Alcohol

A Hepatologists Perspective

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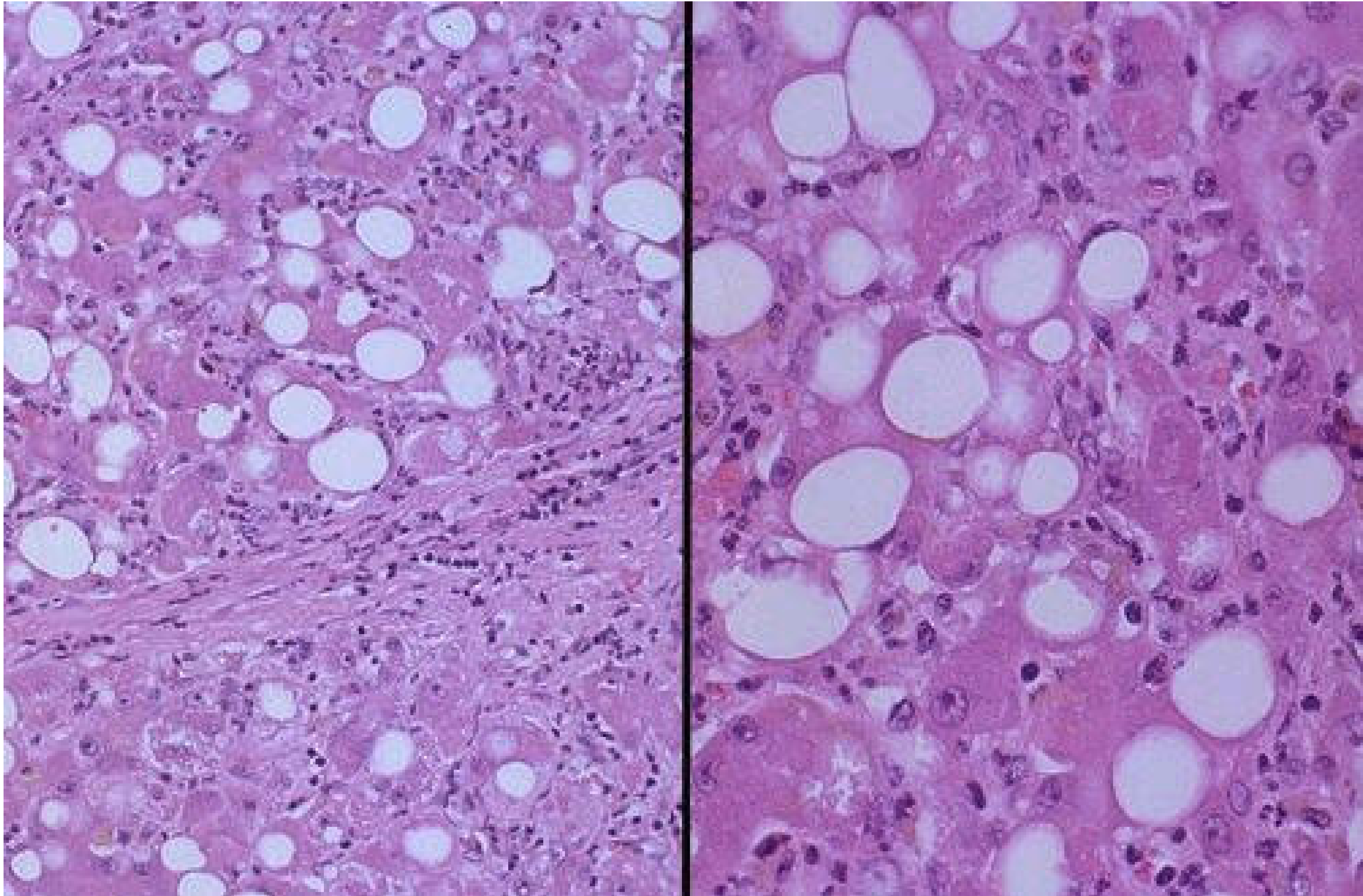
