ASAMNEWS

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Newsletter of The American Society of Addiction Medicine

ASAM Cautions White House Against Over-Hasty Approval of Tobacco Settlement

G. Douglas Talbott, M.D.

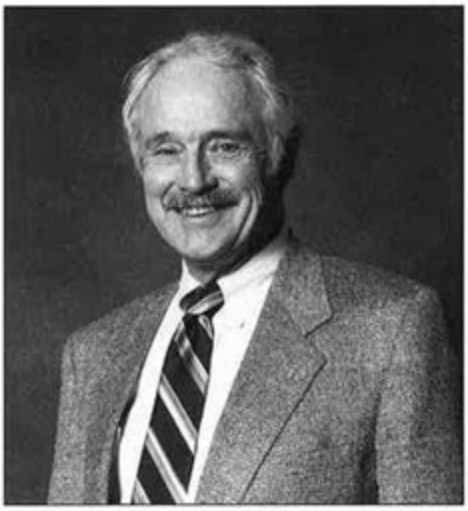
On behalf of the officers and members of the Society, I have sent the following letter to President Clinton, commenting on the proposed tobacco settlement:

Dear President Clinton:

Tobacco is both the leading cause of preventable death and the leading cause of addiction in the United States today. Working out a solution to this problem is too important for it to be done in haste, and it seems folly to do it before all the facts are known.

The manufacturers of tobacco products have never been accountable for the harm their products cause. The main objective of any legislation in this area must be, finally, to hold the industry accountable. This is the most certain way to reduce the terrible toll of illness and death from these products. Unfortunately, the Proposed Resolution negotiated by some of the states' Attorneys General with the larger manufacturers falls far short of this goal.

While the American Society of Addiction Medicine is open to the possibility that new federal legislation might make the industry accountable, the Society is profoundly disturbed by the seeming haste with which things are moving forward on this matter.



G. Douglas Talbott, M.D.

The Society is especially concerned that some of the short-term gains, such as changes in advertising, are being oversold to members of Congress and the public as being of greater public health importance than they actually are.

The Proposed Resolution has been found seriously wanting by every medical and public health group of which the Society is aware. Rumors abound of negotiations which are leading to changes in the terms, but there has yet been no public examination of these new terms.

Any revision to the original proposal will have to be examined by all interested parties with great care. There is a profound imbalance here: the tobacco companies are intimately involved in the present discussions, but the public health community is not. Only after the industry reaches agreement with the Administration will the public health community be able to examine what is being recommended.

The health of the nation is too important for this deal to be done in haste. Any legislative proposal which comes out of the discussions the Administration is having with the litigants in the state suits should be fully aired and carefully, deliberately reviewed. Moreover, the state litigation should be encouraged to continue to unfold. The state case in Minnesota is scheduled to begin in January, and it promises to show more clearly than any other the way these companies behave and the degree to which they can be trusted.

The tobacco industry must become accountable. Legislation to resolve the tobacco issues now on the public agenda should be considered with great deliberation. Hasty action will lead to needless illness and death. Artificial early deadlines to complete action on this matter only work to the advantage of the tobacco product manufacturers. They are not in the public interest.

(Copies of this letter also were delivered to Vice President Gore, ONDCP Director Gen. Barry McCaffrey, members of Congress, and John Slade, M.D., FASAM, Chair of the ASAM Nicotine Dependence Committee.)

"The Society is especially concerned that some of the short term gains...are being oversold to members of Congress and the public as being of greater public health importance than they actually are."

INSIDE

American Society
of
Addiction Medicine

ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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JAMA PUBLISHES ASAM PRACTICE GUIDELINE ON MANAGEMENT OF ALCOHOL WITHDRAWAL

Michael Mayo-Smith, M.D.

Significant advances in the management of alcohol withdrawal and treatment of alcohol dependence were signaled with publication in the *Journal of the American Medical Association* of a clinical practice guideline developed by ASAM on the "Pharmacologic Management of Alcohol Withdrawal: A Meta-analysis and Evidence-Based Practice Guideline" (*JAMA 1997;278(2):144-151*). The ASAM Guideline was developed by a group of physicians including specialists in addiction medicine, primary care physicians and researchers in alcohol withdrawal drawn from institutions around the country including Harvard, Yale, and Johns Hopkins Medical Schools. The evidence-based process used in developing the Guideline incorporated the latest recommendations on clinical practice guidelines from such organizations as the Institute of Medicine, the Agency for Health Care Policy and Research, and the American Medical Association.

The review demonstrated that a certain class of medications, the benzodiazepines, have been proven to both lessen the severity of alcohol withdrawal and prevent major complications including seizures and delirium tremens. In addition, it was found that individualizing therapy using objective withdrawal severity scores greatly reduced the amount of medication needed, and the duration of treatment, without lessening safety. Surveys have shown that this approach is largely underutilized in the field.

For your copy of ASAM's new
Practice Guideline on the Pharmacologic Management of Alcohol Withdrawal,
see the pull-out section beginning on page 7 of this issue of *ASAM News*.

The Guideline, derived from a careful analysis of published scientific studies, is strongly evidence-based. All scientific studies published in the medical literature regarding pharmacologic management of alcohol withdrawal were identified and carefully reviewed. While previous individual studies have suggested that benzodiazepines lessened the severity of alcohol withdrawal and prevent major complications, the opportunity to pull together a large number of studies from the literature and combine their results, allowed this finding to stand out in a striking way. The review also found that, although dozens of other medications have been used to treat alcohol withdrawal, none have been proven to be as effective as the benzodiazepines.

This Guideline is one of several evidence-based guidelines being developed by ASAM's Committee on Practice Guidelines to strengthen the scientific foundation of addiction treatment and improve the care of patients with these disorders throughout the country.

VOTE 425 ON THE AMA SPECIALTY SOCIETY BALLOT

Michael M. Miller, M.D., ASAM Delegate to the AMA

The American Medical Association is again asking AMA member physicians to indicate the medical specialty society they want to represent them in the AMA House of Delegates.

Ballots must be received by December 31, 1997. Voting can be done in several ways:

- ❑ Faxing a ballot reply card that was attached to the October 13 issue of *AMNews*;
- ❑ Calling a toll-free phone number: **888/200-5309**; or
- ❑ E-mailing the choice to **ballot@ama-assn.org**.

However you cast your ballot, remember to **"Vote 425"** for ASAM as your representative medical specialty society!

MILITARY MANAGED CARE WILL USE ASAM "GOLD STANDARD"

If the various elements of the military heath care system could be viewed as soldiers marching in unison, then substance abuse treatment traditionally has been the recruit having trouble keeping up with the group. But as managed care gradually envelops the military, addiction treatment is expected to evolve into a multidisciplinary system of care steeped in the field's most widely accepted guidelines.

Substance abuse has been off to the side in the military health care system," Roger Hartman, health policy analyst in the Department of Defense's Office of the Assistant Secretary for Health Affairs, told *ADAW*. "Our programs of treatment have been very service-specific; that is, the Army, Navy and Air Force all have done their own thing. The other feature was a "one-size-fits-all" approach to treatment, Hartman continued. "There was four-week residential treatment if that was indicated, and there was a comparable stay for outpatient. Those were about the only two choices."

But a policy memorandum issued earlier this year indicates that the old system is changing in a big way. As the military's medical program for active-duty members, retirees and qualified family members becomes a managed care system known as TRICARE, substance abuse treatment will grow to resemble the continuum of care outlined in ASAM's *Patient Placement Criteria*, which come closest to being the nation's clinical standards for addiction treatment.

"We pretty much recognized that ASAM is the gold standard in the industry right now," Hartman said.

Under TRICARE, the continental United States has been divided into 12 regions for health care services; in each region, one branch of the military or one facility has the lead role in overseeing care. Seven regions have managed care contracts already in place, with the remainder expected to have contracts by the end of this year or early 1998, Hartman said.

Hartman described the evolving substance abuse treatment system as offering "a full range of services provided by requisite professionals," including certified substance abuse counselors, mental health professionals and primary care physicians. With ASAM's patient placement criteria as a guide, the Department of Defense will be seeking to place clients in the least restrictive setting appropriate to their case, with civilian providers playing a prominent role.

Hartman, who worked in the Navy's drug and alcohol program for 10 years, says TRICARE's regional approach will result in a much more efficient system of substance abuse treatment services. In the past, active-duty members who were diagnosed as having addiction problems often had to be sent halfway across the country for the appropriate residential treatment, he said. Under TRICARE, line personnel still will have some involvement, but all treatment and aftercare services will be overseen by medical personnel, Hartman said.

ADDICTION MEDICINE NEWS

HEROIN USE IN U.S. DOUBLED SINCE 1994

Heroin use has never been higher in the U.S., and it is spreading rapidly from small towns to major cities, according to a report published in *USA Today*. Heroin is cheap, pure and plentiful in the U.S., with purity of the street drug at record levels—10 times higher than it was in 1980. This more potent form is easy and inexpensive to smoke, making it more attractive to new users. The U.S. Drug Enforcement Administration reports that twice as many people smoked heroin in 1995 as in 1994. Heroin deaths also are at their highest rate ever. "The same criminal structure that is pushing 240 metric tons of cocaine into America is also aggressively marketing heroin to a new generation of users," said Gen. Barry McCaffrey, Director of the Office of National Drug Control Policy.

