Management of Dependence on Alcohol - Second Of Two Articles[a]

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Introduction

The management of alcohol dependence consists of psychological, social and pharmacotherapeutic interventions aimed at reducing alcohol associated problems. This involves detoxification and rehabilitation [1].

Detoxification manages the signs and symptoms of withdrawal such as restlessness, irritability, anorexia, sleeplessness, frightening visual rather than auditory hallucinations, progressive clouding of consciousness, disorientation, dysarthria and fits (often occurring 12 – 48 hours after alcohol withdrawal)[2].

Rehabilitation treatments are psychosocial consisting of individual and group therapies, residential treatment in alcohol–free settings and self-help groups such as Alcoholics Anonymous (AA)[3]. To the best of my knowledge there are no rehabilitation arrangements for treating alcohol dependence in the Southern Sudan, let alone self-help groups such as AA. All patients should be carefully screened with a validated instrument such as the **CAGE** questionnaire for alcohol dependence – see Box 1. This questionnaire is brief and was designed to detect alcohol dependence.

The possibility of unhealthy alcohol use should be routinely considered in patients with hypertension (especially if the condition is difficult to treat), depression, insomnia, abnormal liver enzyme levels, heartburn, anaemia, thrombocytopenia, injury or problems in social life or at work such as missed work due to a handover[4]. Confusion in inpatients admitted for surgery or some other reason who often drink regularly provide a hint of possible alcohol withdrawal and the appropriate questions should be asked so that detoxification is offered.

Box 1. CAGE questionnaire[5]

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

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

   Yes ☐ No ☐

Each "yes" answer scores 1 point.
A total score of 2 points or above are thought to be clinically significant and indicate alcohol dependence.

Detoxification

If a person is diagnosed with alcohol withdrawal, Benzodiazepines are the only medications proven to ameliorate symptoms and decrease the risk of seizures and delirium tremens[4] (confusion, agitation, disorientation and visual hallucinations such as seeing insects, snakes or pink elephants).

Suggested detoxification regimes for treatment of alcohol withdrawal are shown in Tables 1[4] and 2[6].

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Table 1. Detoxification regime for treatment of alcohol withdrawal [4]

Drugs	Mechanism of action	Dose	Comments
Benzodiazepines: - Diazepam - Chlordiazepoxide - Lorazepam	Decrease hyper autonomic state by facilitating inhibitory gamma aminobutyric acid receptor transmission which is down-regulated by long-term exposure to alcohol.	**Diazepam** 10-20mg **Chlordiazepoxide** 50-100mg **Lorazepam** 1-2mg	Administer 1-2 hourly until symptoms subside. No tapering for Diazepam (because it is long-acting). Lorazepam is best given to elderly patients, those with hepatic synthetic dysfunction or those at risk of respiratory depression/failure.

Cautions If frequent reassessments will not occur, add a dose four times a day for 24 hours followed by half a dose 4 times daily for 48 hours. Assess withdrawal symptoms 1-2 hours after each dose. Daily assessment by a clinician is recommended.

Table 2. Alternative Detoxification Regime Using Chlordiazepoxide Reducing Schedule [6]

Date	Day	0800 hrs	Nurse's signature	1230 hrs	Nurse's signature	1700 hrs	Nurse's signature	2200 hrs	Nurse's signature
	1	20mg		20mg		20mg		20mg	
	2	15mg		15mg		15mg		15mg	
	3	15mg		10mg		10mg		15mg	
	4	10mg		5mg		5mg		10mg	
	5	5mg		5mg		5mg		10mg	
	6	5mg		5mg		5mg		5mg	
	7	5mg		X	X	X	X	5mg	
	8	X	X	X		X	X	5mg	

Maintenance of Abstinence

Counselling of patients about setting a goal for a reduction in alcohol consumption and suggesting ways to achieve that goal have been shown to be useful[4]. Interventions may be effective regardless of a patient's readiness to change but understanding the patient's perception of the problem and whether he or she is ready to change is useful.

The clinician should:

- Be prepared to listen and not to be judgmental in dealing with patients with an alcohol problem. These patients need sympathy.
- If possible refer patients to a local alcoholic anonymous group where they may learn how to reduce the alcohol drinking from someone with a similar problem.
- Start giving acamprosate calcium as soon as possible after the alcohol withdrawal period and maintaining it if the patient relapses[7].

This drug is recommended for a period of one year for patients aged 18 – 65 years at the following doses:

- weight is 60 kg or over - give 666 mg three times a day
- weight is less than 60 kg – give 666 mg at breakfast, 333 mg at midday and 333 mg at night

Warn patients of possible diarrhoea, nausea, vomiting, abdominal pain, fluctuation in libido, pruritus, maculo papular rash and rarely bullous skin reactions. Do not prescribe to those with:

- severe hepatic impairment
- renal impairment if the creatinine is greater than 120mcml/l.

It is also contraindicated in pregnancy and mothers who are breastfeeding[7].

References

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5. *Detecting Alcoholism: The CAGE Questionnaire,* JAMA 1984; 252: 1905 -1907.
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