Don't balk at using medical therapy to manage alcohol use disorder

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There is ample evidence in the medical literature, as well as clinical experience, that patients seeking help for chemical dependency benefit from pharmacotherapy. It is common, however, for physicians, patients, and family to balk at the idea. Even within the psychiatry community, where there should be better understanding of substance use disorders, many practitioners hesitate to employ medications, especially for alcohol use disorder (AUD).

Efficacy for such FDA-approved medications has been demonstrated in well-designed, randomized controlled trials, but many trainees, and even experienced professionals, have never seen these medications used effectively and appropriately. Medication-assisted treatment (MAT) is not an alternative to biopsychosocial approaches but is an augmentation that can (1) help stabilize the patient until he (she) can be educated in relapse prevention skills and (2) allow the brain to rewire and heal until he regains impulse control.

Diverse presentations

Do you remember that patient who often arrived for appointments intoxicated, promising that he plans to cut down? How about the man you saw in the emergency department with an elevated blood alcohol level, who was constantly endorsing suicidal thoughts that subsided when he reached clinical sobriety? What about the college student who often was treated for alcohol poisoning after binge drinking on weekends, but who never considered this behavior problematic? And, how about the elderly woman who was evaluated for anxiety, but had been drinking 4 beers nightly for the past 30 years?

Despite the diverse presentations, these patients all have a chronic disease and we fail them when we do not apply evidence-based medicine to their treatment.

As psychiatrists, we encounter many patients with AUD as a primary or comorbid diagnosis. This is a global problem associated with significant human and financial cost. With 80% of American adolescents having reported using alcohol in the past year, the problem will continue to grow.[1] Furthermore, a greater prevalence of AUD is noted in clinical populations undergoing psychiatric treatment.[2] Ongoing alcohol abuse complicates the course of medical and psychiatric conditions and incites significant societal exclusion.

Pharmacotherapy is underutilized

Despite an increase in the use of psychotropic medications for treating psychiatric illness, pharmacotherapy for AUD is underutilized: only 3% of patients have received an FDA-approved treatment.[2,3] Nearly one-

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Table

FDA-approved pharmacotherapy for alcohol use disorder

Generic	Dosing recommendation	Goal	Other considerations
Disulfiram	125 to 500 mg/d (250 mg/d is standard dosage)	Complete abstinence	1. Disulfiram-ethanol reaction if consumed (nausea, vomiting, hypertension). This can be triggered by small amounts of ethanol present in household products. Those with heart conditions might not tolerate such a reaction 2. Exercise caution with those on metronidazole 3. Ensure adequate liver function
Acamprosate	666 to 999 mg, TID	Relapse prevention (reduce drinking, prevent cravings)	1. Ensure adequate renal function 2. No hepatic metabolism 3. No titration required but TID dosing may be challenging
Naltrexone	50 to 100 mg/d by mouth; 380 mg/month subcutaneous	Relapse prevention (reduce drinking, prevent cravings)	1. Exercise caution in patients with chronic pain on opioid therapy 2. Ensure adequate liver function 3. Injectable form addresses noncompliance and bypasses first pass hepatic metabolism

TID: 3 times a day

Clinical Point

Medication-assisted treatment can help the patient stabilize and allow the brain to rewire and heal until he (she) regains impulse control

third of adults are affected by AUD during their lifetime, yet only 20% seek help.[3] Management today remains limited to episodic, brief inpatient detoxification and psychosocial therapy.

Recovery rates are highest when addiction treatment that monitors abstinence is *continuous*; yet, for most part, alcohol addiction is treated in discrete episodes upon relapse. Although MAT is recommended by experts for "moderate" and "severe" substance use disorders, practitioners, in general, have demonstrated considerable resistance to using this modality as part of routine practice.[4,5] This is regrettable: Regardless of terminology used to describe their condition, these people suffer a potentially fatal disease characterized by high post-treatment recidivism.

Neuroscience supports the brain disease model of addiction, with neuroplasticity changes being made during phases of drug use. Medications are shown to assist in preventing relapse while the brain is healing and normal emotional and decision-making capacities are being restored.[6]

Why hesitate to use pharmacotherapeutics?

There are diverse pharmacotherapeutic options that can be pursued for treating AUD with minimal disruption to home and work life. Alarmingly, many trainees have never prescribed or even considered such medications. Despite modest effect sizes in randomized controlled trials, efficacy has been demonstrated in reducing relapse rates and overall severity of drinking days.[4,5] So, from where does the ambivalence of patients and providers about using these treatments to achieve lasting recovery stem?

Starting MAT certainly requires both parties to be in agreement. A patient might decline medication because of a fear of dependence or because he overestimates his ability to achieve remission on his

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own. There also may be financial barriers in a current alcohol treatment system that is traditionally non-medically oriented. Prescribers also fail to offer medications because of:

- lack of familiarity with available agents
- absence of guidelines for use
- disbelief that the condition is treatable.

Given that treatment often is based on a 12-step approach, such as Alcoholics Anonymous (AA), providers might hesitate to prescribe medication for an illness that is thought to be managed through psychosocial interventions, such as group and motivational therapy.

Clinical Point

The overall goals and expectations of the patient should be the most important consideration when chosing medication for AUD

Therapeutic options

Choice of medication depends on the prescriber's comfort level, reputation of the medication, potential side-effect profile, medical contraindications, and affordability; the most important consideration, however, should be the overall goals and expectations of the patient.

There are 4 FDA-approved medications for AUD (***Table, page 51***); many others are off-label. It is advisable to start with an FDA-approved medication such as disulfiram for the motivated patient who has a collaborator and desires complete abstinence; naltrexone for a patient who wants to cut down on intake (a long-acting formulation can be used for poorly adherent patients); and acamprosate for a patient with at least some established sobriety who needs help with post-withdrawal sleep disturbances.

With regard to off-label medications, topiramate has the highest evidence for efficacy. Gabapentin can augment naltrexone and also helps with sleep, anxiety, withdrawal, and cravings.[4,5]

Psychosocial interventions

Medications are just 1 tool in recovery; patients should be engaged in a program of counseling. Encourage attendance at AA meetings. An up-and-coming concept is the use of smartphone applications to prevent relapse (or even induce remission); apps that provide an accurate blood alcohol tracking systems and integrated psychosocial therapies are in the pipeline. The novel Reddit online forum r/StopDrinking is a 24-hour peer-support community that relies on fellowship, accountability, monitoring, and anonymity; the forum can compete with motivational interviewing for efficacy in increasing abstinence and preventing relapse.

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