Outpatient Alcohol Treatment

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How to Support People Who Use Substances

1

Get your X Waiver without completing the 8–24-hour training

2

Incorporate overdose prevention

- Universal naloxone DISPENSING
- Start low go slow
- Use with a buddy

3

Assess your patients for SUD and their interest in change

4

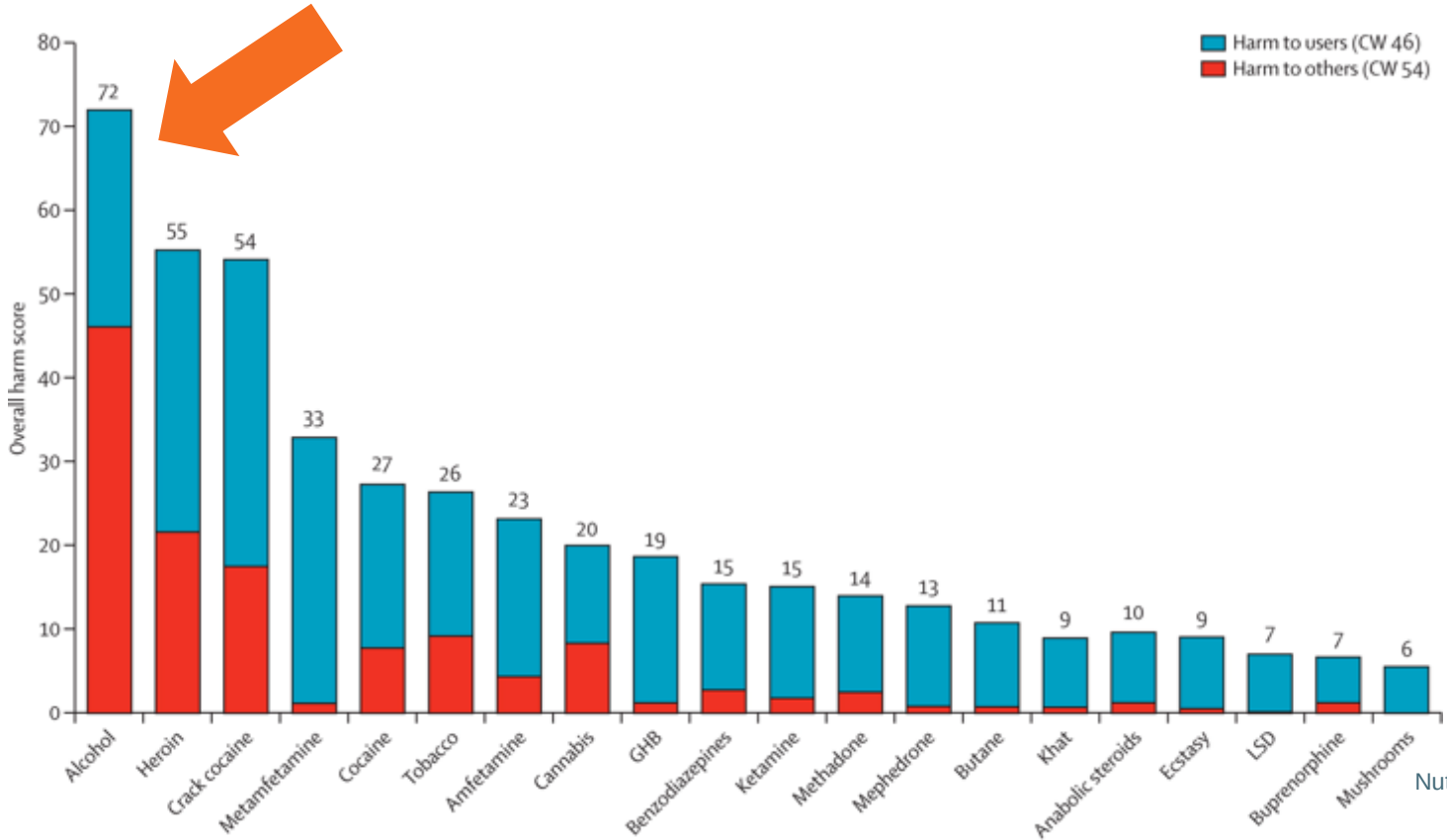
Continue and/or start SUD medications

SAMHSA

Buprenorphine Waiver Notification

https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

Alcohol use causes *most* harm compared to other substances.



