

CLINICAL UPDATE

Alcohol

2nd Edition 2007

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Digestive Health Foundation

The Digestive Health Foundation (DHF) is an educational body committed to promoting better health for all Australians by promoting education and community health programs related to the digestive system.

The DHF is the educational arm of the Gastroenterological Society of Australia, the professional body representing the specialty of gastrointestinal and liver disease in Australia. Members of the Society are drawn from physicians, surgeons, scientists and other medical specialties with an interest in GI disorders.

Since its establishment in 1990 the DHF has been involved in the development of programs to improve community awareness and the understanding of digestive diseases.

Research and education into gastrointestinal disease are essential to contain the effects of these disorders on all Australians.

Guidelines for General Practitioners and patient leaflets are available on a range of topics related to GI disorders. Copies are available by contacting the Secretariat at the address below.

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ALCOHOL

Alcohol is a mood-altering drug which has been used for centuries for ceremonial, cultural and other reasons. Alcohol related health problems occur in every society where alcohol is consumed. The prevalence of some of these problems (e.g. cirrhosis of the liver) varies with per capita consumption of alcohol. Early intervention can promote safe drinking patterns and prevent more severe alcohol related problems. Treatment of advanced alcohol dependence is more intensive and less successful, although new medications may improve outcomes.

This document has been prepared by the Digestive Health Foundation of the Gastroenterological Society of Australia and every care has been taken in its compilation. The booklet is intended as a guide only and not as an authoritative statement of every conceivable circumstance which could relate to the management of diseases related to alcohol.

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Information leaflets on alcohol for patients and the general public are available through the Digestive Health Foundation, 145 Macquarie Street, Sydney, NSW, 2000.
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1. ALCOHOL - SOME BENEFITS OF OUR FAVOURITE DRUG

Alcohol, like most mood affecting drugs, has benefits as well as dangers. Most of those who drink alcohol do not experience significant harms. As a social lubricant, alcohol is second to none. Alcohol is believed to be an appetite stimulant and to enhance the flavour of food.

Alcohol in modest doses exerts a protective effect against coronary artery disease and diabetes mellitus. One to two standard drinks of alcohol twice a week is associated with a reduction in mortality due to coronary disease of up to 35% compared to non-drinkers. This effect is most apparent in middle aged males who have high risk of myocardial infarction, but may not apply to younger females whose risk of breast cancer, for which alcohol may be a co-factor, is higher than the risk of ischaemic heart disease. It is likely that alcohol affords no protection in young males who have a low risk of coronary artery disease but a high risk of alcohol related trauma. Coronary risk reduction can also be achieved by other means (stopping smoking, losing weight, improving diet, increasing exercise).

2. ALCOHOL USE AND ASSOCIATED PROBLEMS

In Australia, alcohol consumption has fallen from a peak 11.1 litres of pure alcohol per head of population in 1978 to 9.8 litres in 2004-5. It has been estimated that the cost of alcohol abuse in 1998-99 totalled \$7.6 billion.

Comparison of the 1993 and 2004 National Drug Strategy Household Surveys reveals generally increasing use of alcohol in the community. The number of people who drink has risen from 75% to 84%. In 2004, 41% of people aged 14 and above consumed alcohol on a weekly basis and 9% drank every day. Forty-eight percent of males and 35% of females drank at least one day per week.

In 2004, about 77% of males and 71% of females aged 14 years and over consumed alcohol at levels at which there is minimal risk of long-term alcohol related harm. Overall, one in ten Australians consumed alcohol at levels that are considered risky or high risk for alcohol related harm in the long-term.

In 2004, about one in three people (35%) aged 14 years and over consumed alcohol in a way that put them at an increased risk of alcohol related harm in the short-term. While 31% of women drank at risky and/or high-risk levels of harm in the short-term, 40% of males had this drinking pattern.

The peak ages where the highest proportion of males drank at risky and high-risk levels in the short-term was 20–29 years, where nearly two in three (65%) drank at these levels at least once in the last 12 months. Risky and high-risk drinking also peaked at ages 20–29 years for women with over half (57%) drinking at these levels in 2004.

Heavy drinking among teenagers is at an unacceptable level: approximately one in ten males and females aged 14-19 years consumed alcohol at risky and high-risk levels at least weekly.

In 2001 there were an estimated 3,000 deaths due to alcohol consumption at risky and high-risk levels. There were around three times as many deaths for males compared with females.

