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 hospitalisation 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 community residential detoxification unit (CRDU). The choice of services will depend on severity of alcohol use, availability of services and patient circumstances.

2.1 Ambulatory patients

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

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 TDS
Day 3: Diazepam 5mg QID
Day 4: Diazepam 5mg TDS
Day 5: Diazepam 5mg BD

NOTE: The use of diazepam carries some risk if combined with alcohol and ideally limited quantities should be supplied to patients and monitored closely by the prescriber and/or a visiting nurse. If alcohol relapse occurs during diazepam treatment, the patient's management plan should be reviewed.

2.1.2 Symptomatic medication
Some patients will require antiemetics and paracetamol for symptoms of alcohol withdrawal

2.1.3 Thiamine & other supplementation
All patients should be given oral or IM thiamine, of at least 200-300mg daily
Example:
Day 1-3: Thiamine 200mg IM
From day 5: Thiamine 100mg tid oral daily

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

Referral to inpatient or specialist services should be considered in the following settings:

- History of complex alcohol withdrawal including delirium, confusion or seizures
- Comorbid other substance use, significant physical or psychiatric illness
- High risk or unstable home environment, poor social supports

Or when complications of withdrawal develop during ambulatory withdrawal.

2.2 Inpatient and community residential detoxification unit (CRDU) based 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.

Inpatient or CRDU care may include;

2.2.1 Diazepam or other benzodiazepine therapy over 5-7 days, as:

- Fixed tapering doses of diazepam (see 2.1.1)
- Diazepam "loading"
- Symptom triggered dosing based on CIWA-Ar or similar alcohol withdrawal scale.

2.2.2 Symptomatic medication, thiamine and other supplementation should follow the guidelines in 2.1. In some cases thiamine infusions of 300-900mg over 24 hours may be required for those diagnosed with or at risk of Wernicke's encephalopathy**.** If W.E. suspected we recommend further discussion with DACAS.

2.2.3 Acute confusional states that are related to alcohol withdrawal may require small doses of antipsychotic medication (such as haloperidol or a sedating atypical antipsychotic).

Staff within inpatient settings should refer to their services' clinical guidelines for the management of alcohol withdrawal. For any queries about withdrawal, GPs or hospital staff should contact DACAS.

3. 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.

4. 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

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This information is a general guide for the management of alcohol withdrawal. Consultation with a specialist service (e.g. DACAS) is recommended for patients using multiple drugs or with serious medical or psychiatric conditions. The drug doses given are a guide only and should be adjusted to suit individuals.