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ADDICTION IN THE OFFICE

A brief primer on dealing with withdrawal and addiction in your practice. Bring cases to discuss that we can all learn from. The focus will be on uncomplicated treatment of the most common substances of abuse (opiates, alcohol, stimulants, marijuana, benzos).

1. Define addiction, withdrawal, dependence 2. Treat withdrawal symptoms of alcohol, opiates, stimulants, marijuana 3. Treat addiction to help your patients avoid relapse

Addiction in the Office

Trish Uniac, MD, CCFP

CSAM Definition of addiction

Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. The relief of withdrawal symptoms that is provided by someone's drug of choice is a reward, reinforcing the need one feels for that drug.

Addiction medicine is, at least in part, the study of how to relieve these withdrawal symptoms and provide support for patients in their sobriety.
Nora Volkow, neuroscientist and addiction badass explains addiction in her Ted talk. It's focused on obesity, but the same principles apply.
https://www.youtube.com/watch?v=Mnd2-al4LCU

Dependence on a substance - when giving that substances causes lessening of the symptoms of withdrawal.

SBIRT

- Screening
- Brief Intervention
- Referral to Treatment

Recommended we do it at the periodic health exam, prenatal visit, change in health status, concern raised by staff or family. Also consider screening for addiction when someone presents with new depression or anxiety, dyspepsia, or GI upset.
The CPFC has a document with recommendations for making this a part of your practice, I'll let you look at it yourself.
http://www.cfpc.ca/uploadedFiles/Resources/_PDFs/CFPCCCSA%20Alcohol%20Screening%20Brief%20Intervention%20and%20Referral.pptx.pdf

General Principles of Withdrawal Management

- *Focus is going to be on straightforward patients (not pregnant, HIV negative, not psychotic)*
- Reduce withdrawal symptoms to reduce risk of relapase
- Implement structure and balance into the patients' days - sleep regularly, eat regularly (real food, not chips and pop), socialize daily with sober friends and allies, gentle exercise daily (e.g. yoga, going for a walk)
- be in contact with treatment team
- Offer support with volatile emotions - they are to be expected
- Suicide is real concern during detoxification and withdrawal
- Manage cravings medically and with coaching, reminding the patient that it won't last and helping them work through it
- Use inpatient treatment for patients who are medically unstable
- Assist patient with creating a safe recovery environment at home
    - get rid of drugs and paraphernalia (can induce spontaneous withdrawal)
    - ask family and cohabitants to be on board - everyone should stay sober • Groceries, Advil, water, Gravol, Imodium, books, movies, clean laundry

http://www.womenscollegehospital.ca/programs-and-services/METAPHI

Alcohol Withdrawal

Signs and symptoms

- Severe: hyperautonomic signs, seizures, withdrawal delirium, death
- CIWA protocol
http://www.reseaufranco.com/en/assessment_and_treatment_information/assessment_tools/clinical_institute_withdrawal_assessment_for_alcohol_ciwa.pdf
- acute: nausea, vomiting, headache, hallucinations (tactile, auditory, visual), disorientation, tremor, sweats, anxiety, agitation
- Subacute: constipation, peripheral edema, nightmares, confusion and poor memory
- The best predictor of a complicated withdrawal (seizures, DTs) is a history of the same. Ask your patient what happened the last time they tried to stop drinking. How long were they able to abstain? You want to see what 5 days of sobriety looked like for this patient. The risk should be considered for anyone who has been drinking 6 or more standard drinks for more than a week.

Medications for withdrawal

- Diazepam - 20mg qhs or according to CIWA protocol (only provide if given in less than 5 pieces at a time or into the hand of someone else who will ensure they are not misused). DON'T DRIVE.
- Gravol, osmotic agent for constipation
- May want to try using Gabapentin for withdrawal and seizure prophylaxis if there is concern about misuse of diazepam. We often use 300mg caps, TID, 1 - 3. Advise the patient it will be sedating. DON'T DRIVE. (Off label use)
- Thiamine - 100mg PO daily for 5 days, if this will be an inpatient withdrawal, use IM instead before patient eats their first meal.

Medications for cravings/to decrease relapse

Gabapentin - off label use. I usually start with 300mg qhs if sleep is an issue, 100mg TID if patient is complaining of social anxiety. In large doses causes sedation. Start low, go slow when in the maintenance phase.

- evidence is that 1500mg daily will decrease cravings for alcohol in the outpatient setting

Naltrexone - especially good if likely genetic. Also effective for overeating and may help with opiate addiction. Also good for patients who are not ready to be abstinent - each drink doesn't taste as good as they are used to so they are less likely to have a second or third. Makes it good for binge drinkers.

- Start with 25mg daily, increase to up to 100mg over a few months
- side effects I usually see in this setting is nausea and dizziness
- may cause increase in LFTs so start after checking labs
- getting coverage in Ontario is quick (less than 5 days) after submitting an EAP
- this is the most successful tool I see in my practice

Acamprosate - 666mg TID. Best for those who describe strong cravings and triggers with their drinking.