Problem drinkers who visit general practitioners because of physical, social or psychological complications of alcohol make up a larger percentage (approximately 80%) of the heavy drinking population than those with alcohol dependence. These latter individuals are often recognised because of the development of withdrawal symptoms when consumption is deliberately or inadvertently curtailed, or because of severe physical illness, e.g. cirrhosis.

3. HOW DO ALCOHOL RELATED HEALTH CARE PROBLEMS PRESENT IN GENERAL PRACTICE?

A patient's use of alcohol may be relevant to a consultation in several ways:

- It may be a significant risk factor for future problems for patients who are drinking hazardously.
- It may be a significant co-factor in the aetiology of clinical presentation.
- Some patients will be alcohol dependent (addicted or 'alcoholic') where addressing the alcohol consumption pattern itself is the central issue.
- It may create problems in the management of other conditions due to interactions with prescribed drugs.

3.1 Alcohol as a risk factor

Epidemiological evidence associates long-term risky drinking (i.e. >2 standard drinks per day for women, >4 standard drinks per day for men) with increased risk of tissue damage, including cirrhosis, pancreatitis and alcohol related brain damage. This is the basis for the National Health and Medical Research Council's recommendations on safer levels of alcohol consumption (Tables 1 and 2).

Excessive use of alcohol by young people is often a symptom of underlying emotional or social problems including depression; personality disorders; alienation; neglect and abuse.

Such individuals may also be involved in polydrug use. Medical practitioners dealing with adolescents need to be aware of this and know how to involve families, school and peers as well as other support services in managing

Table 1: How much is a standard drink?

Beer, wine and spirits have different alcohol contents and it is usual to express consumption in terms of standard drinks, each containing approximately 10g of alcohol. The percentage of ethanol (v/v) is now on the label.

STANDARD DRINK	STRENGTH BY VOLUME	SIZE (VOLUME)
Beer	Light: 2.7% = 0.8 std drink	Schooner/stubby/can (375 ml)
	Medium: 3.5% = 1 std drink	
	Full: 4.9% = 1.5 std drinks	
Red or white table wine	12%	100ml (1/2 glass)
Fortified wine (e.g. Port, sherry)	18%	60ml
Spirits (e.g. Gin, whisky)	40%	30ml

Table 2: NHMRC Guidelines for low risk drinking

RISK OF HARM IN SHORT-TERM	MALES ALCOHOL/DAY	FEMALES ALCOHOL/DAY
Low risk	Up to 6 drinks on any one day	Up to 4 drinks on any one day
Risky	7-10 per day	5-6 per day
High risk	11 or more per day	7 or more per day
Two alcohol free days per week are recommended.		
RISK OF HARM IN LONG-TERM	MALES ALCOHOL/DAY	FEMALES ALCOHOL/DAY
Low risk	Up to 4 drinks on an average day; up to 28 per week	Up to 2 drinks on an average day; up to 14 per week
Risky	5-6 per day; 29-42 per week	3-4 per day; 15-28 per week
High risk	7 or more per day; 43 or more per week	5 or more per day; 29 or more per week
Two alcohol free days per week are recommended.		

these high risk individuals. In the majority of cases of heavy drinking in teenagers or people in their early 20s, consumption patterns moderate (without any intervention) after a brief period of adolescent turmoil or with the onset of adult responsibilities such as marriage.

4. HOW DO ALCOHOL RELATED HEALTH CARE PROBLEMS PRESENT IN GENERAL PRACTICE?

4.1 Alcohol as a co-factor

Alcohol may play a role in a variety of clinical situations where 'use' and not necessarily 'abuse' may be significant. For example, alcohol is a co-factor in up to one-third of motor vehicle accidents. It is less widely appreciated that alcohol is a co-factor in a substantial proportion of work-related accidents and injuries.

Many common clinical problems are affected by alcohol - e.g. epilepsy; depression; diabetes; gout; hypertension; anxiety; infertility; obesity and dyspepsia. A complete alcohol history is essential as patients seldom associate alcohol with their presenting problem.

4.2 Aetiology of alcohol dependence

A role for genetic factors in the aetiology of alcohol dependence has been established by family and twin studies. The disorder is thought to be polygenic, but the genes involved remain unclear. Certain personality traits have been associated with alcohol abuse. At a population level, factors such as price and availability influence total alcohol consumption.

