MANAGING ALCOHOL USE DISORDER IN BC: NEW GUIDELINES, CHALLENGES & CLINICAL PEARLS

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DISCLOSURES

Planning Team

- **Dr. Bob Bluman (UBC CPD):** No conflicts of interest
- **Nicole Esligar (UBC CPD):** No conflicts of interest
- **Kathryn Young (UBC CPD):** No conflicts of interest
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Panelists

- **Dr. Simon Moore:** No conflicts of interest
- **Dr. Paxton Bach:** No conflicts of interest
- **Dr. Julius Elefante:** No conflicts of interest
- **Dr. Alana Hirsh:** No conflicts of interest
- **Dr. Sasha Langille-Rowe** No conflicts of interest

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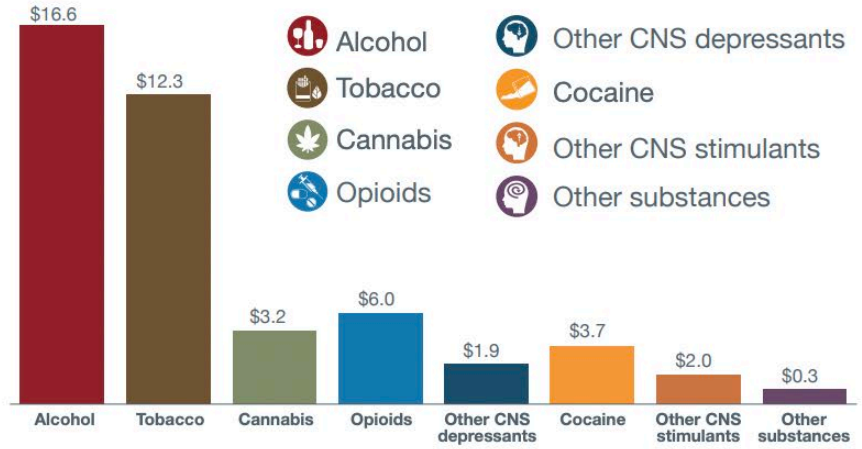
In 2017, substance use cost Canadians a total of

$46 BILLION

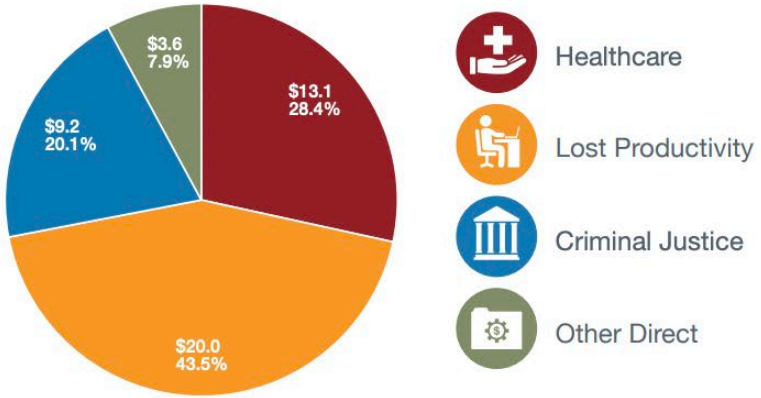
Which amounts to almost $1,260 for every Canadian regardless of age

The cost of substance use (in billions)

