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TREATING ALCOHOL USE DISORDER

A FACT BOOK

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Treating Alcohol Use Disorder

A Fact Book

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Alcohol: An Overview

The Basics

Composition: Alcohol, also known as ethanol, is the byproduct of the metabolism of any starch or sugar with the addition of yeast. The resultant chemical, CH_3CH_2OH, is an ethyl group linked to a hydroxyl group (hence the term "ethanol").

Prevalence: Alcohol is the most widely misused substance. Currently, 90% of US men and 70% of US women consume some form of alcohol, though most of them do not consume large amounts. In any given month, 23% of Americans binge drink, and 6% drink heavily.

Mechanism: Alcohol acts rapidly because it is very lipid soluble. Cell membranes, with their lipid bilayers, offer almost no impediment to it. Alcohol's effects on the gamma-aminobutyric acid (GABA) receptor lead to its psychoactive effects, though we don't precisely know the biochemical mechanism of intoxication.

Intoxication: At low to moderate doses, alcohol creates relaxation and disinhibition. However, with greater consumption, alcohol affects deeper brain structures, causing sedation and amnesia ("blackouts") and ultimately affecting the respiratory drive.

Assessment for Alcohol Use Disorder (AUD)

Assessment includes a standard diagnostic interview that focuses on uncovering alcohol use issues (see "Alcohol Use Disorder: Initial Evaluation Template" and "Alcohol Use Disorder: Tips for the Initial Assessment"), determining how many DSM-5 AUD criteria are met (see "How to Ask DSM-5 Focused Questions for Alcohol Use Disorder"), reviewing labs, and assessing for any medical issues (see "Medical Issues and Alcohol Use Disorder").

Psychosocial Consequences

Alcohol use and intoxication can additionally lead to the following:

- Impact of DUI (driving under the influence charge), including deaths and injuries
- Poor decision making while under the influence
- Loss of interest in hobbies or anything other than alcohol (ie, anhedonia, avolition)
- Secondary psychiatric complications

Withdrawal

Withdrawal symptoms typically begin six to eight hours after the last drink and last 24–48 hours. They can include:

- Autonomic hyperactivity (sweating or pulse >100 bpm, elevated temperature, elevated blood pressure)
- Increased hand tremor (also tongue fasciculations)
- Insomnia
- Nausea or vomiting
- Transient visual, tactile, or auditory hallucinations
- Psychomotor agitation
- Anxiety
- Generalized tonic-clonic seizures

Treatment

Treatment is divided into short term (medically guided withdrawal management) and long term (psychotherapy and long-term medication treatment). Withdrawal symptoms can be life-threatening (see "Alcohol Withdrawal Time Course and Symptoms") and there are several detox protocols to choose from, depending on the detox setting (see "How to Manage Alcohol Withdrawal in Outpatient Settings" and "How to Manage Alcohol Withdrawal in Inpatient

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Most yeasts cannot grow in alcohol concentrations greater than 18% by volume. This creates a natural limit to the strength of fermented beverages like wine and beer.

Alcohol Use Disorder: Tips for the Initial Assessment

Introduction

This fact sheet suggests a typical flow of questions during a conversational initial assessment of a patient's alcohol use. While many of these questions can be used to establish a DSM-5 alcohol use disorder diagnosis, they are not explicitly tied to the DSM-5 criteria. To conduct a more formal interview based on the DSM-5, see "How to Ask DSM-5 Focused Questions in Alcohol Use Disorder."

Initial Questions

Start with a nonthreatening question like, "Do you have a drink now and then?"

If the patient's response is, "I don't drink," it's possible they are part of the 15%–20% of people who do not drink. If so, follow up by determining the reason for not drinking (often it's due to a bad family experience with alcohol). Sometimes this response doesn't mean that the patient never drinks, but simply indicates that they don't drink often.

"How often do you typically drink?" You can also include a gentle assumption in this question, such as, "How often do you drink—daily? A few times a week?"

Assessing Consumption and Withdrawal Risk

"How much have you been drinking in the last two to four weeks? Has your drinking gone up or down recently?" Patients who have been drinking consistently and heavily for four weeks or more are at higher risk of alcohol withdrawal symptoms.

