

**Disulfiram (Antabuse) for maintenance of alcohol abstinence**

ESCA: Adjunct in the treatment of chronic alcohol dependence (under medical supervision)  
in adults (18 – 65 years)

**(For patients seen by/referred to the Derbyshire Recovery partnership)**

**1. REFERRAL CRITERIA**

- Alcohol dependence confirmed
- Suitability for drug treatment
- Motivation to remain abstinent assessed
- No contraindications to treatment. Any cautions taken into account.
- Provide evidence via a breathalyser of abstinence for a minimum of 24 hours prior to treatment commencing
- Appropriate preferred support/supervisory network in place for Patient
- Possess an agreed recovery plan
- Condition is stable /predictable
- Effective monitoring is established

**2. PRINCIPLES FOR THE SHARING OF CARE**

- This shared care agreement outlines ways in which the responsibilities for managing the prescribing are shared between the specialist services and general practitioners (GP) where shared care provides an optimal solution for the patient.
- GPs are invited to participate and if not confident to undertake these responsibilities, then he/she is under no obligation to accept shared care.
- Where shared care is not accepted total clinical responsibility for the patient for the diagnosed condition and on-going supply of medication remains with the specialist.
- Sharing care assumes close communication between the specialist and GP therefore a specialist asks the GP to prescribe this drug, the GP should reply to the request as soon as practicable.
- Sharing care assumes communication between the specialist, GP and Patient therefore the process should be explained to the patient by the specialist initiating treatment and they are in agreement.
- The practitioner who prescribes the medication legally assumes clinical responsibility for the drug and the consequences of its use.

### 3. AREAS OF RESPONSIBILITY

GP responsibilities	Specialist responsibilities
<ol style="list-style-type: none"> <li>1. <b>See section 5vi for GP monitoring responsibilities</b></li> <li>2. To assess and monitor the patients physical health prior to, and during treatment once accepted into shared care if necessary</li> <li>3. To reply to the request for shared care as soon as practicable</li> <li>4. To continue the prescribing (normally on a 6 monthly basis)</li> <li>5. To monitor the alcohol consumption and general health on a regular basis</li> <li>6. To promote patient compliance</li> <li>7. Ensure patient awareness of recovery support services available from alcohol services and/or GP support during the prescribing period.</li> <li>8. To refer back to the specialist in the event of a relapse to drinking, or concerns over patient compliance</li> <li>9. To report to and seek advice from the specialist on any aspects of patient care that is a concern and may affect treatment</li> <li>10. To report any adverse effects to the referring specialist and the MHRA yellow card scheme</li> <li>11. Stop treatment on the advice of the specialist Staff or immediately if urgent need to stop treatment arises</li> <li>12. To ensure specialist 6 monthly reviews has taken place before continuing prescribing.</li> <li>13. To monitor LFT minimum 6 monthly (NICE CG 115)</li> </ol>	<ol style="list-style-type: none"> <li>1. To carry out a full holistic review and assessment of the patients suitability for treatment prior to prescribing</li> <li>2. To be satisfied the patient is alcohol dependent</li> <li>3. To arrange for a physical assessment to be carried out by the GP, to discuss the results and record this in the patients notes prior to prescribing if required</li> <li>4. To discuss the risk/benefits of treatment with the patient and the need to avoid alcohol or products containing alcohol (including external products)</li> <li>5. To ensure the patient is alcohol free for 24 hours prior to commencement of treatment achieved through supervised medication detox or drink down</li> <li>6. To stabilise the patient on treatment</li> <li>7. To see the patient every 2 weeks for the first 2 months and then 4 weekly up to 6 months.</li> <li>8. To ensure that the patient is stable on the Disulfiram prior to transfer of prescribing pack</li> <li>9. To ensure the patient is abstinent from alcohol</li> <li>10. To agree the recovery plan with the patient</li> <li>11. To consult GP whether he/she is willing to participate in prescribing/shared care.</li> <li>12. To continue to prescribe until GP has agreed to take over prescribing</li> <li>13. On request for shared care and transfer of prescribing, to supply four weeks maintenance therapy to allow GP handover.</li> <li><b>14. To review patient 6 monthly and advise GP on continued treatment</b></li> <li>15. To ensure local arrangements are made to support administration preferably by a carer or relative</li> <li>16. To keep the GP informed of the patients progress</li> <li>17. To advise the GP when the treatment should be discontinued</li> <li>18. To ensure a mechanism is in place to receive rapid referral of a patient from the GP if required if the patient deteriorates</li> <li>19. To report any adverse effects to the MHRA yellow card scheme and GP</li> <li>20. To ensure that clear communication and support is in place for the GPs to obtain if required</li> </ol>
<p><b>Patient responsibilities</b></p> <ul style="list-style-type: none"> <li>• To be alcohol free for 24 hours prior to commencement of treatment with the specialist</li> <li>• To report to the specialist prescriber or GP if he/she does not understand the treatment clearly</li> <li>• To maintain contact and engagement with services, as per the recovery plan, to enable them to work towards their recovery goals and overcome alcohol dependence</li> <li>• To attend GP and other follow up appointments as scheduled</li> <li>• To share any concerns in relation to treatment</li> <li>• To seek medical assistance if he/she experiences an adverse reaction or side effect</li> <li>• To report any adverse effects or warning symptoms to the specialist prescriber or GP</li> </ul>	