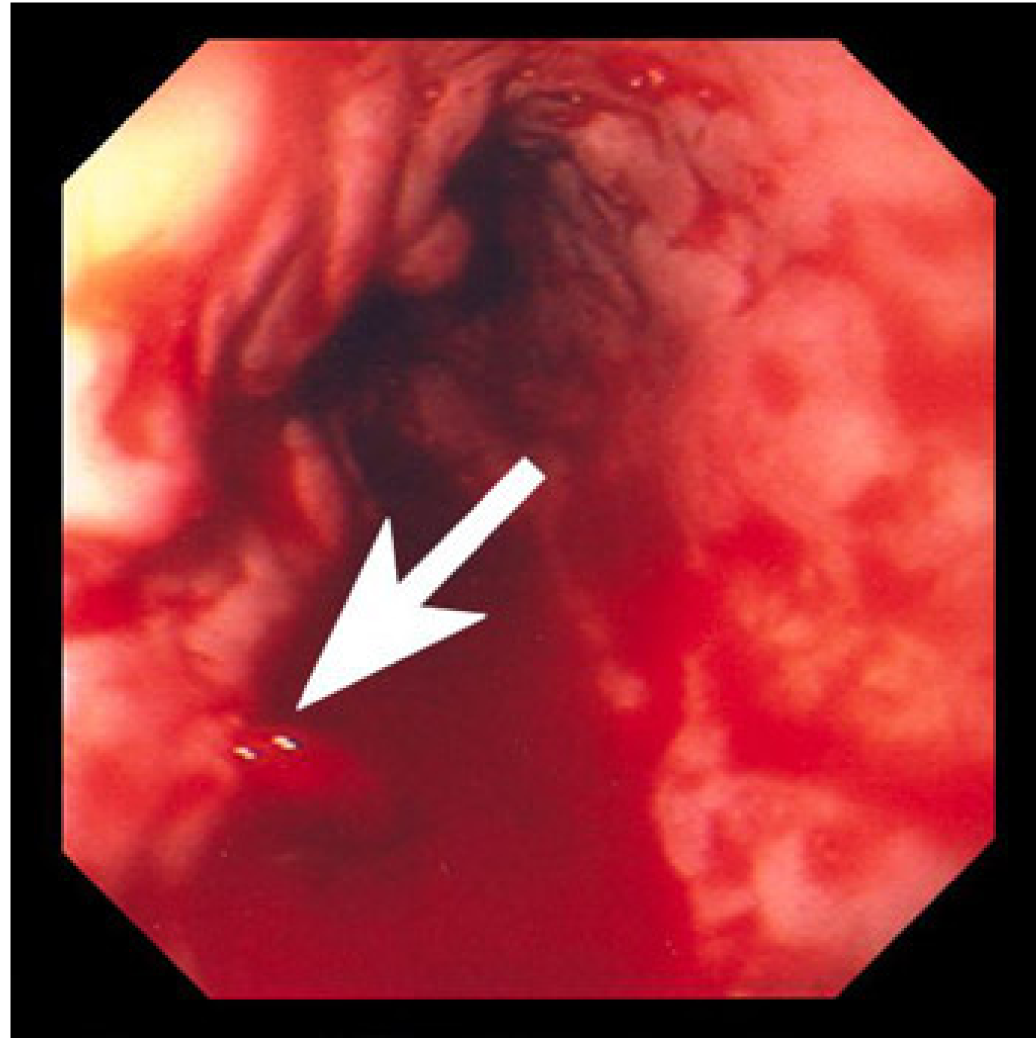
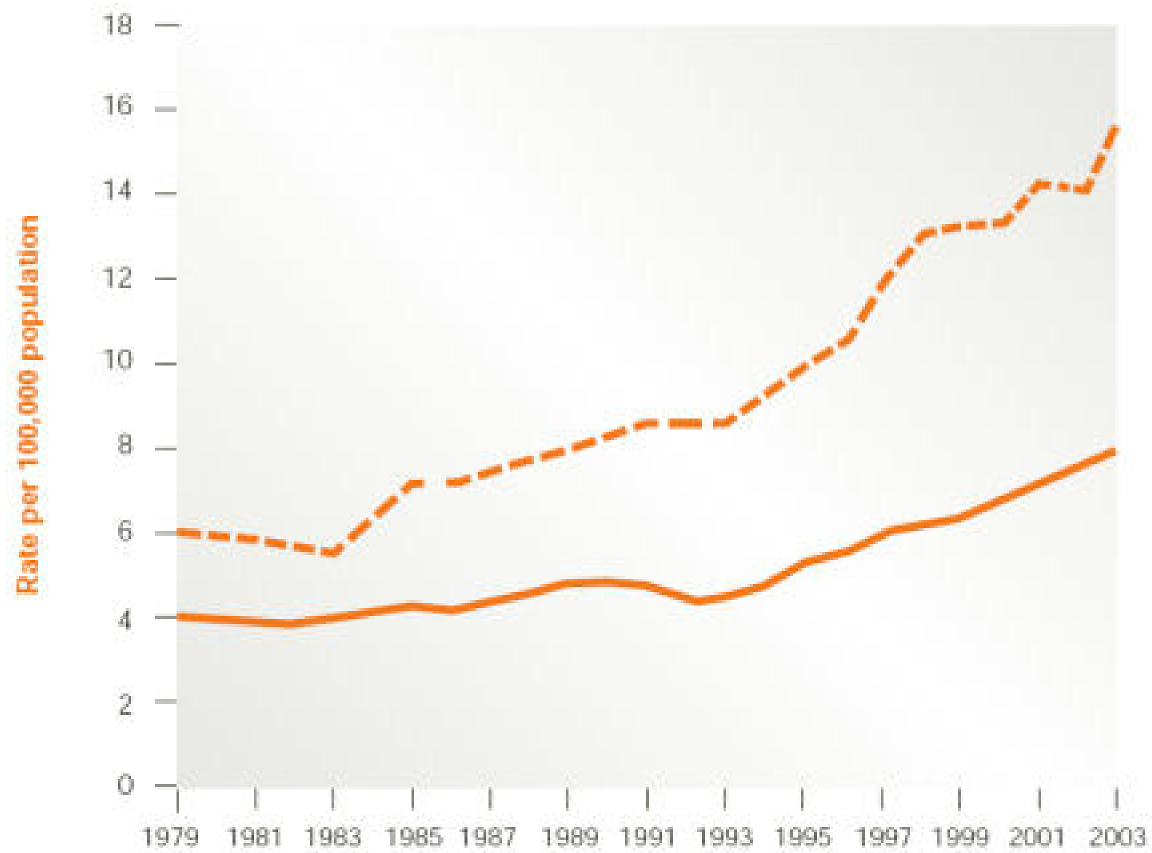
Alcoholic Hepatitis



