

# Implementation Plan of the Clinical Practice Guideline for the Early Detection, Diagnosis and Treatment of Patients With Alcohol Abuse or Dependence in a Colombian Hospital

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## Abstract

**Objective:** Implement a Clinical Practice Guideline for the early detection, diagnosis and treatment of the acute phase of intoxication of patients with alcohol abuse or dependence in the priority consultation services and outpatient consultation of the E.S.E Cari Neurosciences Hospital of the city of Barranquilla.

**Introduction:** Alcoholism is the first drug addiction in many countries of the world. It affects all ages, both sexes and in almost all social groups. Alcohol is estimated to cause nearly 4% of deaths worldwide and is one of the top 20 causes of disability-adjusted life years (DALYs), either due to associated neurological and / or psychiatric conditions (38%), accidental injury (28%) or intentional injury (12%). In Colombia, alcohol consumption is widely accepted and promoted. The life prevalence of psychoactive substance use disorders is 10.6%, and alcohol abuse is the most prevalent disorder.

**Materials and Methods:** An implementation plan for a management CPG for the early detection, diagnosis and treatment of an acute phase of intoxication of patients with alcohol abuse or dependence will be developed, according to the manual methodology of implementation of guidelines Clinical practice based on evidence from the Colombian Ministry of Health.

**Conclusions:** The CPGs contain recommendations with the best clinical evidence available. Therefore, it is necessary that they be adopted by users, for which it is necessary to follow the dissemination, dissemination and implementation plan, address the intrinsic and extrinsic obstacles and facilitators of the CPGs and monitor the indicators described to measure the process of implementing CPGs in clinical practice.

**Keywords:** alcoholism, clinical practice guide, communication barriers

## 1. Introduction

Alcoholism is the first drug addiction in many countries in the world. It affects all ages, both sexes and in almost all social groups. It is the direct cause of more than half of car accidents (Cenetec, 2013).

The abuse of alcoholic beverages and alcohol dependence represent a serious public health problem worldwide, both because of the economic and social costs generated by society, and because of the effects on individuals and families. According to the World Health Organization, 3.3 million deaths occur worldwide each year due to the harmful consumption of alcohol, which represents 5.9% of all deaths. The consumption of alcohol causes deaths and disability at a relatively early age. Between 20 and 39 years, 25% of deaths are attributable to alcohol consumption. Alcoholism is not only a causative agent of several serious diseases, but also a catalyst for aggressions and violent situations (Alwan, 2011)

Alcohol is carcinogenic and increases the risk of cancer of the mouth, esophageal (throat), laryngeal, liver and breast, in the case of women; and to a lesser extent cancer of the stomach, colon and rectum, in that order. The

annual risk of death from cancers related to alcohol consumption (mouth, pharynx, throat and liver) increases from 14 per 100 thousand for middle-aged abstainers and 50 per 100 thousand for drinkers with four or more drinks per day (40g of alcohol). Currently, there is strong evidence that alcohol increases the risk of breast cancer in women. At age 80, the risk increases from 88 for every 1,000 abstaining women to 133 for every 1,000 women who consume six drinks per day (60g of alcohol). It is very likely that alcohol increases the risk of breast cancer due to the increase in hormone levels, which are known to be a risk factor for this type of cancer (Organización Panamericana de la Salud OPS/ OMS, 2008).

In the country, alcohol consumption is widely accepted and promoted: According to the National Mental Health Survey, the prevalence of life of disorders due to the use of psychoactive substances is 10.6%. Alcohol abuse is the most prevalent disorder. It is estimated that one in 15 Colombians abuses alcohol, with a male to female ratio of 5 to 1 (Alcaldía de Barranquilla, González Martínez, & Granados De la Hoz, 2014)

In 2013, it was reported that the average age of onset of alcohol consumption in Colombia was 15.9 years, an average higher than that obtained in the 2008 study (Yokoyama et al., 2015). The age of onset of substance-related disorders is between 18 and 26 years, with an average age of onset of alcohol abuse at 23 years, and the highest rate of current use is among young people aged 18 to 24 years, which they constitute the largest proportion of subjects with harmful consumption or risk of alcohol. The lifetime prevalence of alcohol abuse is 6.8% and dependence 2.4% (Dirección Nacional de Estupefacientes, 2008).

