Initiating pharmacotherapy for relapse prevention in a person with alcohol use disorder

English summary
SUMMARY

Initiating pharmacotherapy for relapse prevention in a person with alcohol use disorder

Introduction

Alcohol abuse is associated with considerable morbidity. For people with alcohol use disorder (AUD), pharmacotherapy aimed at maintaining abstinence or reducing consumption can play a key role in the continuity of care, whether after withdrawal or cessation or reduction of alcohol use. In 2014, the Ministère de la Santé et des Services sociaux (MSSS) asked the Institut national d'excellence en santé et en services sociaux (INESSS) to develop, host and update the current national medical protocols and prescription templates. To facilitate the care of this population, and in the context of implementing the 2018-2028 Plan d’action interministériel en dépendance (PAID), the MSSS’s Direction nationale des soins et services infirmiers, following a prioritization exercise, asked INESSS to develop a national medical protocol (NMP) together with a corresponding collective prescription (CP) template on initiating pharmacotherapy for relapse prevention in an individual with AUD.

Methodology

A systematic review of clinical practice guidelines (CPGs), expert consensus statements, consensus conference reports, guidance documents and any other items containing clinical recommendations was conducted across several databases in accordance with INESSS’s standards. The literature search was limited to items published between January 2015 and May 2020. The selected items concerned individuals with AUD. The search parameters were the contraindications to pharmacotherapy, the health status assessment criteria, the laboratory tests to be ordered, the pharmacological treatments and the related administration details, their adverse effects, the precautions and the drug interactions that one should be aware of in order to initiate pharmacological treatment, and the follow-up required for such treatment.

In addition, a manual literature search was conducted by consulting the websites of health technology assessment agencies and organizations, and those of government and paragovernmental agencies and professional associations or bodies pertaining to the topic of interest. The lists of references in the selected publications were examined for other relevant items.

The data were analyzed from the perspective of contextualizing Québec practice, using mainly legislative, regulatory and organizational contextual elements specific to Québec, and the experiential knowledge provided by the different stakeholders consulted.
Additionally, a systematic review (SR) of primary studies examining the efficacy and safety of anticonvulsants and baclofen in relapse prevention was carried out as part of this project. The analysis of these data is presented in a separate report [INESSS, 2021b].

Results

The data search yielded 4941 items, from which 10 CPGs were selected. These CPGs were deemed to be of adequate methodological quality for use, based on the AGREE II instrument.

First, the review of the best clinical practice recommendations, together with the contextual information and the experiential knowledge provided by the members of the advisory committee, served to define the clinical situation indicated in the NMP and to include in it both individuals who have withdrawn from alcohol and those who have not completely withdrawn. In addition, certain guidelines have been defined to ensure the safe management of the latter population and to avoid, as much as possible, any concurrent withdrawal symptoms when initiating pharmacotherapy for relapse prevention.

Second, the process of developing the national medical protocol and the collective prescription template made it possible to position naltrexone as a first-line treatment for relapse prevention. In order not to limit the application of the NMP when naltrexone cannot be administered, it was deemed appropriate to include alternative treatment options in the protocol, among which acamprosate, gabapentin and topiramate were considered suitable. Although the last two drugs have not been approved by Health Canada for relapse prevention, the data collected as well as the contextual information and the experiential knowledge provided by the experts consulted support their use in this context. It should be noted, however, that the use of acamprosate and topiramate is reserved for authorized prescribers because of administrative barriers associated with the prescribing of acamprosate and special precautions required when monitoring treatment with topiramate.

Lastly, the importance of a close follow-up by a member of the multidisciplinary team, especially during the first 6 months of treatment, is emphasized in the protocol. In addition, the use of the collective prescription has been limited to 1 month of treatment since the patient should undergo a medical assessment at that time. As well, patients with renal impairment or liver failure and those with cirrhosis or acute hepatitis have been added to the list of contraindications to the use of the collective prescription so that these clinical situations are managed only by an authorized prescriber.
Conclusion

The development of this national medical protocol and the corresponding collective prescription template was based on best clinical practice recommendations and a systematic primary literature review, which were enhanced with the experiential knowledge provided by different experts and clinicians along with contextual information. Given the analysis involving the triangulation of the data from these different sources, the protocol and template should promote interdisciplinarity and better management of individuals with AUD in order to offer them pharmacotherapy for relapse prevention as soon as possible. The usefulness of updating the national medical protocol will be assessed at least every four years so that it can be revised within five years.