CASE RECOMMENDATION FORM

Presenter Credential: PharmD

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Summary: 30-year-old male with a 10-year history of heavy alcohol use and elevated liver transaminases. His psychiatric history includes childhood ADHD (inattentive type) currently managed with Vyvanse 50 mg daily for over five years, possible ASD, untreated depression (unipolar vs. bipolar II), and seasonal affective disorder. He reports a history of failure to thrive in adolescence and a family history of alcohol and opioid use disorders. Past treatments include Ritalin, unspecified antidepressants, and intermittent counseling attempts. Despite efforts, he has been unable to reduce his alcohol consumption and demonstrates fair medication adherence. The case raises questions about accessing injectable naltrexone, criteria for inpatient versus outpatient alcohol detox (particularly with concurrent benzodiazepine use), and managing necessary opioid pain treatment following dental infection two weeks post–alcohol detox.

Recommendations:

- Pain Management Post Detox:
  - For a patient without a history of OUD, who recently completed alcohol detoxification, pain should be managed using standard clinical approaches.
    - Begin with scheduled acetaminophen and NSAIDs as first-line therapy.
    - Nonopioid alternatives such as ketorolac (Toradol) can be effective for acute pain management but should not be used for more than 5 days.
  - If opioids are required:
    - Prescribe the lowest effective dose and limit the quantity (typically a 3-day supply for perioperative pain).
    - Dispense in small amounts to reduce the risk of combining opioids with alcohol.
    - Always co-prescribe Narcan when providing an opioids prescription.
- Balancing Pain Control and Sobriety:
  - Untreated pain can trigger relapse – withholding evidence-based pain management may increase cravings and risk of substance use.
  - Have an open discussion with the patient about:
    - Their increased risk of developing a new SUD due to prior alcohol dependence.
    - The rationale for a short opioid course is to balance pain control and relapse preventions.
  - Emphasize that adherence to a detoxification and pain management plain significantly reduces relapse risk.
- Naltrexone Initiation:
  - Start naltrexone whenever the patient is ready, willing, and able – if they are not currently on opioids or in acute pain.
  - Oral naltrexone can be used as a short-term bridge before initiating injectable naltrexone.
  - There is no risk of precipitated withdrawal when initiating naltrexone for AUD.
  - Avoid naltrexone is the patient may need opioid pain treatment, as it will block opioid effects.

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  - For compliant patients, oral and injectable naltrexone are equally effective, but oral can be preferred due to lower costs. In OUD, the injectable form is more effective due to adherence and delayed access challenges.
- Managing Acute Pain in Patients on Naltrexone:
  - If an elective procedure is taking place, stop oral treatment 72 hours before the procedure and stop the injection 30 days prior.
  - If a patient on injectable naltrexone experiences severs or unexpected pain, do not attempt to override the effects of the drug in an outpatient setting, but this can be done with inpatient pain management.
  - Consider local anesthesia injections by the dental team, along with NSAIDs, acetaminophen, and hot/cold therapy.
- Benzodiazepine and Opioid Use Considerations
  - Avoid the combination of drugs whenever possible.
  - For pain management, consider buprenorphine (partial) rather than a full mu-opioid agonist.
  - Patients with alcohol withdrawal and opioid use should be managed in a controlled inpatient setting.
  - If alcohol use is mild, gabapentin may be considered as an alternative, though still with caution. It carries less risk than benzodiazepines combined with opioids.

Consider presenting follow-up for this patient case or any other patient cases at a future ECHO Clinic session.

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