UNC SON ECHO ABC for MOUD

Addiction and Behavioral Clinic for Medication for Opioid Use Disorder Treatment

TREATING

ALCOHOL USE DISORDER

IN PRIMARY CARE

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Disclosures

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- I have potential conflicts of interest pertaining to the material in this presentation

Objectives

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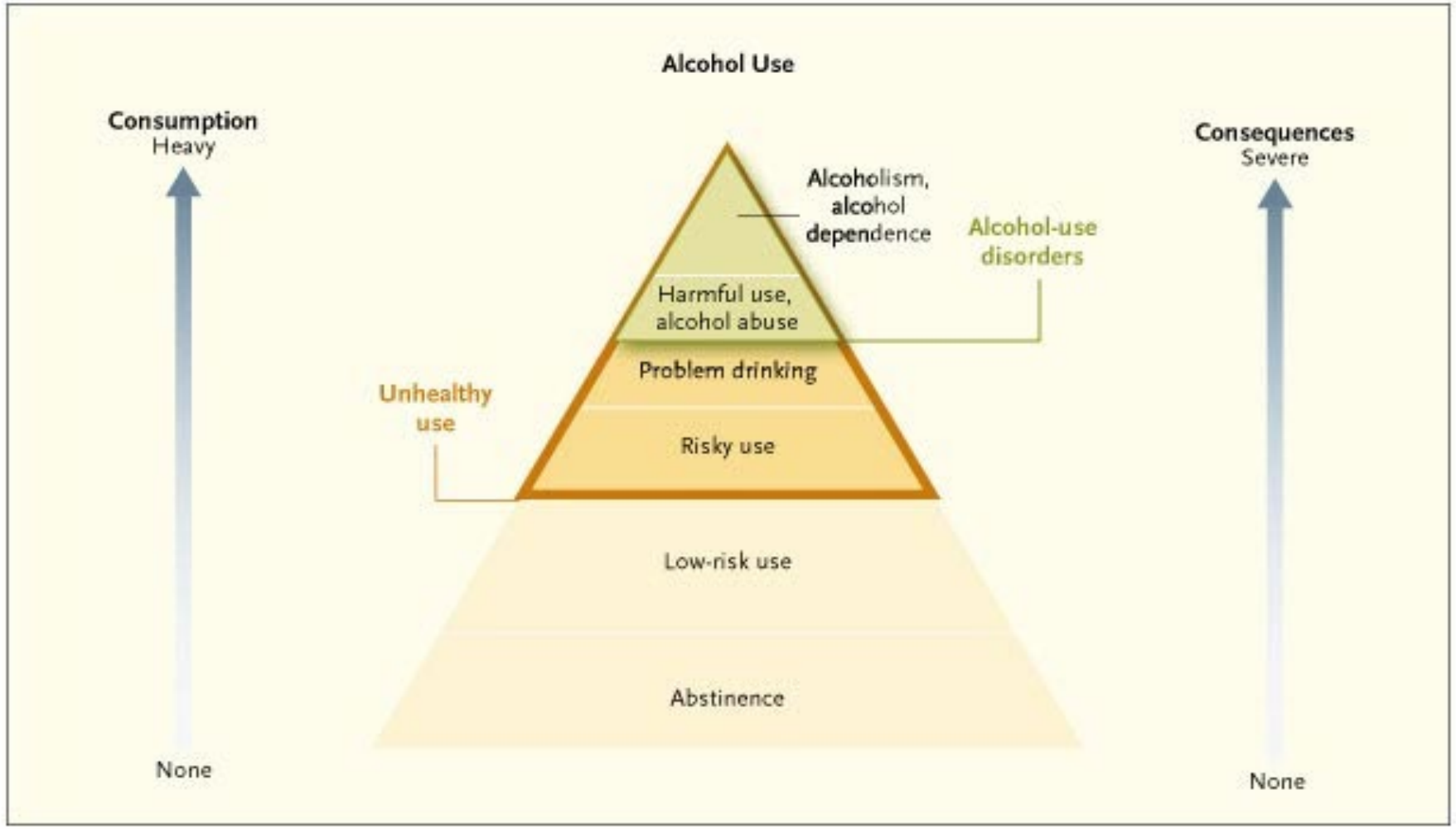
- Review the definition of the spectrum of unhealthy alcohol use
- Discuss treatment options available in primary care for unhealthy alcohol use
- Practice brief intervention
- Know when to refer to a higher level of care


THE LAST
MOSQUITO
THAT BIT ME
WAS DRUNK
FOR A WEEK


WHATEVER...


