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CHALLENGES OF TREATMENT OF ACUTELY ILL PATIENTS ENROLLED IN A MANAGED ALCOHOL PROGRAM

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In Canada, alcohol use disorder (AUD) affects 3.2% of the population [1], and is the single biggest contributor of substance use disorder-related hospitalisations [1, 2]. Frequency of hospitalisation has been demonstrated to increase with severity of AUD [3]. For some individuals with severe AUD, participation in a Managed Alcohol Program (MAP) can be an effective harm reduction strategy [4–6]. MAPs are a consideration for patients who use toxic non-beverage alcohols (NBA) [7] or experience significant consequences (homelessness, frequent hospitalisations, etc) of unstable alcohol use. For MAP participants, there are documented improvements in hygiene, health and medical care participation and reduction of NBA consumption [4–6]. Although MAP patients have a reduction in admissions to health-care facilities [5, 6], as people with severe AUD, they still require frequent hospitalisation [3]. To date, the benefits of MAP have been described exclusively in community populations, with little known about its potential use in acute care settings [4–6].

An example of such a challenging case occurred recently at an urban Canadian hospital. Patient consent was obtained for case publication. A MAP participant with severe AUD, decompensated alcoholic and hepatitis C-induced liver disease and oesophageal varices required admission for management of an acute drop in haemoglobin and acute exacerbation of hepatitis. Both conditions were aetiologically direct consequences of her AUD; as such, the patient's MAP was discontinued upon admission. She received treatment for alcohol withdrawal with benzodiazepines. Subsequently, the patient's 16 day hospitalisation was complicated by repeated absences from hospital to consume alcohol, with an eventual return to the consumption of NBA. Though initially she stabilized medically, with no gastrointestinal bleeding found on investigation and both liver and haemoglobin parameters improving with supportive care, as her alcohol-seeking behaviours escalated, her liver function further decompensated. Furthermore, the quality of her care was impacted by her frequent absences, resulting in missed medical assessments and incomplete investigations.

Considerable debate occurred amongst the managing medical teams throughout the admission regarding the potential use of in-hospital managed alcohol administration for this patient. She was extremely ill, both acutely and chronically, with imminent risk of death

from ongoing alcohol consumption [8]. Alcohol abstinence was the cornerstone of management for her acute hepatitis and anaemia; indeed, as the literature demonstrates, continued alcohol consumption in the setting of alcoholic liver disease and oesophageal varices results in increased morbidity and mortality [8, 9]. The hospital's ethics department stated that, given the relationship of the patient's medical issues and decompensation to alcohol, provision of alcohol could not constitute harm reduction. They noted that morally a patient's desire for something does not in and of itself ethically justify providing it, that benefit must be demonstrated. Thus, the patient remained off of her MAP.

As witnessed, however, by the patient's repeated absences, ultimate return to NBA consumption and subsequent clinical decompensation, the abstinence-based approach represented a clear barrier to retaining her in hospital for medical care. This ultimately resulted in clinical deterioration, arguably representing net harm. Furthermore, the potential for repeated episodes of sub-optimally managed alcohol withdrawal put her at risk for more severe subsequent withdrawals [10]. Thus, when the patient returned to NBA consumption, the hospital's Addiction Medicine service advocated for in-patient MAP initiation not only to curb her NBA consumption, but also to avoid absences and thus improve her engagement with medical care and overall health outcomes. Consequently, MAP was initiated, continuing until the patient ultimately left against medical advice. There was no further clinical deterioration with MAP resumption; however the remainder of her hospitalisation was brief.

This case represents the difficulty in weighing harms of suspending versus continuing MAP for in-patients with AUD-related complications. It parallels decisions in the community regarding use of MAP for those with chronic AUD complications. This is a classic contrast of error of omission versus error of commission—whether the harmful consequences of doing nothing outweigh the harm of acting. The physician's primary role is to do no harm, but the question remains for some patients as to whether withholding alcohol, with potential results as described here, is less harmful than providing it in a controlled environment, knowing that any alcohol at all will cause physical harm. In the community, early literature suggests that provision of alcohol in such a manner can in fact be beneficial for some patients [4–6]. While there are at least five hospitals in Canada of which the authors are aware that do provide alcohol in a controlled manner (but do not have formal in-patient MAPs), no in-patient literature currently exists to help inform decision-making regarding MAPs. Most commonly, alcohol is used in hospital for patients without acute alcohol-related complications, however, arguably may be beneficial in some cases such as the one described here, and should be considered as an option. Until further data is available, the balance of benefit versus harm of in-patient MAP must be assessed on a case-by-case basis.

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