*ABC of Alcohol*G SMERDON
A PATON

DETECTION IN GENERAL PRACTICE

The problems of detecting alcoholism include the conceptual difficulty of defining it and the practical difficulty of identifying the excessive drinker. A working definition for general practice might be: the devotion of time to alcohol instead of to oneself or one's family, friends, hobbies, and job. The drinker hides the extent of his drinking from himself; those around him may suspect or know that he drinks but cannot discuss it with him and may collude in concealing it.

Diagnosis is a process of pattern recognition. We have a mental image of the "alcoholic" as a man aged 30-60 who, after years of heavy drinking, has isolated himself from the normal sources of social and personal support by a series of crises, in one of which the general practitioner becomes involved. This damaged person feels different from us and the hurt he causes alienates our sympathy. We see the problems but have previously missed their beginnings. There are several other pictures.

Portraits of problem drinkers

Teenagers with drinking problems are seldom seen in the surgery but may be known to the police for drinking under age or drink-driving offences. Parents may complain that they are out a lot, lethargic, and difficult at home.

Housewives take to drink because they feel lonely or unvalued and this leads to sexual discord, family friction, and even drinking husbands. Women who work outside the home are also at risk, especially in competitive jobs.

The elderly are prone to physical deterioration, intellectual failure, and social isolation. The drinking may be lost in the confusion.

The respected use their status to conceal and their intelligence to rationalise trouble. Regard for them diminishes the critical powers of colleagues, and false loyalties may delay help.

Children are the most vulnerable members of the family. Infants born to mothers who drink may be damaged. Excessive drinking by the mother in pregnancy is teratogenic and may also cause the fetal alcohol syndrome. Disordered communications cause developmental delay (due to lack of input) or non-accidental injury (violent input). If parents do not respond to simple advice about a child's problems, the general practitioner should ask himself where the block is: alcohol could be the hidden cause.

Members of the family are often the presenting sign of a drinking problem, but their prodromal approach is frequently missed. The general practitioner treats the symptoms without recognising the underlying cause. Non-drinking members of the family suffer too, are patients, and need our care. They are often the best way into a drinking problem, and yield the first rewards for efforts to help.

Identification

All general practitioners share the salutary experience of having treated a patient for years without recognising their dependence on alcohol. We need to raise our index of suspicion by asking ourselves early and every time whether alcohol abuse could be contributing to the patients' illness. The pattern for problem drinking is a constellation of clues, no one diagnostic in itself but together indicating that alcohol in the patient or someone close to him is the probable underlying factor.

The physical complaints of heavy drinkers are frequently vague and without demonstrable organic cause: loss of appetite, tummy upsets, morning shakes, sweats, backache, memory lapses, and accidents. Signs of psychological incompetence include unhappiness, erratic moods, sexual failure, family conflicts, confusion, and "going on the wagon." Social inadequacy is shown by requests for a sickness certificate, underachievement, out-of-character behaviour, work problems, money shortage, and trouble with the law.

The patient must be asked how much he drinks, when, how often, and whether his drinking has ever caused problems. If he resents such questions, why does he do so? The drink lessens his feelings of isolation and worthlessness, and because he sees his problems as the cause and not the result of his drinking he may become aggressive or clamp down if this solution is threatened. These are physical signs and should not irritate the doctor.

The doctor should ask himself whether an attitude of disapproval will help. He should be direct and specific, challenging any vagueness, wariness, evasion, inconsistencies, bluff, or facile assurances.

The patient will not give a true answer until he can be honest with himself. If he will talk the doctor should encourage any sign that he is beginning to examine himself. Progress depends on his confidence in the doctor, and on the doctor's sensitivity as to when the patient is ready to accept some insight.

The doctor should watch out for the gaps of what is not said and for non-verbal signs—a swallow, a flush, or sudden stillness. Physical signs include a smell of alcohol or peppermint, obesity, sweating, shakes, rapid pulse, liver palms, a tender liver, and injuries, either to the drinker himself or to others, the cause of which he will usually deny.

Records

Date	★	CLINICAL NOTES
6.7.79		Indigestion. Appetite good. Smoking 30/day. Advised mag. frasil.
2.1.81		Bruised hand. Tender @ 5th MP joint. No deformity. Reassured.
2.3.81		Irritable - overworking (self-employed now) - not sleeping.
12.8.81		Came late to discuss son's school refusal - slammed out when asked to wait. Nitazepam 20.
3.9.81		More stomach pains - depressed - in tears critical. Smoking ↑ 40. Drinks x 2 weekly - social.
15.9.81		Hands shaky, check blood for MCV + SG-T. Last week wife walked out with children. Patient turned car over. Breathalyser +. Blood alcohol awaited. Strands to lose his business (taxi). States alcohol no problem - has been dry since! Resists referral - just wants children back.

★ This column has been provided for doctors to enter A, V or C at their discretion.
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Records are the general practitioner's paper instruments for detecting problem drinkers. Their value depends on the quality of the recording, the ease of retrieval by arrangement in chronological order, and the existence of summaries and cross references to the records of other members of the family. Patterns of presentation suggesting problem drinking may fit our template. Evidence of stress, frequent consultations, loss of communication within the family, and changes of spouse, address, or doctor provide further clues. Specific test results, such as a high mean corpuscular volume (MCV) on a previous routine blood count or an abnormal liver function value may complete the pattern.

Bilirubin	S.G.O.T.
10	25
μmol/l	units
5 - 17	< 25
Glucose	γ-GT
	55.6
mmol/l	units
2.5 - 4.7 fasting	M6-28/F4-18

8.8	WBC x 10 ⁹ /l	Eth
4.63	RBC x 10 ¹² /l	
16.2	Hb g/dl	
48.6	PCV	
105	MCV fl	
34.9	MCH pg	
33.3	MCHC g/dl	Tre
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Communications

Other sources of information are part of the general practitioner's network of communications. He is in a unique position to recognise alcoholism in its early and remediable stages, and listening does not compromise confidentiality. He must avoid both the wasteful pursuit of an illness-centred diagnosis, and the neglect of any opportunity to assume his responsibility for the health of those families who have entrusted themselves to his care.

Members of the primary care team have considerable opportunity to identify problem drinkers. The aim must be that not only shall they do this but they shall also provide treatment and care.

Advisory Committee on Alcoholism 1978

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