Kliiniline küsimus nr 19

Kas kõigil alkoholi kuritarvitavatel ja alkoholsõltuvusega patsientidel tuleb ravitulemuse jälgimiseks lisaks anamneesile kasutada enesehinnangulisi teste vs laboratoorseid analüüse vs muid hindamisvahendeid vs mitte kasutada?

Kriitilised tulemusnäitajad:
uuringumeetodi tundlikkus ja spetsiifilisus, positiivne ja negatiivne ennustatav väärtus

Ravijuhendid

Kokkuvõte tõendusmaterjali kvaliteedist

Ravitulemuse jälgimise vahend peaks olema: universaalne ning ei tohiks olla piiratud konkreetse aine või sotsiaalse grupi poolt; tema valiidsus ja usaldusväärsus peaksid olema tõestatud ning peaks olema ilmunud tõendusmaterjali tema psühhomeetriliste omaduste kohta; ta peaks olema tundlik muutustele; ta peaks olema kergesti loetav ja neutraalse keelekasutusega; peaks olema kas tervishoiutöötaja poolt täidetav, ise täidetav või mõlemat; peaks sobima kasutamiseks kliinilisse keskkonda **(Raistrick et al. 2006)**. Mitmeid hindamisvahendeid on spetsiaalselt välja töötatud ravitulemuse jälgimiseks, millest kõige enam kasutatavad on: Addiction Severity Index (ASI), AUDIT, the Maudsley Addiction Profile (MAP), the Christo Inventory for Substance Misuse Services (CISS), the Comprehensive Drinker Profile (CDP), the Routine Evaluation of the Substance-Use Ladder of Treatments (RESULT) and the Treatment Outcomes Profile (TOP) **(NICE 2011)**. **NICE (2011)** hindas eelpool mainitud ravitulemuse hindamisvahendite kliinilist kasulikkus ja praktilisust, võttes arvesse hindamisvahendi valiidsust ja usaldusväärsust alkoholisõltuvusega patsientide populatsioonis ning kasutatavust (kui arusaadav ta on ning millist lisakoolitust läbiviimiseks vajab) vt LISA 1. **NICE (2011)** identifitseeris AUDIT-i kui kõige usaldusväärsema ja teostatavama ravitulemuse jälgimise vahendi, mida kasutada rutiinsel hindamisel. Eriliselt rõhutati AUDIT-C kasulikkust. AUDIT-C on 3 küsimust sisaldav AUDIT-i vesioon, mis mõõdab ainult alkoholi tarvitamist (tarbimise sagedust, tavaliselt tarbitud kogust ning tugeva alkoholi tarbimise epidoodide sagedust). Uuring, mille läbiviijateks olid **Bush et al. (1998)** näitas, et täis AUDIT on täpsem kui AUDIT-C aktiivse alkoholi liigtarvitamise või sõltuvuse identifitseerimisel (AUC 0.811 vs 0.786; P<0.001), küsimustikud olid sarnase efektiivsusega tugeva alkoholitarbimise ja/või aktiivse liigtarvitamise või sõltuvuse tuvastamisel (AUC 0.880 vs 0.881). AUDIT-C oli antud uuringus efektiivsem kui täis AUDIT tugeva alkoholitarmbimise identifitseerimisel (AUC 0.891 vs 0.881; P = 0.03). Uuringu tulemused näitasid ka, et kui kasutada läbilõikepunktina 3 võimalikust 12 punktist siis suudab AUDIT-C tuvastada 90% aktiivseid alkoholi liigtarvitajaid/sõltuvust ning 98% tugevaid alkoholitarbijaid. Uuringute **Dawson et al. (2005b)** ja **Gual et al. (2002)** tulemused näitasid, et optimaalseks läbilõikepunktiks alkoholi tarvitamise häire tuvastamiseks AUDIT testil on ≥ 5 meeste jaoks ja ≥ 4, et tagada optimaailseim tundlikkus ja spetsiifilisus. **Frank et al. (2008)** näitas et AUDIT-C on võrdväärse efektiivsusega erinevates etnilistes gruppides. Mainimist märgib, et kui AUDIT-C kasutada kui skriinimise vahendit, siis tal on kõrge valepositiivsete tulemuste määr **(Nordqvist et al. 2004)**. APQ on leidnud Ühendkuningriigis laialdast kasutust alkoholiga seotud kaasuvate probleemide hindamisel **(Drummond 1990; Drummond et al. 2009; UKATT Research Team 2005).**

APA (2006) kasutatud madala kvaliteediga tõendusmaterjal (kirjanduse ülevaated, õpikud) viitab, et hingeõhu, vere, sülje ja uriini testimine erinevate ainete kasutamise hindamiseks on abiks tagasilanguse varajasel avastamisel. **APA (2006)** rõhutab, et testimise viisi valikul tuleks lähtuda millise aine liigtarvitamist kahtlustatakse. Hingeõhu testimise positiivseks küljeks on asjaolu, et sest see ei ole invasiivne protseduur ning annab kohese tulemuse. Uriini testimine annab informatsiooni eelmise 5 päevase perioodi kohta, kui kahtlustatakse selliste ainete tarvitamist nagu kokaiin, opiaadid, kanep, amfetamiin, bensodiasepiinid ja PCP. Alkoholi saab määrata uriinist kuni 24h jooksul pärast tarvitamist, alkoholi metaboliiti etüül glükuroniiti (EtG) 2-3 päeva pärast alkoholi seedimist. Teatud biomarkerid nagu CDT, MCV ja GGT suudavad tuvastada äsjast alkoholi tarvitamist.

SIGN (2003) soovitab kasutda biomarkereid alkoholi tarvitamise monitoorimisel, viidates ühele hea kvaliteediga (käsitletud eelnevalt K2) süstemaatilisele ülevaatele, mis hindab GGT, MCV, ASAT ja ALAT tundlikkust ja spetsiifilisust **(Salaspuro et al. 1999)** ja ühele keskmise

kvaliteediga süstemaatilisele ülevaatele mis võrdleb omavahel CDT, GGT ja IEF **(Scouller 2000)** (vt. LISA 2).