Nutt et al., 2010

How to Support People Who Drink Alcohol

1. Advertise support and ask about drinking (NIDA, AUDIT-C)
2. Treat withdrawal (gabapentin, benzos)
3. Offer AUD Treatment (naltrexone first line)
4. Refer for additional support prn

WANT TO TALK ABOUT DRUGS OR ALCOHOL?

Ask us about medications to help today

STOP OVERDOSE SF

San Francisco Department of Public Health

Alcohol Use Disorder Treatment

Only **1 in 10** patients with AUD are ***treated***.

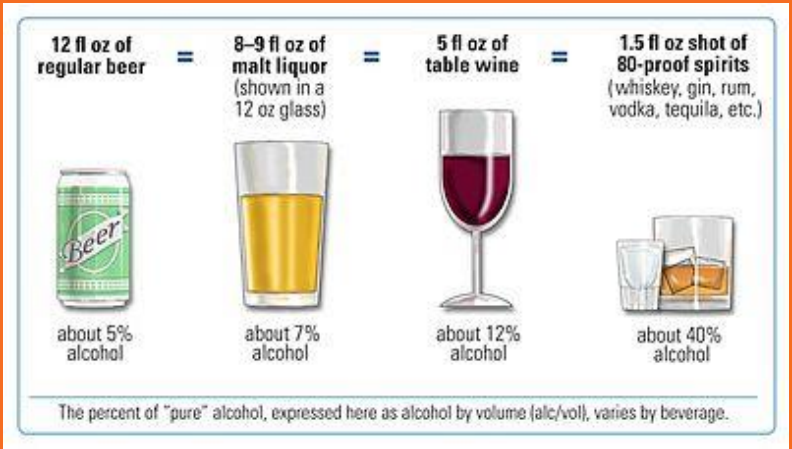
Only *half* of those are on medications for AUD.

Kranzler et al.

Identifying patients

- Posters
- AUDIT-C
  - How often did you have a drink containing alcohol in the past year?
  - How many drinks did you have on a typical drinking day in the past year?
  - How often did you have 6+ in the past year?
- Single Alcohol Screening Question
  - How many times in the past year have you had [5 for men/4 for women] drinks?
- Screening, Brief Intervention, and Treatment!

Standard drinks



Medications for AUD

FDA Approved

- Naltrexone*
- Disulfiram
- Acamprosate

Off-Label

- Gabapentin*
- Topiramate
- Carbamazepine
- Baclofen
- Varenicline

Naltrexone

- Opioid antagonist
- Number needed to treat (NNT) 12 prevents return to heavy drinking
- Not a treatment for withdrawal

Naltrexone

PO Naltrexone

50 mg PO daily

IM Naltrexone

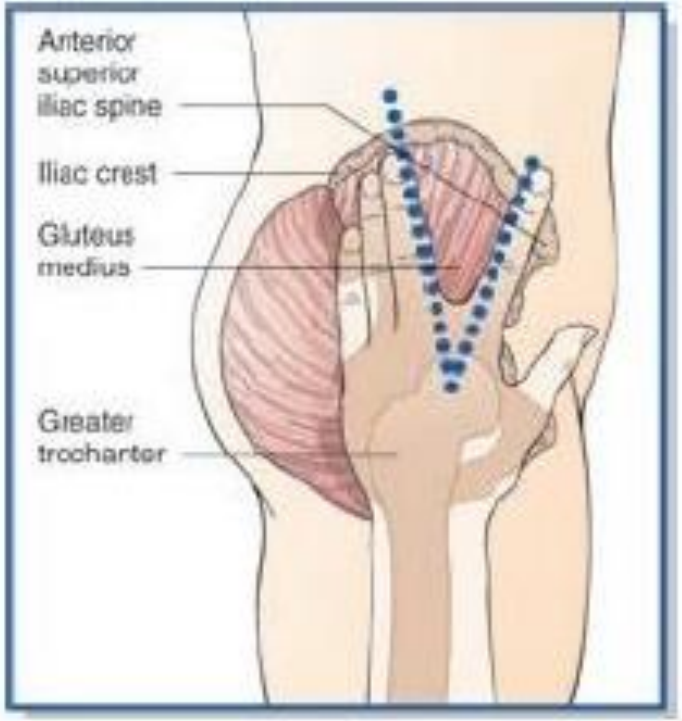
380 mg IM q monthly

When you should *not* use Naltrexone

- Opioid use (risk precipitated withdrawal, despite original indication)
- Liver function tests >5x upper limit of normal (ULN) or decompensated cirrhosis (Childs Pugh C)
- Pregnant (?)
- Not working!

