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Alcohol Use Disorder During the COVID-19 Pandemic: The Instrumental Role of the Primary Care Provider

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Objectives

1) Recognize the prevalence of alcohol use disorder and the harms associated with underdiagnosis and barriers to care, particularly during a pandemic
2) Utilize screening tools and apply DSM-5 criteria to detect alcohol use disorder in patients presenting for routine preventative care and/or chronic disease management
3) Perform a brief intervention followed by referral to treatment vs. treatment within the primary care setting based on level of acuity and patient goals
4) Leverage telehealth to reduce barriers to care for patients with alcohol use disorder

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Definitions: How Much is Too Much?

- Unhealthy alcohol use: Drinking in excess of guidelines
- Binge drinking: Exceeding the daily limit in a two-hour period
- Alcohol use disorder (AUD):
  - Unhealthy alcohol use meeting DSM-5 criteria
  - Cravings, Loss of Control, Consequences

	Drinks/Day	Drinks/Week
Men	> 4	> 14
Women	> 3	> 7
All Age >65	> 3	> 7

National Institute for Alcohol Abuse and Alcoholism

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Epidemiology

Pre-COVID19 (2/2020)

- Drinking in excess of guidelines: 30%
  - Similar to lifetime prevalence of hypertension
  - Third leading cause of preventable death in the U.S.
- Binge drinking: 23.4%
- Lifetime AUD: 29%

COVID19 (4/2020)

- Increased to 36%
  - Disproportionate increase among women and people identifying as Black non-Hispanic
- Increased to 28.4%

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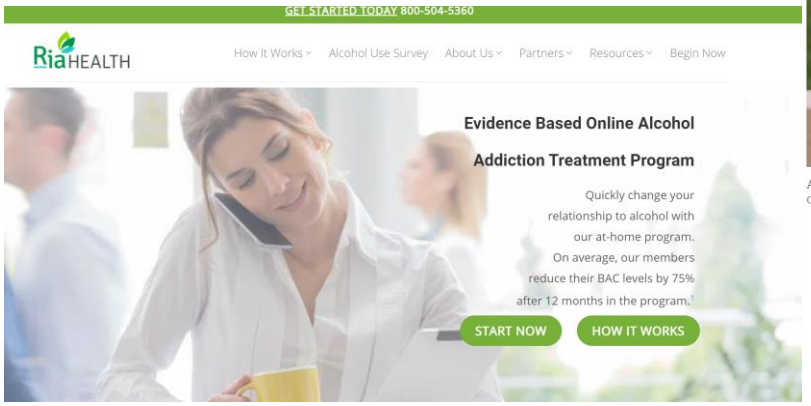
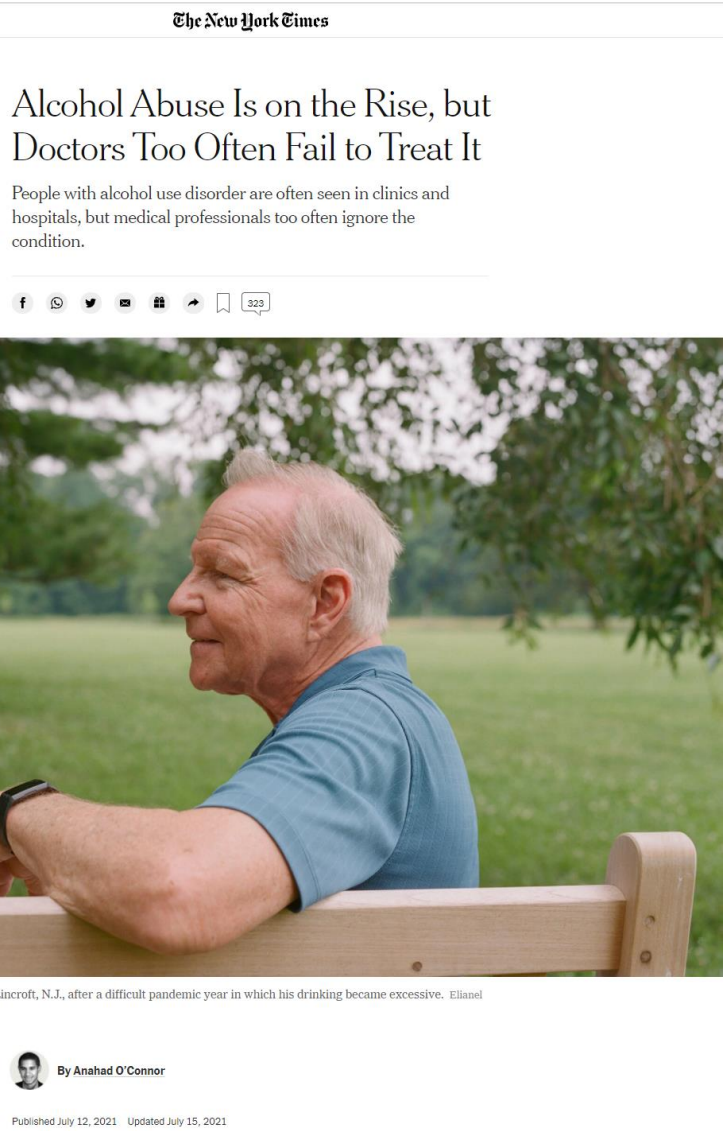
Underdiagnosis and Siloed Care

