GUIDE

Acute Care Treatment of Alcohol Use Disorder

QUICK REFERENCE

Steps to reduce emergency department visits and help your patient by combining withdrawal treatment with craving reduction:

1. **Treat Acute Withdrawal**

   Use your preferred strategy/hospital standard practice with benzodiazepine and/or phenobarbital to treat acute withdrawal.

2. **At Discharge**

   a. Prescribe Medication for protracted withdrawal.

   Gabapentin 600mg-900 TID, #42

   - Avoid/use with caution in renal disease.
   - If history of severe withdrawal may need additional treatment including with benzodiazepines)

   b. Prescribe Medication to reduce craving and relapse.

   Naltrexone 50mg PO Daily #14;

   Contraindications:

   - Any opioid use--incl. planned surgery/anesthesia, buprenorphine starts, or OUD
   - Acute liver injury with LFTS > 5x normal
   - Decompensated cirrhosis

3. **Contact the SUN (Substance Use Navigator)**

   The SUN will problem solve, motivate and arrange follow up care.

4. **At follow up**

   Offer 30day Naltrexone injection (Vivitrol)

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Eleven million Americans have an alcohol use disorder while two million Americans have an opioid use disorder. Screening, brief intervention, and referral to treatment is proven to decrease risky drinking and alcohol use disorder-related behaviors in acute care settings. Targeting patients presenting for trauma may be particularly effective.

This guidance is for hospitals participating in the California Bridge Program who would like to incorporate treatment for alcohol use disorder into their emergency departments and inpatient settings. This is part of the *Practice Under Development* series presenting information about practices we are piloting and continuing to refine. This guidance does not focus on withdrawal treatment, rather the focus here is on the initiation of medications to decrease cravings and acute care utilization.

Consider screening:

- Men < 65 yo: *How many times in the past year have you had 5 or more drinks in a day?*
- All women, men > 65: *How many times in the past year have you had 4 or more drinks in a day?*

Alcohol withdrawal management:

- Treat per the protocols of your facility
- Consider phenobarbital, benzodiazepines
- Consider gabapentin (ex: gabapentin 600 mg PO TID #42), caution in renal disease, if severe withdrawal may need additional treatment

Offer maintenance treatment:

- First line is naltrexone, which is FDA approved for AUD treatment:
    - **Naltrexone PO:**
        - E.g.: naltrexone 50 mg PO, 1 tab PO qday, dispense #14, 0 refills
    - **Naltrexone IM:**
        - Consider if patients unable to take daily medication, but have tolerated PO naltrexone
        - Naltrexone 380 mg IM x 1 in buttock monthly – consider at least one trial PO dose before injection
        - Covered by MediCal for outpatient treatment, pharmaceutical company may be able to provide acute care doses
    - *Cautions and contraindications:*
        - Avoid if patient has active OUD or opioid dependence or is on buprenorphine (recommend at least 7 days off of opioids if physically dependent)—can consider test dose of naloxone or PO naltrexone to ensure no withdrawal
        - Avoid if planned surgery or anesthesia needed
        - Avoid if AST and ALT >5x upper limit of normal or Childs Pugh class C
    - *Adverse effects:*
        - Headache, GI distress, opioid withdrawal, injection site reaction, transaminitis
- Second line: Multiple agents, select based on comorbidities and patient preference (see table below)

Discharge from acute care with direct linkage to ongoing treatment if possible in clinic, intensive outpatient program, medically assisted withdrawal (detox) facility, residential treatment as fits patient's interest and program availability

Consider the first dose of IM naltrexone in acute care for those who have not been able to successfully connect on prior presentations if possible

Always contact your SUN who can work with the patient to motivate, make shared decisions, and ensure follow up.

