Alcohol Withdrawal Management

These toolkits are derived from the QLD Alcohol and Drug Withdrawal Clinical Practice Guidelines 2012.
Medical Addiction specialists will be able to offer additional expert opinion based upon current evidence.

insight
Alcohol and other drug training and workforce development Queensland

1 SCREENING

AUDIT-C Test

How often do you have a drink containing alcohol?				
Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
0	1	2	3	4
How many drinks containing alcohol do you have on a typical day when you are drinking?				
1 or 2	3 or 4	5 or 6	7 or 9	10 or more
0	1	2	3	4
How often do you have five or more drinks on one occasion?				
Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4
Alcohol > 3 indicates high-risk drinking (Lawrinson P, Copeland J, Gerber S, Gilmour S. 2007)				

2 ASSESSMENT

Perform Comprehensive Assessment

1. **Alcohol consumption:** Quantity (10 gms = 1 Standard Drink); frequency; pattern of use; two week history, last alcohol use and withdrawal onset, history of withdrawal, duration of this episode, previous treatment.
   In general >80gm daily intake indicates possible withdrawal syndrome / seizures
2. **Biopsychosocial history:** Medical and psychiatric conditions, social history and collateral relating to presentation
3. **Investigations:** Bloods (eLFTS (↑ ALT/AST +/- ↑ GGT), FBC, INR), Urinalysis, Blood Alcohol Level, Blood Borne Virus screen
4. **Physical examination:** Neurological observations, visual inspection for stigmata of chronic liver disease (including prominent facial capillaries, spider naevi, palmar erythema, pain, oedema, jaundice)

Low-strength beer 375mls 2.7% Alcohol	Full-strength beer long neck 750ml 4.8% Alcohol	Full-strength beer Carton 24x375ml 4.8% Alcohol	White Wine 100ml glass 11.5% Alcohol	Red Wine bottle 750ml 13.5% Alcohol	Red Wine 2L Cask 13.5% Alcohol	Ready-to-drink Sprits 375ml 5% Alcohol	High-strength Spirits bottle 750ml 40% Alcohol
0.8 Standard drinks	2.8 Standard drinks	34 Standard drinks	0.9 Standard drinks	8 Standard drinks	21 Standard drinks	1.5 Standard drinks	22 Standard drinks
							
Australian Government; Department of Health, 2010							

3 MONITORING

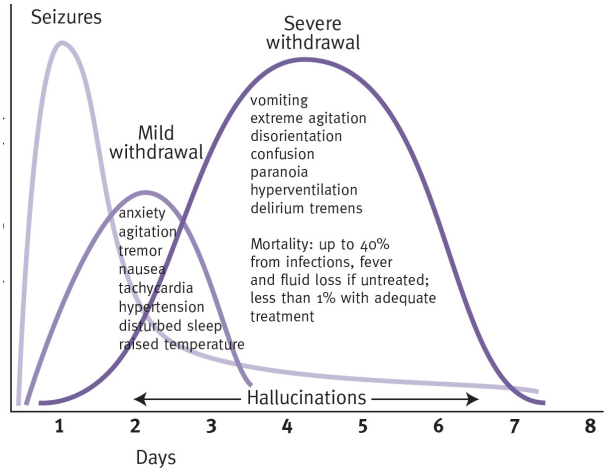
Alcohol Withdrawal Scale CIWA-Ar

All patients at risk of alcohol withdrawal should be monitored at least 4 hourly for the first 24 hours of presentation

	CIWA-ar Score
MILD – Monitor patient 4 times per day	<10
MODERATE – Monitor patient 1-4 hourly	10 - 20
SEVERE – Monitor patient 1-2 hourly	>20

Note: a rising score indicates an urgent need for aggressive treatment and monitoring
Withdrawal scales have a limited role under these circumstances, and health professionals should consult a specialist drug and alcohol clinician about monitoring and management of withdrawal.

Course of Withdrawal



Adapted from Frank L, Pead J, (1995). *New Concepts in Drug Withdrawal: a resource handbook.* Victoria. Reproduced with permission.

Supportive Therapies

Symptomatic pharmacotherapy	
Dehydration and electrolyte imbalance	Corrective therapies (magnesium, folic acid, potassium)
Nausea	Metoclopramide, antacids
Headache and pain	Paracetamol * consider liver impairment
Diarrhoea	Loperamide
Thiamine replacement	
All patients	100mg TDS IM / 300mg IV for 3 days then 100mg oral TDS for several weeks
Suspected Wernicke's Encephalopathy	500mg IV TDS for 3 days, then orally TDS for one month
Supportive treatment	
Quiet, low lit environment Encourage diet and hydration Visual observations minimum 4th hourly Supportive psychotherapeutic interventions: Cognitive Behavioural Therapy; Mindfulness, Motivational Interviewing; Solution-Focused Brief Therapies	

Prescribing Regimes

Example of regimen - mild withdrawal	
Day 1	10mg diazepam four times daily
Day 2-3	5-10mg diazepam three times daily
Day 4	5 mg diazepam twice daily
Day 5-7	5mg diazepam nocte
Moderate withdrawal	
Initial 10-20mg diazepam on development of withdrawal symptoms repeated every 2 hours until good symptoms control- up to 80mg (if more required consider contacting specialist). Taper doses titrating against withdrawal symptoms.	
Severe withdrawal (including delirium tremens)	
20mg initially. May require IV sedation – refer to guidelines or contact specialist for advice For hallucinations, add olanzapine 5 to 10mg wafer, repeated to 30mg daily as required if not responding to diazepam alone.	
Diazepam contraindicated in respiratory failure, severe hepatic impairment, head injury or stroke and in older populations seek specialist advice. If patient is sedated, the dose can be reduced or omitted. Additional diazepam doses can be given as needed based on clinical observation or monitoring scores	

Variances to Standard Withdrawal Protocols

Delirium Tremens	Wernickes Encephalopathy	Alcoholic Hepatitis/ Significant Liver Dysfunction
Develops 2-5 days after stopping or significantly reducing intake. Last 3-14 days Clinical features: confusion, agitation, paranoia, gross tremor, delusions, hallucinations, autonomic instablitiy, haemodynamic instabilty Consider lorazepam 2mg IM and transfer patient to high dependency unit for further management. *Isolated delirium tremens is rare - screen for other factors that may be contributing to delirium*	Acute thiamine deficiency associated with prolonged alcohol use. Symptoms include global confusion plus ataxia, nystagmus, memory loss	Consider oxazepam to reduce sedation caused by active metabolites of diazepam monitor liver functions

Alcohol and Drug Clinical Advisory Service: 1800 290 928

Post-Withdrawal Treatment Options

Pharmacotherapies	Acamprosate Naltrexone (caution impaired hepatic function) Second-line agents (baclofen, disulfiram and topiramate)
Relapse Prevention	Adis 24/7 Alcohol and Drug Support 1800 177 833 adis.health.qld.gov.au Individual counselling Self-help groups (AA, NA, Smart Recovery) Residential rehabilitation Family Drug Support (FDS) - 1300 368 186