What's up with Sam?

ADDICTION MEDICINE

A middle-aged man complains of abdominal pain, insomnia, tiredness and depression.

SAM is a 56-year-old man who separated from his wife six years ago. She still lives in the family home and he has two adult daughters who live independently. He has worked as a storeman for the past 26 years but has been put "on probation".

Sam was held in high esteem until about two years ago, when he started making errors at work, was increasingly on sick leave and had periods of unexplained absenteeism.

Sam lives alone in a rented flat. He goes to the local pub after work for a few beers before going home. At night, he usually watches television and has "a few" more drinks. He has drunk alcohol since late adolescence and is a smoker. Occasionally, his estranged wife or daughters visit and cook him a meal.

History

Sam presents to the surgery complaining of abdominal pain and nausea. He also says he is a "terrible sleeper" and wakes early. When he wakes, he feels tired and anxious.

Some days, he feels he cannot face work and stays in bed feeling depressed and lethargic. He denies any suicidal ideation.

Examinations

On examination, the GP notes a slight tremor. Sam states that he has always been a "bit nervy".

Aside from some mild epigastric discomfort, the rest of the examination is essentially normal. Blood tests including FBC, LFTs, TSH, urea electrolytes and creatinine, folate and vitamin D levels are ordered.

The GP considers Sam might have gastritis and possible depression. He is prescribed a short-term PPI, given dietary advice and advice about sleep hygiene, and asked to return after the blood tests are done.

The GP does not hear from Sam until three weeks later, when the local hospital ED calls asking that Sam be given an appointment as soon as possible. Sam had been taken to the ED by ambulance as he was found unconscious on the footpath between his flat and the local hotel. He had a blood alcohol level of 0.34.

Prior to Sam's appointment, the GP receives test results from the hospital.

Notable results were: MCV 102; gamma-glutamyl transferase 451; AST 221; and low folate levels.

CT scan of the brain indicated slight general atrophic changes.

Discussion

Sam attends the scheduled appointment with his ex-wife, who reports that Sam has been drinking alcohol at problematic levels for many years.

His alcohol use was the primary reason for the separation. She said she was unsure how much he'd been drinking recently but when they were last together he'd arrive home drunk every night from the pub and continue drinking wine or beer until late. He would not be able to eat dinner at times as he was not hungry.

After he moved out she noticed that he had lost weight, mainly in his arms and legs. He had minimal food in the fridge and the flat was untidy.

He had continued to manage at work until a new system was introduced two years ago. He had problems managing the new system and avoided it.

His workplace had apparently noticed Sam was having trouble coping. This was attributed to his marriage break-up and loneliness. His manager had made allowances for his difficulties as he was a long-term, valued employee. However, continued absenteeism forced the HR department to put him "on notice".

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The blood test results showed Sam had a significant problematic alcohol use pattern and the CT scan changes were consistent with alcohol-related brain injury.

Management

The muscle loss in the arms and legs was due to vitamin deficiency, and treatment with daily thiamine and multivitamins was commenced.

He was also diagnosed as having depression and an SNRI was commenced.

Sam was referred to an inpatient withdrawal service, then to a psychologist for cognitive assessment (given a period of abstinence) and counselling for his depression.

He also attended the employee assistance program, which referred him to specialist drug and alcohol services.

His ex-wife agreed to monitor him on a daily basis along with his daughters. His workplace agreed to hold his position until he was medically fit to return.

Outcome

Sam continued to remain abstinent after a medically assisted detoxification with the support of his family, Disability Services and his workplace.

His depression was treated with an SNRI and psychological counselling, both of which continue on an ongoing basis. He attends regular Alcoholic Anonymous meetings.

THE AUTHOR

Rinaldo Minniti is a clinical and health psychologist with the Drug and Alcohol Services SA.

This article is one in a series on brain injuries, in association with Brain Injury Australia.

HAVE AN INTERESTING CLINICAL CASE?
Send it to grandrounds @cirrusmedia.com.au
Photos are encouraged.

Omnio

App of the Week

DESIGNED specifically for healthcare professionals, this free app offers ready access to a range of useful clinical resources.

In addition to the complete *Merck Manual*, the app provides a range of clinical calculators, from alcohol dependence questionnaires to prostatism symptom score surveys.

There is also a free drug identification tool, which uses information about a tablet's shape, colour and scoring to help you work out what your patient means when they say they're on "the new, little, white one for my heart".

There is also a library of other texts you can trial before deciding if you want to buy them.

This app was developed in the US, so the newsfeed is perhaps of less relevance to Australian GPs but, on balance, it is likely to prove beneficial for practising clinicians.

Staff writers

Specifications

COST: Free
COMPATIBLE WITH: iPhone, iPad and Android
REQUIRES: iOS 8.0 or later, Android 4.4 and up

Surgery

Associate Professor Maurice Brygel

A digital divide

A 35-YEAR-old woman presented two days after cutting the volar aspect of her index finger with a kitchen knife. At the time of injury, bleeding was profuse and pulsatile.

She dressed it herself but now complains of numbness on one side of her finger.

Professor Maurice Brygel is a general surgeon in Melbourne, and co-author of the ebook *Exploring Essential Surgery: Compilation*.

THE QUIZ

Q. The most likely cause of the numbness is:
a. Neuropraxia secondary to swelling
b. Neuropraxia secondary to a tight dressing
c. Division of digital nerve
d. Infection

A: The answer is c. In addition to the distribution of paraesthesia, the history of pulsatile, profuse bleeding suggests the digital artery was divided.

This supports the diagnosis of damage to the digital nerve as the digital nerves are superficial to the arteries in both the fingers and toes.

Q. The most appropriate management of this woman would be:
a. Referral for wound exploration and digital nerve repair
b. Explore wound under local anaesthetic (digital block) and suture with non-absorbable sutures
c. Explore wound under local anaesthetic (digital block) and steri-strip wound as suturing is not appropriate after this length of time
d. Dress wound and treat conservatively as, after two days, surgical repair of severed tendons, nerves and skin is unlikely to be successful

A: The answer is a. While it is best to repair nerves, tendons and skin as soon as possible after the injury, successful repair of these tissues can occur up to a week later, provided there is no infection present.

The patient was referred for digital nerve repair and at the time of surgery, she was also noted to have a partially divided flexor tendon, which was also repaired.

Q. In relation to this case, which of the following statements are true?
a. Examination for nerve and tendon damage following a laceration should take place prior to infiltration with local anaesthetic
b. The patient's tetanus immunity should be checked
c. Following repair of the laceration, the finger should be splinted in full extension
d. Following repair of the laceration, the finger should be splinted in the position of function

A: The answers are a,b and d. Splinting the finger in fixed extension can lead to a permanent stiffness even after the injury has healed.