Addictions Webinar Series: Alcohol Use Disorders – an update for psychiatrists

Webinar Questions and Answers – Tuesday 28 September 2021

The following questions were asked during Addictions Webinar Series: Alcohol Use Disorders – an update for psychiatrists held on Tuesday 28 September 2021. Some of these and many others were answered by the speakers during the conference – please watch the relevant session to see these.

Please note: not all questions that were asked are included below. We hope to add to this document as further answers become available.

Tuesday 28 September	
What are your thoughts about reviewing patients in crisis that are under the influence / current service provisions around this patient cohort?	Like Dr Lawrence says we need to treat both i.e., mental illness and addictions. this is what is dual diagnosis/co-occurring work we all are responsible to take up. I think this is very difficult, and in these days of low resources, hardly surprising it's not always well managed. Yet these patients will be at risk of harm/ suicide, and it can be hard to exclude serious mental illness (even without this, it would be good to be able to offer respite). NICE CG16 makes it clear that: 1.) people who are intoxicated should be able to wait somewhere safe until they are assessable 2.) all people who present following a suicidal act should have a specialist assessment by a mental health professional. PHE guidelines re co-occurring disorders: 'Everyone's job' and 'No wrong door' - patients should have both MH and substance use assessed wherever they turn up.

	This question was also answered live.
Joint working very limited / non-existent in England with substance misuse services entirely outside the NHS in many trusts - e.g., Leicester	This is where we need to draw up join working protocols, even though addiction services are in the 3rd sector they are commissioned to provide service for NHS patients. ring and build networks. TEAMS has slightly revolutionised this for us during COVID - we have much closer communication with third sector partners. Regular meetings/case discussions can help. Someone who is 'front of house' for the community MH services and substance use services respectively - a point of contact for either organisation - can improve things.
Sub-specialty endorsement in addictions psychiatry always seems to be under fire. Adding in the fragmentation of MH and substance misuse (especially England), are we at risk of losing this all together as fewer consultant-level posts are available?	Being an Addiction Psychiatrist I understand the frustrations. Julia and the addictions faculty worry about this and adequate steps and plans underway to support training in 3rd sector and create future addictions psychiatrist. And we have no trouble attracting trainees to addictions posts in Scotland - some stay with addictions, but highly useful for those in general adult and others.
Do we need to think about extending the addictions sub-specialty endorsement to old age psychiatry, given the rise in prevalence in this patient group, along with alcohol-related brain injury?	I think this would be very helpful indeed. Not only are they drinking, but there is also the issue of polypharmacy/ opioids. Very relevant to addictions.
What about alcohol use comorbid with respiratory conditions or high amounts of smoking? What alternatives to benzodiazepines are there in terms of detox?	In theory carbamazepine can be used although there is limited experience with it in the UK. I would say that you can use benzodiazepines but with additional monitoring and liaison with the respiratory team re additional respiratory support (if an in-patient). There is cross-tolerance to benzos in people who are alcohol dependent so even those on the respiratory ward can do ok with quite large doses. The monitoring is the important bit - and that links to appropriate setting for MAW. This question was also answered live.

Any reason for choosing chlordiazepoxide over diazepam to treat withdrawal?	In theory chlordiazepoxide has lower abuse liability but pharmacologically there is little difference. In my service (in Edinburgh) we use chlordiazepoxide because it seems to have less value on the street. I would be happy to use either, and have.
A question/clarification for Dr Kalk - your slide said pts at highest risk of WE are those missing >100 meals per month (i.e., 3 meals per day x 30 days = only 90 meals) - is this just another way of stating those that eat basically NO regular meals?	Good point - that doesn't make sense - 'do you regularly miss meals' probably more helpful!
Is protracted delirium tremens seen (say more than 7 days) if there is no underlying other cause for delirium?	Yes, it can last a while, but I would usually be looking for other contributing causes as complexity is the rule not the exception in such cases. I've not seen this happen; patients who become delirious later usually have another cause/ ARBD. BUT - important to remember that we are seeing treated DTs, i.e., modified by benzos, and the outcome might be very different without, including significant mortality. I've seen very severe 'DTs' with GBL withdrawal - but usually briefer, presumably as shorter-acting.
What about combining medications for relapse prevention, for example, Acamprosate with Naltrexone, is it advisable/feasible/effective?	There will be situations when you can do that. as Dr Sinclair suggest they work very differently on our CNS as long as their Liver approves it. Yes, I usually discuss all appropriate ones with patients & try to work out what is best. Unusual to use naltrexone and disulfiram together though, as people often trying to reduce with former.
I think there was a network meta-analysis a few years ago that essentially said none of the relapse prevention medications work (it had limitations, e.g., none of the studies included were powered enough to measure alcohol-	I think the benefits are small, and probably connected with motivation. e.g., disulfiram appears not to work if unsupervised. I see them as part of the whole relapse prevention approach, to be combined with psychosocial and peer support interventions. I know it sounds a bit obvious, but people have to want to take them, and that will affect any outcomes.