SOOME (2010) soovitus põhineb samuti eespoolmainitud süstemaatilisel ülevaatel, mis hindab GGT, MCV, ASAT ja ALAT tundlikkust ja spetsiifilisust **(Salaspuro et al. 1999).** Samuti viidatakse mitmele madala kvaliteediga uuringule, mis on vaadelnud muutusi biomarkerites alkoholiravi jooksul. **Helander et al. (1996)** poolt läbi viidud väikese valimiga (n=10) longituudne uuring näitas GTT ja CDT keskmiste tasemete langust, uuringu esimesel kuul, kui uuritavad ei tarbinud alkoholi ning keskmiste tasemete tõusu tagasilanguse tekkimisel järgeval uuringu perioodil. Kaks väikese valimiga uuringut, vaatles erinevusi CDT ja GGT tasemetes alkoholravil olevate inimeste seas. Täheldati olulist erinevust CDT tasemetes abstinentsi hoidvate ja uuesti alkoholi tarbima hakanud uuritavate seas. GGT tasemetes ei olnud gruppidevahelist olulist erinevust **(Anton et al. 1996, Mitchell et al. 1997).** 101 meesoost uuritava seas läbi viidud uuring, kestvusega 6 kuud, näitas et CDT PPT (*positive predictive value*) tagasilanguse tuvastamisel oli 76,2% ja GGT PPV oli 32,9% **(Scmidt et al. 1997).** Üks juhtkontroll uuring (n=444 uuritavat ja n=204 kontrolli) hindas CDT ja GGT täpsust tugeva alkoholi tarbimise tuvastamisel ja kasutamise monitoorimisel. Mõlemad markerid näitasid langust 4 nädalat pärast alkoholi tarbimise lõpetamist. CDT 30% tõus abstinetsi perioodi baastasemest, suutis tagasilangust meeste seas paremini tuvastada kui tõus GGT-s. Tagasilangust, eriti meeste seas suutis kõige paremini tuvastada mõlema markeri, 30% tõus abstinentsi perioodi baastasemest, kasutamine **(Anton et al. 2002)**.

Läbivaadatud ravijuhendid soovitavad ravitulemuse jälgimiseks kasutada samu teste, mida diagnoosi täpsustamiseks. Seetõttu on uuesti lisatud kokkuvõttetabel erinevate enesehinnaguliste testide ja biomarkerite tundlikkust spetsiifilisust hinavatest uuringutest, mida on esmaselt käsitletud K2 (vt. LISA 2). Kuna läbivaadatud ravijuhendites viidati artiklitele, mis on madala kvaliteediga ning mille läbi viimisest on möödas pikk ajaperiood, teostas sekretariaadi liige lisaotsingu. Lisaotsing teostati Pubmed-is detsembrikuus 2014. Otsingukriteeriumid on lisatud viidete sektsioonis. Otsingi tulemusena leiti 220 artiklit, millest 1 sobis antud teemaga: **Kummer et al. (2013)**, viisid läbi pospektiivse uuringu, mille eesmärgiks oli valideerida EtG (*ethyl glucuronide*) ja EtS (*ethyl sulphate*) uriinist mõõtmine, kui alkoholi tarbimise indikaator. Uuringu valim koosnes 27 vabatahtlikkust, kes raporteerisid enda alkoholi tarbimist 5 eelneva päeva jooksul enne analüüsi teostamist. Positiivset tulemust defineeriti läbilõikepunktiga 0,1µg/mL. Kõigi 14 uuritava, kes ei tarbinud 5 eelneva päeva jooksul alkoholi, EtG ja EtS olid negatiivsed. 13 alkoholi tarbinud inimesest olid 10-l mõlemad näitajad positiivsed. Uurijad hüpotiseerisid, et valenegatiivseid tulemusi võis põhjustada tarvitatud alkoholi väikene kogus, mida on näidanud ka eelnevad uuringud. Kasutades läbilõikepunktina 0,1µg/mL, suudavad EtG ja Etg tuvastada alkoholi tarbimist 24h jooksul pärast tarbimist, andmata valepositiivseid tulemusi.

Kokkuvõte ravijuhendites leiduvatest soovitustest

Antud küsimusele vastamiseks vaadati läbi 1 alkoholi liigtarvitamise preventsiooni juhend (USPSTF 2013) ja 10 ravijuhendit (BAP 2012, NICE 2011, SOOME 2010, NICE 2010a, AUSTRALIA 2009, SAMHSA 2009, WFSBP 2008, NSW 2008, APA 2006, SIGN 2003). Nendest 6 sisaldasid informatsiooni käesoleva küsimuse kohta (NICE 2011, Soome 2010, SAMHSA 2009, NSW 2008, APA 2006, SIGN 2003,). 4 ravijuhendis (BAP 2012, NICE 2010a, Australia 2009, WFSBP 2008) ja alkoholi liigtarvitamise preventsiooni juhendis (USPSTF 2013) käesoleva küsimuse kohta informatsiooni ei sisaldunud. Eelpool mainitud ravijuhenditest vaadati läbi teemaga seotud tõenduspõhised uuringud, millest kokkuvõtted on esitatud viidetes tabeli vormis.

NICE (2011) ütleb, et alkoholi tarbimise hindamine (nagu alkoholi tarbimise intensiivsus ja sagedus) on ravitulemuse jälgimise põhikomponendid. Nädalased joomise päevikud on kliinilises praktikas laialdaselt levinud, kuid nende valiidsust ja usaldusväärsust on teadmata. AUDIT küsimustik identifitseeriti kui kõige usaldusväärseim ja kasutatavaim ravitulemuse regulaarse monitoorimise vahend. APQ on kasulik alkoholi kasutamisega seotud probleemide hindamisel kui hinnatakse ravitulemust.

SIGN (2003) ütleb, et bioloogilised markerid on kasulikud alkoholi tarbimise muutuse monitoorimises. **SIGN (2003)** annab eksperthinnanguil põhineva soovituse, et bioloogilised markereid tuleks kasutada monitoorimaks patsientide progressi alkoholi tarbimise vähendamisel.

SOOME (2010) annab tugeva soovituse (A – tugev tõendusmaterjal), et laboratoorsed testid nagu (CDT ja GT) on olulised monitoorimaks ravitulemusi alkoholisõltuvusega patsientidel, vähemalt meestel (tõendusmaterjal põhineb uuringutel kus valimites vähe naissoost uuritavaid).

NSW (2008) ütleb, et psühhosotsiaalse raviprogrammi oluline osa on regulaarne raviprotsessi hindamine, vastavalt kliendi poolt seatud eesmärkidele. Mõnesid hindamise osasid saab läbi viia mitteformaalselt iga ravisessiooni käigus (nt võõrutussümptomite hindamine, ravistrateegiate rakendamiste arutelud, ravimite kõrvaltoimed). Samas peaks hindamine sisaldama ka formaalseid tulemusnäitajaid nagu probleemset alkoholi kasutamist, psühiaatrilist sümptomaatikat, bioloogilisi mõõtmisi (veri, uriin jne). Formaalne, objektiivne hindamine on siinkohal üliloluline, et mitte ülehinnata ravitulemust (antud soovituse formuleerimisel viidatakse järgnevatele allikatele: APA 2006; TPP 2000).

