



**Western Health  
and Social Care Trust**

**Management and Treatment Guidelines  
For  
Acute Alcohol Withdrawal Policy**

**2014**



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## Glossary

### **Abbreviations:**

<b>ALN:</b>	Alcohol Liaison Nurse
<b>ARBD:</b>	Alcohol Related Brain Damage – an umbrella term for various psycho-neurological / cognitive conditions that are associated with long term alcohol misuse and related vitamin deficiencies. At one extreme is the classical presentation of Wernicke-Korsakoff syndrome and at the ‘milder’ end subtle frontal lobe dysfunction.
<b>AWS:</b>	Alcohol Withdrawal Syndrome
<b>DTs:</b>	Delirium Tremens
<b>CDZ:</b>	Chlordiazepoxide

### **Screening / assessment tools:**

<b>AUDIT:</b>	Alcohol Use Disorders Identification Test ( <i>appendix 3</i> ). A simple tool used to detect alcohol problems experienced within the last year. The test contains 10 multiple choice questions on quantity and frequency of alcohol consumption, dependence and alcohol-related problems.
<b>CIWA-Ar:</b>	Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised ( <i>appendix 4</i> ) is a guide to measuring the severity of alcohol withdrawal symptoms and in turn affords some guidance to the amount of benzodiazepine to give.
<b>PAT:</b>	Paddington Alcohol Test ( <i>appendix 2</i> ) is a pragmatic screening tool for identifying alcohol-related problems in A and E attenders and those in hospital beds. PAT is non-judgemental, enabling patients to develop insight into their drinking, its cause and effect.
<b>SADQ:</b>	The Severity of Alcohol Dependence Questionnaire ( <i>appendix 5</i> ) is a self-administered, 20-item questionnaire designed by the World Health Organisation to measure severity of dependence on alcohol. It can be useful as an indicator of how severe potential withdrawals may be and give guidance on starting doses of detox medication



**Terms:**

**Symptom-triggered detoxification:** treatment is tailored to the patient's requirements as determined by the severity of their withdrawal signs and symptoms.

**Fixed dose detoxification:** regimens start with a standard dose, which is then reduced over several days. Most include an "as required" option to treat breakthrough symptoms.

**High risk drinking:** males consuming more than 50 and females more than 35 units of alcohol / week on a regular basis

**Dependence:** A cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. Neuro-adaptation leads to tolerance (being able to consume larger amounts without intoxication) and withdrawal symptoms



## 1. Introduction

Northern Ireland has a high prevalence of alcohol dependence and alcohol-related illness, with the Western Trust area having the highest proportion of individuals drinking above recommended daily drinking levels across the country. There were over 2000 admissions to the Trust's acute hospitals with a diagnosis of Alcohol Related Illness or with alcohol involvement (e.g. admitted with a trauma under the influence of alcohol) for the year 2013.

Most detoxifications from alcohol generally occur in the community (where patients in the Western Trust can be supported by an Alcohol Detox Nurse (ADN) working with the Alcohol and Drug Services). However there are individuals for whom community detoxification would pose a high risk of complications and hence require inpatient medical input (*planned detoxes*) and others who are admitted for an intercurrent illness and require detoxification medication due to being physically dependent on alcohol prior to admission (*unplanned detox*).

These guidelines outline who may require a detoxification as an inpatient and describes how to manage alcohol related detoxification and its potential complications in the hospital environment. They are derived from UK and international publications, being informed by both the available evidence base and by professional consensus where this is limited.

These guidelines refer to the treatment of individuals' admitted to adult hospital beds. This can include anyone over the age of 14. For those under 18 it is important to consider an individual's size and level of development.

They are intended for use within the acute hospitals of this Trust, but may be used to help guide management in other clinical areas (guidelines are also available for supported community detox). It is important to remember that failure to consider alcohol misuse as an underlying diagnostic possibility may constitute negligence, whilst failure to identify and manage potentially serious withdrawal complications may lead to legal liability and awarding of damages.

In both Altnagelvin and SWAH, Alcohol Liaison Nurses (ALN) support the management of alcohol related disorders in both A and E and on the wards (available 9-5 Mon – Fri). Both work within the Alcohol and Drug Service and as well as managing addiction issues on the ward liaise with the wider Addictions team including the Alcohol Detox Nurse working in the community to facilitate transfer of patients both into and out of hospital.



## 2. Goals of Guidelines:

To minimise morbidity, mortality and patient distress through:

- Identification of alcohol-use disorders in hospital attendees
- Identification of sub-groups with, or at risk of, severe and potentially life threatening complications of alcohol misuse and withdrawal
- Prompt initiation of effective medical management for alcohol related conditions

## 3. Alcohol Detoxification:

Detoxification refers to a treatment designed to control the medical and psychological complications that may occur after a period of heavy and sustained alcohol use.

**NB** - Detox is more likely to be completed successfully and abstinence maintained if there is a period of preparation first and plans for aftercare are in place. Multiple and repeated detoxifications from alcohol are correlated with severe withdrawal symptoms (DTs, seizures, ARBD) and can therefore be harmful.

Many dependent patients manage their alcohol withdrawal symptoms every day with continued alcohol consumption and it is often appropriate for them to continue with this until they can be assessed formally by addiction services to determine the best treatment for their alcohol dependence. For people attending A and E who are alcohol dependent but do not require admission to hospital (see below) , offer advice to avoid a sudden reduction in alcohol intake and provide an appointment with the ALN and / or information about how to contact local alcohol support services (*see Appendix 10*).

### 3.1 Need for detox:

Detoxification prescribing / pharmacotherapy **is** likely to be required for:

- patients drinking in a continuous pattern and showing symptoms and signs of a dependence on alcohol
- patients regularly drinking over 15 units of alcohol per day and / or who score 15 or more on the AUDIT / SADQ



Patients in groups below **may not** need medication for detox:

- patients with high risk but non-continuous alcohol use and / or low level dependence
- no recent withdrawal symptoms or recent drinking to prevent withdrawal symptoms
- no alcohol on breath test and no withdrawal signs / symptoms
- binge / periodic drinkers whose last bout was < 1 week long
- typical consumption < 15u /day
- drinking pattern 3-4 days / week only
- recent detox within last 2/52
- AUDIT < 15
- SADQ <15

### 3.2 Need for hospital detox:

Consider the need for **hospital** detoxification if any of the below factors:

- Absolute indications / urgent admission required:
  - Acutely confused state / hallucinating / severe tremor and autonomic disturbance (probable delirium tremens)
  - Any symptoms of confusion / ataxia / nystagmus / ocular palsies / hypotension and hypothermia / reduced conscious level (potential Wernicke's encephalopathy)
  - Following or in withdrawal seizure
  - Current suicide risk
- Consider strongly:
  - Persistent vomiting so as to be unable to sustain regular oral intake / severe diarrhoea
  - Signs of malnutrition / BMI < 18.5 or recent significant weight loss (increased risk of Wernicke's)
  - Drinking > 30 units / day (scoring > 30 on SADQ)
  - Showing marked signs and symptoms of AWS / autonomic over-activity with blood ethanol concentration greater than 100mg / 100ml
  - History of epilepsy (especially if unstable)
  - Electrolyte imbalance – especially K or Mg instability (increased seizure risk)
  - History of seizures or delirium tremens during previous withdrawal
  - Associated significant benzodiazepine or other drug abuse / dependence
  - Any other severe concomitant physical or psychiatric co-morbidity
  - Pregnancy
  - A recent history of aggression towards staff / public
  - Unable to take medication by mouth

Consider a lower threshold for inpatient withdrawal in vulnerable groups, for example, homeless, under 18s and older people, those with cognitive impairment or learning disability

#### 4. Alcohol Withdrawal Syndrome:

- Withdrawal symptoms are variable in presentation, onset and intensity
- Usually begins within 6 to 8 hours after an abrupt reduction in alcohol intake, but can be earlier in severe dependence or may not manifest for up to 72 hours
- Can develop before the blood alcohol level has fallen to zero
- Generally peaks within 10 to 30 hours and lasts for 3 to 7 days.

