Australian Government
National Health and Medical Research Council

Public consultation: draft *Australian guidelines to reduce health risks from drinking alcohol*

Personal details

Full name Stroke Foundation

[NHMRC has removed personal information]

Submission reflects

Organisation / Individual An organisation

Organisation Name Stroke Foundation

Please identify the best term to describe the Organisation Advocacy organisation (e.g. disability, patient, disease-based)

Questions

1. **Please indicate which format you read the guideline in.**
   Both formats
2. **The draft guidelines are presented in a new IT platform, MAGICapp. Please indicate how strongly you agree with the following statement: *The draft Australian Guidelines to Reduce Health Risks from Drinking Alcohol are easy to navigate in MAGICapp.***
   Agree
3. **Please indicate how strongly you agree with the following statement: *The Plain English summary is clear, simple and easy to understand*.**
   Disagree
4. **Do you have any comments on how the *Plain English summary* could be improved?**
   The Plain English summary should be clear and concise. Currently, each of the three public health recommendations are clear and prominent; however, there is a lot of unnecessary detail in each of the three Guideline summaries. If intended for a lay audience, it is important these summaries are succinct and easy to digest.
   Stroke Foundation supports the changes to Guideline One, which lowers the weekly recommended limit to no more than 10 standard drinks (compared with 14 standard drinks in the 2009 guidelines), and identifies a daily limit of no more than four standard drinks, to reduce alcohol-related harm.
   Importantly, the last sentence of the recommendation states that 'For some people not drinking at all is the safest option'. Given there is some level of risk associated with any level of alcohol consumption, not drinking is the safest option for all people, not just some. As currently expressed, this sentence implies there is a safe level of alcohol consumption for most people.

As a result of the change in wording from a daily limit to a weekly limit, Stroke Foundation recommends consumer testing be undertaken to explore understanding and interpretation of the new guideline wording. Consumer testing is needed to ensure Australians understand the recommendation of no more than 10 standard drinks per week, and that this does not encourage higher consumption of alcohol in a single occasion. We need to understand if consumers think about their alcohol consumption in terms of a total weekly figure or whether daily recommendations are simpler to understand.

In addition, Stroke Foundation recommends Government investment in the dissemination and communication of the guideline recommendations to health professionals, as well as public education campaigns to ensure these recommendations are communicated to individuals and are able to inform community attitudes and behaviour.

5. **Do you have any comments on how the *Introduction* could be improved?**

   Stroke Foundation supports the NHMRC guideline development process. The 'Introduction' provides a sound overview of the objective and scope of the guideline, as well as the methodology used to update the evidence and develop the three public health recommendations.

   Stroke Foundation supports the presentation of the current guideline in the MAGICapp (Making Grade the Irresistible Choice) IT platform. Use of this tool will facilitate timely updates of the guideline as new evidence becomes available.

   Stroke Foundation is itself using this innovative guideline development and publishing platform in its dissemination of world-first 'Living Guidelines for Stroke Management'. This 'living evidence' pilot, delivered in partnership with Cochrane Australia and funded by the Medical Research Future Fund, draws on the latest evidence synthesis technologies that continually identify relevant new research and enable this research to be incorporated into living systematic reviews. This enables rapid updates of individual guideline recommendations whenever there is an important change in the evidence.

6. **Do you have any comments on how the *Background* could be improved?**

   In the 'Background' section of the guidelines, the cumulative effects of alcohol on cardiovascular disease, including stroke, are discussed. It is stated that 'Low levels of alcohol consumption have been found to be associated with protective effects against coronary artery disease in some studies and in certain age groups; however, recent evidence suggests that the magnitude of these effects is smaller than previously thought'. Importantly, in addition to coronary artery disease, the above statement is also true for ischaemic stroke, and details of this are outlined in our responses to questions 9 and 10. Therefore, a statement should be added to this part of the 'Background' section reflecting this.

7. **Please indicate how strongly you agree with the following statement: *The Understanding risk section is clear, simple and easy to understand*.**

   Strongly agree

8. **Do you have any comments on how the *Understanding risk* section could be improved?**

   No Comment.

9. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline One?**

   Research indicates approximately 80 percent of strokes can be prevented. As the voice of stroke in Australia, Stroke Foundation is committed to reducing the number of strokes in this country by supporting the community to identify and manage its risk of stroke. As such, we strongly support Guideline One, which recommends limiting alcohol consumption in order to reduce alcohol-related harms, including stroke.

As outlined in the Guideline, the consumption of larger amounts of alcohol, whether as high single occasion doses or high cumulative lifetime levels, increases the incidence of stroke, as well as risk factors for stroke including atrial fibrillation, high blood pressure, dyslipidaemia and diabetes mellitus.