### 4. COMMUNICATION AND SUPPORT

<p><b>DHCFT</b> <b>Derbyshire Recovery Partnership</b></p>	<p>Out of hours contacts and procedures: <b>Attend GP out of Hours or contact 111</b></p>
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<p><a href="http://www.derbyshirerecoverypartnership.co.uk">www.derbyshirerecoverypartnership.co.uk</a></p> <p>42 St Marys Gat, Chesterfield S41 7TH tel 0300 123 1201</p> <p>The Mews, 7 Church Street. Ripley DE5 3BU tel 01773 744594</p> <p>Erewash House, Station Rd., Ilkeston tel. 01159 309442</p> <p>Bankgate, Unit 13-15 Rinkway Ind Estate, Rink Drive, Swadlincote DE11 8JU tel. 0300 790 0263</p>	
<p><b>Specialist support/resources available to GP including patient information.</b></p> <p>Patient leaflets and treatment cards are available from the manufacturer. Downloadable patient information : <a href="http://www.medicines.org.uk">http://www.medicines.org.uk</a></p> <p>GPs can liaise with the specialist alcohol services for any information or advice regarding disulfiram.</p>	

## 5. CLINICAL INFORMATION

<p><b>i. Prescribed indications</b></p>	<p>Licensed as an 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.</p>
<p><b>ii. Therapeutic summary</b></p>	<p>Disulfiram blocks the activity of the liver enzyme aldehyde dehydrogenase in the body when alcohol has been consumed and leads to an accumulation of acetaldehyde in the blood stream.</p>
<p><b>iii. Dose &amp; Route of administration</b></p>	<p>Adults and Elderly Patients only: It is recommended that treatment with Disulfiram should be initiated only in a hospital or specialised clinic and by clinicians experienced in its use. The Patient should have adequate social and family support to avoid ingestion of alcohol. Suitable Patients should not have ingested alcohol for at least 24 hours and must be warned that a Disulfiram-alcohol reaction is potentially dangerous.</p> <p>200mg daily increased if necessary; max dose 500mg daily</p> <p>In the routine management of the alcoholic it is not recommended to carry out an alcohol challenge test. If the clinician feels an alcohol challenge test is essential for the success of the therapy, full information of the procedure and risks of this test can be obtained from the company. As severe reactions can occur any alcohol challenge should be carried out in specialised units by physicians acquainted with the procedure. Full resuscitation facilities must be immediately available.</p>
<p><b>iv. Duration of treatment</b></p>	<p>The patient will be reviewed at 6 months intervals by the specialist and then decision made to carry on communicated to the GP</p>
<p><b>v. Adverse effects</b></p>	<p>During initial treatment, drowsiness and fatigue may occur; nausea, vomiting, halitosis and reduction in libido have been reported. If side effects are marked the dosage may be reduced. Psychotic reactions, including depression, paranoia, schizophrenia and mania occur rarely in patients receiving Disulfiram. Allergic dermatitis, peripheral neuritis and hepatic cell</p>

