INESSS
LE SAVOIR PREND FORME

AUGUST 2021

Alcohol withdrawal and relapse prevention

English summary

Une production de l'Institut national
d'excellence en santé
et en services sociaux (INESSS)

Québec

SUMMARY

Alcohol withdrawal and relapse prevention

Introduction

Withdrawal after prolonged, heavy alcohol use can lead to a number of symptoms that cause clinically significant suffering or impaired social or occupational functioning. Without adequate pharmacotherapy, these symptoms of varying severity can progress to major complications, such as seizures or delirium tremens, and can sometimes lead to death. Although most addiction facilities utilize a hierarchical model of withdrawal severity based on the assessment of the individual's risks using standardized clinical tools, the nature of these tools is heterogenous across the different facilities, and certain aspects of the practices vary from one region of Québec to another. Furthermore, many people with alcohol use disorder (AUD) could benefit from relapse prevention therapy immediately after withdrawal in that it could help them achieve and maintain their goals concerning their AUD.

In order to reduce the impact of alcohol withdrawal on the physical and psychological health of individuals, the Plan d'action interministériel en dépendance 2018-2028 (PAID) (2018-2028 Interministerial Addiction Action Plan) recommends, among other things, using protocols and approaches that are recognized as being effective and validated clinical assessment tools to assess the risks associated with alcohol withdrawal. To better support health professionals in their clinical decisions, INESSS has undertaken work to produce an optimal use guide (OUG) on pharmacological treatments for alcohol withdrawal and relapse prevention.

Method

This optimal use guide is based on the best available scientific data from systematic reviews (SRs) of primary studies and on clinical practice guideline (CPG) recommendations. They were supplemented with legislative and organizational contextual elements specific to Québec and the perspectives of a number of Québec experts and clinicians who collaborated in this project. A systematic review was carried out, in collaboration with a scientific information specialist, in the MEDLINE, EBM Reviews and Embase databases to identify clinical practice guidelines and guidance documents on the subject. The literature search was limited to items published between January 2015 and May 2020 in French or English. In addition, a grey literature search was conducted by consulting, among others, the websites of the Canadian Agency for Drugs and Technologies in Health (CADTH), the British Columbia Guidelines, the Canadian Coalition for Seniors' Mental Health (CCSMH), the Société française d'alcoologie (SFA), the National Institute for Health and Care Excellence (NICE), the United States Department of Veterans Affairs - Division of Defense (Va/DoD), the University of Medicine and Health Sciences (UMHS), the American Society of Addiction Medicine (ASAM), and the American

Psychological Association (APA). The websites of two Québec-based organizations, the Équipe de soutien clinique et organisationnel en dépendance et itinérance (Addiction and Homelessness Organizational and Clinical Support Team) and the Communauté de pratique médicale en dépendance (CPMD) (Community of Practice in Addiction Medicine), were consulted as well. The bibliographies of the selected publications were examined for other relevant items, and the Google search engine was used to find publications from regulatory agencies. The official product monographs for the main drugs of interest in this project were also consulted.

Results

The scientific information search yielded 4941 publications, from which 10 clinical practice guidelines were selected.

For the management of alcohol withdrawal, our work confirms that benzodiazepines, such as lorazepam and diazepam, are still the most frequently recommended first-line treatments, mainly because of their proven efficacy in reducing withdrawal symptoms, regardless of their severity. Moreover, since benzodiazepines have also demonstrated their efficacy in reducing the incidence of alcohol withdrawal-related complications, these drugs are the most appropriate treatment for severe withdrawal or withdrawal with a risk of complications for which pharmacological management should be carried out quickly and in a hospital setting. Nonetheless, this work also supports the use of gabapentin as an appropriate treatment option for alcohol withdrawal of mild to moderate severity with a low risk of complications. For individuals at low risk for withdrawal-related complications and who have a low risk of developping a withdrawal syndrome or mild active withdrawal symptoms, consideration should be given to administering pharmacotherapy and managing them on an outpatient basis. During withdrawal therapy, especially in a hospital setting, frequent and rigorous assessments of the individual's status are required. The drug doses need to be adjusted according to the course of the withdrawal symptoms. In this connection, our work identified several validated tools that can supplement the physical examination and support clinical judgment, whether for assessing the risk of withdrawal-related complications or the severity of the individual's withdrawal symptoms. Lastly, after successful withdrawal management, and to ensure continuity of care, pharmacotherapy for relapse prevention should be offered to all individuals with AUD. In this regard, our work confirms the use of naltrexone as a first-line treatment and acamprosate as a second-line treatment, both of which are approved by Health Canada for the maintenance of post-withdrawal abstinence and for relapse prevention in individuals with AUD. In addition, our work identified gabapentin and topiramate as appropriate second-line treatment options. Among other things, when choosing a pharmacological treatment, the clinician should take the person's treatment goals, prior experiences, and preferences into consideration. Since AUD is a chronic and recurring condition that requires ongoing, individualized interdisciplinary management, pharmacotherapy should be accompanied by a brief intervention, a motivational conversation, and a proposal of psychosocial interventions, which, however, should not be seen as being conditional or mandatory for accessing the treatment. Lastly, to limit the risk of overdose and the

diversion of benzodiazepines, gabapentin or topiramate, it was deemed important to consider implementing measures such as prescription splitting and more frequent pharmacy visits in cases of outpatient withdrawal or pharmacological management for relapse prevention.

Conclusion

The recommendations developed in this project reflect the latest changes likely to influence Québec practice in the treatment of alcohol withdrawal and relapse prevention, in particular, the addition of certain anticonvulsants to the treatment options and the inclusion of the main instruments that have been validated for supporting the clinical assessment of individuals with AUD. By emphasizing the pharmacological treatments that should be preferred according to the degree of severity and the risk of alcohol withdrawal-related complications, the tools we have developed should help better guide and support health professionals and thus optimize the use of these drugs. Furthermore, including both alcohol withdrawal and relapse prevention in the same optimal use guide is likely to promote continuity of care for individuals with AUD.

Siège social

2535, boulevard Laurier, 5e étage
Québec (Québec) G1V 4M3
418 643-1339

Bureau de Montréal

2021, avenue Union, 12e étage, bureau 1200
Montréal (Québec) H3A 2S9
514 873-2563
inesss.qc.ca