APA (2006) annab tugeva soovituse, et monitoorimise sagedust tuleks intensiivistada perioodidel kui patsiendil on kõrge risk tagasilanguseks: ravi varajane staadium, üleminek vähem intensiivsele ravile, aasta aega pärast aktiivse ravi lõppu.

SAMHSA (2009) ütleb, et tervishoiuteenuse pakkujad saavad joomiskäitumise hindamise monitoorimiseks kasutada järgmisi strateegiaid:

- Patsiendi enda raporteeritud joomiskäitumise kirjeldus on ravi edukuse tähtis indikaator. Tervishoiuteenuse pakkuja peaks arutama patsiendiga joomise kogust ja sagedust eriti stressirohketel perioodidel (nt nagu pühad, pidustused, suuremad elumuutused).

- Laboratoorsed testid, mis hõlmavad AST, GGT, CDT, EtG ja uriinist narkootiliste ainete tuvastamist. Sellele lisaks võivad tervishoiuteenuse pakkujad perioodiliselt kasutada hingeõhust mõõtvaid teste (kuigi need tuvastavad vaid hiljutist kasutamist), et monitoorida alkoholi tarvitamist ning anda abstinetsi säilitavatele patsientidele positiivset tagasisidet.

SAMHSA (2009) ütleb, et patsiendi progressi tuleks monitoorida ka alljärgnevates valdkondades:

Tervis:

- eelnevalt kõrgenenud vererõhu normaliseerumine

- maksafunktsiooni paranemine

- Enne ravi algustamist kogetud kaasuvate terviseprobleemide stabiliseerumine (nt vere glükoositasemed, astma, kardiomüopaatia, ensefalopaatia, gastriit, astsiit, ödeem).

- Märgid patsiendipoolsest huvist oma tervisliku seisundi vastu ning kaasuvate terviseprobleemidega seotud ravisoostumuse paranemine (nt astma- või vererõhuravimid).

Perekond/sotsiaalsed tegevused:

- veedetakse rohkem aega laste ja/või kaasaga.

- suureneb suhtlus perekonnaga

- paranenud intiimsuhted

- vähenenud perekondlikud konfliktid

- kaasategemine vabaaja tegevustes mis pole seotud alkoholi tarvitamisega

Tööstatus:

- töö leidmine, kui varasemalt töötu

- tööl regulaarselt kohalkäimine

- vähem tööga seotud ja finantsprobleeme

- paranenud töösooritus

Õiguslik staatus:

- Pole uusi seaduserikkumisi

Vaimne seisund:

- ärevuse ja ärritumise vähenemine
- paranenud tuju
- une paranemine
- teiste psühhiaatriliste häirete asjakohane ravi, mitte alkoholiga leevendamine

Ravijuhendite soovituste tekstid inglise keeles

SIGN 2003

Even though these tests have limited sensitivity and specificity, if elevated in a given patient, they may help motivate a patient to reduce drinking and they are then useful in monitooring change in consumption.

- Biological tests should be used to monitor patients progress in reducing their drinking.

(Soovitus põhineb eksperthinnangul)

NICE 2011

Routine outcome monitooring

Routine outcome monitoring is an essential part of any effective healthcare system provision. The AUDIT questionnaire was identified as the most reliable and feasible measure for routine outcome monitoring. Prospective drinking diaries are of unknown reliability and validity. The APQ was also identified as beneficial for the assessment of alcohol-related problems when monitoring treatment outcome.

SOOME 2010

Laboratory tests (CDT and GT) are relevant for monitoring the results of treatment of alcoholdependent patients, at least in men [A]

NSW 2008

An important part of the psychosocial treatment program is regular review and assessment of the client's progress in relation to their treatment goals. Some of these factors can be carried out informally during each treatment session (eg. assessing withdrawal symptoms, implementation of strategies discussed during session, medication side effects, etc), with treatment tailored accordingly. However, it will also involve the formal measurement/ review of relevant outcomes, such as quantity/frequency of problematic drug and alcohol use, psychiatric symptomatology, biological measurements (blood, urine, etc) as guided by the initial assessment, and/or the service policy within which the D&A professional is operating. Formal, objective outcome measurements are essential to this process, as they minimise the risk of both clients and D&A professionals overestimating the effect of a treatment program, and of focusing too much on one domain of the client's presentation, when another area may be deteriorating.

APA 2006

It is important to intensify the monitoring for substance use during periods when the patient is at a high risk of relapsing, including during the early stages of treatment, times of transition to less intensive levels of care, and the first year after active treatment has ceased [I].

[I] Recommended with substantial clinical confidence.

SAMHASA 2009

The ways in which providers can monitor patients' drinking behavior include the following:

- *Patient self-reports* can be useful indicators of treatment success. The provider should discuss with the patient the quantity and frequency of drinking, especially during stressful periods (e.g., holidays, celebrations, major life changes).

- *Laboratory tests* may include AST, GGT, CDT, EtG, and urine drug screening.

In addition, providers can use periodic Breathalyzer™ tests (although these detect only for a short period following ingestion) to monitor alcohol intake and provide positive feedback to patients who are successful in maintaining abstinence.

Monitoring Health Status and Social Functioning

Ultimately, the goal of treatment is improved quality of life. It is important to monitor patients' progress over time in the following areas:

Health

- Normalization of previously elevated blood pressure
- Improvement of liver function
- Stabilization of related medical problems that the patient was experiencing before treatment (e.g., control of blood glucose, stabilization of asthma, cardiomyopathy, encephalopathy, gastritis, ascites and edema)
- Signs of increased concern about health care, such as seeing a physician for the first time in years and/or increased compliance with prescribed medication regimens not related to AUD treatment (e.g., asthma or blood pressure medications)

Family/social activities

- Spending more positive time with children and/or spouse
- Greater involvement/participation with family members
- Improved intimate relationships
- Reduced family conflict
- Engagement in nondrinking leisure and recreational activities

Work/vocational status

- Obtaining employment if previously unemployed
- Improved attendance at work
- Fewer job-related and financial problems
- Improved job performance

Legal status

- No parole or probation violations (in a patient with legal problems)
- No new driving-under-the-influence charges

Mental status

- Decreased irritability and anxiety

- Improved mood
- Improved sleep
- Getting appropriate treatment for anxiety disorders, suicidal ideation, depression, or schizophrenia rather than self-medicating with alcohol.

Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
NICE 2011	
Objective: To evaluate the 3 alcohol consumption questions from the Alcohol Use Disorders Identification Test (AUDIT-C) as a brief screening test for heavy drinking and/or active alcohol abuse or dependence. **Methods**: Patients from 3 Veterans Affairs general medical clinics were mailed questionnaires. A random, weighted sample of Health History Questionnaire respondents, who had 5 or more drinks over the past year, were eligible for telephone interviews (N = 447). Heavy drinkers were oversampled 2:1. Patients were excluded if they could not be contacted by telephone, were too ill for interviews, or were female (n = 54). Areas under receiver operating characteristic curves (AUROCs) were used to compare mailed alcohol screening questionnaires (AUDIT-C and full AUDIT) with 3 comparison standards based on telephone interviews: (1) past year heavy drinking (>14 drinks/week or > or =5 drinks/ occasion); (2) active alcohol abuse or dependence according to the Diagnostic and Statistical Manual of Mental Disorders, Revised Third Edition, criteria; and (3) either. **Results:** Of 393 eligible patients, 243 (62%) completed AUDIT-C and interviews. For detecting heavy drinking, AUDIT-C had a higher AUROC than the full AUDIT (0.891 vs 0.881; P = .03). Although the full AUDIT performed better than AUDIT-C for detecting active alcohol abuse or dependence (0.811 vs 0.786; P<.001), the 2 questionnaires performed similarly for detecting heavy drinking and/or active abuse or dependence (0.880 vs 0.881).	Bush K, Kivlahan DR, McDonell MB, et al. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for probleem drinking. Archives of Internal Medicine 1998; 158: 1789–1795.
This article examines the performance of the AUDIT-C, as embedded in a large national survey, as a screener for alcohol use disorders (AUDs) and risk drinking among individuals with past-year psychopathology. The analysis is based on data collected in personal interviews from a representative population sample of US adults. The study population consisted of past-year drinkers with any past-year mood disorder (n = 2818), any past-year anxiety disorder (n = 3173), or any personality disorder (n = 4389). Screening performance was evaluated by means of sensitivity, specificity, and areas under receiver operating characteristic curves (AUCs). The AUCs for the AUDIT-C were from 0.888 to 0.893 for alcohol dependence, from 0.864 to 0.876 for any AUD, and from 0.941 to 0.951 for any AUD or risk drinking-all on a par with those observed in the general population. Among men, cut points of either > or =5 or > or =6 points (the former favoring sensitivity and the latter favoring specificity) were optimal for detecting dependence, and cut points of > or =5 points were optimal for any AUD and for any AUD or	Dawson DA, Grant BF,Stinson FS. The AUDIT-C: screening for alcohol use disorders and risk drinking in the presence of other psychiatric disorders. Comprehensive Psychiatry 2005; 46: 405–416.

risk drinking. Among women, a cut point of > or =4 points was optimal for the outcomes of both alcohol dependence and any AUD, whereas a cut point of > or =3 points was preferable for detecting any AUD or risk drinking.	
Aims: To identify suitable short versions of the Alcohol Use Disorders Identification Test (AUDIT) and to evaluate their effectiveness as screening tests for 'risky drinking' among men and women in primary health care (PHC) settings. **Methods:** A total of 255 patients attending five PHC centres in Catalonia (Spain) were interviewed by clinicians regarding health status and drinking pattern. Patients also completed the AUDIT. Clinicians' diagnosis of risky drinking was used as a gold standard to evaluate the effectiveness of three forms of AUDIT. **Results:** AUDIT-3 and AUDIT-4 performed similarly to AUDIT-10 in detecting risky drinking and had equivalent receiver operating characteristics curves and their areas under the curve.	Gual A, Segura L, Contel M, *et al.* AUDIT-3 and AUDIT-4: effectiveness of two short forms of the alcohol use disorders identification test. Alcohol and Alcoholism 2002; 37: 61–66.
A questionnaire including the three AUDIT-C items was used to screen for alcohol use among trauma patients. The aim was to display, in a pragmatic way, how the AUDIT-C scores can be converted into different levels and kind of risky drinking. Using AUDIT-C scores with a cut-off score of 4 points for women and 5 for men indicated that 28% of the women and 40% of the men were risky drinkers. When calculating weekly alcohol consumption from the answers in AUDIT-C, 3% of the women and 7% of the men were hazardous and/or harmful drinkers. Regarding heavy episodic drinking 7% of the women and 30% of the men was drinking 72g alcohol or more at on at least one occasion a month. These results indicate that the AUDIT-C score as such give little information about the pattern of alcohol consumption and that evaluation of risky drinking must be calculated from the three items in order to differentiate between risky drinking in terms of alcohol consumed per week and heavy episodic drinking.	Nordqvist C, Johansson K, Bendtsen P. Routine screening for risky alcohol consumption at an emergency department using the AUDIT-C questionnaire. Drug and Alcohol Dependence 2004; 74: 71–75.
Raistrick D, Heather N, Godfrey C. (2006) Review of the Effectiveness of Treatment for Alcohol Problems. London: National Treatment Agency for Substance Misuse. Frank D, DeBenedetti AF, Volk R J, et al. . Effectiveness of the AUDITC as a screening tests for alcohol misuse in three race/ethnic groups. Journal of General Internal Medicine 2008; 23: 781–787. Drummond C. The relationship between alcohol dependence and alcoholrelated problems in a clinical population. British Journal of Addiction 1990; 85: 357–366. Drummond C. (2009) Treatment services for alcohol use disorders. In The New Oxford Textbook of Psychiatry (eds M. Gelder, N. Andreasen, J. Lopez-Ibor, et al.), 2nd edn. Oxford: Oxford University Press. UKATT Research Team. Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). British Medical Journal 2005; 331: 541–545.	
SOOME 2010	
This is a systematic review of the studies in which carbohydrate-deficient transferrin (CDT) has been compared to other laboratory markers in different experimental conditions, clinical settings, and populations. Only the studies (n = 54) in which CDT was compared either to the conventional or new biological markers of alcoholism, heavy drinking, or alcohol use were selected for further evaluation. Two prospective studies indicate that in men CDT is slightly more sensitive than gamma-GT in reflecting changes in these markers caused by drinking of a moderate and fixed amount of alcohol during three to four weeks. In one prospective study, in which the drinking history of male heavy drinking volunteers was as close the golden standard as possible; that is, obtained by a prospective anonymous drinking diary, CDT was slightly but not significantly better marker than conventional laboratory markers (ASAT, ALAT, gamma-GT and beta-Hex) in the identification of men drinking	Salaspuro M. Carbohydrate-deficient transferrin as compared to other markers of alcoholism: a systematic review. Alcohol 1999; 19:261-71. SYSTEMATIC REVIEW

