Alcohol Related Brain damage

Dr Abhi Goli

@abhigoli

overview

- What is ARBD
- Classification
- Criteria
- Signs to recognise
- Treatment and Management

What is ARBD

- Mild moderate severe depending on which part of the brain damaged and for how long
- Reversible to irreversible/permanent damage
- Impact on memory and functioning
- 0.5% in the UK
- Under diagnosis
- Poor detection
- The highest prevalence of ARBD is found between the ages of 50 and 60
- Women's alcohol consumption is on the increase
- Women tend to have a shorter drinking history and present 10–20 years younger than men

Classification

Acute

- acute withdrawal syndromes and delirium tremens
- alcoholic hallucinosis
- alcoholic blackouts
- Wernicke's encephalopathy
- hepatic encephalopathy
- alcoholic pellagra encephalopathy

Chronic

- Frontal Lobe dysfunction
- Wernicke's Korsakoff syndrome
- Alcoholic Dementia

Criteria - Amnesic Syndrome

ICD10

- memory impairment for recent memory
- absence of defect in immediate recall, impairment of consciousness, and of generalized cognitive impairment
- particularly high-dose use of alcohol

DSM V

- evidence of difficulty in learning new information and problems in recalling previously learned information.
- The memory impairment should be to such a degree that there is impairment and decline in occupational and social functioning.
- It is important to confirm that the memory impairment is not solely associated with a dementia, delirium or ongoing intoxication or withdrawal.
- There should also be evidence that the memory impairment is related to persisting effects of alcohol misuse as demonstrated by physical examination, the history or laboratory test

Signs to recognise in inpatient setting

- Often subtle cognitive dysfunction/impairment- short term memory issues, long term memory issues : confabulation
- Poor understanding the implications of decisions
- Prone to high levels of fire hazards
- Agitation- controlling impulses
- Disinhibition
- delusional experiences and aggression
- Poor motivation
- Dysexecutive syndrome
- Physically active

Treatment and Management

- Good nutritional and adequate fluid intake- look for thiamine deficiency
- Improve sleep pattern
- Screening – ACE, BADS
- Managing alcohol withdrawals- use of benzodiazepines
- AVOID PERMANENT DAMAGE
- Thiamine- Thiamine- Thiamine
- Maintaining abstinence
- Psychosocial support
- Cognitive rehab
- 5stages- Prof Wilson etal

Treatments and Management

- Referral to alcohol services – future management, abstinent work and ?neuropsych assessment
- Dual Diagnosis framework
- MCA vs MHA
- Multi-professional approach

References

- college-report-cr185.pdf (rcpsych.ac.uk)
- Wilson K (2011) Alcohol-related brain damage: a 21st-century management conundrum. British Journal of Psychiatry
- The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines
- Department of Health (2009) Local Routes: Guidance for Developing Alcohol Treatment Pathways. Department of Health
- National Institute for Health and Clinical Excellence (2011) Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence (Clinical Guideline CG115). NICE.
- Addenbrooke's Cognitive Examination–III (ACE–III).
- Wirral severe ARBD model