The Guideline's Evidence Evaluation Report states drinking more than two drinks per day is associated with an increased risk of ischaemic stroke and drinking more than four drinks per day is associated with an increased risk of haemorrhagic stroke.

The Evaluation Report also states evidence of an association between increasing risk of stroke with increasing alcohol consumption has become clearer in recent years. This is important, as previous research has indicated light and moderate alcohol consumption (up to two drinks per day) was associated with a reduced risk of ischaemic stroke. The Guideline states there is now uncertainty about evidence underpinning such a 'protective effect', due largely to improved approaches to research study designs. Importantly, large studies published more recently have indicated no protective effects of light or moderate alcohol consumption for ischaemic stroke, and are discussed in our response to question 10.

Section 5.8.7 of Guideline One describes a number of commonly prescribed classes of medications, including benzodiazepines, opiates, analgesics, antidepressants, anticonvulsants, antibiotics, antihistamines, anti-inflammatories, antipsychotics, and medications for erectile dysfunction and diabetes, which interact with alcohol and can have serious side effects as a result. One omission is anticoagulants such as Warfarin, which play a major role in primary and secondary prevention of ischaemic strokes. When Warfarin is combined with alcohol, the effects of the drug can be altered, which may lead to a greater risk of bleeding. Among the many risk factors for major bleeding on Warfarin, alcohol use is among the strongest.(1-4) Roth JA, Bradley K, Thummel KE, Veenstra DL, Boudreau D. Alcohol misuse, genetics, and major bleeding among warfarin therapy patients in a community setting. Pharmacoepidemiol Drug Saf. 2015; 24(6):619-27. Lip GY, Banerjee A, Lagrenade I, Lane DA, Taillandier S, Fauchier L. Assessing the risk of bleeding in patients with atrial fibrillation: the Loire Valley Atrial Fibrillation project. Circ Arrhythm Electrophysiol. 2012; 5(5):941-8. Shireman TI, Mahnken JD, Howard PA, Kresowik TF, Hou Q, Ellerbeck EF. Development of a contemporary bleeding risk model for elderly warfarin recipients. Chest. 2006; 130(5):1390-6. Berwaerts J, Webster J. Analysis of risk factors involved in oral-anticoagulant-related intracranial haemorrhages. QJM. 2000 Aug;93(8):513-21.

10. Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).

The Guideline's Evidence Evaluation Report was based on literature published between 1 January 2007 and 5 January 2017.

Importantly, in April 2019, researchers from Peking University, the Chinese Academy of Medical Sciences and the University of Oxford published the findings of a study that examined the impact of alcohol on stroke in 500,000 Chinese adults over 10 years.(1) This study found that drinking one to two glasses of alcohol a day increased stroke risk by 10 to 15 percent, and that four drinks a day increased the risk of having a stroke by 35 percent. These results suggest that there are no protective effects of moderate alcohol intake, and even moderate alcohol consumption increases the risk of having a stroke. Similarly, a 2018 meta-analysis of the findings from conventional epidemiological analyses of 83 prospective studies, mainly in populations of European descent, found that, among drinkers, stroke incidence increased steadily with the amount of alcohol consumed.(2) Millwood IY et al; China Kadoorie Biobank Collaborative Group. Conventional and genetic evidence on alcohol and vascular disease aetiology: a prospective study of 500 000 men and women in China. Lancet. 2019;

393(10183):1831-1842. Wood AM et al. Risk thresholds for alcohol consumption: combined analysis of individual participant data for599 912 current drinkers in 83 prospective studies. Lancet. 2018; 391: 1513–1523.

11. **Do you have any editorial or readability comments on the sections that make up Guideline One?**
    No Comment.
12. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline Two?**
    No Comment.
13. **Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).**
    No Comment.
14. **Do you have any editorial or readability comments on the sections that make up Guideline Two?**
    No Comment.
15. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline Three?**
    No Comment.
16. **Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).**
    No Comment.
17. **Do you have any editorial or readability comments on the sections that make up Guideline Three?**
    No Comment.
18. **Do you have any comments on how the *Drinking frequency* section could be improved?**
    No Comment.
19. **Do you have any comments on how the *Administrative report* could be improved?**
    No Comment.
20. **Are there any additional terms that should be added to the *glossary*?**
    No Comment.
21. **Are there any additional abbreviations or acronyms that should be added to this section?**
    No Comment.
22. **Do you have any comments on how the *Australian standard drinks* section could be improved?**
    No Comment.

Disclaimer I have read the security warning/disclaimer below and accept the risks and conditions outlined.

Permission to publish yes