Alcohol problems in outpatients

- Alcohol consumption contributes to 3 million deaths each year globally, as well as to the disabilities and poor health of millions of people. Overall, harmful use of alcohol is responsible for 5.1% of global burden of disease.
- There is no completely safe level of drinking; the risk of developing a range of illnesses increases with any amount of alcohol consumed. If someone does drink alcohol, then the general advice is to drink no more than six alcoholic drinks spread through the week in order to lower the risk of harming health.
- Alcohol problem drinking may be discovered through screening in higher risk populations, OR because of signs of acute withdrawal or alcohol dependence.
- Be alert to thinking about alcohol problems!

Screening

Screen ALL patients as part of social history

Take special care if:

- Related physical conditions e.g. GI or liver disorders, hypertension
- Mental health problems
- History of assault
- Regular unintentional injuries or minor trauma
- Regular STIs or repeated requests for emergency contraception
- Altered LFTS or raised MCV

↓

Ask if patient drinks alcohol at all.
If YES, ask following question:

↓

How often have you had 6 or more drinks on one occasion in the last year?	SCORING SYSTEM				
	0	**1**	**2**	**3**	**4**
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

If does not drink alcohol or if score <2, reinforce safe alcohol use

If score ≥2, complete full AUDIT questionnaire (page 2)

↓

AUDIT score	Risk level	Action
0-7	Low risk	Feedback result in a positive manner
8–15	Increasing risk (hazardous)	Brief advice & printed material
16–19	Higher risk (harmful)	Brief advice & printed material, refer to psychology team, continued monitoring, manage other medical conditions
≥20	Possible dependency	• Brief advice & printed material • Refer to psychology team or specialist services • Assess for risk of acute withdrawal and manage accordingly (see red box) • Assess for signs of **alcohol-related brain damage** (see page 3) and manage accordingly • Manage other medical conditions • Consider need for referral to nutritionist or thiamine supplements (50mg QDS if malnutrition or at risk of malnutrition, or if decompensated liver disease). *Note use of long-term Vit B Compounds no longer recommended.* • **DO NOT ADMIT** unless signs of acute withdrawal! • **DO NOT OFFER MEDICAL WITHDRAWAL IN COMMUNITY!** Needs to be part of a specialist programme.

Acute alcohol withdrawal

Suspect in anyone who is alcohol dependent and has stopped or reduced their drinking within hours or days of presentation

Anxiety, nausea and vomiting, autonomic dysfunction (sweating, tremor, tachycardia), insomnia

If untreated this can progress to severe withdrawal (p3):

- **Delirium tremens** (2-5d after stopping/reducing alcohol if high intake; confusion, perceptual disturbances, hallucinations, delusions, tremor, altered sleep–wake cycle, sweating, emotional lability, fever, hypertension, tachycardia)
- **Seizures**
- **Wernicke's encephalopathy** (ocular motility disorders, ataxia, mental state changes, nystagmus)

↓

- Discuss with consultant and transfer to casualty
- Consider differential diagnosis (sepsis, head injury, decompensated liver disease, gastritis, pancreatitis, metabolic derangements, other intoxication or withdrawal)

Brief advice in alcohol excess

Should take <10 minutes and be accompanied by self-help material. Studies show that it does work: 1 in 8 people reduce their alcohol to low-risk levels after brief advice

- Give feedback from the AUDIT questionnaire, be encouraging
- Identify risks and discuss consequences
- Provide medical advice
- Give printed information leaflet
- Ask how they feel about this, ask about readiness to change (see table on page 2 for more details)
- Solicit patient commitment
- Identify goal - reduced drinking or abstinence (a good way to cut down on alcohol us to have several drink-free days each week)
- IF ALCOHOL USE IS VERY HIGH - advise NOT to suddenly stop or significantly reduce their alcohol intake as this could be very dangerous. (Should reduce by NO MORE THAN 25% every 2w)

MEDICAL ADVICE - advise patients NOT to drink if:

- driving or operating machinery
- pregnant or considering pregnancy
- a contraindicated medical condition is present
- using medications, such as sedatives, codeine, NSAIDs

Discuss with consultant if:

- Signs of acute alcohol withdrawal
- History of seizures or DTs
- Audit score ≥20 or concern over high alcohol use
- Age<16y
- History of previous alcohol withdrawal
- Fever, high anxiety
- Hypoglycaemia, hypocalcaemia, hypokalaemia
- Poor background health
- Suspected alcohol-related brain damage
- Other psychiatric disorders

AUDIT questionnaire (WHO)					
QUESTIONS	**SCORING SYSTEM**				
	0	**1**	**2**	**3**	**4**
1. How often did you have a drink containing alcohol in the last year?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
2. How many drinks containing alcohol do you have on a typical day when you were drinking in the last year?	1-2	3-4	5-6	7-9	10+
3. How often have you had 6 or more drinks on one occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often in the las year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often in the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative or friend or a health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year

TABLE 1: Model of brief behaviour change counselling.

