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MEDICATION

IN THE TREATMENT OF ALCOHOL DISORDERS

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B - vitamins

- All people with harmful or dependent drinking should be taking B vitamins regularly
- Thiamine 100mg t.d.s.
- Vit B co forte 2 tablets tds
- Parenteral B vitamins should be given to all people having medical detoxification from alcohol in a hospital setting
- Increasing interest in giving parenteral B vitamins on an out-patient basis in the week prior to community alcohol detoxification
- Patients detoxifying in the community should be given intramuscular Pabrinex (one pair of ampoules daily for three days) if they present with features which put them at risk of Wernicke-Korsakov syndrome. (S.I.G.N.)

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RELAPSE PREVENTION MEDICATION

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RELAPSE PREVENTION MEDICATION

- ACAMPROSATE
- NALTREXONE
- DISULFIRAM(ANTABUSE)

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RELAPSE PREVENTION MEDICATION

Who should be prescribing it?

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RELAPSE PREVENTION MEDICATION

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- Should not be *initiated* as stand-alone treatments – combine with psychosocial interventions, at least initially
- GPs may think that these should be *initiated* by a specialist service - however, GPs may be asked to continue prescribing
- *Pharmacological and/or non-pharmacological relapse prevention interventions (primary care alcohol service – currently open to tender)*

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RELAPSE PREVENTION MEDICATION

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- 'Pharmacological interventions should be administered by specialist and competent staff' (N.I.C.E.)
- 'Acamprosate will usually be initiated by a specialist service within a few days of successful detoxification. If a specialist service is not available, the GP should offer acamprosate, monitor its efficacy and provide links to local support organisations' (S.I.G.N.).

Relapse prevention medication - costs

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- Acamprosate 333mg 168 tablets (1 Month) £24
- Naltrexone 50mg 28 tablets (1 Month) £22.34
- Disulfiram 50 tablets (2 months) £24.78

ACAMPROSATE AND NALTREXONE – N.I.C.E.

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- After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention focused specifically on alcohol misuse
- For harmful drinkers and people with mild alcohol dependence who have not responded to psychological interventions alone, or who have specifically requested a pharmacological intervention, consider offering acamprosate or oral naltrexone in combination with an individual psychological intervention

Acamprosate

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- Acts on excitatory glutamate NDMA system in the brain (high levels of glutamate involved in hyper-excitatory states during alcohol and benzodiazepine withdrawal)
- Initially interest focussed on its use in detoxification – but it is actually used for relapse prevention in practice

ACAMPROSATE

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- Very safe drug
- Few side effects, few contraindications
- No interactions

ACAMPROSATE – B.A.P.

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- There are a number of good-quality systematic reviews and meta-analyses of trials of acamprosate
- Compared with placebo, acamprosate is moderately effective in increasing the amount of abstinence after detoxification
- It can be given safely to a wide number of patients with physical comorbidity, although with caution or even contraindicated in those with severe liver and renal impairment

Acamprosate - BNF

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- It should be initiated as soon as possible after abstinence has been achieved, and continued for one year. Treatment should be maintained if the patient has a temporary relapse, but stopped if the person returns to regular or excessive drinking that persists 4-6 weeks after starting treatment. Acamprosate is not effective in all patients, so efficacy should be regularly assessed.

NALTREXONE

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NALTREXONE

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Not licensed for use in alcohol disorders – but BNF describes it as 'a useful adjunct' in treatment of alcohol dependence after successful withdrawal

NALTREXONE

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- Relatively safe drug
- More side effects and interactions than acamprosate
- Evidence for greater efficacy
- Possible side effects of depression, drowsyness, GI disturbance
- Cannot be combined with opiate analgesics
- LFTs before initiation, and at interval during treatment

NALTREXONE – B.A.P.

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- Naltrexone is a non-selective opioid antagonist. There is growing evidence for a role of the endogenous opioid system and its receptors in addiction
- Naltrexone reduces alcohol's rewarding effects and also motivation to drink or 'craving'
- There have been several meta-analyses and systematic reviews which broadly have the same conclusion that oral naltrexone significantly reduces return to heavy drinking, probably by reducing 'lapse to relapse', but does not necessarily improve cumulative or continuous abstinence rates.
- The most common side-effects are nausea and sedation

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NALTREXONE - BNF

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- 'Treatment should be under specialist supervision, and reviewed monthly for the first six months, and then at reduced intervals. Naltrexone should be stopped if drinking continues for 4-6 weeks after starting treatment'
- Personally, I would moderate this last clause to say that it should be stopped if *problematic* drinking continues

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ACAMPROSATE AND NALTREXONE – B.A.P.