I'm alcohol! I can fill any spacee!!
a glass
a barrel
an empty heart

Continuum of Alcohol Use – FROM MBA



https://www.nejm.org/doi/full/10.1056/nejmcp042262

Definitions of Unhealthy Alcohol Use -MBA

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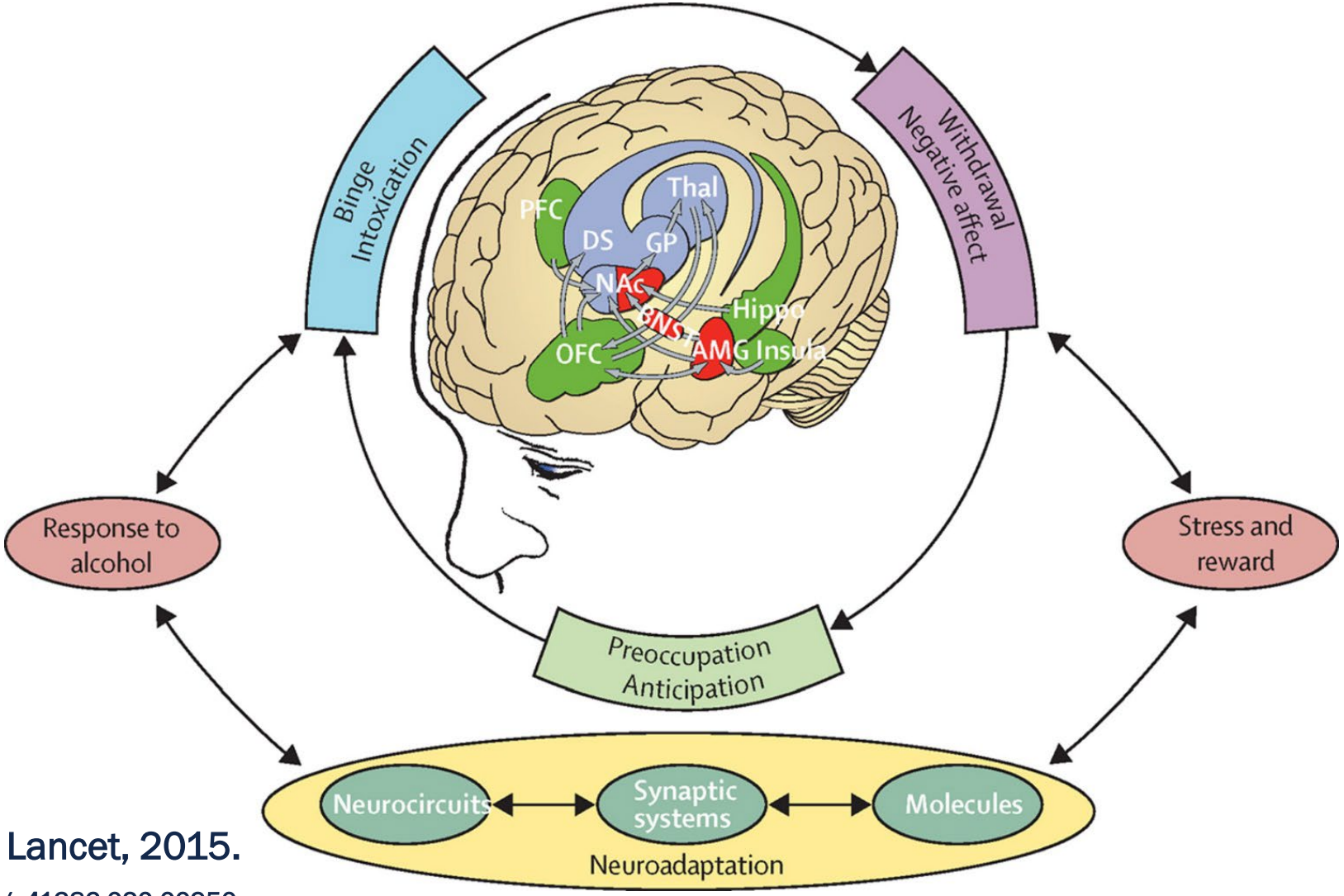
Table 1. Definitions of Unhealthy Alcohol Use.*

