Alcoholism and Related Problems

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Alcoholism is a condition in which the individual has lost control over his drinking or is unable to abstain.

Problem drinking is a term used to describe abnormal drinking which has not yet progressed to the stage of dependence. It is important from the clinical point of view because heavy bouts of drinking on weekends may be dangerous to the family, to the self and to others like driving, work etc. The Characteristics of Alcoholism are (Jellinek 1946) as follows:

Pre-Alcoholic Phase: when alcohol is more taken as a relief and this becomes more regular while tolerance is increased;

Prodromal Phase: marked by *blackouts* in which the drinker, after a moderate amount of alcohol by his own standards, may show no signs of intoxication and be able to carry out acts requiring a high degree of coordination of which he subsequently has no recollection - an important warning. At this point the patient has more *blackouts* alternating between a superficial attitude to his problem and short periods of insight and guilt.

The Crucial Phase is ushered in by a loss of control in which the ingestion of even a very small quantity of alcohol sets up a compulsive demand for more which ceases only when his stomach or nervous system calls a halt.

The Chronic Phase is marked by prolonged periods of intoxication with absence from work, serious deterioration in ethical attitudes, covered by a variety of shallow realisations of his drinking behaviour; difficulty in obtaining the usual spirits may now lead to drinking of cheap spirits like methylated spirit.

The more important points that the individual is an alcoholic are:

i) Subjective awareness that a few drinks are not enough and one drink leads to another till his *promised upper level* is exceeded:
ii) Withdrawal phenomenon - morning withdrawal symptoms such as shakes sweating and *butterflies* in the stomach. These are relieved by more of the drug, and hence the morning drink. Withdrawal fits may occur.
iii) Tolerance Phenomena. There is first a raised tolerance, and then in the later stages of the illness tolerance declines and the alcoholic *begins to get drunk on less.*
iv) Amnesias. Alcohol amnesias or blackouts are a frequent phenomena. There is no actual loss of consciousness but in the morning the patient cannot remember the night before.
90% of Alcoholics are not diagnosed.

Blocks to Diagnosis (Griffit Edwards)[2]

i) Expecting the alcoholic to conform in appearance to the skidrow stereotype;
ii) Expecting the alcoholic to be someone with gross physical signs. An enlarged liver will seldom be found, but **Palpation under the Right Costal Margin** will often elicit tenderness. Gross alcoholic neuritis is a rarity, but absent or diminished ankle jerks are a common clue. An obvious tremor is unlikely but a slight tremor of the outstreched hands or the tongue may be suggestive evidence.
iii) Forgetting that women too suffer from alcoholism.
iv) The alcoholic often comes into the surgery, asking for a 'certificate' on nebulous grounds; or asking for something for *bad nerves*; asking for something *for his stomach*; asking for a certificate on nebulous grounds; or carrying a letter from the casualty department for a minor accident.
v) Occupation hazards like publicans, travelling salesmen, journalists, entertainers, hard pressed executives.

Assessment of an Alcoholic:

i) The amount he drinks:

Patients hide the amount they consume so that in asking always assume twice the amount the patient volunteers. A heavy drinker is usually drinking half a bottle of whisky a day or eight pints of beer and one must definitely prevent escalation beyond this point. He should be asked whether he drinks in the morning; whether he worries that supply of spirits is not enough for his demands; whether he hides empty bottles; whether he shows signs and symptoms of physical and psychological sequelae (See Chart).

ii) Assess damage to mental health:

Bad nerves; irritability; explosive espisodes; blackouts; irresponsible behaviour, pathological jealousy; transient 'confusional state' with fears hallucinations and tremors (Delirium Termens); hallucinosis; memory defects with confabulation (Korsakoff's or Wernicke's): depression.

iii) Assess damage to physical health

"not feeling at all fit"; peripheral neuropathy; liver damage; brain organic syndrome; trauma; peptic ulcer; avitaminosis; Tuberculosis; impotence.

iv) Assess damage to social health:

Motor vehicle accidents; absenteeism from work; firing from duties; family friction and breakdown; debt; wife battering or other cruelties; loss of sexual relations.

Investigations:

Blood Count and Picture might reveal hypochromic anaemia from malnutrition as well as thrombocytopaenia (Folic Acid deficiency). Increased cholesterol is a usual finding. Abnormal Liver Function may be detected as well as unsatisfactory Renal functioning.