The 2003 National Mental Health Study showed that only one in ten people with a mental disorder received psychiatric care. These limitations on access to mental health services have been addressed and in recent years improvements have been made in the laws that govern this issue, positively influenced by the purpose of achieving universality in the affiliation to all Colombians General Social Security System (Ministerio de Salud y Protección social, 2005; Posada-Villa, José A.; Aguilar-Gaxiola, Sergio A; Magana, Cristina G, Gomez, 2004).

In the 2007 National Health Survey, access to mental health services was studied from a domain that uniquely involved the search for and the start of care. In this survey it was evidenced that only 0.8% of the attention received was due to illness or mental, nervous or behavioral problems; In contrast, the results of the last study of disease burden for Colombia refer to the first twenty causes according to total DALY's (x1000 people), and within them it is evident that of these twenty causes four are from the group of mental illnesses (Peñaloza Quintero, Salamanca Balen, Rodríguez Hernández, Rodríguez García, & Beltrán Villegas, 2014).

## 2. Methods

This research developed a Plan for the implementation of a management CPG for the early detection, diagnosis and treatment of the acute phase of intoxication of patients with alcohol abuse or dependence at the ESE Cari Neurosciences Hospital of Barranquilla, according to the methodology of manual of implementation of clinical practice guidelines based on evidence from the Ministry of Health (Duarte Osorio, Torres Amaya, & Vélez, 2014). Although in Colombia there is a CPG for the management of early detection, diagnosis and treatment of the acute phase of intoxication of patients with alcohol abuse or dependence developed by the Ministry of health and social protection (Centro Nacional de Investigación en Evidencia y tecnologías en salud Cinets, 2013); A rigorous methodological search was conducted to review CPG - according to evidence - based medicine - of alcohol dependency management that have a considerable clinical quality to be implemented in the ESE Cari Neurosciences of Barranquilla (Peñaloza Quintero et al., 2014). For the identification of evidence-based clinical practice guidelines (CPG) to be implemented, systematic searches were made of international databases of development organizations or compilers of clinical practice guidelines, and databases that collected scientific literature on subjects related to clinical practice. abuse or dependence on alcohol (see Table 1). To search for local guides, psychiatrists specialized in the management of this pathology in the city of Barranquilla (who had an employment relationship with the ESE Cari Mental Hospital and the academy) were asked to report on the existence of clinical practice guidelines based on the evidence of its use and knowledge. The following search structure was used in English: • ("Guidelines as Topic" [Mesh]) OR ("Practice Guidelines as Topic" [Mesh]) OR ("Guideline" [Publication Type]) OR ("Practice Guideline" [Publication Type]) OR (guideline [Title / Abstract]) AND (adapt \* [tw] OR tailor \* [tw]). On the other hand, the terms of most frequent use were adapted to the search in Spanish. The search was filtered to include only clinical practice guidelines. The criteria for inclusion of the CPG were the following:

- Evidence-based guidelines,
- Guides developed through a process by an expert group
- Guidelines that establish recommendations,
- Guidelines whose scope and purpose are related to alcoholism, withdrawal syndrome or acute alcohol intoxication.