- 80 percent of people with AUD visited a medical provider within the past year
  - 70% screened
  - Under 12% received brief intervention
  - 5% referred to treatment
  - 6% treated
- Proliferation of separate telehealth programs during the pandemic
  - Cost? Coordination of care?





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Screening

- US Preventive Services Task Force recommends universal screening for AUD (Grade B)
- June 9, 2020: USPSTF recommends screening for unhealthy drug use in all adults (Grade B)
- Special importance during the pandemic: Psychosocial stress, job losses, increased idle time, addiction treatment facility closures

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Screening Tools

- NIAAA Single Item Screening Questionnaire
  - How many times in the past year have you had 5 or more drinks in a day (♂) or 4 or more drinks in a day (♀ or ♂ > 65 yo)?
  - Positive: >=1 or difficulty answering the question
  - For unhealthy drinking: 73% sensitive, 84% specific
  - For AUD: 86% / 74%
- Others:
  - AUDIT-C (requires scoring)
  - CAGE (less reliable)

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Diagnostic Framework: 3 C's

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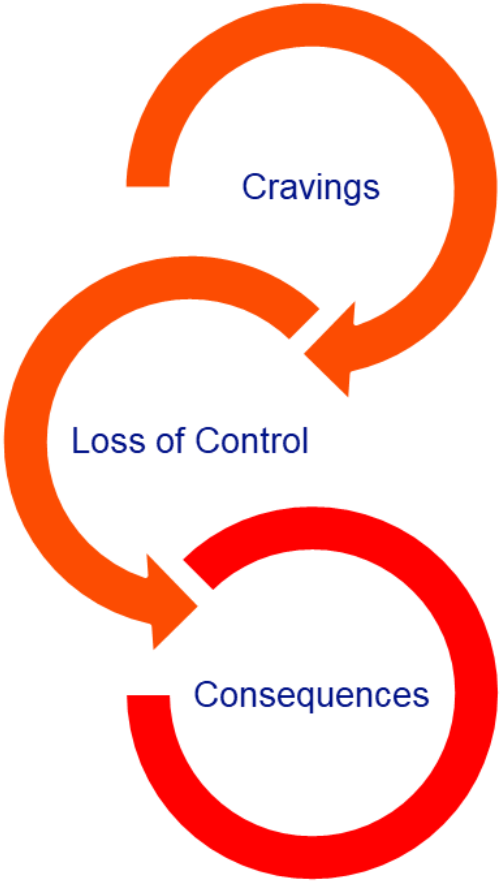
AUD DSM-5 Diagnostic Criteria



- 9 items of the 3 C's + tolerance, withdrawal = 11 total criteria
- 2 or 3: mild
- 4 or 5: moderate
- 6 or more: severe

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What Comes Next?

