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How I Manage ... The Alcoholic Patient

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I thank the college for inviting me to make this presentation on how I manage alcohol related problems in my practice. The hypothetical case is one of a middle-aged businessman who, during one of his rare visits, complains of symptoms of anxiety and difficulty in sleeping, attributed to pressures at work. During questioning he avoids my probing into his alcohol intake, but does reveal that his wife is being treated by another doctor for depression.

Notwithstanding the patient's reluctance, it is essential that one should investigate the quantity and quality of alcohol intake and the relationship of the suspected abuse of alcohol to the patient's social, family and personal problems.

It is important to assess whether alcohol intake is in fact excessive, and thus the daily quantity drunk should be determined. A critical level which may trigger dependence is approximately 150 ml per 24 hours, or approximately $^1/_2$ a bottle of spirits, 1 $^1/_2$ bottles of wine, or 4 to 7 pints of beer. Pointed questions should be asked to look for specific features which, if present, indicate a tendency to alcohol dependence. It may be very difficult to differentiate heavy social drinking from alcoholism, but the presence of these features is indicative.

Features of Alcoholism

1. Inability to abstain
2. Alcoholic "blackouts" – pt. forgets what happened during last night's binge
3. Decreased memory capability, concentration and ability to work profitably e.g. frequently late to work on Monday, following weekend
4. Accident prone – especially car accidents
5. Emotional lability with outbursts of rage followed by remorse
6. Bonhomie with drinking companions but inconsiderate and self-centred with family
7. Deteriorating sex life due to inconsiderateness
8. Thinking about drink – about getting a drink – about stopping
9. Early drinking to combat early morning "shakes" due to night-time abstinence

Next, one would investigate the relationship between alcohol abuse and the patient's problems. Alcoholism may be symptomatic of underlying mental illness, and the psychotic patient may drink to dull feelings of depression, delusions or hallucinations; therefore one must keep in mind that the patient's anxiety and sleep disorder may be due to causes other than pure alcoholism. In the majority of cases the symptoms are mainly alcohol related and should improve with improved control of drinking.

The patient should be asked about his home situation and whether his drinking has brought on domestic conflict and contributed to his wife's depression, or whether he is drinking because of his anxieties about his spouse's health problems. The patient's marital relationship is very relevant in that family support plays a crucial role in helping the patient to stop.

One would enquire about smoking, heavy smoking being prevalent in individuals prone to use alcohol as an escape mechanism. Poor eating habits, with little regard to eating a balanced diet is also common. In extreme cases diet may be very poor, predisposing to vitamin deficiencies and complex health problems.

A detailed social history is taken, with reference to the patient's work environment and work relationships. A drug history is also taken with details of use or abuse of tranquillisers and sleeping tablets, compliance with other medication, such as anti-hypertensive treatment, and, if appropriate, use of illicit drugs. One would also ask about other symptomatology, such as heartburn, shortness of breath, chest pain, haematemesis and melaena, etc.

During the physical examination, one would pay attention to general physical health and body habitus. One looks for the stigmata of liver disease, such as jaundice, palmar erythema, gynaecomastia, finger clubbing, spider naevi, etc. Chest and cardiovascular assessment is carried out, and abdominal examination should include palpation of the liver and spleen to assess size and texture, and digital rectal examination to detect haemorrhoids. Haematological investigations should include parameters which may indicate abuse and may serve to monitor abstinence, such as MCV and Gamma-GT which are elevated in alcohol abusers.

Complications of Alcohol Abuse

1. Psychosocial — domestic conflict, assault, wife and baby battering, road accidents, loss of work, homicide, suicide,

2. Physical obesity, early morning nausea & vomiting, tremors, suffused facies
heavy smoking, laryngitis, tracheitis, bronchitis, gastritis, peptic ulcer
pancreatitis, acute and chronic
liver disease: fatty liver, hepatitis, cirrhosis, liver failure
bleeding oesopageal varices
dysrhythmias, cardiomyopathy
polyneuritis, cerebellar degeneration, retrobulbar neuropathy
falls and subdural haematoma
epileptic fits
anaemia, haemolysis
alcoholic hallucinations, delerium tremens
Korsakow's psychosis, Wernicke's encephalopathy
dementia

Alcoholism

Alcohol induces a feeling of warmth, wellbeing and exhilaration, but is a cerebral depressant and thus keeps anxiety, conscience and self-criticism at bay. Teetotallers can metabolise 7 to 20 ml of alcohol per hour, but chronic drinkers can metabolise much more and also develop central nervous system tolerance. Thus tolerance may be considerable, but although appearing sober their reflexes may be dulled and their capability to perform complex tasks such as driving may be severely impaired.

Prevalence is on the increase in both sexes, but it is difficult to quantify because of reluctance to see a doctor due to lack of insight, fear of ridicule or of a hostile reaction, and socio-economic repercussions. Many cases present due to domestic conflict or car accidents. It may also be difficult to distinguish from heavy social drinking, which may however develop into more obvious dependence.

Primary alcoholism is due to a conditioned reflex such as demonstrated by Pavlov, where drinking brings on relief from anxieties, conscience or internal conflict. Alcoholism may also be secondary to mental illness, bringing relief from delusions of persecution, nagging hallucinations or depression. Susceptibility may be hereditary, but a positive family history is not found in all cases. Occupational exposure play a part and prevalence is higher in bartenders, but also actors and other entertainers, armed forces personnel, medical practitioners and insurance brokers. Age is usually over thirty but prevalence in teenagers is on the increase. In females a different picture prevails with home or "wardrobe" drinking.

Management

Motivation and co-operation essential
Examine patient's life situation and determine difficulties to be solved
Enlist help of spouse and family – make drink and money less available
Refer to self-help group, e.g. A.A.
? antabuse
? behavioural therapy
- reverse conditioning
- mix drink with foul tasting substance
- electric shocks

Goals

To stop all drink at once may be counterproductive – pt. drinks in defiance "I AM NOT SICK!"
Teach patient to estimate intake and keep an "alcoholic diary", listing successes and failures
Feedback with improvements – weight, MCV, gamma-GT

Tricks

Limit to social occasions – sip not gulp
Decrease frequency of sips – shadow a slow drinker and put down your glass with him to avoid subconscious sipping
Drink more non-alcoholic drinks
Don't buy yourself a drink when buying a round
Decrease the period of drinking – go out to the bar later
Rest days with no drinking
Catch phrases to refuse a drink – "no thanks, I have to drive home"

Conclusion

In conclusion, alcoholism is a commonly encountered problem in family practice, and the family doctor is in a unique position to treat it in the family setting, addressing more aspects of the problem and recruiting the help of the family as a whole. Successful treatment, although difficult to achieve, will improve the patient's physical and mental health, allow him to improve his home and work situation and avoid debilitating and potentially life-threatening complications, and this makes for a very satisfying challenge for the family doctor to meet.

Thank you for your attention.