Diagnosis and Treatment Retention Podcast
Episode Two: Treatment

NOTE: Please be sure to download the provider and patient handouts that accompany this activity, at the website.

[Music]

Ilana Hardesty: Welcome to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's new podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. I'm Ilana Hardesty, your moderator. This series consists of three episodes. If at any point you want more information on receiving credit for this course, please visit the website that is linked in the podcast description. There are also resources that accompany this series. All of them can be found at that website. In this episode I'll be speaking with Drs. Daniel Alford and Alyssa Peterkin. Dr. Alford is a primary care physician and Dr. Peterkin is a hospitalist at Boston Medical Center. Both are addiction medicine specialists and are on the faculty at Boston University. We'll be discussing the treatment of patients with alcohol use disorder. We'll also meet Jeanette, a real patient in recovery from alcohol use disorder and hear about her lived experience.

Let's start with the case scenario. Robert Sterling is a 42-year-old man who presents for a first visit to primary care with his wife. His previous primary care physician retired. He has a history of high blood pressure, which is controlled with lisinopril. He was recently fired from his job as a car salesman. His wife is very concerned about her husband's drinking and thinks he needs help.

Dr. Alford: Hi Mr. Sterling; nice to meet you.
Robert: Nice to meet you.
Dr. Alford: And you are?
Sue: I'm Sue…Bobby's wife. He didn't want me to come but I'm worried about him…
Dr. Alford: Well, it's very nice to meet you too. So, what are you guys worried about?
Robert: I am not worried…she's just overreacting as usual and thinks that I drink too much.
Sue: I'm definitely not overreacting…It started with drinking on the weekends while watching football. Now that he's no longer working, he drinks every day at a bar with his friends.

Robert: I am looking for work and have a few interviews lined up…but I drink to relax. Ever since I was fired life has been really stressful for me and she knows that…
Sue: Because he's drinking so much he missed work at the dealership, which I'm sure is why he was fired. And he's missed our daughter's soccer games even though he promised her that he would be there...it's just gotten really bad.
Robert: I mean you know I hated that job and I was going to quit anyway…and I told you I am sorry about missing Stephanie's games…
Sue: He needs help…
Robert: If I need to stop I can do it on my own…doc, I'm sure you drink…right?

[Music]

Ilana Hardesty: We'll discuss treatment options for this patient. But before we do, how do you approach a patient who seems to minimize the impact drinking is having on his life? Dr. Alford?

Dr. Alford: So, I would consider this patient pre-contemplative. That is, he's either unconcerned about his current drinking or he may be concerned, but he's just not ready to change. And how do I approach a patient like this? Well, the goal is fairly simple. It's to kind of increase the patient's consciousness of the problem. And how do we help move patients? Well, we try to develop rapport and build trust and build an alliance. And we want to express our concern and leave the door open in case they change their mind. We want to state the problem non-judgmentally and even advise a trial of abstinence or cutting back. And it really is important to arrange close follow-up, even if the patient is still drinking. And overall, less intensity is better than more intensity in terms of your interaction.

Ilana Hardesty: So what would be your specific approach for a patient like Mr. Sterling?

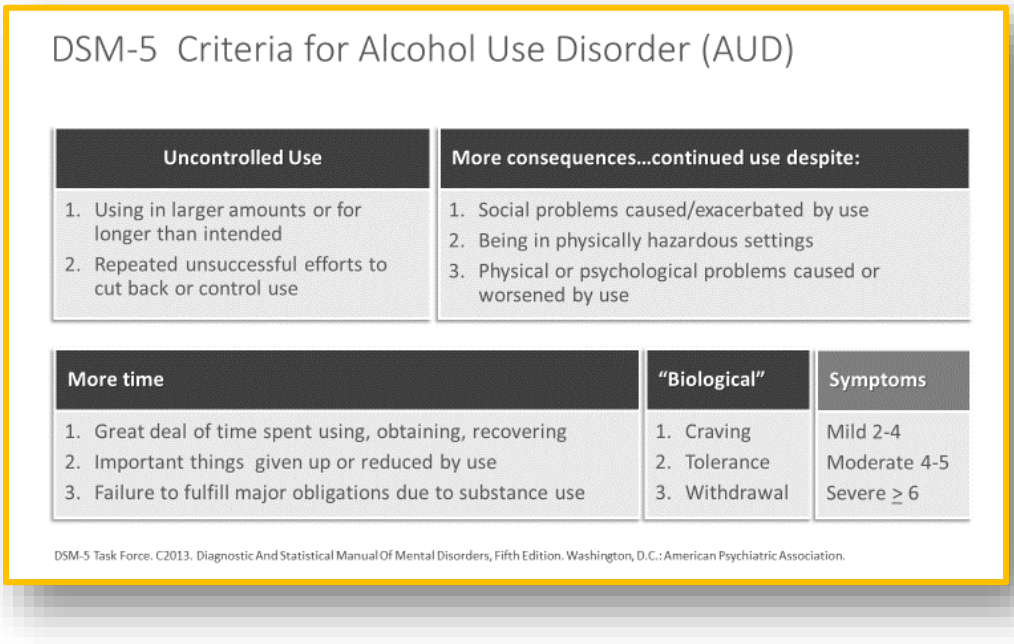
Dr. Alford: We did talk about Brief Negotiated Interview skills in Episode One, and I would use many of the skills there, such as asking permission to discuss the patient's drinking and before giving information, eliciting