Category of Use	Prevalence	Definition and Features
	%	
Risky use	30	For women and persons >65 years of age, >7 standard drinks per week or >3 drinks per occasion; for men ≤65 years of age, >14 standard drinks per week or >4 drinks per occasion; there are no alcohol-related consequences, but the risk of future physical, psychological, or social harm increases with increasing levels of consumption; risks associated with exceeding the amounts per occasion that constitute "binge" drinking in the short term include injury and trauma; risks associated with exceeding weekly amounts in the long term include cirrhosis, cancer, and other chronic illnesses; "risky use" is sometimes used to refer to the spectrum of unhealthy use but usually excludes dependence; one third of patients in this category are at risk for dependence†
Problem drinking	Varies‡	Use of alcohol accompanied by alcohol-related consequences but not meeting ICD-10 or DSM-IV criteria; sometimes used to refer to the spectrum of unhealthy use but usually excludes dependence
Alcohol abuse, harmful use	5	In DSM-IV, recurrence of the following clinically significant impairments within 12 months: failure to fulfill major role obligations, use in hazardous situations, alcohol-related legal problems, or social or interpersonal problems caused or exacerbated by alcohol; in ICD-10, physical or mental health consequences only
Alcohol dependence, alcoholism	4	In DSM-IV, clinically significant impairment or distress in the presence of three or more of the following: tolerance; withdrawal; a great deal of time spent obtaining alcohol, using alcohol, or recovering from its effects; reducing or giving up important activities because of alcohol; drinking more or longer than intended; a persistent desire or unsuccessful efforts to cut down or control use; continued use despite having a physical or psychological problem caused or exacerbated by alcohol; in ICD-10, similar definition

Neurobiology of Addiction – FROM MBA



Volkow and Koob, The Lancet, 2015.

https://www.nature.com/articles/s41386-020-00950-y

Screening questions

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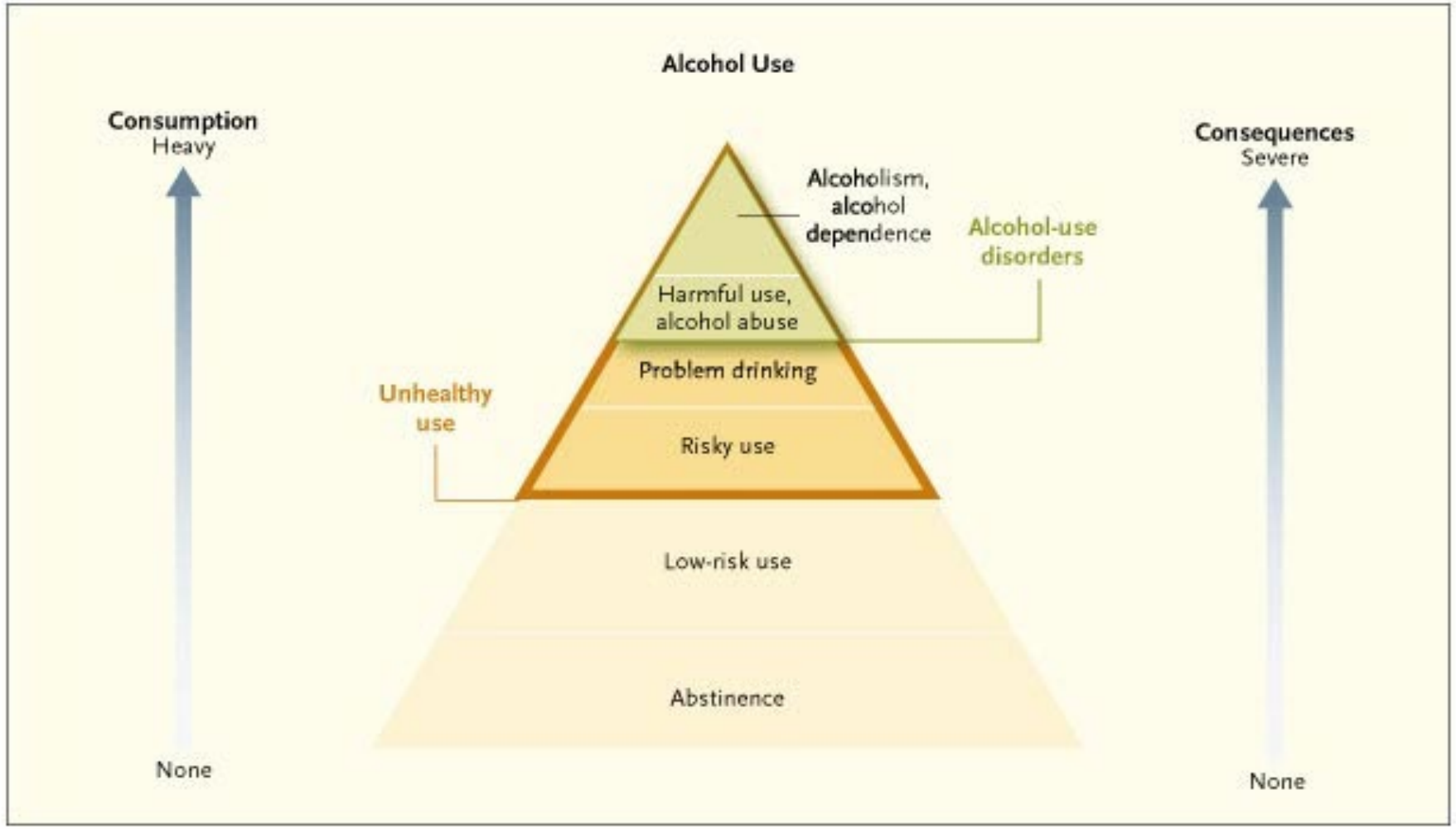
- 3 Questions - if positive, go to full 10 question AUDIT

