BEDFORDSHIRE & LUTON JOINT PRESCRIBING COMMITTEE (JPC)

SHARED CARE GUIDELINES FOR USE OF ACAMPROSATE IN THE TREATMENT OF ALCOHOL DEPENDENCE

Approved by JPC, September 2020, ratified by ELFT Medicines management committee, Nov 2020
(Review date Nov 2023)

PATIENT'S NAME:

PATIENT'S ADDRESS:

PATIENT'S NHS NUMBER:

SPECIALIST SERVICE NAME AND NUMBER

CONSULTANT'S NAME:

GP's NAME:

Acamprosate Calcium is used for the maintenance of abstinence in alcohol dependence.

Acamprosate is used alongside counselling to help people not to drink alcohol. It works by restoring the natural balance of chemicals in the brain (neurotransmitters).

The recommended treatment period is one year. Treatment with Acamprosate should be initiated as soon as possible after the withdrawal period. Before starting this medication, patients should no longer be drinking alcohol. If patients begin drinking again, they should keep taking the medication and let their keyworker/GP know.
Acamprosate does not prevent the harmful effects of continuous alcohol abuse. Continued alcohol abuse negates the therapeutic benefit; therefore, Acamprosate treatment should only be initiated after weaning therapy, once the patient is abstinent from alcohol

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.

NICE Clinical Guideline CG115 (2011). Alcohol-use disorders: diagnosis, assessment and management of harmful (high-risk drinking and alcohol dependence.

BNF: Acamprosate Calcium

Indications and dose

1. Maintenance of abstinence in alcohol-dependent patients. By mouth
    - Adult 18–65 years (body-weight up to 60 kg). 666 mg once daily at breakfast and 333 mg twice daily at midday and at night.
    - Adult 18–65 years (body-weight 60 kg and above). 666 mg 3 times a day.
2. **Cautions:** Continued alcohol abuse (risk of treatment failure)
3. I**nteractions**: No significant interactions have been associated with the use of Acamprosate. Acamprosate taking with food has lower bioavailability than in the fasting state. However, some patients are more comfortable taking the tablets with food. No interactions have been shown between Acamprosate and diazepam, disulfiram or imipramine
4. **Side-effects: Common or very common**:
   abdominal lpain; diarrhoea; flatulence; nausea; sexual dysfunction; skin reactions; vomiting
5. **Pregnancy:** Avoid unless potential benefit outweighs risk.
6. **Breast feeding:** Avoid.
7. **Hepatic impairment**. Caution in severe hepatic failure
8. R**enal impairment.** Avoid if serum-creatinine greater than 120 micromol/litre.

NB:- For full prescribing and drug related information regarding contraindications , cautions , side effects etc , clinicians should refer to the Summary of Product Characteristics (SmPCs) and the current electronic BNF . www.medicines.org.uk/emc www.bnf.org/products/bnf-online

Alcohol Service responsibility

a) Assess suitability for Acamprosate (physical/mental health, social issues, alcohol use, U&E's LFT's (including GGT), breathalyse)
b) Inform patient of benefits/side effects/risks/dosage regime/what to report (verbally and in writing)
c) P2R/Resolution to supervise patient and provide 6 months prescribing prior to considering handover to GP
d) P2R/Resolution to review at 5 months and provide 28-day prescription ensuring that the patient is stabilised on treatment prior to handover.
e) Provide handover to GP (including patient history, recent care, psychosocial support, monitoring tests required, medication review intervals, initial recommended period of treatment and risk plans) and a copy of the shared care guideline (or electronic link to it).
f) Provide psychosocial support during treatment (and introduction to self-help e.g. AA)
g) Inform GP with recommendations (verbally and in writing)
    - If patient reports alcohol use, or if alcohol use is suspected
    - any other changes in presentation that indicate cessation of treatment
h) Review patient before the end of the 12th month and advise GP whether ongoing treatment for a second year is required.(**NB:** The GP needs to be informed if treatment is to continue for a second year in a timely manner to ensure continuity of prescribing by the GP for the start of month 1 of the second year.)
i) Support the GP with specialist advice as required.

j) Have a mechanism in place to receive rapid referral of a patient in the event of deteriorating clinical condition.
k) Ensure that clear backup arrangements exist for GPs to obtain advice and support.

GP responsibility

(NB – other members of the Primary Care Team can undertake these responsibilities as agreed within the practice)

a) Review patient at 6 and 9 months in the first year of treatment but continue prescribing to 12 months, monitoring the patient's overall health and well-being. (See Appendix 1 for advice from Specialist Team on indicators of relapse). NB Prescribing will be required
b) GP to prescribe at recommended dose/regime from month 6 to month 12 (12 months total prescribing of medicine) and review.
c) GP to refer back to specialist service after 9-month review to enable specialist service to review the patient before 12 months and advise GP on whether ongoing treatment is required for a second year.
d) Treatment for a second year is advised if there are very clear benefits such as continuing abstinence from alcohol use and self-reported patient satisfaction with the treatment.
e) If the specialist team recommends treatment for a second year, GP to continue prescribing and reviewing patient every 3 months until treatment stops at 24 months.
f) Cease treatment/take advice from Alcohol Service if there is a significant change in patient presentation/ contraindication/side effects or if drinking persists for more than 4-6 weeks etc.
g) Arrange and monitor blood test results and response to Acamprosate. These tests will be the LFT's, U & E's, FBC and Gamma GT on referral back to GP and at least 3-monthly intervals until the completion of the treatment regimen.
h) The GP will end treatment if the patient defaults from follow up arrangements. The GP can re-refer the patient to the alcohol team at any time for a review if needed.
i) Inform specialist services of concerns regarding the patient's alcohol use.
NOTE: Isolated incidents of non-attendance for blood tests are not a reason to cease prescribing. In the event of repeated non-attendance, GPs should discontinue treatment and inform the Specialist Alcohol Service.

