Dear Colleague,

The Canadian Alcohol Use Disorder Society has created this handout in order to help your patient share and discuss treatment options for alcohol use disorder with you.

Medical treatment options for AUD are becoming increasingly understood and are endorsed by organizations and institutions such as the BC Centre on Substance Use and the Mayo Clinic. We hope you will take a few moments to look over this information.

Prescribing Information

AUD is a chronic, relapsing, remitting brain disorder with a highly heterogeneous clinical and pathological course. It is entirely treatable with several effective and commonly prescribed medications, depending on a person's personal, family or consumption history.

The BC Centre on Substance Use is leading the way when it comes to developing prescribing guidelines, and as such, we have included their AUD Guidelines Summary and Pharmacotherapy Options Chart with this package. You can find the full BCCSU provincial guideline for the clinical management of high-risk drinking and alcohol use disorder, as well as many other resources, on our website:

www.cauds.org

National prescribing guidelines are in development. Contact us through our website to learn more. We also welcome you to sign up for our quarterly newsletter to view latest resources, as well as hear about launch dates for upcoming resources:

- Online clinician education sessions
- A prescribing community of practice
- An interactive prescribing guide
- Conference and research opportunities

Sincerely,

Dr. Roland Engelbrecht, MBChB, Dip PEC, CCFP(AM), ISAM(c)
Canadian Alcohol Use Disorder Society

About The Canadian Alcohol Use Disorder Society

Formed in Sept. 2020, this national nonprofit organization aims to provide hope and improve quality of life by advancing proven and effective treatment for Alcohol Use Disorder. By positively transforming attitudes, beliefs and behaviours, it also advocates for a more compassionate perception of this disorder amongst care providers, patients and society as a whole. We are not affiliated with or funded by pharmaceutical or related enterprise.

A Guideline for the Clinical Management of

High-Risk Drinking and Alcohol Use Disorder

ALCOHOL-RELATED HARMS

Alcohol use, and specifically the consumption of alcohol above recommended daily and weekly limits for safer or "low-risk" use, is a serious public health issue.

- In BC, there were ~27 alcohol-related deaths per 100,000 people in 2014, which was more than 3 times higher than the mortality rate for all illicit drugs combined
- From 2002 to 2014, hospitalization rates for alcohol-attributable conditions increased from 383 to 513 per 100,000 individuals
- From 2001 to 2011, the number of primary care visits for alcohol-attributable conditions in BC increased by 53%

ACCESS TO TREATMENT

Despite the significant burden of disease, social harms, and economic costs attributed to alcohol use in BC, high-risk drinking and alcohol use disorder frequently go unrecognized and untreated in the healthcare system.

Although nationally-representative data from Canada is not available, data from the U.S. and Europe have shown that fewer than 10% of people with AUD receive evidence-based treatment.

The BCCSU convened an expert panel to review the literature and develop a consensus guideline for the optimal screening, diagnosis, treatment, and care of individuals drinking above low-risk limits. The guideline sets out 13 recommendations that are supported by high-quality, current, and rigorously reviewed evidence.

The guideline aims to bridge the significant research-to-practice gap in this field, which will, in turn, improve access to evidence-based treatment for patients and families, and reduce the significant harms associated with alcohol use in British Columbia.

BRITISH COLUMBIA

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

SUMMARY OF RECOMMENDATIONS

Screening and Brief Intervention

Clinicians should provide education about Canada's Low-Risk Alcohol Drinking Guidelines to all adult and youth patients

All adult and youth patients should be screened annually for alcohol use above low-risk limits.

All patients who are drinking alcohol above low-risk limits but do not have an AUD should receive a brief counselling intervention.