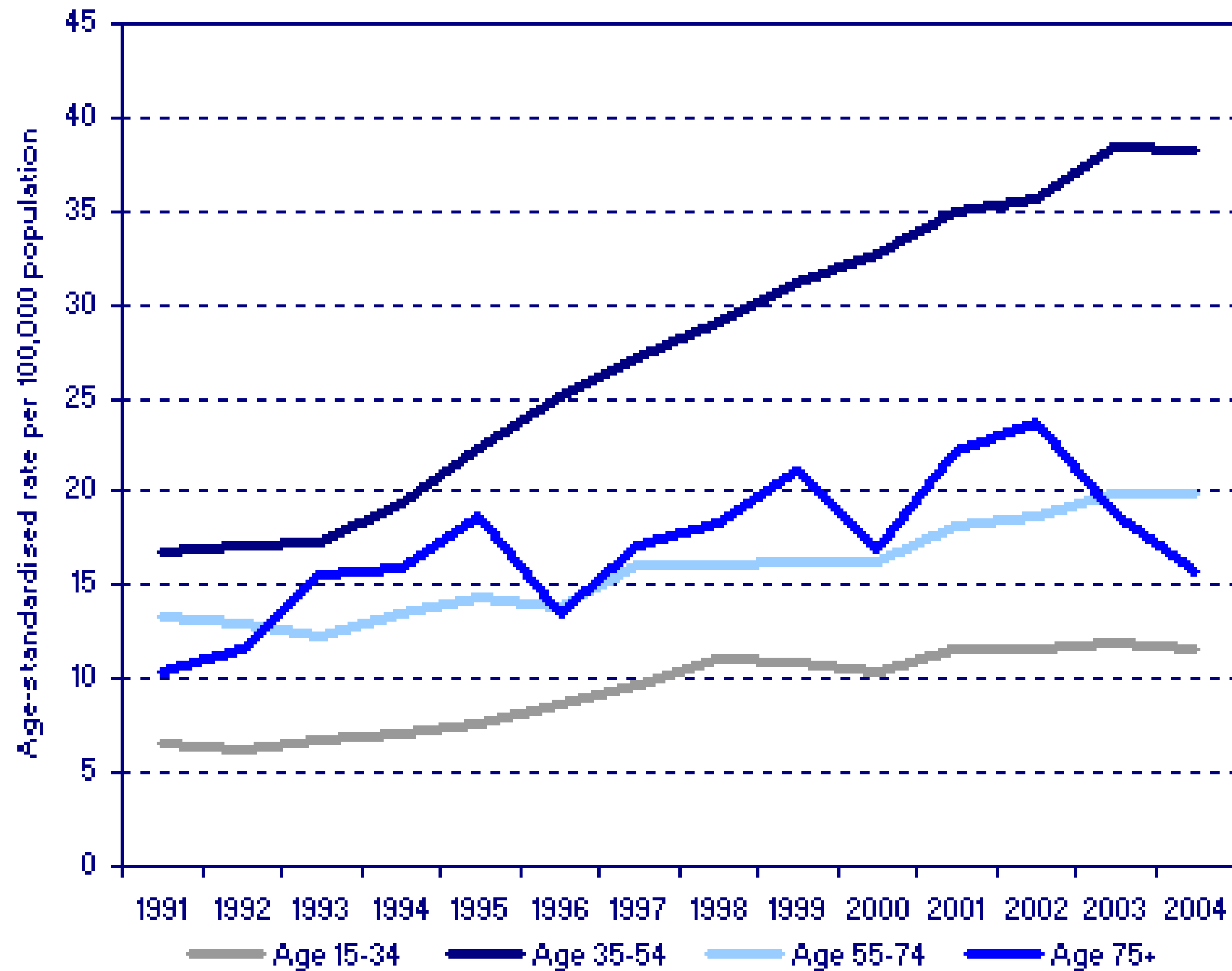
Variceal Haemorrhage



A growing problem in the UK



Changing demographics



Changing demographics

- No longer a disease of the elderly
- Increasing in young people (esp. women)
- Accounts for 7% of deaths among men aged 15-44 years and 6% for women. This has tripled since the early 1980s.
- Decreasing almost everywhere in Europe: except UK

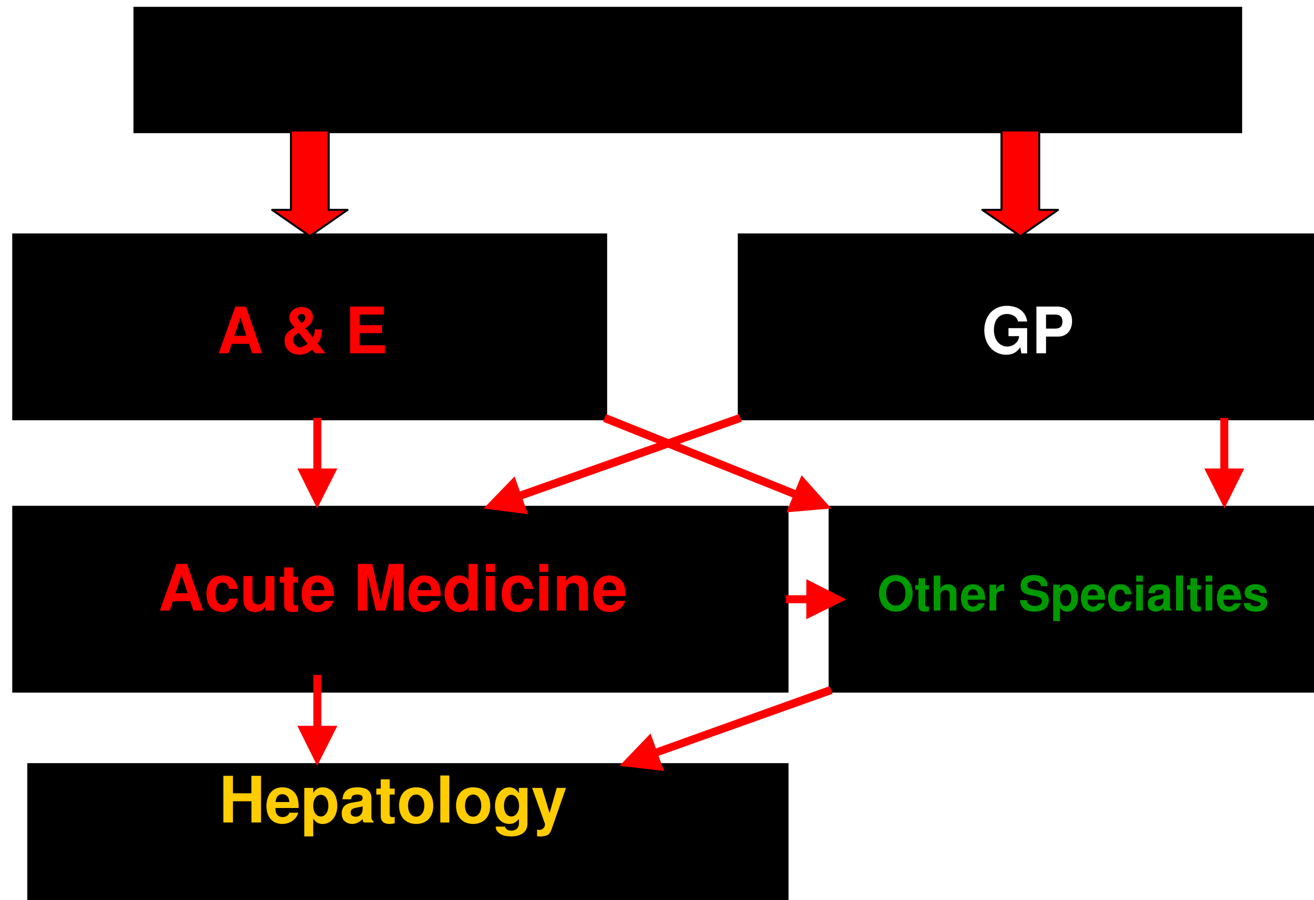
Why the change?