MORE U.S. WOMEN DRINK WHILE PREGNANT

More pregnant women were drinking in 1995 than in 1991, raising the risk that more babies will suffer mental retardation, learning disorders and other problems associated with *in utero* exposure to alcohol, according to a new study from the Centers for Disease Control and Prevention. A telephone survey by the CDC found that 3.5 percent of 1,313 pregnant women in 1995 said they had had seven or more drinks per week, or binged on five or more drinks at once, within the preceding 30 days. That represents an increase from 0.8 percent of 1,053 pregnant women surveyed in 1991.

From the sample results, the researchers project that 140,000 pregnant women nationwide were frequent drinkers in 1995, compared with 32,000 women in 1991. The CDC also estimated that 16.3 percent of pregnant women surveyed in 1995 had at least one drink in the preceding month, compared to 12.4 percent in 1991. The reason for the increase is unclear, but CDC researchers plan to re-examine the survey to data in an effort to pinpoint causes.

TEEN SMOKING UP SHARPLY

Researchers calculate that teenage smoking rates, after declining in the 1970s and leveling off in the 1980s, have climbed sharply over the last five years.

Although everything from why the trend began to what might stop it is in dispute, it adds up to a huge health problem for the country and a public relations disaster for the tobacco industry. Indeed, the trend has played a crucial role in driving the once intractable industry into negotiations for a global settlement with regulators and its legal ad-age smoking rates are still lower than in the 1970s. But the percentage of 12th-graders who smoked daily last year jumped 20 percent since 1991, to 22 percent, according to the most recent edition of the University of Michigan's Monitoring the Future Survey. The rate among 10th-graders jumped 45 percent, to 18.3 percent, and the rate for eighth-graders is up 44 percent, to 10.4 percent.

Five million people now younger than 18 will eventually die of tobacco-related illnesses, at current smoking rates, according to the most recent projections from the Centers for Disease Control and Prevention in Atlanta. Rising youth smoking rates have been cited by the Food and Drug Administration and President Clinton as evidence that the industry is marketing its products to youth and should by restricted by the FDA. They are also fueling demands in many states and in the Congress for higher taxes on tobacco, based on research showing price increases typically discourage teen smokers more than adults.

MONEY FOR TREATMENT II: CLASS ACTION SUITS —A ROLE FOR YOU?

Marc Galanter, M.D., FASAM

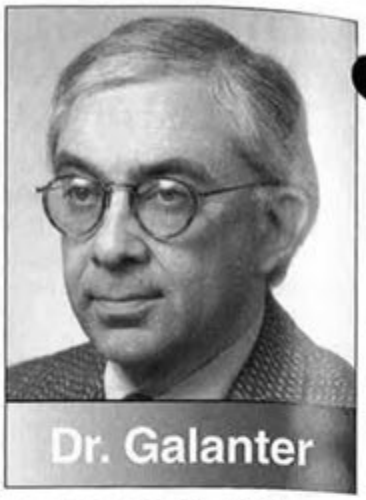
How many times have you been on the phone with a representative of managed care and been told that your treatment plan is not accepted? How can we in addiction medicine address this un- "manage"-able problem?

Fortunately, the time is ripe for us to take steps to limit the way managed care companies can compromise our patients' care. The public and their representatives in government are beginning to understand why doctors should not be blocked from making their own medical judgments. In fact, requirements are being imposed on managed care plans to provide a fairer system of appeals for emergency care and for inadequate care, as when needed hospitalization is denied. Recent investigations of managed care plans' operations suggest that numerous such abuses have occurred.

In "Money for Treatment I" (May-June *ASAM News*), we considered the many roles ASAM has played as an organization to assure proper coverage for addiction treatment. In this column, we will consider one way that individual physicians can confront corporate wrongdoers: namely, the class action lawsuit. In the addiction field, the effectiveness of this approach has been amply evidenced by tobacco. Individuals compromised by billion-dollar purveyors of cigarettes have gotten their day in court when represented as a group.

Here are some particulars about one relevant set of lawsuits, and information on how you can contact the attorneys who are undertaking this initiative if you have relevant information.

Up to 23 class action lawsuits are being considered against Blue Cross plans that "carve out" substance abuse and mental health from their managed care operations and then use Green Spring Health Services, Inc., to review the appropriateness of proposed treatment. The underlying allegation is that patients are being denied needed care because the criteria used by Green Spring to evaluate an inpatient stay are more restrictive than those spelled out in the description of benefits patients received from Blue Cross. The suits would allege that Green Spring deliberately uses its criteria for medical necessity, and that these criteria are more restrictive and impose more preconditions than those described in the publicly available benefit documents. Not only will the lawsuits seek to enforce the criteria described by Blue Cross, they will attempt to correct the harm from this practice by having all prior denials reviewed using the Blue Cross criteria.


Dr. Galanter

ASAM's Executive Committee has decided to provide you with the following information so that, as an independent practitioner, you can decide whether you wish to bring any cases to the attention of the law firm handling the class action suits, although ASAM as an organization is not taking a formal position on the suits at this time.

Members of ASAM have been invited by the law firm pressing the suits to provide clinical examples of the practices being alleged. The attorneys have asked for case histories of patients who could bring suit in order for the class actions to succeed. They will represent patients who: (1) are covered under a health insurance plan issued or administered by a Blue Cross plan, and (2) have been denied coverage for substance abuse treatment at any time due to a determination by Green Spring that the treatment was not medically necessary.

If you have such a patient in your practice, you can prepare a case summary with blinded patient identity, giving particulars of (1) the patient's characteristics and diagnosis, (2) the indications for care, and (3) the denial of care, so that its suitability can be reviewed. Patient identification might later be undertaken, with the patient's consent, if the case is added to the suit.

You should send this material directly to Edward Carnot at the law firm of Carnot, Zapor & Klassen, P.C., Suite 290, 1370 Piccard Drive, Rockville, MD 20850-4304; or phone 301/258-1994 or fax 301/948-2155.

IN MEMORIAM

Long-time ASAM member Julian F. Keith, M.D., died July 18, 1997, after a long illness. During his illness, Dr. Keith continued his leadership activities in the field of addiction medicine, which he served most recently as Director of Alcohol and Other Drug Services in the North Carolina Department of Human Resources.

Dr. Keith is survived by his wife, Sue Ann Keith, and by his five sons and one daughter. The family has requested that memorials be directed to the Hazelden Foundation (Center City, MN 55012-0176); the Julian F. Keith Family Medicine Visiting Professorship at the Bowman Gray School of Medicine (Winston-Salem, NC 27157); the Julian F. Keith Prevention Advocacy Center (c/o Sue Gray, UNC Campus, Box 7470, Chapel Hill, NC 27599); or the Hospice of Wake County (4513 Creedmoor Road, Raleigh, NC 27612).

THOUGHTS ON SPIRITUALITY AND HIV INFECTION

Charles W. Morgan, M.D.

Each of the Medical-Scientific Conferences of the American Society of Addiction Medicine has highlighted the tremendous advances in our knowledge of the basic science of addiction. Similarly, treatment options for and knowledge of the disease process in patients infected with HIV have advanced significantly. Triple therapy has resulted in plummeting viral loads, which have remained low or nil over time. Understandably, we are delighted with our increased scientific knowledge and its clinical applications.

However, we also must remember the importance of spiritual recovery and treatment for our patients who are infected with HIV. As addictionists, we know that it is necessary to address the needs of the body, the mind and the spirit. This is equally true of persons who have HIV infection. Our expertise in treating the patient's physical problems must be complemented by attending to their emotional and spiritual needs. Many of us have heard statements such as, "If I were infected with HIV, I don't know if I would get sober either." Such hopeless, negative attitudes are communicated to patients in subtle ways by treatment providers. We may have heard fellow professionals say these things, or even said or thought them ourselves. At the same time, we are convinced that there are only the best reasons to become sober, regardless of--or perhaps even because of--whatever other conditions our patients may have.

Certainly with triple drug therapy, long-term survival seems increasingly within reach for many patients. Regardless of life expectancy, quality of life is supremely important. Even if total life expectancy is short, we can assure our patients of increased survival rates if risky behaviors are reduced, if self-care is increased, and if the likelihood of contracting other related or unrelated illnesses and injuries is decreased. When these conditions are met, length and quality of life improve.

One of the main gifts we have to offer our patients is hope, either for longer term survival or for enhanced quality of life. We can offer this to our patients who are HIV-positive whether or not they have associated problems with addiction.

In addition, there is a growing body of evidence that shows a direct correlation of improved immune function with enhanced emotional health. Helping others (e.g., volunteer work or 12th Step work in a recovery program) boosts immunity. Intercessory prayer has been shown to enhance survival in acute exacerbation of chronic illness. Therefore, attention to the spiritual needs of patients with HIV infection is certainly indicated.