Chronic alcohol consumption is associated with alterations of a range of CNS neurotransmitters including dopamine, GABA, glutamate and opiates. These changes are thought to mediate the physical and psychological aspects of the dependent syndrome, namely tolerance, withdrawal and alcohol craving. Several pharmacological agents interfere with these alcohol receptor interactions and are finding a role in treatment.

Some drugs may interact in a clinically significant manner with alcohol, e.g. warfarin, aspirin, antihistamines, benzodiazepines and other psychotropic agents, as well as metronidazole.

5. HOW DO ALCOHOL-RELATED HEALTH CARE PROBLEMS PRESENT IN GENERAL PRACTICE?

5.1 Complications of chronic hazardous consumption

Prolonged hazardous consumption leads to a number of well-known medical sequelae (Table 3). These can arise in addition to or independent of a range of social, work and interpersonal problems. While nearly all GPs would recognise that cirrhosis, pancreatitis and gout are associated with alcohol use, it is perhaps less often realised that hypertension, cardiomyopathy, certain arrhythmias, anxiety, depression and a range of problems related to the nervous system can be due to excessive alcohol consumption. It has been estimated that harmful levels of consumption of alcohol raise a woman's lifetime risk of developing breast cancer by 67% from 1 in 14 to 1 in 9. Alcohol consumption puts patients at a higher risk of hemorrhagic stroke, but contributes to lower risk of ischemic stroke.

Early recognition of hazardous alcohol consumption is an essential part of the management of any patient with one of the conditions listed in Table 3.

5.2 Alcohol dependence

Dependence has both physical and psychological components. Formal diagnostic criteria are defined by ICD-10 and DSM-IV.

An individual is considered physically dependent when alcohol consumption produces tolerance (drinking more to produce the same effect) or withdrawal (tremor; anxiety; agitation; sweating and in severe cases seizures, confusion, hallucinations and dehydration) on sudden cessation of alcohol.

Psychological dependence refers to people in whom alcohol consumption assumes priority over most other activities (salience) and in whom craving and continuing to drink despite problems are the key features.

Table 3: Alcohol related health problems

ALCOHOL DEPENDENCE	
PHYSICAL	
Tolerance	<ul style="list-style-type: none"> • Ability to drink progressively larger amounts without apparent intoxication.
Withdrawal	<ul style="list-style-type: none"> • Hyper-adrenergic syndrome when alcohol consumption is suddenly stopped with anxiety, agitation, sweating, tremor and tachycardia. • Severe: above features plus seizures or agitated delirium with confusion and hallucinations (delirium tremens)
PSYCHOLOGICAL	
Alcohol seeking behaviour Saliency	<ul style="list-style-type: none"> • Craving, continuing to drink despite adverse effects. • Alcohol assumes priority over other activities
MEDICAL	
Liver disease	<ul style="list-style-type: none"> • Fatty liver • Alcoholic hepatitis • Cirrhosis
Gastrointestinal disease	<ul style="list-style-type: none"> • Reflux oesophagitis • Dyspepsia due to gastritis • Diarrhoea • Acute and chronic pancreatitis • Pancreatic insufficiency • Carcinoma of liver, oesophagus and large bowel
Neurological	<ul style="list-style-type: none"> • Alcohol-related dementia • Korsakoff's psychosis • Wernicke's encephalopathy • Cerebellar ataxia • Peripheral neuropathy
Heart diseases	<ul style="list-style-type: none"> • Hypertension • Cardiomyopathy • Arrhythmias
Lung diseases	<ul style="list-style-type: none"> • Aspiration pneumonia
Sexual and reproductive disorders	<ul style="list-style-type: none"> • Impotence, testicular atrophy. • Prematurity, foetal alcohol syndrome
Bone and joint disorders	<ul style="list-style-type: none"> • Gout • Osteoporosis
Metabolic	<ul style="list-style-type: none"> • Hypertriglyceridaemia • Hypoglycaemia • Ketoacidosis

ALCOHOL DEPENDENCE

MEDICAL continued

Accidents

- Head injury
- Subdural haematoma
- Fractured bones (especially ribs)
- Multiple trauma (from road accidents etc)

Nutrition

- Malnutrition
- Obesity
- Vitamin deficiencies (especially thiamine)

PSYCHOLOGICAL

- Insomnia
- Anxiety, panic attacks
- Depression, paranoid ideation
- Confusion, hallucinations
- Alcoholic 'blackouts' (amnesic episodes)
- Suicidal ideation and acts