- The British Drinking Culture?
- Regional variations: Scotland by far the worst
- Alcohol advertising
- Increasing strength of drinks
- Licensing laws?......probably little effect.

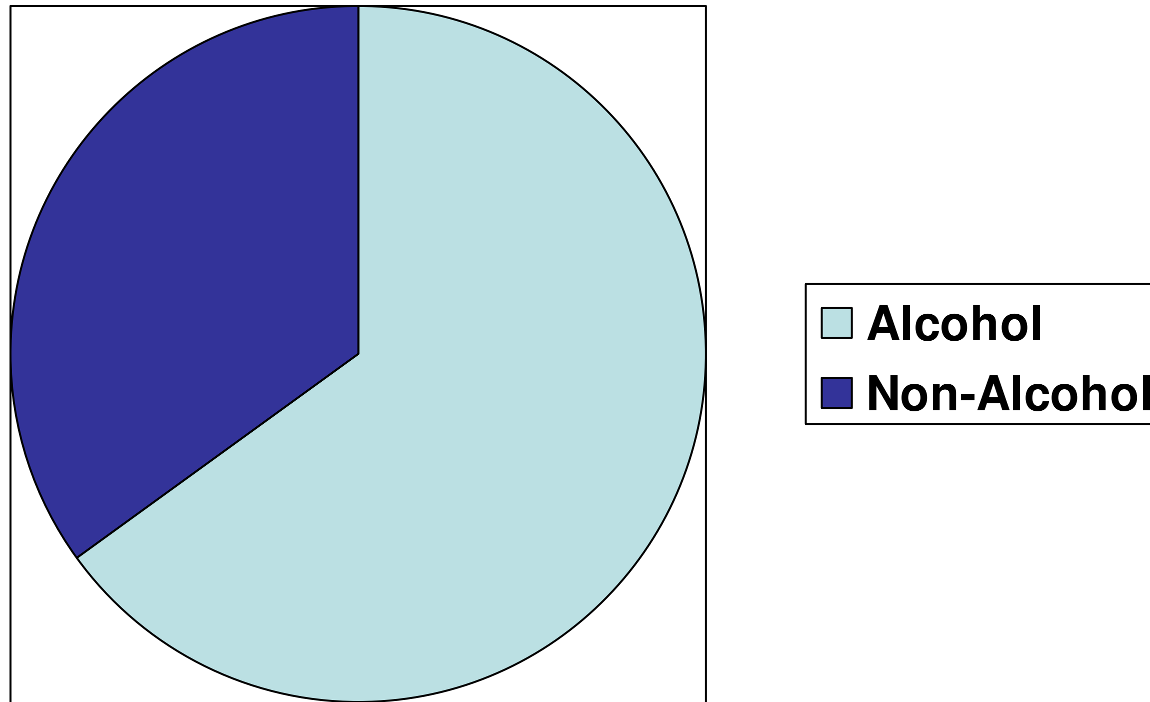
Inpatients and Alcohol

- An increasing problem!
- Adnission for alcohol withdrawal
  2001: **76**, 2003: **136**, 2006: ???
- One day snapshot, January 2006: **80 inpatients as a result of alcohol**
- Probably gross underestimates
- Poorly identified, poorly managed
- Expensive, dangerous, prolonged stays, recidivism

