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Letter to the Editor

Some alcohol-related brain injury is preventable. Why aren't we preventing it?

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Dear Editor,

A patient can receive parenteral thiamine in hospital, leave with a discharge prescription for oral thiamine but be unable to continue thiamine due to the lack of a simple reimbursement process in primary care. Thiamine deficiency contributes to Wernicke encephalopathy (WE) and Korsakoff syndrome (KS) within the broader spectrum of alcohol-related brain injury (ARBI). Timely thiamine treatment may reduce the risk of deficiency-related neurological injury. WE remains easy to miss: Harper and colleagues found the classical triad in only 16% of 131 cases confirmed at necropsy (Harper *et al.* 1986). When WE is not recognised and treated adequately, the consequence can be KS, a largely irreversible disorder characterised by profound amnesia and, in more severe cases, executive dysfunction, apathy, confabulation, and impaired social cognition (Arts *et al.* 2017).

The human cost often begins during working age. Contributors to an Irish service consultation described people with KS aged 20–60 years, including adults who had lost independence and become separated from family. Some were placed in nursing homes, long-stay psychiatric settings or homelessness services because appropriate specialist pathways were unavailable (Neurological Alliance of Ireland 2021). While we found no Irish estimate of quality-adjusted life-years or life-years lost specifically through thiamine-preventable ARBI, disability may persist over decades. Irish hospital data recorded a mean of 314 ARBI-coded admissions annually from 2015 to 2023; a broader brain-injury-plus-alcohol proxy identified 969 annual discharges (Doyle 2025). These data count episodes rather than individuals, depend on recognition and coding, and do not isolate thiamine-preventable injury. They nevertheless demonstrate a recurrent national burden.

The financial consequences are also substantial. A UK model followed a hypothetical 30-year-old man with harmful or dependent alcohol use and possible WE over 35 years. Under its assumptions, providing five rather than two days of intravenous thiamine was estimated to reduce NHS and social-care costs by approximately £87,000 per patient, mainly through reduced progression to KS and long-term care (Wilson *et al.* 2016). Treatment effects were informed by expert elicitation. This was a cost model, not a quality-adjusted life-year analysis, and it did not evaluate community oral prophylaxis. Published 2026 HSE public nursing-home costs commonly exceed €60,000 per resident annually. These figures are not KS-specific, but indicate the scale of expenditure when long-term residential care is required (Health Service Executive 2026).

July 2024 HSE supply-disruption recommendations advised oral thiamine 100 mg three times daily for harmful or dependent drinkers meeting specified clinical risk criteria. Following parenteral treatment or prophylaxis, they advised oral thiamine 100–300 mg daily until the patient was no longer at risk (Health Service Executive 2024). Irish emergency medicine guidance similarly advises oral thiamine while risky or hazardous drinking continues, with general-practice follow-up (Irish Association for Emergency Medicine 2019). The evidence does not establish one optimal dose, route, or duration (Day *et al.* 2013), but a prescribed treatment still needs to be obtainable. The practical questions are who supplies and funds thiamine, and who reviews treatment and reassesses risk.

In 2018, Deputy Éamon Ó Cuív asked why prescribed thiamine was not available free under the medical-card scheme. The Minister for Health referred the matter to the HSE (Dáil Éireann 2018). The Primary Care Reimbursement Service (PCRS) handbook describes a common reimbursable-items list for the General Medical Services (GMS) and Drugs Payment schemes (Health Service Executive Primary Care Reimbursement Service 2025). Separately, Beaumont Hospital Pharmacy colleagues advise that PCRS may reimburse oral thiamine individually, but describe administrative burdens, inconsistency, and potential financial disincentives for community pharmacies (M. Ferguson, personal communication, 6 July 2026). They report that patients may consequently be advised to purchase thiamine privately. These statements reflect local professional advice, not independently verified national thiamine reimbursement policy. Locally quoted prices were €16.90 for 60 and €31.50 for 120 thiamine 100 mg tablets: 20 and 40 days of treatment at 100 mg three times daily. These are illustrative quotations, not a national price survey.

Our concern about community access rests primarily on local observations and professional advice. We present no national data on prescribing, dispensing, reimbursement outcomes, treatment discontinuation or unmet need. The prevalence and geographical distribution of access difficulties therefore remain to be established. The effect of improved community oral-thiamine access on neurological outcomes also requires evaluation.

We are undertaking a local clinical audit of thiamine prescribing, discharge planning and documented access in an acute-hospital alcohol-liaison pathway. Its purpose is to map where responsibility and continuity may be lost between hospital and

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community care. Findings will be reported separately; no preliminary results are presented here.

As proportionate responses to a plausible problem whose national scale remains unquantified, three linked measures merit consideration: a protocolised starter supply before discharge for adults meeting agreed risk criteria; a consistent funded community route without case-by-case applications; and collaboration with suppliers and regulators to explore Irish authorisation and routine HSE reimbursement for an adult thiamine tablet. Eligibility, duration, named clinical responsibility and review arrangements should be agreed nationally and evaluated prospectively, including access, treatment continuation and clinical outcomes. We invite the HSE and PCRS, hospital and community pharmacists, general practitioners, addiction and homeless-health services, people with lived experience, and relevant suppliers to develop that response.

Irish recommendations recognise the need for continued treatment. Improving access may support continuity of preventive treatment, while national evaluation establishes the extent and consequences of interruptions.

We suggest that thiamine should be available without charge at the point of clinical contact for adults meeting agreed risk criteria, with opportunistic provision and assertive follow-up for patients least likely to navigate complex reimbursement processes.

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