According to the Eurobarometer Survey, Irish adults binge drink more than adults in any other European country. Known the world over as a nation of avid drinkers, our average alcohol consumption here in 2010 was 145% higher than that of 1960. As GPs, we are often the first port of call for our patients and their families when it comes to tackling the issue of alcohol misuse. We may find ourselves privy to the chaos and destruction this can bring upon the lives of those it affects. Our patients know us and they trust us, and this places us in a unique position as health professionals to manage this issue.

Management is multifaceted and time is an ever more limited resource, but we can still offer meaningful interventions and guidance to our patients. This article will outline the mainstays of management, including brief intervention, withdrawal management and relapse prevention.

Assessment and intervention

Brief intervention is a valuable method of reducing hazardous drinking in general practice. It involves firstly screening a patient for unhealthy alcohol use, employing a screening tool such as the AUDIT tool. If this screen is positive, brief intervention should follow. This should be performed by the GP in the same consultation.

It should include feedback (the result of the screening tool), information (hazards and consequences of excessive alcohol consumption), setting a goal, and providing advice and management.

Throughout the process, it is important to establish what stage the patient is at in the cycle of contemplation. The stages of this cycle include pre-contemplation, contemplation, preparation, action, maintenance and, potentially, relapse. It is vital to remain empathetic and non-judgemental in demeanour, and to actively listen while conveying a sense of understanding and concern for the person in distress.

Wilk et al’s 1997 trial highlighted the benefits of brief intervention. It showed that hazardous drinkers who received brief intervention were twice as likely to reduce their alcohol intake over six to 12 months compared with those who received no intervention.

A recent review also highlighted ‘less is more’, endorsing the value of brief intervention. It showed it can be difficult to motivate patients to return for additional counselling, and a one-off intervention is very useful.

An issue frequently raised is the length of time this consultation could take and how to allocate this time in a busy general practice. According to the WHO guidelines on brief intervention in hazardous alcohol drinking, screening should only take two to four minutes, with less than one minute taken to score the test. The brief intervention should then take up to 15 minutes to provide the feedback and information, and to develop a plan.

While this is longer than an average consultation, the evidence strongly supports its effectiveness, and the long term benefits of reducing hazardous alcohol drinking should reduce the burden on the health service, including primary care.

Managing withdrawal

About half of alcohol dependent patients (between 13% and 71%) will develop features of alcohol withdrawal when their drinking ceases abruptly. These signs and symptoms can be categorised in three ways – autonomic, gastrointestinal and cognitive and perceptual. They range in severity from mild and self-limiting (GI upset, tremor, poor sleep, nausea) to severe (electrolyte disturbance, seizures, hallucinations and, in less than 5% of cases, delirium tremens). Their severity will depend on the pattern, quantity, duration and frequency of the drinking, as well as comorbidities, other illicit drug use and other medications.

Alcohol withdrawal seizures usually occur 12-48 hours after cessation of drinking and delirium tremens from 48-96 hours. Mortality rates with DTs have been reportedly as high as 15% in the past, but have fallen to less that 1% with recent therapeutic and management advances.

As GPs we must first assess if patients require medically-supervised alcohol withdrawal and whether they may...
be suitable candidates for community based withdrawal/management strategies. History of delirium tremens and withdrawal seizures obviously precludes this, as do clinical findings suggestive of severe withdrawal at the time of the assessment. Co-existing severe depressive disorder, suicidal ideation or medical illnesses such as pancreatitis should be identified and managed appropriately.

A reliable social support network is also of utmost importance for successful safe withdrawal. Benzodiazepines are the drug class of choice for detoxification, with chloridiazepoxide being recommended for community withdrawal. A reducing dose prescription should be prescribed, and the patient should be reviewed regularly during this time. ICGP guidelines recommend limiting the administration of chloridiazepoxide to a maximum of seven days. GPs should prescribe for instalment dispensing, with a limit to two days supply being dispensed at a time.

Oral thiamine should be prescribed, and adequate hydration advised. If the risk of Wernicke-Korsakoff syndrome is high, parenteral thiamine should be prescribed, ideally in an inpatient setting.

Maintaining abstinence and avoiding relapse

Having successfully achieved safe withdrawal, the maintenance of meaningful abstinence poses a huge challenge for alcohol dependent patients.

Project MATCH is the largest behavioural intervention trial conducted on alcohol dependence. It was a multisite eight-year investigation that began in 1989 in the US. It looked at three different forms of one-to-one psychological treatments: motivational enhancement therapy (MET), twelve step facilitation (TSF) and cognitive behavioural therapy (CBT).

While it found that all three were effective treatments, patients who received TSF had the highest abstinence rates at three-year follow up, compared with MET and CBT (36%, 27% and 24% respectively). Twelve step facilitation is based on the principles employed by Alcoholics Anonymous. Given the cost issue of psychological therapies, AA arguably continues to be the best form of widely available and easily accessible treatment for patients. Guiding patients through the stages of change is done in the knowledge that the steps along this journey may be slow, halting, erratic or abrupt. Yet with a combination of individual work and group support, a happier, healthier future is available to many. Relapse prevention work and ongoing support from professionals can be crucial to getting past the first three months of abstinence, at which point research has shown that those recovering from addiction are more likely to remain abstinent for a year than to relapse.

Patients who have alcohol dependence syndrome can be considered for relapse prevention medication as an additional therapeutic measure to improve their chance of remaining abstinent. This treatment should be started immediately after detoxification and continue for at least 12 months.

The main treatment options are acamprosate, naltrexone and disulfiram. Acamprosate is only effective when combined with psychosocial therapies. In one study, twice as many patients remained abstinent on acamprosate one year after the end of treatment compared with the control group. It should only be prescribed in patients aged 18-65. It is contraindicated in breastfeeding and if a patient’s creatinine is >120. Its safety is not yet established in patients with severe liver insufficiency. The dose is 666mg TDS with meals if the patient is >60kg.

Naltrexone decreases the frequency and severity of relapse. There is also evidence for its use in patients who continue to consume alcohol. It helps reduce the quantity of alcohol consumed in this group. It is contraindicated in severe renal and hepatic impairment and acute hepatitis. Patients should be warned against concomitant use of opioids including cough medications and analgesia. The dose is 50mg OD.

Both medications require high levels of adherence to maximise treatment effects and are relatively expensive. Disulfiram is a third treatment option. It is a less expensive medication but its consumption should ideally be supervised by family or friends. It is only recommended in patients who intend to remain abstinent and it has many contraindications and interactions. Careful patient selection and education must be carried out prior to its commencement. There is less evidence for its use compared to acamprosate and naltrexone.

Excessive alcohol consumption is an ever-growing problem. Now more than ever, in these times of economic strain, we can be sure that as GPs, this added burden will impact directly on our day to day practice. In a world that is far from ideal when it comes to addiction services for our patients, primary care givers are often the only available source of assistance in the management of alcohol abuse.

It is vital that GPs are aware of brief clinical interventions to reduce overall alcohol intake, prevent harmful drinking and dependency in the first place, and prevent relapse in those who are struggling to control problem drinking and its toxic influence in their daily lives. Brief interventions remain at the forefront of managing problem drinking in a variety of settings, especially in primary care.

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References
2. www.alcoholireland.ie
7. Victor and Adams 1953; Saltz et al. 1994; Oegemhardt et al 2000
8. Mayo-Smith et al 2004
10. Anderson A. ICGP guidelines appendix 4 Helping Patients with Alcohol Problems – a Guide for Primary Care Staff
11. NICE clinical guideline 115
15. IMB Naltrexone SPC, www.medicines.ie