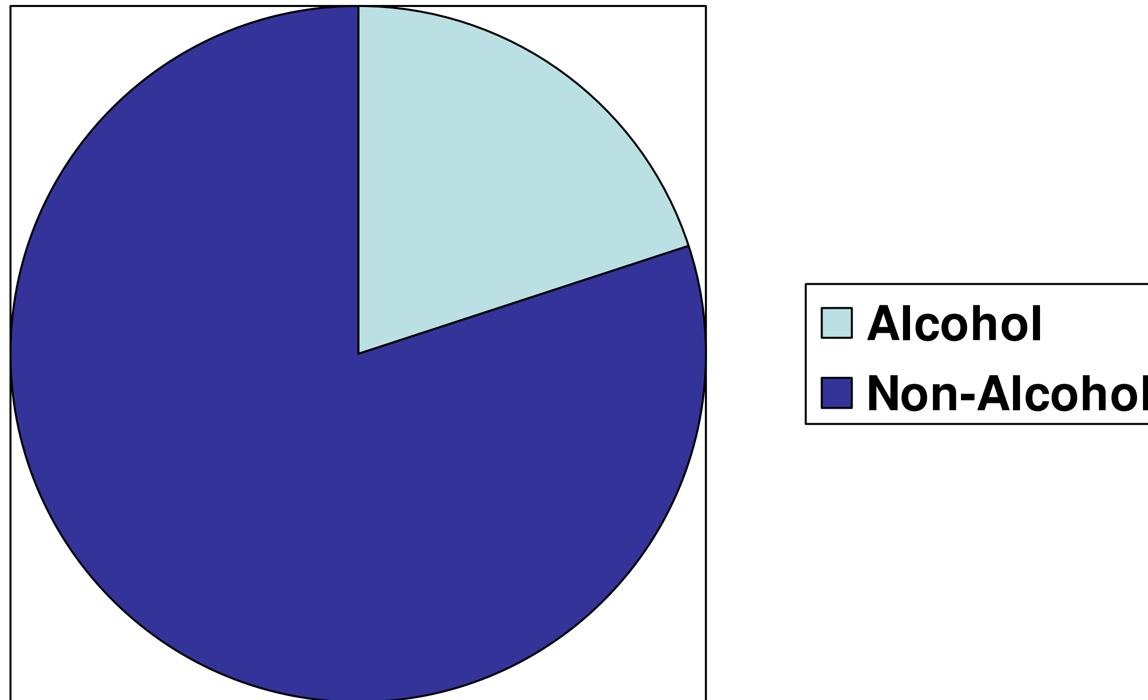
The Secondary Care Environment



The Hepatology Work-load
Inpatients



The Hepatology Work-load
Outpatients



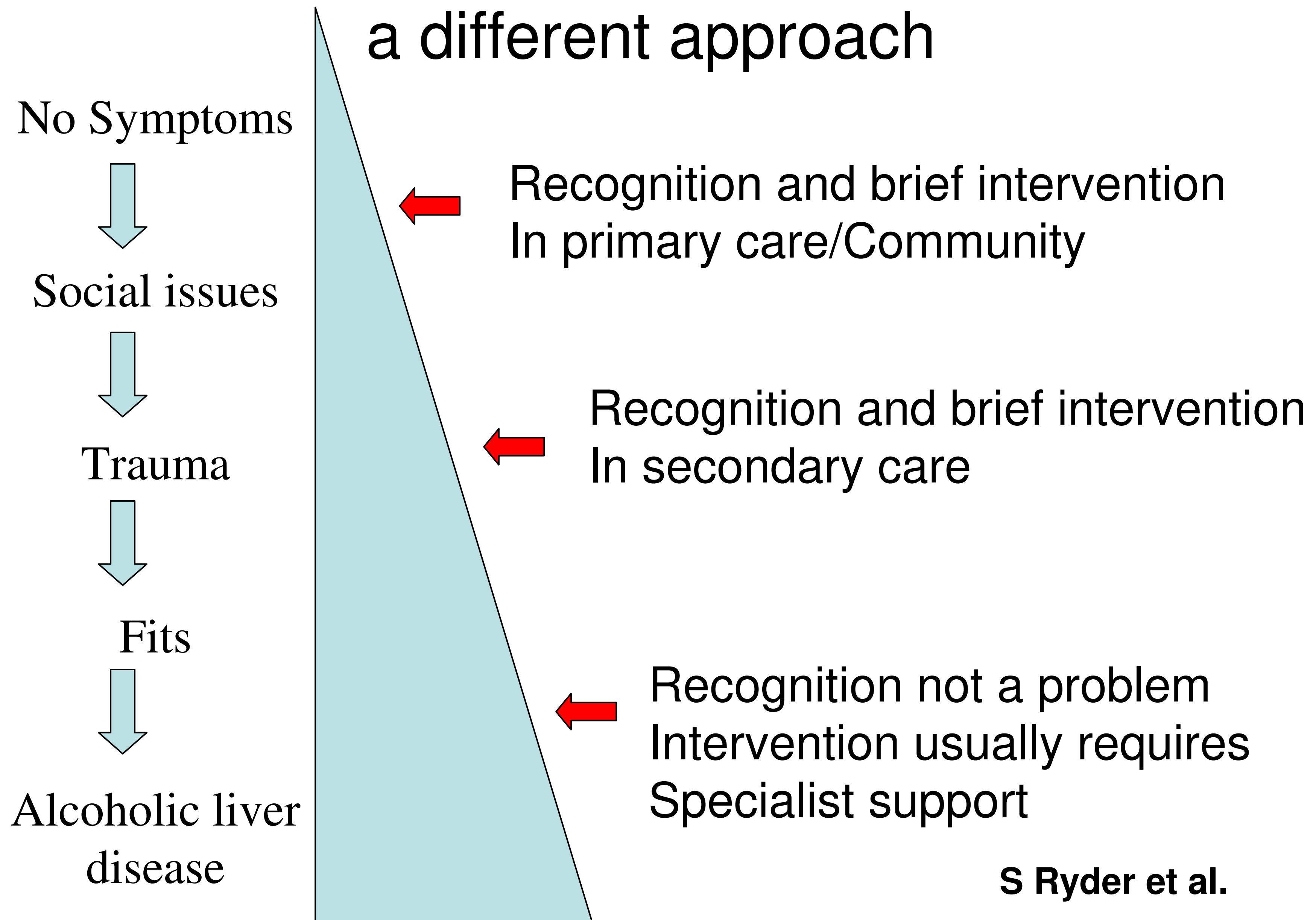
Snapshot Day
19th September 2006

- 26 year old with end stage severe liver disease
- 49 year old with severe encephalopathy awaiting transplant
- 41 year old with first presentation of severe alcoholic hepatitis
- 51 year old abstinent with recent TIPSS insertion
- 62 year old with end stage liver disease and malnutrition
- 39 year old frequent attender with withdrawal fits

