Depression, excessive alcohol consumption and nalmefene

Danny Allen MB BS, LLM, MRCGP, FRCPsych

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 consumption, was used effectively in a woman with depression.
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 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’. 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…’.

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. 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. 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 and publications 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.

Dr Allen is Consultant Adult Psychiatrist at Phoenix Mental Health Services, High Wycombe

Acknowledgement

Patient consent was obtained for publishing this case.

Declaration of interests

There are no conflicts of interest declared.

References