##### ***Mild to moderate symptoms (generally earlier onset):***

- Tremulousness of hands, arms, legs, may include head and trunk
- Sweating
- Insomnia, nightmares
- Nausea, retching, vomiting, diarrhoea
- Autonomic disturbance (pyrexia, tachycardia, hypertension)
- Muscle pain
- Hyperactivity, anxiety and agitation - “must leave hospital”

##### ***Severe symptoms:***

Failure to assess the risk and effectively treat AWS can result in three potentially life threatening complications:

#### 4.1 Delerium Tremens (DTs)

- Occurs in less than 5% of patients during withdrawal
- Usual onset 24 – 72 hours after alcohol cessation or decreased intake
- Can last for 3-5 days
- Is fatal in 15-20% of inappropriately managed patients
- Appropriate prophylactic sedation reduces mortality to 1-5%.
- **NB** – there is an increased risk of death if associated with an underlying physical disorder. Always check for other medical condition(s) e.g. head injury, metabolic disturbance, infection, pancreatitis (*see section 5.5*)

##### *Symptoms:*

- Course tremor
- Fear, paranoid thinking and agitation
- Disorientation in time, person and place, especially at night
- Clouding of consciousness
- Visual illusions, misperceptions, hallucinations
- Tachycardia, fever and hypertension
- Profuse sweating and dehydration
- Risk of circulatory collapse, ketoacidosis

#### 4.2 Seizures

- Generally occur between 12 and 48 hours after alcohol cessation or decreased intake, only rarely after this
- Occur in about 8% of chronic alcohol misusers
- Tend to be generalised
- Predisposing factors include hypoglycaemia, hypocalcaemia, hypomagnesaemia and history of epilepsy.
- Risk of death associated with seizures occurring in risky situation e.g. in bath, up ladder or prolonged seizures. Therefore safety advice recommended and appropriate supervision necessary during at risk period

#### 4.3 Wernicke's Encephalopathy

- May occur in as many as 12.5% of chronic alcohol misusers (post-mortem studies)
- May develop rapidly or sub-acutely over a number of days
- Inappropriately managed it is the primary or a contributory cause of death in up to 20% of patients and results in permanent brain damage (Korsakoff's Amnesic Disorder / Alcohol Related Brain Damage) in 85% of survivors
- Is initially reversible with parenteral B vitamins so treatment should be initiated immediately a diagnosis is suspected or risk factors identified
- May be difficult to separate out from intoxication, DTs, other causes of delirium, head injury
- **NB** - As it is a medical emergency a low index of suspicion in making the diagnosis / commencing treatment is recommended

##### *Symptoms:*

- clouding of consciousness, global confusional state ) *Classic triad but only*
- ataxia of gait ) *evident in less*
- nystagmus, ocular nerve palsies ) *than 10% of cases*
- hypothermia, hypotension
- reduced conscious level, coma or unconsciousness

##### *The following characteristics identify a group at high-risk of developing Wernicke's:*

- signs of malnourishment or risk of malnourishment
- persistent vomiting so as to be unable to sustain regular oral intake / severe diarrhoea
- recent significant weight loss
- reduced BMI < 18.5
- homelessness
- alcohol-related liver disease / associated acute illness / chronic ill health
- peripheral neuropathy

## 5. Assessment stages to clinically manage alcohol withdrawal

### 5.1 Establish a comprehensive alcohol history:

- Drinking pattern - daily / continuous or episodic / binge drinking
- Units of alcohol consumed per typical drinking day / week
- Date and time of last drink
- Symptoms indicative of physical dependence on alcohol – tolerance, morning / relief drinking to manage withdrawals, regular episodes of amnesia / 'blackouts'
- Symptoms during previous episodes of alcohol withdrawal (with / without medication), particularly any history of fits, confusion or hallucinations
- Levels of prescribing required during any previous detoxes
- Other physical / psychiatric history
- Medication
- Other substance use – prescription / illicit / over the counter
- Social circumstances
- Involvement with treatment services
- Obtain collateral history if possible

### 5.2 Consider use of assessment tools:

- PAT (*appendix 2*) – screening for harmful alcohol use
- AUDIT (*appendix 3*) – screening for harmful alcohol use, guide to severity of dependence
- SADQ (*appendix 5*) - can give indication of whether detoxification is required and act as a guide to potential medication requirement

### 5.3 Complete full physical and mental state examination especially for alcohol related conditions

### 5.4 Carry out the following essential investigations:

- Full Blood Picture
- Renal function / Electrolyte Profile, Magnesium, Phosphate and Calcium
- Liver profile
- Serum glucose
- Serum ethanol / Breath alcohol level
- Coagulation screen
- Consider urinary drug screen

**NB** - Treatment with sedatives should not be delayed whilst awaiting results

### 5.5 Be wary of and treat any complications which may need managed:

- Dehydration and Electrolyte depletion
  - Both are likely in those who are withdrawing from prolonged alcohol binges
  - The degree of dehydration and electrolyte deficiency may be profound and require substantial replacement (particularly potassium, magnesium and phosphate)
  - Hypomagnesaemia is particularly significant and should be treated as it decreases seizure threshold, failure to replace magnesium may make treatment of hypokalaemia refractory and hypomagnesaemia reduces thiamine absorption
  - Dehydration and volume depletion increases autonomic activity and contributes to the physiological challenge posed by AWS
  - Crystalloid fluids containing potassium at standard maintenance rates are necessary while the patient is sedated and not ingesting normal fluid intake
  - Fluids may need to be given at an accelerated rate initially depending on estimates of haemodynamic compromise, dehydration and serum electrolyte levels. Caution should be exercised where there is suspicion, or evidence of decompensation of liver or cardiac function
  - Sodium chloride 0.9% should be given initially to replete electrolytes and fluid.
  - **Glucose 5% should be reserved until after haemodynamic stability is achieved and IV thiamine (Pabrinex®) is given**
- Hypoglycaemia
  - **IV thiamine (Pabrinex®) should always be given before IV glucose administration**
- Alcoholic ketoacidosis
  - A form of starvation ketosis due to carbohydrate depletion. Contributes to the illness and physiological instability. Low pH with raised serum or capillary ketones (beta-hydroxybutyrate). Treated after initial high-dose IV thiamine (Pabrinex®) with glucose 5% with KCl.
- Delirium caused by alternative causes such as infection, aspiration or head injury
- Complications such as liver failure, pancreatitis, subarachnoid / subdural haemorrhage and GI bleeding can occur in these patients. Additional investigations may be required.

## 5.6 Consider which category of potential severity of AWS the patient is in:

### Low:

- patients with high risk but non-continuous alcohol use and / or low level dependence
- neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- binge / periodic drinkers whose last bout was < 1 week long
- no alcohol on breath test and no significant withdrawal signs / symptoms (CIWA < 8)
- typical consumption < 15u /day
- drinking pattern 3-4 days / week only
- recent detox within last 2/52
- AUDIT < 15
- SADQ <15

### Medium:

- continuous pattern to alcohol consumption
- consuming 15 - 30 units / day
- drinking to relieve withdrawal symptoms
- evidence of significant alcohol withdrawal
- no evidence or history of severe withdrawals (seizures / DTs)
- 15 - 30 SADQ

### High:

- current high alcohol intake (>30 units/day) for at least 5 days consecutively
- history of severe withdrawal, DTs or withdrawal seizures
- signs suggestive of Wernicke's encephalopathy
- high medication requirement during previous detoxifications
- multiple substance addiction e.g. heavy regular or chronic benzodiazepine use in particular
- high levels of agitation / confusion
- high physiological early warning score
- evidence of visual or auditory hallucinations
- hyperpyrexia or profuse sweating
- significant withdrawal symptoms / signs at blood alcohol level >100mg/100ml
- SADQ score > 30

### 5.7 Assess the severity of withdrawal using the CIWA-Ar scale:

The CIWA-Ar scale (Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised) (*appendix 4*) is a guide to measuring the severity of alcohol withdrawal symptoms and in turn affords some guidance to the amount of benzodiazepine to give. The scale takes less than 5 minutes to complete. It is not always necessary to ask the patient all 10 questions as observations will often be sufficient to rate symptoms. The maximum possible score is 67.

