HERPC
Hull & East Riding Prescribing Committee

Prescribing Framework for DISULFIRAM as an adjunct in the treatment of alcohol dependence

Patient's Name:……..… NHS Number: ……

Patient's Address:……..……(Use addressograph sticker)

GP's Name:……..

Communication

We agree to treat this patient within this Prescribing Framework

Specialist Prescriber's Name…… Prof Reg. No. ……

Specialist Prescriber's Signature…… Date:…….

Where prescriber is <u>not</u> a consultant:

Consultant's Name: …… GMC No ……..

Consultant's Signature ……..... ……. Date:…….

GP's Signature:…… Date:……..

GP's Name (if different from listed above)……..

The front page of this form should be completed by the specialist and the form sent to the patient's general practitioner.
The patient's GP should sign and **<u>send back to specialist</u>**, to confirm agreement to enter into shared care arrangement. If the General Practitioner is **<u>unwilling</u>** to accept prescribing responsibility for the above patient the specialist should be informed within two weeks of receipt of this framework and specialist's letter.

Full copy of framework can also be found at : https://www.hey.nhs.uk/herpc/amber/

SHARED CARE FRAMEWORK FOR CLINICAL INFORMATION ONLY.
Drug and alcohol treatment services in Hull and East Riding are directly commissioned by Public Health with specialists and GPs, who prescribe treatment for opioid/ alcohol dependence as part of this locally commissioned Public Health service. GPs prescribing outside of these arrangements using this framework should do so in accordance with NICE guidance.

1. Background

Alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people.

Harmful drinking is defined as a pattern of alcohol consumption causing health problems directly related to alcohol. This could include psychological problems such as depression, alcohol-related accidents or physical illness such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer.

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or depression). Alcohol dependence is also associated with increased criminal activity and domestic violence, and an increased rate of significant mental and physical disorders.

People with moderate dependence (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks. People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting.

Chronic alcohol intake alters the balance of excitatory (e.g. glutamate) and inhibitory amino acids (e.g. gamma amino butyric acid) within the brain. Acamprosate crosses the blood brain barrier and is thought to act by complex neuromodulatory processes to restore the balance, especially the inhibition of glutamate which is thought to have an important role in dependency. It reduces craving and therefore the risk of relapse.

NICE Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence: Clinical guideline (CG115) Published: 23 February 2011 supports the use of disulfiram as an adjunct in the treatment of alcohol dependence.

After a successful withdrawal for people with moderate and severe alcohol dependence, consider offering disulfiram in combination with a psychological intervention to service users who:

- have a goal of abstinence but for whom acamprosate and oral naltrexone are not suitable

OR

- prefer disulfiram and understand the relative risks of taking the drug

2. Indication

Adjunct in the treatment of alcohol dependence (under expert supervision)

3. Dose

Adult- 200 mg daily, increased if necessary up to 500 mg daily.

4. Duration of treatment

Treatment should be commenced as soon as possible after alcohol withdrawal and should continue for 6 months to one year. Although treatment should be maintained if the patient

relapses (SPC recommendation), it should be discontinued if drinking continues 4-6 weeks after starting medication.
Service users taking disulfiran should stay under supervision, at least monthly, for 6 months, and at reduced but regular intervals if the drug is continued after 6 months. Do not use blood tests routinely, but consider them to monitor for recovery of liver function and as a motivational aid for service users to show improvement.

5. Contraindications and cautions

Disulfiram is contraindicated in patients with cardiac failure; coronary artery disease; history of cerebrovascular accident; hypertension; psychosis; severe personality disorder and suicide risk

Disulfiram should be avoided in patients with acute porphyrias; diabetes mellitus; epilepsy and respiratory disease

Alcohol challenge is not recommended on routine basis (if considered essential it should only be undertaken in specialist units with resuscitation facilities)

6. Adverse effects

Frequency not known: Allergic dermatitis; breath odour; depression; drowsiness; encephalopathy; fatigue; hepatocellular injury; libido decreased; mania; nausea; nerve disorders; paranoia; schizophrenia; vomiting

