Considerations for Crisis Centers and Clinicians in Managing the Treatment of Alcohol or Benzodiazepine Withdrawal during the COVID-19 Epidemic: March 19, 2020

Overview: The COVID-19 Epidemic has created countless primary and secondary challenges for those delivering care to our most vulnerable populations. An additional concern has arisen for those with alcohol use disorder, benzodiazepine use disorder, or other conditions that increase the risk of seizures. While we recognize that there is high variability in the capacity for crisis centers and practitioners to receive and treat these individuals, we offer precautionary guidance to those that are prepared and capable.

Alcohol use disorder, depending on the severity can be managed at various treatment settings. Those determined to be at high risk for withdrawal complications should receive treatment at higher levels of care, but crisis centers may be faced with a surge of patients seeking relief. Some of these patients can be safely managed at crisis centers. These patients would benefit from receiving medications to ameliorate some withdrawal symptoms and prevent withdrawal complications.

Benzodiazepines are frequently utilized in a tapering fashion for medical withdrawal from alcohol or benzodiazepine dependence. It is likely that individuals will have difficulty being admitted to a facility that could safely administer these medications and there will be need for outpatient management of these conditions in the current medical emergency presented by the COVID-19 epidemic. SAMHSA urges providers to consider utilizing benzodiazepines in situations in which they believe that the individual would not benefit from administration of anticonvulsant medications that have been effective in treatment of alcohol withdrawal. Medications such as gabapentin, topiramate, or carbamazepine are useful in preventing seizures related to alcohol or benzodiazepine withdrawal. These medications also possess a much lower abuse potential. Limited doses of benzodiazepines might be considered for specific symptom relief for a short duration (several days).

Crisis centers that are able to remain operational and dispense medications to be administered unsupervised are asked to consider this guidance to minimize the potential for overdose and/or diversion. There are many options for treating mental and substance use disorders which have an evidence base and/or are best practices. We ask that crisis centers and practitioners experiencing an increase in those with alcohol or benzodiazepine use disorder keep these considerations in mind in addressing clinical issues.

CNS Drugs. 2015 Apr;29(4):293-311. doi: 10.1007/s40263-015-0240-4.

Anticonvulsants for the treatment of alcohol withdrawal syndrome and alcohol use disorders.

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Author information

Abstract

Alcoholic patients suffer from harmful allostatic neuroplastic changes in the brain causing an acute withdrawal syndrome upon cessation of drinking followed by a protracted abstinence syndrome and an increased risk of relapse to heavy drinking. Benzodiazepines have long been the

treatment of choice for detoxifying patients and managing alcohol withdrawal syndrome (AWS). Non-benzodiazepine anticonvulsants (NBACs) are increasingly being used both for alcohol withdrawal management and for ongoing outpatient treatment of alcohol dependence, with the goal of either abstinence or harm reduction. This expert narrative review summarizes the scientific basis and clinical evidence supporting the use of NBACs in treating AWS and for reducing harmful drinking patterns. There is less evidence in support of NBAC therapy for AWS, with few placebo-controlled trials. Carbamazepine and gabapentin appear to be the most promising adjunctive treatments for AWS, and they may be useful as monotherapy in select cases, especially in outpatient settings and for the treatment of mild-to-moderate low-risk patients with the AWS. The body of evidence supporting the use of the NBACs for reducing harmful drinking in the outpatient setting is stronger. Topiramate appears to have a robust effect on reducing harmful drinking in alcoholics. Gabapentin is a potentially efficacious treatment for reducing the risk of relapse to harmful drinking patterns in outpatient management of alcoholism. Gabapentin's ease of use, rapid titration, good tolerability, and efficacy in both the withdrawal and chronic phases of treatment make it particularly appealing. In summary, several NBACs appear to be beneficial in treating AWS and alcohol use disorders.

Full paper at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759952/

Ann Pharmacother. 2013 Jul-Aug;47(7-8):961-9. doi: 10.1345/aph.1R751. Epub 2013 Jun 18.

Gabapentin versus chlordiazepoxide for outpatient alcohol detoxification treatment.

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Author information

Abstract

BACKGROUND:

Benzodiazepines are used to treat alcohol withdrawal (AW) but cause cognitive impairment, sedation, and ataxia, and interact with alcohol. Nonbenzodiazepine anticonvulsants are promising and possibly safer alternatives for the treatment of AW.

OBJECTIVE:

To compare follow-up measures of Epworth Sleepiness Scale (ESS), Penn Alcohol Craving Scale (PACS), ataxia rating, and Clinical Institute Withdrawal Assessment for Alcohol revised (CIWA-Ar) symptoms between alcohol-dependent individuals randomized to treatment with gabapentin or chlordiazepoxide.