"What has been your longest period of abstinence? Have you been able to go for several days without a drink in the last six or 12 months?"

"Have you been through alcohol withdrawal before?" This question helps you to assess the chances that the patient will go into withdrawal in the future. If the patient doesn't know what withdrawal means, use specific phrasing such as, "If you go without a drink for a day or two, do you get shaky or sweaty?"

Assessing Consequences of Drinking

"Have bad things happened to you as a result of drinking? Have you experienced any legal consequences, like a DUI? Have you had any relationship problems because of drinking? Have you lost any jobs?"

In our experience, patients don't always realize the negative consequences of their drinking. For example, a patient's alcohol use may have led to a divorce, but unless the ex-spouse made the reason for the split clear, the patient might not be aware of it. Other examples of consequences that may not be so obvious include:

- Not speaking to one's children for a prolonged period, perhaps because when the parent is drunk, the kids don't enjoy the interaction
- Not being allowed to see grandchildren (or nieces or nephews) because the parents of the children don't want to risk that the patient will be drinking then
- Changing jobs frequently, possibly as a result of poor performance caused by frequent hangovers
- Having a friend group consisting solely of drinking buddies

Assessing History of Treatment

"Have you done anything to try to quit drinking? Have you gone to AA meetings? Have you taken any meds like

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things with patients, but they are useful for busy primary care practices.

"How many times in the past year have you had X or more drinks on one occasion?" (where X = 5 for men and 4 for women). Once in the past year is considered positive and requires further assessment of drinking.

Alcohol Withdrawal Time Course and Symptoms

Time Course

- Alcohol withdrawal symptom onset: Usually within six to eight hours of last drink, though in some very heavy drinkers, withdrawal may not begin until 24 hours after last drink.
- Peak withdrawal: Within 24–48 hours.
- Duration of withdrawal:
  - Mild withdrawal will usually last not more than 72 hours (three days) after symptoms begin.
  - More severe withdrawal can last significantly longer and involve the symptoms below.

Symptoms

- Initial symptoms: Insomnia, anxiety, tremor, sweating, palpitations, headache, gastrointestinal upset.
- Progressive symptoms: Nausea, irritability, elevated blood pressure, tachycardia, elevated body temperature, diaphoresis, increased tremulousness, hyperarousal, and disorientation.
- Withdrawal seizures typically occur within six to 48 hours after last drink and present as generalized, tonic-clonic seizures with a short postictal period.
  - A history of withdrawal seizures increases risk of subsequent seizures (kindling effect).
  - Untreated seizures can progress to delirium tremens (DT) in one-third of patients.
- Alcoholic hallucinosis involves hallucinations that develop within 12–48 hours after last drink and occur with clear sensorium and minimal vital sign changes.
  - Are usually visual, though can occur in any sensory modality.
  - Can persist for up to one week after last drink.
- DT is the most severe form of alcohol withdrawal. It presents with disorientation, hallucinations or illusions, tremors, tachycardia, hypertension, hyperthermia, anxiety, agitation, and diaphoresis.
  - Usually begins 48–96 hours after last drink and can last up to two weeks.
  - DT is a life-threatening condition with mortality ranges of 5%–8%. Death most commonly occurs due to arrhythmias or complications from comorbid medical conditions.

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ACAMPROSATE (Campral) Fact Sheet [G]

Bottom Line

Acamprosate is best for maintaining abstinence in patients who have already quit drinking, but it can be helpful even after patients relapse. Naltrexone is the better choice for patients who are still drinking, since it is better at helping patients quit. Acamprosate is preferred over naltrexone in patients with hepatic impairment.

FDA Indications

Alcohol use disorder.

Dosage Forms

Delayed-release tablets [G]: 333 mg.

Dosage Guidance

- Start 666 mg TID. Give 333 mg TID in patients with renal impairment.
- Can give 999 mg twice a day if patients can't remember to take it three times daily.

Monitoring: No routine monitoring recommended unless clinical picture warrants.