Naltrexone

- ED, inpatient, outpatient
  - PHC ED pilot
- Opioid ANTAgonist
- Monitoring: LFTs 1 mo after initiation and q6months

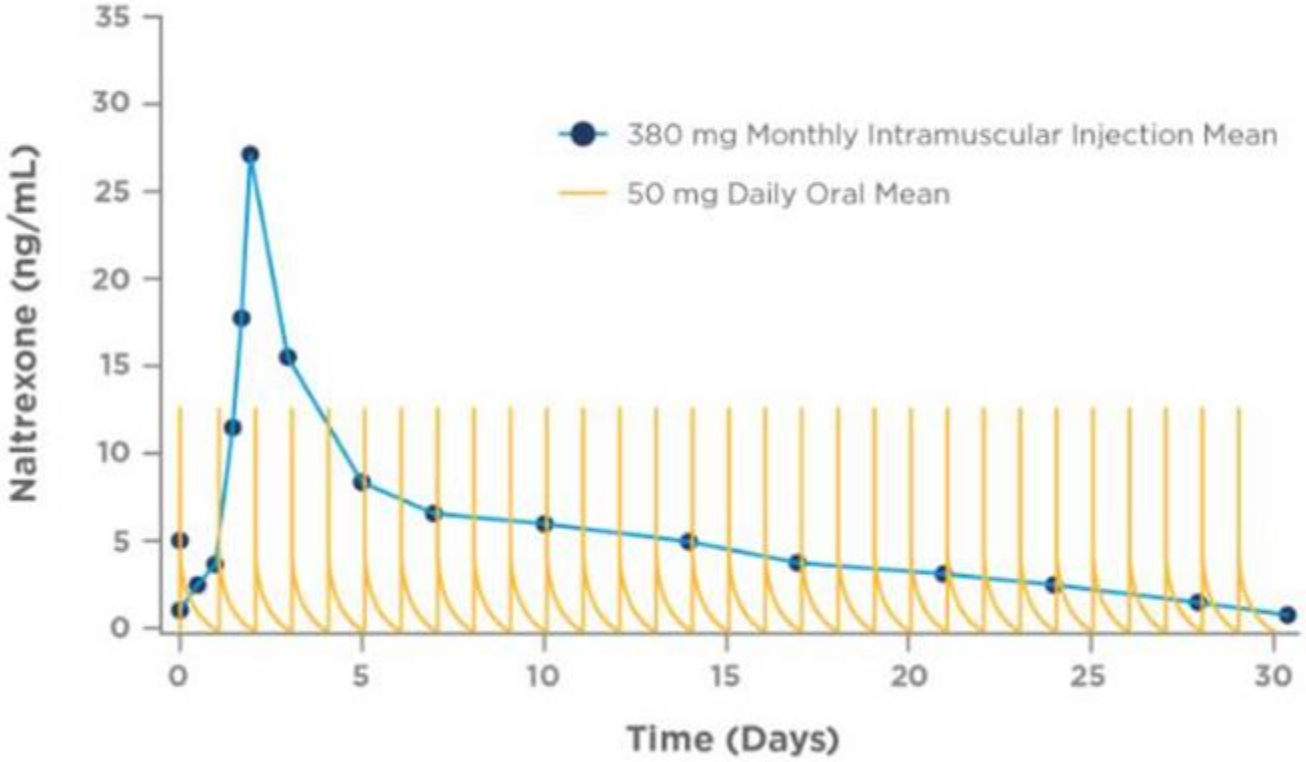


Naltrexone

- Want to cut back or quit?
- Any liver disease, pregnancy, opioid use?
- Have you tried meds before? This is not disulfiram!

