Medication Assisted Treatment for Alcohol Use Disorder (AUD)

Approach: Start with a needs assessment (*Can someone tell me about a case where medication for alcohol use disorder was an important part of care?*). Hand out blank charts for students to fill out/keep and draw an empty chart on the board that you will fill out. To promote active learning, ask students what they know about each of the medicines; supplement what they don't know with the information below.

Hook: If you have a patient starting one of these meds on the inpatient unit, see if you can aid the team in the informed consent process: learn how to speak to patients about the differences among these medications and the nuanced options available (e.g. an injectable for relapsing AUD).

Disparities in Care: Racial and ethnic minority patients 2/3 as likely to receive medical treatment for AUD compared with White patients, with Latinx individuals born outside the US having the lowest rates of medical treatment (Mulia et al., *Psych Services,* 2014).

	Basics	**Pros**	**Cons**
Naltrexone (Revia, Vivitrol)	● Opioid antagonist ● Predictors of response: positive family history, strong cravings, early onset of AUD ● Dose: 50mg/day PO (may increase to 100mg/day after 1 week if needed), 380mg IM q 4 weeks (LAI) ● Monitor LFTs	● May start if still drinking ● First-line medication ● Available as an LAI ● Makes alcohol consumption less rewarding; especially helpful to reduce heavy drinking	● Contraindicated with opioids (warn about acute pain management) ● SEs: nausea, HA, dizziness (should subside over time) ● Risk of liver toxicity (OK to start if AST/ALT < 3x upper limit of normal)
Acamprosate (Campral)	● Modulates glutamate transmission ● Predictors of response: anxiety, negative family history, ● Dose: 666mg TID	● May start if still drinking ● Thought to be especially helpful in post-acute withdrawal period (lengthens time to relapse but does not decrease # of drinks) ● Safe in liver disease	● TID dosing (difficult to take consistently) ● Contraindicated in renal failure (creatinine clearance < 30mL/min.) ● SEs: diarrhea, anxiety, insomnia, depression, dizziness
Disulfiram (Antabuse)	● Aversive agent: causes acetaldehyde to build up, resulting in "hangover" symptoms (sweating, N/V, HA, also hypotension and tachycardia) ● Dose: 200-500mg daily ● Monitor LFTs	● May be used as a situational PRN for people in sustained remission	● Requires 48 hours without alcohol to initiate ● Helpful to have observed dosing (partner, support, able to receive at a clinic) ● Contraindicated in CAD or psychosis ● Educate on hidden alcohol sources (e.g., foods)
Topiramate (Topamax)	● Increases GABA, inhibits glutamate ● Dose: 25mg daily for 4 weeks, increase by 50mg/week to max of 300mg daily (doses over 50mg typically divided)	● Useful if comorbid indications (obesity, binge eating, migraines, seizure disorder)	● Lower doses required in renal impairment ● SEs: GI, weight loss, dizziness, sedation, cognitive impairment, paresthesias ● Not FDA approved for AUD
Gabapentin (Neurontin)	● Interacts with voltage-gated calcium channels, reduces excitatory neurotransmitters ● Dose: 300mg daily, increase by 300mg every 1-2 days as tolerated to target of 600mg 3x daily	● Anxiolytic (off-label) ● Reduces cravings ● Reduces risk of seizures in acute withdrawal	● Lower doses required in renal impairment ● SEs: dizziness, sedation, mood changes, nausea, diarrhea ● Not FDA approved for AUD ● Risk of misuse

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