AAFP

Alcohol Withdrawal

Registrar Education Series

Updated February 2023

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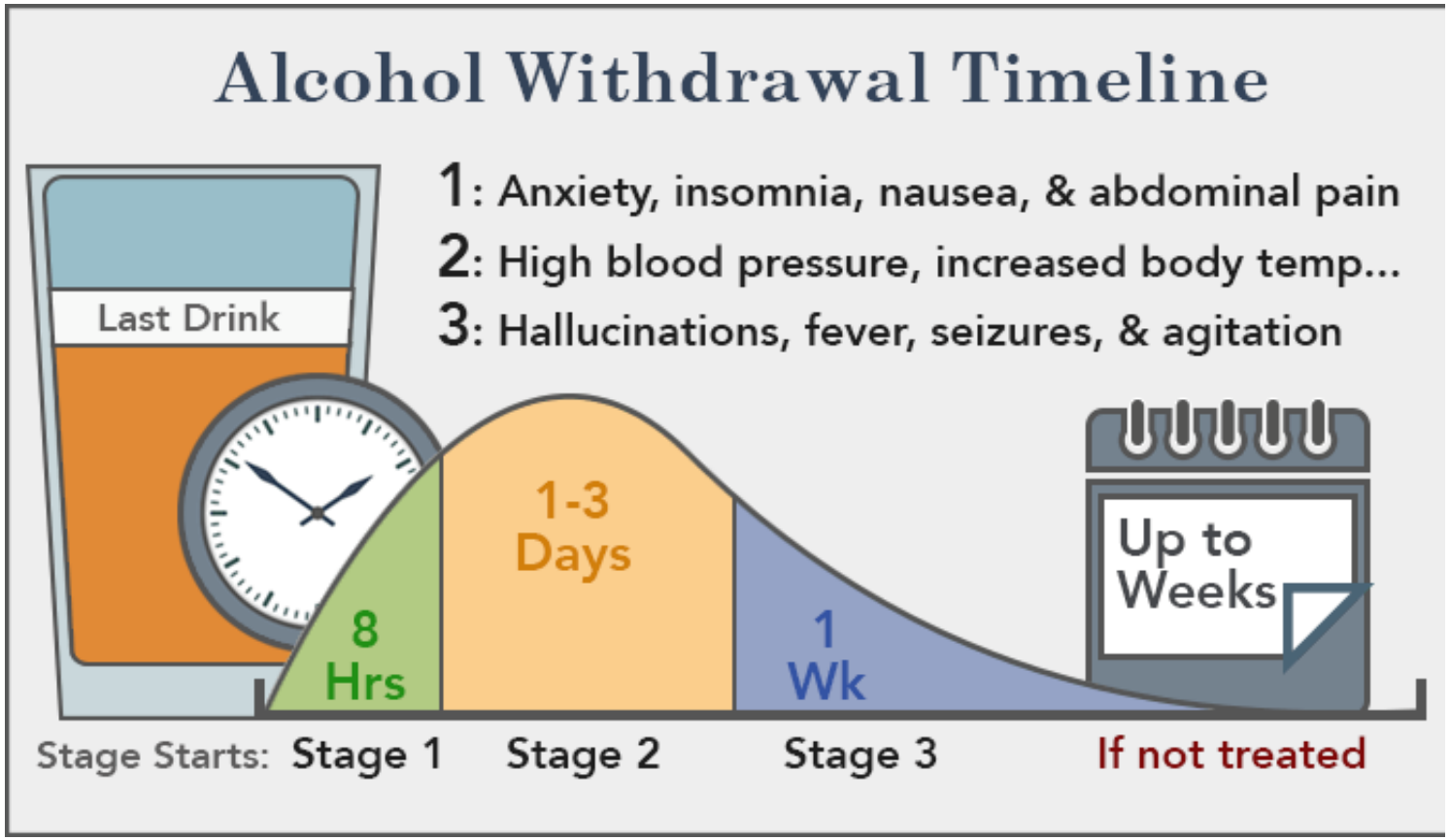
Background?

- What percentage of people with alcohol use disorder who abruptly stop drinking will experience withdrawal symptoms?
- How early do signs of withdrawal begin and how does it evolve?