- Communicate the diagnosis in empowering language
  - "You meet criteria for a moderate alcohol use disorder"
  - NOT, "You have a drinking problem"
  - NEVER, "You are an alcoholic"
- Triage and assess patient goals
  - Pt at risk for withdrawal: CIWA, assess history of complicated withdrawal (seizures, delirium tremens), time since last drink
    - 48-72 hours and no (or very mild) withdrawal: reassuring
    - Before this window, treatment indicated
      - Inpatient if CIWA ≥15
  - If pt not ready to stop completely, no withdrawal risk
    - Brief intervention, pharmacotherapy to help cut down

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Case

- 55M with h/o GERD presenting for annual physical
- NIAAA Single Item Screen positive for ETOH; no other drugs
- On further questioning, alcohol use has increased during COVID19 from 2 drinks/day to 8 drinks/day
- Meets 5 of 11 DSM-5 criteria for AUD
- Bp 160/90 at triage, repeat 175/95, HR 90, repeat 99
- As visit continues, appears anxious, +mild tremor
- No diaphoresis
- Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR): 3 points

Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-Ar)

Nausea and vomiting
0: No nausea or vomiting
1
2
3
4: Intermittent nausea with dry heaves
5
6
7: Constant nausea, frequent dry heaves and vomiting
Paroxysmal sweats
0: No sweats visible
1: Barely perceptible sweating, palms moist
2
3
4: Beads of sweat obvious on forehead
5
6
7: Drenching sweats
Anxiety
0: No anxiety, at ease
1
2
3
4: Moderately anxious, guarded
5
6
7: Acute panic state, consistent with severe delirium or acute schizophrenia
Agitation
0: Normal activity
1: Somewhat more than normal activity
2
3
4: Moderately fidgety and restless
5
6
7: Paces back and forth during most of the interview or constantly thrashes about
Tremor
0: No tremor
1: Not visible, but can be felt at fingertips
2
3
4: Moderate when patient's hands extended
5
6
7: Severe, even with arms not extended

Headache
0: Not present
1: Very mild
2: Mild
3: Moderate
4: Moderately severe
5: Severe
6: Very severe
7: Extremely severe
Auditory disturbances
0: Not present
1: Very mild harshness or ability to frighten
2: Mild harshness or ability to frighten
3: Moderate harshness or ability to frighten
4: Moderately severe hallucinations
5: Severe hallucinations
6: Extremely severe hallucinations
7: Continuous hallucinations
Visual disturbances
0: Not present
1: Very mild photosensitivity
2: Mild photosensitivity
3: Moderate photosensitivity
4: Moderately severe visual hallucinations
5: Severe visual hallucinations
6: Extremely severe visual hallucinations
7: Continuous visual hallucinations
Tactile disturbances
0: None
1: Very mild paresthesias
2: Mild paresthesias
3: Moderate paresthesias
4: Moderately severe hallucinations
5: Severe hallucinations
6: Extremely severe hallucinations
7: Continuous hallucinations
Orientation and clouding of sensorium
0: Oriented and can do serial additions
1: Cannot do serial additions
2: Disoriented for date by no more than 2 calendar days
3: Disoriented for date by more than 2 calendar days
4: Disoriented for place and/or patient
Total score is a simple sum of each item score (maximum score is 67)
Score:
<10: Very mild withdrawal
10 to 15: Mild withdrawal
16 to 20: Modest withdrawal
>20: Severe withdrawal

Adapted from Sullivan JT, Skyora K, Schneiderman J, et al. Br J Addict 1989; 84:1353.

UpToDate

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Ambulatory ETOH withdrawal management

Criteria

- CIWA < 15
- Vitals stable
- No history of complicated withdrawal
- No significant medical or psychiatric comorbidities
- Able to take PO meds
- Capacity for daily or near daily follow up
- Reliable household member to supervise

Protocols

- Lorazepam 2-4 mg every 6 hours as needed on Day 1, 2 mg q6h prn Days 2-5

OR

- Diazepam 20 mg q6-12h prn Day 1, 10 mg q6-12h prn Days 2-5
  - Long-acting: avoid in patients with advanced liver disease

OR

- Benzodiazepine sparing protocols for very mild cases
  - Gabapentin
  - Carbamazepine