1. In the past year, how often have you **used** alcohol?
2. When did you last **use** alcohol?
3. During COVID-19, I have seen more of my patients **using** alcohol, have you noticed any changes with your alcohol **use**?

Continuum of Alcohol Use – FROM MBA



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Treatment to fit the patient

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- Brief Intervention = risky drinking and above
- Pharmacologic management = AUD

Brief Interventions

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- Screening, Brief Intervention, Referral to Treatment (SBIRT)

- Goal is Harm Reduction
- Help pt understand their level of alcohol use and possible health impact
- Motivational Interviewing is the key
- Patient is the expert, clinician listens, respects and empowers

- SBIRT – Training - https://sbirt.care/training.aspx

Interventions, Education and Support

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- https://auditscreen.org/cmsb/uploads/drink_less_booklet.pdf
- Reframe App https://www.joinreframeapp.com/
- 12 Step Programs
  - https://www.aa.org/find-aa
  - https://www.smartrecovery.org/
- NIH - https://www.niaaa.nih.gov/publications/brochures-and-fact-sheets/treatment-alcohol-problems-finding-and-getting-help
- Local resources

What about Withdrawal?

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- Assess Symptoms
- Decide on location of treatment

Inpatient vs Outpatient vs My clinic

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- Depends on
  - Patient symptoms
  - Risk of severe or complicated withdrawal
  - Social factors (support and environment)

- And your comfort level!

OUTPATIENT	INPATIENT
Mild to moderate withdrawal symptoms	Severe or complicated withdrawal (past or present)
No significant additional SUD	Additional SUD (cocaine, benzo, opioid etc)
Generally healthy with any chronic diseases under control	Uncontrolled medical problem or seizure disorder
Mild or controlled mental illness	Uncontrolled mental illness, psychiatric symptoms or cognitive impairment
Stable care giver to assess daily	Limited social support
Strong personal commitment	Limited commitment, uncooperative
Stable transportation/housing	No transportation/housing

ASAM Clinical Practice Guideline on Alcohol Withdrawal Management - PocketBook

Severity of Alcohol Withdrawal Syndrome

Mild	Moderate	Severe	DT
Anxiety	Anxiety	Anxiety	Anxiety
Sweating	Sweating	Sweating	Sweating
Insomnia	Insomnia	Insomnia	Insomnia
	Tremor	Severe Tremor	Tremor
			Confusion
			Hallucinations
			Seizures

Outpatient Management

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- Patient Education
  - What to expect (daily assessment, low stim environment)
  - How to evaluate withdrawal symptoms
  - When to seek care (severe symptoms, return to alcohol, syncope, worsening mental illness)
- Monitoring
  - Daily for 5 days
  - Symptom checklist
  - Phone/video/in person
- Medication/Treatment
  - Non caff beverages, Mvi, thiamine 100mg/d x5 days
  - Discuss and consider starting chosen treatment for AUD
  - Mild withdrawal = supportive care +/- carbamazepine or gabapentin
  - Moderate withdrawal = supportive care + benzo vs carbamazepine or gabapentin
  - Gabapentin, carbamazepine and valproate can be adjuncts if benzos not enough
  - Prescribe benzos only until next in person appt – ideally 1-2 days at a time