more than 400 g of alcohol daily. Similar prospective studies concerning women have not been done. Six prospective treatment outcome studies indicate that CDT may be a significantly more sensitive marker than gamma-glutamyltransferase (gamma-GT) in the detection of relapses in male alcoholics. However, these two tests can also be considered to be complementary markers. Furthermore, in the detection of relapses the baseline values of CDT and gamma-GT should be measured and compared on individual basis to the pretreatment values. Comparable data are not available from female alcoholics. In selective materials comprising male alcoholics and heavy drinkers, CDT was found to be a slightly more sensitive marker than gamma-GT in seven retrospective studies. In five studies, gamma-GT was slightly better. However, the differences between CDT and gamma-GT in general were not statistically significant. In three studies, the combined use of CDT and gamma-GT improved the sensitivity but with the expense of specificity. Only four studies included women and in three of these the sensitivity of gamma-GT was better than that of CDT, whereas in one study CDT was better than gamma-GT in the detection of female heavy drinkers. Seven studies performed in primary health care settings and among young populations demonstrate that the performance of CDT in the identification of heavy and problem drinkers in this type of populations is very low, although comparable to the poor performance of the conventional laboratory markers, too. According to seven studies, the sensitivity of gamma-GT is slightly better than that of CDT in the identification of excessive alcohol consumption among hospitalized male and female patients. However, in this type of hospital setting, the specificity of CDT is markedly higher than that of gamma-GT. There is some evidence indicating that the performance of the tests can be improved with the combined use of both tests. Eight studies indicate that both in men and women CDT is a better marker than gamma-GT in the identification of alcohol abuse among patients with alcoholic and nonalcoholic liver diseases. This is mostly due to the higher specificity of CDT as compared to that of gamma-GT	

Helander A, Carlsson AV, Borg S. Longitudinal comparison of carbohydrate-deficient transferrin and gamma-glutamyl transferase: complementary markers of excessive alcohol consumption. Alcohol Alcohol.1996;31:101-7.

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Viited

Otsing: ((((alcohol) OR alcohol treatment)) AND ((((((((((((((((((AUDIT) OR AUDIT-C) OR AUDIT C) OR CDT) OR Carbohydrate-deficient transferrin) OR Carbohydrate deficient transferrin) OR GGT) OR Gamma-glutamyl transferase) OR Gamma glutamyl transferase) OR AST) OR ASAT) OR aspartate aminotransferase) OR ALT) OR ALAT) OR EtG) OR Ethyl glucuronide) OR ((alcohol) OR alcohol treatment)) OR alanine aminotransferase)) AND ((monitoring) OR outcome) Filters: **Full text; published in the last 10 years; Humans; English; Field: Title**

Kokkuvõtte (abstract või kokkuvõtlikum info)	**Viide kirjandusallikale**
A method for the quantification of ethyl glucuronide (EtG) and ethyl sulphate (EtS) in human urine is developed and fully validated according to international guidelines. Protein precipitation is used as sample preparation. During the development of the method on an UPLC-ESI-MS/MS system using a CSH C18 column, special attention was paid to reduce matrix effects to improve assay sensitivity and to improve detection of the second transition for EtS for specificity purposes. The method was linear from 0.1 to 10µg/mL for both analytes. Ion suppression less than 24% (RSD<15%) was observed for EtG and no significant matrix effect was measured for EtS. The recovery was around 80% (RSD<14%) for both compounds. This method provides good precision (RSDr and RSDt<10%) and bias (<15%) for internal and external quality control samples. The reproducibility of the method was demonstrated by the successful participation to proficiency tests (z-score<0.86). This method was finally used to analyze urine samples obtained from twenty-seven volunteers whose alcohol consumption during the 5 days before sampling was monitored. Concentrations between 0.5 and 101.9µg/mL (mean 10.9, median 1.4) for EtG and between 0.1 and 37.9µg/mL (mean 3.6, median 0.3) for EtS were detected in urine samples of volunteers who declared having consumed alcohol the day before the sampling. EtG and EtS concentrations in urine were highly correlated (r=0.996, p<0.001). A moderate correlation between the number of drinks the day before sampling and the concentration of EtG (r=0.448, p<0.02) or EtS (r=0.406, p<0.04) was observed. Using a cut-off value at 0.1µg/mL for EtG and EtS, this method is able to detect social alcohol consumption approximately 24h after the intake, without showing any false positive result.	Kummer N, Wille S, Di Fazio V, Lambert W, Samyn N. A fully validated method for the quantification of ethyl glucuronide and ethyl sulphate in urine by UPLC-ESI-MS/MS applied in a prospective alcohol self-monitoring study. J Chromatogr B Analyt Technol Biomed Life Sci. 2013;15;929:149-54

LISA 1

Outcome monitoring tool	Is there adequate psychometric data in primarily alcohol dependent population?	Does the tool have high usability (for example, readable, short time to administer, limited training required)?	Source study
Addiction Severity Index (ASI)	Yes (but validity and reliability are questionable)	No – requires a trained interviewer and takes 50 to 60 minutes	McLellan and colleagues (1980)
Alcohol Use Disorders Identification Test (AUDIT)	Yes – extensive data that supports validity and reliability	Yes – takes 2 minutes	Babor and colleagues (2001)
Maudsley Addiction Profile (MAP)	No	Yes – takes 20 minutes	Marsden and colleagues (1998)
Christo Inventory for Substance Misuse Services (CISS)	No	Yes – takes 10 minutes	Christo and colleagues (2000)
Comprehensive Drinker Profile (CDP)	No	No – requires a trained interviewer and takes 2 hours	Miller and Marlatt (1987)
Routine Evaluation of the Substance-Use Ladder of Treatments (RESULT)	No	Yes – takes 30 minutes	Raistrick and Tober (2003)
Treatment Outcomes Profile (TOP)	No – primarily in drug misuse population	Yes – one page, 20 items	Marsden and colleagues (2007)