We also must address the spiritual needs of family members and friends of HIV-positive patients. The patient's lover, spouse, parents, children and friends can provide tremendous support to the patient and each other which can enhance not only the quality of life of the HIV-positive patient, but also the long term survival. Providing encouragement for involvement in support groups is of paramount importance.

For our addicted patients, the ongoing support of 12 Step programs for HIV-positive patients and their loved ones is of inestimable importance in maintaining sobriety and building emotional support networks. Various 12 Step groups around the country have developed in which it is now common to speak of one's HIV infection and the emotional, physical and spiritual aspects of dealing with the infection. 12 Step meetings for Gay and Lesbian people have led the way for this openness. The twelve steps themselves provide effective ways for dealing with the emotional aspects of one's own HIV infection or the infection of a loved one, as well as clinical improvement in the disease process.

The spiritual aspect of making panels for the AIDS Quilt, as well as providing support for memorialization in various organizations, is extremely helpful. Decisions will be made during the course of HIV infection, including decisions about various arrangements such as Living Wills and powers of attorney, as well as who will give the care and what kind of care will be given.

Caring for HIV-positive patients and their loved ones in a non-judgmental way is one of the truly important ways that we can be helpful to our patients. We can naturally bring this skill with us as a result of our experience in treating addicted patients. Our caring, compassionate, loving approach can intensify the spiritual well-being of our patients.

As addiction professionals, we are uniquely and especially situated to help our patients harness powerful tools to deal with a remarkable problem. We need to recognize this fact, use it to our patients' advantage in dealing with a complex problem, and encourage our staffs and colleagues to do the same.

Dr. Morgan welcomes replies to his commentary, which may be addressed to him at West Jersey Health System, 1000 Atlantic Ave., Camden, NJ 08104. Members are encouraged to contribute articles to ASAM News, which should be sent to the ASAM office c/o the Editor.

MEMBERS IN SERVICE TO ASAM

Dr. Gitlow Wins Caron Award

The Caron Foundation has honored Stanley E. Gitlow, M.D., with its Richard J. Caron Award of Excellence. In making the award, the Foundation cited Dr. Gitlow's "profound impact on the advancement of Addiction Medicine."

In commenting on the award, ASAM President G. Douglas Talbott, M.D., noted that Dr. Gitlow has "touched the lives of untold numbers of individuals and families affected by chemical dependency." The award was to be presented at the Caron Foundation's November 6 annual benefit.

Dr. Schneider to Chair NCADD

Max A. Schneider, M.D., FASAM, has been elected chair of the National Council on Alcoholism and Drug Dependence, Inc. (NCADD) for a two-year term, to begin January 1, 1998. Founded in 1944, NCADD and its national network of affiliates advocates prevention, intervention and treatment and is committed to ridding the disease of chemical dependency of its stigma and its sufferers of their denial and shame.

Dr. Schneider, who is a past president of ASAM, has served on the NCADD board since 1983.

NEW IN PRINT

ALCOHOL AND THE CARDIOVASCULAR SYSTEM

Number 31 in the Research Monograph series from the National Institute on Alcohol Abuse and Alcoholism, *Alcohol and the Cardiovascular System,* presents the results of state-of-the-art research on the consequences of both moderate and immoderate consumption on the heart, blood and blood vessels. The book is divided into major sections on Epidemiological Studies, Clinical Studies, Biochemical and Molecular Studies (Alcohol and the Heart, Alcohol Interactions with Cardiovascular Risk Factors, Alcohol and Blood Vessels), and Alcohol Interactions with Medications. Edited by Sam Zakhari, Ph.D. and Momtaz Wassef, Ph.D., the 712-page book is available at no charge from NIAAA. *Research Monograph No. 31–Alcohol and the Cardiovascular System, NIH Publication No. 96-4133. Order from the NIAAA, Scientific Communications Branch, Office of Scientific Affairs, 6000 Executive Blvd., Suite 409, Bethesda, MD 20892-7003.*

ASSESSING DRUG ABUSE WITHIN AND ACROSS COMMUNITIES

Edited by Nicholas J. Kozel and Dr. Zili Sloboda of NIDA's Division of Epidemiology and Prevention Research, this guide was developed as a resource for state, county, city and local organizations that are interested in developing the capacity to identify and monitor drug abuse patterns and trends. Based on the Community Epidemiology Work Group (CEWG) model, the methods described in the guide can be used to collect and analyze data to assist in formulating public health policy, drug abuse prevention and treatment resource management, needs assessments and research plans, and public education campaigns. 100+ pages; single copies are available without charge from NIDA. *Assessing Drug Abuse Within and Across Communities: A Guide for Local Community Epidemiology Work Groups, May 1997. Order from George Beschner, Project Director, The CDM Group, Inc., 5530 Wisconsin Ave., Suite 1600, Chevy Chase, MD 20815; Fax 301/654-2210; or order from gbeschner@cdmgroup.com.*

WOMEN AND ALCOHOL: ISSUES FOR PREVENTION RESEARCH

NIAAA's Research Monograph No. 32 presents current research in the area of alcohol use among women, and provides recommendations for future studies that could better serve this population. Topics include alcohol use across the life span, alcohol use in the workplace, alcohol-related birth defects, drinking and driving, parenting interventions for preventing alcohol and drug use among children, and the influence of genetics, sexuality and violent victimization on women's alcohol use. 361 pages; single copies are available without charge. *Research Monograph No. 32–Women and Alcohol: Issues for Prevention Research, NIH Publication No. 96-3817. Order from the NIAAA, Scientific Communications Branch, Office of Scientific Affairs, 6000 Executive Blvd., Suite 409, Bethesda, MD 20892-7003.*

EPIDEMIOLOGIC TRENDS IN DRUG ABUSE

The Advance Report is a synthesis of findings presented at the 42nd meeting of the Community Epidemiology Work Group (CEWG) and the 3rd meeting of the International Epidemiology Work Group (IEWG) on Drug Abuse, held in Washington, DC, in June 1997. The CEWG is a network of epidemiologists and researchers in the U.S., sponsored by the National Institute on Drug Abuse, that meets twice a year to review current and emerging substance abuse problems. At the most recent meeting, members reported that use of cocaine hydrochoride and crack, while still at high levels, decreased in 17 of the 21 CEWG areas. Heroin use, on the other hand, increased in 17 areas. Methamphetamine patterns were variable. Indicators of marijuana use show a continuation of the dramatic increases reported over the past several years. The 25-page report is available at no charge from NIDA. *Advance Report: Epidemiologic Trends in Drug Abuse—Report of the Community Epidemiology Work Group, June 1997. NIH Publication No. 97-4206. Order from Ms. Marcia Meth, Johnson, Bassin, Shaw Inc., 8630 Fenton St., Suite 1200, Silver Spring, MD 20910; Fax 301/587-4352; or order through the CEWG Home Page at www.NIDA.NIH.GOV or www.CDMGROUP.COM/CEWG.*

Certification Reminder!

The standard deadline for the ASAM Certification Application is January 30, 1998. Late registration, at an extra fee, will be available through April 30, 1998. This will allow attendees at the ASAM Annual Medical-Scientific Conference to apply to sit for the examination. The next Certification/Recertification Examination for physicians in addiction medicine is to be offered Saturday, November 21, 1998, at three sites: Atlanta, GA; Newark, NJ; and Los Angeles, CA.

Physicians who wish to sit for the examination must complete and submit an application. All applications will be reviewed and candidates notified by mail as to whether they qualify to sit for the examination. Physicians who pass the examination become ASAM Certified/Recertified in Addiction Medicine. Since the examinations first were offered in 1986, 2,939 physicians have passed the examination, including many of the nation's top addiction treatment professionals.

ASAM certification is recognized by the National Committee for Quality Assurance (NCQA), which in its 1997 standards for credentialing and recredentialing requires that behavioral health care organizations accredited by NCQA have credentialing procedures that assure that "psychiatrists and/or physicians who are certified in addiction medicine" are available to care for patients.

Fellows Reminder!

Applications for fellow status (FASAM) will be accepted through December 31, 1997. ASAM inaugurated the Fellow program in 1996 to recognize substantial and lasting contributions to the Society and the field of addiction medicine. Candidates must meet certain criteria to quality for Fellow status: they must have been an ASAM members for at least five consecutive years; (2) they must be ASAM-certified; (3) they must have taken a leadership role in ASAM through committee service, or have been an officer of a state chapter; and they must have made and continue to make significant contributions to the addictions field. To date, a total of 108 member physicians have been elected Fellows of the American Society of Addiction Medicine.

Reviews

Pharmacological Management of Alcohol Withdrawal

A Meta-analysis and Evidence-Based Practice Guideline

Michael F. Mayo-Smith, MD, MPH; for the American Society of Addiction Medicine Working Group on Pharmacological Management of Alcohol Withdrawal

Objective.—To provide an evidence-based practice guideline on the pharmacological management of alcohol withdrawal.

Data Sources.—English-language articles published before July 1, 1995, identified through MEDLINE search on "substance withdrawal—ethyl alcohol" and review of references from identified articles.