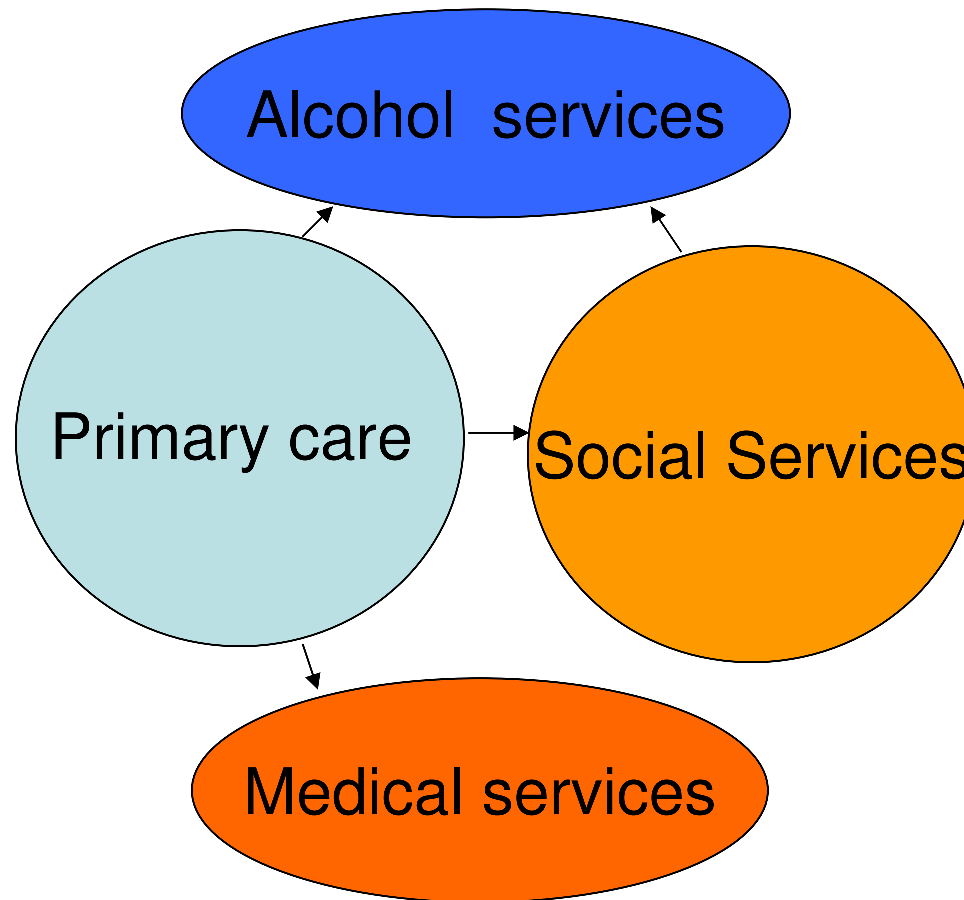
What can we do?

- Crisis management
  - Diagnosis and optimisation
  - Decompensated liver disease
  - Bleeding varices
  - Alcoholic hepatitis
  - Transplant assessment
- Inpatient detox
  - Effective
  - Established protocol
  - Links with community
  - Capacity issues
  - Risk management

Different presentations will require a different approach



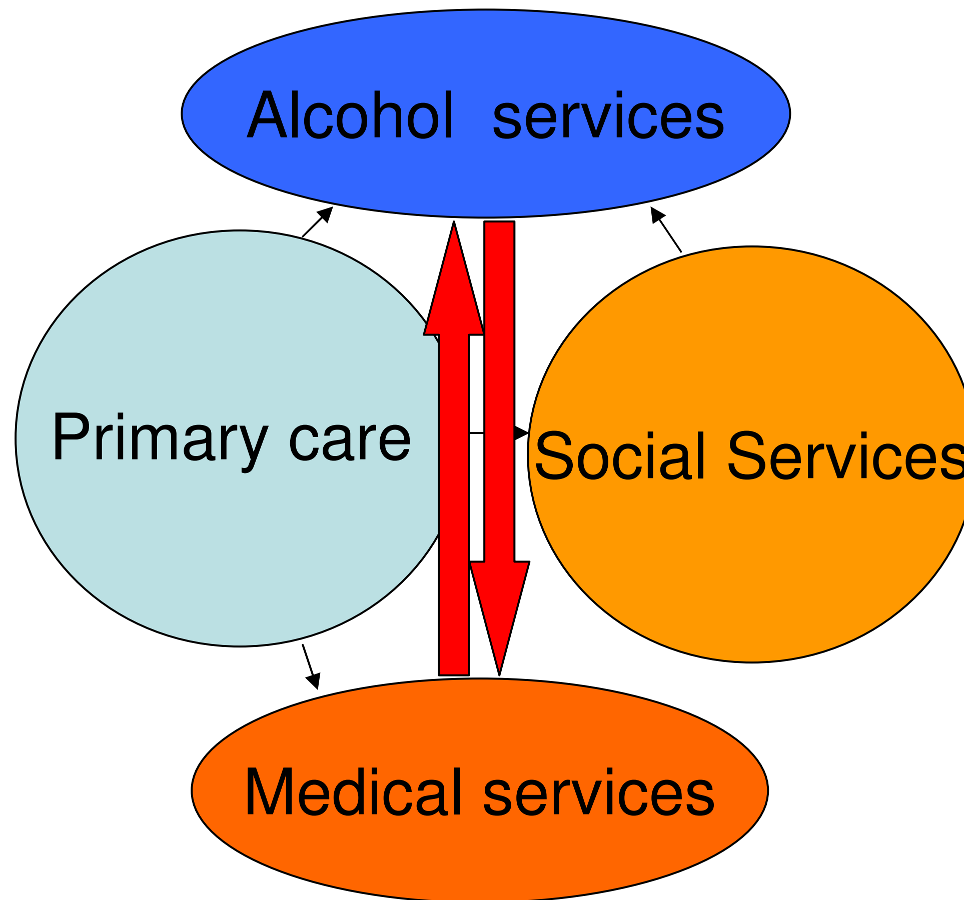
The Hospital and the Community



Working together, working apart

- Good community alcohol services
- Good hepatology Service
- Lots of interest in the issues
- No link between medical and alcohol services
- Lack of physical input to psychiatric services
- Doing the same thing differently

The Hospital and the Community



An Alcohol Services Group

- Community alcohol services
- Hepatologists, clinical nurse specialists, emergency physicians
- Psychiatric services
- Health service management
    - Lobbying of MPs
    - Highlighting problems in media campaigns
    - Developing cogent strategies and forging links

