Depression, excessive alcohol consumption and nalmefene

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It is common for people with low mood to drink alcohol to excess, thus setting up a cycle of worsening depression. It is well recognised that antidepressants are not a stand-alone treatment and that concurrent treatment to help the patient reduce or stop drinking is also required. This article describes how nalmefene, a relatively new drug which helps reduce alcohol comsumption, was used effectively in a woman with depression.

Depression is one of the most common presenting conditions in psychiatry. Sometimes a careful history will reveal that the cause is more complex than appears at first glance to be the case, and conditions such as anxiety disorders, obsessive compulsive disorder, borderline personality disorder and schizophrenia can all present in this way. Even when the symptoms merit a diagnosis of major depressive disorder, one must always look behind the presenting symptoms to see whether there are any precipitating or perpetuating factors which are preventing (or would prevent) a response to antidepressant medication. In practice, a common cause is the regular ingestion of a depressant substance, the most prominent of which, in our society at least, is alcohol.

Because of the ready acceptance of alcohol consumption as a social habit, it can be easy to lose sight of the way in which people drink – classically, to alter their mental state – or the amount they consume. Yet alcohol is such a strong depressant drug that it is now well recognised that it is inefficacious to try treating depression unless the alcohol consumption is also concurrently addressed.

Here I present a case of a woman with a history of major depression, which was only partially recovered; she had returned to work and said that she used increasing amounts of alcohol in connection with stress she encountered. Her condition responded well to a 'prescribed reduction' of alcohol in conjunction with nalmefene.

Presentation

A 54-year-old married woman, who worked in a senior position in a global company, was referred to a private psychiatric clinic by her GP. She gave a history of a recurrent depressive disorder – with three or four previous episodes occurring at intervals of a decade – which she had tried to get over on her own. The current episode had proved more difficult and she had five months off work, during which she was prescribed sertraline 50mg mane by her GP but did not take it regularly, and then had a phased return to work. This was complicated by a difficult relationship with a manager.

Alcohol was not an issue in earlier episodes, but since returning to work she had been drinking about four to five bottles of wine most weeks. She recognised that she was using it to improve her mental state while being aware that it acted as a depressant. She had more than enough symptoms to make a diagnosis of a major depressive disorder with associated anxiety. The symptoms were clinically significant and interfered with both her social and occupational functioning. She expressed her mood at this time as being 20% of her good normal self. There was also a family history of bipolar disorder and likely schizophrenia.

The immediate plan was for her to keep a drink diary with the intention of trying not to drink over the next 10 days, and for her to see an alcohol specialist nurse to support and advise on reducing alcohol. She was also to take sertraline 50mg mane regularly and remain off sick.

The drink diary showed that she was drinking 10 units (a bottle of wine) a day but 15 when she drank with her husband. Since only drinking with her husband was a suggestion from the alcohol nurse to reduce her drinking, we agreed that she would not find it possible to reduce her drinking without assistance. Therefore I suggested instead that she start using nalmefene 18mg whenever she felt the urge to drink – which at this point was a daily occurrence. We planned a 'prescribed' weekly decrease of 1 unit – achieved by throwing away the initial unit(s) from a bottle of wine.

At the next review she had achieved her aim and was drinking 9 units per day. Her mood was reported to be 50% of normal. She stated that nalmefene gave her the ability to think about her drinking

in a different way so that she was able to decide to stick to her decision more easily. The only side effect was an initial transient dissociative feeling (which was duly reported via the Company Adverse Event Report form). After this appointment it was agreed that she would increase the dose of sertraline to 100mg mane. There was, however, already a slight elevation of mood by this stage.

Over subsequent appointments there was a gradual reduction of alcohol intake in accordance with the plan – albeit with a number of exceptions, particularly around times of celebration and especially when drinking with her husband. She took nalmefene daily though. On 7 units a day she reported her mood to be 60% of normal; by the time she was down to 5 units she felt 70% of normal. At 2 units a day she said that she felt 80–85% of her good normal self. It was agreed that it would be best if she could stop drinking entirely, at least for some months, primarily to remove the depressant effect of alcohol, but also because part of the plan was to start cognitive behavioural therapy (CBT), and this is difficult to do effectively while drinking. Just after she had stopped drinking she reported her mood to be 90% of normal.

After she had stopped drinking, it was agreed that she would take nalmefene for a week and then half a tablet per day for a further week. This is not something which is advised by the manufacturer, but was felt intuitively to be something which might help psychologically with staying off alcohol. This achieved its aim and she was then able to commence CBT. CBT continued for a period of approximately six months during which she was seen 14 times after assessment. During this time she did not reinstate her drinking and her mood remained stable.

Discussion

The clinical presentation in this case was one of moderately severe depression. The imperative on the clinician is to treat this as efficiently and speedily as possible. The comorbidity of depression and alcohol disorders is well recognised[1] and, although 'antidepressant medication exerts a modest beneficial effect for patients with combined depressive and substance-use disorders', 'concurrent therapy targeting the addiction is also indicated'.[2] Opioid antagonists for alcohol dependence were reviewed in a Cochrane study which looked at naltrexone, but the narrative bracketed it with nalmefene, presumably because of the overlap (in terms of mu-opioid antagonism) between the mode of action of the two drugs. The authors concluded that 'even though the sizes of treatment effects might appear moderate … these should be valued against … the relapsing nature of alcoholism and the limited therapeutic options available…'.[3]

A literature search shows that there has not been any research directly comparing nalmefene and naltrexone, but three studies in recent years have confirmed the efficacy of nalmefene.[4–6] There is one study, of particular relevance to this case, which demonstrates that a combination of sertraline and naltrexone (compared to each drug alone) is more efficacious in achieving abstinence from alcohol, delayed relapse to heavy drinking and improvement in depression.[7] It is clear from the licence that nalmefene is to be used as adjunctive treatment with appropriate counselling and in this case this was readily available. In the NHS it can be problematic to obtain this in either primary care or the generic mental health services as there is a strong tendency to 'treat in silos' with the alcohol problem hived off to specialist services. In this case it was possible to follow the guidance, making the patient's care quite seamless.

The licence allows nalmefene to be taken on an as-required basis; in this case, because of the nature of the addiction – not at all uncommon – this translated as daily use. The tailing off method chosen after the 'prescribed reduction' in alcohol was arrived at by discussion and patient choice – clinicians should be free to exercise discretion. Subjectively, the mode of action was experienced as one of 'enabling to think'; one might speculate the patient felt the nalmefene interrupted what, with alcohol, sometimes happens – namely that she gave up thinking. This would be in line with comments made in numerous papers published over the last 20 years on the subjective effect of naltrexone. The overall conclusion is that nalmefene provides a useful tool for the clinician faced with a need to reduce alcohol intake efficaciously in order to treat underlying depression.

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Acknowledgement

Patient consent was obtained for publishing this case.

Declaration of interests

There are no conflicts of interest declared.

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