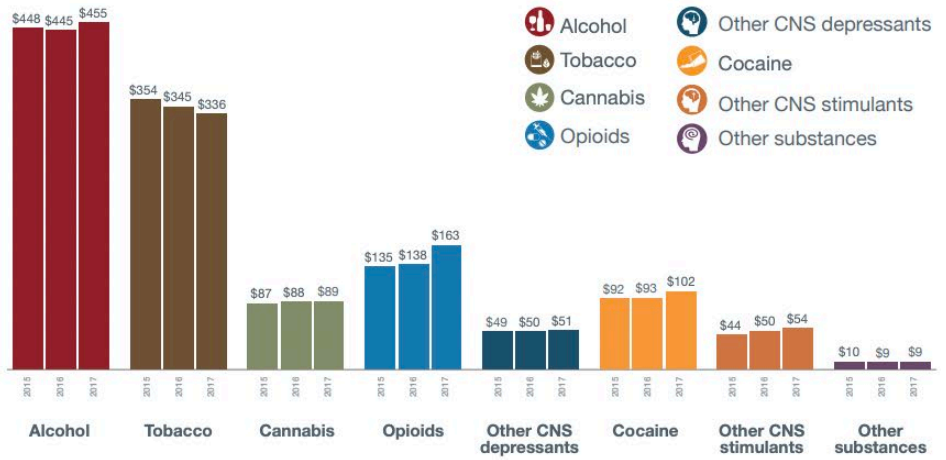


63% of total costs are due to alcohol and tobacco

Overall costs attributable to substance use in billions



Per person costs attributed to substance use



Canada Substance Use Costs and Harms, 2020.

- **There are more hospitalizations for alcohol than for heart attacks.** In 2015–2016, there were about 77,000 hospitalizations entirely caused by alcohol compared with about 75,000 for heart attacks.

Canadian Institute for Health Information, 2017.

Alcohol Use Disorder in Canada

	Lifetime (%)	12-month (%)
Substance use disorder	21.6	4.4
Alcohol abuse or dependence	18.1	3.2
Cannabis abuse or dependence	6.8	1.3
Other drug abuse or dependence (excluding cannabis)	4.0	0.7

*DSM-IV diagnoses

Canadian Community Health Survey – Mental Health. Statistics Canada. 2012.

Appendix 2: Screening and Diagnosis

Universal alcohol use screening of adult and youth patients has a significant role in health promotion, as the identification of high-risk alcohol use facilitates the prevention of the wide range of alcohol-related conditions as well as AUD. This appendix provides an instructive overview of the screening and diagnosis process as depicted in Figure 1.

Figure 1. Screening, Diagnosis, and Treatment Pathway

AUD Pathway

1 Pre-screen — "Do you sometimes drink beer, wine, or other alcoholic beverages?"

NO

YES

2 Initial screen — "How many times in the past year have you had 5 (for men) / 4 (for women) or more drinks in 1 day?"

NEVER

No or low risk drinking
- Offer encouragement
- If the patient indicates having recently discontinued or reduced drinking, offer support as appropriate

