Alcohol use disorders

In their Seminar (March 5, p 988), Jason Connor and colleagues[1] stressed that a comprehensive psychiatric assessment is essential to the identification of the primary disorder (psychiatric or alcohol use disorder). They also emphasised that research into health services is needed to improve the identification and treatment of the most common and remediable forms of psychiatric comorbidities in patients with alcohol use disorder, particularly anxiety disorders.

In clinical practice, it is crucial to distinguish symptoms of primary anxiety disorders from those of alcohol withdrawal anxiety. As indicated in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), alcohol withdrawal anxiety typically begins when blood concentrations of alcohol decline sharply (within 4–12 h) after alcohol use has been stopped or reduced.[2] Patients with severe alcohol use disorder experience, on a daily basis, subthreshold withdrawal anxiety symptoms, characterised by irritability associated with tremors and craving for alcohol. By contrast, individuals with primary anxiety disorders have different features: those with generalised anxiety disorder commonly worry about routine life circumstances—eg, possible job responsibilities, personal health and finances, the health of family members, misfortune to their children, or minor matters. Patients with social phobia commonly present a marked fear or anxiety of social situations in which they might be scrutinised by others. Alcohol could be used as a self-medication for social fears, but the symptoms of alcohol withdrawal might also be a source of further social fear.[3,4] Disentangling the symptoms of primary anxiety disorders from anxiety symptoms due to minor withdrawal can help patients with alcohol use disorder to understand the vicious circle of addiction and thus increase their motivation for abstinence.

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2 McKeon A, Frye MA, Delanty N. The alcohol withdrawal syndrome. *J Neurol Neurosurg Psychiatry* 2008; **79:** 854–62.
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Outcomes reporting of the FAME trial

The publication by Lokien van Nunen and colleagues[1] (Nov 7, 2015, p 1853) reported outcomes that were different from those initially registered (NCT00267774).

The Article correctly highlighted one outcome as not being prespecified. However, there were two outcomes, (total events and events per patient) which were not presented with sufficient clarity to determine if they were prespecified before trial commencement. In addition, the paper reports two combined endpoints (all cause mortality or myocardial infarction, and cardiac mortality or myocardial infarction) that were not prespecified, without flagging them as such.

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1 van Nunen L, Zimmermann F, Tonino P, et al. Fractional flow reserve versus angiography for guidance of PCI in patients with multivessel coronary artery disease (FAME): 5-year follow-up of a randomised controlled trial. *Lancet* 2015; **386:** 1853–60.

For more on the **COMPare project** see www.COMPare-Trials.org

Department of Error

Hobbs FDR, Bankhead C, Mukhtar T, et al, on behalf of the National Institute for Health Research School for Primary Care Research. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. Lancet *2016;* **387:** *2323–30*—This Article should have been published under a Creative Commons CC BY open access licence. This correction has been made as of June 2, 2016, and the printed Article is correct.

Thompson M, Walter F. Increases in general practice workload in England. Lancet *2016;* **387:** *2270–72*—This Comment should have been published under a Creative Commons CC BY open access licence. This correction has been made as of June 2, 2016.