ASAM Clinical Practice Guideline on Alcohol Withdrawal Management - PocketBook

TABLE 5

Oral Medications Used to Treat Mild to Moderate AWS

Medications	Typical dosing	Comments
Nonbenzodiazepine anticonvulsants		Appropriate monotherapy in mild AWS
Carbamazepine (Tegretol)	600 mg to 800 mg	600 mg to 800 mg per day tapered to 200 mg to 400 mg per day over 4 to 9 days
Gabapentin (Neurontin)	Loading dose: 1,200 mg Days 1 through 3: 600 mg to 1,200 mg per day Days 4 through 7: taper to 300 mg to 600 mg per day	Adjunctive therapy dosing: 300 mg to 500 mg every 6 to 8 hours Consider in those with continuing treatment for AUD (1,200 mg per day)
Benzodiazepines		First-line treatment for moderate AWS. Longer-acting types are preferred; if concern for liver disease, use benzodiazepines with less hepatic metabolism
Chlordiazepoxide (Librium)	50 mg to 100 mg	Single dose of 50 mg to 100 mg or symptom-triggered dose every 4 to 6 hours
Diazepam (Valium)	10 mg to 20 mg	10 mg to 20 mg every 6 to 12 hours for the first 24 hours, then reduce to 5 mg to 10 mg every 6 to 12 hours for the next 3 to 5 days Alternative front-loading regimen of 20 mg every 1 to 2 hours for 3 doses, then proceed to symptom-triggered regimen
Lorazepam (Ativan)	0.5 mg to 2 mg	0.5 mg to 1 mg every 6 to 8 hours on a scheduled basis, plus 1 mg every 4 hours if needed for mild symptoms or plus 2 mg every 2 hours if needed for moderate symptoms
Oxazepam (Serax)	15 mg to 30 mg	15 mg to 30 mg every 6 to 8 hours
Phenobarbital	60 mg to 260 mg*	Narrow therapeutic window, should be used by physicians with extensive experience or in Level 2 Withdrawal Management facility
Adjunctive therapy with benzodiazepines		Used if symptoms persist despite adequate benzodiazepine use
Beta blockers	Atenolol: 25 mg to 50 mg daily Metoprolol: 25 mg to 50 mg every 12 hours	For persistent hypertension and tachycardia
Carbamazepine	200 mg every 8 hours or 400 mg every 12 hours	For additional control; reduces craving
Clonidine	0.2 mg	For autonomic hyperactivity or anxiety
Gabapentin	400 mg every 6 to 8 hours	For additional control; reduces craving
Valproate (Depacon)	300 mg to 500 mg every 6 hours	Contraindicated in pregnancy and in patients with liver disease; should not be used as monotherapy for withdrawal

AUD = alcohol use disorder; AWS = alcohol withdrawal syndrome.

*—Can also be given intramuscularly.

Information from references 8 and 14.

Am Fam Physician. 2021;104(2):253-262

TABLE 3

Expected Symptoms of Alcohol Withdrawal Syndrome after Cessation of Alcohol Use

Symptoms	Time of appearance after cessation of alcohol use
Anorexia, diaphoresis, gastrointestinal upset, headache, insomnia, mild anxiety, palpitations, tremulousness	6 to 12 hours
Alcoholic hallucinosis: auditory, tactile, or visual hallucinations	12 to 24 hours*
Withdrawal seizures: generalized tonic-clonic seizures	24 to 48 hours†
Alcohol withdrawal delirium (delirium tremens): agitation, diaphoresis, disorientation, hallucinations (predominantly visual), hypertension, low-grade fever, tachycardia	48 to 72 hours‡

*—Symptoms generally resolve within 48 hours.
†—Symptoms reported as early as 2 hours after cessation.
‡—Symptoms peak at 5 days.

Information from references 8-10.

Short Alcohol Withdrawal Scale

- Mild Symptoms =

  <12

- Moderate to Severe Symptoms =

  12 or >

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

Elholm B, Larsen K, Hornnes N, et al. A psychometric validation of the Short Alcohol Withdrawal Scale (SAWS). Alcohol. 2010;45(4):362.