what they already know, provide the information you want to provide, and then elicit their response to what you just gave them. And you want to make sure that before the patient leaves your office, that they're informed about the risks that you're worried about, that, ultimately, it's up to them to control their behaviors. Now, in terms of responding to this patient where he said, 'I can do it on my own,' that's a great opportunity to say, 'okay, why don't you give it a try and then come back and tell me how you did. It doesn't have to be a very long try. Just give it a try and see how it goes.'

Ilana Hardesty: I'm curious if and how you would respond to this patient when he asked you if you drink.

Dr. Alford: I'm not really that interested in talking about my behaviors, so I turn it around back to him and I say, "Why do you ask?" And he'll usually respond something like, "Well, drinking is common. I mean, all my friends drink…" and basically the conversation turns back to the patient as opposed to you.

Ilana Hardesty: Does this patient have an alcohol use disorder? What makes you say one way or another?



Dr. Alford: Yeah, it's an important question. And we know that alcohol use disorders are actually common in our country. Over 28 million US adults have an alcohol use disorder; that's about 11% of our adult population. So how do you diagnose it? Well, you really need to go the Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition or DSM-5. And we're going to do is look at the 11 signs and symptoms that are listed in that diagnostic criteria. If you have two to three, you're considered to have a mild disorder, four to five, a moderate disorder, and six or more

considered to have a severe disorder. And I really like to break them up into three major chunks.

One is biological. Does this person have tolerance? That is, they're able to drink more and more and tolerate more and more. Withdrawal: that is, if they stop drinking, do they go through withdrawing it sick? And are they craving or having an urge to drink? Those are all biological.

And then there are the symptoms of loss of control. That is, are they using larger amounts over longer periods of time? Are they unable to cut back or cut down or control use? And are they spending a whole lot more of their time during the day trying to use the substance that you're worried about?

And then finally continued use despite harm. That is, the patient is drinking and they're failing at home and at work and at school. They're having all kinds of interpersonal problems like this patient. They're reducing other activities because of their substance use. They have physical and psychological harm and they're using in hazardous situations such as, is he driving while he's drinking?

Ilana Hardesty: Dr. Peterkin, I know that for some patients, alcohol withdrawal can be severe and even fatal. Are you worried that if this patient stops drinking, he will go into alcohol withdrawal?

Dr. Peterkin: So it's certainly possible that this patient will experience alcohol withdrawal. We know that about half of people who stop drinking abruptly will have some form of alcohol withdrawal syndrome, and about maybe 10% will actually experience severe alcohol withdrawal. So these are sort of helpful statistics for us to keep in mind and counsel patients on.

Ilana Hardesty: So how can one determine if this patient can safely stop drinking? How would you know if he is in the 10% who will have severe alcohol withdrawal?

Dr. Peterkin: When we think about how do we assess or treat alcohol withdrawal safely in an outpatient setting, there is one tool in particular that I find helpful. The PAWS, or the Prediction of Alcohol Withdrawal Severity, is a tool that can be used to predict complicated alcohol withdrawal. While it was developed primarily to assess hospitalized and medically ill patients, it's often a tool that people use to help predict if someone is at risk for severe alcohol withdrawal. But when I'm, you know, thinking about who might be at risk or who might it not

be safe to manage in an outpatient setting, there are a couple of important pieces of a person's history that are helpful.