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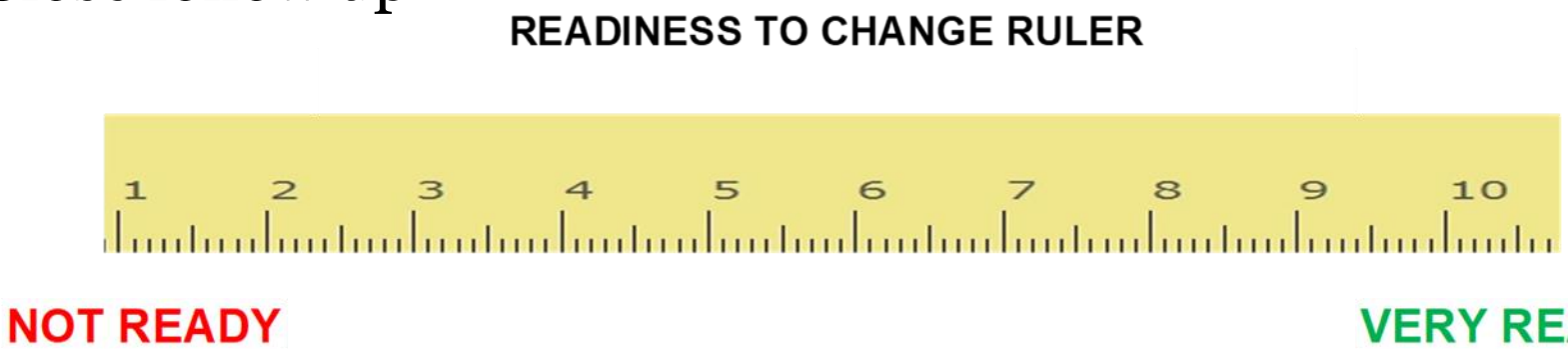
Patient not ready to stop: Brief Intervention

- Educate the patient
  - Show NIAAA guidelines
- Connect symptoms, medical problems to substance use
- Assess readiness to change
- Negotiate a goal
- Consider pharmacotherapy to help cut down
- Close follow up



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AUD: Vitamins

- Thiamine (B1)
  - 100 mg PO daily
  - Prevents Wernicke's Encephalopathy
  - Often not available at pharmacies; can order online
- Folic acid
  - 400 mcg – 1 mg daily

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Pharmacotherapy for AUD

- Simpler than treating diabetes!
- 3 FDA-approved medications:
  - Naltrexone
  - Disulfiram
  - Acamprosate
- Multiple off-label options
  - Beyond the scope of this talk
  - Feel free to reach out if interested!

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Naltrexone (PO Revia, IM Vivitrol)

- Mu opioid antagonist
- Decreases reward associated with alcohol
- Better evidence for reduction in drinking than for cessation
- Large study showed that naltrexone and support from a primary care practitioner had better outcomes than other medication and counseling options
  - Including specialty addiction counseling
- Well tolerated
  - Main adverse effect: nausea
  - Does carry warning of depression
  - IM formulation can cause injection-site reactions

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Naltrexone: Dosing, Administration

- PO dosing: 50 mg daily
  - Start with 25 mg for the first 2 days
  - Take on a full stomach to prevent nausea
- IM dosing: 380 mg monthly
  - Trial PO formulation x 1-2 weeks before transitioning to IM
- Monitoring:
  - Liver Function Tests
    - Monthly, then less frequently
  - Depression, suicidal ideation

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Naltrexone: Contraindications

- Opioid use
  - Screen for opioid use
  - Anticipated future opioid use (e.g. need for surgery)
  - Need 7-10 day opioid-free period before initiation
  - PO naltrexone should be stopped at least 72h before surgery
- Severe liver disease
  - Cirrhosis
    - May be safe in early, compensated cirrhosis
  - LFTs > 3-5 x upper limit of normal
  - Note: not hepatotoxic

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Disulfiram (Antabuse)

- Inhibits aldehyde dehydrogenase, an enzyme necessary for normal alcohol metabolism
- Leads to a buildup of the toxic acetaldehyde
- Patients will get sick when they drink!
  - Really sick - can cause arrhythmias
- Avoid in patients with cardiovascular disease
- Need to avoid ANY alcohol – including in cooking and mouthwash

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Disulfiram: Dosing, Administration

- Wait 48h after last drink before initiating
- 250 mg PO daily
  - Can start with a 500 mg load, but utility of this is limited
- Observed therapy is helpful

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Acamprosate: Dosing, Administration

- CrCl > 50: 666 mg PO tid
- CrCl 30-50: 333 mg PO tid
- CrCl < 30: Contraindicated
- Safe in liver disease
- Ideally started after a period of abstinence, but no contraindication to starting it while pt actively drinking

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Acamprosate (Campral)

