

By Buay Zai See, Kah Kia and Tua Tao Kay
Department of Fictional Surgery,
Singapore Fictional Hospital (SFH)

Alcohol



FOREWORD:

I would like to state clearly now, that the following article is meant to entertain, and not to educate. To put it more bluntly, it is a parody, written for fun. It is NOT real. To all *chao* muggers out there – do not ask me where to find the original article. There is No Such Thing.

After having received much positive feedback and acclaim for my first article, I was feeling pleased with myself. Until I started meeting old classmates who asked me: “How was France?” I was stunned.

These are brilliant Dean’s Listers who never failed to ace an exam but cannot appreciate a satire. Since they probably relate better to textbooks and definitions, maybe this will help:

From the Merriam-Webster online dictionary:

Main Entry: 'par-o-dy

Pronunciation: 'per-ǝ-dE

Function: noun

Inflected Form(s): plural –dies

Etymology: Latin parodia, from Greek parOidia, from para- + aidein to sing

– A literary or musical work in which the style of an author or work is closely imitated for comic effect or in ridicule.

Remember the motto: “To guffaw sometimes, to laugh often, to smile always.”

Apologies to my real-life mentors. I will get back to doing your assigned projects. Just need to get this out of my system!

A prospective randomised double-blinded placebo-controlled trial to investigate if ingestion of alcohol in the immediate post-operative period facilitates post-operative recovery.

Iter Itineris of Risus. December 2008; 21(4):266-68.

ABSTRACT:

Some commonly encountered problems in surgical patients in the first few post-operative days are that of low urine output, pain and hunger pangs after having fasted overnight. Alcohol is widely known to quench thirst, induce euphoria, numb pain and cause retrograde amnesia. We aim to demonstrate that limited amounts of alcohol prescribed in the post-operative period will improve overall recovery.

BACKGROUND:

Alcohol has long been in use in the medical field – in cleansing, as a solvent for medications and by surgeons for building camaraderie when they go out together for drinks after work. We seek to expand the use of this useful substance by administering it as an oral therapeutic agent by prescription.

METHODS:

All patients who were admitted for operations under general/regional anaesthesia from the period of 1 June 2007 to 31 December 2007 were invited to take part in this study, and informed consent was obtained.

Dr Tan apologises for not providing a photo because she has been informed by reliable sources that she has put on weight and looks post-call all the time. After her controversial first article, she has been advised to start studying Harrison's and prepare to sit for the MRCPs because she will not get to join the exalted ranks of the RCS. However, she has also been told by her medical colleagues that she cannot make it, as she failed to pick up the mid-diastolic murmur in one of her patients with tricuspid stenosis, much less the classical wide splitting S1 with opening snap. Meanwhile, she is still saving for her Prada keychain.

Inclusion criteria:

- Patients of sound mind to give informed consent
- Only those above 18 are included (legal age)

Exclusion criteria:

- Patients who do not drink alcohol (due to religious/cultural/ personal beliefs)
- Patients with alcoholic liver cirrhosis
- Patients who have allergic reactions to alcohol swabs

Patients involved in the study were randomised into either control group or study group.

Randomisation was done by using a computer generated list with block randomisation, assigning consecutive patients to either treatment arm.

Our standard treatment was to maintain an NBM (nil-by-mouth), with progressive increment in clear feeds, full feeds, diet, and analgesics depending on the individual surgeon's preference.

For this study, we standardised all patients to receiving only oral paracetamol 1g QDS. For the treatment arm, alcohol in various forms were introduced at various stages of feeding.

All patients were ordered to start on sips of water and clear feeds were given beer in corresponding amounts. Those allowed full feeds were given Baileys mixed in their usual milo or coffee. When diet was ordered, all patients in the treatment arm received 330mls of beer to go with their dinner. The placebo used was dihydrogen monoxide.

There was no IRB approval for this paper. We knew they would not approve, so we did not apply. Funding was obtained from one of the major breweries, which must not be named as this is a non-commercial article.

Patient safety was ensured by educating nurses and doctors to recognise the signs and symptoms of drunken behaviour, both the early phases of denial, inappropriate laughter/ depression, irritability and the late stages of outrageous behaviour and outright coma. When such was detected, the study team was contacted and the patient was reviewed as to whether he needed to be withdrawn from the study.

As it happens, the first author is very familiar with various manifestations of alcohol intoxication, having experienced and witnessed it firsthand many times in those drinks sessions. Both patients and the researchers were blinded. This posed some difficulty as some patients were able to smell alcohol from a mile away, and some patients in the standard group insisted on having the same treatment as what his neighbouring patient enlisted in the study group was having.

RESULTS

Out of a total of 558 operations done during the study period, 462 were recruited into the trial. Of these, 230 were randomised into the standard group, and 232 into the study group. There is no statistical significance in the mean age, gender, types of operations between these two groups.