- Assess the patient and rate each of the 10 criteria
- Add the score for each criterion to give the patient's total CIWA-Ar score
  - 0 – 7: absent or minimal withdrawal
  - 8 – 15: moderate withdrawal
  - more than 15: severe withdrawal
- Consider score in context of time since last drink and blood ethanol level
- Pulse, BP and temperature are also useful indicators of withdrawal severity

## 6. Prescribing

The aim of detox prescribing is to rapidly control symptoms of withdrawal, stabilise the patient and then gradually reduce the dosage down to stop over 5-7 days keeping the patient safe and comfortable.

It is important to avoid either under-treatment, which may lead to DTs or seizures or over-treatment, which is associated with excess sedation, aspiration pneumonitis, hypotension and paradoxical agitation. The overall therapeutic aim with prescribing benzodiazepines is to achieve light sedation, or light sleep from which the patient can be easily roused.

**Chlordiazepoxide** (Librium) is the **benzodiazepine of choice** for alcohol withdrawal due to its long half-life (less risk of rebound symptoms). Diazepam is also effective but has higher abuse potential and resale value. There is also more risk of accumulation when compared to Chlordiazepoxide. An alternative diazepam detox regimen is included in *Appendix 7*.

Short-acting benzodiazepines (such as Lorazepam) may be preferred in those for whom over-sedation must be avoided, for example in people with liver disease who may not be able to metabolise long-acting agents efficiently, in people with chronic obstructive pulmonary disease (COPD) and in the frail elderly – *see more complex detoxes section 8*

If a patient is being sedated for other reasons it may be more appropriate to adjust the dose of their current sedating regimen if required rather than e.g. add in chlordiazepoxide

**NB Chlormethiazole** (Heminevrin) is **not recommended** (particularly in community detoxes) as it is shorter acting; therefore has higher abuse potential and more importantly, it can have fatal consequences in overdose resulting from coma and respiratory depression, especially when taken with alcohol.

## 6.1 Principles of dosing:

### **Stage 1 – achieving stability**

- The primary goal is for the patient to achieve stability / control over any withdrawal symptoms
- This is best achieved in the initial stages by making an estimation of starting dosage required (determined by clinical picture – see *section 6.2*) followed by symptom triggered / as needed dosing with close monitoring of ongoing withdrawal symptoms (see *section 7*)
- Large enough initial doses are important to prevent severe withdrawal developing
- Stabilisation should ideally be achieved in the first 24-48 hours and is indicated by repeated minimal withdrawal symptoms (CIWA-Ar < 8) and no further need for prn dosages
- Doses should not be reduced in the first 24 hours unless the patient is clearly already over-sedated
- If PRN doses are required after 48 hours of therapy then initial doses have been inadequate and the patient's AWS has not been stabilised. Persist with the doses on that day for a further 24h and the sedative effect will accumulate.

### **Stage 2 - fixed –dosage reduction**

- Once stability is achieved prescribing can move to a fixed dose reducing regimen with a lesser degree of monitoring required
- Steady state of blood chlordiazepoxide levels occur after 3 days on average and sedation requirements during AWS fall with time, therefore the dose after stabilisation should generally be reduced in the region of 20% on a daily basis. This also prevents replacing one dependence with another.
- All too often patients receive PRN doses long after stabilisation has been achieved and even without any further evidence of physical withdrawal – chlordiazepoxide is then serving as an anxiolytic rather than for withdrawal management and this **should be avoided**.

## 6.2 Deciding on starting doses:

Pharmacotherapy should be delivered with the dose tailored to the patient's requirements.

To individualise treatment, several factors have to be taken into account, including:

- the severity of dependence (history and assessment tools e.g. SADQ)
- the severity of the current withdrawal episode
- the patient's physical status / other medication being taken

For example, a young male patient with a high alcohol intake, a history of withdrawal seizures and normal liver function will likely require higher doses of pharmacotherapy than a small older female patient with cirrhosis who develops mild withdrawal on the background of a moderate alcohol intake.

Working through the steps in *section 7* and following the flowchart (*appendix 9*) should give some guidance, although clinical judgement will still need to be used alongside this

### 6.3 Deciding when to give first dose:

It is better to give medication before significant withdrawal symptoms begin to emerge. Delay in initiating treatment can result in withdrawal symptoms either becoming difficult to control or the emergence of complications such as DTs or seizures.

However it should be noted that the use of benzodiazepine sedation while the patient is still intoxicated with alcohol can lead to respiratory depression with its complications and death itself.

Therefore personal clinical judgement needs to be used alongside the guidelines below:

- Ideally 6-8 hours after last drink
  - **NB** patients may have consumed significant amounts of alcohol just prior to entering hospital
- Blood ethanol level should be as close to zero as possible, ideally <100mg/100ml and falling
  - Falling implies two successive levels or by clear evidence of patient becoming clinically less intoxicated over time
  - Metabolism generally reduces serum ethanol by 20mg/100mL/hour, although this may vary and in habituated drinkers reaches up to approximately 30mg/100mL/hour
- The more severe the alcohol dependence, the earlier withdrawal symptoms emerge after last alcohol intake.
  - Some people who are severely alcohol dependent can experience significant withdrawal with a blood alcohol concentration of 100mg per 100ml or more. Medication may be required but use caution with dosages and consult with senior doctors.

### 6.4 Omitting doses:

- If patient is asleep or appears over-sedated omit prescribed dose and then review when next dose due
- Beware risk of respiratory depression - monitor pulse, oximetry and respiratory rate.
- There should be access to Flumazenil.
- Consider re-using breathalyser if there is any suspicion of alcohol consumption on ward

## 7. Steps for managing alcohol withdrawal: (see flowchart Appendix 9)

Always ensure patients are nursed in a well-lit, cool environment with good ventilation. As with anyone with or at risk of delirium a calm and reassuring environment can help settle the patient.

1. History / examination / assessment tool / investigations (see sections 5.1 – 5.5) indicate heavy alcohol use / dependence
2. Determine category of risk patient is in (see section 5.6)
3. If detox medication is required assess appropriate time to give first dose (see section 6.3)
4. Treat any electrolyte imbalances (see section 5.5)
5. Prescribe Thiamine (see Section 10)
6. Start detox - Remember 2 prescribing stages – **initial stabilisation** followed by **fixed dose reduction**

### ▪ If low risk category:

- Monitor using CIWA every hour
- Write up for prn chlordiazepoxide (CDZ) 20mg dosages, up to 80mg in 24 hrs
- Review after 1 hour
- If CIWA < 8 – nil If CIWA ≥ 8 give 20mg CDZ stat
- Review after 1 hour
- If CIWA < 8 – nil If CIWA ≥ 8 give 20mg CDZ stat
- If 2 consecutive CIWA scores of < 8 probably OK to stop formal monitoring
- If > 2 prn doses required review clinical picture, consider re-categorising patient and consider commencing fixed dose regimen starting from 20mg qds (see p19)

### ▪ If medium risk category + initial CIWA < 15:

- Give 30mg CDZ stat
- Write up for prn CDZ 30mg dosages, up to maximum 250mg in 24 hrs
- Review after 1 hour
- If CIWA < 8 - nil If CIWA ≥ 8 – give further 30mg CDZ stat
- Review after 1 hour
- CIWA < 8 - nil If CIWA ≥ 8 – give 30mg CDZ stat
- Continue hourly reviews until 2 consecutive CIWA < 8 then start fixed dose regimen from 30mg qds (see p19)
- If > 2 consecutive 30mg stat doses needed review clinical picture and consider transfer to high risk pathway

### ▪ If high risk category or medium risk + initial CIWA ≥ 15

- Give 40mg CDZ stat
- Write up for prn CDZ 40mg dosages, up to maximum 250mg in 24 hrs
- Review after 1 hour
- If CIWA < 8 - nil If CIWA ≥ 8 – give further 40mg CDZ stat
- Review after 1 hour
- If CIWA < 8 - nil If CIWA ≥ 8 – give 40mg stat
- Continue hourly reviews until 2 consecutive CIWA < 8 then start fixed dose regimen from 40mg qds (see p19)
- If > 3 doses at 40mg look at policy on difficult to stabilise patients (see section 8.1)

**Fixed dose Chlordiazepoxide reducing regimen:**

Day 1	40mg qds
Day 2	30mg qds
Day 3	20mg qds
Day 4	20mg tds
Day 5	10mg qds
Day 6	10mg bd

- Community detoxes generally start on Day 2 (i.e. 5 day reducing course from 30mg qds).
- Hospital detoxes have the initial stabilisation period which is essentially 'front loading' the patient before the fixed dose reducing regime begins.
- Having comparable reducing regimens in hospital and in the community allows for ease of communication if patients are admitted or discharged.