Background



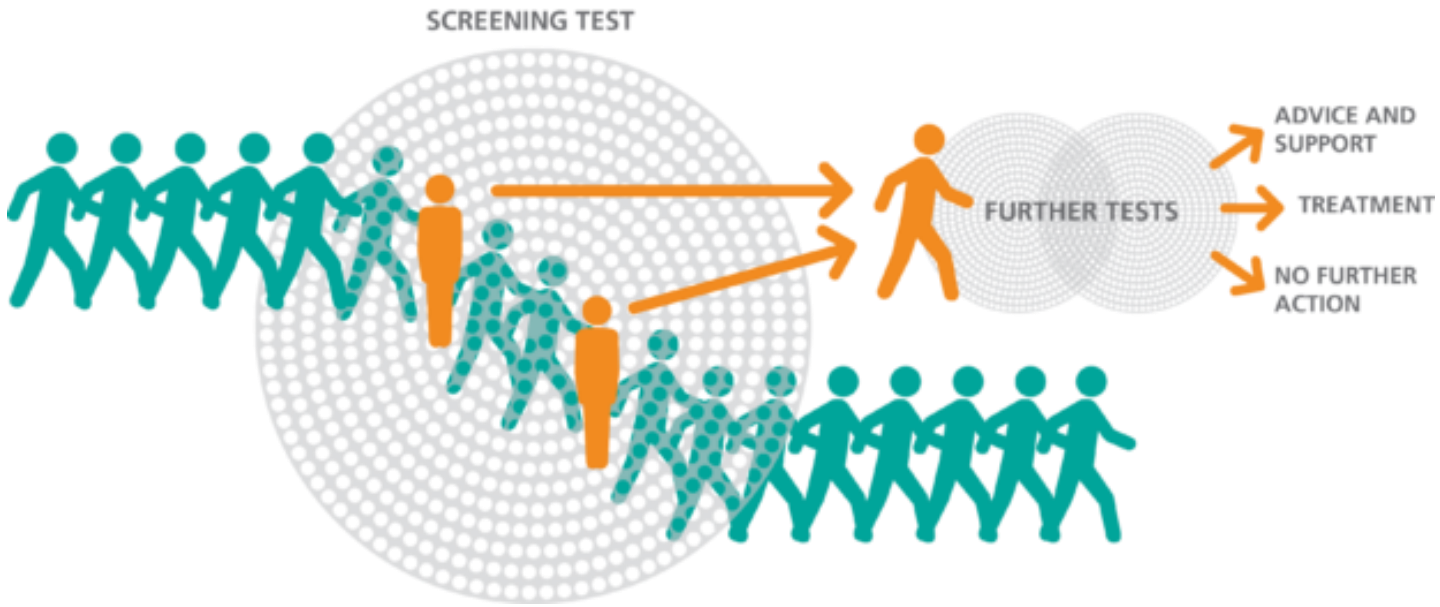
- ½ of people with *AUD* who abruptly reduce or abstain from alcohol will experience symptoms of withdrawal
- Withdrawal begins within 6-24 hours
- 6-12 hours: anorexia, diaphoresis, GI upset, headache, insomnia, mild anxiety, palpitations, tremulousness
- 12-24 hours: alcoholic hallucinosis: auditory, tactile or visual hallucinations
- 12-48 hours withdrawal seizures (50% will progress to DTs)
- 48 hours – 5 days Delirium tremens

Screening?

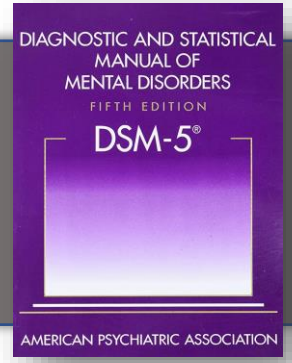
- What screening tools are used to detect alcohol use disorder?
- What is considered risky drinking?
- How is alcohol withdrawal classified/scored?
- What are the treatment goals when caring for someone experiencing withdrawal?

Screening

- Screen for *alcohol use disorder* with *AUDIT-C*, SASQ, if positive than do the full AUDIT
- Risky drinking
  - Men: Drinking ≥ 5 drinks on one occasion or ≥ 15 per week
  - Women and men > 65yo: Drinking 4 or more drinks on one occasion or more than 7 per week
- Alcohol withdrawal is classified as *Mild*, *Moderate*, *Severe* and complicated (seizures or delirium)
  - Provider scored *CIWA-Ar*, *PAWSS*
  - Patient scored SAWS
- Treatment goals: Lower mortality, prevent seizures and prevent progression to delirium tremens and reduce withdrawal symptoms



Alcohol Use Disorder – DSM V



- Mild 2-3
- Moderate 4 - 5
- Severe ≥ 6

Alcohol is often taken in larger amounts or over a longer period than was intended.
There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
Craving, or a strong desire or urge to use alcohol.
Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
Recurrent alcohol use in situations in which it is physically hazardous.
Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
Tolerance
Withdrawal

Treatment settings for withdrawal?

