High rates of concurrent alcohol and psychotropic drug use have been reported in Germany, Sweden, Spain, the US, and Canada. Alcohol may have additive interactions with psychotropic drugs, and concurrent use may result in excess sedation and cross-dependence. We have previously reported that middle-aged men who consume >14 drinks per week were more likely to use sedative/anxiolytic drugs. We also reported that men who consume 5 or more drinks in a single session were more likely to use sedative/anxiolytic drugs. Heavy drinking and psychotropic drug use may occur concomitantly as the result of similar genetic and environmental factors, or heavy drinking and psychotropic drug use may be causally related.

The possible causal relationship between alcohol consumption and psychotropic drug use has not been assessed in epidemiologic research. However, a causal pathway between alcohol consumption and subsequent major depression has been proposed. A prospective cohort study in Finland found that baseline binge drinking was associated with depressive symptoms 5 years later. Predictors of new-onset long-term use of sedative/anxiolytic drugs include depressive symptoms, hypertension, joint pain, poor self-perceived health, and multi-

**BACKGROUND:** Most studies on heavy drinking and sedative/anxiolytic drug use have been cross-sectional, and evidence for a possible temporal association is lacking.

**OBJECTIVE:** To prospectively investigate whether heavy drinking predicts initiation, continuation, or discontinuation of sedative/anxiolytic drugs at 4 and 11 years and, conversely, whether sedative/anxiolytic drug use predicts heavy drinking.

**METHOD:** This was a longitudinal population-based study conducted in Kuopio, Finland. An age-stratified random sample of 1516 men aged 42, 48, 54, and 60 years received a structured clinical examination at baseline (August 1986-December 1989). Follow-up clinical examinations were conducted at 4 (n = 1038) and 11 (n = 854) years. Multinomial logistic regression was used to compute odds ratios and 95% confidence intervals for the association between sedative/anxiolytic drug use and initiation, continuation, and discontinuation of heavy drinking (>14 drinks/wk). The reverse association between heavy drinking and sedative/anxiolytic drug use was also investigated. Regression models were adjusted for age, working status, smoking, and depressive symptoms.

**RESULTS:** At baseline 12.9% (134/1038) of participants were heavy drinkers and 4.0% (41/1000) used sedative/anxiolytic drugs. In multivariate analyses, baseline heavy drinking predicted initiation of sedative/anxiolytic drug use at 4 years (OR 2.96; 95% CI 1.23 to 7.15). Conversely, baseline sedative/anxiolytic drug use predicted continuation of heavy drinking at 11 years in unadjusted analyses (OR 3.30; 95% CI 1.19 to 8.44). However, the association was not statistically significant in adjusted analyses (OR 2.69; 95% CI 0.86 to 8.44).

**CONCLUSIONS:** The main finding of this study was the association between heavy drinking and subsequent initiation of sedative/anxiolytic drugs that was not fully explained by baseline depressive symptoms. This may inform strategies to optimize the use of sedative/anxiolytic drugs, and assist in the early identification of patients at risk of heavy drinking. Clinicians should consider a patient's alcohol consumption prior to prescribing or dispensing sedative/anxiolytic drugs. Clinicians should also monitor patients prescribed sedative/anxiolytic drugs for subsequent heavy drinking.

**KEY WORDS:** alcohol drinking, epidemiology, Finland, longitudinal studies, psychotropic drugs.
Patients with pain frequently use psychotropic drugs, and these patients may increase their consumption of alcohol as a form of self-medication.

To our knowledge, no longitudinal studies have investigated the possible causal association between heavy drinking and sedative/anxiolytic drug use. The objective of this study was to prospectively investigate whether heavy drinking predicts initiation, continuation, or discontinuation of sedative/anxiolytic drugs at 4 and 11 years and, conversely, whether sedative/anxiolytic drug use predicts heavy drinking.

