Practice Guidelines: Alcohol Withdrawal

OBJECTIVES:

1. Identify patients at risk for alcohol withdrawal and monitor closely for signs and symptoms of withdrawal.
2. Initiate multimodal therapy early.
3. Offer referral to outpatient therapy for addition medicine.

GUIDELINES:

- Obtain history of frequency of alcohol use and history of previous episodes of withdrawal and time since last drink.
- Early identification of history of alcohol abuse with a thorough social history and SBIRT* screening:
    - Screening
    - Brief Intervention
    - Referral to Treatment
- Evaluate for signs and symptoms including nausea, tremors, anxiety, agitation, diaphoresis, delirium, tactile disturbances, auditory disturbances, visual disturbances and headache.
- Consider other diagnosis that may be confounding diagnosis of withdrawal such as sepsis, hemorrhage, seizure disorder, traumatic brain injury, etc.
- Initiate CIWA (Clinical Institute Withdrawal Assessment Scale for Alcohol) every two hours with vital signs until a score of less than 8 is achieved for 2 consecutive evaluations then score every 4 hours with vital signs.
- Consider fall precautions, seizure precautions and 1:1 monitoring.
- Administer Thiamine 100mg PO/IV prior to any glucose containing fluid.
- Initiate thiamine 100 mg PO daily, Folic acid 1 mg PO daily and multivitamin 1 tab PO daily.
- If unable to tolerate PO, administer banana bag.
- Consider Gabapentin taper if CIWA >8 or considered high risk for alcohol withdrawal
    - Gabapentin 600 mg PO q6 hrs for three days, followed by 400 mg PO Q8 hours for 1 day
- Symptom triggered dosing of benzodiazepines. House staff to be notified to perform bedside clinical exam of patient's symptoms prior to initiation of benzodiazepine.
    - Lorazepam 2 or 4 mg PO/IV every two hours for CIWA of greater than or equal to 8.
        - Longer duration of onset may lead to over sedation if titrated too rapidly.
        - Preferred benzodiazepine in the presence of hepatic or renal dysfunction.
    - Diazepam 5 or 10 mg PO/IV every two hours for CIWA of greater than or equal to 8.
        - Rapid onset preferred for severe cases
        - Active metabolites
- If condition worsens or patient develops DT's transfer to ICU and consider benzodiazepine, propofol or precedex infusions.
- Offer referral for social work consultation and consultation to addiction medicine for outpatient treatment programs for alcohol dependence.

*SBIRT is a comprehensive, integrated, public health approach to identify those who may be at risk for developing a substance abuse disorder. Please refer to the following for instructions. http://www.upstate.edu/obgyn/pdf/intro_sbirt_interviewing_pt_behav.pdf

References:

Daeppen JB, et al. Symptom-triggered vs fixed-schedule dose of benzodiazepine for alcohol withdrawal: a randomized treatment trial. Arch Intern Med. 2002 May 27; 162(10):1117-21.

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Myrick H, et al. A double-blind trial of gabapentin versus lorazepam in the treatment of alcohol withdrawal. Alcohol Clin Exp Res. 2009 Sep; 33(9): 1582-8.

http://www.upstate.edu/policies/documents/intra/procedures/PROC_CM_A-22A.pdf