Alcohol Use Disorder Pathway

Screen, assess withdrawal risk, treat with pharmacotherapy

CLINICAL PATHWAY

Screen with AUDIT-C at every opportunity. Assess withdrawal risk **before** advising abstinence — sudden cessation in a physically dependent drinker can cause life-threatening withdrawal. Give thiamine before glucose or IV fluids, always.

SCREENING & RISK STRATIFICATION

- **AUDIT-C (3 Qs):** positive screen ≥4 (men) / ≥3 (women) → full AUDIT or clinical assessment. Standard drink = 10g alcohol
- **Full AUDIT:** 8–15 hazardous (brief intervention) · 16–19 harmful (brief intervention + consider referral) · ≥20 likely dependence
- **NHMRC safe limits:** ≤10 standard drinks/week and ≤4 on any one day — no level is entirely without risk
- **Brief intervention (FRAMES):** Feedback, Responsibility, Advice, Menu, Empathy, Self-efficacy — 5–15 min, repeat at every visit

WITHDRAWAL RISK ASSESSMENT

- **CIWA-Ar:** <8 mild · 8–15 moderate · >15 severe — score at each review
- **High risk → inpatient:** prior DTs/seizures, poly-substance dependence, significant medical/psychiatric illness, poor social support
- **Baseline bloods:** FBC (MCV), GGT, ALT/AST, glucose, electrolytes, Mg, creatinine

WITHDRAWAL MANAGEMENT

Ambulatory if CIWA-Ar <15, good support, no prior complicated withdrawal — daily review for ~5 days with a written contingency plan. **Diazepam**, symptom-triggered and tapered over 5–7 days, is commonly preferred (lorazepam if hepatic impairment — no active metabolites). **Thiamine first, always** — oral for routine prophylaxis; use the IV/high-dose regimen urgently if Wernicke's is suspected (confusion + ataxia + ophthalmoplegia).

PHARMACOTHERAPY OPTIONS

Start after withdrawal is complete

1. **Naltrexone (1st-line)** — opioid antagonist; reduces craving/heavy drinking. Avoid with current opioid use or if ALT/AST >3× ULN; not CI in compensated liver disease
2. **Acamprosate (1st-line)** — reduces craving in abstinent patients; renally excreted, no liver risk; avoid in severe renal impairment and pregnancy; can combine with naltrexone
3. **Disulfiram (2nd-line)** — aversion therapy; not PBS-listed; supervised administration preferred; avoid in CVD, psychosis, pregnancy and significant hepatic disease

EXACT DOSES & PBS CRITERIA

Naltrexone and acamprosate are PBS-subsidised for dependence within a comprehensive treatment program (authority requirements apply and have changed over time) — confirm current doses, authority method and full prescribing criteria at pbs.gov.au and in the AMH before prescribing.

PSYCHOSOCIAL SUPPORT (required alongside drug Rx)

- **Brief intervention / motivational interviewing** at each consult — explore ambivalence, non-confrontational
- **CBT / counselling** — triggers, coping strategies, relapse prevention (psychologist or AOD counsellor)
- **SMART Recovery or AA** — evidence-based peer/self-help support, widely available

■ SAFETY

- Thiamine always before glucose or IV fluids — Wernicke's risk
- Diazepam: titrate to CIWA-Ar; review if >80mg needed in 24h
- Naltrexone is contraindicated with current opioid use — precipitates withdrawal
- Acamprosate contraindicated in severe renal failure (CrCl <30) and pregnancy

■ RED FLAGS / REFER

- CIWA-Ar ≥15 or deteriorating, or prior DTs/seizures — inpatient detox
- Complex comorbidities — liver failure, cardiac disease, psychosis, poly-drug use, suicidality
- Failed two or more outpatient attempts — residential detox / AOD specialist
- Severe depression, psychosis or suicidality — reassess after 4–6 weeks sobriety before attributing to alcohol

For health-professional use. Adapted from NHMRC alcohol guidelines, DACAS, and Australian Prescriber.
Exact PBS criteria, doses & cautions — confirm at pbs.gov.au and the AMH; this is a summary, not the full PI.
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