	Target population	Efficacy	Contraindications/ADEs	Dosing
Naltrexone (first line)	First line for most people without contraindications	NNT 9 for return to heavy drinking	Opioid use (risk of withdrawal), planned surgery/anesthesia AST and ALT >5x ULN ADEs: HA, GI distress, opioid w/d, injection site rxn, transaminitis	50 mg PO **qday** OR 380 mg IM **qmonth**
Topiramate	Consider if also using cocaine, PTSD, seizure hx, overweight	NNT 7.5 for return to heavy drinking 7.5	Dose reduce in CKD Cognitive slowing, weight loss, paresthesias, altered taste, metabolic acidosis Avoid if hx kidney stones, narrow-angle glaucoma	Goal 150 mg ***BID*** (slowly uptitrate)
Baclofen	Consider if also chronic pain, liver disease	Not effective in meta-analyses	Dose reduce in CKD Somnolence, dizziness	10-20 mg ***TID***
Gabapentin	Consider if neuropathic pain, anxious, EtOH withdrawal Helps when added to naltrexone if naltrexone had some efficacy	Mixed evidence	Dose reduce in CKD Somnolence, dizziness, GI effects, HA Note, some abuse liability and can potentiate opioids	600 mg ***TID***
Acamprosate (FDA approved)	Patients who are already abstaining, prevents relapse, safe in liver disease	NNT 9 to reduce risk of any drinking	Dose reduce in CKD Causes diarrhea, fatigue, GI upset	2x 333 mg tablets ***TID***
Disulfiram (FDA approved)	Patients who are already abstaining, prevents relapse, only effective if observed dosing by family, opioid treatment program	If not directly observed, outcomes similar to placebo	Causes physical illness if return to use, do not start if ongoing EtOH use Causes metallic taste, hepatotoxicity, optic neuritis, peripheral neuropathy	250-500 mg **qday**
Varenicline	Men who are also smokers	Decreased heavy drinking in male smokers	Dose reduce in CKD Caution in depression	2mg **qday** (start with 0.5 qday and uptitrate)

REFERENCES

Anton, RF. Naltrexone for the management of alcohol dependence. *N Engl J Med*. 2008;359(7):715-721. doi:10.1056/NEJMct0801733

Fuster D, Samet JH. Alcohol use in patients with chronic liver disease. *N Engl J Med*. 2018;379(26):1251-1261. doi:10.1056/NEJMc1814129

Gentilello LM, Ebel BE, Wickizer TM, Salkever DS, Rivara FP. Alcohol interventions for trauma patients treated in emergency departments and hospitals: a cost benefit analysis. *Ann Surg*. 2005;241(4):541–550. doi: 10.1097/01.sla.0000157133.80396.1c

O'Malley SS, Zweben A, Fucito LM, et al. Effect of varenicline combined with medical management on alcohol use disorder with comorbid cigarette smoking: a randomized clinical trial. *JAMA Psychiatry.* 2018;75(2):129–138. doi:10.1001/jamapsychiatry.2017.3544

Maisel NC, Blodgett JC, Wilbourne PL, Humphreys K, Finney JW. Meta-analysis of naltrexone and acamprosate for treating alcohol use disorders: when are these medications most helpful? *Addiction*. 2013;108(2):275–293. doi:10.1111/j.1360-0443.2012.04054.x

Mason BJ, Quello S, Goodell V, Shadan F, Kyle M, Begovic A. Gabapentin treatment for alcohol dependence: a randomized clinical trial. *JAMA Intern Med*. 2014;174(1):70-77. doi:10.1001/jamainternmed.2013.11950

Minozzi S, Saulle R, Rösner S. Baclofen for alcohol use disorder. *Cochrane Database of Systematic Reviews*. 2018 Nov 26; Issue 11. Art. No.: CD012557. doi: 10.1002/14651858.CD012557.pub2

Mooney L. Pharmacotherapy for Alcohol Use Disorders. Providers' Clinical Support System for Medication Assisted Treatment. https://cf8b2643ab1d3c05e8f6-d3dc0d8f838e182b6b722cea42bb6a35.ssl.cf2.rackcdn.com/aaap_147ca562b37f1d0cd584057aa46cf5f7.pdf. Updated March 19, 2019. Accessed September 19, 2019.

Pringle JL, Kelley DK, Kearney SM, et al. Screening, brief intervention, and referral to treatment in the emergency department. *Med Care*. 2018 Feb;56(2):146–152. doi: 10.1097/MLR.0000000000000859

Rösner S, Hackl-Herrwerth A, Leucht S, Lehert P, Vecchi S, Soyka M. Acamprosate for alcohol dependence. Cochrane Database of Systematic Reviews. 2010 Sept 8; Issue 9. Art. No.: CD004332. doi: 10.1002/14651858.CD004332.pub2.