PHYSICAL MORBIDITY IN PATIENTS ADMITTED TO A PRIVATE HOSPITAL FOR DETOXIFICATION FROM ALCOHOL

A. S. WYLIE*1, S. MILNE1 and R. G. RAMSAY2

Department of Psychiatry, Gartnaval General Hospital, 1053 Great Western Road, Glasgow G12 0YN, 1Ashworth Hospital, Maghull, Liverpool and 2St Anns Centre, The Ridge, Hastings, East Sussex, UK

(Received 1 September 1994; in revised form 15 May 1995; accepted 19 June 1995)

Abstract — A survey of patients admitted to a private hospital for detoxification from alcohol found similar levels of physical morbidity and withdrawal complications to a group admitted to a National Health Service alcohol treatment unit. Although private patients tended to be older than National Health Service patients, the two groups were similar on a number of other variables. The implications for those involved in the management of patients who abuse alcohol are discussed.

INTRODUCTION

In a previous study of admissions to a National Health Service (NHS) alcohol treatment unit (ATU), Milne et al. (1991) found a considerable level of physical morbidity on admission, with a substantial proportion developing complications during detoxification, despite drug treatment. The authors concluded that the early detection and management of physical complications of alcohol misuse remained an important function of ATUs, despite recent questions about their role (Potamianos et al., 1986; Edwards, 1988).

Admissions to NHS units are increasingly restricted by diminishing bed numbers. It is possible that only those at the more severe end of the disease spectrum gain admission. The same is not true, however, of the private sector. Since admission is partly dependent on ability to pay, cases may be postulated to be less severe. Some health insurance companies, however, restrict cover for in-patient alcohol dependency treatment.

The aim of the present study was to assess the physical morbidity of patients admitted to a private ATU for detoxification.

METHOD

All patients admitted over a 6-month period to a London private psychiatric clinic for detoxification from alcohol were included. Information was collected regarding basic demographic details and medical histories. A detailed alcohol history was taken, as was a history of drug abuse (use of illicit or non-prescribed drugs). Physical examinations on admission were undertaken by one member of the research team and routine biochemical and haematological investigations were performed.

Patients were detoxified using a reducing regime of chlormethiazole or chlordiazepoxide (with the initial dose being decided on clinical grounds), thiamine and multivitamins as appropriate. Patients with a past history of alcohol withdrawal seizures received either prophylactic phenytoin or carbamazepine.

The data from the previous study of physical morbidity in an NHS ATU (Milne et al., 1991) were obtained and compared with the results from the current survey. Mann–Whitney and \( \chi^2 \) values were calculated for relevant data.

RESULTS

Private Patients

Twenty-two male patients and 11 female patients were admitted. Male patients were of a similar age to female patients (46.4 years compared with 42.3 years; Mann–Whitney \( U = 80.5, P = 0.12 \)). Male patients admitted to a greater daily consumption of alcohol than females (40.4 units per day compared with 23.8 units per day; Mann–Whitney \( U = 44, P = 0.003 \)).
Amongst the private patients, 75.8% were found to exhibit physical morbidity. The physical signs and symptoms found on admission were palpable liver edge (14 cases), other liver stigmata (two), diastolic pressure >100 mmHg (nine), chest infection (three), peripheral neuropathy (six), finger clubbing (one), gastritis (one) and diarrhoea (one). No significant associations were found between overall physical morbidity on admission and age (Mann-Whitney \(U = 96.0, P = 0.27\)), sex (\(\chi^2 = 0.59, d.f. = 1, P = 0.44\)), reported alcohol consumption (Mann-Whitney \(U = 93.5, P = 0.50\)), current drug misuse (\(\chi^2 = 1.31, d.f. = 1, P = 0.25\)) or history of fits (\(\chi^2 = 2.60, d.f. = 1, P = 0.11\)). A palpable liver edge was associated with a higher reported consumption of alcohol (Mann-Whitney \(U = 40.5, P = 0.002\)). Women were as likely as men to exhibit hepatomegaly (\(\chi^2 = 2.62, d.f. = 1, P = 0.11\)). Complete data regarding blood tests upon admission could not be obtained, because of occasional procedural or laboratory failures. A number of patients refused blood tests. Liver function tests (LFTs: alkaline phosphatase, gamma-glutamyl transpeptidase, aspartate aminotransferase and alanine aminotransferase) and mean corpuscular volume were obtained on 69.7% of the private patients. Amongst those having blood tests, elevated LFTs were found in 59.1% and macrocytosis in 45.5%. Neither raised LFTs nor macrocytosis were found to be associated with a palpable liver edge (\(\chi^2 = 1.96, d.f. = 1, P = 0.16\) and \(\chi^2 = 0.96, d.f. = 1, P = 0.33\)), or other physical morbidity (\(\chi^2 = 0.76, d.f. = 1, P = 0.38\) and \(\chi^2 = 0.24, d.f. = 1, P = 0.62\), respectively).