Methods

STUDY SAMPLE

Data were obtained from the prospective KIHD (Kuopio Ischaemic Heart Disease Risk Factor) study, an ongoing population-based cohort study conducted in Eastern Finland that was designed to investigate risk factors for cardiovascular diseases. The FinDrink study is an ongoing project supported by the Academy of Finland that is conducted in conjunction with the KIHD study. The FinDrink study aims to explore the distribution, determinants, and dynamics of alcohol consumption in Finland. By using clinical data collected as part of the KIHD study, it aims to investigate novel associations between drinking behavior and health outcomes.

At baseline, an age-stratified random sample of 1935 men aged 42, 48, 54, and 60 years from Kuopio, Finland, was recruited. Of these men, 1516 (78%) participated in the baseline structured clinical examination between August 1986 and December 1989. The reasons for not participating in the baseline examination were refusal (n = 186), no contact information (n = 136), death (n = 41), migration (n = 30), and severe illness (n = 26). Follow-up examinations were conducted at 4 years (March 1991-December 1993) and 11 years (March 1998-February 2001). At the 4-year follow-up 1038 of an eligible 1229 men (84%) participated. At the 11-year follow-up 854 of an eligible 1030 and 832 participants when sedative/anxiolytic use was examined and 1030 and 832 participants when heavy drinking was examined, at 4 and 11 years, respectively. The study was approved by the ethics review board of the University of Kuopio (University of Eastern Finland since January 2010), and informed consent was obtained from the participants at the time of examination. All procedures were conducted in accordance with the World Medical Association Declaration of Helsinki.

ASSESSMENT OF ALCOHOL CONSUMPTION

Alcohol consumption was assessed using the same participant self-completed questionnaire at each time point. The questionnaire included a modified version of the Nordic Alcohol Consumption Inventory, which was included in the Scandinavian Drinking Survey. This 15-item inventory is based on the quantity-frequency method that is a widely used and validated tool for collecting data on alcohol consumption in survey research. Participants were asked to report the average number of glasses or bottles of alcoholic drinks they had consumed on one drinking occasion and how often they drank each type of beverage (beer, wine, and spirits) during the preceding year. Average weekly alcohol consumption was calculated for each participant. In Finland, 1 unit is equivalent to 12 g of ethanol.

Participants were categorized as non-heavy drinkers (alcohol consumption <14 drinks/wk) or heavy drinkers (≥14 drinks/wk). This categorization was consistent with our previous study and earlier North American research. At follow-up, participants were categorized as never heavy drinkers (non-heavy drinker at baseline and follow-up), initiating heavy drinkers (non-heavy drinker at baseline but heavy drinker at follow-up), continuing heavy drinkers (heavy drinker at baseline and follow-up), and former heavy drinkers (heavy drinker at baseline but not at follow-up).

ASSESSMENT OF SEDATIVE/ANXIOLYTIC DRUG USE

Drug utilization was assessed using the same items within the participant self-completed questionnaire at each time point. Participants were asked to list prescription, nonprescription, and complementary and alternative medicines they were taking on a regular basis. After completing the questionnaire, participants attended a structured clinical examination to which they were asked to bring their drug packages, containers, and prescription forms. This provided the opportunity for the interviewer to address any apparent discrepancies in each participant’s self-reported list of regularly used drugs.
Drugs were categorized using the Anatomical Therapeutic Chemical (ATC) classification system recommended by the World Health Organization. The ATC classification is a hierarchical categorization of drugs based on the organ or system on which a drug acts, and also its therapeutic, pharmacologic, and chemical properties. For the purpose of the analyses, sedatives and anxiolytics included anxiolytic drugs in class N05B (primarily benzodiazepine derivatives used as anxiolytics; eg, diazepam, alprazolam, oxazepam) and hypnotic and sedative drugs in class N05C (primarily benzodiazepine derivatives used as sedatives; eg, temazepam, midazolam; and benzodiazepine-related drugs; eg, zolpidem). A participant was classified as a sedative/anxiolytic drug user if he reported using 1 or more drugs from classes N05B and N05C.

At follow-up, participants were categorized as never-users of sedative/anxiolytic drugs (nonuser at baseline and follow-up), initiating users of sedative/anxiolytic drugs (nonuser at baseline but user at follow-up), continuing users of anxiolytic/sedative drugs (user at baseline and follow-up), and former users of sedative/anxiolytic drugs (user at baseline but not at follow-up).

