SPECIALTY

Psychiatry/Addiction Medicine

CHIEF COMPLAINT

Alcohol Misuse

COMMENTS TO SPECIALIST

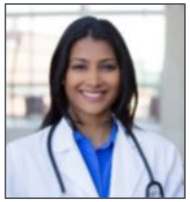
The patient is a 53-year-old female. Past medical history includes hypokalemia, anxiety, depression, obstructive sleep apnea (OSA), pulmonary hypertension (PH), and congestive heart failure (CHF).

The patient was seen at the emergency room for alcohol withdrawal. She was vomiting, with no headache, and minor dizziness. Minor chest pain. Per the emergency note "patient states she sips on vodka all day and is unsure of actual intake."

She has been prescribed Naltrexone but does not take it.

MAIN QUESTION

Please review this case and provide recommendations for the ongoing management of this patient.



Response from eConsult Specialist

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NPI: 1000000013

SUMMARY

Treatment options are available at the primary care level.

DETAILS

This patient definitely meets the criteria for alcohol use disorder with exacerbations of significant chronic illness due to excessive alcohol intake. She has multiple comorbidities.

Naltrexone is probably the most appropriate medication option as it does not require absolute abstinence from alcohol. Depending on other history such as alcohol withdrawal, she may not be a candidate for outpatient detoxification. A tapering strategy would likely be safer. The fact that she is not taking it probably should not be considered a treatment failure. It has few side effects. Nausea usually resolves if the dose is titrated from 1/4 or 1/2 of a 50 mg tablet per day over a few days. If she can be convinced to resume taking it, it is a good option.

If she finds the naltrexone to be effective but has a hard time with compliance, then Vivitrol (naltrexone injection) would be an option at a significantly higher expense. This would have its own compliance issues as the patient must come in for monthly injections. This is most often started as part of a detox program. Inpatient detoxification can be considered with a 90-day program having better outcomes than 30 days or shorter.

Abstinence-based treatment or detox is always an option. For alcohol use disorders, this is usually an inpatient procedure due to the risk of seizures and the controlled medications used like phenobarbital or benzodiazepines. There are some outpatient protocols that do require daily monitoring. Abstinence-based treatment has fallen out of favor with many Addiction Medicine specialists who favor evidence-based treatments.

Gabapentin can be used for anxiety associated with alcohol withdrawal. This would be most appropriate if the patient significantly curtails her drinking as it is a CNS depressant. Higher doses can cause edema so 900 to 1800 mg per day would likely be the maximal dosing.

- Antabuse is an option; however, this requires abstinence and is not used as commonly these days.
- Acamprosate (Campral) is used to address craving, usually, after detox.

Sometimes topiramate is used off-label for alcohol use disorder. This may be something that would be considered in conjunction with psychiatry.

This patient is a good candidate for oral naltrexone, (also known as the Sinclair Method) to help reduce the amount of alcohol consumed. It will also reduce concerns of alcohol withdrawal complications, including seizures. The dose of naltrexone is typically 50 mg per day and does not have to be taken every day.

DETAILS (continued...)

Many people take it only when they are typically going to be drinking such as on weekends. Common side effects include nausea so have the patient take 1/2 pill a day for a couple of days at first.

Naltrexone is not a DEA Scheduled medication, is not addictive, and practically has very little toxicity although monitoring liver function periodically is recommended. The patient can not be dependent on opioids, or it will cause precipitated withdrawal. There is a good YouTube lecture by a woman named Claudia Christian (search: "TED Talk Sinclair Method"). Vivitrol is an extended-release monthly injection of naltrexone that can be used for patients who need more help with compliance.

An additional option that can be added is gabapentin 300 mg tid which helps with anxiety, insomnia, restless leg and can be taken indefinitely.

- There is anecdotal evidence that baclofen is effective for some patients in higher doses and is easily prescribed.
- Point-of-care urine drug screen to r/o other substance use such as opiates, benzos.

Use CIWA-AR Assessment for Alcohol Withdrawal screening questions to evaluate the risk of alcohol withdrawal. Patients with scores <8 typically do not require medication for withdrawal. This applies if the patient is going to stop drinking completely.

The patient should find a peer support or 12-step program that they fit in with including AA, Smart Recovery, Secular Recovery, or chemical dependency counseling. Most of these meetings are going to be virtual, these days. Virtual meetings are not as effective as in-person meetings, but they are more accessible online.

Follow-up within a few weeks to gauge the patient's progress. If testing is required, ETOH urine levels are not sensitive enough to determine compliance as alcohol is cleared within hours. Serum gamma-glutamyltransferase (GGT) or urine Ethyl glucuronide (EtG) / ethyl sulfate (EtS) will detect ETOH metabolites several days after use. Elevated liver function test (LFT) or fatty liver should be re-evaluated periodically over months.

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