Withdrawal Management

Clinicians should use the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) to assess the risk of severe complications of alcohol withdrawal in patients with AUD, in order to select the most appropriate withdrawal management pathway

Patients at low risk of severe complications of alcohol withdrawal (PAWSS<4) who have no other concurrent conditions that would require inpatient management should be offered outpatient withdrawal management

Clinicians should consider prescribing non-benzodiazepine medications, such as gabapentin, carbamazepine, orclonidine, for the outpatient management of patients at low risk of severe complications of alcohol withdrawal

Patients at high risk of severe complications of withdrawal (PAWSS ≥ 4) should be referred to an inpatient facility (i.e., withdrawal management facility or hospital) where they can receive a benzodiazepine treatment regimen under close observation, and emergency care can be administered immediately if needed

All patients who complete withdrawal management should be connected to continuing AUD care

Continuing Care

Adult patients with moderate to severe AUD should be offered naltrexone or acamprosate as a first-line pharmacotherapy to support achievement of patient-identified treatment goals

A. Naltrexone is recommended for patients who have a treatment goal of either abstinence or a reduction in alcohol consumption
B. Acamprosate is recommended for patients who have a treatment goal of abstinence

Adult patients with moderate to severe AUD who do not benefit from, have contraindications to, or express a preference for an alternative to first-line medications, can be offered topiramate or gabapentin

Clinicians should provide motivational interviewing-based counselling to all patients with mild to severe AUD to support achievement of treatment goals

All patients with mild to severe AUD can be provided with information about and referrals to specialist-led psychosocial treatment interventions

All patients with mild to severe AUD can be provided with information about and referrals to peer-support groups and other recovery-oriented services in the community

Pharmacotherapy Options for Alcohol Use Disorder

	First Line Pharmacotherapy		*Second Line Pharmacotherapy*	
	Naltrexone	**Acamprosate**	**Topiramate**	**Gabapentin**
Concurrent Alcohol Use	No well-described safety risk Tx after WDM may be more effective	No well-described safety risk Tx after WDM may be more effective	No well-described safety risk	No well-described safety risk at therapeutic dose Abstinence recommended after tx Abstinence for ≥3 days may improve outcomes
Contra-indications	1. Naltrexone hypersensitivity 2. Any current opioid use (Rx or nonmedical) 3. Acute opioid withdrawal 4. Acute hepatitis or liver failure	1. Acamprosate hypersensitivity 2. Severe renal impairment 3. Breastfeeding	1. Topiramate hypersensitivity 2. Pregnant or planning pregnancy 3. Narrow angle glaucoma 4. Nephrolithiasis	Gabapentin hypersensitivity
Cautions	1. Renal impairment 2. Severe hepatic impairment 3. Concomitant use of other potentially hepatotoxic drugs 4. Pregnancy and breastfeeding* 5. Adolescent patients (<18 years)*	1. Moderate renal impairment 2. Adolescent and geriatric (>65 years) patients* 3. Pregnancy*	1. Concomitant use of valproic acid 2. Conditions/therapies that predispose to acidosis	1. Renal impairment 2. Pregnancy and breastfeeding* 3. Adolescent and geriatric (>65 years) patients* 4. Concomitant use of opioids and other CNS depressants 5. Compromised respiratory function 6. Neurological disease or cognitive impairment
Side Effects	Nausea, headache, and dizziness Starting at low dose and/or abstinence can reduce side effects	Diarrhea, vomiting, and abdominal pain	Psychomotor slowing, difficulty concentrating, speech/language problems, somnolence, fatigue, and mood disturbance Starting at low dose and titrating up can reduce side effects	Ataxia, slurred speech, and drowsiness
Coverage and Cost**	Full coverage under Fair PharmaCare, and PharmaCare Plans C, G, and W Requires the Collaborative Prescribing Agreement		Full coverage under Fair PharmaCare, and PharmaCare Plans C and W	
	$105 per month	$165 per month	$75 per month	$30 per month
Safety and Other Considerations	Liver function tests (LFT) at initial tx, and 1, 3, and 6 mo. More frequent monitoring if LFTs are elevated Due to risk of hepatic injury, advise patients on signs of acute hepatitis and to stop tx if symptoms appear	No safety risk w/ mild renal impairment Moderate impairment requires dose reduction No hepatic toxicity	Due to risk of fetal harm, advise women to use effective contraception No safety risk w/ liver disease Monitor for signs of hyperammonemia and metabolic acidosis	No safety risk w/ liver disease Requires conservative dosing in patients with renal impairment
Dosing	**Start:** 12.5mg BID for 3 days **Titrate:** to 50mg OD over 2 wks as tolerated	2 x 333mg tablets TID	**Titrate:** to 2 x 50mg tablets BID over several wks as tolerated	**Start:** at 100-300mg TID, **Titrate:** PRN to 1800mg max daily