- What are different options for treating settings?
- What patient characteristics are optimal for each setting?

Treatment settings

- Outpatient
  - Mild symptoms and otherwise medically and psychiatrically stable
  - Daily follow up for up to 5 days after last drink.
  - Evaluate symptom severity, overall health, mental status, hydration, sleep, mood, suicidality and substance use
- Level 2 Outpatient
  - extended on-site monitoring
  - moderate symptoms with a risk of complicated withdrawal
- In-patient
  - PAWSS ≥4, severe, complicated or additional risk factors

Mild

- CIWA-Ar: <10 or SAWS <12 symptoms with minimal risk of developing severe/complicated withdrawal can be treated with supported care with or without pharmacotherapy
- Minimal risk (none): history of withdrawal-related delirium or seizures, multiple prior withdrawal episodes comorbid illness, age older than 65 years, long duration of alcohol consumption (e.g., heavy alcohol use five or more days in the past month), seizures during current withdrawal episode, marked autonomic hyperactivity on presentation, and physiologic dependence on GABAergic agents
- Supportive care: educating patients on the course of withdrawal, monitoring for severe withdrawal, instructing them on how to maintain low-stimulation home environments, consuming noncaffeinated fluids
- Recommend a daily multivitamin containing 400 mcg of folic acid, and prescribe thiamine 100 mg daily for three to five days

- Medications
  - Benzodiazepines (CIWA-Ar ≥8)
  - Carbamazepine (Tegretol)
  - Gabapentin (Neurontin)

Moderate

- CIWA-Ar 10-18 or SAWS >12
- Triggered benzodiazepines preferred
- Long acting chlordiazepoxide (Librium) and diazepam (Valium) are preferred
- If significant liver disease is present lorazepam (Ativan) and oxazepam (Serax) should be used

Severe

- CIWA-Ar ≥19
- Complicated if there are seizures or delirium tremens
- Symptom triggered (preferred) benzodiazepines to achieve a calm but alert state for seizure
- Cooperative patient can take oral therapy
- Agitated or uncooperative patient, unable to tolerate oral will need IV therapy

Withdrawal treatment basics?

What are the basics to in-patient alcohol withdrawal?

Alcohol Withdrawal Treatment Basics

- PAWSS ≥ 4 needs to be admitted inpatient
- Daily multivitamin containing 400 mcg of folic acid
- Thiamine 100 mg daily for three to five days
  - If Wernicke encephalopathy is suspected increase to 500mg IV TID
- Symptom triggered *benzodiazepines* are preferred in-patient with a CIWA-Ar ≥ 8 to achieve a calm but alert state
  - Long-acting diazepam and chlordiazepoxide are preferred
  - If advanced liver disease, alcoholic hepatitis or >65yo lorazepam or oxazepam are preferred
- Front loading is preferred in high-risk patients who have a history of seizures or delirium tremens
- Use of *adjunct therapies* is controversial as the focus should be on benzodiazepine treatment to prevent mortality, seizures and delirium tremens
- Plan ahead
  - Discharge plan considering harm reduction, 12-step program, abstinence

Benzodiazepines

Medication	Fixed schedule	Symptom-triggered
Day 1 Diazepam (Valium) Chlordiazepoxide (Librium) Lorazepam (Ativan)	10mg q6h 25-50mg q6h 2mg q8h	10mg q4h 25-50mg q4h 2mg q6h
Day 2 Diazepam (Valium) Chlordiazepoxide (Librium) Lorazepam (Ativan)	10mg q8h 25-50mg q8h 2mg q8h	10mg q6h 25-50mg q6h 2mg q6h
Day 3 Diazepam (Valium) Chlordiazepoxide (Librium) Lorazepam (Ativan)	10mg q12h 25-50mg q12h 1mg q8h	10mg q6h 25-50mg q6h 1mg q8h
Day 4 Diazepam (Valium) Chlordiazepoxide (Librium) Lorazepam (Ativan)	10mg at bedtime 25-50mg at bedtime 1mg q12h	10mg q12h 25-50mg q12h 1mg q12h
Day 5 Diazepam (Valium) Chlordiazepoxide (Librium) Lorazepam (Ativan)	10mg at bedtime 25-50mg at bedtime 1mg q12h	10mg q12h 25-50mg q12h 1mg q12h