Study Selection.—Articles with original data on human subjects.

Data Abstraction.—Structured review to determine study design, sample size, interventions used, and outcomes of withdrawal severity, delirium, seizures, completion of withdrawal, entry into rehabilitation, adverse effects, and costs. Data from prospective controlled trials with methodologically sound end points corresponding to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, were abstracted by 2 independent reviewers and underwent meta-analysis.

Data Synthesis.—Benzodiazepines reduce withdrawal severity, reduce incidence of delirium (–4.9 cases per 100 patients; 95% confidence interval, –9.0 to –0.7; P=.04), and reduce seizures (–7.7 seizures per 100 patients; 95% confidence interval, –12.0 to –3.5; P=.003). Individualizing therapy with withdrawal scales results in administration of significantly less medication and shorter treatment (P<.001). β-Blockers, clonidine, and carbamazepine ameliorate withdrawal severity, but evidence is inadequate to determine their effect on delirium and seizures. Phenothiazines ameliorate withdrawal but are less effective than benzodiazepines in reducing delirium (P=.002) or seizures (P<.001).

Conclusions.—Benzodiazepines are suitable agents for alcohol withdrawal, with choice among different agents guided by duration of action, rapidity of onset, and cost. Dosage should be individualized, based on withdrawal severity measured by withdrawal scales, comorbid illness, and history of withdrawal seizures. β-Blockers, clonidine, carbamazepine, and neuroleptics may be used as adjunctive therapy but are not recommended as monotherapy.

JAMA. 1997;278:144-151

ALCOHOL dependence continues to be a major public health problem, and among its many associated medical problems is a well-characterized withdrawal syndrome. Withdrawal signs and symptoms are frequently minor but can develop into a severe, even fatal, condition. Because of its medical complications, alcohol dependence is seen frequently by physicians, occurring in 15% to 20% of primary care and hospitalized patients.[1-3]

From the American Society of Addiction Medicine Committee on Practice Guidelines.

A complete list of the members of the Working Group on Pharmacological Management of Alcohol Withdrawal appears at the end of this article.

Reprints: California Society of Addiction Medicine, 3803 Broadway, Oakland, CA 94611-5615.

Physicians in all areas of medicine therefore frequently encounter the problem of managing withdrawal, particularly as medical encounters, such as hospital admission or pregnancy, are often a precipitating event for cessation of alcohol.

In recent decades there has been extensive research on pharmacological interventions aimed at ameliorating withdrawal. However, these studies are widely dispersed in the medical literature, generally involved few subjects, and are often of uncertain methodological quality.[4] Uncertainty continues to exist about the role of pharmacotherapy[5] and its effectiveness in reducing the rate of major complications, such as seizures or delirium. Significant variation in physician management of withdrawal has been documented, even among specialists in the field, with a wide range in choice of medication, approaches to medication delivery, and method of patient monitoring.[6] Recommendations from authoritative sources, such as medical and surgical textbooks, vary even more widely, with recommendations for agents that have never been tested in clinical trials[7] or for approaches that have been shown to result in administration of unnecessary medication.[8] Given the frequency with which this condition is encountered by physicians, the wide variety of settings in which it occurs, and the variation in the way it is managed, we believed an evidence-based guideline would have widespread utility.

The purpose of this review and guideline, therefore, is to aid physicians in providing the appropriate pharmacological management of alcohol withdrawal. This guideline does not address treatment of the patient who is examined after having an alcohol withdrawal seizure or who has already developed alcohol withdrawal delirium (delirium tremens), or the optimal setting for withdrawal management (inpatient or outpatient). These are important issues and will be addressed in separate guidelines. The role of phenytoin in alcohol withdrawal is the topic of a guideline already published.[9]

METHODS

Selection of the Topic

Pharmacological management of alcohol withdrawal was a topic identified for guideline development by the Practice Guideline Committee of the American Society of Addiction Medicine. A work group was appointed that included individuals with training in internal medicine, family practice, psychiatry, and pharmacology and individuals involved in primary care medicine, addiction medicine, and research on alcohol withdrawal.

Outcomes

Outcomes studied were (1) severity of alcohol withdrawal syndrome, corre-

Table 1.—Method of Grading Levels of Evidence and Recommendations*

Levels of evidence	
Level I studies	Randomized trials with low false-positive and low false-negative errors
Level II studies	Randomized trials with high false-positive and/or high false-negative errors
Level III studies	Nonrandomized, concurrent cohort comparisons
Level IV studies	Nonrandomized historical cohort comparisons
Level V studies	Case series without controls
Recommendations	
Grade A	Supported by ≥1 level I studies or by a meta-analysis in which the lower limit of the confidence interval for the effect of treatment exceeds the minimally clinically significant benefit
Grade B	Supported by either ≥1 level II studies or by a meta-analysis in which the estimate of treatment effect exceeds the minimal clinically significant benefit but the lower limit of the confidence interval does not
Grade C	Supported by data other than prospective controlled trials, including secondary analyses of level I or II studies

*Data from Cook et al.[16]

Table 2.—Prospective, Placebo-Controlled Trials Examining the Effectiveness of Benzodiazepines in Reducing the Incidence of Delirium or Seizures*

Source, y	Intervention	No. of Patients With Delirium/No. of Patients in Group	No. of Patients With Seizures/No. of Patients in Group
Rosenfeld and Bizzoco,[29] 1961	Chlordiazepoxide	2/30	...
	Placebo	2/30	...
Sereny and Kalant,[25] 1965	Chlordiazepoxide	0/24	0/24
	Placebo	1/11	0/11
Kaim et al,[28] 1969	Chlordiazepoxide	1/103	1/103
	Placebo	8/130 RR=0.16; 95% CI, 0.02-1.24 P=.08	9/130 RR=0.14; 95% CI, 0.02-1.09 P=.046
Zilm et al,[33] 1980	Chlordiazepoxide	0/15	0/15
	Placebo	0/15	2/15
Sellers et al,[69] 1983	Diazepam	...	0/25
	Placebo	...	4/25
Naranjo et al,[67] 1983	Lorazepam	...	0/15
	Placebo	...	2/15
Summary and meta-analysis	Benzodiazepine vs placebo	Risk difference with benzodiazepine: −4.9 cases of delirium/100 patients 95% CI, −9.0 to −0.7 P=.04	Risk difference with benzodiazepine: −7.7 cases of seizures/100 patients 95% CI, −12.0 to −3.5 P<.001

*RR indicates relative risk; CI, confidence interval; and ellipses, data not reported.

sponding to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, definition,[10(pp197-199)] (2) alcohol **withdrawal delirium**, corresponding to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, definition,[10(pp123-132)] (3) **withdrawal** seizures, (4) **completion of withdrawal**, (5) entry **into rehabilitation**, (6) **adverse** effects, and (7) **cost. Acquisition costs** were determined by averaging wholesale prices listed in the *Red Book*.[11]

Options

Pharmacological management was defined as the use of any pharmacological agent to affect one or more of the outcomes listed above. Different strategies for administering medication were reviewed when data were available.

Review of the Evidence

The English-language medical literature was reviewed by searching MEDLINE with the key words "substance withdrawal syndrome, ethyl alcohol" from MEDLINE's initial entries in 1966 through June 1995. References from selected articles and reviews were also examined. Articles were considered only if they involved human subjects and included clinical data. Articles that met these criteria underwent structured review. Prospective controlled trials with methodologically sound end points and documented reporting of the end point in question underwent further review, with 2 reviewers independently extracting data from each article. Differences reported in individual studies were analyzed by means of the Fisher exact test and 95% confidence intervals for the relative risk calculated by means of Taylor series.[12] When appropriate, meta-analysis was performed by means of a random effects model,[13-15] with risk differences used as the measure of effect. All tests were 2 tailed, and differences were considered statistically significant when $P \leq .05$.

Recommendations

Recommendations based on the evidence were drafted and graded according to a published system (Table 1).[16] In several areas it was recognized that a single recommendation could not be formulated to guide the treatment of all patients, but that the decisions should be guided by a series of clinical considerations. In such areas the level of evidence supporting these considerations was identified. In formulating recommendations, greatest value was placed on patient safety, followed by facilitation of treatment of alcohol dependence, patient comfort, and then cost.

Guideline Review

The draft guideline was sent for review to first authors of articles from the past 10 years that met inclusion criteria and to representatives of 68 medical organizations. The American Society of Addiction Medicine board of directors approved the final version in June 1996, with review and revision scheduled for June 2001, unless new information requires revision before then.

RESULTS

Original data were found in 134 articles,[17-150] which included 65 prospective controlled trials and involved 42 different medications. In the following sections, data on different agents are reviewed.

Benzodiazepines and Other Sedative-Hypnotic Agents

Six prospective trials involving 5 different agents all demonstrated that benzodiazepines are more effective than placebo in reducing the signs and symptoms of alcohol withdrawal.[26,41,67,93,61,150] Summary and meta-analysis of prospective, placebo-controlled trials (Table 2) also demonstrated a highly significant reduction of seizures (risk reduction of 7.7 seizures per 100 patients treated; $P=.003$) as well as delirium (risk reduction of 4.9 cases of delirium per 100 patients treated; $P=.04$).

