ALCOHOLISM—DIAGNOSTIC CRITERIA AND VARIABILITY

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Diagnosis is the process of identifying and specifying the necessary condition. In clinical research, diagnostic criteria are a set of rules needed for identification. These are important and improvement of diagnostic criteria often precedes other major advances in understanding other areas viz. aetiology and treatment.

As regards diagnosis of alcoholism, there are several criteria and definitions. Some of these are for research purposes. Some for day to day clinical practice and others for screening in the community. The rules are different and only modest degree of overlap is seen. In other words, patient diagnosed to have ‘alcoholism’ by one criteria would not satisfy the other systems. The above mentioned points are made clearer by examining four commonly used definitions. These are: Michigan Alcoholism Screening Test (MAST) (Selzer, 1971), Diagnostic and Statistical Manual 3rd Edition (DSM III) (APA, 1980), Research Diagnostic Criteria (RDC) (Spitzer et al., 1978) and ICD-9 (WHO, 1977).

The comparison (DSM III, RDC & MAST) reveals that pathological drinking pattern is considered in all the three systems. However, ‘inability to stop’ or ‘cut down’ and ‘black out’ are the only common questions. Only DSM III has items such as ‘need for daily use’, ‘binge drinking’, ‘drinking despite illness’ and ‘drinking non beverage alcohol’. ‘Bender’ or ‘drinking more than a specified amount’ is common in RDC and MAST. Drinking before noon or breakfast is found only in RDC and MAST.

Items regarding social and occupational impairments are common for a large extent in all the criteria. However ‘problem with wife’, ‘divorce or separation’ are found only in RDC and MAST. Dependence as manifested by presence of withdrawal symptoms are mentioned in all the 3 systems. Confusional states, hallucinations and seizure are not listed as withdrawal symptoms in DSM III. These are however used as diagnostic aids in MAST & RDC along with cirrhosis of liver, polyneuropathy and amnestic syndrome. DSM III alone permits a diagnosis of alcoholism on the basis of tolerance only along with pathological drinking pattern and social impairment.

Questions like ‘previous help sought’, ‘either by the patient or family’, ‘admission to a hospital for alcoholism’ and ‘attendance to A. A. meetings’ are unique for MAST and can even be diagnostic.

The above discussion makes it obvious that the current definitions differ widely, so also are the meanings attached to words like disease, disorder and essential features (Babor et al., 1986). With all these in mind we looked into diagnosis of alcoholism using different criteria and the overlap.

MATERIAL AND METHODS

Thirtyfive consecutive persons reporting to our OPD for help regarding their drinking habit were interviewed with the help of a questionnaire. The proforma was geared to diagnose alcoholism as per MAST, RDC DSM III and ICD-9. It was difficult to operationalise ICD-9. The crucial concept in ICD-9 is “compulsion to drink on a continuous or a periodic basis”. We framed it

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as “Do you have to drink daily to function adequately?” The questionnaire was administered in English and Kannada by a single interviewer (T.N.).

RESULTS AND DISCUSSION

One person was non alcoholic by all the criteria, MAST defined the largest number (N = 33), and ICD-9 the smallest number (N = 16). RDC defined 32 persons and DSM III 31 persons as alcoholic (Table).

It is important to remember that ours is a small sample, attending psychiatry OPD of a Neuro-psychiatry hospital. They could be very different from those attending medical OPD or sample from a community. Excluding ICD-9, 90% of subjects diagnosed by one set satisfied the other diagnostic criteria. ICD-9 appears to be most stringent, in fact due to difficulty in operational definition. Boyd et al. (1983) tried a similar exercise, they defined compulsion as “inability to stop drinking”. We feel such a definition conveys ‘loss of control’ rather than ‘compulsion’. It is seen that MAST identifies everyone. This is because the criteria are broad as it is mainly for screening purpose; our sample because of the setting comprise of severe cases.

It is apparent that the controversy on diagnosis of alcoholism continues and we need better definition. In this regard, DSM III-R (APA, 1987) is quite different and emphasis have changed. This includes symptoms like: use in large amounts or for longer period, efforts to moderate or stop, alcohol seeking behaviour, frequent intoxication leading to neglect of obligation, recurrent use despite harm, tolerance and withdrawal symptoms. These are very similar to the criteria suggested by Edwards et al. (1977) for the WHO model supposedly for ICD-10. Here dependence would mean cluster of symptoms from cognitive, behavioural and physiological domains. Presence of withdrawal is only a part of it. Even then it is seen that these two recent models though similar, are a very general one and not specific to any particular drug or alcohol. Moreover it does not specify the relative importance of any factor. Further we need to have interview schedule to elicit the information on these revised criteria. Hence the search is on. The prospectus of consensus will depend upon the ability of clinician, researchers and policy planners to express their purposes of definitions and their subsequent utilization (Babor et al., 1986).

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