

# Drug and Alcohol Dependence

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## Commentary

Emergency Department (ED) doctors meet regularly with patients seeking treatment for alcohol and substance abuse problems. This data supports the belief that the emergency department plays an important role in identifying and assisting patients with alcohol and substance abuse. Although the first test may seem routine, these patients have some physical and emotional problems that need to be addressed as much as possible. Emergency Physicians (EPs) should endeavor to identify patients who may benefit from referrals to drug and alcohol problems. The emergency department will be the first or only contact with the medical system for these patients [1-4].

Studies have shown that short interventions in the emergency department may be effective for alcohol users. This concept is sometimes referred to as the "moment when it can be taught." In one study, injured alcoholic ED patients (n=494) were randomly assigned to either simple counseling or no counseling on alcohol abuse, completing a 12-month follow-up interview. Groups with brief counseling tended to report lower alcohol consumption at 12 months of follow-up compared to groups without counseling [5-8]. However, an article in the Cochrane database of 11 studies and a systematic review of 2,441 patients concluded that evidence of the benefits of short-term interventions for severe alcohol users was not conclusive. Data from two studies have shown that follow-up alcohol consumption may decrease after one year, but more studies are needed. Similarly, in urban adolescents identified in self-reported drinking and aggression emergency rooms, short-term intervention reduced both behaviors. Walton approximately one-quarter of adolescent ED patients surveyed reported both alcohol (alcohol consumption, drinking, and/or the effects of alcohol) and violence (companion aggression and violence and/or the effects of violence). I found out that. Patients (n=254) who received a 35-minute intervention in the emergency room by a therapist had a 34.3% reduction in peer aggression after 3 months and a 32.2% reduction in alcohol effect after 6 months. I showed that. Control patients (n=235) who received the pamphlet showed a 16.4% and 17.7% decrease, respectively. Patients (n=237) who received computer-aided intervention had a 29.1% reduction in alcohol effect after 6 months.

Excellent literature reviews on screening and simple interventions for patients with alcohol use disorders (AUD) in the emergency room are available online. Based on their study, the authors suggest that screening and simple interventions in ED settings are feasible and effective. Visits to the ED provide an important opportunity for physicians to screen patients for alcohol problems and initiate simple interventions. The American College of Emergency Physicians (ACEP) has created a resource kit called Alcohol Screening and Simple Intervention in ED. It provides a framework for screening and intervention that takes into account the time and resource constraints of the emergency department. It lists recommendations from the National Institute of Alcohol Abuse and Alcoholism (NIAAA) advocating the use of quantity and

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frequency (Q & F) and CAGE questions to screen for alcohol problems. Q & F questions can help determine if a patient is above the recommended level of moderate drinking and therefore "at risk" of illness or injury. The 90% specificity and 76% sensitivity CAGE questionnaire is suitable for identifying addictions when used in the emergency room. Since CAGE was originally designed for lifetime prevalence, it may be helpful to say "last 12 months". One way to use the screen is to ask a Q & F question and add a CAGE question when the answer is above a medium level. Another approach is to skip to the CAGE question for patients who are or are suspected of being addicted to very high levels of ethanol. This eliminates the negative implications and resistance that can occur when asking a patient to quantify their drinking.

Abuse drugs include alcohol, cocaine, opiates, amphetamines, and hallucinogens. This article outlines the physiological effects of these substances and outlines the signs of withdrawal and physiological effects that caregivers need to be familiar with [9, 10].

## Alcohol

Alcohol is a CNS inhibitor. At low doses, alcohol primarily acts to suppress inhibitory centers. The resulting disinhibiting can lead to abnormal activity (for example, dancing with a lampshade on the head loses long-standing self-confidence). At high doses, alcohol blocks the center of alertness. People can show effects ranging from impaired rational thinking to lack of motor coordination. Physiological effects of chronic alcohol intake include:

- Gastrointestinal hepatic cirrhosis, gastric ulcer, gastric inflammation, pancreatitis and cancer
- Cardiovascular hypertension, dementia, atrial fibrillation ("Holiday Heart Syndrome")
- Neurological peripheral neuropathy leading to ataxia, Wernicke-brain en and structural changes leading to dementia
- Immunological suppression of neutrophil function and cell-mediated immunity
- Increased estrogen in endocrine men and decreased testosterone causes impotence, testicular atrophy, and gynecology
- Obstetrics, fetal alcohol syndrome (i.e., intellectual disability, facial deformities, and other neurological problems)
- Mental Dementia or anxiety disorders

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