

Alcohol Use Disorder: Screening and Management

Alcohol Use Disorders Identification Test (AUDIT)

Low Risk
AUDIT: < 8

Patient Education

UCM A Guide to Low-Risk Drinking
UCM Alcohol Use & Your Health
UCM Substance Use Resources

Hazardous or Harmful Drinking

AUDIT: 8-15

Patient Education

UCM A Guide to Low-Risk Drinking
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AND

Brief Intervention

FLO Brief Intervention Model

Follow-up with patient in 4-6 weeks via MyChart, phone, or in person

Consider possibility of alcohol use disorder (DSM-5 criteria) and escalating to orange box interventions

Pharmacotherapy for Alcohol Use Disorder

Naltrexone

50 mg PO daily (can ↑ to 100 mg at 7 days) 380 mg IM q4 wks

Acamprosate

666 mg PO TID (333mg PO TID if GFR 30-50)

Gabapentin (2nd line, off-label)

300-400mg TID

Inhibits μ opioid receptor, blocks pleasure, decreases cravings Avoid if taking opioids, cirrhosis, AST or ALT> 3x ULN, INR>2

Monitoring: Hepatic function panel prior to initiation, then every 3-6 months Side effects improve with use: nausea, HA, dizziness; injection site reactions (IM)

Stabilizes glutamate neurotransmission, decreases cravings

Avoid if CKD-4/5 (GFR<30); dose reduce to 333mg PO TID if GFR 30-50 Monitoring: Creatinine prior to initiation, then every 3-6 months

Side effects improve with use: diarrhea, anxiety, fatigue

Enhances GABA activity, reduces frequency of heavy drinking, increases abstinence

Consider dose adjustment with GFR <60

Monitoring: Creatinine prior to initiation, then every 6-12 months Side effects: nausea, vomiting, diarrhea, abdominal pain, \downarrow CNS

Likely Alcohol Use Disorder

AUDIT > 15

Is the patient at risk for acute complications of alcohol use disorder or alcohol withdrawal syndrome?

See Alcohol Withdrawal Syndrome section for further evaluation, inpatient vs outpatient withdrawal management

Patient Education

UCM Substance Use Resources

AND

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AND

Use DSM-5 criteria to confirm alcohol use disorder and assess severity

AND

Refer to Peer Support

AND

Refer to Psychiatry and/or Therapy

AND

Consider Pharmacotherapy

AND

If patient experiencing functional impairment, REFER TO SOCIAL WORK for possible withdrawal management, partial hospitalization, residential program, intensive outpatient program

Follow-up with patient in

4-6 weeks via MyChart, phone, or in person

Alcohol Withdrawal Syndrome (AWS): Evaluation and Management

What is AWS?

- Chronic alcohol use leads brain to adapt by down-regulating GABA system; reduction or cessation of alcohol then leads to symptoms associated with low GABA and high glutamate
- Goal of treatment is to control symptoms and prevent complications
- For an individual, each course of AWS can be more severe than prior courses (called the alcohol kindling phenomenon)

AWS Timeline + Symptom Severity

Early/Mild Symptoms: w/in 24H of last drink

➤ GI upset/nausea, tremors, anxiety/agitation, HA, sensory disturbances, sweats (captured in CIWA-Ar)

<u>Alcohol Hallucinosis</u>: occurs day 2-3 in small percentage of patients

can have tactile, auditory, visual hallucinations; are fully oriented and have no sympathetic stimulation/VS changes

<u>Severe/Complicated</u>: occurs on day 3-4; high mortality

seizures, sympathetic stimulation, acute agitated delirium, DTs

Who is at risk for AWS?

- Individuals with alcohol dependence and evidence of tolerance
- Individuals consuming 4-6 standard drinks every day for at least 1 month

Where should AWS be treated?

