ABC of Alcohol

A PATON
J F POTTER
J B SAUNDERS

DETECTION IN HOSPITAL

Alcoholism has replaced syphilis as the great mimic of disease. Its protean symptoms are compounded by the reluctance of many patients, relatives, and doctors to accept that there is a problem. In addition the medical approach is that of the doctor looking for gross signs of disease of the liver, heart, brain, or other organs. To concentrate on these is deceptive and unhelpful. By the time they are present the disease may be irreversible, and their absence gives a false sense of security.

A few people are referred to hospital about their drinking habits; and a few, who may or may not be known to abuse alcohol, are referred because of hepatomegaly or abnormal liver function values. These are the minority. Most people who turn out to be problem drinkers have non-specific symptoms which are often vague, multiple, and do not fit readily into any diagnostic pattern; sometimes they may be bizarre. Gastrointestinal symptoms, chest and abdominal pain, and neuropsychiatric disturbances are the most common, but any system may be affected.

Spotting the problem drinker

The problem drinker may be spotted by his brash, jocular, overfamiliar manner, inappropriate to the circumstances of a medical consultation. He may give shifty answers to preliminary questions, and it is important not to reveal any suspicions and lose his confidence. Symptoms should be regarded sympathetically and not brushed aside; they will often provide further clues.

Certain features in the history should also raise suspicions: absenteeism from work; frequent attendances for unexplained and atypical dyspepsia or for minor gastrointestinal bleeding; hospital admissions for accidents of all kinds or "head injury"; fits, "turns," falls, and neuritis (peripheral neuropathy).

Familial risk factors include alcoholism; teetotalism; depression, especially among women; a broken home; and being last in a large family. Drinking by the spouse, drug taking, and heavy cigarette smoking are often associated.

Ethnic origins should be considered. People of Irish and Scottish descent seem to drink more than the English and to be more prone to physical damage. Europeans may have a high prevalence of alcoholism because they are socially accustomed to high levels of drinking. Jews may drink but intoxication is frowned on. Moslems are, strictly speaking, forbidden by their religion to drink alcohol, but taboos are breaking down, especially among men. Oriental races are said to show exaggerated responses to alcohol.

Young men drink heavily, but in most it is a passing phase; girls may now be following suit. Many occupations are known to increase the risk of alcoholism; this may be due both to the nature of the job and to the individual who is attracted to it. Heavy drinkers are found in all occupations and in all classes of society.

Signs

Certain signs may be helpful, if present: the bloated, plethoric face, with or without telangiectases or spider naevi; bloodshot conjunctivae; acne rosacea; smell of stale alcohol; and raw, red gums which may bleed readily. Facial appearances resembling those of Cushing's syndrome have been recognised recently.

The skin is warm and moist with a fast, bounding pulse, and marked tremor of nicotine-stained fingers (a pseudothyrotoxic state). Other signs, such as palmar erythema, bilateral Dupuytren's contractures, parotid swelling (rare), and gouty tophi, should be sought. Obesity, with a pot belly, gynaecomastia, and striae, are common. Bruising and scarring indicate recurrent falls and brawls.

Before (left) and after (right) stopping drinking.

The physical consequences of alcoholism are well known and this is not the place to discuss them. Successful medical intervention depends on diagnosis before irreversible damage has occurred, and the index of suspicion should be high that alcohol contributes to or causes the following:

Repeated attendance or admissions for relatively minor complaints which cannot be clearly labelled

Fits for the first time in middle age

Gout, whatever the immediate precipitating cause

Mild diabetic symptoms or glycosuria in the young or middle aged

About 15% of all "essential" hypertension, and failure to control the blood pressure with multiple drugs

Atypical cardiac symptoms or cardiac failure in middle-aged men

Attacks of confusion, especially in strange surroundings or after stress (illness, operation, bereavement, etc)

Drug overdoses

Gastrointestinal symptoms where a cause cannot be established

Hepatomegaly, for which no other cause can be found

Anaemia, especially if folate deficient

Lobar pneumonia, especially when it affects the right upper lobe

Atypical endocrine features mimicking Cushing's disease, phaeochromocytoma, and carcinoid.

	Complaints	Mistaken for	Due to
Gastrointestinal	Indigestion Heartburn Vomiting Diarrhoea Bleeding Jaundice	Peptic ulcer Viral hepatitis Gall stones	Oesophagitis Gastritis Enteritis Mallory Weiss syndrome Pancreatitis Alcoholic hepatitis/cirrhosis
Neuropsychiatric	Trembling Sweating Insomnia Headaches Blackouts Fits Confusion Inability to concentrate Burning legs Coma	Neurasthenia Anxiety state Epilepsy	Withdrawal symptoms Hypoglycaemia Depression Acute psychosis Encephalopathy Neuromyopathy Dementia Alcohol poisoning Drug abuse Subdural haematoma
Cardiorespiratory	Palpitations Chest pain Bronchitis Pneumonia	Ischaemic heart disease Essential hypertension	Arrhythmias Cardiomyopathy Upper lobe pneumonia Tuberculosis
Musculoskeletal	Backache Rheumatism Gout Repeated injuries	Idiopathic gout Accidents	Gout Demineralisation
Skin	Acne rosacea Athlete's foot Sweat rash		
Hormonal and metabolic	Obesity "Sugar" Breast swelling Reduced libido Infertility	Cushing's syndrome Diabetes mellitus Breast tumour Phaeochromocytoma Carcinoid	
Pregnancy	Repeated stillbirths Congenital lesions		Fetal alcohol syndrome

Dr A Paton, MD, FRCP, was consultant physician, Dr J F Potter, MB, MRCP, is medical registrar, and Dr J B Saunders, MB, MRCP (now lecturer, Liver Unit, King's College Hospital, London), was Sheldon research fellow, Dudley Road Hospital, Birmingham.