Guideline for GP’s in primary care for safe prescribing of acamprosate in Sheffield

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Introduction

Acamprosate is a medication that can enable abstinence from alcohol following detoxification in alcohol dependent individuals. It was licensed for this indication in the UK in 1996. Its mechanism of action involves blocking the excitatory activity in the brain by enhancing the inhibitory system through GABA, an inhibitory neurotransmitter.

Early studies showed a doubling of the chances of achieving abstinence on acamprosate following detoxification\(^1\). It is better than placebo for a number of other outcomes which include fewer drinking days, greater treatment retention and less craving. The benefits appear to continue after stopping the medication, with higher rates of abstinence when compared to placebo 1 to 2 years after stopping acamprosate\(^2\). There is no clear evidence as to which individuals will benefit from acamprosate. Gender, age of onset, and severity of dependence do not necessarily predict treatment efficacy\(^3\).

Indications for prescribing acamprosate

- Consider prescribing acamprosate in patients who have undergone detoxification and where there is significant craving.
- Acamprosate should be prescribed in combination with psychosocial treatments aimed at maintaining abstinence from alcohol\(^4\).
- It should be started as part of the detoxification process and initiated as soon as possible after abstinence has been achieved.\(^5\) It should be maintained if the individual lapses. Continued alcohol consumption negates the therapeutic effects of acamprosate, occasional lapses do not have this effect\(^6\).
- Acamprosate can be initiated in primary care. If uncertain, please seek advice from the Alcohol Services at Fitzwilliam Centre on 0114 3050500.
Doses\textsuperscript{8} and duration of treatment with acamprosate

General Practitioners may offer acamprosate to their patients undertaking a detoxification from day 3 of the detoxification and in patients who present abstinent from alcohol in the surgery.

General Practitioners should actively monitor its efficacy terms and provide links to local support services.

http://www.shsc.nhs.uk/our-services/substance-misuse/open-access-alcohol-services

Acamprosate should be discontinued in patients who have relapsed to previous levels of drinking following a detoxification.

Base-line investigations:

Before starting treatment the following baseline investigations should be carried out including baseline full blood count; urea and electrolytes and extended liver function test, including GGT (Gamma Glutamyl Transferase).

Table 1: Baseline Investigations

<table>
<thead>
<tr>
<th>Investigation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBC</td>
<td>Some of the physical health complications associated with chronic alcohol use is related to dietary deficits, and the MCV (above 100 fL) can serve as a marker for alcohol use and associated dietary deficits. The MCV usually takes 3 months to correct itself with abstinence.</td>
</tr>
<tr>
<td>U &amp; E</td>
<td>Acamprosate is contraindicated in cases of renal insufficiency (serum Creatinine &gt; 120 micromol/L).</td>
</tr>
<tr>
<td>LFT</td>
<td>The kinetics of acamprosate is not modified in group A or B of the Child-Pugh classification of impaired liver function, a population which is likely to be part of the target population for acamprosate. The safety and efficacy has not been established in patients with severe liver insufficiency (Child-Pugh classification C).</td>
</tr>
</tbody>
</table>
Table 2: Assigning a Child Pugh Score

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Ascites</td>
<td>None</td>
</tr>
<tr>
<td>Encephalopathy (grade)</td>
<td>None</td>
</tr>
<tr>
<td>Bilirubin (micromole/L) OR Bilirubin in Primary</td>
<td>&lt;35</td>
</tr>
<tr>
<td>Biliary Cirrhosis (micromole/L)</td>
<td>&lt;70</td>
</tr>
<tr>
<td>Albumin (g/L)</td>
<td>&gt;35</td>
</tr>
<tr>
<td>INR</td>
<td>&lt;1.7</td>
</tr>
</tbody>
</table>

The sum of the five scores from the above table is used to assign a “Child-Pugh grade” of A, B or C to the patient’s clinical condition at that point in time (see table 3).

Table 3: Classification of Child Pugh Score

<table>
<thead>
<tr>
<th>Child Pugh Grade</th>
<th>Child Pugh Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>5-6</td>
</tr>
<tr>
<td>B</td>
<td>7-9</td>
</tr>
<tr>
<td>C</td>
<td>10-15</td>
</tr>
</tbody>
</table>

If further advice is needed regarding baseline investigations please contact specialist services from the Alcohol Services at Fitzwilliam Centre on 0114 3050500.

- For adults 18 years and over who weigh 60kg and above, the recommended dose is 666mg tds.
- Those who weigh less than 60kg, the dose is 666mg in the morning, 333mg in the afternoon and at night.
- For 16-18 years acamprosate is unlicensed therefore it must only be prescribed under specialist supervision.

Acamprosate is not effective in all patients so its efficacy should be monitored and assessed at regular appointments and the drug withdrawn if there has been no major reduction in drinking.

Follow up

Monitoring of compliance with treatment can comprise of:

Service users taking acamprosate should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. If a patient DNA’s in two consecutive months then consider stopping acamprosate and send a letter to the patient advising them that acamprosate can no longer be issued unless they come in for a review with a clinician. Do not use blood tests routinely, but it is considered good
practice to check LFTs to monitor for recovery of liver function and as a motivational aid for service users to show improvement. It is good practice to check baseline LFT’s then repeat at 3 months to compare any changes in the result of the LFT. If the LFTs have deteriorated then a discussion around alcohol consumption needs to be addressed with the patient.  

CG115 Alcohol dependence and harmful alcohol use: NICE guidance

Acamprosate should usually be prescribed for up to 6 months, or longer for those benefiting from the drug who want to continue with it.

Treatment should be maintained if the patient has a temporary relapse but stopped if the patient returns to regular or excessive drinking that persists for 4-6 weeks after starting the drug. Pre-mature discontinuation may lead to relapse.

Acamprosate can be stopped without the need for dose reduction.

**Side effects and contraindications**

Acamprosate is a safe drug with few interactions. It is well tolerated and side effects tend to be minimal and transient. They include diarrhoea, nausea, vomiting and rash. This is not a complete list; the BNF and SPC remain authoritative.


**Glossary of terms**

**Detoxification**

The use of medication to alleviate the symptoms of withdrawal from alcohol, in an individual dependent on alcohol. It usually comprises of giving chlordiazepoxide or lorazepam in a reducing dosage regime over the course of 5-7 days, depending on the severity of withdrawal symptoms.

A detoxification is often the first step in supporting an individual, who is dependent on alcohol, to stop drinking. Detoxification on its own is often not enough in enabling an individual to maintain abstinence. Individuals can benefit from additional psychological interventions to help maintain abstinence long term.

**Lapse**

A lapse refers to a temporary return to alcohol consumption, usually following a detoxification in an alcohol dependent individual. A typical lapse lasts for about a day with the individual returning to abstinence following this.

**Relapse**

A relapse refers to a return to daily drinking, usually at previous levels of alcohol consumption, following a detoxification in an alcohol dependent
individual. Relapses are a common occurrence in dependent drinkers and are usually indicative of the severity of dependent drinking.

References

5. NICE guidelines; Alcohol dependence and harmful alcohol use, CG115, February 2011

CG115 Alcohol dependence and harmful alcohol use: NICE guidance
8. British National Formulary 64, September 2012