COVARIATES

Detailed descriptions of the structured clinical examination protocol and the measurement of covariates have been reported. Briefly, depressive symptoms were assessed with the 18-item Human Population Laboratory Depression Scale. Participants were defined as having depressive symptoms (yes/no) if their score was 3 or higher. Having a history of cardiovascular disease was defined as a self-reported history of myocardial infarction, angina pectoris, other coronary conditions, or stroke (yes/no). Self-reported history of cardiovascular disease was verified at the baseline structured clinical examination. A participant was defined as a current smoker if he reported smoking regularly or irregularly at the time of examination (yes/no). Working status was defined according to either full- or part-time work (yes/no). Age at the time of baseline examination was included as a continuous variable (years).

STATISTICAL ANALYSES

Baseline characteristics of the participants were expressed as means and proportions. Multinomial logistic regression models were used to investigate the bidirectional unadjusted and adjusted associations between heavy drinking and use of sedative/anxiolytic drugs at the 4- and 11-year follow-up. All drug use and alcohol consumption data were paired, so only participants with complete data for both parameters were included in the analyses. Never-use was treated as the reference group. Models were adjusted for age, working status, smoking status, and depressive symptoms. These adjustment variables were selected on the basis of bivariate associations between the exposure and outcome. The results of the multinomial logistic regression models were expressed as odds ratios with 95% confidence intervals. All statistical analyses were performed using SPSS version 17.0 (SPSS, Inc., Chicago, IL).

Results

CHARACTERISTICS OF THE STUDY POPULATION

Among the study participants, 12.9% were heavy drinkers at baseline. There was a greater percentage of sedative/anxiolytic drug users among the heavy drinkers than among the nonheavy drinkers at baseline (Table 1). In contrast, 4% of the participants used a sedative/anxiolytic drug at baseline. There was a higher percentage of heavy drinkers among the sedative/anxiolytic drug users than among the nonusers at baseline.

Twenty-six (2.5%) participants initiated sedative/anxiolytic drugs between baseline and the 4-year follow-up, and 42 (4.9%) participants initiated sedative/anxiolytic drugs between baseline and the 11-year follow-up (Table 2). Similarly, 54 (5.2%) of the participants initiated heavy drinking between baseline and the 4-year follow-up, and 67 (8.1%) of the participants initiated heavy drinking between baseline and the 11-year follow-up.

BASELINE HEAVY DRINKING AND SEDATIVE/ANXIOLYTIC DRUG USE AT 4 AND 11 YEARS

Baseline heavy drinking was associated with initiation of sedative/anxiolytic drug use at the 4-year follow-up in the adjusted analysis (OR 2.96; 95% CI 1.23 to 7.15) (Table 3). Baseline heavy drinking was not associated with continuation or discontinuation of sedative/anxiolytic drug use at the 4-year follow-up. Similarly, baseline heavy drinking was not associated with sedative/anxiolytic drug use at the 11-year follow-up.

BASELINE SEDATIVE/ANXIOLYTIC DRUG USE AND HEAVY DRINKING AT 4 AND 11 YEARS

Baseline sedative/anxiolytic drug use was not associated with heavy drinking at 4 years (Table 4). However, there was a significant association between baseline sedative/anxiolytic drug use and continuous heavy drinking at 11 years in the unadjusted analysis (OR 3.30; 95% CI 1.19 to 9.17). The association was no longer statistically significant when the regression model was adjusted for age, working status, smoking status, and depressive symptoms (OR 2.69; 95% CI 0.86 to 8.44). The results were nonsignificant for discontinuation and initiation of heavy drinking.
Discussion

MAIN FINDINGS

The main finding of this prospective longitudinal study was that baseline heavy drinking predicted initiation of sedative/anxiolytic drug use at the 4-year follow-up, but not at the 11-year follow-up. There are a number of possible explanations why alcohol consumption may precede the initiation of sedative/anxiolytic drugs. First, baseline alcohol use may be due to initial self-medication with alcohol of diagnosed or undiagnosed anxiety or depressive disorders. Data from the cross-sectional National Epidemiologic Survey on Alcohol and Related Conditions in the US revealed frequent use of alcohol for self-medication of mood and anxiety disorders. One quarter of respondents with mood disorders used alcohol or drugs to relieve their symptoms, with men more than twice as likely to engage in self-medication as women. However, the cross-sectional nature of the survey prevented making assessments concerning causality.

