# Medical issues in the office management of alcohol use disorders: Addiction care is primary care

## OFFICE MANAGEMENT OF ALCOHOL WITHDRAWAL

### INDICATIONS

Alcohol withdrawal can be managed in the office if the patient...

- Reports frequent withdrawal symptoms (tremor in the morning or afternoon, quickly relieved by alcohol).
- Is willing to start psychosocial treatment and/or anti-alcohol medications.
- Has no history of seizures, DTs, or hospitalizations due to withdrawal.
- Is not on high doses of opioids or sedating medications.
- Does not have cirrhosis with liver dysfunction.
- Has supports at home.

### BEFORE TREATMENT

Advise patient to have their last drink the night before the morning appointment. If patient shows up intoxicated, reschedule and/or admit to withdrawal management.

### Withdrawal scale – Sweating, Hallucination, Orientation, Tremor (SHOT)

| | |
|---|---|
| **SWEATING** | **0 – No visible sweating**<br>**1 – Palms moderately moist**<br>**2 – Visible beads of sweat on forehead** |
| **HALLUCINATIONS**<br>"Are you feeling, seeing, or hearing anything that is disturbing to you? Are you seeing or hearing things you know are not there?" | **0 – No hallucinations**<br>**1 – Tactile hallucinations only**<br>**2 – Visual and/or auditory hallucinations** |
| **ORIENTATION**<br>"What is the date, month, and year? Where are you? Who am I?" | **0 – Oriented**<br>**1 – Disoriented to date by one month or more**<br>**2 – Disoriented to place or person** |
| **TREMOR**<br>Extend arms and reach for object.<br>Walk across hall (optional). | **0 – No tremor**<br>**1 – Minimally visible tremor**<br>**2 – Mild tremor**<br>**3 – Moderate tremor**<br>**4 – Severe tremor** |

### PROTOCOL

Assess every 1–2 hours.

Administer benzodiazepines for SHOT ≥ 2, or definite tremor:

- Diazepam 10–20 mg (PO/IV) is first-line choice
- If patient is 60 or older, is on opioids or other sedating medications, has low serum albumin, or has liver dysfunction, use lorazepam 2–4 mg (SL/PO)

Interpret SHOT with caution if patient has a febrile illness, cerebellar disease or benign essential tremor, psychosis, dementia, impaired consciousness, or delirium not related to alcohol. Treatment is complete when SHOT ≤ 1 on 2 consecutive occasions, or patient has minimal or no tremor. Send the patient to hospital if patient has not improved or has worsened despite 1 or more doses; if they display marked tremor, vomiting, sweating, agitation, or confusion; or if they have risk factors for electrolyte imbalance or arrhythmias.

### ON LEAVING THE CLINIC

Initiate anti-alcohol medication. Advise patient to attend a mutual aid group or other psychosocial treatment program. Arrange follow-up in a few days (1–2 days if lorazepam was used). Ensure patient leaves accompanied by friend or relative.

If uncertain whether withdrawal is resolved, give 1-2 days' supply of diazepam 10 mg q4h (4–5 10 mg tablets) or lorazepam 1–2 mg q4H (10–12 1 mg tablets) for tremor, to be dispensed by partner if possible. Warn patients to stop their benzodiazepine if they resume drinking; when taken with alcohol, benzodiazepines can cause aspiration, trauma and other harms.

## PRESCRIBING ANTI-CRAVING MEDICATIONS

Anti-craving medications should be routinely offered to patients with AUD. They are safe and well tolerated, and there is good evidence that they improve drinking outcomes and reduce ED visits and hospitalizations. Read product monograph for full prescribing information.

| MEDICATION | ACTION | PRECAUTIONS/ CONTRA-INDICATIONS | ROLE IN TREATMENT | DOSE |
|---|---|---|---|---|
| NALTREXONE | Competitive opioid antagonist | Triggers withdrawal in patients on opioids<br>Use with caution in patients with severe liver disease | Reduces the reinforcing effects of alcohol<br>Indicated for mild, moderate, severe AUD | Initial: 50 mg OD<br>Max: 150 mg OD |
| ACAMPROSATE | Glutamate antagonist | Lower dose in renal insufficiency | Reduces subacute withdrawal symptoms (insomnia, dysphoria)<br>Start after a few days of abstinence | 666 mg tid |
| GABAPENTIN | Modulates dopamine | Can cause suicidal ideation (rare) | Reduces subacute withdrawal symptoms<br>May relieve anxiety | Initial: 300 mg bid–tid<br>Optimal: 600 mg tid |
| DISULFIRAM | Acetaldehyde accumulates if alcohol consumed | Can cause toxic hepatitis | Deters drinking. Most effective when administered by spouse or pharmacist | Usual dose 125 mg OD |

## DEPRESSION AND ANXIETY

- Always ask patients with alcohol problems about mood, and ask patients with mood problems about alcohol.
- Explain that abstinence or reduced drinking often markedly improves anxiety and depression over weeks/months.
- Strongly encourage anxious/depressed patients to participate in treatment for alcohol use disorder
- Routinely prescribe anti-craving medications.
- Prescribe antidepressants along with anti-craving medications for moderate to severe anxiety and depression.
- Sertraline is well tolerated. Use caution with bupropion in heavy drinkers at risk for withdrawal seizures.
- For anxiety, pregabalin or buspirone may be used in conjunction with SSRIs, as they have a faster onset of action (1-2 weeks). Buspirone should not be used with trazodone or MAO inhibitors.
- Refer patients with post traumatic stress disorder to seeking safety programs. Mindfulness, CBT, and Acceptance and Commitment programs are also helpful.

## OPIOID AND BENZODIAZEPINE PRESCRIBING IN PATIENTS WHO ARE ACTIVELY DRINKING

- Benzodiazepines and opioids increase the risk of falls and overdose, and can cause fatigue and depression.
- Benzodiazepine tapering is recommended especially if patient is on a daily dose of > 15 mg diazepam or equivalent, > 65 years of age, or has sleep apnea, falls, or mood disorder.
- If patient fails to respond to all non-opioid treatments, use small-moderate doses of weak opioids (codeine, tramadol products, buprenorphine patch) - < 50 mg MED. Avoid higher doses of potent opioids. Advise patients not to drink when taking acetaminophen-opioid products.

## INSOMNIA

Alcohol use exacerbates sleep apnea and contributes to hypertension, accidents, and arrhythmias. Abstinence or reduced drinking is the best management. Subacute withdrawal causes insomnia, dysphoria, and alcohol cravings in the first few weeks or months of abstinence. Acamprosate has been shown to improve insomnia and other withdrawal symptoms in abstinent patients.

For insomnia due to night-time alcohol use, behavioural interventions (e.g., CBT, progressive muscle relaxation) are more effective than medications. Two medications have been shown to improve sleep in heavy drinkers: Trazodone 50–200 mg (low risk of addiction) and gabapentin 300–1800 mg (can also reduce alcohol cravings).

CREATED BY
Mentoring, Education, and Clinical Tools for Addictions: Primary Care–Hospital Integration
Published by Families for Addiction Recovery (www.farcanada.org)
Endorsed by The College of Family Physicians of Canada