Am Fam Physician. 2016;93(6):457-465

Table 3. Medications for the Treatment of Alcohol Use Disorder

Best for maintaining abstinence

Medication	*FDA approved for alcohol use disorder*	*Dosage*	*Adverse effects*
Acamprosate‡ (Campral)	Yes	Two 333-mg enteric-coated tablets three times per day Moderate renal impairment (creatinine clearance of 30 to 50 mL per minute per 1.73 m^2 [0.50 to 0.83 mL per second per m^2]): initially, one tablet three times per day	Diarrhea, insomnia, anxiety, depression, asthenia, anorexia, pain, flatulence, nausea, dizziness, pruritus, dry mouth, paresthesia, sweating
Disulfiram (Antabuse)	Yes	Begin with 250 mg once per day; if not effective, increase to 500 mg once per day	Disulfiram-alcohol interaction: flushing, palpitations, nausea, vomiting, headache Optic neuritis, peripheral neuritis, polyneuritis, peripheral neuropathy, hepatitis, drowsiness, fatigability, impotence, headache, acneiform eruptions, allergic dermatitis, metallic or garlic-like aftertaste
Fluoxetine (Prozac)	No	Begin with 20 mg per day; may increase to 60 to 80 mg per day	Ejaculatory dysfunction, nausea, headache, insomnia, nervousness, somnolence, anxiety, diarrhea, anorexia, dry mouth, tremor, asthenia, sweating, dyspepsia, influenza-like illness, serotonin syndrome FDA warning§
Gabapentin (Neurontin)	No	Variable Studies have used 300 mg twice per day or once-daily dosages up to 1,800 mg at bedtime Could begin with 300 mg per day on the first day, then 300 mg twice per day on the second day and 300 mg three times per day on the third day; may increase to maximum dosage of 1,800 mg per day	Dizziness, somnolence, fatigue, peripheral edema, hostility, diarrhea, asthenia, infection, dry mouth, nystagmus, constipation, nausea, vomiting, ataxia, fever, amblyopia

Am Fam Physician. 2016;93(6):457-465

Naltrexone (Revia [oral], Vivitrol [injectable])‡	Yes	Oral: 50 to 100 mg per day (alternative dosing: 50 mg every weekday with a 100-mg dose on Saturday, 100 mg every other day, or 150 mg every third day) Injectable: 380 mg once every four weeks	Nausea, vomiting, headache, dizziness, nervousness, fatigue, low energy, insomnia, anxiety, difficulty sleeping, abdominal pain or cramps, joint or muscle pain
Ondansetron (Zofran)	No	4 mcg per kg twice per day (higher dosages may be used); available in 4-mg, 8-mg, 16-mg, and 24-mg oral doses	Malaise, fatigue, headache, dizziness, anxiety, serotonin syndrome; QT interval prolongation and torsades de pointes have been reported
Sertraline (Zoloft)	No	Begin with 50 mg per day; may increase to 200 mg per day	Ejaculatory dysfunction, dry mouth, sweating, somnolence, fatigue, tremor, anorexia, dizziness, headache, diarrhea, dyspepsia, nausea, constipation, agitation, insomnia, serotonin syndrome FDA warning§
Topiramate (Topamax)	No	Begin with 25-mg dose; increase to a total of 300 mg given twice per day in divided doses Renal impairment (creatinine clearance < 60 mL per minute per 1.73 m^2 [1.17 mL per second per m^2]): one-half of usual dosage	Hyperchloremic, nonanion gap, metabolic acidosis; acute myopia associated with secondary angle-closure glaucoma has been reported Anorexia, anxiety, diarrhea, fatigue, fever, infection, weight loss, cognitive problems, paresthesia, somnolence, taste perversion, mood problems, nausea, nervousness, confusion

Decrease euphoria and cravings

FDA = U.S. Food and Drug Administration; MAOI = monoamine oxidase inhibitor.

**—Other than hypersensitivity to the drug, which is a possible contraindication for all medications listed.*

†—Estimated retail price of one month's supply based on information obtained from http://www.goodrx.com (accessed December 3, 2015). Generic price listed first, brand price listed in parentheses.

‡—Good evidence to support use in patients with alcohol use disorder.

§—Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder and other psychiatric disorders.

Information from reference 13.

When to refer?

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- Your comfort level
- Moderate to high risk for complicated withdrawal
- Uncontrolled medical or psychiatric problems
- Return to alcohol use
- Multiple substances involved
- Pt’s symptoms not controlled or worsening despite tx

References

- Medication for Alcohol Use Disorder. *Am Fam Physician.* 2016;93(6):457-465
- ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. https://eguideline.guidelinecentral.com/i/1254278-alcohol-withdrawal-management/0
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- Maldonado JR, Sher Y, Ashouri JF, et al. The "Prediction of Alcohol Withdrawal Severity Scale" (PAWSS): systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. *Alcohol*. 2014;48(4):375-390.