8.1 Alcohol dependence

Alcohol dependence

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Description of condition

Alcohol dependence is a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol, tolerance to its effects, and difficulties controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences, such as physical or mental health problems.

In severely dependent patients who have been drinking excessively for a prolonged period of time, an abrupt reduction in alcohol intake may result in the development of an alcohol withdrawal syndrome, which, in the absence of medical management, can lead to seizures, delirium tremens, and death.

Assisted alcohol withdrawal

EvGr Patients with mild alcohol dependence usually do not need assisted alcohol withdrawal. Patients with moderate dependence can generally be treated in a community setting unless they are at high risk of developing alcohol withdrawal seizures or delirium tremens; individuals with severe dependence should undergo withdrawal in an inpatient setting. Patients with decompensated liver disease should be treated under specialist supervision.

A long-acting benzodiazepine, such as chlordiazepoxide hydrochloride p. 360 or diazepam p. 360, is recommended to attenuate alcohol withdrawal symptoms; local clinical protocols should be followed.

In primary care, *fixed-dose reducing regimens* are used. This involves using a standard, initial dose (determined by the severity of alcohol dependence or level of alcohol consumption), followed by dose reduction to zero, usually over 7–10 days. In inpatient or residential settings, a *fixed-dose regimen* or a *symptom-triggered regimen* can be used. A symptom-triggered approach involves tailoring the drug regimen according to the severity of withdrawal and any complications in an individual patient; adequate monitoring facilities should be available. The patient should be monitored on a regular basis and treatment only continued as long as there are withdrawal symptoms.

Carbamazepine p. 327 [unlicensed indication] can be used as an alternative treatment in acute alcohol withdrawal.

Clomethiazole p. 511 may be considered as an alternative to a benzodiazepine or carbamazepine p. 327. It should only be used in an inpatient setting and should not be prescribed if the patient is liable to continue drinking alcohol. A **Note:** Alcohol combined with clomethiazole p. 511, particularly in patients with cirrhosis, can lead to fatal respiratory depression even with short-term use.

EvGr When managing withdrawal from **co-existing** benzodiazepine and alcohol dependence, the dose of benzodiazepine used for withdrawal should be increased. The initial daily dose is calculated, based on the requirements for alcohol withdrawal plus the equivalent regularly used daily dose of benzodiazepine. A single benzodiazepine (chlordiazepoxide hydrochloride p. 360 or diazepam p. 360) should be used rather than multiple benzodiazepines. Inpatient withdrawal regimens should last for 2–3 weeks or longer, depending on the severity of benzodiazepine dependence. When withdrawal is managed in the community, or where there is a high level of benzodiazepine dependence, or both, the regimen should last for a minimum of 3 weeks (according to the patient's symptoms).

If alcohol withdrawal seizures occur, a fast-acting benzodiazepine (such as lorazepam p. 355 [unlicensed indication]) should be prescribed to reduce the likelihood of further seizures. If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen. A

Delirium tremens

EvGr Delirium tremens is a medical emergency that requires specialist inpatient care. In patients with delirium tremens (characterised by agitation, confusion, paranoia, and visual and auditory hallucinations), oral lorazepam p. 355 should be used as first-line treatment. If symptoms persist or oral medication is declined, parenteral lorazepam p. 355 [unlicensed], or haloperidol p. 404 [unlicensed] can be given as adjunctive therapy. If delirium tremens develops during treatment for acute alcohol withdrawal, the withdrawal drug regimen should also be reviewed. A

Alcohol dependence

EvGr In harmful drinkers or patients with mild alcohol dependence, a psychological intervention (such as cognitive behavioural therapy) should be offered. In those who have not responded to psychological interventions alone or who have specifically requested a pharmacological treatment, acamprosate calcium p. 518 or oral naltrexone hydrochloride p. 519 can be used in combination with a psychological intervention.

Acamprosate calcium p. 518 or oral naltrexone hydrochloride p. 519 in combination with a psychological intervention are recommended for relapse prevention in patients with moderate and severe alcohol dependence, to start after successful assisted withdrawal. Disulfiram p. 518 is an alternative for patients in whom acamprosate calcium p. 518 and oral naltrexone hydrochloride p. 519 are not suitable, or if the patient prefers disulfiram p. 518 and understands the risks of taking the drug.

Nalmefene p. 518 is recommended for the reduction of alcohol consumption in patients with alcohol dependence who have a high drinking risk level, without physical withdrawal symptoms, and who do not require immediate detoxification (see *National funding/access decisions* for nalmefene p. 518).

Patients with severe alcohol-related hepatitis with a discriminant function of 32 or more can be given corticosteroids but only after any active infection or gastrointestinal bleeding is treated, any renal impairment is controlled, and following discussion of the potential benefits and risks of treatment. Corticosteroid treatment has been shown to improve survival in the short term (1 month) but not over a longer term (3 months to 1 year). It has also been shown to increase the risk of serious infections within the first 3 months of starting treatment.

Patients with chronic alcohol-related pancreatitis should be offered nutritional support; those who have symptoms of steatorrhoea or who have poor nutritional status due to Exocrine pancreatic insufficiency p. 103 should be prescribed pancreatic enzyme supplements; supplements are not indicated when pain is the only symptom. A

Wernicke's encephalopathy

EvGr Patients with alcohol dependence are at risk of developing Wernicke's encephalopathy; patients at high risk are those who are malnourished, at risk of malnourishment, or have decompensated liver disease. Parenteral thiamine p. 1141, followed by oral thiamine p. 1141, should be given to patients with suspected Wernicke's encephalopathy, those who are malnourished or at risk of malnourishment, those who have decompensated liver disease or who are attending hospital for acute treatment. Prophylactic oral thiamine p. 1141 should also be given to harmful or dependent drinkers if they are in acute withdrawal, or before and during assisted alcohol withdrawal. A. Parenteral thiamine is available as part of a vitamin B substances with ascorbic acid p. 1142 preparation.