Pharmacologic treatment of alcohol use disorder

Caitlin R Finley MSc Carly Rumley MD Christina S Korownyk MD CCFP

Clinical question
Which Health Canada–approved pharmacologic treatments are effective for alcohol use disorder (AUD)?

Bottom line
Both acamprosate and naltrexone show benefit for alcohol abstinence compared with placebo. For every 12 patients treated with acamprosate, and every 20 patients treated with naltrexone, 1 fewer patient returns to drinking compared with placebo after 12 to 52 weeks. For harm reduction, naltrexone can reduce return to heavy drinking for 1 of every 13 patients.

Evidence
Results are statistically significant unless noted.

- In a systematic review of RCTs of 12- to 52-week treatments, most included supportive therapy and required detoxification. Results versus placebo were as follows:
  - Return to any drinking:
    - For acamprosate (16 RCTs, N=4847), the most common dose was 666 mg 3 times per day. The rate was 76% versus 83% for placebo (number needed to treat [NNT] of 12).
    - For 50 mg of oral naltrexone daily (16 RCTs, N=2347), the rate was 63% versus 68% with placebo (NNT=20).
    - There was no difference with injectable naltrexone (2 RCTs, N=939) or disulfiram (2 RCTs, N=492).
  - Return to heavy drinking:
    - For 50 mg of oral naltrexone daily (19 RCTs, N=2875), the rate was 46% versus 54% with placebo (NNT=13).
    - There was no difference with acamprosate (7 RCTs, N=2496).
  - Earlier systematic reviews of acamprosate and naltrexone reported similar results.
  - Evidence is insufficient or finds no benefit for acamprosate or naltrexone on mortality or quality of life.
  - The most common adverse effects for naltrexone were nausea (26% vs 16% for placebo, number needed to harm [NNH] of 10) and sleepiness (21% vs 16% for placebo, NNH=20). For acamprosate, the incidence of diarrhea (16% vs 10% for placebo, NNH=17) decreases after the first 4 weeks of treatment.

Context
- Guidelines suggest that first-line pharmacotherapy include acamprosate for abstinence or naltrexone for reduced drinking or abstinence, and give practical prescribing tips.
  - Limited evidence has evaluated as-needed naltrexone. It might reduce alcohol consumption when used as cravings arise or before expected drinking.7
  - Supportive interventions, including brief interventions in primary care, might benefit 1 in 10 individuals with excessive alcohol intake.8
  - If patients do not respond to approved medications, a trial of alternative medications (eg, topiramate, gabapentin) might be reasonable.6

Implementation
In Canada, alcohol use is linked to about 8% of all deaths.9 Hospitalizations for AUD have increased over time, as has the number of patients presenting to primary care for alcohol-attributable diseases.9 Only limited numbers of individuals with AUD are offered treatment.4 The existence of multiple medications with evidence of benefit provides options for shared, informed decision making with patients. While abstinence is a laudable goal, reductions in return to heavy drinking or reduced heavy drinking days are also associated with improved outcomes.10

Ms Finley is a medical student, Dr Rumley is a second-year family medicine resident, and Dr Korownyk is a family physician and Associate Professor in the Department of Family Medicine, all at the University of Alberta in Edmonton.

Competition interests
None declared.

The opinions expressed in Tools for Practice articles are those of the authors and do not necessarily mirror the perspective and policy of the Alberta College of Family Physicians.

References

This article is eligible for Mainpro+ certified Self-Learning credits. To earn credits, go to www.cfp.ca and click on the Mainpro+ link.

La traduction en français de cet article se trouve à www.cfp.ca dans la table des matières du numéro d’août 2020 à la page e216.

Tools for Practice articles in Canadian Family Physician are adapted from articles published on the Alberta College of Family Physicians (ACFP) website, summarizing medical evidence with a focus on topical issues and practice-modifying information. The ACFP summaries and the series in Canadian Family Physician are coordinated by Dr G. Michael Allan, and the summaries are co-authored by at least 1 practising family physician and are peer reviewed. Feedback is welcome and can be sent to toolsforpractice@cfpc.ca. Archived articles are available on the ACFP website: www.acfp.ca.

Vol 66: AUGUST | AOÛT 2020  Canadian Family Physician | Le Médecin de famille canadien 583