Symptom triggered vs Front loading

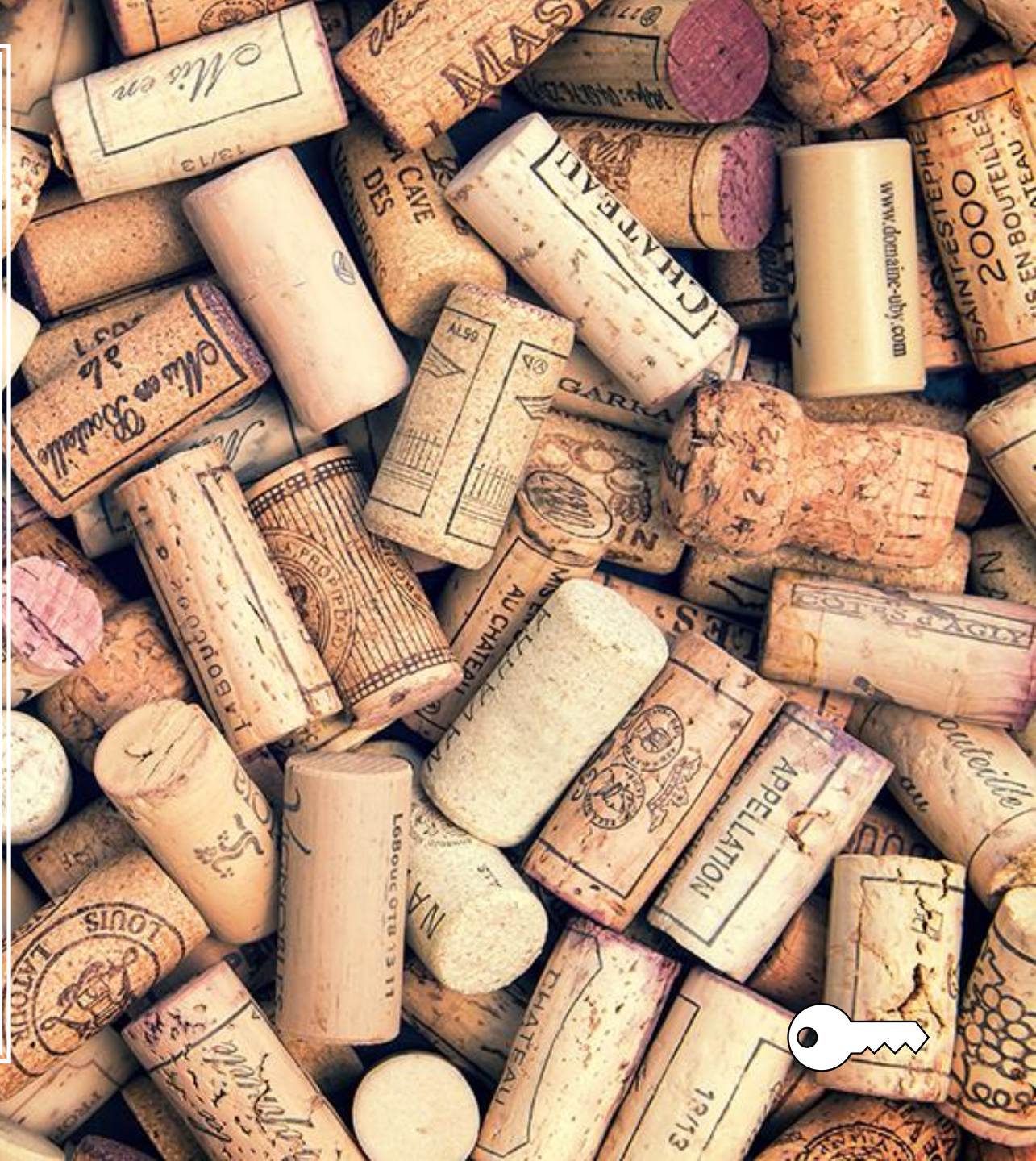
Symptom triggered: CIWA-Ar ≥ 8	Front loading
IV: diazepam 5 to 10 mg IV Lorazepam 2 to 4 mg IV in patients with severe liver disease	**IV:** diazepam, 5 to 10 mg IV every 5 to 10 minutes, until the appropriate level of sedation is achieved Lorazepam, 2 to 4 mg IV every 15 to 20 minutes
Oral: chlordiazepoxide 25 to 100 mg orally Oxazepam 10 to 30 mg orally in patients with severe liver disease	**Oral:** Chlordiazepoxide (Librium) 50 mg to 100 mg Oxazepam (Serax) 15 mg to 30 mg 15 mg to 30 mg every 6 to 8 hours