1 OR MORE

3 Full screen — AUDIT or AUDIT-C

LOW RISK

MODERATE RISK

Moderate risk drinking
- Brief advice

HIGH RISK

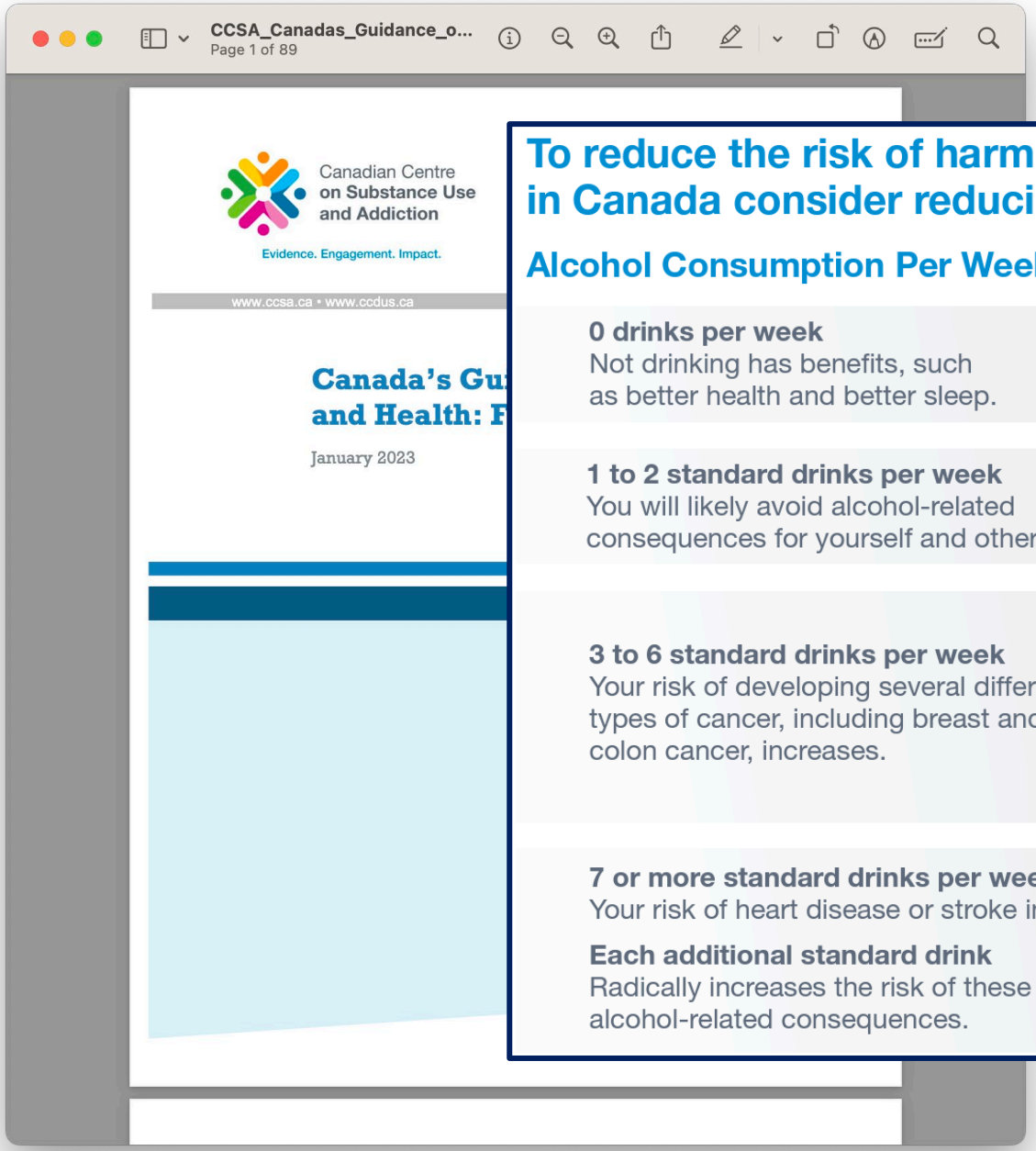
4 Diagnosis — Diagnostic interview using the DSM-5-TR

5 Assessment and care planning

< 2 CRITERIA	2-3 CRITERIA	4-5 CRITERIA	≥ 6 CRITERIA
High risk drinking	**Mild AUD***	**Moderate AUD**	**Severe AUD**
- Brief intervention	- Brief intervention Options: - Psychosocial treatment - Psychosocial supports	- Brief intervention Options: - Withdrawal management - Psychosocial treatment - Psychosocial supports - Pharmacotherapy**	- Brief intervention Options: - Withdrawal management - Psychosocial treatment - Psychosocial supports - Pharmacotherapy**

*Previously labeled as alcohol abuse in DSM-IV
**First-line pharmacotherapies are naltrexone and acamprosate

BCCSU High-Risk Drinking and AUD Provincial Guidelines. 2019; Canadian Clinical High Risk Drinking and AUD Guideline, 2023.



To reduce the risk of harm from alcohol, it is recommended that people living in Canada consider reducing their alcohol use.

Alcohol Consumption Per Week

0 drinks per week Not drinking has benefits, such as better health and better sleep.	No risk	0
1 to 2 standard drinks per week You will likely avoid alcohol-related consequences for yourself and others.	Low risk	1 2
3 to 6 standard drinks per week Your risk of developing several different types of cancer, including breast and colon cancer, increases.	Moderate risk	3 4 5 6
7 or more standard drinks per week Your risk of heart disease or stroke increases. **Each additional standard drink** Radically increases the risk of these alcohol-related consequences.	Increasingly high risk	7 8 + ++

Canadian Centre on Substance Use and Addiction, 2023.

24/7 ADDICTION MEDICINE CLINICIAN SUPPORT LINE

Telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists providing addiction and substance use care.

Available 24/7, 365 days a year. More info at www.bccsu.ca/24-7.