LISA 2

Autor, aasta	Rahvastik	Hõlmatud üksik-uuringute arv	Valimi kogu-suurus	Tarvistamise iseloom	Kasutatud testid	Tund-likkus	Spetsii-filisus	PEV	NEV	Pos ROC	AUROC	Ratio of OR (CI 95%)	Kvaliteet
Fiellin et al. 2000 Süstemaatiline ülevaade	Esmatasand, täiskasvanud	38	Pole öeldud	Ohustav, ohtlik alkoholi tarvitamine/alkoholi riskitarvitamine Alkoholi kuritarvitamine või alkoholi sõltuvus	AUDIT ≥ 8 CAGE ≥ 2 SMAST ≥ 2 **Eluaegne** AUDIT ≥ 8 CAGE ≥ 2 SMAST ≥ 2 **Praegune** AUDIT ≥ 8 CAGE ≥ 2 SMAST ≥ 2	57-97% 14-84% 68% 33-91% 43-74% 21-82% 61-96% 77-94% 100	78-96% 75-97% 92% 84-96% 70-93% 77-97% 85-96% 79-97% 85%						Keskmise (*fair*) kvaliteediga
Bradley et al. 1998 Süstemaatiline ülevaade	Esmatasand ja sünnitusabi	5	6,724	Alkoholi sõltuvus viimase aasta jooksul Eluaegne alkoholi kuritarvitamine või sõltuvus	**EMO** AUDIT ≥8 AUDIT ≥7 CAGE ≥ 2 CAGE ≥ 1 TWEAK ≥ 3 TWEAK ≥ 2 BMAST ≥ 6 BMAST ≥ 5 BMAST ≥ 4 Trauma ≥ 2 **Esmatasand** CAGE ≥ 2 CAGE ≥ 1	N M 59-66% 90-91% 70% 92% 50-83% 58-84% 89% 93% 71-80% 81-89% 87% 95% 23-53% 24-40% 40% 29% 57% 47% 40-53% 51-52% 38-74% 47% 89%	N M 93-97% 79-86% 95% 75% 93-96% 80-90% 86% 67% 90-93% 74-80% 87% 56% 97-99% 96-99% 90% 80% 90% 80% 80-93% 70-83% 92-93% 93% 83%				N M 0.87 0.88 0.84 0.84 0.90 0.89 0.75 0.64 0.59 0.57 0.92		Keskmise (*fair*) kvaliteediga
Berner et al. 2007	Esmatasand, täiskasvanud,	13 esmatasand	22,195	Alkoholi riskitarvitamine	**Esmatasand** AUDIT ≥8	31-89%	83-96%						Hea (*good*)

Süstemaatiline ülevaade	üliõpilased, eakad	i + 1 üliõpilasi käsitlev			**Haigla stats** AUDIT **EMO** AUDIT **Üliõpilased** AUDIT **Vanurid** AUDIT	94% 72% 82% 55 -83%	94% 88% 78% 96%						kvaliteediga
Kriston et al. 2008 Süstemaatiline ülevaade	Esmatasand, ambulatoorsed patsiendid, üldrahvastik	14	112-13,438 patsienti (mediaan 609)	Episoodiline ohustav alkoholi tarvitamine, alkoholi riskitarvitamine	**Alkoholi riskitarvitamine** AUDIT AUDIT-C **Alkoholi tarvitamise häire** AUDIT AUDIT-C **Mõlemad** AUDIT AUDIT-C					6.62 2.99 4.03 3.82 4.82 3.91			++
Berks & McCormick, 2008 Süstemaatiline ülevaade	Primary care (Studies testing screening in patients aged over 60 yrs were included.	9	6353	Ohustav alkoholi tarvitamine ja alkoholi kuritarvitamine Sõltuvus	**Alcohol abuse and dependence** CAGE >=1 MAST >=4 MAST>-3 MAST-G>=5 SMAST >=2 AUDIT >=8 **Hazardous or excessive drinking** CAGE >=1 CAGE>=2	**Alkohol abuse and dependence** 79,1 – 88% 91,4% 64-97,1% 69,8-91% 48% 33,3% 31-60% 14-38,9%	 55,8 – 88% 83,9% 66,7-79% 80,5-84% 100% 90,7% 92-100% 97-97,1%						++

					AUDIT>=8 AUDIT-C >=3	66,7% 100%	95,3% 80,7%						
O'Connell *et al.*, 2004 (Systematic review, +)	Elderly inpatients and outpatients	-	-	Alkoholi väärtarvitamine	MAST AUDIT ARPS sharps	91,4% 33-79% 93% 91%	83.9% 86-100% 66% 66%						+
Burns, 2010 Süstemaatili ne ülevaade	Rasedad	5	6724	Alkoholi riskitarvitamine Sõltuvus	T-ACE TWEAK AUDIT-C AUDIT-C	69-88% 71-91% 95% 100%	71-89% 73-83% 98% 71%						
Jonas DE, Garbutt JC, Brown JM, Amick HR, Brownley KA, Council CL, et al. Screening,	Primary care	5 süstemaa-tilise ülevaate analüüs: Berks et al. Int Psychogeria tr. 2008	6353 + 10865+ 6724+?? +22195	Alkoholi väärtarvitamine	 AUDIT>=8 AUDIT-C>=3	Male/Female 54-58% / 27% 92-95% / 6- -73%	Male/Female 95-96% / 90% 60-79% / 91-96%						+

Behavioral Counseling, and Referral in Primary Care to Reduce Alcohol Misuse. Comparative Effectiveness Review		Bradley et al. JAMA. 1998 Burns et al. Addiction. 2010 Fiellin et al. Arch Intern Med. 2000 Berner et al. J Stud Alcohol Drugs. 2007		Ohustav alkoholi tarvitamine (male and female) Sõltuvus (male and female)	Single-question screen AUDIT>=8 AUDIT-C>=3 CAGE>=2 SMAST QF>7dr/w AUDIT>=8 AUDIT-C>=3 CAGE>=2 LAST>=2 SMAST>=2 TWEAK>=3 QF> 20 dr/wk QF> 4 dr/day	0.82 to 0.87 25%-97% 98% 49-84% 68% 50% 61-96% 90% 77-94% 63% 100% 75% 20% 47%	0.61 to 0.79 61%-96% 57% 75-97% 92% 87% 85-96% 45% 79-97% 93% 85% 90% 97% 96%						