Trials comparing different benzodiazepines demonstrated that all appear similarly efficacious in reducing signs and symptoms of withdrawal.* However, there is some evidence that longer-acting agents may be more effective in preventing seizures.[139,149] A summary of prospective controlled trials (Table 3) also demonstrates a trend in this direction. There are few data on the comparative efficacy in reducing delirium. Pharmacological data and clinical experience[139] suggest that longer-acting agents can pose a risk of excess sedation in selected groups, in-

*References 26, 63, 68, 70, 77, 88, 90, 98, 150.

cluding the elderly and those with marked liver disease. Longer-acting agents, however, contribute to an overall smoother withdrawal course with less breakthrough or rebound symptoms.[26]

Another consideration in the choice of benzodiazepine is their potential for abuse. Prospective, double-blind, randomized controlled trials have shown that certain agents are preferred by individuals with addictive disorders,[63,151-153] evidence substantiated by patterns of illicit drug use. Agents with rapid onset of action, including diazepam, alprazolam, and lorazepam, demonstrate higher abuse potential than those with slower onset of action, such as chlordiazepoxide, oxazepam, or halazepam. This consideration may be relevant in an outpatient setting or for patients with a history of benzodiazepine or other substance abuse. However, when rapid control of symptoms is needed, the quicker onset of these medications may offer an advantage.

A final consideration is cost. The average wholesale costs in oral form at approximately equivalent dosages are as follows: chlordiazepoxide, 25 mg, $0.033; diazepam, 5 mg, $0.071; lorazepam, 1 mg, $0.115; oxazepam, 15 mg, $0.25; prazapam, 10 mg, $0.37; alprazolam, 0.5 mg, $0.56; and chlorazepate, 7.5 mg, $1.05.[11] Some practitioners have also described the use of continuous infusion of short-acting benzodiazepines, such as lorazepam or midalozam.[144,154,155] Such infusions can require large amounts of medication over several hours or days, and reports of direct drug costs (excluding costs of preparation, administration, and monitoring) of $50 335 for a 25-hour infusion of midalozam in 1 patient[154] and $26 045 for a hospital stay for another individual patient[144] have been published. There is no evidence that continuous infusion therapy with short-acting agents provides better outcomes than oral or intravenous bolus therapy with longer-acting agents. In 1 institution, implementation of a guideline emphasizing the use of longer-acting agents instead of continuous infusion of short-acting agents was prospectively studied. This change led to substantial decreases in costs, from a mean of $1008.72 per patient to $59.79 per patient, with equivalent outcomes and no increase in adverse effects.[145]

Prospective controlled trials involving other sedative-hypnotic agents indicate that chlormethiazole, an agent used in Europe, is better than placebo for reducing signs and symptoms of withdrawal[24,81] and that barbital (a long-acting barbiturate) and tetrabamate are equal to benzodiazepines in this regard.[44,119] The size of these studies was not adequate to draw conclusions on preventing seizures and delirium. Case series describe the use of paraldehyde,[27,31] and 1 controlled trial showed this drug to be superior to promazine,[22] but no controlled trials have compared it with placebo or benzodiazepines. Although barbiturates are used by approximately 10% of detoxification programs in the United States,[6] no controlled trials with the use of phenobarbital could be identified, although uncontrolled studies[95,105,110,137] support its effectiveness. In contrast to many other barbiturates, it has low abuse potential.[151] It is long acting, can be reliably administered by oral, intramuscular, and intravenous routes, has well-documented anticonvulsant activity, and is inexpensive, with an average cost of $0.014 per 30-mg tablet.[11] However, barbiturates, including phenobarbital, pose a greater risk of respiratory depression, particularly when combined with alcohol, and an overall lower safety profile than benzodiazepines when used in high doses.[156]

Table 3.—Prospective, Controlled Trials Examining the Effectiveness of Different Benzodiazepine Agents in Reducing the Incidence of Seizures*

Source, y	Intervention	No. of Patients With Seizures/ No. of Patients in Group
Solomon et al,[79] 1983	Chlordiazepoxide	0/25
	Lorazepam	2/25
Wilson and Vulcano,[80] 1984	Chlordiazepoxide	5/50
	Alprazolam	9/50
Ritson and Chick,[36] 1986	Diazepam	0/20
	Lorazepam	1/20
Summary and meta-analysis	Long-acting agents vs short acting agents	Risk difference with long-acting agents: −6.7 cases of seizures/100 patients 95% CI, −13.0 to −0.0 $P=.07$

*CI indicates confidence interval.

Structured Assessment Scales and Determination of Dosage

Because alcohol withdrawal involves a constellation of nonspecific findings, efforts have been made to develop structured withdrawal severity assessment scales to objectively quantify the severity of withdrawal. The most extensively studied are the Clinical Institute Withdrawal Assessment–Alcohol (CIWA-A) and a shortened version, CIWA-A, revised (CIWA-Ar).[157] These scales have well-documented reliability, reproducibility, and validity based on comparison with ratings by experienced clinicians[56,157,158] and have been shown to be usable in a variety of settings, including detoxification units[69,146] and psychiatry units.[127,159] Studies have also shown that they can be used by nursing staff on general hospital medical/surgical wards, to monitor and treat not only patients admitted specifically for alcohol withdrawal but also patients admitted because of coexisting medical or surgical problems.[107,131] Furthermore, high scores are predictive of the development of seizures and delirium.[69,107]

In most studies, medications were given in fixed amounts at scheduled times, eg, chlordiazepoxide, 50 mg every 6 hours for 5 days. However, it has been shown that many patients can go through withdrawal with only minor symptoms despite receiving little or no medication.[44,56,122] An alternative to giving medication on a fixed schedule, known as symptom-triggered therapy, has been developed. In this approach, the patient is monitored by means of a structured assessment scale and given medication only when symptoms cross a threshold of severity.[56,127,132] Two prospective, randomized controlled trials have demonstrated this approach to be as effective as fixed-dose therapy, but it results in the administration of significantly less medication and a significantly shorter duration of treatment.[140,146] In the larger of these studies, the median amount of chlordiazepoxide given to the symptom-triggered group was 100 mg, compared with 425 mg in the fixed-dose group, and the median duration of treatment was only 9 hours compared with 68 hours.[146]

Withdrawal seizures usually occur early in the course of withdrawal. Because a history of withdrawal seizures is a strong risk factor for seizures during a withdrawal episode,[149-160] some practitioners administer medication on a fixed-dose schedule to patients with a history of withdrawal seizures. Seizures were not observed in series of patients treated with symptom-triggered therapy, however,[127,146] so it is possible that provision of symptom-triggered therapy alone may be adequate to prevent seizures.

β-Adrenergic Antagonists

There is some evidence that β-adrenergic antagonists reduce manifestations of withdrawal.[41,86,88,115,148] Review of these studies shows that these effects are primarily caused by reductions in the autonomic manifestations of withdrawal. β-Blockers have no known anticonvulsant activity, and large enough studies have not been performed to determine whether they reduce, or increase, seizures during

Table 4.—Prospective, Controlled Trials Examining the Effectiveness of Neuroleptic Agents in Reducing the Incidence of Delirium or Seizures*

Source, y	Intervention	No. of Patients With Delirium/ No. of Patients in Group	No. of Patients With Seizures/ No. of Patients in Group
Thomas and Freedman,[77] 1964	Promazine	4/34	...
	Paraldehyde	0/33	...
Sereny and Kalant,[25] 1965	Promazine	1/23	2/23
	Placebo	1/11	0/11
	Chlordiazepoxide	0/24	0/24
Chambers and Schultz,[23] 1965	Promazine	...	5/34
	Diazepam	...	0/35
	Chlordiazepoxide	...	0/34
Kaim et al,[29] 1969	Chlorpromazine	7/98	12/98
	Placebo	8/130	9/130
	Chlordiazepoxide	1/103 Chlorpromazine vs chlordiazepoxide: RR=7.4; 95% CI, 0.9-54 P=.03	1/103 Chlorpromazine vs chlordiazepoxide: RR=12.6; 95% CI, 1.6-95 P=.001
Summary and meta-analysis	Phenothiazine vs placebo	Risk difference, phenothiazine vs placebo: 0.0 cases of delirium/100 patients 95% CI, −5.8 to +6.6 P=.92	Risk difference: +4.6 cases of seizures/ 100 patients with phenothiazine 95% CI, −2.6 to +11.9 P=.19
	Phenothiazine vs cross-tolerant medication (benzodiazepine or paraldehyde)	Risk difference: +6.6 cases of delirium/ 100 patients with phenothiazine 95% CI, +2.4 to +10.8 P=.002	Risk difference: +11.4 cases of seizures/ 100 patients with phenothiazine 95% CI, +6.2 to +16.6 P<.001

*RR indicates relative risk; CI, confidence interval; and ellipses, data not reported.

withdrawal. Furthermore, delirium is a known side effect of β-blockers, particularly those with good central nervous system penetration, such as propranolol.[161] In at least 1 study, the incidence of delirium was increased with propranolol,[53] but studies of adequate size have not been done to accurately assess the effect of β-blockers on this outcome. The selective reduction in certain manifestations of withdrawal may mask the development of other significant withdrawal symptoms and make it difficult to use withdrawal scales to guide therapy. In 1 case report, the diagnosis of withdrawal delirium was significantly delayed in a patient who presented with marked confusion because the patient had earlier been placed on a regimen of propranolol and thus demonstrated none of the autonomic hyperactivity classically associated with alcohol withdrawal delirium.[62]

Clonidine

Well-designed studies have consistently demonstrated the effectiveness of centrally acting α-adrenergic agonists, such as clonidine, in ameliorating symptoms in patients with mild to moderate withdrawal.* As with β-blockers, studies of adequate size have not been reported to indicate what effect these agents have on the rate of delirium or seizures.