	<p>damage have also been reported. Do NOT drive or operate machinery if affected. For full details see SPC</p>
<p><b>vi. Monitoring Requirements</b></p>	<p><b>Specialist service:</b> 2 weekly for first 2 months, monthly for next four months and then at least 6 monthly thereafter. The patient will be reviewed at 6 months by the specialist and then decision made to carry on communicated to the GP</p> <p><b>GP:</b> Monitor alcohol consumption and general health on a 6 monthly basis encouraging compliance following the specialist decision made to carry on prescribing is communicated to the GP</p>
<p><b>vii. Clinically relevant drug interactions</b></p>	<p>The Disulfiram-alcohol reaction can occur within 15 minutes of ingestion of alcohol usually peak within 30 minutes to 1 hour, and then gradually subside over the next few hours. Symptoms may be severe and life-threatening. It is characterised by intense flushing, dyspnoea, headache, palpitations, tachycardia, hypotension, and nausea and vomiting. Supportive therapy should be available and measures may be necessary to counteract hypotension. Severe vomiting may occur and require administration of intravenous fluids.</p> <p>Disulfiram may potentiate the toxic effects of warfarin, antipyrine, phenytoin, chlordiazepoxide and diazepam by inhibiting their metabolism. Animal studies have indicated similar inhibition of metabolism of pethidine, morphine and amphetamines. A few case reports of increase in confusion and changes in affective behaviour have been noted with the concurrent administration of metronidazole, isoniazid or paraldehyde. Potentiation of organic brain syndrome and choreoatphetosis following pimozide has occurred very rarely. The intensity of the Disulfiram-alcohol reaction may be increased by amitriptyline and decreased by diazepam. Chlorpromazine while decreasing certain components of the reaction may increase the overall intensity of the reaction. Disulfiram inhibits the oxidation and renal excretion of rifampicin. Disulfiram inhibits the metabolism of some benzodiazepines enhancing sedative effect e.g. diazepam and chlordiazepoxide. Benzodiazepines may reduce the disulfiram-alcohol reaction.</p>
<p><b>viii. Contra-indications</b></p>	<p>Consumption of alcohol. Presence of cardiac failure, coronary artery disease, previous history of CVA, hypertension, severe personality disorder, suicidal risk or psychosis. Hypersensitivity to disulfiram or any excipients.</p> <p><b>Pregnancy:</b> The use of Disulfiram in the first trimester of pregnancy is not advised. The risk/benefit ratio in assessing adverse effects of alcoholism in pregnancy should be taken into account when considering the use of Disulfiram in pregnant Patients. There have been rare reports of congenital abnormalities in infants whose mothers have received Disulfiram in conjunction with other medicines.</p> <p><b>Lactation:</b> Should not be used. No information is available on whether Disulfiram is excreted in breast milk. Its use during breast feeding is not advised especially where there is a possibility of interaction with medicines that the baby may be taking.</p>
<p><b>ix. Cautions</b></p>	<p><b>Alcohol must not be consumed during treatment and for up to 14 days after discontinuation.</b></p>

	Caution should be exercised in the presence of renal failure, hepatic or respiratory disease, diabetes mellitus, hypothyroidism, cerebral damage and epilepsy. Before initiating treatment it is advised that appropriate examinations should be carried out to establish the suitability of the Patient for treatment. Patients must not ingest alcohol during or for 1 week after ceasing Disulfiram therapy. Patients must be warned of the unpredictable and potentially severe nature of a Disulfiram-alcohol reaction as in rare cases deaths have been reported following the drinking of alcohol by Patients receiving Disulfiram. Certain foods, liquid medicines, remedies, tonics, toiletries, perfumes and aerosol sprays may contain sufficient alcohol to elicit a Disulfiram-alcohol reaction and Patients should be made aware of this. Caution should also be exercised with low alcohol and “non-alcohol” or “alcohol-free” beers and wines, which may provoke a reaction when consumed in sufficient quantities. All personnel involved in the administration of Disulfiram to the Patient know that Disulfiram should not be given during a drinking episode.
<b>x. Supply of ancillary equipment eg. syringe drivers, tubing</b>	Nil
<b>xi. Prepared by</b>	Nurse Practitioners, Derbyshire Recovery Partnership DHCFT DCHFT Drug and Alcohol Advisory Group