## 8. Managing more complex detoxifications

### 8.1 Severe / uncontrolled withdrawal symptoms:

- First step for withdrawals not being controlled is to consider increasing the frequency and dose of **chlordiazepoxide up to 40mg hourly up to a maximum of 3 doses.**
- When increasing chlordiazepoxide doses or giving PRN doses, use caution as over-intoxication may cause a paradoxical agitation
- Review the patient's diagnosis for the presence of any psychotic illness or other organic pathology
- If patient not settling consider options below:

#### *Higher doses of chlordiazepoxide:*

- Appropriate initial dosing estimation, intensive symptom monitoring and use of regular prn doses when indicated in the early stages is the most effective way to manage withdrawal symptoms and helps to reassure the anxious patient
- It is generally more clinically effective to increase the dose of Chlordiazepoxide to adequately control alcohol withdrawal symptoms than to add another type of medication.
- In severe alcohol dependence higher than standard initial doses of Chlordiazepoxide may be required (exceeding the British National Formulary prescribing range)
- Maximum dose in these situations is determined by clinical response and the likelihood of accumulation.
- Examples of higher regular doses are 50-60mg qds for the first 24-48hrs
- Occasionally prior clinical knowledge of the patient may predict the need for such higher regular doses of chlordiazepoxide from the start and is at the discretion of the individual senior doctor / consultant.
- Night time brings on more severe symptoms in many patients; increasing the *nocte* dose of chlordiazepoxide is considered first line treatment for night sedation; otherwise Zopiclone 7.5mg nocte '*For hospital use only*' can be added
- **NB** patients exhibiting significant symptoms over the **BNF recommended maximum of 250mg in 24 hours** may have other complications and **should be discussed with a senior doctor/consultant**

#### *Alternatives to chlordiazepoxide:*

- Some patients do not respond well to chlordiazepoxide. Persistence with chlordiazepoxide in these cases may lead to delayed initial effect and late over-sedation as the drug effect accumulates. They may do better changing to lorazepam for a more rapid effect and reduced risk of dose accumulation
- Where maximum PRN doses have been reached and symptoms of withdrawal are not settling consider switching the choice of PRN benzodiazepine e.g. from chlordiazepoxide to lorazepam instead of the regularly prescribed chlordiazepoxide dose (see *appendix 7: Equivalence Table*).
- At the time of writing this policy lorazepam did not have UK marketing authorisation for the management of alcohol withdrawal. If possible informed consent should be obtained and documented.

## 8.2 Delirium tremens / confusional state / severe agitation

(This section may be revised to be in accordance with any newly developed WHSCT Rapid Tranquillisation Policy. Any advice here will be superseded by such a policy).

### Using lorazepam:

- For delirium tremens or acute disturbances putting patients at risk to themselves or others lorazepam will generally be a better option due to its more rapid effect
  - If patient **not settling after 3 doses of chlordiazepoxide 40mg or acutely disturbed**, consider escalation to lorazepam 2-4mg oral / IM / IV
  - Repeat if required up to 2 doses at 15 minute intervals
  - Always consider oral before the IM route. Absorption from the injection site is considerably slower if the intramuscular route is used and as rapid an effect may be obtained by oral administration.
  - The IM route **should not be** used in patients with bleeding / clotting disorders
  - **NB i.m. Lorazepam injection is contraindicated in severe liver impairment. See section 9.1 and consult with senior medic (also do not use with i.m. Olanzapine)**
- If patient is not responding to benzodiazepines then the receptor may be saturated and further doses will give no increase in sedation / tranquilisation and can lead to paradoxical agitation; in this case addition of Haloperidol may give an independent and adjunctive effect.

### Using Haloperidol:

- Saturation of benzodiazepine receptors is a plausible explanation for limited benefit from dose escalation above usual levels and sedation using neuroleptic and anaesthetic agents may be required.
- For troublesome hallucinations, severe agitation or patient refractory to the above benzodiazepine loading schedule, consider giving:
  - PO / IM haloperidol in addition to the regularly prescribed benzodiazepine.
  - Haloperidol should be used with caution and only short-term due to the risk of decreasing seizure threshold, but may be given early on with or after lorazepam for the severely disturbed who are at risk to themselves or others.

<b>Adult Haloperidol Dose</b>			
<b>Route</b>	<b>Dose</b>	<b>Frequency</b>	<b>Max/24hrs</b>
Oral	500micrograms to 5mg	8 to 12 hourly	15mg
IM/IV	2 to 10mg	4 to 8 hourly	18mg
<b>Elderly &gt;75 years</b>			
<b>Route</b>	<b>Dose</b>	<b>Frequency</b>	<b>Max/24hrs</b>
Oral	500micrograms to 2.5mg	8 to 12 hourly	15mg
IM/IV	2 to 5mg	4 to 8 hourly	18mg
<b>Significant Liver impairment:</b>			
<b>Route</b>	<b>Dose</b>	<b>Frequency</b>	<b>Max/24hrs</b>
Oral	500micrograms	8 to 12 hourly	2mg

### Refractory cases:

- For patients refractory to the above sedation schedule:
  - Sedation by anaesthetic staff in HDU / ICU may be necessary.

### 8.3 Seizures:

Alcohol related seizures occur usually within 12 hours after cessation / significant reduction and are rare beyond 48 hours. Patients presenting with a seizure should be admitted and observed for 24 hrs

- Adequate doses of chlordiazepoxide usually prevent withdrawal seizures.
- For isolated seizures continue with the standard regimen ensuring the patient has received an adequate dose, increasing the dose if necessary.
- If a patient develops prolonged or recurrent seizures
  - Give lorazepam 2-4mg IV as a single dose (in addition to existing benzodiazepine).
  - Dilute 1:1 with Water for Injection before administration.
  - Lorazepam injection is stored in the fridge.
  - Repeat with a second dose after 15 minutes if required.
- If seizing is prolonged (status epilepticus) seek senior medical advice.

## 9. Treatment of special patient groups

### 9.1 Liver Impairment:

Suspected significant liver impairment can be defined as any one of the following, although many of these features are neither sensitive nor specific for significant liver impairment and the full clinical context should be considered:

- Previously diagnosed chronic liver disease.
- Clinically evident liver disease (jaundice, ascites, hepatic encephalopathy, spider naevi, palmar erythema, hepatomegaly, or other clinical stigmata of cirrhosis)
- ↑ Serum bilirubin, ↓ albumin, ↑ prothrombin time
- For mild to moderate liver disease start with half typical doses of chlordiazepoxide or use lorazepam
- Caution is needed with any fixed dose regimen so monitor very closely for signs of build up
- For more severe / decompensated liver disease monitor closely and consider symptom triggered approach using lowest possible prn dosages
- Consider strongly discussing with senior colleague

### 9.2 Respiratory disease

- For severe respiratory disease / type 2 respiratory failure again great caution is needed with fixed dose regimens
- Lowered doses of chlordiazepoxide, lorazepam or symptom triggered approaches as in 9.1 are recommended

### 9.3 Patient's 'Nil by mouth':

- Regular or PRN IV or IM diazepam or lorazepam are alternatives to chlordiazepoxide in patients unable to take oral treatment. Absorption from the IM injection of diazepam may be variable, particularly for the gluteal muscles. This route of administration should only be used if IV administration is not possible.
- Give diazepam 10mg slow IV into a large vein over 2 minutes. Repeat after an interval of not less than 4 hours if no improvement.
- IM route should not be used in patients with bleeding / clotting disorders
- Facilities for resuscitation / Flumazenil should always be available.
- Please note **Diazepam Injection is contraindicated in severe liver impairment.**
- Do not use i.m. Lorazepam with i.m. Olanzapine

## 9.4 Pregnant patients:

- Management of AWS in pregnancy is specifically excluded in NICE Clinical Guideline 100 (July 2010)
- Avoidance of benzodiazepine therapy in pregnancy is advocated in the BNF and use is unlicensed.
- There are limited data on detoxification of alcohol dependent pregnant patients with benzodiazepines or IV thiamine (Pabrinex®). Longest experience and data are available for diazepam, but teratogenicity with even this agent has been described in animal models.
- It is important to balance the risk of significant withdrawals / seizure against the risk of foetal exposure to benzodiazepines
- It is **essential the obstetric team is informed** if the patient presents for detoxification during pregnancy
  
- Local consensus has been forced by a small number of cases of AWS requiring medical assistance.
- The recommended agent is diazepam 5mg which can be assumed to have an equivalent sedative effect to 15mg of Chlordiazepoxide.
- Probably the best approach is a closely monitored symptom triggered one
- Work closely with the ALN on monitoring doses
- Any benzodiazepine use should be at the lowest possible dose for the minimum amount of time.

