Diagnosis and treatment of alcohol use disorder in primary care

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Disclosure
No financial conflicts
Trade names may be used for clarity

Learning Objectives
You should be able to:
• Screen for alcohol use disorder
• Diagnose alcohol use disorder
• ID multiple peer support options for AUD
• ID multiple medication options for AUD

Cases…
On list for clinic this afternoon:
• 44 yo F smoker c/o insomnia to NAL
• 55 yo F hospital DC for hip fx
• 56 yo M with HTN, DM, GERD, anxiety, hypertriglyceridemia, chronic pain
• 62 yo M homeless M with ESLD
• 29 yo F new patient here to establish care

Who should be screened for alcohol use?
Comorbidities with Alcohol use

- Hypertension
- GERD
- Obesity
- Trauma
- DM
- Anemia
- Liver disease
- Depression
- Anxiety
- PTSD
- Insomnia

**If one of above not controlled on max therapy, or you see 3-4 on problem list, ask about alcohol!**

Screen for Alcohol Use Disorder

- USPSTF recommends universal (category B)
- “Single” question 82% sensitive, 79% specific*
  - “Do you ever drink alcohol?”
  - “How many times in the past year have you had ___ or more drinks in a day?”
    - 4 for women or men ≥ 65 yo
    - 5 for men < 65 yo


Some stats

- 87.6% lifetime prevalence of alcohol use
  - 56.9% drank in the last month
- ~25% binge in the last month
- 9.2% men, 4.6% women with AUD
- 88,000 die annually in US from alcohol

*See "Alcohol Facts and Statistics" from NIAAA:

http://www.nhtsa.gov/people/injury/research/pub/impaired_driving/triangle.gif
Diagnosis of Alcohol Use Disorder

1. Had times when you ended up drinking more, or longer, than you intended?
2. More than once wanted to cut down or stop drinking, or tried to, but couldn't?
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)
4. Spent a lot of time drinking? Or being sick or getting over other aftereffects?
5. Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. Continued to drink even though it was causing trouble with your family or friends?


The 4C’s of Addiction

- craving
- loss of control of amount or frequency of use
- compulsion to use
- use despite consequences

Diagnosis of Alcohol Use Disorder

7. Given up or cut back on activities that were important or interesting to you, or gave you pleasure, in order to drink?
8. More than once gotten into situations while or after drinking that increased your chances of getting hurt (such as driving, swimming, using machinery, walking in a dangerous area, or having unsafe sex)?
9. Continued to drink even though it was making you feel depressed or anxious or adding to another health problem? Or after having had a memory blackout?
10. Had to drink much more than you once did to get the effect you want? Or found that your usual number of drinks had much less effect than before?
11. Found that when the effects of alcohol were wearing off, you had withdrawal symptoms, such as trouble sleeping, shakiness, restlessness, nausea, sweating, a racing heart, or a seizure? Or sensed things that were not there?


Diagnosis of Alcohol Use Disorder

2-3 symptoms: Mild
4-5 symptoms: Moderate
6+ symptoms: Severe

Treatment Decisions Depend on Severity and patient goal
Treatment options depend on severity

- Mild (2-3 criteria)
  - Trial of abstinence (TOA)
    - Diagnostic and therapeutic
- Moderate (4-5 criteria)
  - TOA
  - Peer support
  - Pharmacotherapy
- Severe (6+ criteria)
  - TOA → medically supervised withdrawal
  - Peer support
  - Pharmacotherapy

Treatment options depend on patient’s goal

- Abstinence?
- Reduction in # drinks?
- Reduction in # drinking days?
- Reduction in harm to pt from drinking?

Treatment options depend on comorbidities

- Depression/anxiety?
- ESLD?
- Homeless?
- Chronic pain on opioids?
- Other substance use disorder?

