QUICK GUIDE TO OUTPATIENT TREATMENT OF ALCOHOL USE DISORDER

General Approach

If a patient sometimes drinks beer, wine, other alcoholic beverages or non beverage alcohol (e.g., mouthwash, rubbing alcohol, cologne), screen using:
- Single Alcohol Screening Question (SASQ)

How many times in the past year have you had (4 for women, or 5 for men) or more drinks in a day
- AUDIT-C
- AUDIT – *Patient Self-Test*

Assessment

Confirm alcohol use disorder (AUD) using DSM-5 criteria:[1]

DSM-5-TR AUD Criteria:[1]

A problematic sequence of alcohol use resulting in clinically significant distress/impairment is present by a minimum of two or more of the following:

- More use than intended
- Difficulty cutting down
- Lots of time spent drinking
- Cravings
- Tolerance
- Withdrawal
- Continued use despite physical or mental consequences
- Failure to fulfill major obligations
- Interpersonal problems
- Activities given up
- Use in physically hazardous situations

Mild: 2–3
Moderate: 4–5
Severe: 6 or more (within 12-month period)

Psychosocial supports:

- Patients benefit from access to comprehensive treatment approach, including medication, primary care visits, and community-based psychosocial supports.
- **Psychosocial supports:** counseling, group therapy, mutual help groups (12-step [e.g., *AA*] or secular [e.g., *SMART Recovery*, *LifeRing*]), inpatient treatment facilities, intensive outpatient day programs.
- *Motivational interviewing* is an evidence-based approach that family physicians can use to help patients achieve their goals.

Medication coverage:

- Effective April 20, 2023, naltrexone 50 mg and acamprosate 333 mg are now regular benefit.

Substance use history with special attention to other sedatives (e.g., opioids, benzodiazepines), past treatments, patient's goals, and barriers

Consider **complete physical** to assess medical complications of alcohol use

Review **investigations** (special consideration to ALT, AST, GGT, creatinine/GFR, MCV, urine drug screen, HIV, hepatitis C)

Treatment

Consider detox if appropriate and patient is willing (see next page)

Moderate to severe AUD: Offer trial of *naltrexone* or *acamprosate* to reduce drinking; support patient's abstinence while considering contraindications and patient factors. Provide all patients with information on and referrals to **psychosocial treatments** and community-based supports

Trial medication: titrate or switch as needed

Monitoring

Be prepared to consider continuing medication for **6–24 months**

Offer **follow-up** appointments to offer support, monitor progress and relapses

Offer or facilitate referral to **psychosocial support** per patient preference

Medications:

***Naltrexone*:**
- Opioid antagonist; reduces pleasurable effects of alcohol.
- NNT = 10–12 to reduce heavy drinking.
- Often preferred due to simple dosing.
- **Target dose 50 mg once daily.** Expert clinical practice suggests patients may benefit (improved tolerance) from a graduated titration approach 25 mg PO daily × 3 days, then increase to 50 mg.
- Usual dose is 50 mg, rarely up to 150 mg; sometimes used as PRN on drinking days when stable.
- Can start at any time (no need to abstain from alcohol).
- Contraindications: concurrent opioid use (consider Rx or illicit), severe liver dysfunction.
- Side effects: N/V, headache, fatigue, elevated enzymes, naltrexone may cause reversible elevation monitor more closely at baseline.

***Acamprosate*:**
- GABA agonist/glutamate antagonist; rebalances neuronal brain changes from chronic alcohol use.
- **Target dose is 666 mg PO TID.** Expert clincal practice suggests patients may benefit (improved tolerance) from a graduated titration approach of 333 mg PO TID × 3 days then 666 mg PO TID.
- Contraindications: severe renal failure.
- Side effects: diarrhea (common), nausea, headache.

Medication notes:

- If patient resumes alcohol use, they should still continue medication.
- **Disulfiram (Antabuse) rarely used anymore**; exceptions include patient request.
- Emerging evidence for topiramate and gabapentin.
- Pregnancy: safety of acamprosate and naltrexone has not been well established; balance risk of ongoing use. Topiramate use during pregnancy has established risks.

[1] Please refer to full *DSM-5 criteria*, refer to *BCCSU guideline* page 110

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Alcohol Withdrawal as an Outpatient

Considering patient for withdrawal from alcohol

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Assess *Prediction of Alcohol Withdrawal Severity Scale (PAWSS)* **score**

PAWSS < 4

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Low risk for severe alcohol withdrawal syndrome

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Consider suitable for trial of outpatient treatment if no contraindications. Follow guidelines below; consider using gabapentin for symptomatic relief.

PAWSS ≥ 4

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High risk for severe alcohol withdrawal syndrome

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Recommend prescribing benzodiasepines (3 to 7 days) to manage acute withdrawal. See below. Recommend care provided in medically monitored setting.

Tips for managing outpatient alcohol withdrawal:

- Patient should have a reliable caregiver or access to intensive supportive daily outpatient services.
- Start early in the week and assess the patient daily × 3–4 days for vitals, withdrawal symptoms, hydration, orientation, sleep, and general condition.
- Consider prescribing gabepentin 300mg PO TID +/- 300mg at HS; can add 300mg PRN per dose to a maximum of 2400mg and consider dailying dispensing; caution in renal impairment. See. p. 2 of *BCCSU's pharmacotherapy table* for more information.
- Prescribe **thiamine 100 mg PO TID** × **1 week**, then daily × 2 months, as well as a daily multivitamin (may need to pay out of pocket).

Contraindications to outpatient management include:

- Any history of withdrawal seizure or delirium.
- Unstable medical or psychiatric conditions.
- Concurrent sedative use disorders.
- Pregnancy.
- Multiple unsuccessful attempts.

Note on benzodiazepines:

- Benzodiazepines should not be prescribed beyond the acute withdrawal period. Prolonged benzodiazepines have not been found to be effective and are potentially harmful.
- Prescribe benzodiazepines to those with a high risk of withdrawal.
- However, they pose significant risk in an unsupervised setting, including oversedation, respiratory depression, falls, delirium (especially if patient relapses to drinking) .
- 80% of alcohol withdrawal syndrome does not require aggressive medical intervention, such as with benzodiazepines; hence why we screen with PAWSS.
- See *Tips for managing outpatient alcohol withdrawal* box.

Medication notes:

If a patient has a PAWSS ≥ 4 but inpatient treatment is not feasible due to patient preference or scarcity of beds, clinicians should arrange for:

- community-based monitoring and support during treatment
  - (e.g., home withdrawal programs, intensive outpatient programs, connection with community pharmacist, involve family members, friends, caregivers, or community support person) and
- monitor patient closely
  - (daily phone calls, telehealth check-ins, frequent clinical visits).

References and Resources:

- Adapted from Molavi A, Guruge S, Kelly P. Outpatient treatment for alcohol use disorders. BC Medical Journal. 2020;62(8):272-6.

- For consultative support, contact the RACE line for Addiction Medicine: **1-877-696-2131**.

[1] Prediction of Alcohol Withdrawal Severity Scale is an evidence-based screening tool for assessing the likelihood that a patient will experience severe alcohol withdrawal syndrome: *https://www.mdcalc.com/prediction-alcohol-withdrawal-severity-scale*

* Inpatient withdrawal management facility