## 9.5 Elderly patients (>75 years old or >65 with frailty):

- The elderly are particularly vulnerable to the effects of over-sedation and to its complications such as falls, particularly with fractures and subdural haematomata.
- The elderly have a reduced capacity to metabolise and eliminate benzodiazepines
- **NB** - Particular wariness should be had during routine reviews for over-sedation, paradoxical agitation or delirium.
- A general principle to compensate for these factors is to **reduce usual sedation doses by half**
- Dosage intervals can also be increased if necessary
- **Doses must be reviewed at 24 and 48 hours in this group**
- Again consider lorazepam as an alternative to chlordiazepoxide if there is a risk of accumulation

## 9.6 Children and young people:

- There is a lack of clinical evidence suggesting the appropriate dose of medication for assisted withdrawal
- In general doses should be lower than that provided for a working-age adult
- Take into consideration the age, size, and gender of the individual.
- This population is particularly vulnerable and admission should be considered at a lower threshold in those under 18 and advised in those under 16.

## 9.7 Benzodiazepine dependent patients:

- Patients dependent on regular doses of other benzodiazepines, e.g. temazepam or regular diazepam, prior to admission should generally be continued on the same dose in addition to the Chlordiazepoxide reducing dose. Such patients are often habituated to their therapy and may suffer benzodiazepine withdrawal if these were discontinued during detox.
- Bear in mind that tolerance to benzodiazepines may have an impact on the required dosages of chlordiazepoxide to control alcohol withdrawals.
- However also consider that hospital alcohol detoxification may present an opportunity to discuss with the patient the option to reduce or even come off their benzodiazepines
- Work closely with ALNs in this group of patients

## 10. Prescribing Thiamine

- As the majority of patients undergoing alcohol detoxification in hospital will either be severely dependent and at risk of severe withdrawals or have an associated co-morbidity, it is advised that they **all** receive parenteral Thiamine (Pabrinex®) as a protection against or treatment for Wernicke's encephalopathy.
- This ideally should be given by intravenous infusion, although can be by deep intramuscular injection if venous access is not possible.
- Facilities for treating anaphylaxis should be available when administered
- IV thiamine (Pabrinex®) should always be given before IV glucose administration
- Oral thiamine 100mg tds should be prescribed and administered **at the same time** as IV therapy and should be continued for 3-6 months after abstinence is achieved or indefinitely if heavy drinking continues
- Prescribing guidelines (BNF, NI formulary, NICE, BAP) vary slightly in their recommendations on dosages required and length of treatment
- Taking these above mentioned guidelines into consideration and bearing in mind other factors such as the difficulty in diagnosing Wernicke's Encephalopathy accurately and the advantage of only having one regime; these guideline's authors felt that a pragmatic and safer approach was to not try and separate out patients at risk and those with suspected / confirmed WE but to have a set regimen for all those undergoing an alcohol detoxification in hospital (see below).

IV Thiamine (Pabrinex®) dose for all patients admitted with AWS			
Dose	Frequency	Route	Duration
2 x pairs (amps 1 and 2)	Three times daily	IV infusion over 30mins in 100mls of sodium chloride 0.9%	3 -5 days or until settled clinically / ready for discharge
<ul style="list-style-type: none"> <li>Oral thiamine 100mg three times daily for 3-6 months after abstinence is achieved or indefinitely if heavy drinking continues</li> </ul>			

- If patient has **suspected Wernicke's** on admission Pabrinex should continue for **a minimum of 5 days even if symptoms settle**
- Guidance suggests extending Pabrinex courses for further than 5 days if there are ongoing signs of memory improvement or if a patient has a very poor nutritional state and is not taking an adequate diet

## 11. Discharge:

- All patients should have been referred to the **Addiction Liaison Nurse** by this point.
- Once patients have been seen by the Consultant and a treatment plan is in place, nurse led discharge may proceed for patient's on 30mg QDS or less of chlordiazepoxide.
- It is preferable for there to be someone available in the community to manage medication and monitor the patient's progress.
- Discuss with the patient who can continue to support them through the remainder of their detox
- For those without adequate support at home consider referral to Damien House (Derry – male only) or Ramona House (Omagh - male or female) for 'tail-end' detox
- Both home and hostel detoxes can be supported by the **Alcohol Detox Nurses** based in the community (*see numbers in Appendix 10 for contact details*)

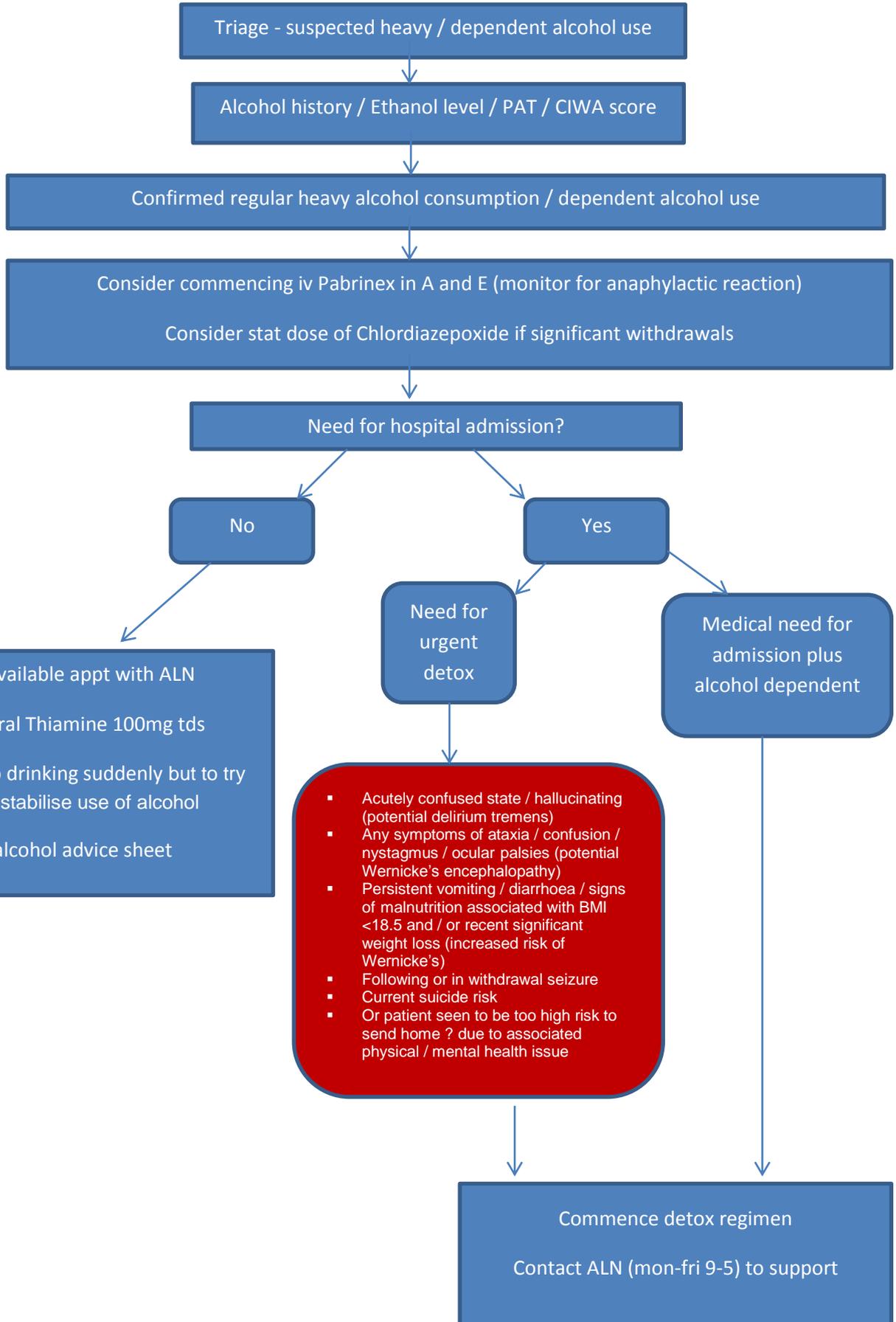
### Medication on discharge for in-patient detoxification:

- All patients should be prescribed oral thiamine and the **minimum amount of benzodiazepine** to complete the reducing course on discharge (*see p 19*).
- Shorter acting benzodiazepines (e.g. **lorazepam**) have a higher addictive potential and should **generally not be prescribed at discharge**. Patients should be switched to equivalent dose chlordiazepoxide to complete the reducing course.
- Patients should be advised to complete the course and of the significant risks associated with drinking on top of benzodiazepines
- A **maximum** 5 days' supply of chlordiazepoxide should be dispensed on discharge
- However always consider the need for **splitting the script** and the **exceptions below**:

Exceptions	Maximum supply
<ul style="list-style-type: none"> <li>• History of overdose</li> <li>• Previous history of benzodiazepine dependence / abuse / diversion</li> <li>• No social support</li> </ul>	<p><b>1-2 day supply</b> Advise patient to attend GP as soon as possible Liaise with ADN</p>
<ul style="list-style-type: none"> <li>• Expressed or strongly suspect intention to divert dispensed medicine</li> <li>• Intention to continue drinking</li> </ul>	<p><b>No supply</b> Justification for this must be clearly recorded in the medical notes</p>

- An initial discharge letter should be completed by the doctor at ward level / A&E dept.
- Provide a copy of the patient / supporter information leaflet re managing breakthrough symptoms
- Formal GP discharge letter to follow

**Appendix 1: A and E Alcohol Treatment Pathway**



PATIENT IDENTIFICATION STICKER:

**Appendix 2: PADDINGTON ALCOHOL TEST**

Consider PAT for ALL the **TOP 10 reasons for attendance** . Circle number(s) – for any specific trigger(s);

1. **FALL** (i. trip)                      2. **COLLAPSE** (i. fits)                      3. **HEAD INJURY** (i. facial)                      4. **ASSAULT**  
 5. **ACCIDENT** (i. Burn, RTA)                      6. **UNWELL** (i. Request detox / help, self neglect)                      7. **NON-SPECIFIC G.I.**  
 8. **PSYCHIATRIC** (specify)                      9. **CARDIAC** (i. Chest pain)                      10. **REPEAT ATTENDER**                      Other (specify) :-

Proceed only after dealing with patient’s ‘agenda,’ i.e. patient’s reason for attendance.

**We routinely ask all patients with (state reason for screening) about their use of alcohol.**

1	Do you drink alcohol?	<b>YES</b> <b>NO (end)</b>
---	-----------------------	-------------------------------

2	What is the most you will drink in any one day?	<b>total per day</b> (standard alcohol units)= <div style="border: 2px solid black; width: 40px; height: 40px; display: inline-block; margin-left: 10px;"></div>
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If necessary, please use the following guide to estimate total daily units.  
 (Standard pub measures in brackets; home measures often three times the amount!)

Beer / Lager / Cider	Strong Beer / Lager / Cider	Wine	Fortified Wine (Sherry , Martini)	Spirits (Gin, Vodka, Whiskey)
Pints (2) <input style="width: 40px; height: 20px;" type="text"/>	Pints (5) <input style="width: 40px; height: 20px;" type="text"/>	Glasses (1.5) <input style="width: 40px; height: 20px;" type="text"/>	Glasses (1) <input style="width: 40px; height: 20px;" type="text"/>	Singles (1) <input style="width: 40px; height: 20px;" type="text"/>
Cans / Small Bottles (1.5) <input style="width: 40px; height: 20px;" type="text"/>	Cans / Small Bottles (4) <input style="width: 40px; height: 20px;" type="text"/>	Bottles (9) <input style="width: 40px; height: 20px;" type="text"/>	Bottles (12) <input style="width: 40px; height: 20px;" type="text"/>	Bottles (30) <input style="width: 40px; height: 20px;" type="text"/>
Large Bottles (4) <input style="width: 40px; height: 20px;" type="text"/>	Large Bottles (10) <input style="width: 40px; height: 20px;" type="text"/>	Alcopop Bottles (1.5) <input style="width: 40px; height: 20px;" type="text"/>		

3	How often do you drink <u>more than</u> twice the recommended amount?	
	: Everyday	<b>Dependent Drinker</b> (PAT+ve) (? Pabrinex)
	: _____ times per week	<b>Hazardous Drinker</b> (PAT+ve ?)
	: Never / Less than weekly	<b>GO TO QUESTION 4</b>

4	Do you feel your attendance here is related to alcohol?	<b>YES (PAT+ve)</b>  <b>NO</b>
---	---	--------------------------------------

**If PAT +ve give feedback eg “We advise you that this drinking is harming your health”.**

5	Would you like to see our Alcohol Liaison Nurse?	<b>YES</b> <b>NO - give leaflet</b>
---	--	--

If “YES” to #5 give ALN appointment card and make appointment in diary DATE .....TIME .....  
 Please note if patient admitted to ward .....

SIGNATURE:    NAME:    DATE:

## **HOW TO USE 'PAT'**

The Paddington Alcohol Test (PAT) is a clinical and therapeutic tool for screening hospital patients for alcohol problems such as hazardous drinking and dependency.

The PAT was specifically developed for use by clinicians in a busy Accident & Emergency department, employing the admission to hospital as a “**TEACHABLE MOMENT**” (Williams S et al, Drug & Alcohol Dependence 2005).

PAT is non-judgemental, enabling patients to develop insight into their drinking, its cause and effect.

Using the PAT, plus referral for specialist alcohol assessment, results in lower alcohol consumption and **reduces the likelihood of re-attendance.** (Crawford, Patton, Touquet et al, Lancet, 2004)

It takes only about 30 seconds to complete the PAT.

- Deal with the patient’s reason for attending and their presenting condition **first**, thereby **gaining their confidence** so they are in a more receptive frame of mind.
- If patient has one of the **TOP 10 conditions**, listed overleaf at the top of PAT, or other indication of recent consumption of alcohol, proceed with the PAT questions.
- **Question 1:** ‘*We routinely ask all patients with (this condition) if they drink alcohol - do you drink?*’ **If No:** PAT-ve, discontinue (providing clinician agrees with the answer).
- **If yes: go to Question 2:** What is the most that patient will drink in one day.

For **United Kingdom:** 8gms absolute alcohol = 10ml alcohol = 1 unit  
Standard Alcohol Units (SAU) = % **ABV x volume** (in litres)  
where ‘% ABV’ is ‘% of alcohol **by volume**’ as indicated on bottle or can.

Please use the guide to help you (and the patient) calculate amounts - drinks vary so much that the use of standard alcohol units is necessary for consistency. It may be less judgemental to focus solely on quantity rather than what they drink.

- Having estimated the number of units consumed, if this is more than double the recommended daily limits, ie 8 units (male), or 6 units (female), ask **Question 3:** how often do they drink more than 8 or 6 units? This helps differentiate the dependent drinker, who will need more complex management, from the hazardous or “binge” drinker who will benefit from advice and information about cutting down or controlled drinking. The earlier that binge drinking is detected the more effective is the use of PAT. The acceptance of an appointment with an Alcohol Liaison Nurse (ALN) demonstrates awareness of a problem and the desire for help, **thereby showing some insight.**
- If there is evidence of chronic alcohol misuse, poor diet and confusion /ataxia /ophthalmoplegia: then give I.V.Pabrinex at the earliest opportunity (I&II (X2) in 100ml 0.9% saline infused over half an hour). (Thompson et al., Alcohol & Alcoholism, 2002).
- Everyone who has said yes to Q.1 should be asked **Question 4:** ‘*Do you feel your current attendance is related to alcohol?*’ **If yes** then you have started the process of brief intervention by the patient associating drinking with resulting hospital attendance. If they deny any association, but in your clinical judgement have been drinking, you might say: ‘*would you be in hospital if you had NOT been drinking?*’
- **Question 5:** If “YES” **Leave PAT form in AHW referrals box, with diary.** Offer the patient an appointment with the Alcohol Liaison Nurse at 10am on the next morning when Alcohol Liaison session is scheduled. NB it is known that the earlier that appointment is offered, the more likely the patient will be to attend – please encourage them to take the next available appointment rather than defer it.