Reinert et al. 2002 Kirjanduse ülevaade	Erinevad asukohad	13	Pole öeldud	Alkoholi kuritarvitamine või alkoholi sõltuvus/liigtarvitamine Ohustav, ohtlik alkoholi tarvitamine	AUDIT	33-93% 97%	70-97% 69%	32-87% 65%	68-98%				Keskmise kvaliteediga *
Reinert et al. 2007 Kirjanduse ülevaade	Erinevad asukohad	26 AUDIT + 26 AUDIT lühiversioon	Pole öeldud	Ohustav, ohtlik alkoholi Tarvitamine, kuritarvitamine ja sõltuvus	**Täisversioon** AUDIT **Lühiversioon** AUDIT ≥ 3 AUDIT ≥ 4 AUDIT ≥ 5 AUDIT ≥ 6	24-100% 60-96% 38-100% 50-98% 39-87%	65-100% 52-95% 49-98% 58-98% 78-100%	16-95%	84-100%		0.79-0.99		Keskmise kvaliteediga*
Aalto *et al.,* 2006 Cross-sectional diagnostic evaluation, ++) Finland	Primary care (ii) 40 year old females		894	Tugev alkoholi tarvitamine	AUDIT >=6 AUDIT-C>=5 AUDIT-PC>=4 AUDIT-QF>=4	84-95% for all	83-90 %for all						++
Tuunanen *et al.* 2007 Finland Cross-sectional diagnostic evaluation,	45 yr old men in primary care, Finland.			Episoodiline ohustav aölkoholi tarvitamine	AUDIT>=8 AUDIT>=7	Moderaate/heavy drinkers 60%/65% 73%/72%	Moderaate/heavy drinkers 81%/81% 76%/76%				0,824 (95%CI 0.789 to 0.859) 0,829(95% CI 0.795 to 0.864)		++

					AUDIT-C>=6 AUDIT-3>=2	70%/72% 0%/72%	77%/77% 73%/73%				0.779 (95%CI 0.739 to 0.818).		
Bradley *et al.,* 2007 (Cross-sectional diagnostic evaluation, USA				Alkoholi väärtarvitamine	AUDIT-C>=4 AUDIT-C>=3 AUDIT-C>=2 AUDIT >=5 AUDIT>=4 AUDIT>=3	Male/Female 86%/no data No data/73% No data/89% 81%/no data 91%/ no data No data/ 79%	Male/Female 89%/no data No data/91% No data/78% 90%/no data 80%/no data No data/ 87%				Male/Female 0,89/0,91		++
Frank *et al.,* 2008 (Cross-sectional diagnostic evaluation, ++) USA	Primary care		1292	Alkoholi väärtarvitamine	AUDIT-C >=3 AUDIT-C>=4	Female 67-85% Male 76-85%	88-92% 84-93%						++
Newcombe *et al.,* 2005 Cross-sectional diagnostic evaluation,	Primary care		150		ASSIST	Alkohol abuse 71% Alcohol Dependence 86%	63% 77%				0,76 0,83		+
ASSIST Humeniuk *et al.,* 2008 Cross-sectional diagnostic evaluation,	Primary care and specialized settings		1047		ASSIST	Abuse Dependence	83% 67%	79% 60%			0,87 0,7		++
Bisson & Milford-Ward, 1994 (Cross-	male soldiers under the age of 30		58	Alkoholi väärtarvitamine	CAGE MAST	97% 100%%							++

sectional diagnostic evaluation, ++) UK :					SADQ MCV GGT CDT	77% 14% 11% 31%							
Coulton *et al.* 2006 UK Cross-sectional diagnostic evaluation,	Primary care		1794	Ohustav alkoholi tarvitamine Iganädalane ohustav alkoholi tarvitamine Igakuine ohustav alk. tarv Sõltuvus	AUDIT>=8 Ohustav alkoholi tarvitamine Iganädalane ohustav alkoholi tarvitamine Igakuine ohustav alk. tarv Sõltuvus CDT ASAT	69% 75% 66% 84%	98% 90% 97% 83%	95% 71% 91% 41%	97%		0,94-0,96 for all alkohol use disorders 0,7 0,5		++
Aertgeerts *et al.* 2001 Belgium Cross-sectional diagnostic evaluation,	(i) General practice (ii) Patients (n=1992) aged over 18 years.		1992	Sõltuvus ja kuritarvitamine	 AUDIT>=5 AUDIT>=8 AUDIT-c>=5 AUDIT-PC>=5	Male/female 82%/65% 60,6/50% 78%/50% 68% / 56,4%	Male/female 73%/92% 90,3/98,7% 75%/93% 84% / 95,7%	Male/female 32%/27 49,7/64 32,8%/26% 40%/38	Male/female 90%/96%		Male: AUDIT - 0,85 AUDIT-C 0,83 AUDIt-PC – 0,83 Female: AUDIT –		++

					CAGE>=1 CAGE>=2 MCV GGT CDT	62,1% / 54,3 47,7% / 37 39,4%/41,3% 6,8%/6,5% 18,2/15,2%	81,2% / 92 92,3% / 97 39,4% / 79,3% 95,5% / 91,8% 95,6% / 95,5%	34,2/24 49/35 19,9%/8 ,6% 19,1% / 3,6% 39,0% / 14%	88,7% / 96,6% 86,7% / 95,4% 88% / 96%		0,87 AUDIT-C 0,82 Lab.. tests: Female 0,6-0,67 Male 0,57-0,65		
Scouller et al 2000 Süstemaatiline ülevaade	Pole öeldud	110	Pole öeldud	Alkoholi kuritarvitamine, ohtlik alkoholi tarvitamine/alkoholi riskitarvitamine	CDTect (orig) vs GGT CDTect (mod) vs GGT IEF vs GGT AXIS vs CDTect (mod) IEF vs CDTect (mod)							27.1 (3.8 -193) 1.3 (0.6–2.7) 3.4 (0.6–19.7) 1.2 (0.4–3.1) 3.4 (1.3–9.0)	Keskmise kvaliteediga*
Salaspuro et al 1999 Süstemaatiline ülevaade	Erinevad asukohad (esmatasand, statsionaarne osakond jne)	54	Pole öeldud	Ohustav/ohtlik alkoholi tarbimine Päevane tarbimine >40g/>60g, alkoholism	**Tugev alkoholi tarbimine/alkoholikud** CDT GGT MCV (%) ASAT (%) ALAT (%) CDT+GGT (%) **Esmatasandil ja noores rahvastikus**	 29-85% 11-85% 28-67% 17-85% 22-65% 57-95%	 0(13)-100%? 0(25)-95%? 93-98% 0(13)-98%? 0(13)-87%? 79%						Hea kvaliteediga*