Second, sedative/anxiolytic drug use at follow-up may be associated with depressive symptoms. Our analyses were adjusted for baseline depressive symptoms; however, alcohol use may precede the diagnosis of major depression. It has been suggested that alcohol consumption may trigger genetic markers that increase the risk of major depression. Depressive symptoms were associated with benzodiazepine use in the cross-sectional European Study of the Epidemiology of Mental Disorders. Sleep disturbances are symptoms of both depression and alcohol use disorder.

Third, alcohol dependence has been associated with insomnia after 10 years. Baseline heavy drinking could have prompted the prescription of sedative/anxiolytic drugs for insomnia at the 4-year follow-up. It is possible that use of sedative/anxiolytic drugs reflected, at least in part, the prescription of these drugs for alcohol withdrawal. Sedative/anxiolytic drugs are widely prescribed to treat alcohol withdrawal symptoms. However, evidence in relation to the safety and effectiveness of sedative/anxiolytic drugs for this purpose is mixed.

While the association between alcohol consumption and the initiation of sedative/anxiolytic drugs was significant at 4 years, there was no corresponding association at 11 years. This may be due to change in drinking patterns over time. While there was an overall increase in alcohol consumption among younger participants (aged 42 years at baseline) in our cohort, most previous studies have indicated that total alcohol consumption declines in older age. This is in contrast to the use of sedative and anxiolytic drugs that typically increases with age. Furthermore, heavy drinkers at baseline may have reduced their alcohol consumption in response to the emergence of chronic illnesses in mid-to-later life. We have previously reported that 11% of men aged 65 years and 26% of men aged 53 years in Kuopio, Finland, were heavy drinkers in 1998 to 2001. Halme et al. reported that 19% of all Finnish men aged 65–69 years consume 15 units or more of alcohol per week.

Long-term sedative/anxiolytic drug use has been associated with an increased risk of depression. In turn, depres-

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Baseline Heavy Drinkinga</th>
<th>Baseline Sedative/Anxiolytic Drug Useb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No (n = 904)</td>
<td>Yes (n = 134)</td>
</tr>
<tr>
<td>Sedative/anxiolytic use, n (%)</td>
<td>34 (3.8)</td>
<td>7 (5.2)</td>
</tr>
<tr>
<td>Heavy drinking, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (y), n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>192 (21.2)</td>
<td>44 (32.8)</td>
</tr>
<tr>
<td>48</td>
<td>218 (24.1)</td>
<td>29 (21.6)</td>
</tr>
<tr>
<td>54</td>
<td>255 (28.2)</td>
<td>29 (21.6)</td>
</tr>
<tr>
<td>60</td>
<td>239 (26.4)</td>
<td>32 (23.9)</td>
</tr>
<tr>
<td>Married, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>801 (88.6)</td>
<td>81 (85.1)</td>
<td></td>
</tr>
<tr>
<td>Working full or part-time, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>620 (68.6)</td>
<td>64 (62.7)</td>
<td></td>
</tr>
<tr>
<td>Current smoker, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>285 (31.5)</td>
<td>73 (54.5)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Depression (HPL &gt;3), n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>135 (14.9)</td>
<td>30 (22.4)</td>
<td></td>
</tr>
<tr>
<td>CVD, n (%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>214 (23.7)</td>
<td>34 (25.4)</td>
<td>0.667</td>
</tr>
</tbody>
</table>

CVD = cardiovascular disease; HPL = Human Population Laboratory depression scale.

*Average alcohol consumption ≥14 drinks/week.

*Classes N05B and N05C of the Anatomical Therapeutic Chemical classification system.

