Alcohol-related presentations

Alcohol-induced anxiety, depression, and suicidal ideation

Management	If patient is intoxicated and suicidal, observe patient in ED until intoxication resolves. Even if suicidal ideation resolves when sober, refer patient to psychiatry if: • Patient has recently attempted suicide. • Patient remains severely depressed. • Patient has frequent alcohol binges and major risk factors for suicide (e.g., recent loss, has feasible suicide plan). If suicidal ideation does not resolve, refer to psychiatry and place on Form 1 if indicated.
Discharge advice and referral	Heavy drinking can cause or worsen depression and anxiety. Abstinence or reduced drinking usually improves mood within weeks. **Refer patient to rapid access addiction medicine clinic** and to community addiction treatment upon discharge.

Trauma caused by alcohol intoxication

General discharge and referral	Screen for alcohol use disorder. Inform patient that risk of trauma dramatically increases with each drink. Advise patient on harm-reduction strategies (see below). **Offer all patients referral to rapid access addiction medicine clinic.**
Advice on preventing alcohol-related accidents and violence	*Avoid intoxication:* • No more than one drink per hour. • Sip rather than gulp. • Avoid unmeasured drinks (especially vodka and other spirits). • Alternate alcoholic drinks with non-alcoholic drinks. • Eat before and while drinking. *Avoid dangerous situations:* • Do not drive a car or boat after drinking. • Do not get in a car or boat with people who have been drinking. • Do not engage in arguments with intoxicated people. • Leave a social event if uninvited strangers arrive, and/or if heavy drinking and aggressive behaviour takes place. • Have a non-drinking friend accompany you and take you home.

Alcoholic cirrhosis

- If consent is provided, speak to patient with family members present.
- Patients with decompensated cirrhosis should be advised that treatment may be life-saving: 5-year survival rate of 60% with abstinence, 30% with continued drinking.
- **Refer all patients to the rapid access addiction medicine clinic.**
- Arrange follow-up with family physician and gastroenterologist for consideration of endoscopy, beta blockers for portal hypertension, low-salt diet, etc.

Alcohol use in the elderly: Falls, confusion, depression, problematic failure to cope

Identify alcohol problems in the elderly	Always ask about alcohol use in elderly patients presenting with falls, confusion, depression, problematic benzodiazepine use, or failure to cope. Obtain collateral from family if patient provides consent. Order CBC, LFTs including GGT, +/- BAL.
Discharge advice and referral	Explain to patient and family that the patient's problems (falls, confusion, etc.) are caused by alcohol. Involve social worker in addiction treatment planning; options may be limited in patients who are cognitively impaired or lack mobility. **Refer to rapid access addiction medicine clinic.** If applicable, send letter to family physician suggesting benzodiazepine taper. Discuss ways the family can assist (e.g., frequent supervision, limiting availability of alcohol in the home).