CALL 778-945-7619

Dr. Sasha Langille-Rowe, CCFP –
UBC Rural North West Residency Program Site Director
and Terrace Addiction Medicine Lead

A Rural Family Medicine Perspective

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1. Screening can be quick

2. The relationship you have with your patients can make a difference

3. There are several effective interventions for the outpatient setting

Dr. Alana Hirsh–
Clinical Assistant Professor, UBC;
Physician at Kilala Lelum Urban Indigenous Health and Healing Cooperative

AUD Pharmacotherapy

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Recommendations 10 & 11

- 1st Line:
  - Naltrexone
  - Acamprosate

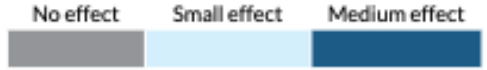
- 2nd Line:
  - Gabapentin
  - Topiramate

To prevent one individual from returning to any drinking, the number needed to treat (NNT) is:

Acamprosate
12 people must be treated
to prevent 1 relapse

Naltrexone
20 people must be treated
to prevent 1 relapse

Table 24. Comparison of AUD Pharmacotherapies



	Naltrexone	Acamprosate	Gabapentin	Topiramate
Efficacy				
Abstinence				
Heavy Drinking				
Craving				
Contraindications (▲) and Cautions (●)				
Opioid Use	▲		●	
Liver Failure / Hepatitis	▲			
Severe Kidney Impairment	●	▲	●	
Kidney Stones				▲
Narrow angle glaucoma				▲
Current alcohol use				
Safe to use while drinking?	✔	✔	✘	✔
Pre-treatment abstinence is beneficial	✔	✔	✔	

Table 24. Comparison of AUD Pharmacotherapies

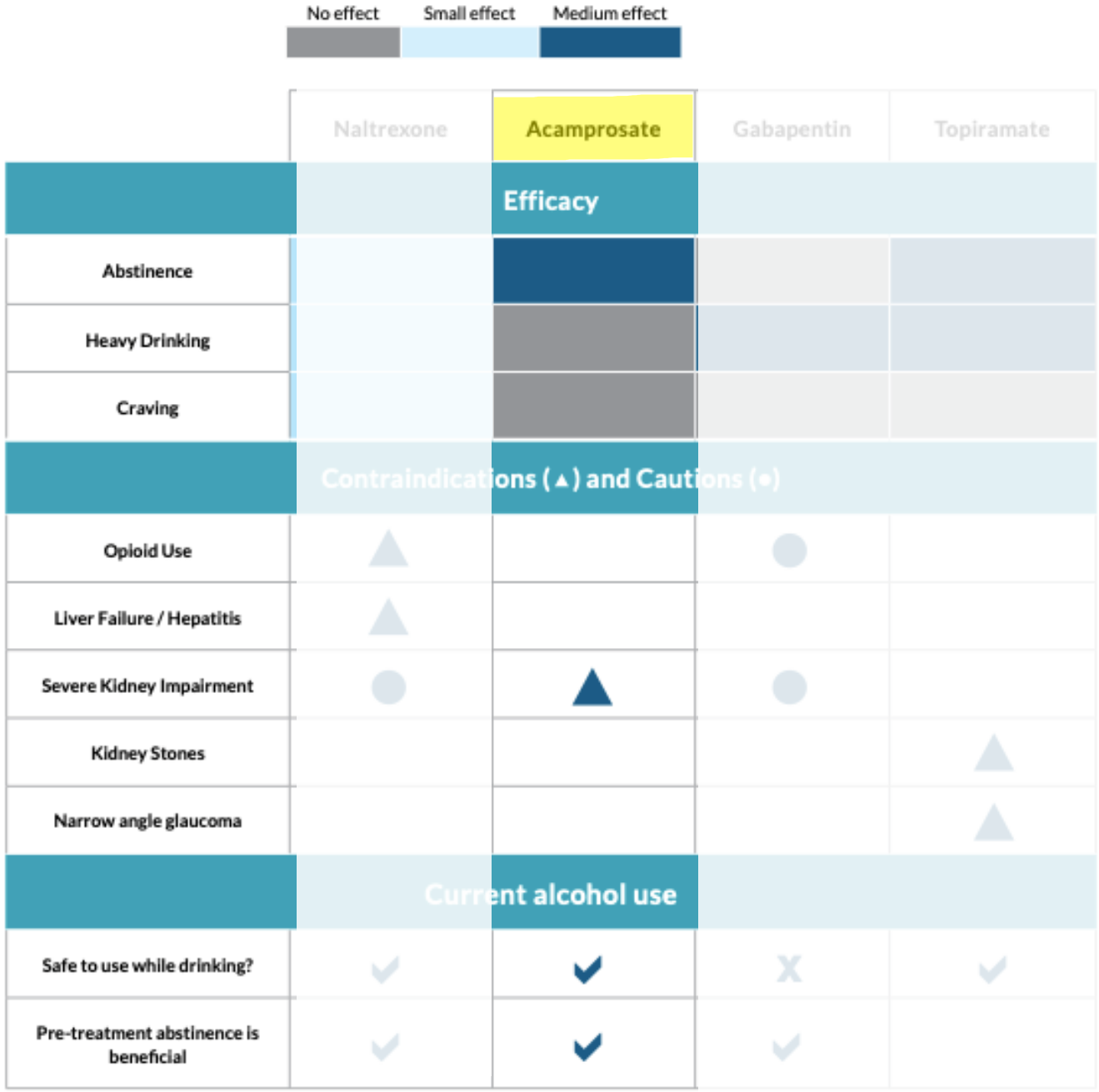
No effect | Small effect | Medium effect