The Case: 42 yo M +EtOH screen

42 yo M presents for txfer care HTN, insomnia.
+needs 3-4 now to get “buzz”
+hangovers led to missed work twice
Doesn’t see EtOH as ongoing problem

Any “tests” or treatment would you recommend?
Diagnosis of Alcohol Use Disorder

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2. More than once wanted to cut down or stop drinking, or tried to, but couldn’t?
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Spent a lot of time drinking? Or being sick or getting over other after effects?
5. Found that drinking—or being sick from drinking—often interfered with taking care of your home or family? Or caused job troubles? Or school problems?
6. Continued to drink even though it was causing trouble with your family or friends?


42 yo M mild-moderate AUD

Mild-Moderate AUD, new to pt: Brief Intervention
- Educate on alcohol effects
  - “Can I tell you a little about how alcohol and sleep?”
- Give the diagnosis
  - “You meet criteria for Alcohol Use Disorder”
- TOA
  - Patient agrees to 2 week trial of abstinence: 8/10 confidence
- Schedule follow-up
  - made it 5 days without (“sleep was a little tough”), then family reunion. 4 more nights since, 3 of them 5+ drinks.

42 yo M moderate AUD

- Wants another TOA
- “I’ll do it this time, doc, 10 out of 10”

Other next steps?
PEER SUPPORT GROUPS

Something for everyone

Do 12-step groups work?

- Meta-analysis says no*
- Project MATCH: AA as good as CBT if facilitated to get there**
  - 35% 3 y abstinence

*Ferri et al., Cochrane Syst Rev, 2006
42 yo M moderate-severe AUD

- 2 weeks f/u: drank again by day 3.
  Increased arguments with GF. “I think I need some more help”

What pharmacotherapy might you offer?

There’s a pill (or a shot) for that

PHARMACOTHERAPY FOR AUD
Meds to treat alcohol use disorder

Maintain abstinence

- Acamprosate
- ?Naltrexone
- Gabapentin*
- ?Baclofen*
- Disulfiram**

Decrease binges

- Naltrexone
- Gabapentin*
- Topiramate*
- Baclofen*
- Ondansetron*
- Varenicline*

*not FDA-approved
**in highly structured environment only

Pro
- Well studied: MA (n=6915)
  - NNT 9 to prevent one relapse within 8-24 wks*
- Safe in liver dz
- FDA-approved

Con
- 6 pills per day
- Contraindicated in ESRD
- SE: diarrhea in 10-15%
- ?mechanism
- No help with active drinker cutting down

Ideal candidates: post-medically supervised withdrawal, no ESRD, able to manage pills
Rx: 666 mg po tid

*Rosner S, et al., Cochrane Database Syst Rev, 2010

Decrease binges: naltrexone

Pro
- Mu-opioid antagonist reduces endogenous reward from EtOH
  - Pt “learns” not to drink too much
- Well-studied for preventing return to heavy drinking:
  - MA (n=7793) RR 0.83*
  - MA (n=2875) NNT 12**
- Safe to take with EtOH

Con
- ?improvement in abstinence
  - MA (n=2347): risk reduction 0.05 (0.1 – 0.002)
- SE: transaminitis
- Contraindications: opioids, LFTs > 5x ULN

Ideal candidate: actively drinking patient not on opioids who wants help to “cut down”
Rx: 50 mg po qday or 380 mg IM q4wks

*Rosner S, et al., Cochrane Database Syst Rev, 2010
**Jonas DE, et al., JAMA, 2014

Maintain abstinence: disulfiram

Pro
- Inhibits aldehyde dehydrogenase effectively punishing EtOH intake
- FDA-approved

Con
- MA: n=492 no diff placebo*
- SE: severe hepatitis (rare), reaction with “hidden” EtOH (mouthwash, sauce)

Ideal candidate: patient in methadone maintenance (or other clinic with DOT capability)
Rx: 250 mg po qday

*Jonas DE, et al., JAMA, 2014
Decrease use OR maintain abstinence: gabapentin

**Pro**
- Can be used for “detox” as well as maintenance*
- RCT showed incr abstinence and reduced binge with dose-related response; NNT 8**
- Treats common sx in patients trying to reduce or quit drinking (anxiety, insomnia, craving)
- Naltrexone combo works***

