# Emergency Department Management of Alcohol Use Disorder

## Additional Clinical Guidance

- Alcohol use disorder (AUD) is a treatable health condition. Recovery often requires multiple treatment attempts.
- AUD is highly prevalent and undertreated, with less than 2% of patients receiving evidence-based medications. An ED encounter is a valuable opportunity for intervention.
- Patients with AUD are stigmatized. Stigma prevents people from seeking care and worsens health outcomes. Providers should challenge biases to provide compassionate, evidence-based care.

### Assessment

- Assess for opioid dependence and opioid use disorder (OUD) prior to initiating naltrexone.
- Consider screening for mental health comorbidities and referring to psychiatry as appropriate.

### Pharmacotherapy

Use the following table and additional information below to aid in decision-making.

| MEDICATION CONSIDERATIONS | | | | |
|---|---|---|---|---|
| **Medication** | **Dose** | **Caution** | **Contraindication** | **Additional Indications and Benefits** |
| **Naltrexone** | 380 mg IM monthly OR 50 mg PO daily | | Opioid dependence, severe hepatic impairment | Methamphetamine use disorder, protection from accidental opioid ingestion |
| **Gabapentin** | 300-600 mg TID | | Age >65, renal impairment | Alcohol withdrawal, anxiety, neuropathic pain |
| **Acamprosate** | 666 mg TID | Moderate kidney dysfunction, body weight <60 kg (start at 333 mg TID) | Renal impairment | |
| **Topiramate** | 50 mg daily starting dose x 2 weeks<br><br>Follow up for dose escalation up to 150mg BID | History/risk of seizures, CKD, low BMI, advanced age, cognitive dysfunction, brain injury | Pregnancy, renal impairment, glaucoma | Cocaine use disorder |

- **Naltrexone**
  - **Do not administer naltrexone to an opioid-dependent patient.** Naltrexone is an opioid antagonist that can precipitate delayed, long-lasting, and severe withdrawal symptoms in an opioid-dependent patient.
    - If dependency status is uncertain, consider a test dose of naloxone 0.4 mg, as it is shorter acting. Reassure the patient that if withdrawal occurs, symptoms will be treated. See **Precipitated Withdrawal**.
  - If the patient has co-occurring opioid use disorder (OUD):
    - Buprenorphine and methadone are the preferred treatments and cannot be combined with naltrexone.
    - Naltrexone is a second-line option for OUD. It may be suitable to treat co-occurring OUD and AUD in some patients, such as in cases of prolonged abstinence from opioids, and with careful education regarding high overdose risk at treatment cessation.
  - Offer long-acting injectable naltrexone (Vivitrol) for improved treatment adherence.
- **Gabapentin**
  - One RCT demonstrated that individuals receiving both gabapentin and naltrexone had improved drinking outcomes and improved sleep over those who receive naltrexone alone.
- **Acamprosate**
  - Metanalyses demonstrate that acamprosate is efficacious in maintaining abstinence in those recently withdrawn from alcohol.
  - An initial lower dose of 333 mg three times daily is recommended for individuals with moderate kidney dysfunction or body weight <60 kg.
  - Three times daily dosing may be more difficult for patients to adhere to, compared to once daily naltrexone.
- **Topiramate**
  - While appropriate for some patients, topiramate is not described in this protocol as a first-line option in the acute setting due to its side effect profile/lower tolerability, complexity of initiating/tapering, and incompatibility with several common medications, including warfarin, phenytoin, and divalproex, and the availability of other treatment options.
  - Topiramate has been shown to decrease the number of heavy drinking days and has similar efficacy to naltrexone and acamprosate.
  - Topiramate may be useful for patients with seizure disorders, with careful education on the risk of increased seizures with abrupt cessation.
  - Topiramate may be a useful alternative for AUD treatment in those who do not tolerate or are poor candidates for other AUD medications.

- If topiramate is indicated, the following is a suggested dose escalation schedule:

| Week | AM dose | PM dose | Total daily dose |
|---|---|---|---|
| 1-2 | None | 50 mg | 50 mg |
| 3 | 25 mg | 50 mg | 75 mg |
| 4 | 50 mg | 50 mg | 100 mg |
| 5 | 50 mg | 100 mg | 150 mg |
| 6 | 100 mg | 100 mg | 200 mg |
| 7 | 100 mg | 150 mg | 250 mg |
| 8 | 150 mg | 150 mg | 300 mg |

### Special populations

- Topiramate is contraindicated in pregnancy.

## Polysubstance use

- Ask about other substance use and treat co-occurring substance use disorders as appropriate.

### Patient safety

- Monitor for signs of Alcohol Withdrawal Syndrome (see *Related Protocols*).
- Patients with AUD are commonly deficient in thiamine and folate and should receive supplementation. Thiamine supplementation can prevent Wernicke encephalopathy, which is life threatening.

### Discharge planning

- Help the patient schedule a follow up appointment with primary care.
  - Ask the patient if they have an established provider and where they want to receive ongoing care.
  - Assist the patient with scheduling appointments and addressing barriers, like transportation. Refer to social work, if available.
  - Outpatient and inpatient/residential treatment programs can be found on the Department of Health's **Behavioral Health Agency Greenbook**.
  - Ensure patients are prescribed enough medication to last until their follow up appointment—at least 7-14 days is advised.
  - Provide naloxone for patients that use any street drugs and discuss safer use strategies, including not using alone. Discharge medications for AWS.

## Patient Education

**Educate patients on:**

- Strategies to reduce the harms of alcohol (see *Discharge Instructions*).
- Treatment options for alcohol use disorder (see *Related Protocols*).
- The risks of combining alcohol with sedating substances.