	Naltrexone	Acamprosate	Gabapentin	Topiramate
Efficacy				
Abstinence				
Heavy Drinking				
Craving				
Contraindications (▲) and Cautions (●)				
Opioid Use	▲		●	
Liver Failure / Hepatitis	▲			
Severe Kidney Impairment	●	▲	●	
Kidney Stones				▲
Narrow angle glaucoma				▲
Current alcohol use				
Safe to use while drinking?	✔	✔	✘	✔
Pre-treatment abstinence is beneficial	✔	✔	✔	

NALTREXONE

- Mu-opioid receptor antagonist, blocks euphoria associated with alcohol consumption.
- Treatment goal abstinence/Etoh reduction
- Start at 25mg OD for 3-4 days, titrate: to 50mg OD. Can go up to 150mg if needed.
- Some evidence for using PRN
- Monitor LFTs at 0,1,3,6 mo

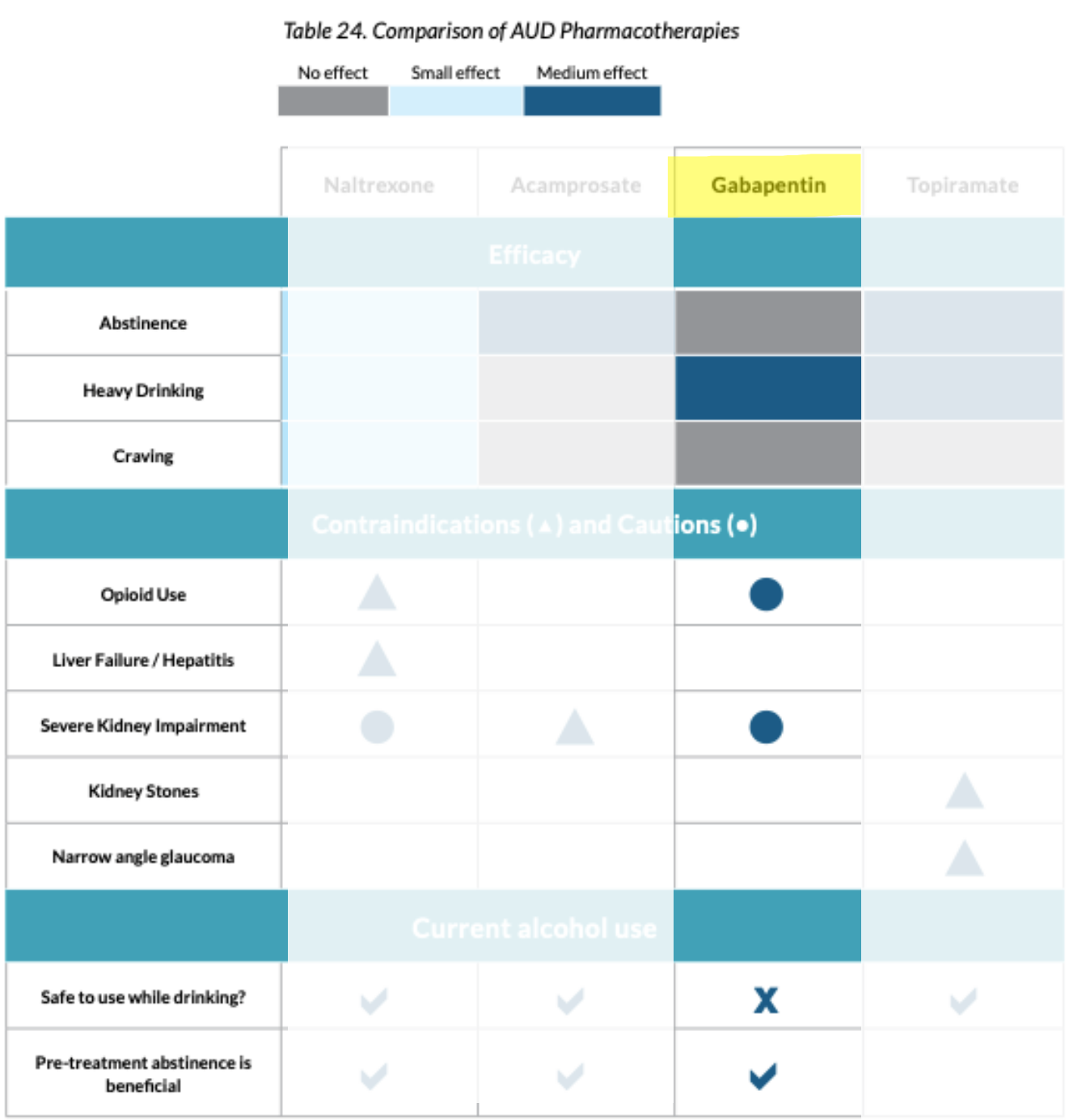
Table 24. Comparison of AUD Pharmacotherapies



ACAMPROSATE

- Mechanism of action not well understood.
- Treatment goal abstinence (not reduced drinking)
- Start at maintenance dosage: 2 x 333mg tablets (666mg) TID
- Avoid in severe renal dysfunction

Table 24. Comparison of AUD Pharmacotherapies



GABAPENTIN

- Anticonvulsant, used for Etoh withdrawal, and off-label for AUD
- Dosing: Start at 100–300mg TID, titrate up to 1800mg daily
- Monitor for renal function, CNS side effects

Table 24. Comparison of AUD Pharmacotherapies