SOCIAL

Domestic and allied problems

- Loss of friends
- Deterioration in marital and other significant relationships
- Separation/divorce
- Physical abuse
- Neglect of children

Occupational

- Lateness or absences from work
- Demotion/failure to gain promotion
- Dismissal/unemployment

Financial problems

- Loss of regular income from employment
- Hardship from money spent on alcohol
- Gambling debts

Legal problems

- Drink-driving offences/loss of licence
- Property crime
- Assault
- Homicide
- Neglect of children

6. ASSESSMENT OF AN INDIVIDUAL WITH AN ALCOHOL RELATED PROBLEM

6.1 History

The key to recognising an ‘at risk’ drinker or an individual with an alcohol related health problem is an accurate alcohol consumption history. This is usually best taken as part of the lifestyle assessment. If embedded in a part of the interview, which relates to other lifestyle issues (such as nutrition, exercise and other health risk factors), it rarely causes embarrassment for doctor or patient. The doctor should enquire about the frequency of use, the quantity usually drunk on occasions when alcohol is consumed, the pattern of use (whether consumption is daily or intermittent) and the duration of use. If alcohol consumption is frequent but accurate amounts are difficult to discern, it may be of value to use the ‘7 day recall method’. The doctor should enquire about use each day, starting with the day of the consultation and going back for one week.

The drinking history should be taken in a non-judgmental manner. It is often helpful to include prompts such as:

**“In a typical week on how many days do you drink alcohol...7, 1, 3 or 4?
On a typical drinking day which beverage do you drink most of...beer, wine, spirits?”**

“On a typical drinking day when you drink a beer, how much do you usually drink?”

(give a choice of high, average or low levels). This should be repeated for each beverage consumed.

If consumption levels are significant, the doctor should look for evidence of dependency. Enquiry should be made about alcohol related problems - physical, social or emotional. Medical practitioners need to be aware that alcohol is often used to cope with the distress of anxiety, depression and other mental illnesses. It is important to explore these possibilities.

It is likely that social issues such as drink-driving offences, motor vehicle accidents, marital discord and poor work performance will occur earlier than the recognised physical complications such as liver disease, neurological or cardiac damage.

Genetic make-up plays a role in determining an individual's response to alcohol. A history of alcohol dependence in a first degree relative places an individual at a four-fold increased risk of becoming alcohol dependent. Currently, there are no laboratory tests to quantitate the role of genetic factors.

6.2 Examination

The interview should be followed by a detailed physical examination, looking for evidence of the disorders listed in Table 3.

6.3 Investigations

In an individual with few health problems, detailed investigations are rarely indicated. A set of liver function tests is often helpful. However, the presence of normal liver function tests should not give the clinician, or the patient, a false sense of security. Other investigations will be guided by the interview and physical examination. For example, in the individual who is poorly nourished, a full blood count, serum folate and plasma albumin may be abnormal. Individuals with an enlarged liver and/or spleen require organ imaging. Individuals with concurrent or past use of other drugs (particularly intravenous drug use) should have hepatitis B and C tests.

7. ASSESSMENT OF AN INDIVIDUAL WITH AN ALCOHOL-RELATED PROBLEM

7.1 Screening tests

Some doctors are uncomfortable discussing drug and alcohol consumption with their patients and prefer to use screening questionnaires (Table 4). These self-completed questionnaires are quick and do give reliable information. However, if screening suggests a problem, a detailed history and full examination are mandatory. Other doctors rely on laboratory tests such as the gamma-glutamyl transpeptidase (GGT), mean corpuscular volume (MCV) and serum uric acid to detect alcohol abuse. However, it is not wise to rely on laboratory tests to make a diagnosis of disability, abuse or dependence due to alcohol. The tests are often only abnormal in advanced disease.

7.2 Alcoholic liver disease

Alcohol is the commonest aetiology for liver disease. The pathological spectrum includes fatty liver, alcoholic hepatitis and cirrhosis. The diagnosis rests on the presence of liver disease with alcohol abuse and the absence of other aetiological factors.

Symptoms are not a reliable indicator of severity and the disease often first presents in the advanced stage with the complications of cirrhosis. Fatty liver may lead to right upper quadrant discomfort associated with hepatomegaly.

Alcoholic hepatitis may present with tender hepatomegaly associated with nausea, jaundice, malaise, fever and neutrophilia. Cirrhosis may present with lethargy, or with complications including variceal bleeding, hepatic encephalopathy, ascites or hepatocellular carcinoma.

