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Treating Alcohol Use Disorder: Bringing hope, compassion and the opportunity for a full recovery

Written by Dr. Jeff Harries on May 10, 2021 for CanadianHealthcareNetwork.ca

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Alcohol Use Disorder is a highly treatable medical condition, like many other disorders we help our patients with.

Although significantly underused, there are many pharmacotherapies, with a strong evidence base supporting their use, that we can use to treat just about everyone. The medications can be started while the patient is still drinking or not, and can be used to achieve the patient's goals of reduced drinking or abstinence.

It's important we start to treat AUD differently. At least 20% of Canadians consume amounts above Canada's Low-Risk Drinking Guidelines, and this number is on the rise with the pandemic. In British Columbia, during the first three months of the pandemic, 30% reported increased consumption, with a 40% increase among young adults.

The option to send every person with AUD to a specialized treatment program may be a significant hardship on the patient and their family and is often unnecessary. There is a better way.

More and more physicians are prescribing medications for Alcohol Use Disorder and seeing successes first-hand is a great motivator. Here's just a small sample of my patients' feedback:

"The pills worked for me this week! Didn't drink since Sunday and today I've had 2 beers and I stopped. That never happens. I'm doing great!"

"I was totally surprised and I'm over the moon. It felt like I was given a lifeline."

Even amidst the pandemic, there's reason for hope. A mother wrote about her son's success with medication assisted AUD treatment last year: "Most people write off 2020, but my son says it's been the best year he's had in 20 years. He's loving this new life!"

Seeing how effective the right medication can be for patients gave me hope, as well as giving them, their family and their community hope that they could attain their goals—whether that was abstinence or reduced heavy drinking. And, the medications provide stability so that the work of healing and recovery, through counselling, cultural supports and family could take place.

Here's how I approached prescribing for AUD:

First, I'm thoughtful and methodical about trying each option before I can arrive at the best one for a patient. Over time, I learned that the most sensitive measure is that of the patient describing how they feel under different conditions or therapies. Like so many other conditions we treat, the patient's history and response to treatment can guide the choice of therapeutic options. The choices of medications include:

1. Naltrexone is a first-line therapy, an opiate receptor antagonist that makes alcohol less rewarding over time. It can be effective both at helping to reduce heavy drinking, as well as promoting abstinence from alcohol. The starting dose is

12.5mg BID x 3 days, with subsequent increases towards 50 mg as needed and/or tolerated. It can also be used on a prn basis using The Sinclair Method (TSM). Do not use naltrexone if a patient is taking an opiate or may need to take an opiate.

2. Acamprosate is another first-line therapy that is useful for patients to reduce their chance of going back to drinking once they have stopped. However, if the patient is still drinking or resumes drinking, acamprosate is less likely to be effective. The dose is 2 x 333mg TID, except if renally impaired.

3. Topiramate is also well-evidenced to help people both reduce or stop drinking. Start at a dose of 25 mg once daily or 12.5 mg BID and titrate up daily dose by 25 to 50 mg each week, to a target daily dose of 200 to 300mg as tolerated. Note that side effects of topiramate such as parasthesias, dysgeusia, and cognitive fogging may occur but are less common in people who find it effective.

4. Gabapentin has been shown to help people reduce or stop drinking. Start at a dose of 100-300mg TID titrate up to maximum of 1800mg daily as tolerated. Gabapentin has some additional safety considerations including physiologic dependence, potential for non-medical use and increased overdose risk.

More details on using these medications can be found in the BC Centre on Substance Use: Provincial Guidelines for the Clinical Management of High-Risk Drinking and Alcohol Use Disorder. An important message is that one of these medications can help someone suffering with AUD. Choose the medication most likely to work, but if it doesn't then try the next most likely. If none of the first or second-line therapies described in the BCCSU AUD Guidelines work, an addictions specialist may suggest a trial of other pharmacotherapies that early research shows may work for particular sub-groups of patients (micro-dose ondansetron, baclofen, varenicline, prazosin and others).

Patients don't necessarily need to be on these medications forever. A trial of three to six months is usually recommended, depending on the circumstances, with the option to continue for as long as the patient feels as if the medications are helpful, and they may be restarted if a relapse occurs. It's important to understand that counselling, reconnection to family and culture and providing required supports may all be necessary as well to ensure the quickest, most lasting recovery.

It's so important to impart hope to the patients, families and to society as a whole by both helping people understand AUD as a chronic disease of the brain, and also changing the perception of this disorder to help eliminate stigma. Like other medical conditions it deserves to be treated with compassion.

A few years ago, I started out advocating for these new treatments and for a more compassionate perception of this disorder in our local health authority. With success, I travelled B.C. and into western Canada spreading the word to thousands of clinicians, and to those who work in fields that are affected by AUD, including supreme court judges, counsellors, addictions clinicians and many community leaders. I'm also pleased to have worked on the B.C. Centre on Substance Use AUD Clinical Management Guidelines, which were updated in 2019 and informs all AUD care in BC. Unfortunately, I developed ALS over the last three years and am no longer able to continue this work.

In September 2020, I helped found the Canadian Alcohol Use Disorder Society, to spread the word on a national scale. Activities include the development of clinician prescribing resources, patient resources, informational and training videos and much more, which can be found on our website. We also continue with presentations, research and care improvement projects, most recently a quality improvement project for a better AUD care pathway in emergency departments. The unnecessary suffering that untreated or under-treated AUD causes must end and an understanding of what level of alcohol use puts us at risk for poor health must be more broadly appreciated. Please visit our website for more information.

Dr. Jeff Harries worked as a general practitioner in Penticton, B.C. for more than 30 years.