Step in the 5 As	Tasks in a guiding style
Ask	Ask about and document behavioural risks: Identify risk behaviour and document in record. Ask the patient what he/she already knows about the risks associated with the behaviour or would like to know. Respectfully affirm what he/she knows. Request permission to provide further information.
Alert	Provide relevant information in a neutral manner: Before giving information, emphasise that your role is to assist the patient in making informed choices, not to compel them to a particular course of action. Offer information on the health risks or benefits of change in a neutral way. Provide information using the 'E-P-E' method which is to elicit what the patient already knows and wants to know, provide relevant information, and elicit the patients understanding of this. If there is already a health problem related to the risk behaviour, clearly link the two.
Assess	Assess readiness to change: Ask the patient how they feel about the information provided and the possibility of making a change at this time. Assess how important change is for the patient and how confident he/she feels about change. Recognise and respond to 'change talk', which are statements by the patient revealing a desire, ability, reason, need or commitment to change. Offer support and assistance, but respect the patient's decision.
Assist	If response is 'Not ready to change': Ask about and acknowledge patient's concerns with empathy, avoiding any arguments. Offer help if he/she comes to a decision to change in the future. Request permission to give patient materials (if available), which could assist in them making a decision in the future. If response is 'Yes, am ready to change' then provide practical assistance to change such as: Positively reinforce any intentions to change which the patient expressed, no matter how small they may be. Express confidence in their capacity to achieve their health goal. Offer materials which teach behavioural change strategies and skills and express confidence that they will help. Prompt the patient to anticipate problems and barriers and to consider how to overcome these. Prompt patient to seek social support in their social environment. Prescribe medication, if appropriate.
Arrange	Arrange for follow up and/or referral: Document decisions made and materials given in the clinic record, add a reminder to discuss progress during the next visit and schedule follow up contact. Reiterate your and clinic staff's commitment to provide further information and support during behavioural change process. Refer patient to other health care providers for more intensive counselling if possible or to community based resources.

Emergency syndromes of alcohol dependence and tolerance	
Delirium tremens	• Occurs in about 5% of patients affected by severe alcohol withdrawal syndrome. • Develops 2–4d after decrease or stopping chronically-high alcohol consumption, and peaks at 5d. • Signs and symptoms include confusion, perceptual disturbances, hallucinations (including tactile hallucinations), delusions, tremor, altered sleep–wake cycle, changes in psychomotor activity, sweating, emotional lability, fever, and autonomic hyper-responsiveness with hypertension and tachycardia. • Early mental state changes include difficulty in estimating the passage of time: try asking the person to estimate how long the consultation has lasted. • May be fatal, most commonly due to cardiac arrhythmias or respiratory complications: mortality is 15–20% if untreated, dropping to 1% with treatment. • Arrange admission to hospital. Treatment is with benzodiazepines.
Seizures	• These occur as a complication of severe alcohol withdrawal. • Other risk factors include pre-existing epilepsy, structural brain lesions and the use of illicit drugs.
Wernicke's encephalopathy	• This is linked to severe thiamine deficiency. • It is characterised by: ocular motility disorders, ataxia, mental state changes, nystagmus. • If suspected, **arrange urgent admission to hospital for high-dose parenteral thiamine**. • If not treated adequately (if no, or low dose thiamine), can lead to Korsakoff's syndrome (see below).

Alcohol-related brain damage

- May contribute to 10-24% of all cases of dementia!
- Different types of ARBD but similar symptoms and treatment
- Likely associated comorbidities which need to be treated e.g. liver/heart failure

Wernicke-Korsakoff syndrome (WKS)	• A spectrum of disease resulting from thiamine deficiency, usually related to alcohol abuse • Wernicke's encephalopathy is the acute phase, and Korsakoff's syndrome is the late manifestation of the condition, resulting when Wernicke's encephalopathy has not been adequately treated
Korsakoff's syndrome	• This is characterised by disorientation, confabulation and both anterograde and retrograde amnesia. • Signs include: polyneuropathy, abnormal reflexes, ataxia and coordination abnormalities, muscle atrophy and weakness, horizontal nystagmus, cachexia, change in personality • Higher prevalence in homeless, older people living alone or in isolation, and in psychiatric inpatients • Required multidisciplinary involvement including psychiatry, nutritionist, OT/physio; long term oral thiamine after initial IV therapy, treatment of liver disease, treatment of heart failure
Alcohol-related 'dementia'	• Due to nerve cell damage and brain atrophy, particularly of frontal lobes • Patient will struggle with day-to-day tasks, decision making, memory loss and controlling their emotions. Also mood disturbance. • May demonstrate ataxia and poor coordination, even when sober, due to cerebellar damage • Decline in symptoms can stop or even reverse with cessation of alcohol, better nutrition and multidisciplinary support.
Traumatic brain injury	• Due to repeated head trauma when drunk
Alcohol-related stroke	• Vascular damage and high BP due to alcohol
Other	• Mild cognitive impairment • Peripheral neuropathy

References

mhGAP Intervention Guide, WHO, 2018 (version 2); https://www.redwhale.co.uk/content/alcohol; https://www.who.int/health-topics/alcohol#tab=tab_3; https://iris.who.int/bitstream/handle/10665/44322/9789241599405_eng.pdf?sequence=1; National Guidelines on Alcohol and Drug Use Prevention, National Authority for the Campaign against Alcohol and Drug Abuse, 2021; What is alcohol-related brain damage (ARBD)? Factsheet 438LP, June 2020, Alzheimer's Society; https://patient.info/doctor/wernicke-korsakoff-syndrome