Case 1

• 46 year old male who you’ve been following for a year comes in for a “routine” visit for hypertension.
• Your excellent review of symptoms reveals that he has abdominal pain almost every day.
• The only time he’s been without this pain is when he stops drinking.
• He’s been drinking steadily (about 8-12 beers a day) for three years and is considering trying to stop again.
• The last time he tried to stop, he got so shaky that he had trouble working as a tree trimmer and started drinking after a day or two.
• He’s never had seizures or DTs.

What do you do next?

Outpatient Treatment

• Appropriate if:
  1. mild to moderate withdrawal symptoms (CIWA <15)*
  2. no serious psychiatric or medical comorbidities
• As effective as inpatient detoxification
• Generally greater social support, fewer disruptions, fewer treatment costs

Clinical Institute of Withdrawal Assessment for Alcohol

Inpatient Treatment Criteria

• Severe alcohol withdrawal (CIWA 15 or greater)
• History of DTs or seizures
• Inability to tolerate oral medication
• Active psychosis or severe cognitive impairment
• Recent high levels of alcohol consumption
• Pregnancy
### Pharmacologic treatment of alcohol withdrawal

<table>
<thead>
<tr>
<th>Medication</th>
<th>Comments</th>
<th>LOE</th>
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<tbody>
<tr>
<td>Benzodiazepines</td>
<td>Highly significant decrease in seizures and delirium</td>
<td>A</td>
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<tr>
<td></td>
<td>Risk reduction 77% seizure/100 patients, 4.9 DT/100 patients</td>
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<td></td>
<td>Some abuse potential</td>
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<tr>
<td>Carbamazepine</td>
<td>Well documented anticonvulsant activity; prevents seizures from EtOH withdrawal</td>
<td>A</td>
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<tr>
<td></td>
<td>No abuse potential</td>
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<td></td>
<td>Especially good for those with multiple previously treated withdrawals</td>
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<td>Relative risk of first drink after withdrawal in benzo group over 3 times higher than carbamazepine</td>
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<tr>
<td>Valproic Acid</td>
<td>Significantly affects the course of acute EtOH withdrawal and reduces need for treatment with benzos</td>
<td>A</td>
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<tr>
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<td>Unlikely to induce side effects which mimic EtOH withdrawal</td>
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<td>Wide therapeutic range makes unintentional overdose uncommon</td>
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### Otoutpatient Treatment for Alcohol Detoxification

- **Thiamine**: 100 mg orally per day for 3 days  
  Consider folate (5 mg) and multiple vitamin injection

### Case 2

- **32 year old female comes in for an establish care visit after moving from another state with no medical records.** She states that she has chronic abdominal pain and that the only thing that has ever made it feel better is Xanax.
- **Which questions are really important now?**
  - A. How much do you drink?
  - B. Would you sign an ROI (release of information)?
  - C. Do you have any blood in your stool?
  - D. When was your last dose of Xanax or any other benzodiazepine and how much do you usually take?
  - E. All of the above.

### Opate dependence treatment: Replacement therapy

- **Methadone**: developed in 1937 to solve Germany's opium shortage  
  Used to treat addiction in the U.S. since 1947  
  Must be dispensed by an FDA-approved program (SRTP and DAAC)

### Replacement Therapy

- **Buprenorphine/naloxone (Suboxone)**
  Training required to be eligible to prescribe (http://www.buppractice.com)
  Prevents withdrawal (have to be beginning withdrawal to undergo “induction”)  
  Naloxone blocks effects if injected
Case 3

- 26 year old male comes in with cellulitis of his right lower extremity. No known medical problems, other than intravenous drug use (mostly methamphetamines) on and off for several years.
- He expresses guilt and embarrassment over how he acquired the infection. States, “I deserve this. I shouldn’t be shooting speed.”
- After giving him some cephalexin and reassurance, you schedule him to see you in a week.
- On his return visit, he states that he is “tired of this $#& and wants to get off speed.”
- How can you help?

Stimulant Abuse Treatment

- Withdrawal from chronic use of stimulants (cocaine, methamphetamines) can result in profound anhedonia, increase in appetite and somnolence.
- Residential treatment programs seem to be effective, but just as with other substances, return to environment in which one used is associated with a high relapse rate.
- Most promising pharmacologic agent is the naltrexone implant (RCC in heroin and amphetamine users).
- Some users find that tyrosine can help cravings (despite less-than-promising initial studies).
- As with other substances, mental health services are key.

Local Treatment Facilities

- VFHC: close follow up with PCP, harm reduction
  Mental health intake, nurse visits, Suboxone (Dr. Eliaser, Dr. Duncan)
- Turning Point (707) 267-7460
  3 day non-medical detoxification program. Some clients are able to stay for an extended period.
- DAAC (707) 544-3995
  Outpatient treatment for adults, teens (16-25) youth (12-18), A2A (Alternatives to Detention) pregnant women, drug court.
- DAAC Support Group at Brookwood
  Intake: 707-583-8700 ext. 690 (Lynea)

Needle exchange

- DAAC: 2403 Professional Drive, Ste 103 (last door on the right)
  Lynn Campanario (707) 481-9827 or Lorie Violette (707) 548-0140
  Mondays (discretely because of other services going on) from 12-5:30pm
  Fridays from 5-8pm
- Brookwood: at the mobile HIV/HCV testing van parked in back. Mondays 9-11am
  - Provide new syringes, cotton, cookers, water, tourniquets, alcohol, bleach, etc.

Questions?

http://find.mapmuse.com/interest/substance-abuse-treatment-centers
Links

- Clickable map of treatment centers
  http://find.mapmuse.com/interest/substance-abuse-treatment-centers

- DAAC (Drug Abuse Alternatives Center)
  http://www.daacinfo.org/PS_outpatient.html

- ASAM (American Society of Addiction Medicine)
  http://www.asam.org/

- Suboxone Qualifications

- NIDA (National Institute on Drug Abuse)
  http://www.drugabuse.gov/nidamed-medical-health-professionals

References