Cost: $$

Side Effects

- Most common: Diarrhea (dose related, transient), weakness, peripheral edema, insomnia, anxiety.
- Serious but rare: Acute renal failure reported in a few cases; suicidal ideation, attempts, and completions rare but greater than with placebo in studies.

Mechanism, Pharmacokinetics, and Drug Interactions

- Mechanism of action is not fully defined; it appears to work by promoting a balance between the excitatory and inhibitory neurotransmitters, glutamate and GABA, respectively (glutamate and GABA activities appear to be disrupted in alcohol dependence). Basically, we don't know how it works—it just does.
- Not metabolized, cleared as unchanged drug by kidneys; t ½: 20–33 hours.
- No significant drug interactions.

Clinical Pearls

- Approved by the FDA in 2004, but it has been used in France and other countries since 1989.
- Does not eliminate or treat symptoms of alcohol withdrawal. Usually prescribed for maintenance of abstinence; may continue even if patient relapses with alcohol.
- Clinically, acamprosate has demonstrated efficacy in more than 25 placebo-controlled trials, and it has generally been found to be more effective than placebo in reducing risk of returning to any drinking and increasing the cumulative duration of abstinence. However, in reducing heavy drinking, acamprosate appears to be no better than placebo.
- Acamprosate can be used with naltrexone or disulfiram (different mechanism of action), although the combination with naltrexone may not increase efficacy per available studies.
- Taking with food is not necessary, but telling patients to take it three times daily with meals as a memory aid may

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ACAMPROSATE Fact Sheet for Patients

Generic Name: Acamprosate (a-KAM-pro-sate)

Brand Name:

- Campral
  - Delayed-release enteric-coated tablet: 333 mg

What Does It Treat?

Moderate to severe alcohol use disorder.

How Does It Work?

Acamprosate works in the brain to treat alcohol use disorder. Its exact mechanism is not known, but it has been shown to decrease cravings for alcohol. Especially when combined with other types of therapy or support, it can help people to stop using alcohol and prevent relapse.

How Do I Take It?

Acamprosate is usually taken by mouth as two tablets with or without food three times daily.

How Long Will I Take It?

Acamprosate is taken for 12 months and then can be stopped, but its effects on alcohol cravings will last for at least another 12 months.

What if I Miss a Dose?

If you miss a dose of acamprosate, take it as soon as you remember unless it is closer to the time of your next dose. Do not double your next dose.

What Are Possible Side Effects?

- Most common: Diarrhea, weakness, swelling, insomnia, anxiety.
- Rare: Changes in kidney function.

What Else Should I Know?

- Do not cut, crush, or chew acamprosate tablets; they should be swallowed whole.
- You can take acamprosate with or without food, but taking it with meals may help you to remember to take each of the three daily doses.
- If you have kidney problems, you may need to take a lower dose and be monitored with blood tests while taking acamprosate.

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TREATING ALCOHOL USE DISORDER

A FACT BOOK

This latest Carlat Fact Book provides you with all the tools and information needed to assess and treat your patients who are struggling with alcohol use disorder. Unlike traditional textbooks, this Fact Book distills each critical aspect of clinical decision making into a single sheet, with tips and bullet points that you can use at the point of care. Topics covered include assessing severity of use, treating withdrawal symptoms, use of basic therapeutic techniques, and appropriate prescription of medications for alcohol use disorder.

PRACTICAL TOPICS INCLUDE:

- ✔ Tips for the initial assessment
- ✔ How to use motivational interviewing
- ✔ How to use cognitive behavioral therapy techniques
- ✔ How to conduct a family meeting
- ✔ Withdrawal time course and symptoms
- ✔ How to use phenobarbital to manage withdrawal

MEDICATION FACT SHEETS INCLUDE:

- ✔ Naltrexone (ReVia, Vivitrol)
- ✔ Acamprosate (Campral)
- ✔ Disulfiram (Antabuse)
- ✔ Gabapentin (Gralise, Horizant, Neurontin)
- ✔ Topiramate (Eprontia, Qudexy XR, Topamax, Trokendi XR)

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