Abnormalities of the liver function tests usually precede symptoms. Typically, the GGT is the first test to rise and elevated levels are a useful monitoring test to detect continuing alcohol consumption. The aspartic acid aminotransferase (AST) is usually higher than the alanine aminotransferase (ALT) level. Elevated bilirubin, falling albumin levels and rising prothrombin time (usually reported as INR) indicate liver failure and a need for specialist assessment.

8. ASSESSMENT OF AN INDIVIDUAL WITH AN ALCOHOL RELATED PROBLEM

Table 4: Screening questionnaires for alcohol abuse: CAGE and AUDIT

CAGE QUESTIONS

C Have you ever felt you should **C**ut down on your drinking?

A Have people **A**nnoyed you by criticising your drinking?

G Have you ever felt bad or **G**uilty about your drinking?

E Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scores: Two or more positive responses indicate 75% likelihood of an alcohol abuse disorder. Further clinical assessment is recommended. (Mayfield et al, Am J Psychiatry 131:1121, 1974)

8.1 THE AUDIT QUESTIONNAIRE

Circle the number that comes closest to the patient's answer.

1. How often do you have a drink containing alcohol?

- (0) Never (1) Monthly or less (2) Two to four times a week (3) Two to three times a month (4) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking? (CODE NUMBER OF STANDARD DRINKS*)

- (0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7 or 9 (4) 10 or more
- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily
- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

3. How often do you have six or more drinks on one occasion?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 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?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) 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?

- (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

- (0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

- (0) No (3) Yes, but not in the last year (4) Yes, during the last year

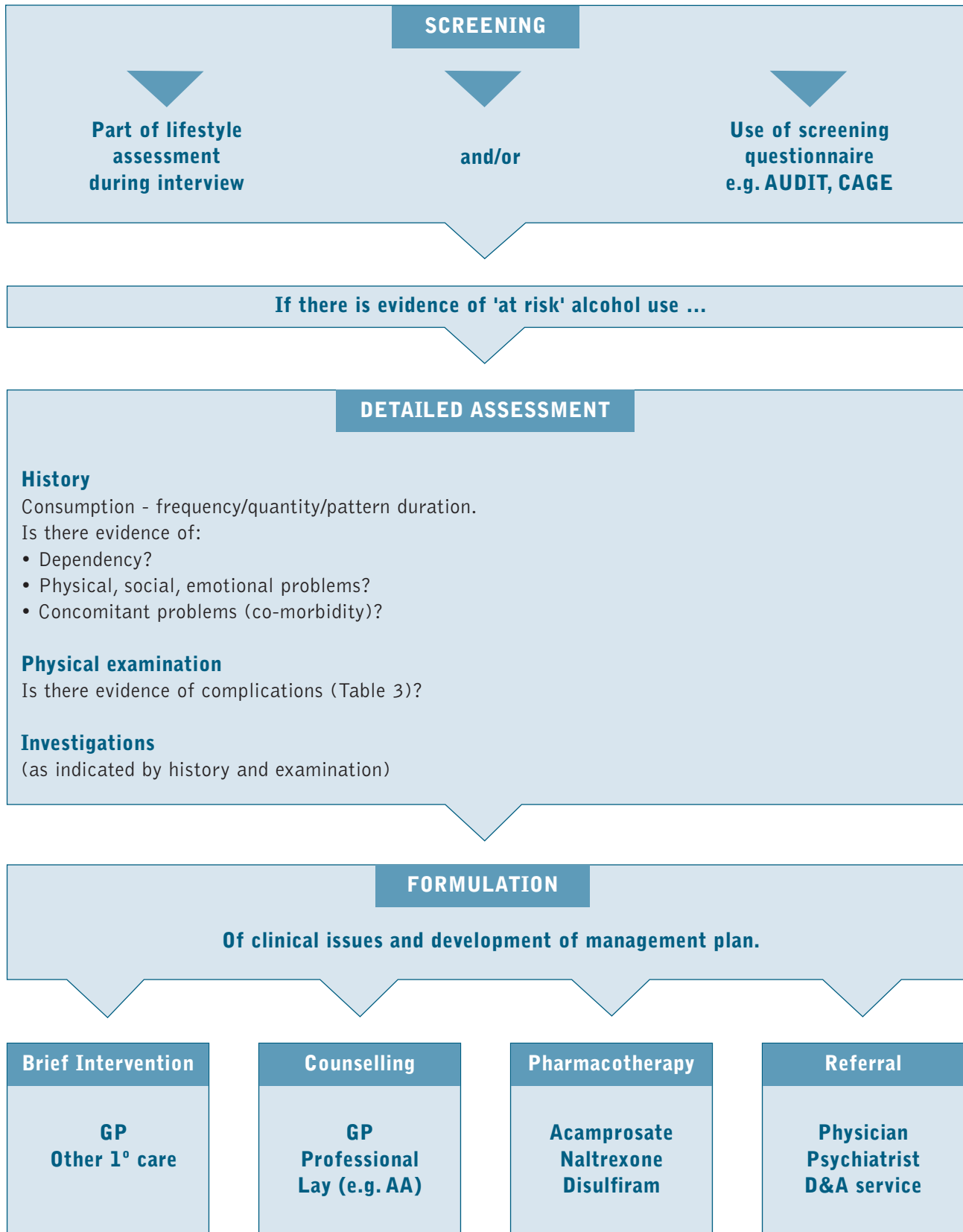
RECORD SUM OF INDIVIDUAL ITEM SCORES HERE:

Scores >8 suggest alcohol abuse. Detailed assessment is recommended and, if indicated, brief intervention.

Scores >13 suggest alcohol dependence. Detailed assessment is recommended with consideration of referral.

*In determining the response categories it has been assumed that one "drink" contains 10 g alcohol.

9. ASSESSMENT OF AN INDIVIDUAL WITH AN ALCOHOL RELATED PROBLEM



10. HOW DO I MANAGE ALCOHOL RELATED PROBLEMS?

The management of alcohol related health problems encompasses prevention; assessment; early intervention; management of complications and treatment of the underlying cause. GPs have an important role to play in performing assessments, managing uncomplicated alcohol withdrawal, giving supportive counselling and being involved in shared care with specialists. The general practitioner can be involved as a sole practitioner in the treatment of straightforward cases, or as part of a multi-disciplinary team caring for individuals with complicated disease, significant co-morbidity or polydrug use.

10.1 Selecting appropriate treatment

All patients will benefit from general advice on reducing harm (Table 5).

The goal of treatment is to match an individual's problems and beliefs with an appropriate therapeutic response. High risk drinkers who do not recognise that they have problems are usually best managed by their general practitioners. They may benefit from brief advice and written material. Continuing efforts should be made to improve their understanding of the relationship between drinking and social, emotional and physical problems.

'At risk' drinkers who are concerned about their health and have no evidence of dependency may respond well to a brief early intervention program. (Table 6)

Dependent drinkers who recognise the need for intervention will often require withdrawal support ('detoxification') and specialist therapy with or without the assistance of self-help or support groups.

Table 5: drinking tips to reduce harm

- **Don't drink alcohol to quench your thirst. Use non-alcoholic drinks.**
- **Use spacers (alcohol free drinks) between alcoholic drinks to prevent excessive alcohol consumption.**
- **Drink low alcohol beverages.**
- **Count your drinks, keeping within the recommended guidelines.**
- **Don't refill your glass until it is empty.**
- **Don't gulp drinks. Take smaller sips.**
- **Eat before drinking. Your drink will take longer to be absorbed.**
- **Don't drink if you are pregnant. It may damage the health of your unborn child.**
- **Don't drink if you are operating machinery; you put your fellow workers as well as yourself at risk.**
- **If you are a regular drinker, have at least two alcohol free days each week.**
- **Don't drink to cope with stress. Exercise, relaxation, meditation or talking to friends are safer ways of coping.**

TABLE 6: BRIEF INTERVENTION
1 to 2 counselling sessions lasting from 5 to 30 minutes

- **Feedback the results of the interview, physical findings and laboratory tests.**
The doctor informs patients of current and potential future health problems.
- **Advice, usually accompanied by an information booklet, on 'low risk' drinking levels.**
Encourage self-efficacy and empathise.
- **Monitoring with follow-up visits and possibly a drinking diary.**

The goal of this approach is often controlled alcohol use rather than total abstinence.
However, many patients gradually reduce their intake to zero.

11. HOW DO I MANAGE ALCOHOL RELATED PROBLEMS?

11.1 Early intervention, including motivational interviewing

At any time prior to the development of problems, there will be a group of 'at risk' drinkers who may present to their general practitioners for other reasons. A doctor should be able to identify these and intervene before major health problems occur.

