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Physicians' Tools for Treating Patients Who Drink Too Much

WHAT CAN WE DO AS A PHYSICIAN TO HELP PATIENTS WHO DRINK TOO MUCH

What can we as physicians do in our office besides sending our patients to rehab when they drink too much. You are listening to the Clinician's Round Table. I am your host, Dr. Larry Kaskel. Joining me today is Dr. Mark Willenbring, Clinical Professor of Psychiatry at George Washington University School of Medicine and Director of The Treatment and Recovery Research Division of the National Institute on Alcohol Abuse and Alcoholism.

DR. LARRY KASKEL:

Dr. Willenbring welcome to the show.

DR. MARK WILLENBRING:

Thanks for having me.

DR. LARRY KASKEL:

Can you tell me a little bit about some of the newer clinical tools that the NIAAA has actually come out with to help us, assess our patients, to see if they are problematic.

DR. MARK WILLENBRING:

I would be happy to. For about 15 years, NIAAA has published a Physician's Guide and in 2005, we revised it rather substantially and it is now called the Clinician's Guide, because it may be helpful for other clinicians besides physicians, but it is primarily oriented towards physicians or other prescribers, primary care providers for example and this Clinician's Guide provides doctors with the tools they need to do screening, assessment, and treatment in their offices in a very time-efficient way in addition to having the option of referring people with alcohol dependence to an alcohol treatment program.

DR. LARRY KASKEL:

I want to jump in there because I am a general internist, and I have 12 minutes to spend with each patient, so I don't see how I can do a good job at counseling and/or even unearthing a drinking problem and/or doing it well in 12 minutes, its just my hands are full enough.

DR. MARK WILLENBRING:

Well it is not expected that every time you see the patient, you are going to be doing this and we recognize that most physicians will do this selectively, just like you do for every other disease. In other words, I imagine you would probably treat depression in your practice.

DR. LARRY KASKEL:

I do.

DR. MARK WILLENBRING:

But you don't spend, you know, half an hour with every patient to do an assessment of their mental health and so forth. Most of your patients probably come saying I am depressed and by the way I am interested in getting treatment for it. I think there is a huge need for that and I think that there are many people out there, who are functional, but they are alcohol dependent and they know it and if they thought that there was a treatment that was effective that they could get from their primary care doctor, I think they would present with this problem. They would say, I really want some help. I am drinking too much. I heard about this medication doctor, can you prescribe it.

DR. LARRY KASKEL:

So the stigma has to be removed as it was for Prozac many years ago.

DR. MARK WILLENBRING:

For depression, yes that's right. What I ask people to do, if they haven't been through this, you know, picture yourself entering a treatment program tomorrow, walking in and getting the stigmatizing diagnosis you'll never get rid of. It is not a treatment that I think people find very appealing frankly. I think, I don't think most people like the idea of group counseling and I am not saying that's not effective, I am just saying that I think one of the reasons it is not used more is not only because it is hard to access for many people, but also because I think people are frightened of it or they are worried about the stigma. I think it is very different to go to your own doctor and say you know, could I try that medication for my drinking. I really, I have been trying to stop and I really can't and you know it is causing me some distress; some trouble and I would really like to stop. So what we have available now is, its extremely easy to scream. We have a single screening question. For men, the screening question is, how many times in the past year you have had 5 or more drinks in a day and what is a drink, while a drink is the amount of alcohol in about 12 ounces of beer or about 5 ounces of table wine like Burgundy or Chablis, and about 1.5 ounces, which is a shot in the US for 40% proof distilled beverages like vodka. They all have about the same amount of alcohol. One of the things that people should recognize of course is that beer has alcohol like any other beverages. Sometimes people don't even think of beer as an alcoholic beverage.

DR. LARRY KASKEL:

What's cut-off in terms of what's the appropriate answer?

DR. MARK WILLENBRING:

Basically it is zero. Because our recommendation is that healthy men never drink more than 4 drinks in a day and no more than 14 in a week. For women, the recommendations are no more than 3 in a day and 7 in a week. We find that simply by starting the conversation with that question, you can very rapidly screen for whether a person is engaging in heavy drinking on any regular basis. It turns out that over 70% of adults in the country never exceed those limits. So its often pretty quick that you rule this out.

DR. LARRY KASKEL:

If you have just tuned in, you are listening to the Clinician's Roundtable. I am your host, Dr. Larry Kaskel and my guest today is Dr. Mark Willenbring, Clinical Professor of Psychiatry at George Washington University School of Medicine and Director of the Treatment and Recovery Research Division of the National Institute on Alcohol Abuse and Alcoholism, and we are talking about what we can do as physicians to help our patients, who drink too much.

Dr. Willenbring you are saying that if you ask someone if they have had more than 5 drinks a day, that they have not done that ever in the last year and I got to think that college kids and people fresh out of college when they go out drinking on the weekends, they are going to have 5 to 6 drinks. They are going to fail that screen.

DR. MARK WILLENBRING:

You are absolutely right. Heavy drinking occurs primarily between the ages of 18 and 25 or 30 and then it goes down fairly rapidly and stabilizes until 50 where it really goes down to very low levels. So a positive screen is going to be more common among young people. That's why in step 2 of our guide, we provide a very quick way to assess whether someone has an alcohol use disorder and I think realistically most physicians will try to divide this into heavy drinking that's not causing problems and heavy drinking that's causing problems in a person's life.

DR. LARRY KASKEL:

Can we still use the rule of doubles when you ask them on how much they drink in a week and just double it whatever they tell us.

