Alcohol Use Disorder

Rapid Clinical Updates
Society of Hospital Medicine

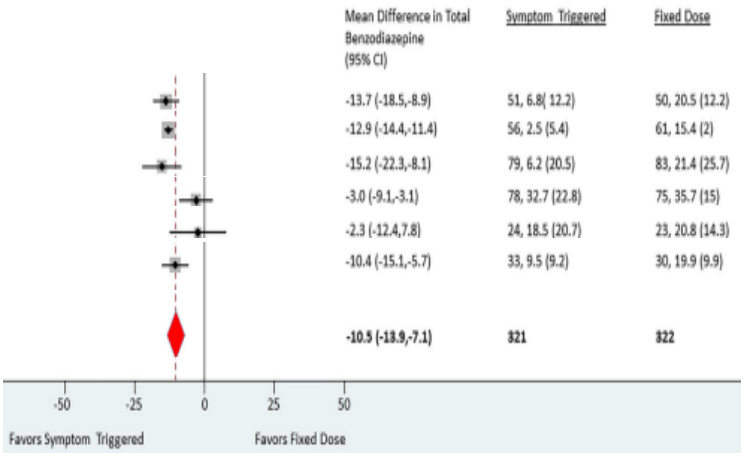
The AUD Endemic

Context: The incidence of AUD is high and rising. Patients with AUD are at high risk for bad outcomes.

Current: AUD is diagnosed via the 5 Cs (Control, inability to Cut down, Compulsive use, Craving, Consequences) and 3 Rs (Role failure, Relationship issues, Risk of harm).[1] Patients with AUD are at high risk for withdrawal syndrome during admissions.

Cutting Edge: An Audit Score (10 questions, cutoff ≥8)[2] and PAWSS score (10 questions, cutoff ≥4)[3] can predict risk of withdrawal during hospitalization.

Alcohol Withdrawal Treatment



Context: Benzodiazepines reduce withdrawal symptoms and risk of seizure.

Current: Symptom-based benzodiazepine dosing (as compared to fixed-dose) results in shorter duration of treatment and less consumption of benzodiazepines without apparent increase in seizures, delirium, or mortality.

Cutting Edge: Phenobarbitol provides gaba inhibition with rapid onset, long duration of effect, and wide safety margin. It may a useful adjunct or as monotherapy.

AUD Treatment

Context: AUD is a relapsing condition that can be managed with long-term prescription medication.

Current: Residential, ambulatory, community-based, or faith-based rehabilitation programs can all be helpful at maintenance of alcohol cessation. Current FDA approved treatments include naltrexone (PO or IM), acamprosate, or disulfiram

Cutting Edge: Hospitalists can and should assess patients for AUD and discuss initiation of therapy during inpatient admissions in order to improve patient outcomes and healthcare utilization.

Medication	Mechanism of Action	Route	Dosage	Indication	Contraindication	Clinical Pearls
Naltrexone (Revia®)	Opioid antagonist/decreases reinforcing effect of EtOH	PO	50 mg/d	Reduction in EtOH or Abstinence	Opioid dependence or active use disorder/agonist Rx	Can start if actively drinking or abstinent
Naltrexone (Vivitrol®)	Opioid antagonist/decreases reinforcing effect of EtOH	IM	380 mg IM/mo gluteal	Reduction in EtOH or Abstinence	Opioid dependence or active use disorder/agonist Rx	If rapid start, observe tolerance of oral dose first at least 60 mins prior to injection
Acamprosate (Campral®)	Unclear: GABA receptor agonist/NMDA modulator/glutamate inhibitor	PO	666mg TID	Abstinence	Severe renal dysfunction	Consider 999mg bid if cannot tolerate TID dosing. Best outcomes if start at least a few days after EtOH cessation
Disulfiram (Antabuse ®)	Aversive, aldehyde dehydrogenase inhibitor causes accumulation of aldehyde	PO	250-500 mg/d	Abstinence	Pregnancy, Elderly, Esophageal Varices, CAD, Nickel Allergy, Active EtOH	Reserved for those patients with clear desire and ability to abstain. Not recommended as first line agent. Can be helpful in risky situations, "prn" Caution with hand sanitizer/mouthwash/other alcohol containing products

References:

1. Battle et al. Diagnostic and Statistical Manual of Mental Disorders (DSM). Codas. 2013;25(2):191-192.
2. Dolman et al. Combining the Audit Questionnaire and Biochemical Markers to Assess Alcohol Use and Risk of Alcohol Withdrawal in Medical Inpatients. Alcohol Alcohol. 2005;40(60:515-519.
3. Maldonado et al. Prospective Validation Study of the Prediction of Alcohol Withdrawal Severity Scale (PAWSS) in Medically Ill Inpatients. Alcohol Alcohol. 2015 Sep;50(5):509-518.
4. Holleck et al. Symptom-Triggered Therapy for Alcohol Withdrawal Syndrome. J Gen Intern Med. 2019 Jun;34(6):1018-1024.