*Calculated using Pearson's $\chi^2$ test.
sion has been linked to increased alcohol consumption. Consistent with these findings, the unadjusted odds ratio for continuous heavy drinking among baseline sedative/anxiolytic drug users was 3.30 (95% CI 1.19 to 9.17) at 11 years. After the model was adjusted for covariates this association was no longer statistically significant. One possible reason why the results did not reach statistical significance may have been the relatively small number of sedative/anxiolytic drug users at baseline (n = 41).

An important strength of this study was that the data were obtained from a well-characterized cohort. This provided the opportunity to adjust our analyses for a variety of demographic and diagnostic parameters. Drug use data were self-reported by the participants, and then verified by a nurse interviewer. This method of drug exposure assessment had several advantages over the use of administrative pharmacy data. Our method of drug exposure assessment captured only those drugs actually taken by the participants. It also covered drugs not reimbursed and therefore not included in administrative pharmacy data (eg, small pack sizes of benzodiazepines). However, a limitation was that self-reported drug use data may be prone to recall errors. Alcohol consumption was assessed by a widely used and previously validated quantity-frequency method. While this represents a methodological strength, self-reported alcohol consumption data are subject to recall errors. This may be particularly true because

### Table 2. Sedative/Anxiolytic Use and Heavy Drinking Status at the Follow-Up Examinations

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>4-Year Follow-Up</th>
<th>11-Year Follow-Up</th>
<th>Lost to Follow-Up from 4 Years to 11 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedative/anxiolytic use, n (%)</td>
<td>n = 1038</td>
<td>n = 854</td>
<td>167 (17.2)</td>
</tr>
<tr>
<td>never user</td>
<td>971 (93.5)</td>
<td>780 (91.3)</td>
<td>8 (30.8)</td>
</tr>
<tr>
<td>initiator</td>
<td>26 (2.5)</td>
<td>42 (4.9)</td>
<td>15 (19.2)</td>
</tr>
<tr>
<td>continuous user</td>
<td>26 (2.5)</td>
<td>15 (1.8)</td>
<td>17 (26.7)</td>
</tr>
<tr>
<td>former user</td>
<td>15 (1.4)</td>
<td>17 (2.0)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>Heavy drinking, n (%)</td>
<td>n = 1030</td>
<td>n = 832</td>
<td>143 (17.0)</td>
</tr>
<tr>
<td>never user</td>
<td>843 (81.8)</td>
<td>661 (79.4)</td>
<td>7 (13.0)</td>
</tr>
<tr>
<td>initiator</td>
<td>54 (5.2)</td>
<td>67 (8.1)</td>
<td>17 (22.1)</td>
</tr>
<tr>
<td>continuous user</td>
<td>77 (7.5)</td>
<td>54 (6.5)</td>
<td>17 (22.1)</td>
</tr>
<tr>
<td>former user</td>
<td>56 (5.4)</td>
<td>47 (5.6)</td>
<td>15 (26.6)</td>
</tr>
</tbody>
</table>

*At the 4-year follow-up, drug consumption data were available for all 1038 participants and alcohol consumption data were available for 1030 participants.

*At the 11-year follow-up, drug consumption data were available for all 854 participants and alcohol consumption data were available for 832 participants.

*Classes N05B and N05C of the Anatomical Therapeutical Chemical classification system.

*Seven initiators at 11 years had already initiated at 4 years and 9 former users at 11 years had already quit at 4 years.

*Average alcohol consumption $\leq 14$ drinks/wk.

*Twenty initiators at 11 years had already initiated at 4 years and 30 former users at 11 years had already quit at 4 years.