There were problems during the detoxification period in 17.9% of patients. No private patients developed delirium tremens or hallucinosis in clear consciousness during detoxification. Two patients experienced tonic-clonic seizures during detoxification. There was one case each of gout, severe vomiting, peripheral neuropathy, undiagnosed severe abdominal pain, unconsciousness due to overdose and status epilepticus. Whilst detoxification problems were more frequent in older patients, this failed to reach statistical significance (Mann-Whitney \(U = 71.0, P = 0.056\)). Concurrent drug misuse or a history of fits were not associated with detoxification problems (\(\chi^2 = 1.65, d.f. = 1, P = 0.20\) and \(\chi^2 = 1.74, d.f. = 1, P = 0.19\) with Yates' correction, respectively). No associations were found between detoxification complications and sex (\(\chi^2 = 1.70, d.f. = 1, P = 0.19\)), hepatomegaly on admission (\(\chi^2 = 0.02, d.f. = 1, P = 0.90\)) or other physical morbidity on admission (\(\chi^2 = 2.35, d.f. = 1, P = 0.12\)). Raised LFTs or macrocytosis were not associated with complications (\(\chi^2 = 3.51, d.f. = 0.06\) and \(\chi^2 = 2.67, d.f. = 1, P = 0.10\), respectively). Detoxification problems were not associated with reported alcohol consumption (Mann-Whitney \(U = 95.0, P = 0.67\)).

**Private compared with NHS patients**

The sex distribution of the private patients was similar to NHS patients (\(\chi^2 = 0.002, d.f. = 1, P = 0.96\)). Private patients were older than their NHS counterparts (Mann-Whitney \(U = 917.0, P = 0.03\)). Private patients were less likely to report concurrent misuse of drugs (\(\chi^2 = 8.7, d.f. = 1, P = 0.003\)). Private patients reported similar levels of alcohol consumption (Mann-Whitney \(U = 1054, P = 0.39\)). Private patients' reporting of a history of fits was similar to NHS patients (\(\chi^2 = 0.43, d.f. = 1, P = 0.51\)). Private patients were less likely to present with a palpable liver edge (\(\chi^2 = 4.03, d.f. = 1, P = 0.04\)) but had similar rates of overall physical morbidity (\(\chi^2 = 0.60, d.f. = 1, P = 0.44\)). Private patients were as likely to experience complications during detoxification (\(\chi^2 = 1.86, d.f. = 1, P = 0.17\)). In contrast to NHS patients, detoxification problems in the private patients were not associated with a reported daily alcohol consumption of >35 units (\(\chi^2 = 1.09, d.f. = 1, P = 0.30\)). Private patients were more likely to refuse blood tests (\(\chi^2 = 8.33, d.f. = 1, P = 0.004\)).

**DISCUSSION**

The results of this study must be viewed with a degree of caution in view of the small sample size. This may account for some of the discrepancies between this and the previous study (Milne et al., 1991). Nevertheless, we found that private patients were very similar to patients admitted to the NHS unit on a number of variables. They...
reported similar levels of alcohol consumption, presented with similar accounts of physical morbidity on admission and experienced as many complications during the detoxification period as their NHS counterparts. The private group tended to be older which may reflect a higher earning capacity or likelihood of having private health insurance with increasing age.

This study supports the findings of Milne et al. (1991) in demonstrating that significant physical morbidity can be found in about three-quarters of patients admitted for detoxification from alcohol and that about one in five patients experience problems in the detoxification period, despite receiving withdrawal medication. None of the variables examined in the present study predicted which individuals would experience detoxification problems. Milne et al. (1991) suggested that a reported alcohol consumption of >35 units per day was associated with detoxification problems. This finding was not replicated in the present study. Self-report of alcohol consumption is known, however, to be unreliable (Midanik, 1988).

Doctors managing people who abuse alcohol need to be aware of the high level of physical morbidity amongst patients presenting for alcohol detoxification. Furthermore, it seems that inpatient detoxification may still be the most prudent form of management for a proportion of both NHS and private patients.

REFERENCES