- May increase renal impairment - start after checking creatinine and recheck a month after using
- May cause some sedation

Antabuse - start with 250mg, may need to have compounded

- can ruin marriages if one partner is providing doses to the other
- Does not work well if patient starts drinking early in the day (sober self needs to trick drunk self)
- we know that punishment doesn't work to stop behaviours
- works best for those patients who know that they are more likely to drink in certain situations and can use it to help them prepare (e.g. flying, family reunions)
- while not a great med in general, I have a few patients who have found it to be very helpful for them. They are quite motivated and have asked me for it themselves.

The METAPHI project has put together this excellent resource:
http://www.womenscollegehospital.ca/assets/pdf/MetaPhi/2017-12-19%20PCP%20alcohol%20guide.pdf

Opiates

Withdrawal Signs and Symptoms

COWS
https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

- Acute: nausea and vomiting, diarrhea, myalgia, anxiety, dysphoria, lacrimation, rhinorrhea, insomnia
  - Incredible uncomfortable for most patients - will describe it as the worst time in their lives
  - Most common reason for relapse is discomfort from withdrawal
- Sub Acute: confusion, dysphoria/depression

Medications for Withdrawal

OTC stuff to have on hand • gravol, imodium, advil, Tylenol - symptom management

- **Decongestant spray** for up to 1 week
- **Trazodone** 100mg qhs for 3 - 5 days
- **Clonidine** - general withdrawal symptoms, especially autonomic symptoms (the creepy crawlies)(Off label use)
  - plan on 0.1mg up to QID for 4 days • do not give if low blood pressure
  - may cause sedation, dizziness
- **Suboxone** - give once patient has moderate withdrawal symptoms. Will take away most symptoms plus reduce cravings considerably.
  - easy to prescribe - review course over a weekend http://www.suboxonecme.ca/

• start with 4 - 8mg daily and increase as needed - patient will need to pick up daily. I usually see these patients early in the morning, assess that they are in withdrawal, send them to the pharmacy for the first 4mg dose and reassess later that day for the second dose of 4mg. Ideally they are seen again a few days later to determine if the dose needs to be titrated up.

Medications for Cravings

- Suboxone
- Methadone - requires special license
    - high street value
    - patient can use opiates on methadone

Stimulants (Crystal Meth, cocaine, speed, ritalin…)

Withdrawal Signs and Symptoms

- Depression (can be severe), anxiety, fatigue, decreased concentration, increased appetite, increased dreaming
- I've had patients believe they have a tape worm because they are eating so much but still hungry and exhausted.

Medications for Withdrawal

- emerging evidence that **clonidine** is helpful, especially for young women with trauma histories (Off label use)
- consider antidepressant if severe or persistent depression
- gabapentin may be helpful for anxiety symptoms

Medications for Cravings

- None with any real evidence
- some try Ritalin, evidence is sketchy at best
- similarly for buproprion

Marijuana

Withdrawal Signs and Symptoms

- Acute: irritability, anxiety, depression, restlessness, anorexia, insomnia, GI upset
- Sub Acute: anxiety, autonomic symptoms • can take days to months

Medications for Withdrawal

- For autonomic and mood symptoms, consider risperidone 0.25mg up to BID (Off label use)
- Trazadone 50mg nightly for the first few months
- Gabapentin decreases anxiety symptoms and has the most evidence for prolonged sobriety (Off label use)

Medications for Cravings

- None - some try to use Nabilone but there is no evidence for prolonged sobriety

Special concerns:

• *Wellbutrin* - may be helpful for some addiction BUT decreases our patients' seizure threshold so please don't use with patients with alcohol use disorder or benzo use disorder • can also be crushed and snorted with effects similar to cocaine (Off label use)

- Generally? I don't prescribe it if concurrent addiction to alcohol, marijuana, benzos
- Prescribe it sparingly to those with stimulant addiction

• *Gabapentin* - Concern about misuse

- •when taken in large quantities can cause feelings of euphoria, don't want to trigger patient to relapse or give them something new to abuse.
- •Prescribe in weekly amounts
- called gummy bears in some prisons

12 Steps - a way of treating a broken spirit

• also known as the fellowship
• http://www.aa.org/
• Alcoholics anonymous, narcotics anonymous, cocaine anonymous, sex and love addicts anonymous
• lots of meetings across Canada, different times of day, meetings exist on the internet if needed
• An opportunity to have someone understand what your patient is going through. AA and the rest are based on the concept of strength in numbers.
• Patients will hate going initially stating that they "don't fit in". Most are uncomfortable with the idea of having to speak about personal issues in public. Who wouldn't be?
• Those who complain of social anxiety symptoms will notice that they improve with sobriety and time in the fellowship.
• Having them start with open meetings can help. Those are meetings with speakers where participants are not all expected to speak.
• *But everyone will know me in the meeting!!* Maybe. While this is often true, it's not as bad as what patients make it out to be. Patients consistently tell me that they are welcomed by the people they know in a meeting.
• *AA is just a cult!* There are similar components in AA as there are in the major religions, a core text, a community greater than yourself, traditions and rituals. What it doesn't have is as many rules and obligations. There is no one deity. Instead, they push a "higher power" that can be whatever the participant sees it as. Initially, many participants will use the group as a whole as their higher power. Others use god as they see him/her through their religious beliefs. The most important piece is recognizing that the world does not revolve around themselves but that there is something much bigger than themselves.
• Connecting to others with addiction is an essential part of recovery.