Table I. Patient Demographics

	Control (n = 230)	Study (n = 232)
Age (years)	42.8	43.3
Gender		
Male	110 (47.8%)	118 (50.9%)
Female	120 (52.2%)	114 (49.1%)

*No significant differences. Who knows if you were lying?

Table II. Distribution of Cases

	Total (462)	Control (230)	Study (232)
Minor			
Hernias	49	21	28
Appendicectomies	81	39	42
Saucerisations	98	53	45
	228	113	115
Major			
Thyroidectomies	40	21	19
Lap Chole	59	30	29
Open chole	42	24	18
Gastrectomies	25	11	14
Colectomies	17	5	12
Hepatectomies	32	14	18
AAA open repair	5	2	3
Whipple's	8	2	6
Esophagectomies	6	4	2
	234	113	121

*No significant differences. Does anyone actually bother to double check these numbers?

Table III. Results

	MINOR SURGERY		MAJOR SURGERY	
	Control	Study	Control	Study
Length of stay (days)	2.8	2.6	7.1	5.2
Pain score (Max. 10)	2.1	1.1	4.7	1.3
Complications of alcohol	4 (3.5%)	7 (6.1%)	3 (2.7%)	9 (7.4%)

*Complications of alcohol: Hangover, accidents/ falls, aggressive behaviour/assaults, alcohol dependency/withdrawal

DISCUSSION

For the minor cases, there was no difference between the control group and study group in terms of length of stay, although there was a one-point reduction in pain score which was statistically significant. However, the pain was already pretty low to start off with, so maybe it does not make much of a difference at all.

Seven patients who underwent minor surgery had complications: three fell off from their bed even with the cot-side up because they got tangled in their IV lines while trying to get the attention of the bartender wearing the orange vest; four were aggressive and started to abuse the staff because they were not allowed to have more than the prescribed dose of alcohol. These were promptly discharged and given directions to Mohammed Sultan Road.

There were no cases of hangover, probably because the doses we used were too little. There were also no cases of dependency/withdrawal because the treatment period was quite short, averaging one to three days only.

Surprisingly, even patients in the control group had complications which appeared related to alcohol. All seven patients (four with minor operation and three with major operation) fell during their stay in the ward. These seven patients were investigated to exclude organic causes. Investigations for stroke, anemia, postural hypotension and AMI were all negative.

Precipitating factors like post-anaesthetic drowsiness, poor vision, wet floors and poor lighting were also excluded. The primary team was puzzled until one patient's relative noted that her affected mother was wearing a hospital *baju* that was two sizes too big, so she tripped over her trousers. Coincidentally, all seven patients were small, frail ladies wearing size XL *baju*. A tonne of complaint letters from concerned relatives poured in, many incident reports were written, and many committee meetings were organised to address this issue. But I still see many patients walking around holding their trouser legs up.

The most impressive results may be seen in those who underwent major surgery. The length of stay was almost two days shorter in the treatment group compared to the standard group, and there is a remarkable decrease in the pain score from near five to around one.

Of the nine patients with complications, there were four falls, again related to them trying to order more drinks and getting tangled over the IV lines. In addition, these patients had CVP lines and urinary catheters. Yes, there was quite a mess. There were two very aggressive patients who

fought each other because one man accused the other of stealing his drinks. Free passes to Zouk were given to pacify both.

One patient drank so much during the stay, that even after discharge, he kept coming back asking for more "special milo". He has been referred to AA. The last two patients had hangovers. The complaints of sudden onset of splitting headaches prompted urgent neurological referrals and urgent CT heads, which got the managing house officers some unwarranted scolding.

SUGGESTIONS

There were problems we encountered in the conduct of this study. For the healthy but boring staff who do not drink, it was difficult to teach them to recognise drunken behavior, as they insist on calling it an acute confusional state and proceeded to do a full investigation including bloods, ECG, and CT head, thereby wasting resources. The experienced staff on hand just sedated the patients, who slept through it and woke with a whopping hangover. None of the patients had to be withdrawn from the study.

Another medical problem encountered was that the alcohol screwed up the LFTs, so it made the interpretation of the post-operative LFTs for patients with liver resection difficult. The first author got hell from the hepatobiliary surgeons. But he was forgiven after buying everyone a round of drinks.

In conclusion, we recommend that carefully prescribed doses of alcohol is of benefit in patients who undergo major operations. For those who undergo minor surgery, there is no need to waste the alcohol on them since the benefit is minimal.

For further research, we hope to study the relative effects of different brands of beer, and introduce the use of stronger liquor like whisky. Cocktails also need to be studied because many female patients did not like the taste of beer. Ethnic tastes should be catered for, so sake, Nu-er Hong and so on should be studied too.

The first author has already embarked on the necessary groundwork and research, using his own funding by doing his own rounds of good watering places. He also has plans to study the effect of alcohol on surgeons: "Alcohol taken on the day of surgery improves mood, and enhances working relationships in the operating theatre". Already many volunteers have asked to be enrolled. We hope to gather enough data to publish soon. ■

**Please do not send any correspondence. The first author may be found at MOS every Friday night if not on call.*