Inpatient management of AWS recommended for (absolute contraindications for ambulatory AWS management):

- History of severe/complicated AWS (DTs, seizures)
- Moderate to severe withdrawal on presentation (CIWA-Ar Score >/= 10)
- Pregnancy

Consider inpatient management of AWS for (relative contraindications for ambulatory AWS management):

- High risk for severe withdrawal or DT: age >65, prolonged heavy drinking (>8yrs, drinking >1 pint or eight 12oz cans of beer daily), signs/symptoms of withdrawal when not drinking, numerous withdrawal episodes previously
- Medical comorbidities: 4Cs (CHF/NYHA class 2+, decompensated cirrhosis, CKD Stage 3+, COPD on O2), h/o TBI
- Unstable psychiatric disease
- Low psychosocial support: eg. housing instability, no reliable contact person, barriers to daily telehealth follow-up
- Other active substance use
- Use of other sedating medications (eg. benzodiazepines, barbiturates)

Ambulatory treatment of AWS

Most patients can be safely and effectively managed for AWS in the ambulatory setting if not meeting the above exclusion criteria.

| Pharmacotherapy | | Diazepam based* | Gabapentin base |
|-----------------|-----------------|-----------------|-----------------|
| | Day 1 | 10mg q6hrs | 300mg q6hrs |
| | Day 2 | 10mg TID | 300mg TID |
| | Day 3 | 10mg BID | 300mg BID |
| | Day 4 | 10mg once | 300mg once |
| | Additional PRNs | 5 x 10mg pills | 5 x 300mg pills |

*Can substitute chlordiazepoxide 50mg for diazepam 10mg

Plan next day check-in, followed by q24-48 hours check-in until AWS resolves



Alcohol Use Disorder: FLO Brief Intervention Model

| "F" Feedback Using AUDIT | Share results You score was (>8) which places you in the category for higher risk of harm Elicit Reaction What do you make of that ? |
|------------------------------|--|
| "L" Listen and Elicit | Explore pros and cons What do you like about drinking? What do you like less about drinking? Summarize both sides On the one hand On the other hand Assess importance On a scale of 1-10, how important is it to you to change? Why did you give it that number and not a lower number? What would it take to raise that number? Assess confidence On a scale of 1-10, how confident are you that you can change successfully? Why did you give it that number and not a lower number? What would it take to raise that number? |
| "O" Options and Goal Setting | Ask key questions about what they want to change, what is their goal Where does this leave you? Do you want to quit? Cut down? Make no change? If appropriate, ask about a plan How will you do that? If you wanted tohow would you? Who will help you? What might get in the way? |
| Close on a Good Note | Summarize patient's statements in favor of change Emphasize their strengths What agreement was reached |

DSM-V Criteria for Alcohol Use Disorder: Provider Assessment Occurring within a 12-month period...

| Alcohol is often taken in <u>larger amounts</u> or over a <u>longer period of time than intended</u> . | |
|--|--|
| There is a <u>persistent desire</u> or <u>unsuccessful efforts to cut down</u> or control alcohol use. | |
| A great deal of time is spent in activities necessary to obtain the alcohol, use the alcohol, or recover from its effects. | |
| <u>Craving</u> , or a strong desire or urge to use alcohol. | |
| Recurrent alcohol use resulting in <u>failure to fulfill major role obligations at work, school or home</u> . | |
| Continued alcohol use <u>despite having persistent or recurrent social or interpersonal problems</u> caused or exacerbated by the effects of alcohol. | |
| Important social, occupational or recreational activities are <u>given up or reduced</u> because of alcohol use. | |
| Recurrent alcohol use in situations in which it is physically hazardous. | |
| Continued alcohol use <u>despite knowledge of having a persistent or recurrent physical or psychological problem</u> that is likely to have been caused or exacerbated by alcohol. | |
| Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of alcohol to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of alcohol | |
| Withdrawal, as manifested by either of the following: (a) the characteristic alcohol withdrawal syndrome (b) alcohol (or a closely related substance, such as benzodiazepine) is taken to relieve or avoid withdrawal symptoms | |

Severity Level:

Mild: 2-3 symptoms

Moderate: 4-5 symptoms Severe: 6+ symptoms

Total Number of Symptoms Checked:

If only GRAY boxes checked, they may NOT have alcohol use disorder.

Provided by the UChicago Medicine Primary Care Group-Behavioral Health Integration Program (Director: Neda Laiteerapong, MD, MS)

DSM-5: American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; ICD-10-CM: International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Clinical Modification.