When is an Alcohol Problem a Problem?

Case

A 35-year-old man was found collapsed in the street following an assault. On admission he smelt strongly of alcohol and he and he had a GCS score of 10. CT scan showed minor intracerebral bleeds compatible with a moderate brain injury. The trauma required no acute medical intervention aside from suturing of a laceration on his forehead. Given an elevated GGT and a history of substantial alcohol intake from his wife a reducing regime of benzodiazepines was initiated. Two days post admission he was oriented, and when reviewed the following day a coherent history was taken. On assessment there were moderate impairments of memory and executive function, but he was thought to be safe to discharge on proviso that his wife took care of him. Alcohol history revealed that although he does not give a history of significant withdrawal symptoms, he does consume approximately 4 pints of continental lager (12 units) a day, and experiences strong cravings for alcohol. He doesn’t drink in the mornings. Does this man have an alcohol problem? Is his alcohol consumption likely to impact on current clinical findings? Is his alcohol consumption putting him at future risk? What should you do?

Does this man have an alcohol problem?

‘Problem drinking’ is a broad term encompassing people not dependent on alcohol but whose consumption is causing harm (physical, psychological or social) through to the severely physically dependent. A diagnosis of alcohol dependence is made when three from the following six symptoms are present: craving; impaired ability to control use; withdrawal; tolerance; neglect of alternative pleasures/interests; and continued use despite harmful consequences. It is craving rather than withdrawal that is the central feature of the syndrome. The patient was consuming 84 units of alcohol a week and clearly described craving; a more detailed history will likely demonstrate alcohol dependence.

Is his alcohol problem relevant to current clinical findings?

The archetypal picture of alcohol-associated cognitive deficits is Korsakoff’s syndrome. This is associated with thalamic and mamillary body atrophy, and arises as a consequence of the thiamine deficiency. In its purest form patients are unable to form new declarative memories in the context of relatively intact attention and working memory. It is recognised however that people with no history of Wernicke-Korsakoff’s syndrome can still manifest alcohol-related cognitive impairment. This is believed to be due to the direct toxic effect of alcohol on the brain. The frontal and parietal lobes are particularly vulnerable, and deficits include attentional, visuospatial and executive impairment.

The cognitive deficits associated with alcohol use and traumatic brain injury (TBI), are similar. Given that co-occurrence of the two conditions is common, this means that determination of the aetiology of cognitive impairments in a heavy-drinking individual who has experienced a TBI is difficult. Visuospatial deficits may be particularly pronounced in alcohol-related damage, but this observation has little clinical utility; in a recent comparative study patients with mild TBI and alcohol abuse could not be reliably differentiated by cognitive testing. While impairment temporarily associated with a TBI can be attributed to it, in practice establishing if cognitive deficits are new or established can be very difficult. Collateral history is frequently unobtainable in socially isolated individuals with alcohol problems. Cognitive deficits solely attributable to alcohol in uncomplicated alcoholics (i.e. no history of medical complications) are uncommon before the fifth decade. This, particularly if the history indicated deficits were new, would suggest they were caused by the TBI. Deficits of either aetiology should improve with time but this will be jeopardised by ongoing alcohol use.

Is his alcohol problem putting him at future risk?

Use of alcohol has long been associated with TBI. 1/3 to 2/3 of patients with TBI are intoxicated at the time of injury, and approximately half of alcoholics have a history of TBI with loss of consciousness and/or hospitalisation. A TBI often encourages individuals to address their alcohol problem; one year post TBI 30% of individuals were completely abstinent form
alcohol, compared to only 8.4% reporting abstinence pre-injury. Unfortunately the effects appear transient and consumption increases again with time. Young males are most likely to return to drinking. Several studies have reported an association between a history of alcohol abuse / dependence at the time of injury and poorer outcomes, but few have explored this by actually ascertaining alcohol use after TBI. Nonetheless, it is generally accepted that alcohol use after TBI can contribute to seizures, increase risk of further head injury during the period of rehabilitation, exacerbate cognitive and behavioural impairments and lower mood. Individuals with a history of alcohol abuse/dependence require additional interventions, including substance abuse treatment and longer-term follow-up.

What treatment is available?
Few studies have investigated the efficacy of alcohol treatments in the TBI population, so evidence must be extrapolated from the general population. This demonstrates that alcohol-based ‘brief interventions’ are useful and practical (Flemming et al., 2003). They consist simply of identifying an alcohol problem and discussing the benefits of change. A motivational interviewing style maximises impact. This is a non-judgemental style of questioning which avoids confrontation and lecturing but helps the individual weigh up the pros and cons of change. The aim is for the patient to make their own arguments for change. In the TBI context the patient would be encouraged to consider the role alcohol played in acquisition of their injury, and the negative consequences ongoing use will have for recovery. It should be emphasised that consumption levels considered relatively low risk in the general population must be very severely considered in post-TBI and abstinence the aim, although any reduction is beneficial. Brief interventions are primarily aimed at hazardous, but not yet dependent drinkers. The latter generally require more sophisticated treatment. The medical need for detoxification must be considered, but maintaining abstinence poses the greatest challenges. Alcoholics Anonymous should always be considered, directly or via the website (www.alcoholics-anonymous.org.uk) can be a useful resource for them.

What if the patient does not want to stop drinking
The patient states that he wishes to return home, where he intends to resume drinking. His wife states that she is not willing to take responsibility for his care in the present circumstances, and wishes him to remain in hospital. Can he be kept in hospital against his will?

The patient has documented cognitive deficits. This constitutes an ‘impairment of functioning’, and raises the question of whether he has capacity to make the decision to leave hospital. Though he was deemed safe for discharge on the basis of his cognitive and general assessment, this was based on the basis that his wife was willing to provide care for him in a safe environment. His wife’s concerns now call for us to ascertain this in question, and the patient’s capacity to make the decision to himself be specifically assessed.

To be able to ascertain this we must first be clear what risks the patient’s cognitive impairment will place him in. These will not be limited to resumption of drinking, and other potential risks must also be identified. At the least this will necessitate occupational therapy functional assessment, addressing issues such as self care and safety in the environment.

Once the risks of discharge are clear, the critical question is whether the patient has capacity to discharge himself given these risks. To have this capacity the patient must be aware of the potential adverse consequences of leaving hospital, understand the nature of these adverse consequences, consider them when making the choice to discharge himself and be able to communicate his reasons for making that choice. It is conceivable that his impairments of memory and executive function are such that he lacks the capacity to discharge himself. If this is the case, use of legislation could be considered to keep him in hospital.

The英国it specifically states that a person is not regarded as mentally disordered by reason only of dependence on, or use of, alcohol or drugs. However, the mental disorder on the basis of which he could be detained would be the remaining cognitive deficits consequent to TBI. Detention would be an outcome of last resort with less restrictive solutions being sought. One potential outcome would be the patient agreeing to remain in hospital a little longer (on a voluntary basis), until further improvements in memory and executive function meant he had capacity to make decisions about discharge; alternatively discharge may be feasible with the input of community services.

REFERENCES