There is ample evidence that brief interventions delivered to non-dependent drinkers can be effective in reducing alcohol consumption and reversing health problems. Just as detection and early treatment of some conditions such as hypertension has reduced morbidity and mortality from cardiovascular disease, a preventative strategy based on detection and therapy for the 'at risk' drinker will produce better results than waiting for major problems to develop.

For those individuals who are uncertain about whether to do something about their drinking, motivational interviewing can be used to encourage them to try brief interventions. This can be particularly useful for those who are considering moderating their drinking but who believe they would have difficulty reducing their intake. Basically this consists of presenting to patients the discrepancies between their current drinking behaviour and their health risks. This approach requires time and skill. There are good teaching materials available.² Some institutions run workshops to teach these skills.

11.2 Management of the physical complications of alcohol consumption

While alcohol dependence is often best managed by a multi-disciplinary team, the medical practitioner has a central role in the management of physical complications such as alcoholic liver disease.

A discussion of the management of the conditions listed in Table 3 is beyond the scope of this booklet but it is important to inform patients that, even in the presence of established alcoholic liver disease, abstinence from alcohol can greatly improve life expectancy³. A shared care arrangement is often helpful, particularly for those with more advanced physical disease.

Alcohol related brain damage may have a major influence on the quality of life of the affected individual and family.

The diagnosis may be difficult because these people often look and feel normal and cannot understand why others are concerned. If suspected, specialist assessment is advised as careful planning is needed to minimise the impact on family and patient.

11.3 The management of the dependent drinker

Many dependent drinkers require supported withdrawal prior to commencing treatment for their health care problems. This may be performed at home or in a residential facility.

11.3.1 Home withdrawal

Who is suitable?

Individuals who are physically dependent on alcohol may be assisted by supervised withdrawal support (a detoxification program).

“Detoxification” can be undertaken at home provided:

- There are no signs of severe withdrawal (e.g. confusion, hallucinations, dehydration, seizures)
- There is no past history of significant withdrawal problems
- There are supportive friends or relatives who will stay with the patient during the period of treatment, supervising medication and calling for help when necessary
- There are no significant concurrent medical (physical or psychological) illnesses, particularly suicidal ideation and seizures
- There is no access to alcohol
- A doctor is available and committed to close supervision of the patient.

If these conditions are not fulfilled, the individual should be looked after in a community-based residential facility or in hospital, depending upon the severity of concurrent physical disease.

What medications are used?

A long-acting benzodiazepine such as diazepam is the mainstay of a medicated withdrawal program. One common regimen is 10mg every six hours which can be supplemented by an additional 10mg on two other occasions during the first 24 hours. The dose is gradually reduced over the next four days. The next prescribed dose of diazepam is withheld if the individual is drowsy or heavily sedated. There are other well accepted benzodiazepine regimens which may be followed. Thiamine supplements should always given. Details of management can be found in suitable publications.

11.3.2 Inpatient withdrawal

Individuals in this setting are closely supervised. Many hospital facilities use an alcohol withdrawal symptoms rating scale to help monitor the severity of withdrawal. A detailed discussion of management in such a facility is beyond the scope of this publication.

12. RELAPSE PREVENTION

12.1 Once safely withdrawn - what then?

To a certain extent it is artificial to talk about relapse prevention as a separate issue. Most individuals who stop drinking either because they have undergone supervised withdrawal or have stopped for some other reason resume heavy drinking, particularly within the next two to three months. Eighty to ninety per cent of individuals who lapse do so because of an identifiable and predictable situation. These include negative emotional states, interpersonal conflict, social pressures or a deliberate testing of personal control. Relapse prevention treatment aims to identify these situations and to map out a specific treatment program, which covers the skills required to cope with them. Many individuals benefit from stress management training.

Relapse prevention treatment may be provided in a number of settings: residential, outpatient, within the private, non-government and public sectors.

Alcoholics Anonymous and other “12 step” programmes can provide valuable support to maintain abstinence.

Relapse is part of the natural history of alcohol dependence and is not a reason for giving up.

12.1.1 Pharmacotherapy

Three agents - naltrexone and acamprostate - are available for the prevention of relapse in alcohol dependence.

Naltrexone (Revia) is an orally active opioid antagonist with a long duration of action. There is evidence from placebo controlled trials that naltrexone reduces alcohol craving and enhances abstinence in alcohol dependent subjects. The drug is usually given as one 50 mg tablet per day.