Benzodiazepines with adequate nursing support

Symptom triggered	Front loading
CIWA-Ar ≥ 8: give diazepam 5 mg PO/IV, recheck in 4 hours	**Diazepam**: 5 to 10 mg IV every 5 to 10 minutes, until the appropriate level of sedation is achieved.
CIWA- Ar ≥ 15: give diazepam 10 mg PO/IV, recheck in 2 hours	**Lorazepam**: 2 to 4 mg IV every 15 to 20 minutes
CIWA-Ar ≥ 20: give diazepam 20 mg PO/IV, recheck in 1 hour	

Harm Reduction?

- What methods can be used to reduce harm in a person with alcohol use disorder?
- Which medications are commonly prescribed?

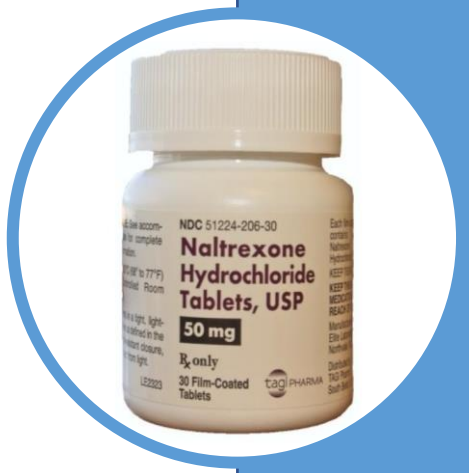


Harm reduction

- *AA* and *12-step programs* are more successful than motivational interviewing
- Regular monthly follow ups increases rates of abstinence
- Pharmacotherapy is underutilized in the treatment of AUD
- Decreases relapse, decrease readmission rates, and decrease drinking days and drinking amount
  - *Acamprosate*
  - *Naltrexone*
  - *Disulfiram*
  - *Gabapentin*
  - *Topiramate*
- Wet houses

Naltrexone

- Revia 50 mg daily
- Prescribed to patients who want to reduce or abstain from alcohol
- Lowers relapse rates
- Lowers cravings
- Decreases heavy drinking days
- Harm reduction in patients who are trying to cut back)
- Naltrexone + gabapentin is superior to naltrexone alone for sobriety



Acamprosate

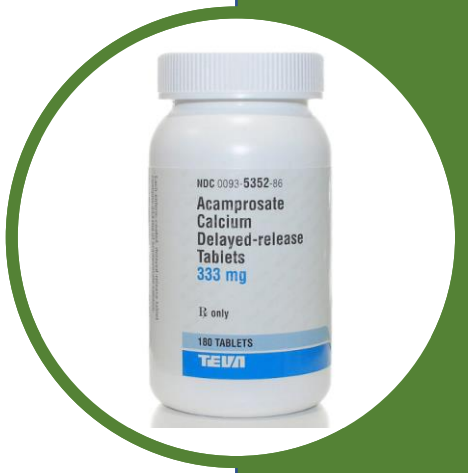
Acamprosate 666 mg TID

Prescribed to patients who want to reduce or abstain from alcohol

Lowers relapse rates

Decreases cravings

Not as effective as naltrexone in head-to-head study in USA



Disulfiram

Antabuse 250-500 mg daily

Used if there is no response to acamprosate or naltrexone

Best if taken under supervision by support person

Do not give to persons who cannot tolerate disulfiram reaction: liver disease, esophageal disease, heart failure, frail

Gabapentin or Topiramate

Decreases relapse rates

Not FDA approved for AUD

Considered second line

Can be started during withdrawal and continued after discharge

Adjunct therapies

Many experts do not like using adjunct therapies as they do not prevent seizures and may mask or decrease the scoring for the severity of the withdrawal

Only given if needed after adequate benzodiazepine therapy

Beta blockers for persistent hypertension and tachycardia: Atenolol 25 mg to 50 mg daily Metoprolol: 25 mg to 50 mg every 12 hours

Carbamazepine for additional control and to reduce cravings: 200 mg every 8 hours or 400 mg every 12 hours

Clonidine 0.2 mg for autonomic hyperactivity or anxiety

Gabapentin for additional control, reduces cravings and can be continued long term for MAT: 400 mg every 6 to 8 hours