Long-Term High-Intensity Drinking

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Binge drinking is defined as consumption that raises blood alcohol concentration to ≥0.08 g/dL, typically 5 or more drinks for men and 4 or more drinks for women within 2 hours.[1] To address variability in severity, the concept of high-intensity drinking (HID) was introduced, defined as ≥2 times the binge threshold.[2] These behaviors are linked to intoxication, neurocognitive impairment, cardiovascular disease, accidents, and violence.[3] This report underscores the need to recognize episodic high-intensity alcohol use as a clinically relevant presentation that carries medical and social risks despite the absence of daily drinking.

Case Report

A 50-year-old man with no psychiatric history was referred after a road traffic accident while intoxicated. He was divorced and employed as a supervisor. Medical history included type 2 diabetes, hypertension, obesity, and hypercholesterolemia; family history was positive for alcohol use disorder.

Since the age of 20 years, he reported a ritualized weekend pattern of binge drinking, consuming about 34 units (~20 standard beers) over 4 hours. He abstained during the week, denied withdrawal, and reported no preoccupation with alcohol outside these episodes. Motivations included euphoria, reduced inhibition, and social facilitation. Despite extreme intake, he maintained occupational functioning, though often isolated the following day. There was occasional cocaine use and disinhibited sexual behavior during intoxication, contributing to his divorce.

Attempts to self-limit (eg, restricting money, blocking credit cards) were unsuccessful, with consistent loss of control once drinking began. The recent accident was the first legal consequence of his drinking; he reported no prior emergency department visits, fights, or injuries.

Seeking help, he requested medication to reduce alcohol's positive effects. Physical examination and laboratory studies, including liver function tests, were unremarkable. Off-label naltrexone 50 mg was prescribed on an as-needed basis before drinking, along with harm-reduction counseling. After 2 months, he reported a 50% reduction in consumption, no further legal issues, and sustained motivation to cut down his drinking.

Discussion

According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision *(DSM-5-TR),*[4] the patient fulfills criteria for moderate alcohol use disorder due to loss of control, inability to cut down use, interpersonal consequences, and associated medical conditions. However, the *DSM-5-TR* does not distinguish episodic high-intensity patterns from daily heavy use, potentially underestimating the unique risks associated with this presentation.

In contrast, the *International Classification of Diseases, Tenth Revision,*[5] allows for recognition of episodic dependence, capturing patterns of compulsive use, loss of control, and priority of alcohol, even if the pattern is not daily. The patient's medical comorbidities (hypertension, diabetes, hypercholesterolemia) and social consequences (divorce, accidents) illustrate that episodic HID can carry substantial harm, reinforcing the need for clinical recognition.

HID produces rapid peaks in blood alcohol concentration, increasing the risk for acute intoxication, aggression, risky sexual behavior, and accidents.[6] Additionally, it is associated with cardiometabolic conditions such as hypertension, hypercholesterolemia, and type 2 diabetes.[7] Aging further increases vulnerability due to reduced liver metabolism and body water.[6] Clinicians should actively assess for HID patterns, even in patients without daily drinking or classic dependence, as they can indicate high-risk behavior warranting intervention.

Pharmacologic off-label strategies such as as-needed naltrexone have shown efficacy in reducing both the quantity of alcohol consumed during binge episodes and the number of binge-drinking days over time.[8–10] In this case, the off-label as-needed regimen, coupled with harm-reduction strategies, proved effective, consistent with emerging evidence, although more research is needed before routine adoption.

Conclusion

Episodic HID is a clinically important but often underrecognized pattern with serious medical and social harm. Even in the absence of daily drinking, a dependence diagnosis can be made. This case illustrates the value of targeted screening for HID and supports the use of harm-reduction strategies, including as-needed naltrexone, to reduce risk in patients with comorbidities.

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