Alcohol and cirrhosis

Introduction

Epidemiology

- 30% ♂, 15% ♀ drink more than recommended limits (England).
- Risk of alcoholic liver disease in ♀>♂ due to different ability to metabolise alcohol.
- >320,000 alcohol related admissions/year (2/3 ♂).
- 2023 - 10,473 UK deaths from alcohol-specific causes.

Complications of alcohol excess

- Injury/death due to trauma, drowning, road traffic and other accidents.
- ↑ risk cancer of the mouth, throat, stomach, colon, liver, breast.
- Cardiac – arrhythmia, hypertension, cardiomyopathy.
- Fatty liver, fibrosis, hepatitis, cirrhosis. Acute/chronic pancreatitis.
- Psychiatric illness – 47% of those who die by suicide have a history of alcohol misuse.
- Wernicke-Korsakoff syndrome – encephalopathy, psychosis, amnesia.
- Foetal alcohol spectrum disorder from alcohol in pregnancy.
- Social complications – alcohol is implicated in >25% of cases of child abuse and domestic abuse.

How to take an alcohol history

Who to ask

- At new patient check, chronic disease management, sexual health check, antenatal appointment, minor injuries, after assault.
- If a physical or psychiatric diagnosis could have had alcohol as a cause/contributor.
- Symptoms of alcohol withdrawal – anxiety, nausea, vomiting, tremor, ↑HR, sweating, confusion, delirium or noticeable smell of alcohol on clothes.
- Consider if there are signs of impulsive behaviour e.g. repeated attendance for emergency contraception/STI screen, repeat injuries/accidents.

How to ask

- Be non-judgmental – patient may have previous experience of stigma.
- Don't use bloods to diagnose alcohol misuse.
- Consider formal assessment tools such as AUDIT-C (brief and suitable for primary care) – see resources section for others.
- CAGE questionnaire is easy to use but only 70% sensitive: more likely to miss milder alcohol issues.
- Consider the use of very brief advice in a normal consultation – some evidence for link to ↓ alcohol consumption.

Primary care management

Acute

- Consider same day admission:
  - Acute alcohol withdrawal at risk of seizures/delirium tremens – lower threshold if frail, poor social support, cognitive impairment.
  - Wernicke's encephalopathy.
- Suicide risk → crisis team.

Long-term

- Refer alcohol support services, don't suddenly stop from high intake.
- Refer to mental health team if dual diagnosis (mental health & alcohol).
- Know what your local services are – some areas have a GP with extended role in drug and alcohol misuse. They may use naltrexone, acamprosate or disulfiram to prevent relapse.
- Inform DVLA and don't drive if persistent alcohol misuse, alcohol dependence with high-risk features, cirrhosis with encephalopathy, alcohol-induced psychosis or cognitive impairment.
- Oral thiamine if malnutrition present/risk, decompensated liver disease, acute withdrawal and during planned medically assisted withdrawal.

Cirrhosis

What is it?

- Irreversible disruption of liver structure due to chronic liver disease. Can evolve from fibrosis, which is reversible if causes are tackled.
- May be compensated (liver still functions effectively) or decompensated (liver failure, potentially fatal).
- Risk factors include alcohol, obesity, type 2 diabetes, viral hepatitis, autoimmune, genetic or iatrogenic liver disease.
- Complications – malnutrition, frailty, osteoporosis, sepsis, acute kidney injury, hepatocellular carcinoma (HCC ~3%/year).

Diagnosis and management

- Diagnosed in secondary care via imaging or biopsy (ultrasound may suggest but can't diagnose).
- Usually remain under secondary care management.
- Treat underlying cause e.g. hepatitis/alcohol.
- Endoscopy to detect oesophageal varices.
- Ultrasound surveillance for HCC development,
- Possible medication:
  - Carvedilol/propranolol to prevent decompensation and bleeding from varices.
  - Prophylactic antibiotics to prevent spontaneous bacterial peritonitis.
- Palliative care if appropriate.