Carbamazepine

Carbamazepine has been widely used in Europe for alcohol withdrawal. Methodologically sound studies have shown it to be superior to placebo and equal in efficacy to barbital and oxazepam for patients with mild to moderate withdrawal.[30,74,118,136] Data comparing its efficacy in preventing seizures or delirium are limited. Carbamazepine was documented to be without significant hematological or hepatic toxic effects when used in 7-day protocols for alcohol withdrawal[118,136] and was associated with less psychiatric distress and a faster return to work.[58,82,136]

Carbamazepine has well-documented anticonvulsant activity and has been shown to prevent alcohol withdrawal seizures in animal studies.[162] It does not potentiate the central nervous system– and respiratory depression caused by alcohol, does not inhibit learning (an important side effect of larger doses of benzodiazepines), and has no abuse potential. It has also been proposed that it may retard a kindlinglike phenomenon in which repeated episodes of alcohol withdrawal may be associated with increasing severity of withdrawal.[163]

Neuroleptic Agents

Neuroleptic agents, including the phenothiazines and the butyrophenone haloperidol, demonstrate some effectiveness in reducing signs and symptoms of withdrawal,[25,26,37] but phenothiazines are less effective than benzodiazepines in preventing delirium (risk difference, 6.6 cases per 100 patients treated; P=.002) (Table 4). These agents increase the incidence of seizures compared with placebo and are much less effective than benzodiazepines in preventing seizures (risk difference, 12.4 seizures per 100 patients treated; P<.001) (Table 4). There are differences in the epileptogenic potential among the neuroleptic agents, and the agents used in these studies, chlorpromazine and promazine, are among those with the greatest effect on seizure threshold. Neuroleptic agents are widely used to calm agitated patients, and uncontrolled clinical experience indicates that they are useful for this purpose in the setting of alcohol withdrawal as well.[164]

Magnesium

It has long been recognized that magnesium levels are frequently low during alcohol withdrawal.[165-167] Closer study showed that magnesium level is usually normal on admission but then drops during the course of withdrawal before spontaneously returning to normal as symptoms subside.[165-167] A double-blind, placebo-controlled randomized trial studying intramuscular administration of magnesium as a supplement to benzodiazepines showed no significant difference in severity of withdrawal symptoms,[80] even after adjustment for magnesium levels. There were also no differences in the incidence of seizures and delirium, although the power to detect these outcomes was limited. Thus, while supplementation with magnesium is without substantial risk, no evidence indicates that such supplementation reduces withdrawal severity or the frequency of delirium or seizures.

Ethyl Alcohol

By definition, intake of alcohol alleviates the initial symptoms of alcohol withdrawal. Alcohol has long been used for this purpose, both by those with alcohol dependence and by some practitioners. Case series describing alcohol given orally or by intravenous drip for the prevention or treatment of withdrawal symptoms have been published.[27,42,49,75,80,126,141] These re-

*References 33, 52, 72, 87, 101, 102, 111, 120, 128.

Table 5.—Examples of Specific Treatment Regimens*

Monitoring
Monitor patient every 4-8 h by means of CIWA-Ar until score has been <8-10 for 24 h; use additional assessments as needed
Symptom-triggered regimens
Administer 1 of the following medications every hour when CIWA-Ar is ≥8-10
Chlordiazepoxide, 50-100 mg
Diazepam, 10-20 mg
Lorazepam, 2-4 mg
Repeat CIWA-Ar 1 h after every dose to assess need for further medication
Fixed-schedule regimens
Chlordiazepoxide, 50 mg every 6 h for 4 doses, then 25 mg every 6 h for 8 doses
Diazepam, 10 mg every 6 h for 4 doses, then 5 mg every 6 h for 8 doses
Lorazepam, 2 mg every 6 h for 4 doses, then 1 mg every 6 h for 8 doses
Provide additional medication as needed when symptoms not controlled (ie, CIWA-Ar ≥ 8-10) with above
Other benzodiazepines may be used at equivalent doses

*CIWA-Ar indicates Clinical Institute Withdrawal Assessment–Alcohol, revised.

ports have been small and uncontrolled and did not use objective or quantitative assessment of withdrawal severity. There are no controlled trials evaluating its safety or relative efficacy, compared with either placebo or benzodiazepines. Intravenous alcohol infusions require close monitoring because of the toxicity of higher doses, involve expense in preparation and administration, and pose risks of tissue damage at the infusion site. As a pharmacological agent, ethyl alcohol has numerous adverse effects, including its well-known hepatic, gastrointestinal tract, hematological, and neurological toxic effects, as well as its effects on mental status and judgment.

Thiamine

In 1 large trial, thiamine did not reduce delirium or seizures.[29] However, individuals with alcohol dependence are frequently thiamine deficient, with a high risk for Wernicke disease and Wernicke-Korsakoff syndrome,[168] sequelae that can be prevented by administration of thiamine.

Other Agents

Results of trials involving other agents show that some ameliorate withdrawal, but no evidence has been published to indicate that any are effective in reducing delirium or seizures.*

Special Populations

No studies were identified on managing withdrawal in adolescents. While the signs and symptoms of withdrawal may differ in older individuals compared with younger individuals,[169,170] no studies of different treatment approaches in the elderly were identified. Similarly, no studies on managing withdrawal in pregnant women were identified. Ethyl alcohol is a well-known teratogen, to be avoided in pregnant women.[156] Retrospective studies have indicated a risk of congenital malformation with both benzodiazepines and barbiturates,[171,172] and a recent study also indicated an association of intelligence deficits with in utero exposure to phenobarbital.[173] Overall, these risks for both classes of agents appear small and must be weighed against the risk of harm to the fetus should severe withdrawal or seizures develop.

No studies were identified that reported on clinical experience in managing alcohol withdrawal in patients with specific coexisting medical or substance abuse disorders. However, concurrent sedative-hypnotic abuse has been identified as a risk factor for major complications during withdrawal.[174,175] In 1 cohort study of hospitalized psychiatric patients, symptom-triggered therapy with a long-acting benzodiazepine was found to be safe and effective.[159]

RECOMMENDATIONS

Choice of Pharmacological Agent

Because of their documented efficacy, benzodiazepines are recommended as suitable agents for alcohol withdrawal (grade A recommendation). All benzodiazepines appear equally efficacious in reducing signs and symptoms of withdrawal, and the choice among them can be guided by the following clinical considerations: (1) Long-acting agents may be more effective in preventing withdrawal seizures (level II evidence). (2) Long-acting agents can contribute to a smoother withdrawal with fewer rebound symptoms (level I evidence). (3) Short-acting agents may have a lower risk of oversedation (level III evidence). (4) Certain benzodiazepines have a higher liability for abuse (level I evidence). (5) Cost of these agents varies considerably.

Benzodiazepines are recommended over most nonbenzodiazepine sedative-hypnotics because they have better documented efficacy, a greater margin of safety, and lower abuse potential. However, phenobarbital appears to be a clinically acceptable alternative, although the margin of safety for this agent may be lower than for benzodiazepines when high doses are needed (grade C recommendation).

Determination of Dose

Withdrawal severity varies greatly, and the amount of medication needed to control symptoms can also vary significantly. Alcohol withdrawal cannot be adequately treated by providing only a fixed standardized dose for all patients. Treatment should allow for a degree of individualization so patients can receive large amounts of medication rapidly if needed (grade A recommendation).

In substance abuse treatment programs, the use of structured assessment scales, such as the CIWA-Ar, for initial assessment and subsequent monitoring is recommended, as this allows objective titration of doses to individual need and reduces administration of unnecessary medication (grade A recommendation). In patients with acute concomitant medical or psychiatric illness, or concurrent withdrawal from other drugs, these scales should be used with caution because they rate signs and symptoms that may be caused by the other condition and not by the alcohol withdrawal.

Determination of the dosage of medication administered should be based on the following clinical considerations.