22 CPGs met the above criteria. The results are presented in Table 1

Table 1. Results of the Preselection of clinical practice guidelines

No.	Title of the guide	Guide based in the evidence	Process from development and group expert	Establishes recommendations	Year of publication > 2000	Scopes and objectives related with the guide	Independence editorial
1	Problem Drinking Part 1: Screening and Assessment Part 2: Brief Intervention Part 3: Office Based Management of Alcohol Withdrawal and Prescribing Medications for Alcohol Dependence (Guidelines and Protocols Advisory Committee, 2013)	Yes	Yes	Yes	Yes	Yes	Yes
2	Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (National Institute for Health and Clinical Excellence, 2011a)	Yes	Yes	Yes	Yes	Yes	Yes
3	Drug and Alcohol Abuse amongst Anaesthetists Guidance on Identification and Management (The Association of Anaesthetists of Great Britain & Ireland, 2011)	Yes	Yes	Yes	Yes	Yes	Yes
4	EFNS guidelines for diagnosis, therapy and prevention of Wernicke encephalopathy (Galvin et al., 2010)	Yes	Yes	Yes	Yes	Yes	Yes
5	Alcohol Use Disorders: Diagnosis And Clinical Management Of Alcohol-Related Physical Complications-Clinical Guideline 100 (National Institute for Health and Clinical Excellence, 2011b).	Yes	Yes	Yes	Yes	Yes	Yes
6	Alcohol and Pregnancy A practical guide for health professionals (Ministry of Health of New Zealand, 2010).	Yes	Yes	Yes	Yes	Yes	Yes
7	Guidelines for the treatment of alcohol problems (Haber, Lintzeris, Proude, & Lopatko, 2009)	Yes	Yes	Yes	Yes	Yes	Yes
8	Australian guidelines to reduce health risks from drinking alcohol (National Health and Medical Research Council, 2009)	Yes	Yes	Yes	Yes	Yes	Yes
9	The Guide to Clinical Preventive Services Task Force - Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse (U.S. Preventive Services Task Force, 2013)	Yes	Yes	Yes	Yes	Yes	Yes
10	Alcohol consumption and the outcomes of pregnancy (Royal College of & Gynaecologists, 2009)	Yes	Yes	Yes	Yes	Yes	Yes
11	Detoxification and substance abuse treatment: physical detoxification services for withdrawal from specific substances (U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, n.d.)	Yes	Yes	Yes	Yes	Yes	Yes
12	Guidelines for the management of alcohol issues in the acute general hospital setting (Wood, 2008)	Si	Si	Si	Si	Si	Si
13	Tratamiento de las Complicaciones de la Dependencia al Alcohol (Caja Costarricense de Seguro Social, 2005)	Yes	Yes	Yes	Yes	Yes	Yes

14	Conductas adictivas y patología dual (Area de Gestión Clínica de Psiquiatría y Salud Mental - Hospital Universitario 12 de Octubre, 2016)	Yes	Yes	Yes	Yes	Yes	Yes
15	Diagnóstico e tratamiento de comorbidades psiquiátricas e dependencia de alcohol (Zaleski et al., 2006)	Yes	Yes	Yes	Yes	Yes	Yes
16	Management of Alcohol Withdrawal Delirium (Mayo-Smith, 2004)	Yes	Yes	Yes	Yes	Yes	Yes
17	Evidence-based guidelines for the pharmacological management of substance misuse, addiction and comorbidity: recommendations from the British Association for Psychopharmacology (Lingford-Hughes, Welch, & Nutt, 2004)	Yes	Yes	Yes	Yes	Yes	No
18	The management of harmful drinking and alcohol dependence in primary care. A national clinical guideline (SIGN 74, 2015)	Yes	Yes	Yes	Yes	Yes	Yes
19	Tratamiento Hospitalario del Síndrome de Deprivación Alcohólica (Monte-Secades, Rabuñal-Rey, & Guerrero-Sande, 2015)	Yes	Yes	Yes	Yes	Yes	Yes
20	Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care (National Health Committee, 2011)	Yes	Yes	Yes	Yes	Yes	Yes
21	Guía de práctica clínica para la detección temprana, diagnóstico y tratamiento de la fase aguda de intoxicación de pacientes con abuso o dependencia del alcohol (Centro Nacional de Investigación en Evidencia y tecnologías en salud Cinets, 2013)	Yes	Yes	Yes	Yes	Yes	Yes
22	Diagnóstico y Tratamiento De la intoxicación aguda por Alcohol etílico en el Adulto en el Segundo y Tercer Nivel de Atención (Cenetec, 2013).	Yes	Yes	Yes	Yes	Yes	Yes