### Table 3. Association Between Baseline Heavy Drinking and Sedative/Anxiolytic Use Status at 4-Year and 11-Year Follow-Up

<table>
<thead>
<tr>
<th>Anxiolytic/Sedative Use Status</th>
<th>Baseline Heavy Drinking, n (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-year follow-up</td>
<td>Unadjusted 3.83 (1.67 to 8.78)</td>
<td>Adjusted 2.96 (1.23 to 7.15)</td>
</tr>
<tr>
<td>initiator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>continuous user</td>
<td>Unadjusted 1.72 (0.64 to 4.65)</td>
<td>Adjusted 1.25 (0.44 to 3.64)</td>
</tr>
<tr>
<td>former user</td>
<td>Unadjusted 1.11 (0.25 to 4.99)</td>
<td>Adjusted 0.76 (0.16 to 3.60)</td>
</tr>
<tr>
<td>11-year follow-up</td>
<td>Unadjusted 1.29 (0.53 to 3.16)</td>
<td>Adjusted 1.05 (0.42 to 2.65)</td>
</tr>
<tr>
<td>initiator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>continuous user</td>
<td>Unadjusted 1.94 (0.55 to 7.01)</td>
<td>Adjusted 1.30 (0.34 to 4.96)</td>
</tr>
<tr>
<td>former user</td>
<td>Unadjusted 1.66 (0.47 to 5.90)</td>
<td>Adjusted 1.12 (0.29 to 4.25)</td>
</tr>
</tbody>
</table>

*Classes N05B and N05C of the Anatomical Therapeutical Chemical classification system.

*Average alcohol consumption $\leq 14$ drinks/wk.

*Adjusted for age, smoking, working status, and depression.
of the long recall period of 12 months. Another limitation was that there were a number of dropouts between baseline and the 4- and 11-year examinations. When assessing sedative/anxiolytic drug use at 11 years, 30.8% of the participants who initiated sedative/anxiolytic drug use at 4 years did not attend the 11-year examination. Similarly, 26.7% of the men who were former sedative/anxiolytic drug users at 4 years did not participate in the 11-year examination. When assessing heavy drinking at 11 years, 22.1% of those who were continuous heavy drinkers at 4 years did not participate in the 11-year examination. This suggests that the number of participants in these categories may have been underestimated at the 11-year follow-up.

Our results can be generalized to countries with similar drinking patterns to Finland, including other Nordic countries, the UK, and Germany. Daily drinking in these countries is low in general (except in Germany), but the amount of alcohol consumed in each drinking occasion is high. In Italy and France, daily drinking is common but the amount consumed at each occasion is lower than in Finland, the UK, Sweden, and Germany.

This study showed that baseline heavy drinking predicted initiation of sedative/anxiolytic drugs at the 4-year follow-up. This finding may inform strategies to optimize the use of sedative/anxiolytic drugs and assist in the early identification of patients at risk of heavy drinking. Clinicians should consider a patient’s alcohol consumption before prescribing sedative/anxiolytic drugs and monitor patients prescribed sedative/anxiolytic drugs for subsequent heavy drinking. Further studies with larger sample sizes are needed to confirm the association between baseline sedative/anxiolytic drug use and initiation of heavy drinking.

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Reprints/Online Access: www.theannals.com/cgi/reprint/aph.1Q375

Conflict of Interest: Authors reported none

Dr. Ilomäki received a research grant from the Finnish Cultural Foundation. The research described in this manuscript was funded by the Academy of Finland (grant number 116551).

We gratefully acknowledge Kimmo Ronkainen MSc, University of Eastern Finland, for assistance with data management.

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9.DOI 10.1097/JGP.0b013e318117f0a


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Consumo Elevado de Alcohol y uso de Fármacos Ansiolíticos o Sedantes en Hombres de Edad Avanzada: Seguimiento de 11 Años de Duración del Estudio FinDrink Study

J Ilomäki, JS Bell, J Kauhanen, y H Enlund

EXTRACCIÓN

ANTECEDENTES: La mayoría de los estudios sobre el consumo elevado de alcohol y el uso de fármacos ansiolíticos o sedantes han sido transversales, y faltan datos que manifiesten una posible relación temporal.

OBJETIVO: Investigar de forma prospectiva si el consumo elevado de alcohol augura el inicio, prosecución o interrupción del uso de fármacos ansiolíticos o sedantes a los 4 y 11 años y, al contrario, si el uso de ansiolíticos o sedantes pronostica el consumo excesivo de alcohol.