**This does not replace the SPC, which should be read in conjunction with it.**

**Date prepared:** October 2008 **Date reviewed:** October 2019

**Next Review date:** September 2022

**Reference:**

[www.BNF.org.uk](http://www.BNF.org.uk)

Pennine Care shared care agreement

Summary of product characteristics Disulfiram: accessed July 2017

<https://www.medicines.org.uk/emc/medicine/519>

NICE Clinical Guideline 115 (2011) Alcohol Use Disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. [www.nice.org.uk](http://www.nice.org.uk)

Department of Health (2006) Models of care for alcohol Misusers (MoCAM)

Sample transfer letter

Hospital No: «HOSPITAL\_NUMBER»  
NHS No: «NHS\_NUMBER»

{Insert date}

**PRIVATE & CONFIDENTIAL**

«GP\_TITLE» «GP\_INITIALS» «GP\_SURNAME»  
«GP\_ADDRESS\_1»  
«GP\_ADDRESS\_2»  
«GP\_ADDRESS\_3»  
«GP\_ADDRESS\_4»  
«GP\_POSTCODE»

**DERBYSHIRE JAPC SHARED CARE AGREEMENT LETTER**

Dear «GP\_TITLE» «GP\_SURNAME»

«FORENAME\_1» «SURNAME» «DATE\_OF\_BIRTH»  
«CURRENT\_ADDRESS\_1» «CURRENT\_ADDRESS\_2» «CURRENT\_ADDRESS\_3»  
«CURRENT\_ADDRESS\_4» «CURRENT\_POSTCODE»

Your patient was seen on {Insert date} with a diagnosis of {Insert diagnosis}. I have initiated the following medication {Insert drug name} and am writing to ask you to participate in the shared care for this patient.

This medication has been accepted as suitable for shared care by the Derbyshire Joint Area Prescribing Committee (JAPC). I agree to the secondary care responsibilities set out in the shared care agreement for this medication (available from [www.derbyshiremedicinesmanagement.nhs.uk/clinical\\_guidelines/shared\\_care\\_guidelines](http://www.derbyshiremedicinesmanagement.nhs.uk/clinical_guidelines/shared_care_guidelines)). I am therefore requesting your agreement to share the care of this patient. Where preliminary tests are set out in the agreement I have carried these out and results are below.

Dose Regimen	Date {Insert medicine name} started	Date for GP to start prescribing {Insert medicine name} from
The baseline test results are (if applicable):		

I can confirm that the following has happened with regard to this treatment:

	Specialist to complete
<i>The patient has been initiated on this therapy and has been on an optimised dose for the following period of time:</i>	
<i>Baseline investigation and monitoring as set out in the shared care documents have been completed and were satisfactory</i>	Yes / No
<i>The condition being treated has a predictable course of progression and the patient can be suitably maintained by primary care</i>	Yes / No
<i>The risks and benefits of treatment have been explained to the patient</i>	Yes / No

<i>The roles of the specialist/specialist team/ Primary Care Prescriber / Patient and pharmacist have been explained and agreed</i>	<i>Yes / No</i>
<i>The patient has agreed to this shared care arrangement, understands the need for ongoing monitoring, and has agreed to attend all necessary appointments</i>	<i>Yes / No</i>
<i>I have enclosed a copy of the shared care protocol which covers this treatment/the SCP can be found here (insert electronic/ web link)</i>	<i>Yes / No</i>
<i>I have included with the letter copies of the information the patient has received</i>	<i>Yes / No</i>
<i>I have provided the patient with sufficient medication to last until</i>	
<i>I have arranged a follow up with this patient in the following timescale</i>	

If you do **NOT** wish to participate in shared care for this patient, usually under clinical grounds, please complete the attached form.