No effect | Small effect | Medium effect

	Naltrexone	Acamprosate	Gabapentin	Topiramate
Efficacy				
Abstinence				
Heavy Drinking				
Craving				
Contraindications (▲) and Cautions (●)				
Opioid Use	▲		●	
Liver Failure / Hepatitis	▲			
Severe Kidney Impairment	●	▲	●	
Kidney Stones				▲
Narrow angle glaucoma				▲
Current alcohol use				
Safe to use while drinking?	✓	✓	✗	✓
Pre-treatment abstinence is beneficial	✓	✓	✓	

TOPIRAMATE

- Anticonvulsant, off label for AUD
- Dosing: start at 25mg qhs, increase by 25mg weekly (divide bid) up to target of 50mg BID
- Monitor for CNS related side-effects
- Avoid in nephrolithiasis and narrow angle glaucoma

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WHAT THE 2023 GUIDELINES SAY

Guideline

Table 2: Summary of recommendations

	Recommendation	Strength of recommendation*	Certainty of evidence[15]
Screening†			
12	Adult and youth patients should not be prescribed antipsychotics or SSRI antidepressants for the treatment of AUD.	Strong	Moderate
13	Prescribing SSRI antidepressants is not recommended for adult and youth patients with AUD and a concurrent anxiety or depressive disorder.	Strong	Moderate
14	Benzodiazepines should not be prescribed as ongoing treatment for AUD.	Strong	High