Note: If treatment is to be continued into year 2, the alcohol specialist service is expected to advise GP in a timely manner to ensure continuous prescribing.

Patient responsibility

a) Take medication as prescribed; attend for blood tests and other appointments.

b) Engage in treatment/psychosocial support, report alcohol use, report any side-effects to treatment, report any other changes in physical or mental health or social circumstances (including family planning).
c) Be aware of the consequences of drinking alcohol in combination with Acamprosate.

d) Inform specialist alcohol service or GP of any other medication being taken, including over-the-counter products or herbal remedies.

Drug and Alcohol Service Contact Details

Bedford Borough and Central Bedfordshire:

Path to Recovery (P2R) Drug & Alcohol Services:

21 The Crescent, Bedford MK40 2RT,

67 High Street North, Dunstable, Bedfordshire LU6 1JF

Telephone: 0333 332 4019

Secure Email: elt-tr.P2RBedford@nhs.net

Website: https://changeyourtomorrow.co.uk/#areas/elft/pages/Home

Patient Self-Referral: https://changeyourtomorrow.co.uk/#areas/elft/referral

Professional Referral:
https://changeyourtomorrow.co.uk/#areas/elft/pages/About.ProfessionalReferral

Resolutions Drug and Alcohol Service

Victoria House, 2 – 12 Victoria Street, Luton LU1 2UA

Telephone: 0800 0546 603

Email address: Resolutions.info@cgl.org.uk

Website: www.resolutions4luton.org

Appendix 1

Clinical Indicators of Relapse to Excessive Alcohol Use

As with all clinical symptoms, signs and investigations, it is a matter of collecting clinical data as it is present and having an appropriate level of suspicion, whilst being prepared to rule out other causes of a symptom/sign/investigation result

This is not a complete list, but will help guide

History

- History of drinking alcohol, continuing over several days (a brief drinking episode that terminates abruptly may be a lapse rather than a relapse)
- History of recent cravings for alcohol
- History of "accidental" encounters with alcohol (e.g. finding a lost bottle of whisky when clearing out a cupboard)
- Refusing to remove all alcohol from the house; giving excuses of limited validity about why he/she has purchased alcohol ("my partner has to have a glass of wine with dinner; you can't expect him to stop just because I have")
- Has met up with a friend who drinks, has been to an old drinking haunt (e.g. the pub, Rugby club), continues or repeats other actions associated with pre-detox alcohol use
- Change of mood, increased arguments with family, friends, work colleagues etc.
- Unexplained physical symptoms (e.g. sudden onset vomiting or diarrhoea, after ruling out e.g. gastroenteritis)
- New medical condition associated with alcohol intake (haematemesis, gastric ulcer, decompensation of liver disease, falls, confusion, memory loss etc)
- Complaining of emotional difficulties (depression, anger issues), sleep complaints
- Police, other professionals involved

Examination and behaviour

- Intoxication: breath smelling of alcohol, red sclera, ruddy face all over, sweating, slurred speech, ataxic gait, disinhibition, elevated affect, maudlin affect
- Withdrawal: sweats, shakes, nausea/vomiting, autonomic hyperactivity (tachycardia, acute hypertension)
- Reluctance to discuss alcohol intake
- Unkempt, unwashed, poor self care
- Carrying a bottle containing an alcoholic drink, wearing pro-alcohol clothing
- Large stack of empty bottles of wine/cans of beer in the home at a Home Visit
- Family members speaking for them
- Missing appointments, not answering the phone; disengaging, self-harming
- Isolating themselves

Motivational analysis

- Talks positively about alcohol, indicates that he misses alcohol
- Arguing in favour of alcohol ("Guinness is good for you")
- Indicating that the decision to stop was for a reason other than to reduce alcohol intake ("I need to stop to get my kids back")
- Minimising the adverse consequences of alcohol intake (either as general topic or in the patient's personal situation)

Investigations

Breathalyser: Reading greater than 0 indicates relapse.

Blood tests: For relapse, GGT is the most helpful marker. You must first take it before detox

Not all patients suffer changes to the MCV or the GGT when they drink excessive alcohol (and when they do, you still need to exclude other causes, e.g. hypothyroidism or B12 deficiency can cause a raised MCV)

For those that do, GGT is a good indicator of drinking in the short term. If the GGT is raised before stopping drinking/during detox, then it should reduce over time when drinking stops (t ½ is approximately 10 days). Thus if a GGT is not going down after a week, it raises the suspicion of continuing drinking.

MCV changes over 3 months and is a better measure of the beginning and ending of an episode.

LFTs will only change if there is associated liver damage.

These comments are a guide. If in doubt, contact your local alcohol service for further advice

References

- NICE Guidelines: CG115 Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence
- SPC Acamprosate accessed online Sept 2020
- British National Formulary 79 March – September 2020