- May have mild HA, nausea
- If you need surgery/have trauma, tell the team you're on naltrexone
- Injection site may get sore, take OTC pain med

▶ MEAN NALTREXONE CONCENTRATION[1-3]



How to Inject

- Allow to reach room temperature (at least 45 minutes outside of fridge).
- Unrefrigerated, microspheres can be stored at temperatures not exceeding 25°C (77°F) for no more than 7 days prior to administration. Can refrigerate if unused for a cumulative total of up to 8 hours after removed from fridge .
- Have to mix microspheres with diluent, then inject using needle in kit into superolateral gluteal muscle
- Work fast--has a tendency to clog. If it does there’s a backup needle

Naltrexone

- Easy
- Minimal ADEs
- 50 mg PO is good for most people—unless severe liver disease
- May consider switch to IM naltrexone or adding gabapentin

2nd Line

Gabapentin

- For people w anxiety, withdrawal
- Withdrawal: 900 mg PO TID, titrate down over 1 week
- Maintenance: 600 mg PO TID

Topiramate

- 50 mg qhs → 150 mg BID
- ADE limited

3rd Line

Acamprosate 666 mg TID

- In people who are already abstinent
- GI ADEs

Varenicline 1 mg BID

- If male smoker

Baclofen 10-20 mg TID

- In liver disease? Efficacy unclear

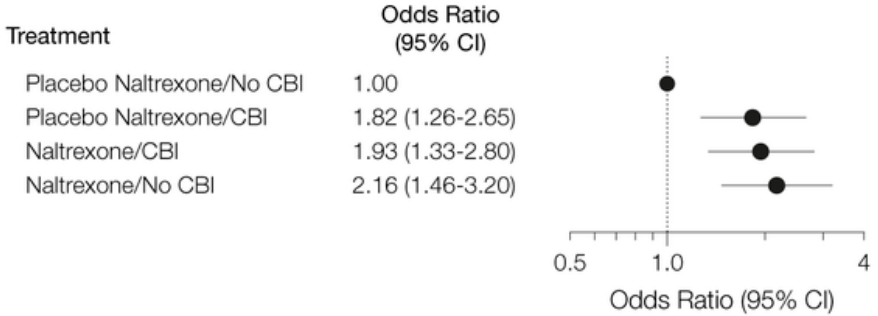
Disulfiram 250-500 mg qday

- Only if patient preference and observed dosing
- Metallic taste, hepatotoxicity, optic neuritis, peripheral neuropathy

Behavioral Treatment

- Offered but not required!
- COMBINE Trial: behavioral health in addition to naltrexone doesn't improve
- 12 step: likely effective, not right for everyone, there are other options

Figure 4. Odds Ratios for Good Composite Clinical Outcome at End of Treatment Compared With Placebo Naltrexone/No Combined Behavioral Intervention (CBI)



Logistic regression model of good clinical outcome (see "Methods" for definition) at the end of the last 8 weeks of treatment was significant for naltrexone × CBI interaction, $P = .02$. CI indicates confidence interval.

ALCOHOL WITHDRAWAL

Prediction of Alcohol Withdrawal Severity Scale ☆

Screens hospitalized patients for complicated alcohol withdrawal (seizures, delirium tremens).

INSTRUCTIONS

Use in patients ≥18 years old admitted to general floor, with or without history of alcohol abuse. Do not use in patients with active or uncontrolled seizure disorder.

When to Use ⌄ | Pearls/Pitfalls ⌄ | Why Use ⌄

Threshold criteria

Patient consumed any amount of alcohol within the last 30 days OR patient had a positive blood alcohol level upon admission	No	**Yes**

Ask the patient

Have you been recently intoxicated or drunk within the last 30 days?	**No 0**	Yes +1
Have you ever experienced previous episodes of alcohol withdrawal?	**No 0**	Yes +1
Have you ever experienced withdrawal seizures?	**No 0**	Yes +1
Have you ever experienced delirium tremens (DTs)?	**No 0**	Yes +1
Have you ever undergone alcohol rehabilitation treatment (i.e., inpatient or outpatient treatment programs, or Alcoholics Anonymous attendance)?	**No 0**	Yes +1
Have you ever experienced blackouts?	**No 0**	Yes +1
Have you combined alcohol with other "downers" (e.g. benzodiazepines, barbiturates) during the last 90 days?	**No 0**	Yes +1
Have you combined alcohol with any other substance of abuse during the last 90 days?	**No 0**	Yes +1