*Safety and efficacy has not been well established in these patient populations. Careful assessment of benefit and risks, fully informed patient consent, and more frequent monitoring is advised.
**Estimated cost if patient is not eligible for coverage
Abbreviations: WDM – withdrawal management, PRN – as needed/when necessary, TID – three times per day, BID – two times per day, OD – once daily

Pharmacotherapy Options for Outpatient Management of Alcohol Withdrawal

	Benzodiazepines	Carbamazepine	Gabapentin	Clonidine
Concurrent Alcohol Use	Potentiates effects of alcohol; can lead to serious safety risks, incl. over sedation, falls, delirium, respiratory depression (e.g., non-fatal or fatal overdose), and prolonged hospitalization	No well-described safety risk	Abstinence recommended after tx due to risk of additive CNS-depressive effects *Note:* Studies suggest at therapeutic doses gabapentin is **not** likely to increase sedation or motor impairment	Risk of additive effect on lowering BP
Contra-indications	1. Severe respiratory insufficiency 2. Hepatic disease 3. Sleep apnea 4. Myasthenia gravis 5. Narrow angle glaucoma	1. Hepatic disease 2. Bone marrow depression 3. Serious blood disorder 4. Atrioventricular heart block	Hypersensitivity to gabapentin	1. Sinus node function impairment 2. Severe bradyarrhythmia 3. Galactose intolerance
Cautions	1. Lactose intolerance 2. Renal impairment 3. Breastfeeding	Associated with rare blood dyscrasias and Stevens Johnson Syndrome with long-term use *Asian ethnicity increases risk of carbamazepine toxicity	Renal impairment	Hypotension in sensitive patients
Side Effects	Drowsiness, dizziness Less common: changes in skin colour, nausea, headache, blurred vision, tremors, hypotension, GI disturbances, memory loss	Dizziness, pruritus, ataxia, headache, drowsiness and nausea (all usually minor and temporary)	Higher doses may cause ataxia, slurred speech and/or drowsiness Profile is better than other anticonvulsants.	Hypotension, dry mouth, dizziness, fatigue, headache, nausea, vomiting, constipation, malaise, sleep disorder, sedation and erectile dysfunction
Other Considerations	Potential for non-medical use, diversion, and dependence Potential for drug-drug interactions leading to excess sedation, impaired psychomotor and cognitive functioning. Due to safety concerns, exercise caution with outpatient use Lorazepam is preferred for those with severe respiratory or liver disease and in elderly (consider lower dosing)	No risk of non-medical use, diversion, or dependence Some side effects resemble w/drawal symptoms; confirm source of symptoms before dose adjustments Baseline and periodic evaluations of hepatic function must be performed in elderly patients and patients w/ history of liver disease	Potential for non-medical use, diversion, and dependence Toxicity profile parallels that of alcohol. Easy to transition from WDM to long-term relapse prevention.	Only use for mild-moderate w/drawal symptoms when low risk of severe complications Safe as adjunct to benzodiazepines or other anticonvulsants Provide education on the signs and symptoms of hypotension
Dosing	Diazepam (Valium) Day 1: 10mg QID Day 2: 10mg TID Day 3: 10mg BID Day 4: 10mg HS Lorazepam (Ativan) Day 1-2: 2mg every 4h Day 3-4: 1mg every 4h	For immediate-release tablets Day 1: Start with 200mg QID Day 2: Taper down to 200mg TID Day 3: 200mg BID Day 4-5: 200mg HS	For immediate-release tablets **Start** 300mg TID + 300mg PRN +600-1200mg HS **Titration** Quickly to 600mg TID + 600-1200mg HS as tolerated Do not exceed 3600mg daily **Taper when acute symptoms resolve** To 600mg TID + 600-900mg HS To zero over next 3-5 days, decreasing dose by 600mg daily	Typically an adjunct tx Start: 0.1-0.2mg BID (last dose HS) Titrate: Can add 0.2mg daily if needed Final dose: Range 0.1-0.6mg BID

All medications are eligible for full coverage under Fair PharmaCare, and PharmaCare Plans C and W.

Abbreviations: BP – blood pressure, PRN – as needed/when necessary, QID – four times per day, TID – three times per day, BID – two times per day, OD – once daily, HS – at bedtime

*Due to higher prevalence of the HLA-B*1502 allele. Genetic testing must be performed to exclude those at high-risk