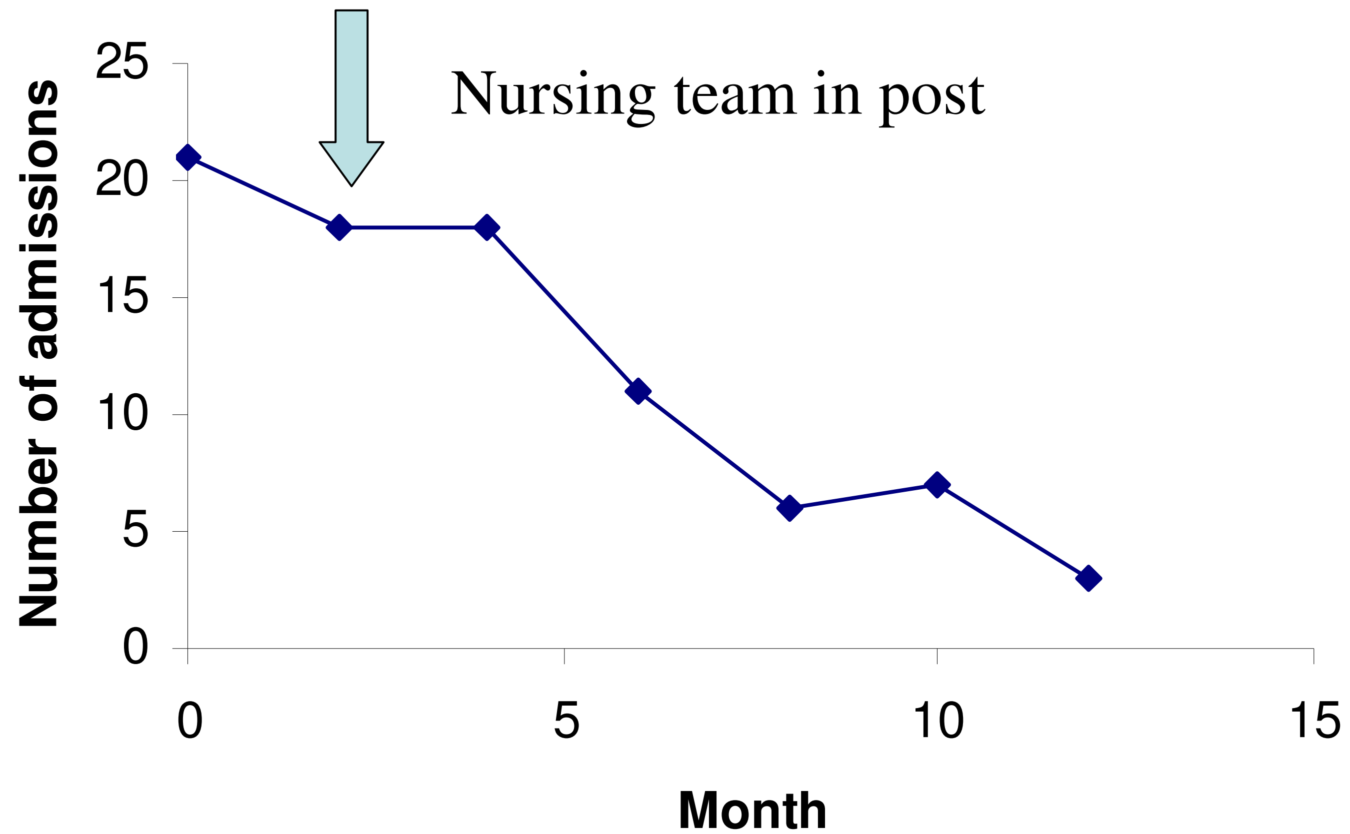
Identifying the problem drinker

- How often do you ask?
- How often do you question the answer?
- How often is the problem drinker signposted as such?
- How often is early intervention initiated?
- What is a problem drinker?
- How many units are in
  a. A bottle of white wine?
  b. A pint of 5% lager?
  c. A bottle of “alcopop”?

Why is identification Important?

- Early intervention works!
- Reduces hospital admissions
- Channels patients to appropriate services
- Identification of associated health problems……NOT just liver disease
- Anticipation and early treatment of inpatient alcohol withdrawal

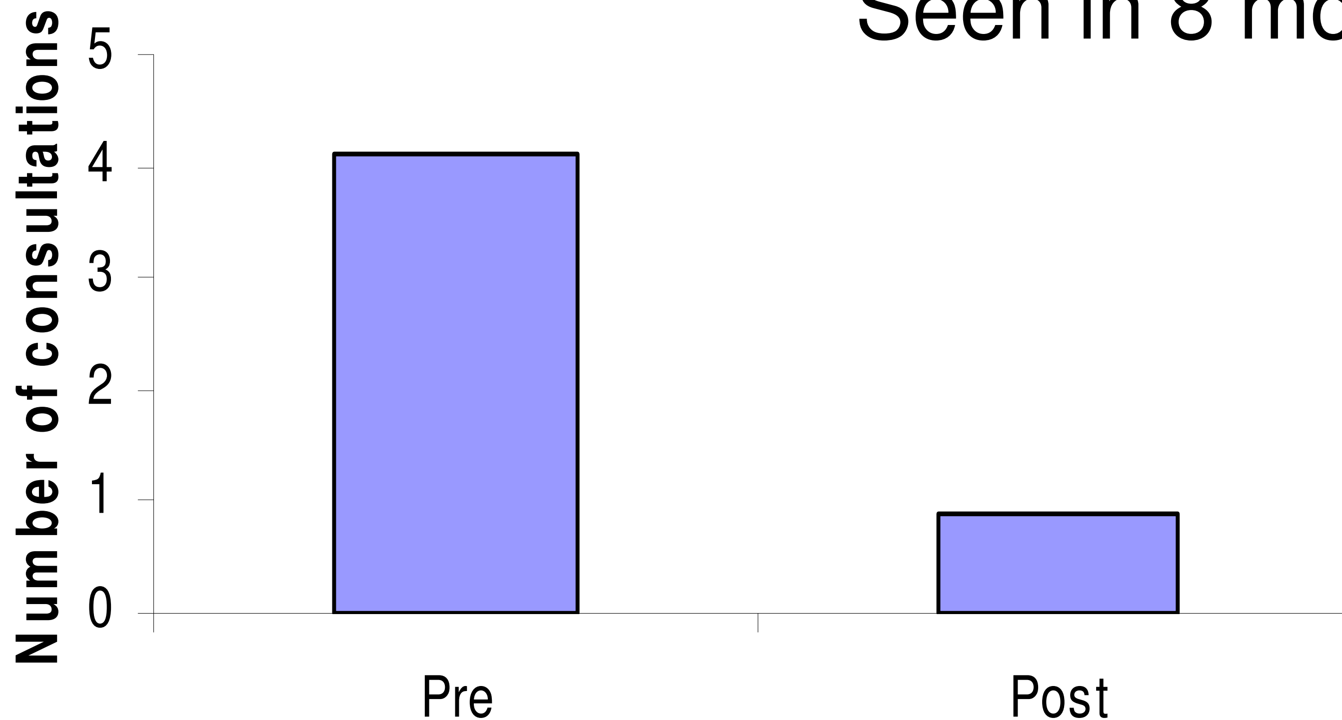
Medical admissions for detoxification



S Ryder et al.