MÉTODOS: Se realizó un estudio poblacional longitudinal en Kuopio, Finlandia. Se utilizó una muestra aleatoria de 1516 hombres con 42, 48, 54, y 60 años que fueron sometidos a un examen clínico estructurado al inicio (desde agosto 1986 a diciembre 1989). Los exámenes clínicos de seguimiento se realizaron a los cuatro (n = 1038) y 11 años (n = 854). Se utilizó una regresión logística multinominal para calcular los odds ratios (ORs) y los intervalos de confianza al 95% (IC) para determinar la relación entre el uso de fármacos ansiolíticos o sedantes, la continuación o interrupción del consumo elevado de alcohol (≥14 bebidas/semana). También se investigó la relación inversa. Los modelos de regresión se ajustaron por edad, estado laboral, ser o no fumador y la presencia o no de síntomas depressivos.

RESULTADOS: Al inicio, el 12.9% (n = 134) de los participantes presentaba un consumo elevado de alcohol y el 4.0% (n = 41) utilizaba fármacos ansiolíticos o sedantes. En el análisis multivariable, el consumo elevado de alcohol a los 11 años en un análisis sin ajustar (OR 3.30; IC 95% 1.19 y 3.75) y ajustado poredad, estado laboral, ser0 no fumador y la presencia0 no de síntomas depresivos. Se deben crear estrategias para optimizar el uso de fármacos ansiolíticos o sedantes y procurar identificar lo antes posible a pacientes con riesgo de consumo elevado de alcohol. Los médicos deberán considerar el consumo de alcohol de los pacientes antes de prescribirlas o dispensarle fármacos ansiolíticos o sedantes y controlar el consumo de alcohol de los pacientes a los que les ha prescrito fármacos ansiolíticos o sedantes.

Traducido por Violeta Lopez Sanchez
Consommation Abusive d’Alcool et Utilisation de Médicaments Sédatifs ou Hypnotiques chez l’Homme: Suivi Après 11 ans de l’Essai FinDrink
J Ilomäki, JS Bell, J Kauhanen, et H Enlund


RÉSUMÉ
INTRODUCTION: La plupart des essais sur la consommation excessive d’alcool et l’abus de médicaments à propriétés sédatives/hypnotiques ont été des études transversales et les preuves d’un lien temporel ne sont pas disponibles.

OBJECTIFS: Réaliser une étude prospective pour déterminer si la consommation excessive d’alcool peut prédire l’initiation, la poursuite ou l’arrêt de médicaments sédatifs/hypnotiques après 4 ou 11 ans, ou à l’inverse, si l’utilisation de médicaments sédatifs/hypnotiques peut prédire la consommation excessive d’alcool.


RÉSULTATS: Au début de l’étude, 12.9% (n = 134) des participants étaient de gros buveurs et 4.0% consommaient des sédatifs/hypnotiques. Les analyses multivariées ont démontré que la consommation initiale d’alcool prédit l’initiation de sédatifs/hypnotiques après 4 ans (RC 2.96; IC 95% 1.23 à 7.15). De plus, la consommation initiale de sédatifs/hypnotiques prédit la poursuite des habitudes de consommation d’alcool à 11 ans dans une analyse sans ajustement (RC 3.30; IC 95% 1.19 à 8.44). Cependant, l’association n’était pas statistiquement significative lors des analyses ajustées (RC 2.69; IC 95% 0.86 à 8.44).

CONCLUSIONS: Le résultat principal de cette étude longitudinale prospective est une association entre la consommation excessive d’alcool et l’initiation subséquente de sédatifs/hypnotiques, mais qui n’est pas complètement expliquée par la présence de symptômes dépressifs à l’origine. Cette information permettra de développer des stratégies d’utilisation des sédatifs/hypnotiques, et de faciliter le dépistage précoce des patients à risque d’abuser de l’alcool. Les cliniciens devraient considérer la consommation d’alcool de leurs patients avant de prescrire ou de fournir des sédatifs ou des hypnotiques. Les cliniciens devraient donc être vigilants face à l’éventualité d’une consommation d’alcool accrue chez les utilisateurs de sédatifs/hypnotiques prescrits.

Traduit par Marc Parent