METHODS:

A randomized, double-blind study was conducted in US veterans with alcohol withdrawal (DSM-IV criteria). Subjects requiring hospitalization or taking benzodiazepines or nonbenzodiazepine anticonvulsants were excluded. Twenty-six participants were randomized: 17 received gabapentin and 9 received chlordiazepoxide. Gabapentin doses were 1200 mg orally for 3 days, followed by 900 mg, 600 mg, and 300 mg for 1 day each. Chlordiazepoxide doses were 100 mg orally for 3 days, followed by 75 mg, 50 mg, and 25 mg for 1 day each. CIWA-Ar, ESS, PACS scales and evaluation for ataxia were administered daily.

RESULTS:

Follow-up mean ESS and PACS scores did not differ significantly between treatment groups in the early treatment period (days 1-4) but were lower (mean difference -3.70; 95% CI -7.21 to -0.19; p = 0.04) and (mean difference -6.05; 95% CI -12.82 to 0.72; p = 0.08), respectively, at the end of the treatment period (days 5-7) in gabapentin-treated subjects. CIWA-Ar scores were reduced similarly in both groups. Ataxia was not observed. No significant adverse events were noted. Limitations include our small sample size and 35% loss to follow-up at the end of the treatment period.

CONCLUSIONS:

In ambulatory veterans with symptoms of alcohol withdrawal, gabapentin treatment resulted in significantly greater reduction in sedation (ESS) and a trend to reduced alcohol craving (PACS) by the end of treatment compared to chlordiazepoxide treatment. Although limited by the small sample size, the suggestion of reduction in sleepiness and less craving warrants replication of the study with a larger sample.

TRIAL REGISTRATION:

ClinicalTrials.gov NCT01573052.

Alcohol Clin Exp Res. 2009 Sep;33(9):1582-8. doi: 10.1111/j.1530-0277.2009.00986.x. Epub 2009 May 26.

A double-blind trial of gabapentin versus lorazepam in the treatment of alcohol withdrawal.

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Author information

Abstract

INTRODUCTION:

Some anticonvulsants ameliorate signs and symptoms of alcohol withdrawal, but have an unacceptable side effect burden. Among the advantages of using anticonvulsant agents in this

capacity is their purported lack of interaction with alcohol that could increase psychomotor deficits, increase cognitive impairment, or increase intoxication. The aim of this study was to evaluate alcohol use and symptom reduction of gabapentin when compared with lorazepam in the treatment of alcohol withdrawal in a double-blinded randomized clinical trial.

METHODS:

One hundred individuals seeking outpatient treatment of alcohol withdrawal with Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) ratings > or =10 were randomized to double-blind treatment with 2 doses of gabapentin (900 mg tapering to 600 mg or 1200 tapering to 800 mg) or lorazepam (6 mg tapering to 4 mg) for 4 days. Severity of alcohol withdrawal was measured by the CIWA-Ar on days 1 to 4 of treatment and on days 5, 7, and 12 post-treatment and alcohol use monitored by verbal report and breath alcohol levels.

RESULTS:

CIWA-Ar scores decreased over time in all groups; high-dose gabapentin was statistically superior but clinically similar to lorazepam ($p = 0.009$). During treatment, lorazepam-treated participants had higher probabilities of drinking on the first day of dose decrease (day 2) and the second day off medication (day 6) compared to gabapentin-treated participants ($p = 0.0002$). Post-treatment, gabapentin-treated participants had less probability of drinking during the follow-up post-treatment period ($p = 0.2$ for 900 mg and $p = 0.3$ for 1200 mg) compared to the lorazepam-treated participants ($p = 0.55$). The gabapentin groups also had less craving, anxiety, and sedation compared to lorazepam.

CONCLUSIONS:

Gabapentin was well tolerated and effectively diminished the symptoms of alcohol withdrawal in our population especially at the higher target dose (1200 mg) used in this study. Gabapentin reduced the probability of drinking during alcohol withdrawal and in the immediate postwithdrawal week compared to lorazepam.

Full paper available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2769515/

CNS Neurol Disord Drug Targets. 2010 Mar;9(1):45-9.

The role of topiramate and other anticonvulsants in the treatment of alcohol dependence: a clinical review.

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Abstract

Alcohol dependence is a major health problem worldwide. Various pharmacological agents have been used in the management of alcohol dependence. This review looks at the role of topiramate and other anticonvulsants in the management of alcohol dependence. Topiramate is the most widely used anticonvulsant in the treatment of alcohol dependence. The literature on topiramate is reviewed and critically analyzed, along with its proposed mechanism of action in alcohol dependence. A review of data available on other anticonvulsants like carbamazepine, oxcarbazepine, sodium valproate, gabapentin and levetiracetam are presented and their potential in the treatment of alcohol dependence is considered, together with future research directions.

Full article at: http://www.eurekaselect.com/93747/article