**If “NO” give them the “Think About Drink” leaflet** and even the AHW appointment card as patient may change their mind and return. **File PAT form in patient notes.** Complete all sections of the PAT

- Prepare GP letter (“for appointment” or “declined”) unless patient admitted to ward.

**For further information about the Paddington Alcohol Test (PAT) contact:**  
**Professor R. Touquet - robin.touquet@st-marys.nhs.uk or Adrian Brown RMN –**  
**ade.brown@nhs.net**

## Appendix 3: AUDIT TOOL

**1. How often do you have a drink containing alcohol?**

- (0) Never (Skip to Questions 9-10)
- (1) Monthly or less
- (2) 2 to 4 times a month
- (3) 2 to 3 times a week
- (4) 4 or more times a week

**2. How many drinks containing alcohol do you have on a typical day when you are drinking?**

- (0) 1 or 2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7, 8, or 9
- (4) 10 or more

**3. How often do you have six or more drinks on one occasion?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**4. How often during the last year have you found that you were not able to stop drinking once you had started?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**5. How often during the last year have you failed to do what was normally expected from you because of drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily



**7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**8. How often during the last year have you had a feeling of guilt or remorse after drinking?**

- (0) Never
- (1) Less than monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

**9. Have you or someone else been injured as a result of your drinking?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

**Add up the points associated with your answers above.**

**A total score of 8 or more indicates harmful drinking behaviour.**



### Appendix 4: Alcohol Withdrawal Assessment Chart (CIWA-Ar Scale)

	<b>Date</b>																
	<b>Time</b> (24hr)																
<b>Assess and rate each of the following:</b> <span style="float: right;"><b>Refer overleaf for guidance to using the CIWA-Ar scale</b></span>																	
<b>Nausea/Vomiting (0-7)</b> 0) None, 1) mild nausea with no vomiting, 4) intermittent nausea with dry heaves, 7) constant nausea, frequent dry heaves and vomiting																	
<b>Tremors (0-7)</b> 0) no tremor, 1) not visible, but can be felt finger tip to finger tip 2) mild, 4) moderate, with patient's arms extended, 7) severe, even with arms not extended																	
<b>Anxiety (0-7)</b> 0) no anxiety, at ease, 1) mildly anxious, 4) moderately anxious, or guarded, so anxiety is inferred, 7) acute panic states as seen in severe delirium or acute schizophrenic reactions																	
<b>Agitation (0-7)</b> 0) normal activity, 1) somewhat more than normal activity, 4) moderately fidgety and restless, 7) paces back and forth or constantly thrashes about																	
<b>Paroxysmal Sweats (0-7)</b> 0) no sweat visible, 1) barely perceptible sweating, palms moist, 4) beads of sweat obvious on forehead, 7) drenching sweats																	
<b>Tactile disturbances (0-7)</b> 0) none, 1) very mild itching, pins & needles, burning /numbness, 2) mild itching, pins and needles, burning or numbness, 3) moderate, 4) moderately severe hallucinations 5) severe hallucinations, 6) extreme severely hallucinations 7) continuous hallucinations																	
<b>Auditory Disturbances (0-7)</b> 0) not present, 1) very mild harshness or ability to frighten 2) mild harshness or ability to frighten, 3) moderate 4) moderately severe hallucinations, 5) severe hallucinations 6) extremely severe hallucinations, 7) continuous hallucination																	
<b>Visual Disturbances (0-7)</b> 0) not present, 1) very mild sensitivity, 2) mild sensitivity, 3) moderate 4) moderately severe hallucinations 5) severe hallucinations 6) extremely severe hallucinations 7) continuous hallucinations																	
<b>Headache (0-7)</b> 0) not present, 1) very mild, 2) mild, 3) moderate, 4) moderately severe, 5) severe, 6) very severe, 7) extremely severe																	
<b>Orientation (0-4)</b> 0) orientated and can do serial additions 1) cannot do serial additions or is uncertain about dates 2) disorientated for date by no more than 2 calendar days 3) disorientated for date by more than 2 calendar days 4) disorientated for place/or person																	
<b>Total CIWA-Ar score</b>																	
<b>PRN medicine administration</b>	<b>Dose given</b>																
	<b>Route</b>																
	<b>Time</b>																
<b>Repeated CIWA-Ar score: (1 hour after PRN dose)</b>																	
<b>Initials</b>																	
<b>Attach patient details / addressograph</b>																	

ALWAYS ENSURE PATIENTS ARE NURSED IN A WELL-LIT,  
COOL ENVIRONMENT WITH GOOD VENTILATION



## Guidance Notes

### Please refer to full treatment guidelines

#### Using the CIWA-Ar Scale.

- Assess the patient and rate each of the 10 criteria overleaf.
- Add the score for each criterion to give the total CIWA-Ar score for the patient. It is not always necessary to ask the patient all 10 questions as observations will often be sufficient to rate symptoms. The maximum possible score is 67.

<b>Nausea and Vomiting</b>	Do you feel sick to your stomach? Have you vomited?
<b>Tremor</b>	Arms extended and fingers spread apart or holding a cup. Patient feels tremulous inside
<b>Anxiety</b>	Do you feel nervous?
<b>Tactile Disturbances</b>	Have you any itching, pins and needles sensations, any burning, numbness or do you feel bugs crawling on or under your skin?"
<b>Auditory Disturbances</b>	"Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?"
<b>Visual Disturbances</b>	Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing something that is disturbing to you? Are you seeing things you know are not there?
<b>Headache</b>	Does your head feel different? Does it feel like there is a band around your head? Do not rate for dizziness or light-headedness. Otherwise, rate severity.
<b>Orientation</b>	What day is this? Where are you? Who am I?

## **Appendix 5: SADQ**

First of all, recall a recent month when you were drinking heavily in a way, which, for you, was fairly typical of a heavy drinking period. Please fill in the month and year:

Month.....

Year

**During this time and during other periods when your drinking was similar, how often did you experience the feelings listed below? Please reply to each statement by circling the number for the most accurate answer for each question.**

**These questions are about the physical symptoms that you have experienced first thing in the morning during these typical periods of heavy drinking.**

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
1) During a heavy drinking period I wake up feeling sweaty.	0	1	2	3
2) During a heavy drinking period my hands shake first thing in the morning	0	1	2	3
3) During a heavy drinking period my whole body shakes violently first thing in the morning if I do not have a drink	0	1	2	3
4) During a heavy drinking period I wake up absolutely drenched in sweat.	0	1	2	3

The following statements also refer to the recent period when your drinking was heavy, and to periods like it.

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
5) During a heavy drinking period I like to have a morning drink	0	1	2	3
6) During a heavy drinking period I gulp my first few morning drinks down as quickly as possible	0	1	2	3
7) During a heavy drinking period I drink in the morning to get rid of the shakes	0	1	2	3
8) During a heavy drinking period I have a very strong craving for a drink when I awaken	0	1	2	3

The following statements refer to moods and states of mind you may have experienced first thing in the morning during these periods of heavy drinking

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
9) When I am drinking heavily I dread waking up in the morning	0	1	1	3
10) During a heavy drinking period I am frightened of meeting people first thing in the morning	0	1	2	3
11) During a heavy drinking period I feel at the edge of despair when I awaken	0	1	2	3
12) During a heavy drinking period I feel very frightened when I awaken	0	1	2	3

Again the following statements refer to the recent period of heavy drinking and the periods like it.