related harms). This has driven some areas to avoid prescribing. How do we combat this? Relapse prevention is much more than what's happening in neurones...	
Any data regarding Ondansetron and SSRIs as relapse prevention medications?	Some studies on this with good outcomes. Overall, less evidence and wouldn't recommend it. risk of serotonin syndrome to watch out for.
Would Topiramate be appropriate in patients with bipolar as it could have both a relapse prevention and mood stabilizing effect?	I wouldn't use it, as I think there are more evidence-based drugs for each condition. But interesting question. This question was also answered live.
Can Nalmefene be used for someone not wishing to consider abstinence but wishes to reduce alcohol consumption, in a patient whose alcohol intake can be variable when drinking (periods of heavy drinking around 90 unit/week to other times when drinking less around 40-50 unit/week)?	Yes, although we tend to use naltrexone. This question was also answered live.
If a patient has both alcohol and benzodiazepine dependence does any drug has better evidence for detoxification?	Benzodiazepine detoxification has a very small evidence base based on samples with iatrogenic dependence. Implication for dual dependence would be consideration of detox in an in-patient setting.
Is baclofen a waste of time for many; it does not seem to have any effect?	We used baclofen quite a lot a few years back (in Edinburgh). Some people did well, but there was concern about abuse. I use it now for some people with severe alcoholic liver disease, as it's fairly safe, but they are not a group who tend to do well, by this point, sadly. Like all drugs baclofen is very effective in some people and of no benefit in others.
What is the optimal duration of treatment with alcohol relapse medication? Is there any	Most patients will have moved on and stopped medication by 1 year. For those (not many) who find it really helpful in their recovery, although the evidence base is

evidence of benefit in prescribing beyond 12 months?	limited, I usually think it helpful for them to continue as there are no specific safety risks. This question was also answered live.
services in my area are all privatised how does one obtain training in addictions psychiatry as an SpR?	This question was answered live.
Topiramate is used quite frequently in my country for relapse prevention. Whereabout, would you rate it after the medication you have listed already? Do you think it is useful at all?	It has a place if you have the services to support its initiation and monitoring. I do not have personal experience of using it because the system in the UK currently would not make it safe to use. This question was also answered live.
Are patients with alcohol related brain injury likely to score poorly on ACE III and how best to differentiate from other possible differentials?	They do tend to have a low score although the issue of Frontal Lobe Paradox can lead them to have a good score even when there is a greater level of functional impairment, so you have to take the score with clinical history. It won't fully differentiate from other possible diagnoses, but the typical pattern is frontal lobe and memory problems, with no deterioration (and perhaps some improvement) with abstinence.
What are your views on the benefits of magnesium supplementation and other micro-nutrients in patients with DTs?	Maximising nutritional status is a really important part of dealing with withdrawal and low magnesium is a seizure risk factor. Most important element is always thiamine though. Absolutely essential. Magnesium is required as a co-factor for metabolism of thiamine to its active form in the liver - so if Wernicke's isn't resolving check the patient's Magnesium and correct it!
How long (and how) would you give thiamine for?	Good question. For treatment - NICE says 3 - 7 days parenterally.

	If there are persistent symptoms, I have continued to give IV pabrinex while the patient remains in hospital and know that others also do this - but there isn't an evidence base for it. Certainly, there is genetic variability in how effective the thiamine transporter is and therefore there's a belief that you need to saturate it.
Are there any Specialist Rehab/Units for ARBD patients in the UK?	The Upstreet Project, Kent: http://thecraftproject.org.uk/ Serenita, Weston-Super-Mare: https://www.arbdcare.co.uk/care-home/serenita/ We have a 12-bed unit in Edinburgh - for 12 weeks rehab. Patients are admitted from acute medical or psychiatric (including detox) beds. I was sceptical, thinking it would get blocked, but it's been excellent. Money came from acute.
We don't have Pabrinex in my country. what are the parenteral Thiamine equivalents for prevention and treatment of WE and the duration of oral treatment if any, once they are discharged ? I work in Sri Lanka. We have Thiamine as Thiamine, both parenteral and oral	The important thing is that parenteral thiamine is more effective than oral thiamine. How long to give oral thiamine? Difficult question. We know that thiamine stores last a month. We know that alcohol affects gut functioning quite a bit and it takes a month for this to resolve. So, I would say at least a month of abstinence. And lots of psychoeducation about how thiamine is the thing you take to protect your memory, because (in the UK) people can be a bit dismissive of vitamins. Thanks! Parenteral is what you need.
What would one look for on brain scans as far as ARBD is concerned?	Mostly just small for age - important more to exclude other problems, I think. Acute Wernicke's: L sign - hyperintensity around third ventricle. Korsakoff's - small mamillary bodies ARBD - Imaging findings that support - disproportionate cerebellar atrophy Imaging findings that go against - small vessel white matter disease See Oslin's diagnostic criteria for ARBD. But as Rebecca states, often just looks a bit atrophic.

Thanks Rebecca, Patient refusing to consider all other alcohol RP meds.	people with alcohol problems need to be motivated and want the change. its perhaps exploring what else can they do to prevent future relapses. quite a number of patients in alcohol services just do abstinent based work and only 30-40% want RP meds.
Are there any studies done on development of dependence in ASD patients, any difference in neuro circuits involved in dependence with ASD?	This question was answered live.
I have had difficulties in diagnosing cognitive deficits in patients with alcohol dependence who are still drinking- often only possible when admitted to hospital. In the interest of early recognition is there anything you would advise?	In most 'healthy' alcoholics there can be subtle deficits in episodic memory and frontal lobe tasks if you look for them. There's a sys review about them. There is quite a bit of reversibility over the course of the first year of abstinence in this group. So, it is about picking it up, giving (parenteral) thiamine, supporting to attain abstinence, and then monitoring and follow up. Many will get a bit better with thiamine, abstinence and good nutrition. This question was also answered live.