Wood E et al. *CMAJ*. 2023 Oct

WHAT OTHER GUIDELINES HAVE SAID

The Canadian Network for Mood and Anxiety Treatments (CANMAT) task force recommendations for the management of patients with mood disorders and comorbid substance use disorders

SSRIs		
Escitalopram	Alcohol	Level 2[46,47]
Fluoxetine	Alcohol	Level 2[48-51] [a]Level 2: negative[52-55]
	Cannabis	[a]Level 2: negative[52,56]
	Cocaine	Level 3: negative[57,58]
	Opiate	Add-on to methadone: level 2: negative[50,59]
Nefazodone	Alcohol	Level 1[60-62]
	Cocaine	Level 2: negative[63]
Sertraline	Alcohol	Level 2: negative[50,64-68] Level 2: naltrexone plus sertraline[69]
	Opiate	Add-on to methadone: level 2: negative[50,70]
OTHER		
Mirtazapine	Alcohol	Level 2[36,71]

Substance	**MDD**
Alcohol	*First choice:* Mirtazapine Add-on naltrexone or alone Add-on naltrexone to sertraline[a]
	Second choice: Add-on disulfiram
	Third choice: Valproic acid Amitriptyline Desipramine Imipramine Escitalopram Memantine
	Not recommended: Fluoxetine[b] Lithium Sertraline Nefazodone (withdrawn from the market)

Beaulieu S et al. *Ann Clin Psychiatry*. 2012 Feb

WHAT OTHER GUIDELINES HAVE SAID

Choosing Wisely Canada™

Psychiatry

9 **Don't routinely prescribe antidepressants as first-line treatment for depression comorbid with an active alcohol use disorder without first considering the possibility of a period of sobriety and subsequent reassessment for the persistence of depressive symptoms.**

The concurrent management of psychiatric illness and alcohol use disorders requires evaluation of the role alcohol plays as a causative factor for depressive symptoms. Studies have found that response rates to antidepressants are higher when antidepressants are reserved for persistence of symptoms after a period of sobriety lasting from two to four weeks. Additionally, studies have demonstrated remission from depressive symptoms with sobriety in the absence of antidepressant treatment in a significant percentage of cases. Management of comorbid psychiatric illness and substance use disorders including alcohol dependence involves assessment and treatment delivered in a concurrent manner.

by
Canadian Academy of Child and Adolescent Psychiatry
Canadian Academy of Geriatric Psychiatry
Canadian Psychiatric Association
Last updated: September 2023

Letters

Navigating the nuances of the Canadian guideline's stance on selective serotonin reuptake inhibitors in concurrent alcohol use disorder and mood or anxiety disorders

Raymond Julius O. Elefante, Clara Lu and Paxton J. Bach

CMAJ March 18, 2024 196 (10) E348; DOI: https://doi.org/10.1503/cmaj.150034-l

- The complete AUD guideline provides an expanded rationale for recommendation 13:
  - "lack of high-quality evidence supporting the effectiveness of SSRIs for those with concurrent AUD and depression, a potentially higher risk of adverse events including worsening drinking outcomes, and research demonstrating a rapid reduction of depressive symptoms following a period of abstinence from alcohol use"

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- The AUD guidelines appropriately caution that their recommendation "does not address severe psychiatric conditions" and that, among patients who "demonstrated benefit from SSRI therapy, continued use of the medication could be considered with close monitoring of clinical response as well as unintended effects"

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- We agree that prescribers should pause before starting SSRIs in the context of AUD with comorbid anxiety or mood disorders
- However, in reviewing the evidence cited by the guidelines, we found that the risk of worsening drinking outcomes is inconsistent, and the cited randomized controlled trials have substantial limitations that prevent definitive conclusions

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- Treating people with concurrent alcohol use and mood/anxiety disorders is complex
  - Heterogeneous population
  - Difficulty attaining abstinence in the face of ongoing psychiatric symptoms
  - Refractory symptoms despite abstinence
  - Past success with pharmacotherapy

THANK YOU

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Comments, questions and suggestions