Asking a patient if they have had a history of severe alcohol withdrawal; so have they had any delirium tremens or withdrawal seizures in the past? How many times have they experienced alcohol withdrawal? We know that for each time someone experiences alcohol withdrawal, they're sort of more at risk for having a more severe episode on subsequent alcohol withdrawal episodes. I always say that age is important to consider, but it's not an exclusion criterion for someone to complete an outpatient alcohol withdrawal protocol. Other things that I think about are their vital signs. Are they very tachycardic? Is their blood pressure really high? That might be an indicator that their withdrawal course is going to be more severe. And if they have another use disorder like a benzodiazepine use disorder, or they have some sort of physiological dependence on GABA agents or benzodiazepines, that might make me very, you know, cautious about managing their alcohol withdrawal in the outpatient setting.

That being said, there are plenty of people that do benefit and do well from alcohol withdrawal management in the outpatient setting. And it's not just managing their withdrawal. It's also thinking about, you know, what are the next steps? How do we keep them in recovery or keep them on their goals? Some people might want to stop drinking or cut down, but how do we think about that in the long term? So it's not just managing their withdrawal, it's supporting them in their recovery.

Ilana Hardesty: How do we do that? What are the long-term treatment options for a patient like this?

Dr. Peterkin: My alcohol use disorder treatment toolbox starts with medications. So there are three FDA approved medications: naltrexone, acamprosate, and disulfiram. I start by talking about which medication might be easier for patients to take. So naltrexone is once a day. It also comes in the injectable formulation. So, someone doesn't have to remember to take a medication every day, they just have to remember to show up for their subsequent injection. And we know that naltrexone, you know, is most efficacious in reducing heavy drinking. And then I move on to acamprosate. So, if for some reason a patient is not a candidate for naltrexone, for example, they are taking an opioid pain medication or they have maybe decompensated liver disease, then I talk about acamprosate, which has a heavy pill burden. So it's a medication that someone has to take three times a day. So I'm very upfront with saying, you know, that you're going to have to take this three times a day and having the patient think through if they would be able to do so. And also letting them know what the adverse reaction is, which the most common one is diarrhea, and also letting them know that if they were to

develop any form of kidney failure, the medication may need to be stopped or the dose might need to be decreased. I end with talking about disulfiram. So letting patients know that this is a medication that if you drink alcohol and take this medication, it will make you sick. I think a lot of people have experience or maybe have heard of disulfiram in social settings. So they initially think that maybe all of the medications for alcohol use disorder have that same mechanism of action. But I let them know that it's disulfiram and sort of what to expect. And the biggest thing I counsel them on is if any form of alcohol, any amounts while consuming disulfiram, will cause that nausea, vomiting, palpitations known as a disulfiram reaction. So those are some of the key things that I review with patients. And just to sort of review some of the efficacy for acamprosate, we know it has a modest effect on abstinence and for disulfiram, we know that it mostly works when people are in a monitored setting. So if they have someone who's holding them accountable for taking the medication or if there's some other structured supervision program, we know that sort of that is where the data supports disulfiram.

Ilana Hardesty: Now let's hear from Jeanette, a patient in recovery, about her experience with naltrexone.

Jeanette: I heard about it from my primary. And when I started the medication, it was all about me just trying to stop drinking. The only one I tried was naltrexone. I really didn't feel anything. It might have slowed down the drinking, but I don't think it kind of stopped the cravings, you know. I don't think it worked out well. I mean, I would recommend the medication. I mean, if it if it helps somebody, by all means, definitely do it. Trying to break the cycle of being an alcoholic is very, very hard. So if a medication can help, then by all means use it.

Ilana Hardesty: Dr. Peterkin, you mentioned the three FDA-approved medications. Are there other medications that can be used?

Dr. Peterkin: The non-FDA-approved medications, off label, for alcohol use disorder, gabapentin, topiramate and baclofen. I primarily talk to patients about gabapentin and topiramate because they sort of have the stronger evidence compared to baclofen. But that being said, topiramate particularly has a lot of adverse reactions. So, it's sort of a risk-benefit: looking at each medication, especially the off-label medications.

Ilana Hardesty: You really don't hear about many patients with alcohol use disorder being treated with any medications. Is that true? And if so, why?

Dr. Peterkin: Unfortunately, that is true. Medications for alcohol use disorder are severely underutilized. About 1 to 2% of people receive a medication for alcohol use disorder. That being said, treatment in general for alcohol use disorder is very, very low. Less than 10% receive treatment. That could be for a variety of reasons. If you think about someone coming into a primary care appointment, you know, maybe their blood pressure is high, maybe they're having some mood dysregulation on top of having an alcohol use disorder. The doctor, the nurse practitioner, the PA now has to decide sort of how can I address all of these in this short period of time? So there are competing priorities. Also you know, prescribers may not feel comfortable prescribing these medications. They might feel like they don't have enough knowledge. And so that may make them less inclined to start them or even talk to patients about them and would want to refer them to a specialist. But if there's no specialists in the area, that should not mean that the patient or the person who needs treatment should not have the opportunity to hear about those options.

