AOD ECHO Network

Session 6

23/11/2

Didactic: 'Alcohol pharmacotherapies; who, how and what to expect'

Case presentation: Dr Michaela Baulderstone

This project is supported with funding from Wellbeing SA

Government of South Australia | Wellbeing SA

Contributing partners:

phn COUNTRY SA An Australian Government Initiative

phn ADELAIDE An Australian Government Initiative

sapmea where knowledge + health meet

AOD ECHO Network - Agenda

- Welcome and introductions
- Announcements
- Didactic presentation: **Panel**
  - Questions on the didactic
- Case presentation – **Dr Michaela Baulderstone**
  - Clarifying questions for **Dr Michaela Baulderstone**
    - Recommendations
- Post-session evaluation survey

ECHO Etiquette

- Remain on ‘Mute’ except when speaking.
- Ask questions or make comment by raising your hand (in ‘Reactions’)

- Use ‘Chat’ if you wish to communicate with the ECHO Coordinator.
- Maintain confidentiality.

Alcohol Pharmacotherapies

Australian Medicines Handbook

Therapeutic Guidelines

Cochrane Library

Overview

- Don’t work unless patient is engaged in other psychosocial treatments and/or with peer support groups such as AA, Smart recovery
- Adherence is critical
- Once per day (or every second day) preferable
- Third party verification/compliance helps
- Effect size is moderate but real. (15% relative risk reduction in return to heavy drinking)
- Under prescribed.

Choice

- Naltrexone (PBS approved) 😋
- Acamprosate (PBS approved) 😋
- Disulfiram – caution 😕
- Topiramate and others – caution 😟
- Baclofen – caution ++ 😮

Naltrexone 😊

- Opioid antagonist
- Not in people taking opioids
- Not in decompensated liver disease

Naltrexone

- 50 mg daily or 100 mg on alternative days
- If side effects present (nausea, headache etc), consider:
  - reducing dose
  - splitting dose 25mg bid
  - taking with meal
  - taking at bedtime

> Review week 1:
  - side effects, compliance, response

> It is generally recommended that the LFTs are reviewed monthly for the first 3 months then every 3 months.

Acamprosate 😂

- Reduces NMDA/aspartate/glutamate surges seen after abstinence achieved.
- Body weight > 60 kg
  - 2 tablets (333mg in one tablet), **three times daily** with meals

> Body weight < 60 kg

- 4 tablets divided into **3 daily doses** with meals (2 tablets in the morning, 1 at noon, and 1 at night)

> Excreted unchanged in urine (contraindicated if serum creatinine >120 µmol/L)

Disulfiram ☹

- Not on PBS $50-100 per month. Shop around!
- >24 hours since last alcohol and BAL negative before commencement
- Client understands risk of drinking on disulfiram & implications for use of alcohol containing products
- Client understands need to wait 7 days after medication cessation before resuming drinking
- Responsible person to witness ingestion of medication & to report if client resumes drinking
- Monthly monitoring of LFTs (& client understands signs of hepatotoxicity to report immediately)
- Start on ½ tab (100mg) and buld up to 200mg after 1 week.

Baclofen 😮 😮

- Variable evidence
- Not first (or second or third) line
- May be indicated in people with end stage liver disease where other options are not available
- Risk benefit needs to be assessed
- Main concern is overdose
- NOT a set-and-forget drug
- Only in consultation with specialist

Topiramate and other agents 😢

- Topiramate
- Ondansetron
- GHB

……none have sufficient evidence.

Could be used in consultation with specialist

Combinations

- Naltrexone + acamprosate 
- Naltrexone + disulfiram 
- Disulfiram + acamprosate 

Links

- SA Health summary of alcohol pharmacotherapies
- NPS
- DACAS webpage

RACGP and ACRRM alcohol and drugs education programs

RACGP - About the program

There are three separate programs:
essential skills,
treatment skills and
advanced skills,

……..requiring 6, 6 and 20 hours of learning activities respectively. Some remuneration is available for completion of the treatment skills and advanced skills programs.