### 3. Results

The final decision to adopt a Hospital Practice Guideline was based on the selection of a guide that had a similar object population to that of ESE Cari Mental and that was easily available: Clinical practice guide for the early detection, diagnosis and treatment of the acute phase of intoxication of patients with alcohol abuse or dependence. This Guide was designed in 2013 for what is new and considers the current legal regulations of the General System of Social Security in Health (SGSSS) (Ministerio de Salud y Protección Social, Fundación Santafe, Grupo de actualización de la Guía Metodológica para el desarrollo de Guías de Práctica Clínica, & Colombiano Evaluación Económica en el SGSSS, 2014)

The respondents that have management of the Colombian CPG explained in their majority:

- 1). Based on the Colombian context, unlike other CPG-depression, such as the Chilean, Spanish and Mexican, to name a few examples.
- 2). The Colombian CPG has 3 years of elaboration. Some guides, on the other hand, have up to 10 years since their last update, when it is not recommended that they be more than 5 years.
- 3). It is based on the MBE (medicine based on evidence).
- 4). It is written in Spanish, which if not, could have become a barrier to adopting the CPG

The group of experts considered the following barriers to the implementation of CPG - alcohol:

- Difficulties in accessing ESE Cari Mental. The ESE Mental Hospital is the only public hospital in the department. It is at Barranquilla, so the user population may find it difficult to travel to receive specialized care.
- Little availability of specialized professionals. In Colombia there are not enough professionals who have the appropriate training in the diagnosis, psychotherapy and psychopharmacotherapy proposed in CPG-alcohol, and those who are available are not equally distributed among the user population. This situation would prevent following the recommendations in this Guide.
- The limited time in the primary care consultation, which would hinder the application of some of the CPG - alcohol recommendations (AUDIT screening scales, brief motivational intervention).
- The lack of applicability of some recommendations, due to the clinical situation in which the patient is located, where there may not be availability of some medications (such as intravenous lorazepam), or recommended paraclinical studies (serum levels of vitamin B12 and folic acid), or the possibility of transfer to a more complex

level for specialized management (acute management by a psychiatrist, and in the long term, rehabilitation due to improper use of alcohol).

- The lack of flexibility in the clinical scenario by healthcare workers towards the incorporation of new practices (the application of the CIWA-AR scale, the administration of a vitamin scheme in patients in whom there is no indication).
- The educational level of the patients, which would be a barrier to adhere to the recommendations given by the health personnel. The available resources according to the General System of Social Security in Health and the Compulsory Health Plan, and the articulation of these with the recommendations proposed in the Alcohol CPG (Barrier of the CPG – alcohol) (Centro Nacional de Investigación en Evidencia y tecnologías en salud Cinets, 2013).

#### 4. Conclusion

In all countries of the world, the demand for health services always exceeds the amount of resources available, even in high-income countries (Organización Mundial de la salud, 2011; WHO, 2012). To make the Colombian General Health Security System viable, it is essential, above all, to ensure the collection and proper administration of the financial resources that support the investment and functioning of health care structures and processes (Díaz & Osorio, 2012; Peñaloza Quintero et al., 2014). But, although, the above is necessary, it is not enough; to reach the equilibrium point of the system implies not only that the contribution and flow of resources is enough, timely and adequate, but also that the expense and investment are reasonable, efficient and proportionate to the available resources.

Thus, CPGs are very useful instruments to assure quality of care and professional self-regulation of health personnel. To the extent that they reduce the undesirable variability in the management of specific clinical conditions and promote the use of care strategies and interventions with scientific evidence on their effectiveness and safety, they not only improve the quality of care and eventually the health outcomes, but must also contribute significantly, but to the reduction of health spending, to the significant improvement of the productive efficiency of the system (Navarro Jimenez, Fontalvo, Laborde, & et al., 2016).

It is essential to have a process of dissemination, dissemination, implementation, and permanent monitoring of the CPGs in clinical practice. This is a complex process that has only recently been the object of study, and does not have enough evidence in this regard. The process of implementing CPGs is continuous, which must be adapted according to the resources and need of the local context

That is why the adoption of CPG in the clinical - administrative context of ESE Cari neurosciences - including other territorial entities - is a decision that results in the rationalization of human and administrative resources, which unfortunately, will always be insufficient.

#### Competing Interests Statement

The authors declare that there are no competing or potential conflicts of interest.

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