CLINICAL PRACTICE BRIEF:
ALCOHOL USE DISORDER

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Introduction
This clinical brief provides updated guidelines on managing alcohol use disorder (AUD) in the outpatient setting, with a focus on evidence-based interventions to support recovery and prevent relapse.

- Guidelines are informed by clinical evidence from organizations including the American Society of Addiction Medicine (ASAM), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), Substance abuse and Mental Health Services Administration (SAMHSA), and the World Health Organization (WHO).
- AUD is a chronic relapsing disorder characterized by compulsive alcohol use, loss of control over alcohol intake, and a negative emotional state when not using alcohol. It is associated with significant morbidity and mortality, including liver disease, cardiovascular complications, and mental health disorders.
- Recommendations for managing AUD are based on the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system. Evidence ranges from high to very low depending on the intervention.

Guideline Summary
Diagnosis

- **Screening:** Use validated tools (Grade B, USPSTF) such as:
  - AUDIT (Alcohol Use Disorders Identification Test), https://nida.nih.gov/sites/default/files/files/AUDIT.pdf
  - CAGE questionnaire, or single-question screening ("How many times in the past year have you had X or more drinks in a day?" where X is 5 for men and 4 for women). https://www.niaaa.nih.gov/health-professionals-communities/core-resource-on-alcohol/screen-and-assess-use-quick-effective-methods#pub-toc2
    - Tools may be preloaded in electronic medical record systems. Please check with your institution.
- **Diagnostic Criteria:** Based on DSM, AUD is diagnosed if two or more criteria are met within a 12-month period (e.g., alcohol craving, continued use despite harm, or withdrawal symptoms).
- Assess for comorbidities such as liver disease, cardiovascular conditions, and psychiatric disorders (e.g., depression, anxiety).

Management

- **Brief Interventions:** For mild AUD, provide motivational interviewing and brief counseling. Set specific goals for reducing or abstaining from alcohol use.
- **Pharmacotherapy:** Recommended as part of a comprehensive treatment plan.
  - **First-line medications:**
    - *Naltrexone, available PO/IM:* Reduces cravings and blocks the rewarding effects of alcohol. Contraindicated in patients with significant liver impairment or opioid use.
    - *Acamprosate, available PO:* Helps maintain abstinence by modulating glutamate activity. Safe in patients with liver disease but contraindicated in severe renal impairment.
      - *Medication adjustments should be guided by continuous assessment and relevant laboratory findings.*
  - **Second-line medications:**
    - *Disulfiram, available PO*: Acts as a deterrent by inducing adverse reactions when alcohol is consumed. Suitable for highly motivated patients with strong support systems.
    - *Gabapentin, available PO and Topiramate, available PO*: May be used off-label for craving reduction and relapse prevention.
- **Psychosocial Interventions:**
  - Cognitive Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET), and 12-step programs (e.g., Alcoholics Anonymous) are effective.
  - Incorporate family or couples therapy when appropriate.
- **Management of Withdrawal**
  - Outpatient Withdrawal: For mild-to-moderate withdrawal, use symptom-triggered benzodiazepine therapy, clonidine or gabapentin. Monitor for progression to severe withdrawal.
    - Benzodiazepines are considered first line treatment due to effectiveness in reduction of withdrawal symptoms including seizure and delirium.
  - For patients in which benzodiazepine use is contraindicated, phenobarbital use may be considered.

- Clonidine can help alleviate some withdrawal symptoms, elevated blood pressure and heart rates associated with AUD.
- Utilization of Clinical Institute Withdrawal Assessment for Alcohol (CIWA) can aid in classification of severity of withdrawal symptoms.
- Severe Withdrawal: Refer to inpatient care for complications such as delirium tremens or seizure.

Follow-up Care

- Regular follow-up appointments to monitor progress, adherence to medications, and engagement in psychosocial treatments.
- Monitor for relapses using urine toxicology if clinically indicated.

Considerations

- **Telehealth:** Can facilitate access to care, especially in underserved or remote areas. Use for counseling, monitoring medication adherence, and follow-up visits.
- **Comorbidities:** Manage co-occurring conditions such as depression, anxiety, PTSD or chronic pain concurrently with AUD.
- **Cultural Competence:** Tailor interventions to align with the patient's cultural, social, and individual needs.
- **Social Determinants of Health:** Address barriers such as housing instability, unemployment, financial and/or lack of transportation that may hinder recovery.
- **Stigma Reduction:** Use person-first language (e.g., "individual with AUD" rather than "alcoholic") and foster a nonjudgmental therapeutic environment.
- **Familial Risk:** Numerous family studies have consistently demonstrated genetic predispositions to AUD. Heritable factors contribute to approximately 40% to 60% of the overall variance in alcoholism risk.

ICD-10 Coding

- **F10.10** Alcohol abuse, uncomplicated.
- **F10.20** Alcohol dependence, uncomplicated.
- **F10.230** Alcohol withdrawal with seizures.
- **F10.231** Alcohol withdrawal delirium.
- **F10.21** Alcohol dependence, in remission.

Health Disparities

- Disparities in AUD prevalence and access to treatment exist across racial and socioeconomic groups. For example:
  - **African Americans:** Higher rates of untreated AUD due to systemic barriers.
  - **Latinx Populations:** Increased stigma and reduced access to culturally tailored services.
  - **Native Americans/Inuit and First Nation:** Limited access to medical services, higher rates of chronic disease, and systemic barriers rooted in historical trauma and underfunded healthcare infrastructure.
- Advocate for equitable access to care and community-based resources.

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