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- The evidence for acamprosate in the treatment of harmful drinkers and people who are mildly alcohol dependent is less robust than that for naltrexone.
- Naltrexone as an oral tablet is licensed in the USA and some European countries to improve drinking behaviour. Whilst not licensed in the UK, it can be used and NICE has recommended its use
- Questions remain about effective dose, and length of treatment, with naltrexone

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DISULFIRAM

This is an aversive treatment approach:
- treatment through p
- punishment treatm
usually don't w
- can be used to mi
fear as an approa
getting people to
drink

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DISULFIRAM

A Strong drug, to be prescribed carefully, and treated with respect

Stronger case for specialist initiation than with Acamprosate and Naltrexone

DISULFIRAM

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- Inhibits enzyme alcohol dehydrogenase
- Extremely unpleasant, occasionally dangerous, reaction, if alcohol is consumed
- Used to DETER person from drinking, NOT as an aversive treatment
- ECG, LFT prior to commencing treatment, and at intervals during treatment
- N.B. Interactions with – warfarin, metronidazole, isoniazid,tricyclic antidepressants

DISULFIRAM – B.A.P.

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- An open prospective study lasting 9 years reported that 2 years of treatment with disulfiram or calcium carbimide resulted in overall abstinence rates of 50%; however, not all patients could take disulfiram or calcium carbimide so received 'sham' treatment, and the authors emphasised the importance of its psychological ingredient (Krampe et al., 2006 cited in B.A.P.)

DISULFIRAM – N.I.C.E.

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After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering disulfiram in combination with a psychological intervention to service users who:

- have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable, **or**
- prefer disulfiram and understand the relative risks of taking the drug

DISULFIRAM – N.I.C.E.

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- If using disulfiram, start treatment at least 24 hours after the last alcoholic drink consumed. Usually prescribe at a dose of 200 mg per day. *For service users who continue to drink, if a dose of 200 mg (taken regularly for at least 1 week) does not cause a sufficiently unpleasant reaction to deter drinking, consider increasing the dose in consultation with the service user.*
- Before starting treatment with disulfiram, test liver function, urea and electrolytes to assess for liver or renal impairment. Check the SPC for warnings and contraindications in pregnancy and in the following conditions: a history of severe mental illness, stroke, heart disease or hypertension

Make sure that service users taking disulfiram:

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- Stay under supervision, at least every 2 weeks for the first 2 months, then monthly for the following 4 months
- If possible, have a family member or carer, who is properly informed about the use of disulfiram, oversee the administration of the drug – (the purpose of this is to ensure continuity of treatment during times of ambivalence)
- Are medically monitored at least every 6 months after the initial 6 months of treatment and monitoring.

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Warn service users taking disulfiram, and their families and carers, about:

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- The interaction between disulfiram and alcohol (which may also be found in food, perfume, aerosol sprays and so on), the symptoms of which may include flushing, nausea, palpitations and, more seriously, arrhythmias, hypotension and collapse
- The rapid and unpredictable onset of the rare complication of hepatotoxicity; advise service users that if they feel unwell or develop a fever or jaundice that they should stop taking disulfiram and seek urgent medical attention.

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ANTIDEPRESSANTS

Screen people i depres
for alcohol.
esp if they are not
responding to Rx

ANTIDEPRESSANTS IN THE TREATMENT OF ALCOHOL MISUSE

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- Do not use antidepressants (including selective serotonin reuptake inhibitors [SSRIs]) routinely for the treatment of alcohol misuse alone. (N.I.C.E.)

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If alcoholic presents i
depressive features
- treat the al
- not the dep
- only if depr
continues lon
of abstinence from
alc

N.I.C.E. on co-morbidity

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- For people who misuse alcohol and have comorbid depression or anxiety disorders, treat the alcohol misuse first
- If depression or anxiety continues after 3 to 4 weeks of abstinence from alcohol, assess the depression or anxiety and consider referral and treatment.

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