Treatment:

Dealing with alcoholics may be very difficult but rewarding. One decides first whether to handle the patient at home or refer him for consultation.

Hospital treatment is *Never* the answer as alcoholism is a life-long problem. Hospitalisation is indicated in the withdrawal stage of alcoholism where the patient is nursed in a quiet room; given enough sweetened drinks, sedated with Heminevrin 200 mg three times daily (or chlorpromanzine 50 mg t.d.s.) and given infusion of large doses of vitamin preparation. He may be admitted to hospital in Korsakoff/ Wernicke's syndrome as well in advanced liver damage.

Consultation with a specialist is called for when the patient is on the stage of becoming an alcoholic, social factors are threatening and psychological functions are disrupting the family's and the patient's well being. The Consultant/Specialist may order routine management and may also order psychotropic drugs like Diazepam 5mg tds, Chlordiazepoxide 10 mg tds or Thioridazine 25mg tds. Sometimes the patient is initiated under specialist supervision with Disulfiram (Antabuse) or more recently Citrated Calcium Carbimide (Abstem) which though producing less severe reactions and toxic effects with alcohol, is still dangerous, as alcohol and disulfiram produce acetaldehyde with consequent rapid pulse, vasodilatation, dyspnoea and a feeling of distress which may be fatal unless i/v Ascorbic Acid is given promptly. The Specialist may refer the patient to psychotherapy, hypnosis, behaviour therapy, group therapy (Alcoholic Anonymous - P.O. Box 300 B'Kara) or even spiritual therapy.

Management at home

i) Acceptance of the patient:

The doctor and the patient must reach the conclusion that the primary problem is alcohol. In this respect the patient must be *Motivated* to do his best to overcome the problem. He must realise that he is weak in the face of alcohol and he must be ready to function at a lower level without alcohol. He must also accept that he may not be completely true in matters related to it and may be questioned. He must keep below the "break off" point of 150 mg% in the blood (1/2 bottle of spirits or 8 pints of beer). He must avoid going to parties though he may host one. Being a host adds the responsibility of behaving in front of guests. The doctor immediately starts *building the patient's health* — with good wholesome food; sugared drinks, exercise, rest and vitamins. He makes himself available as *a friend* for consultations and ready to bear with him in *changing a life style.*

ii) Setting Realistic Treatment Goals:

The ultimate goal should be total abstention of alcohol. This is easier said than done and some patients are overmotivated and grin and bear it. Others relapse and relapse. In each case the doctor takes him on. The patient is told to avoid one party after another and also one starter after another for a limited period till the patient realised that the can do it at some time, perhaps most of the time and exceptionally all the time. The patient is shown clearly the advantages of being free without hang-overs, without making a fool of himself; without hurting people and with the serenity of clear judgement. Sometimes he is praised for being *off* at particularly difficult periods and often to smile at his superiority over his former colleagues.

iii) Treat the whole situation.

The family must activate treatment. The debts are dealt with; apologies spread to the casualties of his loose tongue when drunk; the bar may excuse him serving two instead of "don't know how much." At times he must see the responsibility of his action like leaving his wife as a wall flower while he teases other women with dirty jokes; of driving home alone when he is under the influence of alcohol; of apologising himself when he offends; of paying for the damages he incurred. Hard words are usually avoided and threats are no use.

Prognosis

The success rate is not high but encouraging 20% get well and dry; 20% never respond and 60% are not cured but saved.

GUIDELINES FOR EARLY DETECTION OF ALCOHOLISM

PHYSICAL CLUES:

Gastrointestinal: Vomiting often before breakfast, nausea, dysphagia, vague abdominal pain.
Neurological: black outs, insomnia, headaches.
Cardiovascular: palpitations, bradycardia.
Traumatic: frequent accidents, falls or injuries, cigarette burns on hands and chest.

PSYCHOLOGICAL CLUES:

Behavioural:
- Frequent financial difficulties:
- Excessive abstenteeism and poor performance at work
- Marital discord and multiple separations
- Immoderate use of coffee, tea, tobacco, drugs.

Emotional:
- Anxiety
- Panic attacks
- Hallucinations
- Depression
- Suicidal ideas

Laboratory findings
- Hiperlipidaemia
- Abnormal Liver/Kidney Function
- Anaemia