Yours sincerely

**{Consultant name}**

**GP RESPONSE TO SHARED CARE** (only complete & send if **NOT** participating in shared care)

Shared care is produced by GPs and specialists knowledgeable in the field of that drug usage. The shared care has been approved by the JAPC. This allows a more convenient service to the patient and cost effective use of NHS resources.

Patient:	NHS No:
Consultant:	Medicine requested for shared care:

I will **NOT** be undertaking the GP responsibilities as described in the agreed shared care guideline. My clinical reasons for declining shared care for this patient are listed in the box below:

		Tick which apply
1.	<p><b>The prescriber does not feel clinically confident in managing this individual patient's condition, and there is a sound clinical basis for refusing to accept shared care</b></p> <p>As the patients primary care prescriber I do not feel clinically confident to manage this patient's condition because <i>[insert reason]</i>. I have consulted with other primary care prescribers in my practice who support my decision. This is not an issue which would be resolved through adequate and appropriate training of prescribers within my practice.</p> <p><b>I have discussed my decision with the patient and request that prescribing for this individual remain with you as the specialist, due to the sound clinical basis given above.</b></p>	
2.	<p><b>The medicine or condition does not fall within the criteria defining suitability for inclusion in a shared care arrangement</b></p> <p>As the medicine requested to be prescribed is not included on the national list of shared care drugs as identified by RMOC or is not a locally agreed shared care medicine I am unable to accept clinical responsibility for prescribing this medication at this time.</p> <p><b>Until this medicine is identified either nationally or locally as requiring shared care the responsibility for providing this patient with their medication remains with you</b></p>	
3.	<p><b>A minimum duration of supply by the initiating clinician</b></p> <p>As the patient has not had the minimum supply of medication to be provided by the initiating specialist I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.</p> <p><b>Until the patient has had the appropriate length of supply the responsibility for providing the patient with their medication remains with you.</b></p>	
4.	<p><b>Initiation and optimisation by the initiating specialist</b></p> <p>As the patient has not been optimised on this medication I am unable to take clinical responsibility for prescribing this medication at this time. Therefore can you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.</p> <p><b>Until the patient is optimised on this medication the responsibility for providing the patient with their medication remains with you.</b></p>	
5.	<p><b>Shared Care Protocol not received</b></p> <p>As legal responsibility for clinical care lies with the clinician who signs the prescription, I need to ensure that I am in possession of sufficient clinical information for me to be confident to prescribe this treatment for my patient and it is clear where each of our responsibilities lie to ensure the patient is safely managed.</p> <p>For this reason I am unable to take clinical responsibility for prescribing this medication at this time, therefore would you please contact the patient as soon as possible in order to provide them with the medication that you have recommended.</p> <p><b>Until I receive the appropriate SCP, responsibility for providing the patient with their medication remains with you.</b></p>	



6.	<b>Other (Primary Care Prescriber to complete if there are other reasons why shared care cannot be accepted)</b>	
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Please do not hesitate to contact me if you wish to discuss any aspect of my letter in more detail and I hope to receive more information regarding this shared care agreement as soon as possible

Yours sincerely

{GP name}  
{Surgery}

**Please send a copy of this response to:**

1. The specialist/consultant requesting shared care
2. **AN ANONYMISED COPY OF THIS FORM ONLY** to the Medicines Management and Clinical Policies and Decisions Team, 1st Floor East Point, Cardinal Square, 10 Nottingham Road, Derby, DE1 3QT or E-MAIL: [ddccg.medicinesmanagement@nhs.net](mailto:ddccg.medicinesmanagement@nhs.net)

*(Sending a copy of this form to the Medicines Management and Clinical Policies and Decisions Team will help to identify any inappropriate requests for shared care e.g. indication not covered, hospital monitoring requirements not fulfilled. It will also help to inform the CCG prescribing group of the reasons shared care is not being undertaken allowing for changes to be made in future updates to improve patient care).*