three issues: terminology, assessment and regional differences.

1. *Terminology* In his response, Saitz uses the term alcohol use disorders and thereby treats alcohol abusing and alcohol dependent inpatients equally. We agree that the absolute number of inpatients holding AUDs exceeds the number of inpatients with at-risk drinking only. However, since there is no evidence that brief interventions are not effective for alcohol abusers, the distinction between alcohol dependence and alcohol abuse is of substantial importance.

2. *Assessment* Saitz questions our conclusion by citing two other studies that found the majority of inpatients screened positive to be alcohol dependent. However, these two studies used the alcohol use disorders identification test (AUDIT) with a cut-off value of 8, that has been found to be insensitive for identifying at-risk drinkers (Rumpf et al. 2002; Dybek et al. 2006). Cut-off values of 5 or 6 are now recommended (Reinert and Allen 2007). For example, anyone who consumes 3–4 drinks on a daily basis would screen positive using the cut-off of 5, and negative using the cut-off of 8 points. We have calculated what our results in Bischof et al. (2010) would look like if we had relied on the AUDIT only and if we had used a cut-off of 8 points. Findings are displayed in Table 1. As expected, a substantial group of at-risk consumers not holding an AUD ($n = 54$, 44.3%) would not have been detected if we had chosen a cut-off of 8 points. Thus, using only the AUDIT with 8 points, the proportions among screening-positives holding a diagnosis ($n = 190$) would be: at-risk drinking only 35.8%, alcohol abuse 21.6% and alcohol dependence 42.6%, approaching the numbers found in the studies cited by Saitz.

3. Discrepancies between our findings and the study conducted by Saitz and Colleagues (2006), are harder to explain. Regional differences might play a role in the heterogeneous findings in severity of alcohol use. As we have found in a study covering a whole region in northeastern Germany (Coder et al. 2008), general hospitals that are located in areas with high unemployment rates, have higher proportions of alcohol dependent inpatients than others. As Saitz states that the hospital in which their study was conducted “provided care regardless of ability to pay and most

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Table 1 Prevalence rates using different cut-off values ($n = 1,364$)

	No diagnosis	At-risk only	Abuse	Dependence
AUDIT cut-off 5				
Negative	993 (72.8%)	6 (0.4%)	1 (0.1%)	0 (0.0%)
Positive	117 (8.6%)	116 (8.5%)	46 (3.4%)	85 (6.2%)
AUDIT cut-off 8				
Negative	1,075 (78.8%)	54 (4.0%)	6 (0.4%)	4 (0.3%)
Positive	35 (2.6%)	68 (5.0%)	41 (3.0%)	81 (5.9%)
Overall	1,100 (81.4%)	122 (8.9%)	47 (3.4%)	85 (6.2%)

Data are restricted to the subsample of inpatients receiving the AUDIT (Bischof et al. 2007); individuals holding a diagnosis but are negative on the AUDIT have been identified using the LAST (Rumpf et al. 1997)

admissions are through the emergency department”, this might in part also explain the higher proportion of alcohol dependent inpatients.

We agree that clinicians conducting interventions in general hospital settings will need to address the elevated rates of alcohol-dependent inpatients. However, our findings are the first to prove that inpatients reveal a similar rate of at-risk drinkers than we would expect in the general population and, therefore, indicate that a pessimistic approach towards SBI in the general hospital is not justified from a public health perspective.

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