NHS Cumbria Clinical Commissioning Group

Greater Manchester West Mental Health NHS Foundation Trust

SHARED CARE GUIDELINE

DRUG: DISULFIRAM (ANTABUSE®)

Contact Details	Patient ID Label
Name: _____	**Surname:** _____
Tel ☎: _____	**Forename/s:** _____
Location: _____	**NHS Number:** _____
Date: _____	**Date of Birth:** _____

Introduction	**Indication**: Alcohol deterrent compound. Disulfiram may be indicated as an adjuvant in the treatment of carefully selected and co-operative patients with drinking problems. **Its use must be accompanied by appropriate supportive treatment.** **Background:** Disulfiram is licensed as an adjuvant for maintaining abstinence in those with chronic alcohol dependence. Disulfiram prevents the breakdown of alcohol by irreversibly blocking the enzyme acetaldehyde dehydrogenase. Within 10 minutes of consuming alcohol patients experience an unpleasant reaction mediated by facial flushing, headache, palpitations, tachycardia, dyspnoea, nausea and vomiting. The severity of the reaction varies between individuals and may occasionally become life threatening with hypotension, arrhythmias and collapse. The reaction can last for several hours with peak levels occurring at 8-12 hours. The action of disulfiram lasts for 7 days after the last dose and patients must be warned of this. Patients must be advised to avoid alcohol including low alcohol or non-alcohol beers and wines. They also need to be aware that some food, toiletries, perfumes, aerosol sprays and alcohol hand gels may contain enough alcohol to elicit a reaction. Disulfiram works by changing the expectancy of the effects of alcohol from positive to negative and aversive. In a 1992 study by Chick et al which examined supervised consumption of disulfiram against placebo showed 100 v 69 days abstinent in 6 months and reduced alcohol use 80% vs. 50% as well as an improvement in GGT levels. Response to treatment is better in those with a supervisor. It is not a standalone treatment it is essential that the patient is actively engaged with psychosocial interventions aimed at relapse prevention. Some patients find that they have no reaction at standard dose and may require a higher dose of up to 600mg. For these people and those who drink through the reaction they should be informed of the risk of repeated acetaldehyde toxicity leading to brain damage, liver damage and cardiac problems.
Dose & Administration	**Initial dose:** The initial dose is 200mg once a day. Subsequently, daily dosing should continue at half to one tablet daily for as long as advised by the physician but no longer than six months without review, by a specialist. **All dose adjustments will be the responsibility of the initiating specialist care unless directions have been specified in the medical letter to the GP.** Psychosocial interventions active involvement with an evidence based intervention, e.g., Motivational Enhancement, CBT will be provided.

Secondary Care Responsibilities

1. Investigations / monitoring undertaken by secondary care prior to initiation of treatment:
    - Baseline BP and pulse rate
    - Baseline U+E, LFT, GGT, FBC
    - Baseline ECG if indicated by possibility of cardiac disease
2. Treatment will be initiated and established by the secondary care specialist for 6 to 8 weeks. Once a stable dose is established, this may be transferred to primary care.
3. Identify suitable individuals Initiate treatment and prescribe until dose is stable.
4. Undertake baseline monitoring. The tests may be taken in primary care but should be reviewed by the specialist in making prescribing decisions.
5. Dose adjustments.
6. Monitor patient's initial reaction to and progress on the drug.
7. Continue to monitor and supervise the patient according to this protocol, while the patient remains on this drug, and agree to review the patient promptly if contacted by the GP.
8. Provide GP with diagnosis, relevant clinical information and baseline results, treatment to date and treatment plan, duration of treatment before consultant review.
9. Provide GP with details of outpatient consultations, ideally within 14 days of seeing the patient *or* inform GP if the patient does not attend appointment.
10. Provide GP with advice on when to stop this drug.
11. Provide patient with relevant drug information to enable (see attached patient information forms) Informed consent to therapy.
12. Provide patient with relevant drug information to enable understanding of potential side effects and appropriate action.
13. Provide patient with relevant drug information to enable understanding of the role of monitoring.
14. Provide patient with monitoring booklet where appropriate. Provide information leaflet to nominated supervisor (see attached).

Primary Care Responsibilities

1. Continue treatment as recommended by the specialist, ensuring that there is no potential risk of interactions, with any existing medications.
2. Monitor patient according to the recommendations below.
3. Symptoms or results are appropriately actioned, recorded and communicated to secondary care when necessary.
4. Stop medication if the patient repeatedly fails to collect prescriptions.

Monitoring Required in Primary Care

Monitoring	Frequency	Results	Action
LFT and GGT	6 weeks after initiation, then 6 monthly from initiation (unless advised more frequently by	If significantly elevated from initial bloods	Stop medication and seek expert opinion
		If mildly elevated from initial bloods	Continue medication but

	specialist)		obtain advice from specialist, increase frequency of LFT and GGT to 2 to 4 weeks
Physical state	As appropriate		As indicated by physical findings
Mental health	As appropriate		As indicated by assessment findings

Adverse Effects

Adverse event	Action to be taken	By whom
Drowsiness, sweatiness, halitosis, alteration in taste, impotence, dizziness and headache	generally mild and transient, if severe may require a reduction in dose	GP or specialist
Hypertension	generally mild and transient, but if persists may require reduction in dose or cessation of the drug	GP or specialist
Dermatological reactions including acneiform eruptions, allergic dermatitis	Generally only during the first two weeks of treatment; if persistent, may require reduction or cessation of the drug. Treat dermatitis as required.	GP or specialist
Allergic reaction, including anaphylaxis	Generally within first few doses, treat allergy. Refer back to specialist, stop treatment meanwhile.	A&E
Optic neuritis, peripheral neuritis, polyneuritis	Late onset at about 9 months and is progressive. Refer back to specialist, stop treatment meanwhile.	GP or specialist
Cholestatic and fulminant hepatitis	Hepatotoxicity is very rare and risk peaks between 6-12 weeks, but can occur anytime and can be fatal. Risk is higher with co-existent liver disease. Stop medication and treatment accordingly. Refer back to specialist	A&E or GP
Psychotic reactions (inc. persecutory, depressive and manic presentations ± hallucinations	Stop medication, refer back to specialist	GP or specialist

Cautions

- Caution should be exercised in the presence of renal failure, hepatic or respiratory disease, diabetes mellitus, hypothyroidism, cerebral damage and epilepsy

Drug Interactions	**The following drugs may be prescribed with caution:** Disulfiram inhibits hepatic microsomal enzymes leading to interference of the metabolism of a variety of prescribed drugs: • Warfarin – enhanced effect therefore careful monitoring of INR required • Tricyclics – disulfiram increases the plasma concentration of tricyclics by 50% risk of toxicity may need to reduce dose or use alternative antidepressant. • Amitriptyline – increased disulfiram reaction. • Phenytoin – metabolism inhibited increasing risk of toxicity • Temazepam – increased risk of toxicity • Benzodiazepines – metabolism is inhibited so increased sedative effects can be used and is often commenced during detoxification • Theophylline – metabolism is inhibited so increased risk of toxicity. • Metronidazole, isoniazid and paraldehyde - interact with disulfiram increasing the risk of psychotic reaction.
Contra-indications	• presence of cardiac failure • coronary artery disease • previous history of CVA • hypertension • severe personality disorder • suicidal risk or psychosis • consumption of alcohol • hypersensitivity to disulfiram or to any of the excipients
This guidance does not replace the SPC's, which should be read in conjunction with this guidance.	