Impact on Primary Care Attendance

Data for 127 patients
Seen in 8 months



Number of consultations in primary care in 4 months pre and post intervention. **S Ryder et al.**

Alcohol Withdrawal

Potential for disaster

- Prolonged hospital stay
- Danger to sufferer…delirium tremens has a mortality!
- Danger to other patients
- Danger to staff
- All avoidable if recognised and treated early and fully

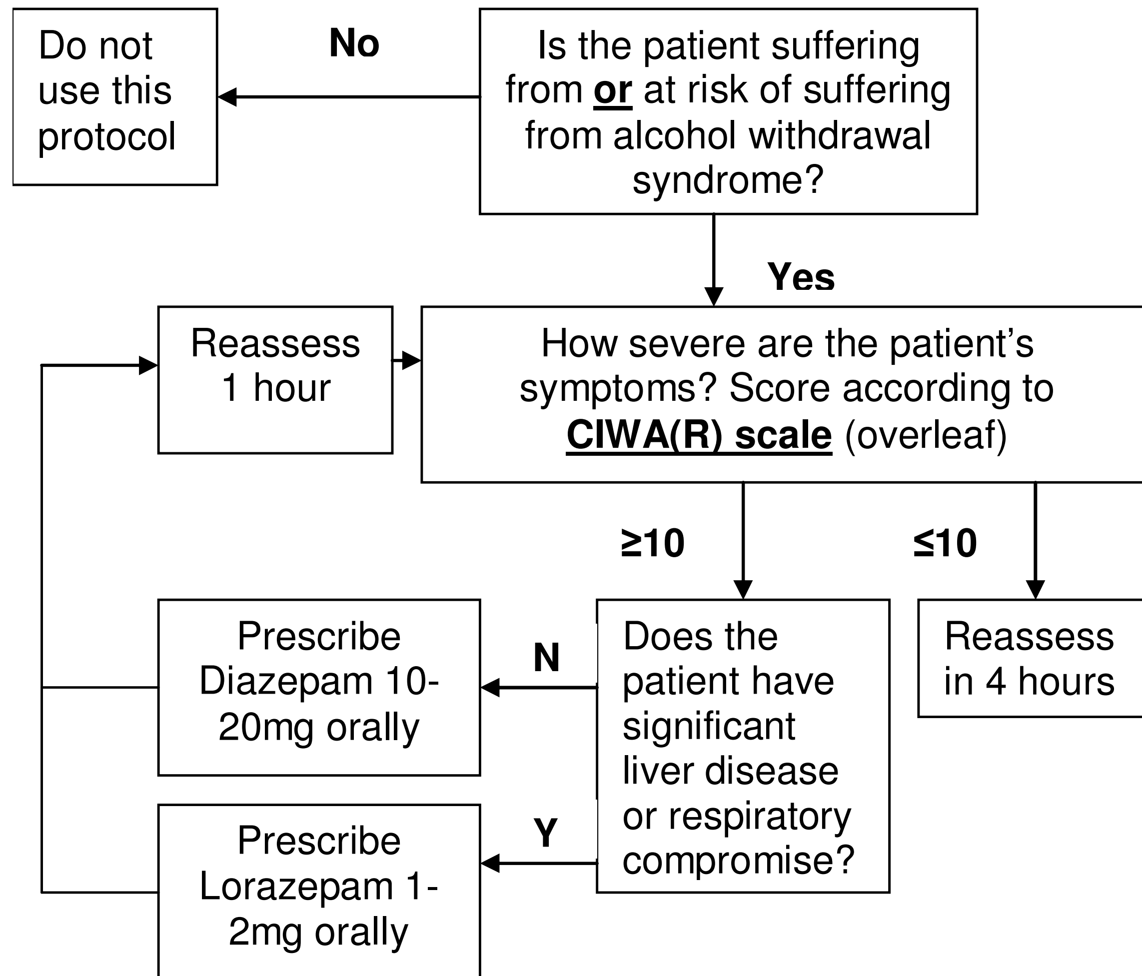
Anecdotes

- A patient with severe alcohol withdrawal set his bed on fire on a medical ward
- A patient with severe unrecognised alcohol withdrawal left the ward and entered theatre in the middle of a heart op
- A patient repeatedly tried to smash a 9th floor window with a fire extinguisher
- A nurse had her finger broken by a patient in severe withdrawal

Alcohol Withdrawal

- Often gradual onset
- Maximal 48-72 hours after last drink
- Confusion is a very late feature
- Physical symptoms dominate
- Symptoms may mimic other conditions therefore may be inappropriately treated
- Alcohol withdrawal protocol allows stratification of symptoms

Alcohol Withdrawal Protocol



The CIWA(R) Score

Clinical Institute Withdrawal Assessment

Anxiety

Tremor

Sweats

Tactile Disturbance

Visual Disturbance

Nausea

Auditory Disturbance

Headache

Haemo-dynamics

Key Points

- Nurse in quiet environment, low light etc.
- Reassurance rather than confrontation
- Diazepam 10-20mg or lorazepam 1-2mg in patients with advanced liver disease, respiratory disease or elderly
- Hourly reassessment
- Use the protocol!

Other key Points

- Involve alcohol services including psychiatry
- Is there underlying psychiatric illness?
- Contact numbers available from hepatology nurses and psychiatric team
- Never discharge with benzodiazepines

Conclusions and key points

- Alcohol related diseases are increasing rapidly
- Prevention is better than cure
- **Communication between hospital and community services**
- Protection of and investment in services