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Patient Case Study

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BACKGROUND (BG)

There is a plethora of evidence supporting the assertion that patients who consume high levels of alcohol are at significant increased risks of brain injuries, these are categorised as Alcohol Related Brain Injuries (ARBI) these include;

- Wernicke's/Korsakoff's Syndrome due to poor nutrition.
- Hepatic Encephalopathy due to liver diseases.
- Traumatic Brain Injury due to accidents.
- Strokes

There is also evidence that ARBIs are often not identified

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BG Continued

This case study will identify the consequences of missed opportunities. Identifying the positive outcomes when accurate diagnosis and appropriate treatments were initiated.

This supports the value of timely, evidenced based intervention/treatments which are imperative to improve the health and wellbeing of the patient and their significant others.

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Case Study

This case study will follow the journey of one patient's admissions over a twelve month period between 2016 to 2017.

This patient had multiple outpatient follow up appointments with the specialities needed for his conditions.

These include;

Hepatology

Diabetes

Cardiology

Psychology

Tissue viability

Dietitians

Weight management

Ophthalmology

Podiatrist

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Patient Profile

- 62 year old male

Social History

- He lived with his wife who was fit and well, unemployed carpenter, no illicit drugs, none smoker

Past Medical History

- T2 diabetic
- HTN/Heart failure
- Mental health problems diagnosed with a bipolar disorder
- Clinically obese

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Patient Profile Continued

- Known Alcohol related Cirrhosis
- Previous Hepatic Encephalopathy
- Gout
- Regular AED attender due to; falls, Acute Alcohol Withdrawal (AAW), generally unwell and collapses.

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A snap shot of AED Presentations and Admissions

DATE	PRESENTATION	DIGAGNOSES	DISCHARGE	EXTRA FOLLOW UP
9/1/16	Fall with head injury	Head injury	10/1/16	NIL
16/1/16	Vomiting	Vomiting	16/1/16	NIL
3/3/16	Confused	EEG 21/3/16 diagnosed Hepatic Encephalopathy (HE)	6/4/16	Commenced on Rifaximin 550mg BD on discharge for HE NEUROLOGY
4/5/16	Fall	Fall	5/5/16	NIL
11/5/16	Confused/jaundiced	Decompensated ALD with HE With septic arthritis	20/6/16	Rheumatology
8/8/16	Fall	Intoxicated	8/8/16	NIL
10/8/16	Collapsed	Exacerbation of ALD	30/8/16	NIL
2/10/16	Generally unwell	Exacerbation of ALD	1/12/16	NIL
4/3/17	Confused	Exacerbation of ALD	6/4/17	Alcohol Treatment Clinic (ATC)

Investigations and results on discharge

investigation	Date	Result
GGT	4/3/17	154
LFTs	4/3/17	Normal range
Clotting	4/3/17	Normal range
Ammonia	4/3/17	Normal range
HB	4/3/17	138
PLT	4/3/17	120
Other FBC	4/3/17	Normal range
urea	4/3/17	2.1
Other U&Es	4/3/17	Normal range
USS abdomen	7/3/17	Echo bright coarse liver. Enlarged spleen 15cm in length

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Medications provided on discharge 6/4/17

Medication	Dose	Route	Days supply	GP to continue
ALLOPURINOL	300MG OD	ORAL	14	YES
BISOPROLOL	2.5MG OD	ORAL	14	YES
LACTULOSE	30MLS BD	ORAL	14	YES
METFOMIN	500MG TDS	ORAL	14	YES
PROCYCLIDINE	5MG TDS	ORAL	14	YES
RAMIPRIL	1.25MG OD	ORAL	14	YES
RANITIDINE	150MG BD	ORAL	14	YES
RIFAXIMIN	550MG BD	ORAL	14	YES
RISPERIDONE	2MG BD	ORAL	14	YES
SERTRALINE	200MG OD	ORAL	14	YES
SIMVASTATIN	40MG OD	ORAL	14	YES
THIAMINE	100MG TDS	ORAL	14	YES
PARACETAMOL	500MG PRN	ORAL	14	YES

ATC Appointment

On the 24/4/17 he was followed up in our Alcohol Treatment Clinic.

He attended with his wife.

He had abstained from alcohol from his discharge 6/4/17

On examination

He presented very drowsy with slurred speech. No Jaundice, mild lower limb oedema, abdomen was soft with no evidence of fluid. Blood pressure and Heart rate were normal, pupils were equal with normal size and reaction

His wife reported that he was more confused than usual and she was finding the situation more difficult to cope with. She became quite emotional and upset.

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ATC Consultation 24/4/17

Review of his medical records showed multiple outpatient follow up appointments with all the specialities. He did not attend approximately 70% of these.

Documentation identified that he continued to consume alcohol. His wife had reported concerns about his increased confusion which was affecting her ability to care for him. As a consequence she was considering the need for a care home. This caused great distress to them both.

We reviewed his medications. Asking the question if he was taking everything as prescribed. Bloods had no significant changes from discharge.

We discovered that his GP had not continued the Rifaximin commenced April 2016. (That's twelve months of omission of HE treatment)

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Actions and their outcomes

- We discussed the discontinued Rifmaximin with our hepatologist, who liaised with the patients GP.
- Referred to social care.

1. Rifaximin recommenced by GP
2. Social care arranged two visits per day with one day a week for 4 hours so wife could go out.

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Outcomes

Patient remained abstinent from alcohol

Reduced encephalitis improved his cognitive function

Within three months the social care was no longer required

His wife was able to care effectively for her husband

Quality of life substantially improved for all involved

No AED presentations or **UNPLANNED** admissions since last discharge in April 2017

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Missed opportunities

He did have an EEG in March 2016 which diagnosed mild hepatic encephalopathy, however his GP did not continue the essential treatment of Rifaximin. Moreover the omission was not identified on any subsequent admissions or by any other outpatient appointments.

FYI

He did not get an CT or MRI head until 2020

MRI Head = Cerebral Atrophy and chronic small vessel ischaemic changes in the periventricular and deep white matter.

CT Head = Generalised cerebral volume loss disproportionate for his age.

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Discussion Points

- Identified the importance of timely **appropriately skilled** interventions.
- Highlighted the importance of effective communications between secondary care, primary care and all health and social care involved.
- Highlighted the importance of utilizing available resources.
- Identified the need for the development of screening criteria for ARBIs with assessment tools and treatment pathways.
- Identified the dire consequences without the above.

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Improvements 2020

All patients with any alcohol related liver disease are automatically followed up by the Alcohol Specialist Nurses 2 weeks after discharge.

An ARBI pathway was developed for inpatients with screening criteria for its initiation.

Any patient who is suspected of consuming too much alcohol are screened, which leads to a referral to the alcohol specialist nurse team.

A treatment pathway has been developed that treats acute alcohol withdrawal, treats/prevents WKS .

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Conclusion

Now in 2020 he attends all his outpatient appointments.

Patient has remained abstinent from alcohol, most likely due to a better understanding of the consequences of his drinking behaviour.

Despite his many co-morbidities his concordance with treatments and advice from the professionals has improved his and his wife's quality of life significantly.

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