7. Interactions

Acenocoumarol- Disulfiram increases the anticoagulant effect of Acenocoumarol. Manufacturer advises monitor and adjust dose. **Severity: Severe**
Alcohol (beverage)- Alcohol (beverage) causes an extremely unpleasant systemic reaction when given with Disulfiram. Manufacturer advises avoid for at least 24 hours before and up to 14 days after stopping treatment. **Severity: Severe**
Fosphenytoin- Both Disulfiram and Fosphenytoin can increase the risk of peripheral neuropathy. Disulfiram increases the concentration of Fosphenytoin. Manufacturer advises monitor concentration and adjust dose. **Severity: Severe**
Metronidazole- Both Disulfiram and Metronidazole can increase the risk of peripheral neuropathy.Disulfiram increases the risk of acute psychoses when given with Metronidazole. Manufacturer makes no recommendation. **Severity: Severe**
Phenindione- Disulfiram is predicted to increase the anticoagulant effect of Phenindione. Manufacturer makes no recommendation. **Severity: Severe**
Phenytoin- Both Disulfiram and Phenytoin can increase the risk of peripheral neuropathy. Disulfiram increases the concentration of Phenytoin. Manufacturer advises monitor concentration and adjust dose. **Severity: Severe**
Warfarin- Disulfiram increases the anticoagulant effect of Warfarin. Manufacturer advises monitor and adjust dose. **Severity: Severe**

Full details of contraindications, cautions, drug interactions and adverse effects listed above are not exhaustive. For further information always check with BNF www.bnf.org.uk or SPC (www.medicines.org.uk).

8. Monitoring

There is no necessity for biochemical or other physical health monitoring, although biochemical monitoring may be considered to monitor for recovery of liver function and as a motivational aid to show improvement. The specialist who initiated the treatment will

review the patient at least monthly for 6 months and at reduced but regular intervals if the drug is continued after 6 months.
During treatment with disulfiram, patients should be monitored for response to treatment at least every 2 weeks for the first 2 months, then each month for the following 4 months, and at least every 6 months thereafter.

9. Information to patient

Patients and their carers should be counselled on the disulfiram-alcohol reaction—reactions may occur following exposure to small amounts of alcohol found in perfume, aerosol sprays, or low alcohol and "non-alcohol" beers and wines; symptoms may be severe and life-threatening and can include nausea, flushing, palpitations, arrhythmias, hypotension, respiratory depression, and coma.

Patients and their carers should be counselled on the signs of hepatotoxicity—patients should discontinue treatment and seek immediate medical attention if they feel unwell or symptoms such as fever or jaundice develop

10. Responsibilities of clinicians involved

Stage of Treatment	Specialist	General Practitioner
Initiation	Evaluate patient's suitability for treatment-some patient factors, for example memory impairment or social circumstances, make compliance to treatment or abstinence from alcohol difficult. • Specialist initiation and monitoring for the first month • Perform baseline renal function and liver function tests including GGT • Provide written and verbal information about Disulfiram • Assess and recommend appropriate treatment to GP, including the duration of treatment and other forms of aftercare	
Maintenance	• Available for advice • Review patient every month for the first 6 months • After 6 months review at a reduced but regular interval • Patient must be in receipt of continuing therapeutic intervention from a specialist team	• Take over prescribing from specialist after the first month. • Monitor response to treatment and adverse effects every 3 months. (Psychiatric and mental co-morbidity may occur in patients with a history of alcohol abuse) • Monitor alcohol intake. • Refer to specialist where necessary

Contact Details:

Contact Specialist as per clinic letter

During office hours	Out of hours:
Humber Teaching NHS Foundation (HTFT) Baker Street (01482 336562	Victoria House and ask for the on-call consultant 01482 223191
CGL ReNEW Hull Trafalgar House, 41-45 Beverley Road Hull, HU3 1XH 01482 620013 earlyhelp.hull@cgl.org.uk	

APPROVAL PROCESS

Written by:	***Jackie Stark, Principal Pharmacist (Clinical Services), HTFT***
Consultation process:	***Include Specialist Team***
Approved by:	***Include MMIG, HTFT DTC***
Ratified by:	***HERPC May 2019***
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