How to diagnose and manage physical complications related to alcohol misuse

Heavy drinking can result in significant harm. A member of the NICE guideline development group discusses the main issues from the latest alcohol misuse guide

For the past two years, the National Institute for Health and Clinical Excellence has worked with an independent group of clinical experts to develop a guideline for the NHS on how to diagnose and treat physical complications caused by alcohol misuse.

Of particular relevance are the recommendations on how to assess patients for their risk of developing acute alcohol withdrawal (AAW), as well as how to ensure that their symptoms are treated in the best way possible.

The guideline also details how to assess heavy drinkers for their risk of thiamine deficiency, and includes advice on ways to prevent this from progressing to Wernicke-Korsakoff syndrome (WKS).

RISKS OF ACUTE ALCOHOL WITHDRAWAL

People who are alcohol dependent are at risk of developing AAW and have complex needs. The guideline is therefore a welcome addition to the tools available to nurses encountering such patients.

Early detection and prompt initiation of treatment is crucial – untreated AAW may progress to delirium tremens, which can be fatal if untreated. Nurses have a key role in ensuring patients receive accurate assessment and optimal treatment, as this can reduce mortality, complications and the course and duration of AAW, which consequently reduces the length of hospital stay.

The dedicated alcohol specialist nurse has a vital role in enhancing patient concordance, augmenting medical treatments and coordinating aftercare and follow-up. Indeed, the guideline states: “People in acute alcohol withdrawal should be assessed immediately on admission to hospital.” All nurses should therefore ensure they have the skills to assess the risk of AAW accurately as well as to monitor progression of withdrawal symptoms and signs.

The guideline recommends that all hospitals develop local protocols to assess and monitor patients in AAW.

A useful tool to aid this assessment is the revised Clinical Institute Withdrawal Assessment for Alcohol (Sullivan et al., 1989). However, as with all tools, this should be used in conjunction with clinical judgement.

WERNICKE-KORSAKOFF SYNDROME

A further risk to heavy drinkers is WKS, which can develop in thiamine deficient patients and is often difficult to detect.

In the early stages it presents as Wernicke’s encephalopathy, which has a triad of symptoms: confusion; eye signs; and ataxia. This condition is reversible if it is detected early enough.

The cause of WKS is most likely linked to inadequate dietary intake and poor thiamine absorption. Oral thiamine absorption is limited and appears to be independently affected by both alcohol and malnutrition.

Factors often seen in people who misuse alcohol, such as poor diet, diarrhoea and vomiting, may affect thiamine absorption. Since thiamine requirements are linked to carbohydrate intake, it is vital intravenous dextrose is not given to a thiamine deficient patient without concomitant thiamine.

The optimal dose and route for thiamine replacement is yet to be determined; however, the guideline recommends oral thiamine should be given in doses toward the upper end of the British National Formulary range.

Most importantly, the guideline asserts nurses and other healthcare professionals should maintain a high level of suspicion for the possibility of Wernicke’s encephalopathy, particularly if the person is intoxicated.

Parenteral treatment to provide thiamine should be given for a minimum of five days in suspected Wernicke’s. Oral thiamine treatment should follow parenteral therapy.

This guideline will help to improve the quality of care given to patients whose drinking has resulted in significant harm and increased risk to their physical health.

The guideline is available at www.nice.org.uk/CG100

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REFERENCE