Management of alcohol use disorders: withdrawal care

Individuals drinking large amounts of alcohol regularly may experience acute withdrawal symptoms when ceasing or reducing their alcohol use. In moderate withdrawal these symptoms may be sweating and tremor, whereas more severe withdrawal may be complicated by delirium or seizures.

Withdrawal from alcohol should be a planned process under medical supervision. Alcohol dependent patients may require hospitalization and emergency department staff should assess comorbidity and risk and consider admission of these patients as with other medical conditions.

1. Assessment

Successful management of alcohol withdrawal includes a comprehensive assessment including:

- History of alcohol use and its treatment, including daily intake and time of last drink and any previous complex withdrawal -episodes (seizures, confusion, delirium)
- Examination focussed on features of acute and chronic alcohol use
- Investigations, such as urine drug screen, FBE, LFTs and U & Es may be useful.

2. Withdrawal management

Current treatment for symptomatic alcohol withdrawal is based on use of a long acting benzodiazepine (preferably diazepam) tapering dose over 5 - 7 days. This treatment has been shown to reduce the incidence of complications of alcohol withdrawal such as seizures or delirium.

Withdrawal care may be undertaken (i) as an ambulatory patient supported by a GP, ideally with a visiting nurse and/or contact information for telephone support; (ii) by a hospital inpatient unit or DASSA Withdrawal Services based at Glenside.

The choice of services will depend on severity of alcohol use, availability of services and patient circumstances.

3. Ambulatory patients

General practitioners are often the first contact for individuals with alcohol use disorders and in many cases can provide effective withdrawal management.

Most patients can be managed in the community.

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Inpatient admission is indicated if:

- They have a history of withdrawal seizures
- They have a history of complicated withdrawal
- They do not have stable accommodation
- They do not have an appropriate support person to monitor them and assist with medication administration
- Are not medically and psychiatrically stable. (If the person has been an inpatient then they need to be medically and/or psychiatrically reviewed and cleared as low risk of complications if transferred to a home setting).

3.1 Reviews

- The person should be reviewed either by a doctor or a nurse once per day for at least five days. The severity of their withdrawal should be monitored using the CIWA-Ar (PDF 45KB).
- A contingency plan should be developed in case of deterioration in the person's condition. This should include who to contact any time of day or night as well as what to do in emergencies.
- Worsening withdrawal at 3 to 10 days after the person's last drink may indicate the need for inpatient treatment.
- The development of any confusion should trigger an urgent review and possible transfer to an inpatient unit.
- Patients should be advised not to drive during withdrawal, due to effects of the withdrawal, as well as the benzodiazepines.
- The support person should be made aware of the above.

3.2 Diazepam

The recommended management of alcohol withdrawal is a regimen of regular doses of diazepam 10-20mg 6 hourly, tapering over 5 days. Example: mild-moderate withdrawal anticipated:

- Day 1: Diazepam 10mg QID
- Day 2: Diazepam 10mg QID
- Day 3: Diazepam 5mg QID
- Day 4: Diazepam 5mg QID
- Day 5 and 6: Diazepam 5mg BD.

NOTE: The use of diazepam carries some risk if combined with alcohol and limited quantities should be supplied to patients.

Daily or second daily dispensing of diazepam is recommended.

If the patient has impaired hepatic synthetic function (raised INR >1.5, low albumin, raised bilirubin) the lorazepam should be used. These patients should be managed in an inpatient unit.

3.3 Symptomatic medication

Some patients will require anti-emetics and paracetamol for symptoms of alcohol withdrawal.

3.4 Thiamine and other supplementation

All patients should be given oral or IM thiamine, of at least 200-300mg daily.

Example:

- Day 1-3: Thiamine 200mg IM (IV if impaired INR, or low platelets)
- From day 5: Thiamine 100mg tid oral daily.

If signs of Wernicke's encephalopathy emerge (confusion OR eye signs OR ataxia) the patient should be transferred to an acute hospital for IV thiamine in high doses.

Multivitamins, zinc and magnesium supplementation may also have some benefit.

4. Inpatient management of alcohol withdrawal

Where ambulatory management of alcohol withdrawal involves unacceptable risk, referral to acute services or specialist alcohol and drug treatment should be considered.

Referral details for DASSA Withdrawal Services are as follows:

Fax: (08) 7087 1750 (follow-up with phone call if you feel it is needed (08) 7087 1700)

Email: Health.DASSALiaisonNurseWithdrawalServ@sa.gov.au

More details on Inpatient Withdrawal Management can be obtained here.

For further clinical information consider calling the Drug and Alcohol Clinical Advisory Service (DACAS) on telephone (08) 7087 1742.

5. Post withdrawal care

Alcohol withdrawal should be part of a planned process that involves medium to long term care of a chronic relapsing condition. Plans should incorporate elements including relapse prevention strategies, pharmacotherapies (such as acamprosate, naltrexone, disulfiram), counselling, residential rehabilitation and peer support.

6. Key messages in withdrawal management

- Without a comprehensive long term plan, withdrawal is less likely to be effective
- Alcohol withdrawal often needs to be carried out with medical supervision, and patients may be triaged to ambulatory or inpatient/specialist care depending on severity of the condition
- Diazepam in tapering doses over 5-7 days is the preferred agent for management of alcohol withdrawal
- Post withdrawal care plans can include medication and non-medical therapies.

Disclaimer

This information is a general guide for the management of alcohol withdrawal. Consultation with a specialist drug and alcohol service such as the Drug and Alcohol Clinical Advisory Service (DACAS) is recommended for patients using multiple drugs or with serious medical or psychiatric conditions. Telephone DACAS on (08) 7087 1742**.** The drug doses given are a guide only and should be adjusted to suit individuals.

For more information

Drug and Alcohol Clinical Advisory Service (DACAS)
Telephone: (08) 7087 1742
24-hour specialist support for advice for health professionals

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