Clinical evidence

Positive blood alcohol level (BAL) on presentation	**No 0**	Yes +1
Evidence of increased autonomic activity (i.e., HR >120, tremor, sweating, agitation, nausea)	**No 0**	Yes +1

0 points

PAWSS

Average risk

Likelihood ratio 0.07 for complicated AWS (withdrawal hallucinosis, withdrawal-related seizures, or delirium tremens)

Copy Results | Next Steps »

Clinical Institute Withdrawal Assessment for Alcohol – revised (CIWA-Ar) scale

Clinical Institute Withdrawal Assessment for Alcohol revised	
Symptoms	**Range of scores**
Nausea or vomiting	0 (no nausea, no vomiting) –7 (constant nausea and/or vomiting)
Tremor	0 (no tremor) – 7 (severe tremors, even with arms not extended)
Paroxysmal sweats	0 (no sweat visible) – 7 (drenching sweats)
Anxiety	0 (no anxiety, at ease) – 7 (acute panic states)
Agitation	0 (normal activity) – 7 (constantly trashes about)
Tactile disturbances	0 (none) – 7 (continuous hallucinations)
Auditory disturbances	0 (not present) – 7 (continuous hallucinations)
Visual disturbances	0 (not present) – 7 (continuous hallucinations)
Headache	0 (not present) – 7 (extremely severe)
Orientation/clouding of sensorium	0 (orientated, can do serial additions) – 4 (Disorientated for place and/or person)

Where to Manage

- If in doubt, eval in ED
- Consider outpatient mgmt. without ED eval if:
  - <8 drinks per day
  - CIWA <10 (10-15 depends on comfort)
  - Able to safely store medications, answer phone, return for follow up
  - No hx of severe withdrawal
  - No unstable major comorbidities
  - No opioid withdrawal
- Always ask why


6-12 h: Mild withdrawal
12-24 h: Alcoholic Hallucinosis
24-48 h: Withdrawal seizures
48-72h: Delirium Tremens

Alcohol Withdrawal

- Gabapentin (outpatient, mild withdrawal)
  - Avoid in renal disease
  - 300-600 TID + taper over approx. 1 week or continue
  - Can add in clonidine, or substitute gabapentin→ valproic acid
- Benzos (outpatient or inpatient or detox)
  - Chlordiazepoxide (Librium), diazepam (Valium) may be preferred due to half life
  - If liver disease, use lorazepam (Ativan)
  - Generally 5 day taper outpatient
- IV Phenobarbital (ED, ICU)
  - Half life 3-4 days
  - Drug-drug interactions, avoid in severe liver disease
- Also start naltrexone!

Things We Do for No Reason

- High dose IV thiamine while inpatient is *not* TWDFNR
- PO thiamine has poor bioavailability
- Polypharmacy! Medi-Cal and HSF prescription limits!
- Can we help with food insecurity instead?
- If worried, consider thiamine containing MV

Things We Do for No Reason™: Prescribing Thiamine, Folate and Multivitamins on Discharge for Patients With Alcohol Use Disorder

Triveni DeFries, MD, MPH[1]*, Sarah Leyde, MD[2], Lawrence A Haber, MD[3], Marlene Martin, MD[3]

TABLE. **Assessment for Vitamin Deficiency Risk Factors in Patients With AUD With Heavy, Regular Alcohol Intake**

Dietary history revealing limited food intake, "tea and toast" diet
Food insecurity
Malnutrition evidenced by weight loss, loss of muscle mass, cachexia
Confirmed vitamin deficiencies
Gastrointestinal conditions such as gastritis, chronic pancreatitis, gastric bypass

Harm Reduction: Alcohol

- Plan transport before you start
- Avoid mixing with other substances
- Keep condoms on hand
- Eat food, drink water
- Sleep
- Add planned abstinence days

Resources

- Substance Use Warmline **(855) 300-3595**
- Adventist Health Ukiah
- Marin Health
- Santa Rosa Memorial
- Adventist Health Clearlake
- Mercy Redding

Take Home Points

- Oral naltrexone is super easy and in scope—almost always step 1
- IM naltrexone has mild logistical challenges
- If mild withdrawal, use gabapentin
- If moderate withdrawal, use benzodiazepines and consider ED evaluation
- Discuss reducing harm
- This is your wheelhouse

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