Drug & Alcohol (acrrm.org.au)

ACRRM offers lecture webinars, tutorial webinars, community profile activities and as well as an online case based learning course, and more interactive webinars.

Alcohol Pharmacotherapy: Practice Nurse Role

Patient will need to continue treatment for approximately 12 months

- Base line observations and routine blood screens.
- Monitor medication side effects and compliance
- Monitor regarding any recent use of alcohol
  - Acamprosate and Naltrexone: continue Tx with a short relapse
    - Identification card> opiate use/pain management
  - Disulfiram: alcohol consumption and exposure to alcohol containing products
    - aftershave, perfume, sanitiser, some hair sprays.
    - foods containing alcohol such as vinegars, kombucha, sauces, vanilla essence.
    - muscle rubs, cough syrups/elixirs and cold and flu preparations
    - Identification card> taking disulfiram>list symptoms of Aldehyde reaction>flushed, hot & sweaty>palpitations, SOB, chest pain> weakness>abdominal pain>vomiting>drowsiness.
    - Seek medical review

- Encouraging links with drug and alcohol counselling service

Other considerations – which one to choose? (outside of contraindications/precautions)

- Consider mechanism of action, patient goal and alcohol use pattern
- Acamprosate:
  - Reduces post-withdrawal cravings via NMDA action
  - Efficacious in patients who experience meaningful withdrawal (extended daily use, at least 8SD males, 6SD females)
  - Goal is extended abstinence (past periods of abstinence?)
  - Return to ongoing drinking means no longer in ‘withdrawal’ (efficacy?)
  - Patient needs to have ceased alcohol consumption for 2 – 7 days

- Naltrexone:
  - Blocks some of the reinforcing properties of alcohol via blocking opioid receptor
  - Therefore when patients drink they tend not to enjoy it as much
  - Also reduces craving for alcohol
  - Not dependent on presence of withdrawal for potential efficacy
  - Goal is abstinence but better option for people who more likely to drink here and there, to reduce relapse back to heavy drinking
  - More suitable option for intermittent binge drinkers (?)
  - Patient needs to have ceased alcohol for 3-4 days before commencing

- Disulfiram
  - Not centrally acting – doesn’t alter craving
  - Incomplete alcohol metabolism – aversive experience via acetaldehyde build up – unpleasant and toxic
  - Goal is abstinence (not even one)
  - Estimate risk of client relapsing (mod-high risk, don’t use)
    - Chronic relapser, unrealistic expectations, poor social support, motivation
  - Commence at least 24 hours after last drink
  - People do drink on it
  - Anecdotally: some clients say has no effect when they drink, others say it reduces cravings

Psychosocial support by GPs

- GPs well placed to provide effective alcohol brief interventions
- low-moderate risk drinkers
- Determine risk (AUDIT/ASSIST) or DSM and deliver feedback about risk and link into presenting concern (eg mental health, sleep, GI disturb.)
- Open ended question about concern about their risk score
- Open ended questions about what they like/don't like about drinking
- Provide advice re: reducing risk by cutting down or stopping
- Safe drinking guidelines
- Assist patient to develop their own 'drinking rules'
- AFDs, how much on drinking days, rate of consumption, eating, spacing

Psychosocial support by GPs

- Alcohol brief intervention as referral for further psych. tx
- Moderate-high risk drinkers
- (Project Match: goal of abstinence is most effective, 'controlled drinking' successful in 23% of people who had at least one year of abstinence)
- If not wanting abstinence, try out 'drinking rules' for 6 weeks, diarise
- Evaluate 'success' at follow up visit and 'where to from here?'
- Repeat plan? Revise rules? Period of abstinence? Psychological referral? Add in Pharmacotherapy?
- If ambivalent: what's going to happen if you don't make (any further) changes to your drinking?