DR. MARK WILLENBRING:

Actually not, in this kind of a context, if it is asked in this kind of a matter-of-fact-way, by the way I usually embed it, I usually, you know ask people if they smoke and then I ask this screening question for alcohol and then I ask about other drugs and I ask about diet and exercise. One of the best…

DR. LARRY KASKEL:

Just slip it in there.

DR. MARK WILLENBRING:

Yeah, absolutely, so its just a matter-of-fact thing and actually the studies are very clear that most people will be quite honest.

DR. LARRY KASKEL:

Lets hear the question again.

DR. MARK WILLENBRING:

Well if for men, it is how many times in the past year have you had 5 or more drinks in a day. For women, it is how many times in the past year have you had 4 or more drinks in a day.

DR. LARRY KASKEL:

So that's easy to put into a screening questionnaire even by a nurse in our electronic medical record. I am going to do it tomorrow.

DR. MARK WILLENBRING:

Exactly and then if somebody is a heavy drinker, the next question is well, do they have drinking with problems, I mean, do they have an alcohol use disorder like alcohol dependence or are they simply an at-risk drinker. You know an at-risk drinker is somebody, who exceeds those limits on some regular basis, lets say once a month or more, but they don't meet any criteria for alcohol abuse or dependence and for those people, they don't have any symptom. They don't experience it as a problem. Most of the time, they simply don't realize its heath risk and so the idea here is simply to do secondary prevention to do risk reduction to educate patients and that's what we call a brief intervention or brief motivational counseling.

DR. LARRY KASKEL:

Dr. Willenbring I feel I have mastered the use of antidepressants in my practice and now I think it is time to enter into a whole new class of drugs to treat my alcohol-impaired patients. Tell me about the drugs that are out there that I should know about.

DR. MARK WILLENBRING:

There are 4 drugs that currently have effectiveness proven in alcohol dependence. The oldest drug and the one that most people are probably aware of is disulfiram, which is commonly known as Antabuse, that's a medication that if you are taking it and you drink alcohol, it makes you ill. That's not used very commonly and I don't think in primary care, that's going to be used very commonly at all. The most common medications, I think will be naltrexone, topiramate, and acamprosate. Now naltrexone is an opiate blocker that has an effect size that is very similar to antidepressants for outpatient depression. Very easy to prescribe, doesn't have very many interactions. It is a single daily dose and it is very well tolerated. The second medication is topiramate, known as Topamax, and most physicians are familiar with that because it is used pretty commonly now for migraine prophylaxis and that actually looks like a very, very good drug.

Now it has more side effects, but the trick there is you have to get the dose up. It actually has more side effects at low doses like 25 or 50 mg a day and the side effects tend to decrease or go away as you get up to 100 mg per day or greater, and one really interesting thing about topiramate is that in a recent study over the course of the study, more and more people in the topiramate group got into 28 days of abstinence. That is more people got into recovery over time and that trend hadn't stopped by the end of treatment.

DR. LARRY KASKEL:

And the beauty of using Topamax is if they are a heavy drinker and they withdraw potentially, they won't seize.

DR. MARK WILLENBRING:

Well that's right, its especially useful in circumstances where you are worried about seizures.

DR. LARRY KASKEL:

Back to naltrexone, what's the other name for that?

DR. MARK WILLENBRING:

You know its actually generic now. It was originally marketed as ReVia. Its marketed under a number of names now, but it is basically a generic medication.

DR. LARRY KASKEL:

I don't have any drug reps calling on me for any of these medicines and all my meetings I go to, none of this is discussed.

DR. MARK WILLENBRING:

This has been a major problem. You know when naltrexone was approved for the treatment of alcohol dependence. It had already been on the market for treatment of opiate dependence and there are only 2 years left in the patent life.

DR. LARRY KASKEL:

Yeah.

DR. MARK WILLENBRING:

So it was never actively marketed.

DR. LARRY KASKEL:

Right.

DR. MARK WILLENBRING:

Topiramate does not have this indication.

DR. LARRY KASKEL:

Indication, okay.

DR. MARK WILLENBRING:

So it can't be marketed for that indication. The only medication that has, well actually there are 2 forms of medication that have been marketed somewhat more aggressively recently and that is an injectable form of naltrexone. Naltrexone comes in a long-acting injectable form that actually lasts a month. It is a very nice product and that's marketed under a name Vivitrol. The other one is acamprosate and that's marketed as Campral. However, that has been primarily marketed to the psychiatric community. I think that one of the challenges here has been that pharmaceutical companies have been somewhat baffled by the market. Typically when you are marketing a drug, let's say a cardiovascular drug, you start with the specialists, the cardiologists, and then you move into primary care from there. With alcohol dependence, currently that doesn't work because treatment programs basically offer group counseling and AA in the United States and they are not medically oriented and they don't have physicians on staff. So trying to start there simply doesn't work and I think that's been a mistake that pharmaceutical companies have made; however, there is growing interest among major pharmaceutical companies now and several of them are pursuing this indication with new medications that are not currently on the market for any other indication and I think they see the potential. The market potential here, I think, is enormous. I think it's similar to that for depression when the SSRIs came out.

DR. LARRY KASKEL:

Dr. Mark Willenbring of the NIAAA, thank you very much for coming on the show.

DR. MARK WILLENBRING:

My pleasure, thanks for having me.

DR. LARRY KASKEL:

I am Dr. Larry Kaskel and you have been listening to the Clinician's Roundtable on ReachMD XM157. If you would like to comment or listen to our full library of on-demand podcasts, please visit our web site at ReachMD.com. Once there, if you register with a promo code 'RADIO', we will give you 6 months free of streaming ReachMD, you can listen to at home or at work. You can also reach us by phone,

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