Dr. Alford: It's interesting because the two examples you gave for competing priorities, you know, the patient might have high blood pressure, they may have a mood problem. And I think of both of those things as potentially related to their alcohol use. So maybe it's worth prioritizing the alcohol use in a patient or a situation like that. But just to say that these medications are extremely easy to prescribe and monitor. The complexity is treating the addiction or the alcohol use disorder, because these medications have a modest effect. It means we should be using them, but we need to think about other treatments concurrently. But we prescribe a lot of complicated medical regimens in primary care. And this is this is not one of them.

Ilana Hardesty: What are some non-pharmacological options?

Dr. Peterkin: I do work on getting them connected to therapy, counseling, mutual support groups, Smart Recovery, Alcoholics Anonymous, those are other options as well. And letting patients know what to expect when attending these groups and letting them know that they have different themes. And it's often worth attending more than one and seeing if it really suits them rather than just turning down the first meeting if it doesn't suit them.

Dr. Alford: So, Alyssa, let me ask you a question. I often recommend AA to my patients, and I would probably recommend it to the patient that we presented in this episode. And I have a lot of patients who decline; who say, "No, thank you," for whatever reason. Sometimes they say it's too religious. So how would you recommend talking to patients about going to an AA meeting?

Dr. Peterkin: I would say, first of all, that there are different themes to these AA meetings, so some might feel more religious than others. And I think that having the different themes helps you connect with the group. And so, I encourage patients to try a couple of meetings with different themes to see if one particular theme might work better than another. I find that a lot of my patients, especially in the pandemic, have lost a lot of their core support. And so engaging in these meetings is a way for them to find a new support network and help them achieve their goals. I wouldn't say that all AA groups are super-religious and that even if someone does not identify as religious or spiritual, it's still something to consider looking into.

Dr. Alford: Yeah, and I agree with everything you said, and I certainly have had patients talk about the spirituality rather than the religious nature of it. I totally agree with the social support structure that is involved. But there's also role modeling. Patients can identify a sponsor, someone at the meeting who's been there a while, who's in remission, who they can connect with and be able to call when they're running into problems. And it's really about sharing stories and not being judged based on your story, because everybody has their own story. It offers hope to people. So I think it can be a very scary endeavor for a patient to go to that very first meeting. I usually ask, you know, do you know anybody that goes to AA and maybe you could go with them and experience your first meeting with somebody who's familiar with it. But it can be very scary for your patient.

Ilana Hardesty: Let's hear again from Jeanette, about her experience with Alcoholics Anonymous.

Jeanette: I was nervous. And shy. Quiet. Yeah, I didn't really feel the vibe. So that's why I went somewhere else. A friend suggested the meeting. Um, second experience was good. I had more people that I could relate to, more people that, you know, noticed that I was a newcomer who welcomed me in the group, made me feel comfortable. I just go to the meetings. I listen to what they say. I come home, I pray. I just I kind of keep to myself so that I could get through it. And I thought about getting a sponsor, but maybe I should. I was going through the meetings almost every day. And now I'm going maybe two or three times a week, depending on what I have going on.

[Music]

Ilana Hardesty: Thank you, Dr. Daniel Alford and Dr. Alyssa Peterkin for this conversation today. Thanks as well to our patient, Jeanette. And thank you for listening to *Managing Unhealthy Alcohol Use in Clinical Practice*, Boston University's newest podcast discussing best practices in the diagnosis and treatment of alcohol use disorder. In this episode, we discussed the

treatment of patients with alcohol use disorder. Join us next time for episode three, where Dr. Alford and I will be joined by Annie Potter, a nurse practitioner who is an addiction specialist. We'll discuss the continued case of Robert. After multiple follow up visits, Robert was unable to stop drinking on his own and reluctantly agreed to try naltrexone and go to an AA meeting. We'll discuss how to keep patients like Robert engaged in their treatment for alcohol use disorder.

This educational activity is funded by an educational grant from Alkermes. Production by Rococo Punch. Please visit the website linked in the program description for visuals, resources, and other relevant materials. To receive credit, you'll need to listen to all three episodes and then go to the website to complete a post-test and evaluation. I'm Ilana Hardesty. Thanks for listening.