

# The Prudent Prescriber

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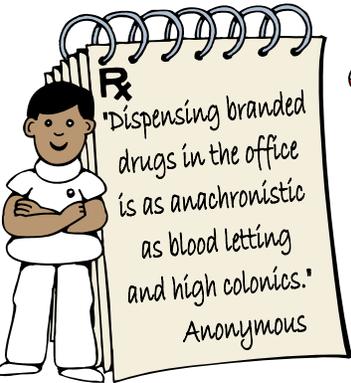
## November 2018

Pharm Reps  $\neq$  Rational Prescribing

(PR)



(RP)



This month's Prudent Prescriber is the work of J.K. Costello MD, MPH. Dr. Costello works with the Steadman Group, a Denver-based, woman-owned consulting firm which is unaffiliated with the Vail orthopedic group. He currently is assisting RMHP with developing their substance use disorder prevention and treatment initiatives in Western Colorado. He has no conflicts of interest regarding any drugs mentioned herein.

Pour Decisions

While opioids have stolen the show over the last five years, alcohol is still king when it comes to substance use disorders. The yearly prevalence of moderate or severe alcohol use disorder (AUD) is 6.7%, making it about 5 times more common than opioid use disorder. (NESARC, 2015) Deaths from alcohol -- 88,000 in 2010--still significantly outpace opioid-related deaths (CDC).

Despite the significant morbidity and mortality from alcohol, less than 10% of those affected received formal health care treatment for their alcohol use in the last year. (NSDUH, 2015) Far fewer received the most evidence-based medical treatments available, all of which are available for use by primary care doctors. Most of them are inexpensive, generic medications. Why does treatment for AUD lag so far behind the evidence for effectiveness?

Antibiotics do NOT



help acute bronchitis

**$\beta$ -blockers in post-MI save lives**



Pill splitters save BIG



## CHE?

Think:

**Ace**  
**Aldactone**  
**B-blocker**  
**Dig**  
**Diuretic**



Avoid these expensive "me-too" drugs:

 Intermezzo  
Vimovo  
Livalo  
Gralise  
Viibryd  
Edarbi  
Daliresp



Treat patients > 60 years to 150/90



**NOW AVAILABLE**  
ON THE  
**GENERIC MARQUEE**

Viagra  $\rightarrow$  sildenafil  
Effient  $\rightarrow$  prasugel  
Strattera  $\rightarrow$  atomoxetine  
Asacol HD  $\rightarrow$  mesalamine DR  
Pristiq  $\rightarrow$  desvenlafaxine

The answers are disparate. Many doctors -- myself included -- were encouraged to send patients with AUD to Alcoholics Anonymous. Then we were given mixed messages about its effectiveness (it's about as effective as CBT). We weren't informed that medications for AUD are effective or given an algorithm for using them. And finally -- as with treatments for other types of substance use disorder -- we struggled with the integration of medical and behavioral therapies, believing that they must be delivered together to be effective.

The first step in better treatment of AUD is identification. Despite the knowledge that AUD is prevalent in primary care settings, AUD itself is often not identified as the presenting problem. Screening all patients and particularly those with any condition associated with alcohol -- hypertension, insomnia, falls -- can be done easily with a single question, "Have you had four or more drinks on any occasion in the last year?" (NIAAA) The USPSTF prefers this method of screening along with AUDIT (a 10 item screening test). Many practitioners use CAGE as well due to its ease of use. For diagnosis, refer to the DSM-V criteria; 2-3 symptoms are mild, 4-5 moderate, and 6+ severe. For mild AUD or people without AUD but concerned about their drinking, brief counseling and advice have been shown effective (Bertholet 2005)

For moderate and severe AUD, primary care management is effective. Pharmacotherapy and counseling in a primary care setting have been shown to be non-inferior to specialized addiction treatment. (Miller 2011) Prior to selection of a medication, agreement on the goals of therapy-- abstinence versus reduction in drinking-- is essential.

There is a range of acceptable medications; three are currently FDA-approved for treatment of AUD. Naltrexone and acamprosate both have A ratings from the AAFP for treatment of AUD (Winslow 2016). The number needed to treat is 12 to reduce heavy drinking (naltrexone) and to maintain abstinence (acamprosate) (Jonas 2014). Often, naltrexone is used to help people cut down on heavy drinking while acamprosate is used for abstinence. The primary contraindication for naltrexone is liver failure and for acamprosate, renal failure. Disulfiram, the third FDA-approved medication, is used rarely in clinical practice, although it has been shown to be effective when taken under supervision (Jorgenson 2011).

If these medications are contraindicated, not tolerated or not effective, fear not. There is a growing body of research on off-label medication use for AUD. While naltrexone and acamprosate are the first-line agents for AUD, there are many second-line medications for treatment of AUD, especially for people with certain comorbid illnesses.

Gabapentin, in a medium-sized RCT, significantly increased rates of both abstinence and no heavy drinking in a dose-dependent fashion (Mason 2014). Topiramate has shown effectiveness in several RCTs at reducing drinking as well as PTSD symptoms; utilization of this medication has more than doubled in the VA population (Del Re 2013). Ondansetron has also shown promise in reducing drinking, particularly among people with early-onset AUD (Johnson 2000). The latter two medications-- topiramate and ondansetron-- carry B ratings from the AAFP for treatment of AUD, while the American Psychiatric Association recommends gabapentin and topiramate as second-line agents (APA 2018)

Baclofen, despite some ballyhoo, was not superior to placebo in a recent RCT (Hauser 2017). Antidepressants -- while effective in reducing drinking in people with comorbid AUD and depression are not effective in treating primary AUD.

Medications for AUD are, nearly across the board, affordable. Prices for a 30-day supply of medication range from \$8.69 for topiramate to \$29.11 for oral naltrexone and \$67.50 for acamprosate. These medications are on formulary with most insurance plans and available without prior authorization; furthermore, they're a bargain, given that medical costs decline by an average of \$3,000 for people with SUD on medical treatment (Hartung 2014).

## Take-home points:

- Screening with a single question, CAGE, or AUDIT is recommended in primary care
- Brief advice is effective for binge drinking and mild AUD.
- Pharmacotherapy plus counseling is the standard of care for moderate and severe AUD and is as effective as referral to a specialist.
- First-line treatments are naltrexone or/and acamprosate.
- Second-line treatments include gabapentin, topiramate, and ondansetron.
- Refusal or lack of attendance at counseling does not warrant discontinuation of medication if there is clinical improvement.

Grant: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5240584/>

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