1. For those with mild symptoms (for example, CIWA-Ar scores <8-10), a reasonable clinical option is supportive nonpharmacological therapy and continued monitoring (level I evidence). Those with moderate symptoms (eg, CIWA-Ar scores of 8-15) benefit symptomatically from medication that will also reduce the risk of major complications. Those with severe symptoms (for example, CIWA-Ar scores ≥15) have a significant risk of major complications if untreated (level I evidence). It is recommended that such patients receive benzodiazepines in the amounts necessary to control symptoms, as well as continued close monitoring until symptoms are controlled.

2. For patients with a history of withdrawal seizures, it is a reasonable option to provide 1 of the recommended medications at the time of presentation, regardless of the severity of withdrawal symptoms (level III evidence). Monitoring the patient and providing symptom-triggered therapy without fixed schedule therapy is also a reasonable option.

3. For patients who have notable comorbid medical illness, medications should be considered even if withdrawal is mild to moderate. In addition, caution should be exercised in treating patients who are using sedative-hypnotic medications, as they may be at higher risk for major complications and may exhibit tolerance to benzodiazepines requiring adjustment of dosage (level III evidence).

The use of structured assessment scales and symptom-triggered therapy is possible in other settings, such as psychiatric inpatient units and general medical/surgical wards, but requires training of staff. Where such training has not taken place, the use of fixed-sched-

*References 29, 66, 81, 103, 104, 114, 117, 129, 133.

ule therapy, with the provision of additional medicine when symptoms are not controlled with scheduled doses, is an acceptable alternative. While this may result in the provision of unnecessary medicine, it provides a margin of safety.

Examples of specific treatment regimens that meet these recommendations are provided in Table 5.

Other Agents

β-Blockers, clonidine, and carbamazepine are not recommended as monotherapy (grade B recommendation). While they reduce selected signs and symptoms of withdrawal, they have not been shown to reduce delirium or seizures. They may be considered for use in conjunction with benzodiazepines in patients with certain coexisting conditions, such as coronary artery disease for β-blockers, opiate withdrawal for clonidine, and benzodiazepine withdrawal for carbamazepine.

It is recommended that neuroleptic agents not be used as monotherapy because they do not reduce delirium and they increase seizures (grade A recommendation). Neuroleptics may be considered for use in conjunction with benzodiazepines for marked agitation or hallucinations.

Routine parenteral administration of magnesium is not recommended because existing controlled data do not demonstrate improvement in alcohol withdrawal severity, delirium, or seizures (grade B recommendation).

Ethyl alcohol is not recommended because of the lack of controlled studies as well as its known adverse effects as a pharmacological agent (grade C recommendation).

It is recommended that thiamine be administered to all patients with alcohol dependence at initial examination (grade C recommendation).

Special Populations

There is no evidence that the recommendations should change for adolescent or geriatric populations. As noted, shorter-acting benzodiazepines may have a lower risk of oversedation, which may be of particular relevance in the elderly (grade C recommendation). Ethyl alcohol should not be used in pregnant women because of its teratogenic effects (grade C recommendation). In addition, because both benzodiazepines and barbiturates have been associated with adverse effects on the fetus, the amount of these medications administered should be limited to that necessary to prevent the major complications of withdrawal (grade C recommendation).

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William Hawthorne, M.D., ASAM Webmaster

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The California and Florida chapters have accepted ASAM's offer to share their Websites with ours. The site is responsible for 25 new ASAM members, who first learned of the organization while surfing the net. These are physicians, like ourselves, looking for a connection with other addiction medicine practitioners. ASAM also has sold publications and conference registrations to people new to the addiction field who found the organization on the World Wide Web.

For all of these reasons, you should take full advantage of what our Website brings to your membership and visit us soon at **http://www.asam.org**!

ASAM CHAPTER UPDATE

California

Chapter President: William Brostoff, M.D.
Regional Director: Gail Shultz, M.D.
At CSAM's annual meeting and State of the Art conference, November 5-8 at the Miyako Hotel in San Francisco, Gail N. Shultz, M.D., will be installed as the chapter's 12th President.

For one part of the conference, the planners have designed something new: a series of very brief presentations called "Epitomes of Progress." Each speaker will review one area of patient care where emerging information is leading clinicians to consider new approaches. In just 12 minutes, the speaker will first describe the traditional thinking, then summarize the newly available data and its clinical relevance. Each segment will close with the speaker's recommendation as to whether it is time to change the practice or await further data. For each topic, the course syllabus will contain one review article and an annotated bibliography. Ten different topics will be reviewed in the series, including rapid opioid detoxification, aggressive pharmacologic treatment of alcohol withdrawal, and kindling.

Florida

Chapter President: Richard Keesal, M.D.
Regional Director: Rick Beach, M.D.
FASAM's 11th Annual Conference is scheduled for January 23-25, 1998, in Orlando. Agenda and registration information is available from Robert Donofrio at the FSAM office, 904/484-3560.

Georgia

Chapter President: John D. Lenton, M.D.
Regional Director: Rick Beach, M.D.
Chapter President John Lenton, M.D., has been appointed to the Governor's Joint Study Committee on the Prevention and Treatment of Substance Abuse. The language of the Senate resolution creating the study committee specifically called for representation from the Georgia ASAM chapter.

Illinois

Chapter President: Martin Doot, M.D.
Regional Director:Andrea Barthwell, M.D.
ISAM will sponsor a pre-conference workshop in connection with its annual meeting (scheduled for November 21-22) in Chicago. At the annual meeting, the chapter will present its lifetime achievement award to Dr. James Leonard.

ISAM also is planning a program for primary care physicians for its Midwest Clinical Conference, scheduled for February 20-22, 1998.

Michigan

Chapter President: Thomas Haynes, M.D.
Regional Director: Norman Miller, M.D.
Chapter members are planning an educational conference for the Detroit area in late March or early April 1998. The chapter also has elected a new slate of officers, who are: President, Thomas Kane, D.O.; President-Elect, Stephen Bendix, M.D.; Immediate Past President, Thomas Haynes, M.D.; Secretary, Martin Gleespen, M.D.; and Treasurer, Herbert Malinoff, M.D.

New York

Chapter President: Merrill Herman, M.D.
Regional Director:
Lawrence Brown, Jr., M.D.
With the assistance of Herbert Peyser, M.D., New York State trustee for the American Psychiatric Association, Dr. Merrill Herman has met with the Executive Committee of the American Psychiatric Association for the purpose of forging a link between the New York Society of Addiction Medicine and the APA in the furtherance of mutual goals related to legislation, managed care, and educational initiatives.

Oregon

Chapter President:Douglas L. Bouvee, M.D.
Regional Director:
Richard E. Tremblay, M.D.
ORSAM had an excellent quarterly meeting in September in Tualatin, with Greg Clark, Ph.D., giving a stimulating talk on the early treatment of depression in patients who present for treatment of alcoholism. Upcoming activities for the chapter include December elections for two Board positions currently held by Douglas Bouvee, M.D. and Robert Senft, M.D.

South Carolina

Chapter President:Timothy L. Fischer, D.O.
Regional Director: Richard Beach, M.D.
South Carolina has scheduled a chapter meeting for December 6, 1997, in conjunction with a conference the chapter is co-hosting with the University of South Carolina School of Medicine. Speakers will include ASAM President G. Douglas Talbott, M.D., and Dr. Velesquez of the University of Texas. Additional information is available from Dr. Fischer at 800/536-4900, ext. 130.

Virginia

Chapter President:
William McConahey, M.D.
Regional Director: Paul Earley, M.D.
The Virginia chapter's 1998 annual meeting has been set for April 30-May 2, 1998, at the Fort Magruder Inn and Conference Center in Williamsburg. Concurrent with the annual meeting, the chapter and the Farley Institute will co-sponsor a conference on "A New Approach for Impaired Healthcare Providers: The Virginia Intervention Program." Conference speakers are to include the intervention program's administrator and medical director. Inquiries about the conference may be directed to Ernie Leclerc at the Farley Institute (800/950-6688). Contact person at the Virginia chapter is Dorothy G. Tompkins, M.D., who can be reached at 804/243-4646.

Region VIII

Region VIII will hold its first annual meeting February 11-13, 1998, at Honolulu, Hawaii. For program information, contact Dr. Gerald McKenna at 808/246-0663. For hotel reservations, call 800/645-5687.

INTERNATIONAL

Iceland

Contact Person: Person G. Bjornsson, SAA
Regional Director: Peter Mezciems, M.D.
Iceland hosted the SAA 20th Anniversary Conference on Alcohol and Substance Abuse, October 16-18, 1997. ASAM representatives participating in the conference were Drs. Sheila B. Blume, David E. Smith, and Norman S. Miller. For information on the Iceland chapter activities, contact Person G. Bjornsson, SAA, at one of the following: telephone (+354) 567-6333; fax (+354) 567-6615; Website: http://www.this.is/saa; or E-mail: saa@this.is.

Panama

Contact Person: Saul Alvarado, M.D.
Regional Director: Peter Mezciems, M.D.
ASAM Past President David E. Smith, M.D., brought greetings from the Society to the 9th Annual Chemical Dependency Conference of the Panamanian Society of Addiction Medicine, held in August 1997. Pictured in the photo are (left to right): Panamanian Society members Carlos Smith, M.D., Carlos Del Rey, M.D., Dr. Smith, and Saul Alvarado, M.D.