- Exact mechanism of action unknown
- Thought to work on NMDA receptors to increase GABA transmission and decrease glutamate
- Evidence: Mixed
  - Most positive trials had a period of abstinence before initiating the medication
  - NNT to return to any drinking: 12
- Generally well tolerated
  - Diarrhea, vomiting may occur
  - Other adverse effects: depression, anxiety, rash, dry mouth, sweating

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Pharmacotherapies for AUD

	Pharmacology	Clinical Effect	Dosing	Adverse Effects	Contra-indications
Naltrexone (Revia [PO]; Vivitrol [IM])	Opioid antagonist (modulates reward pathway)	Decreases cravings	50 mg PO daily / 380 mg IM monthly	HA GI Upset (Depression)	Severe liver disease Opioid use in the past 7-14 days
Disulfiram (Antabuse)	Inhibits aldehyde dehydrogenase → Buildup of acetaldehyde	Produces nausea, flushing, palpitations with alcohol intake	250 mg daily *No alcohol x 48h before initiation	Arrhythmias with alcohol Hepatotoxicity Optic neuritis Peripheral neuropathy	Cardiovascular disease Other advanced comorbidities
Acamprosate (Campral)	Unclear; thought to work on NMDA receptors to balance glutamate/GABA	Prolongs period of abstinence once achieved	333-666 mg tid (renal dosing)	Well tolerated (Mild GI upset, dry mouth, rash, sweating)	CrCl < 30

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Nonpharmacologic modalities

- Self-help groups
  - Alcoholics Anonymous
  - SMART Recovery
  - Women for Sobriety
- Formal counseling if referral warranted

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Leveraging Telehealth for AUD Management

- Benefits
  - Reduces barriers to treatment
  - Frequent touchpoints
  - Improved adherence
  - Home environment assessment

Source: HHS.gov

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Challenges in AUD Management during the pandemic

- Fewer standard monitoring tools
  - Frequent use of tools that remain available
    - Checking CRISP
    - Involving family
  - Implement new tools
    - Home blood pressure monitoring
    - Observed medication-taking

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Back to the Case

- Pt ready to cut down but not quit
  - On readiness to change ruler, score of 6
    - Not lower because he sees connection to his GERD, is struck by how much more he is drinking than recommended limits
    - Not higher because “I’m not an alcoholic,” “I don’t have to drive to work anymore”
- Pt starts naltrexone
  - Appreciates that you did not “make him go to rehab”
- Cuts down from 8 drinks/day to 4 drinks/day over the next month
  - Finds he no longer desires additional ETOH after 3 or 4 drinks on a given occasion
  - LFTs – mildly elevated at time of physical, normalize on naltrexone

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Case Cont'

- GERD still uncontrolled, decides to stop ETOH completely
- Now accepts diagnosis of alcohol use disorder
  - "It explains why I didn't stop when I first got heartburn"
- Completes course of gabapentin for ambulatory withdrawal
  - Follows up daily x 2 days, then qod x 3 days via telehealth
  - No complications, continues naltrexone
- Starts attending virtual SMART Recovery meetings
- Self-discontinues naltrexone
- Few months later, back to the office, anxiety: resumes ETOH use
  - Quickly escalates to 8 drinks/day
  - Uncertain if he is drinking due to work-related anxiety vs if resuming drinking is leading to the anxiety symptoms

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Case: Conclusion

- Pt returns to your office for management
- This time, desires to stop ETOH immediately
- CIWA remains low, but due to risk of "kindling" phenomenon (each ETOH withdrawal episode may be more severe than the last), benzo protocol used
  - Daily telehealth monitoring x 3 days
- Naltrexone resumed after completion of withdrawal
  - Discussion of switching to IM formulation to improve adherence
- Resume peer supports
- Therapist referral for anxiety symptoms
- If anxiety persists despite 1 month of ETOH abstinence, consider independent anxiety disorder

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Take Home Points

- Alcohol Use Disorder is a prevalent chronic condition exacerbated by the COVID-19 pandemic
- Pharmacotherapy for AUD can be used to help patients reduce alcohol consumption and/or achieve total abstinence depending on patient goals
- Primary care providers can play an instrumental role in providing treatment for AUD that is patient-centered and tailored to readiness to change
- Telehealth can be leveraged to increase the frequency of safety monitoring for patients with AUD

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