Acamprosate (Campral) is a synthetic GABA analogue but its mode of action in alcohol dependence is not clear. A number of randomised controlled clinical trials have shown reduced relapse and increased retention in treatment. The medication is generally well tolerated with mild diarrhoea as an occasional transient adverse effect. The recommended dose is two 333 mg tablets tds, reduced in patients weighing less than 60 kg to two morning, one midday and one nocte. The cost of acamprosate is subsidised by the PBS.

Disulfiram (anatabuse), an inhibitor of acetaldehyde dehydrogenase is used as an aversive agent. It may be used in combination with either of the above mentioned agents. Poor treatment compliance usually limits the therapeutic effect. In some countries, closely supervised dosing regimens or depot injections are popular.

The role of medications in treatment is still evolving at the current time.

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14. APPENDIX - WHERE TO GO FOR HELP

Information and consultation

This section lists points of contact within each state and territory.

Drug and alcohol information services

Some also offer telephone counselling for individuals with problems.

NATIONAL

Australian Drug Information Network

www.adin.com.au

ACT

Alcohol and Drug Information Services (ADIS)

02 6205 4545

Alcohol & other Drugs Council of Australia (ADCA) Canberra

02 62811002

www.adca.org.au

NSW

Alcohol & Drug Information Service (ADIS)

Sydney - 02 9361 8000

Rural - 1800 422 599 (toll free to NSW only)

Stimulant Treatment line

Sydney - 02 9361 8088

Rural - 1800 101188

NT

Amity Community Services

Darwin

Darwin - 08 8944 6565

Rural - 1800 684 372 (toll free to NT only)

www.amity.org.au

QLD

Alcohol & Drug Information Service (ADIS)

Brisbane - 07 3837 5989

Rural - 1800 177 833 (toll free to QLD only)

www.healthqld.gov.au

SA

Alcohol & Drug Information Service (ADIS)

Adelaide - 08 8274 3387

Rural - 1300 131 340 (toll free to Adelaide only)

www.dassa.sa.gov.au

TAS

Alcohol & Drug Information Service (ADIS) Hobart

1800 888 236 (via Melbourne service)

VIC

Directline

Melbourne -1800 888 236

www.turningpoint.org.au

www.counsellingonline.org.au

WA

Alcohol & Drug Information Service (ADIS)

Perth - 08 9442 5000

Rural - 1800 198 024 (toll free to WA only)

Specialist clinical advisory services

These services are available to healthcare professionals for telephone advice on patient management.

NSW

Drug & Alcohol Specialist Advisory Service (SAS)

Sydney - 02 9557 2905

QLD

Drug Info

Brisbane - 07 3636 7599 or 07 3636 7098

VIC

Drug & Alcohol Clinical Advisory Service (DACAS)

Toll free - 1800 812 804

NT

Drug & Alcohol Clinical Advisory Service (DACAS)

Toll free - 1800 111 092

www.nt.gov.au/health

Training

These are training programs in alcohol and other drug issues.

NATIONAL

APSAD (Australian Professional Society on Alcohol & Drugs)

Sydney - 02 9331 7747
www.apsad.org.au

NSW

NSW Institute of Psychiatry

02 9840 3833
www.nswiop.nsw.edu.au

VIC

Turning Point Alcohol & Drug Centre

Melbourne - 03 8413 8413
www.turningpoint.org.au

Victorian Medical Postgraduate Foundation

Melbourne - 03 9415 1177
www.vmpf.org.au

QLD

Queensland Alcohol and Drug Research and Education Centre (QADREC)

Brisbane- 07 3365 5189
www.uq.edu.au/qadrec

Alcohol & Drug Foundation, Queensland

Brisbane - 07 3834 0200
www.adfq.org.au

SA

National Centre for Education, Research & Training in Addictions

Adelaide - 08 8201 7535
www.nceta.flinders.edu.au

WA

Alcohol & Drug Information Service (ADIS)

Perth - 08 9370 0333
www.dao.health.wa.gov.au

Addictions Studies Unit, Curtin University

Perth - 08 9266 2561



Digestive Health Foundation

145 Macquarie Street

Sydney NSW 2000

Phone: (02) 9256 5454

Facsimile: (02) 9241 4586

E-mail: dhf@gesa.org.au

Website: <http://www.gesa.org.au>