COMMITTEE REPORTS

WEB SITES OFFER RESOURCES ON MANAGEMENT OF PAIN

Seddon Savage, M.D., Chair
Committee on Pain

Through a recently established ASAM Website link, ASAM members and others can easily access extensive resources on pain and pain management. After signing on to the ASAM website at http://www.asam.org, a virtual world of pain management resources can be accessed by opening "Web Site Links of Interest," then "Treatment and Recovery Resources," then "Worldwide Congress on Pain." Or, to enter directly, sign on to **www.pain.com**. The Worldwide Congress on Pain is in part commercially funded, carries significant advertising and is most directly focused on anesthesia management. However, the site also provides a valuable entry point into the broader world of pain management.

From the Worldwide Congress on Pain, physicians can link to most pain organizations (the American Pain Society, the American Academy of Pain Medicine, and the International Association for the Study of Pain all sponsor useful sites), obtain lists of pain clinics and pain treatment providers in many locations, obtain lists of pain publications, and discuss pain issues with other physicians through chat rooms and forums. Extensive resources on pain can be found at www.pain.com

The ASAM Committee on Pain and Addictive Disease currently is working with Webmaster Bill Hawthorne, M.D., to set up reciprocal direct links from the ASAM Website to the American Pain Society and the American Academy of Pain Medicine.

As with most Internet sites, finding resources that are consistently useful may require some exploration. The library at the Worldwide Congress on Pain seems limited in some areas and at least some of its articles are condensations that differ significantly from the originally published versions. Similarly, the list of pain meetings is incomplete. However, more complete lists of meetings and educational opportunities can be identified by exploring the resource links. Addictionists who want information on pain should be able to find whatever they need by using this point of entry.

RUTH FOX MEMORIAL ENDOWMENT FUND

Dear Colleagues:

As we approach the last few months of the year, it is time for you to review your financial affairs while there still is time to take steps to maximize tax savings and other benefits before the year's end.

You will soon be receiving the Ruth Fox Memorial Endowment Fund year-end letter and brochure, *Giving at Year-End 1997*. This brochure offers a number of ideas you might want to consider when planning your charitable gifts for 1997. We hope that you will remember the Endowment Fund in your plans.

Special thanks to The Yasuda Bank and Trust Company (USA), New York City. They have made another contribution to the Endowment Fund, bringing their total contributions over the years to $10,000. We are very grateful to the bank's officers for their ongoing support.

For contributions, pledges, or information about making a planned gift (bequests, insurance, stock, pensions), contact Ms. Claire Osman at 800/257-6776.

Ruth Fox
(1895–1989)

Max A. Schneider, M.D., FASAM
Chair, Endowment Fund

Jasper G. Chen See, M.D.
Chair Emeritus, Endowment Fund

Claire Osman
Director of Development

Total Pledges: $2,199,821

New Donors, Additional Pledges and Contributions
June 15-August 15, 1997

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($3,000-$4,999)
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Mother of Dr. Howard Heit
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Position: Physician, Clinical Director–Institution
Location: Orofino, in scenic North Central Idaho

Idaho Department of Health and Welfare, State Hospital North, is recruiting a Clinical Director for its 60-bed Adult Psychiatric Hospital with Drug Dependency/Dual Diagnosis Program components. The Hospital will hire a Board Certified psychiatrist who is seeking an opportunity for a progressive and innovative practice in the treatment of patients who are severely mentally ill and drug dependent. A physician with expertise in addictions treatment is desired.

State Hospital North is one of two state hospitals in Idaho, and an important link in the State and Regional Mental Health network. The Hospital values participative and collaborative management, and team approach to treatment.

The Hospital is located on a beautiful campus in a modern facility only two years old. Orofino is an attractive rural community located on the Clearwater River at the base of the Selway-Bitterroot Wilderness Area. Professionals enjoy a quality lifestyle and outdoor recreational activities.

The compensation package includes competitive salary, relocation assistance, and excellent State benefits. For more information, contact Debbie Manfull, Assistant Administrator, State Hospital North, 300 Hospital Drive, Orofino, ID 83544. Phone 208/476-4511.

UCSF Faculty Position Attending Psychiatrist, Outpatient Substance Abuse Services

The Department of Psychiatry at the University of California, San Francisco (UCSF), is searching for an Attending Psychiatrist for the Outpatient Substance Abuse Service (OSAS) at San Francisco General Hospital (SFGH), a major teaching hospital of UCSF. This clinician-teacher position is in the Clinical series at the Clinical Instructor or Assistant Clinical Professor level, and will be available July 1, 1998. The ideal candidate will be a Board-certified/Board-eligible psychiatrist with a commitment to an academic career as a clinician-teacher, and demonstrated interest, commitment, and cultural competence in working with underserved and culturally diverse populations. California licensure is essential. Required: an interest in substance abuse, dual diagnosis of psychiatric disorders and substance abuse, and medical/psychiatric issues including HIV/AIDS; the ability to work effectively with cocaine- and heroin-dependent patients in outpatient substance abuse treatment; strong organizational and writing abilities, and interpersonal skills. Research interest is highly desirable.

Applications must be received by January 20, 1998. Please send letter of interest, curriculum vitae, and names, addresses, and telephone numbers of three references to Mark Leary, MD, Search Committee Chair, c/o Susan Brekhus, Department of Psychiatry-7M36, San Francisco General Hospital, 1001 Potrero Avenue, San Francisco, CA 94110. UCSF is an Equal Opportunity/Affirmative Action Employer. Women and minorities are strongly encouraged to apply.

DEPARTMENT OF VETERANS AFFAIRS

Psychiatrist

The Veterans Affairs Medical Center at Memphis has a vacancy for board certified psychiatrist to serve as Medical Director of the Chemical Dependency Center. Incumbent should possess knowledge, familiarity and an interest in the area of rehabilitation and acute care of veterans with a variety of addictive disorders and theoretical knowledge of program structure and quality. The Medical Center provides primary, secondary and tertiary care for the nearly quarter-million veterans who reside in a 53 county area across West Tennessee, North Mississippi, East Arkansas and Southwest Kentucky. Psychiatric Service Programs include: Psychiatric evaluation/admission unit, acute units, mental health clinic, substance abuse, PTSD and day treatment. Opportunities for research and academic appointment at University of Tennessee, Memphis, College of Medicine, consistent with experience. Licensure in any state required. Send CV to Richard P. Johnson, M.D., Chief, Psychiatry Service or call 901/577-7278.

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WASHINGTON STATE (NO STATE INCOME TAX)

Staff Certified Addictionist (Must be ASAM certified) needed for non-profit organization approximately one hour from Seattle, college town with performing arts center. Physician must be team player with interest in program development and community liaison.

Salary opportunity with all benefits including malpractice insurance, 4 weeks vacation.

Eva Page & Associates
Physician Recruiting
800/833-3449 (WA State)
or fax CV to 360/647-8006
eva@nwmedicalrecruiting.com

ASAM CONFERENCE CALENDAR

1997

November 5-8
CSAM State of the Art Conference
San Francisco, CA
Contact CSAM at 510/428-9091

November 14-16
ASAM MRO Conference
Seattle, WA
19 Category 1 CME credits

1998

February 18-22, 1998
Southern Coastal Conference:
A Medical-Legal Conference on Addiction
(jointly sponsored by ASAM)
Jekyll Island, GA

February 19
Forensic Issues in Addiction Medicine
Atlanta, GA
6 Category 1 CME credits

February 20-22
ASAM MRO Course
Atlanta, GA
19 Category 1 CME credits

April 16
The Ruth Fox Course for Physicians
New Orleans, LA
7 Category 1 CME credits

April 16
Forum on AIDS and Addictions
New Orleans, LA
7 Category 1 CME credits

1998

April 17-19
29th Annual ASAM
Medical-Scientific Conference
New Orleans, LA
23 Category 1 CME credits

July 16-18
ASAM MRO Course
San Diego, CA
19 Category 1 CME credits

October 22-24
Review Course in Addiction Medicine
Chicago, IL
21 Category 1 CME credits

November 5-8
11th National Conference
on Nicotine Dependence
Marina del Ray, CA
17.5 Category 1 CME credits

November 21
Certification/Recertification Examination
Atlanta, GA
LaGuardia, NY
Los Angeles, CA
5 Category 1 CME credits

1999

April 16-18
30th Annual ASAM
Medical-Scientific Conference
New York, NY

ASAM STAFF NOW ONLINE

In addition to accessing ASAM's web page, members can reach any ASAM staff member via E-Mail, at the following addresses:

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BONUS!

Readers of *ASAM News* will find a bonus enclosed with this issue: a handy reference card on **"Screening and Brief Interventions for Alcoholism."**

Developed by ASAM (with the support of an unrestricted educational grant from DuPont Pharma), the card summarizes the best current advice on patient screening and follow-up techniques, including the CAGE.

Readers are encouraged to share the cards with medical students and colleagues in primary care. For information on obtaining additional cards, contact the ASAM office.