					CDT GGT MCV (%) ASAT (%) ALAT (%) CDT+GGT (%) **Statsionaarne osakond** CDT GGT MCV (%) ASAT (%) ALAT (%) CDT+GGT (%) **Maksahaigusega patsientidel** CDT GGT MCV (%) ASAT (%) ALAT (%) CDT+GGT (%)	 0-61% 10-61% 12-63% 7-56% 11-40% 29-85% 15-69% 41-73% 27-54% 46-50% 35-47% - 35-91% 44-96% 19-87% 75% 64% 96%	 33-96% 80-100% 77-94% 92-97% 85-98% 81-92% 81-98% 63-85% 85-91% 77-82% 85-86% - 36-100% 18-100% 63-100% 55% 54% 59%						
Schwan et al 2004 Open multicentre study Juht-kontroll uuring?	Prantsusmaa - ambulatoorsed ravikeskused ja spetsialiseerunud statsionaarsed osakonnad	-	362 uuritavat (103 Alkoholi kuritarvitajat, 160 alkoholi sõltuvusega ja 99 kontrolli).	Kuritarvitamine Ja sõltuvus	**Alkoholi kuritarvitamine** Kokku GGT %CDT TIA GGT koos CDT Naised GGT %CDT TIA GGT koos CDT Mehed GGT	 0.56 (0.47–0.66) 0.80 (0.72–0.87) 0.90 (0.85–0.96) 0.33 (0.15–0.51) 0.67 (0.49–0.85) 0.78 (0.62–0.93) 0.68 (0.57–0.79)	 0.77 (0.68–0.85) 0.83 (0.75–0.90) 0.63 (0.53–0.72) 0.74 (0.63–0.85) 0.86 (0.77–0.95) 0.63 (0.50–0.76) 0.81 (0.69–0.93)						Hea kvaliteediga*

					%CDT TIA GGT koos CDT **Alkoholisõltuvus** Kokku GGT %CDT TIA GGT koos CDT Naised GGT %CDT TIA GGT koos CDT Mehed GGT %CDT TIA GGT koos CDT	0.86 (0.78–0.95) 0.97 (0.94–1.00) 0.86 (0.80–0.91) 0.91 (0.87–0.96) 0.99 (0.98–1.00) 0.75 (0.60–0.90) 0.84 (0.71–0.97) 1.00 (1.00–1.00) 0.88 (0.82–0.94) 0.93 (0.88–0.98) 0.99 (0.98–1.00)	0.79 (0.66–0.91) 0.62 (0.47–0.77) 0.77 (0.68–0.85) 0.83 (0.75–0.90) 0.63 (0.53–0.72) 0.74 (0.63–0.85) 0.86 (0.77–0.95) 0.63 (0.50–0.76) 0.81 (0.69–0.93) 0.79 (0.66–0.91) 0.62 (0.47–0.77)						
Aithal at al, 1998 Cross-sectional diagnostic evaluation	General medical clinics		91	Heavy drinking	**CDT** **GGT** **MCV** **CAGE>=2** CDT, GGT ja MCV võetuna koos	69% 77% 54% 69% 85%	81% 81% 85% 95% 88%	41% 43% 41% 75% 61%					

Conigrave et al 2002 Multicentre study Ristläbilõike line uuring?	Erinevad asukohad, peamiselt kogukonnast ja alkoholi sõltuvuse ravikeskused	-	1863 uuritava t viiest riigist (Austria, Brasiilia, Kanada, Soome, Jaapan)	Kõrge riskitarvitamine viimase kuu jooksul (*high-risk drinking*)	**Mehed (>80 g päevas)** CDT GGT AST CDT ja/või GGT **Naised(>40 g päevas)** CDT GGT AST CDT ja/või GGT	60 67 45 86 29 44 23 61	92 74 90 68 92 90 97 81						Hea kvaliteediga uuring*
Wetterling *et al.,* 1998 Cross-sectional diagnostic evaluation	Erinevad kohad			Sõltuvus Riskitarvitamine	CAGE (≥ 2) MAST (≥ 5) CDT (>26 mg/l females; > 20 mg/l males, as reported) GGT (>19 U/l females; >28 U/l males) MCV (≥ 95 fl) 33.3% CAGE (≥ 2) MAST (≥ 5) CDT (>26 mg/l females; > 20 mg/l males, as reported) GGT (>19 U/l females; >28 U/l males) MCV (≥ 95 fl) 33.3%	49,1% 47,3% 47,3% 57,6% 33,3% 53.8% 50.0% 53.8% 55.9% 38.5%	98.0% 98.7% 88.6% 69.5% 88.4% 89.2% 89.9% 82.4% 62.9% 84.9%	90.0% 92.9% 60.5% 47.5% 52.8 46.7% 46.4% 35.0% GGT 26.8% 31.3%					

Josep Maria Haro at al, 2006, clinical reappraisal study	Mental health centers	4	21,425 Respon dents	Sõltuvus Kuritarvitamine	CIDI vs SCID CIDI vs SCID	43,1% 64,1%	99,9% 98,1%	98,7% 88,1%	91,9% 92.7%		AUROC 0,72 Kappa 0,56 AUROC 0,81 Kappa 0,7	(105.8–7266.2) (28.0–311.3)	
The MINI International neuropsychiatric interview, David Sheehan, 1998, Cross-sectional	Mental health centers	2	636	Sõltuvus	MINI vs CIDI MINI vs SCID	83% 80%	97% 95%	91% 64%	94% 98%		Kappa 0,82 0,67 Test-retest kappa 0,86		
WHO cross-sectional study, Üstün at al, 1997	Erinevad kohad	12	1825	Sõltuvus Kuritarvitamine (ICD10 – riskitarbimine)	SCAN vs DSM-IV SCAN vs ICD-10 CIDI vs DSM-IV CIDI vs ICD-10 AUDADIS vs DSM-IV AUDADIs vs ICD-10 SCAN vs DSM-IV SCAN vs ICD-10 CIDI vs DSM-IV CIDI vs ICD-10						Kappa 0,73 0,76 No 0,75 0,66 0,68 0,6 0,35 No		

					AUDADIS vs DSM-IV AUDADIS vs ICD-10						0,6 0,49 0,17		
Test-retest reliability of CIDI-Auto, Rubio-Stipec, 1999				Sõltuvus Riskitarbimine	CIDI vs DSM-IV/ICD10 CIDI vs DSM-IV/ICD10						KAPPA 0,7-0,95 0,45-0,66		
Deborah Hazin, 2006, PRISM, cross-sectional	Psychiatric settings, among substance abusers	1	Kuritarvitamine	Sõltuvus Abuse	PRISM PRISM						Kappa 0,82 0,56		

*** - koostaja poolt hinnatud** **+ - NICE 2010 ravijuhendi hinnang** **fair/good - US task force hinnang**