**Con**
- Off-label for AUD
- Abuse potential?
- CI for RCT overlapped placebo
- Dose adjust for CKD

Ideal candidate: active drinker no hx seizures goal of abstinence
Rx: titrate up to target dose 600 mg tid

**Mason BJ et al. JAMA Int Med, 2014

Decrease use OR maintain abstinence: baclofen

**Pro**
- GABA-ergic
- 2 of 3 RCT showed improvement in achieving and maintaining abstinence in active drinkers*
- Anti-cravings

**Con**
- Off-label for AUD
- SE: Drowsiness, confusion?
- Dose adjust for CKD

Ideal Candidate: active drinker with goal of reducing use open to abstinence
Rx: 10 mg po tid, can titrate to 20 mg po tid (...or higher?)


The use of very high-doses of baclofen for the treatment of alcohol-dependence: a case series

**Pro**
- 12 week RCT (n=93)
- 68% total abstinence (vs 22%)
  - Mean dose 180 mg

**Con**
- 16 week RCT (n=151)
- No diff in time to relapse placebo, low, or high (150 mg) dose

Decrease use: topiramate

Pro
• MA (n=691) 9% decr in heavy drinking days and -1 drink per average day*
• RCT: helps AUD+PTSD**
• AED: safe in pt with sz
• Appetite-suppression?

Con
• Off-label for AUD
• SE: cognitive (“Dope-amax”)
• Appreite suppression?

Ideal candidate: Overweight patient on chronic opioids with seizure disorder
Rx: 50 mg po qhs, titrating up slowly to max of 150 mg bid


Decrease use: ondansetron

Pro
• RCT: appears to work in certain sub-pop (“early-onset” AUD, genotype)*
  – Reduced 1.5 drinks per day
  – Reduced # drinking episodes ~10%

Con
• Off-label for AUD
• Can’t ID genetics
• QT prolongation

Ideal candidate: young healthy pt normal QT already failed other meds

*Johnson BA, Am J Psychiatry, 2011

Targeting symptoms to choose meds

Anxiety: gabapentin, ?baclofen
Insomnia: gabapentin, topiramate
Cravings: gabapentin, baclofen, ?ondansetron, ?varenicline

“I want to drink like a normal person”: naltrexone

Acute alcohol withdrawal

Benzos > placebo for seizure ppx*
  • RR 0.16
  • Symptom-triggered > fixed schedule

Phenobarbital = placebo for seizure ppx*

•Carbamazepine > placebo, = benzos for seizure ppx in mild to moderate + LESS DRINKING AFTER* 
•Gabapentin = benzo for seizure ppx in mild to moderate + less drinking in RCT**

*Amato L, Cochrane Syst Rev, 2010
**Myrick H, Alcohol Clin Exp Res, 2009
42 yo M mod-severe AUD

- Trial naltrexone – didn’t tolerate (mood and HA)
- Trial gabapentin 300 mg tid – still drinking at 1 mo
- Gabapentin 600 mg tid – 3 drinking episodes @ 1 mo
  - SMART recovery
- 100% Abstinent at 1 mo f/u
- 100% Abstinent at 3 mo f/u
- 100% Abstinent at 6 mo f/u -- +GF sign

Take home messages

- Universal screening!
- Diagnose before physically dependent
- AA is not the only game in town
- Make it a medical—not a moral—problem

Final exam

- 56 yo homeless M with HTN, HCV, opioid use disorder in remission on methadone with AUD in early remission after completing medically-assisted withdrawal.

Final exam

- 56 yo homeless M with HTN, HCV, opioid use disorder in remission on methadone with AUD in early remission after completing medically-assisted withdrawal.

- Evidence supports which of the following medications to increase abstinence from alcohol in this patient?
  a) Topiramate
  b) Naltrexone
  c) Acamprosate
  d) All of the above
Full citations for references cited (1/2)


Full citations for references cited (2/2)