PLEASE ANSWER EVERY QUESTION

Circle one answer	Almost never	Some-Times	Often	Nearly Always
13) During a heavy drinking period I drink more than a quarter of a bottle of spirits per day (4 doubles or 1 bottle of wine or 6 beers)	0	1	1	3
14) During a heavy drinking period I drink More than half a bottle of spirits per day (or 2 bottles of wine, or 12 beers)	0	1	2	3
15) During a heavy drinking period I drink more than one bottle of spirits per day (or 1 gallon of wine, or 24 beers)	0	1	2	3
16) During a heavy drinking period I drink more than two bottles of spirits per day (or 2 gallons of wine, or 48 beers)	0	1	2	3

IMAGINE THE FOLLOWING SITUATION:

- 1) You have COMPLETELY ABSTAINED FROM ALCOHOL FOR A FEW WEEKS
- 2) You then drink VERY HEAVILY for TWO DAYS

How would you feel the morning after those two days of heavy drinking?

PLEASE ANSWER EVERY QUESTION

Circle one answer	Not at all	Slightly	Moderate	Quite a lot
17) I would start to sweat	0	1	2	3
18) My hands would shake	0	1	2	3
19) My body would shake	0	1	2	3
20) I would be craving for a drink	0	1	2	3

**Thank you!**



# Western Health and Social Care Trust

## **INFORMATION ABOUT ALCOHOL WITHDRAWAL FOR PATIENT AND SUPPORTER**



**Alcohol and Drug Service**

### **Environment**

- It is advisable to remove any remaining alcohol from the house.
- It is helpful that other people around stop drinking during the detox programme. It is more difficult for you if those persons around are drinking whilst you are trying to detox.
- It is essential that the home atmosphere is calm and supportive.

### **Withdrawal Symptoms**

If someone has been physically dependent on alcohol, stopping drinking may cause them to get tense, edgy, perhaps shaky or sweaty, and disrupt their sleep. They may have vomiting or diarrhoea.

### **Medication**

The aim of detox medication is to best control these symptoms while the body adjusts to being without alcohol. This usually takes three to seven days from the time of the last alcoholic drink.

Without medication, the symptoms would be worst in the first 48 hours, and then gradually disappear. This is why the dose starts high and then reduces.

Chlordiazepoxide will usually be prescribed to increase safety and comfort during the withdrawal period. As with many drugs this is potentially addictive, therefore, it is important the correct dosage is given and only over a limited number of days (usually 5 days). It is important that the supporter takes responsibility for the medication, holding it and giving it as prescribed.

### **Monitoring / Role of Supporter**

There are on occasions risks associated with alcohol withdrawal. In general if those risks are predictable detox is undertaken in a supported environment. Occasionally, however, they are unpredictable and a key role of the supporter is to monitor the individual undergoing detox and respond appropriately if risky situations occur. The Alcohol Detox Nurse and GP will discuss this with you prior to detox commencing and there is guidance below on how to respond if anything risky does arise.

### **Safety**

During detoxification the patient may feel tremulous or drowsy; it is therefore important to make the environment as safe as possible, e.g.

- supervise smoking
- don't allow the person to pour hot water
- avoid swimming or unsupervised bathing (shower may be safer than bathing)
- no driving or operating machinery

### **Mood Changes**

Someone undergoing detox from alcohol may be anxious, restless or irritable, or even appear suspicious. They may experience significant cravings for alcohol.

Alternatively they may be sleepy or drowsy. Moods may fluctuate throughout the detox.

When the patient is feeling anxious, fearful or unable to sleep, it is best to act in a reassuring manner and avoid unnecessary demands or stresses. Plenty of rest is required, especially in the first few days. Sometimes withdrawal symptoms are worse at night time and if so this may be helped by a light being left on, either in the bedroom or outside the room. If the anxiety or irritability is getting worse it is important that the Detox Nurse / GP are informed of this. Think about ways to help someone to relax e.g. by going for a walk or listening to music. This may also help with cravings.

### **Hygiene**

There may be excessive sweating during detoxification. This is not unusual. Assistance with washing and bathing may be helpful.

### **Hydration**

If there is excessive sweating or vomiting in the early stages of withdrawal, it is important that the patient drinks plenty of fluids. Avoid too much fruit juice or caffeinated drinks, e.g. tea, coffee or fizzy drinks.

### **Eating**

Small meals, little and often, are probably the best in the first few days, but if the appetite is very poor do not worry as it will improve steadily throughout the detox period. A nutritious diet is best which should include fruit and vegetables.

### **Sleep**

You may find that even with medication, sleep is disturbed. Do not worry about this – lack of sleep does not seriously harm you, starting to drink again does. It is preferable to try to resist sleep during the daytime as this may hinder sleep at night time. A good sleep pattern will generally return to normal with continued abstinence. It is better not to take sleeping pills so that your natural sleep rhythm returns. Try going to bed later. Take a bedtime snack or milky drink. Avoid too much tea or coffee.

### **Withdrawal Fits**

**Very rarely** withdrawal fits occur. In the unlikely event of this happening it is important that the supporter follows a few simple rules.

When a person is having a fit the initial stage visible will be collapse and shaking / twitching of the limbs and torso. This may appear dramatic and frightening, but no intervention is

required at this stage except to remove any obstacles that may cause injury. This stage can last for a few seconds, or a few minutes, during which time the person may appear to stop breathing and go blue in the face and hands. This is a normal part of a fit and normal colour will return when the fit stops.

**For the supporter, please note the following points:**

- Call 999 to request an ambulance.
- **Do not** try to restrict the person when he or she is having a fit.
- **Do not** put, or force anything into the mouth when the person is having a fit.
- **Do** remove any obstacles that the person may knock his or herself on.
- **Do** time the fit if possible. When the person has stopped fitting, he or she will go into a drowsy / semi-conscious state. This is a normal part of the process.
- **Do** check the mouth and make sure the airway is clear after the fit. If there are any obstructions in the mouth, remove them.
- **Do** ensure that breathing is normal and then lie the person on one side. Ensure that the mouth is clear of any obstruction and place the head in such a way as to allow any fluids or vomit to run freely without being inhaled.
- For a short time after waking the person may appear irritable or confused, this again is a normal part of the process and will not last long. If the fit continues for longer than a few minutes or stops and starts again then continue to monitor until the ambulance arrives.
- **Do** allow the person time to come round completely then make him or her comfortable and explain what has happened.
- A loss of muscle control during the fit can cause incontinence, which may be embarrassing for the patient. **Do** reassure that this is all right and as soon as the patient is ready, assist in a change into comfortable dry clothes.
- During a fit the person may bite their tongue causing some bleeding in the mouth; although painful this will not harm them.
- **Do** ring the GP/ Detox Nurse to inform him / her of events.

**Confusion**

If the patient starts to lose the sense of where he or she is, or what day it is, or starts to see and hear things that are not there then the GP / Detox Nurse should be informed immediately, or the patient taken to A&E.

**Over-sedation**

If the individual undergoing detox gets very drowsy, miss out a dose and if this continues, or they become difficult to rouse, contact the GP or Detox Nurse.

**IF DRINKING IS RECOMMENCED**

**\*\*\*\*CHLORDIAZEPOXIDE MUST NOT BE COMBINED WITH ALCOHOL AND THE DETOX SHOULD STOP IF THE PATIENT STARTS DRINKING\*\*\*\***

**USEFUL TELEPHONE NUMBERS**

Alcoholics Anonymous	028 90 4434848
Al Anon	028 90 682368
GP Out of Hours	02871 865195
Lifeline	0808 808 8000
Samaritans	028 82 244944
Gransha Hospital	02871 860261
Altnagelvin Hospital	02871 345171
South West Acute Hospital	028 66 382000
Tyrone County Hospital	028 82 833100

**Alcohol and Drug Service**

Alcohol and Drug Service, Woodlea	02871 865237
Addiction Treatment Unit, Omagh	028 82 835453 or 028 82 835365
Community Addiction Team, SWAH	028 66 382073
Damien House, Derry	02871 361156
Ramona House, Omagh	028 82 252730
Foyle Haven, John Street	02871 365259

Number of your own General Practitioner:

.....

Supporter's Contact Number:

.....

## Appendix 7: Benzodiazepine Equivalence Table and example lorazepam and diazepam withdrawal regimens

Equivalence Table (BNF 66, September 2013)	
Benzodiazepine	Dose equivalent to chlordiazepoxide 15mg
Lorazepam	500micrograms
Diazepam	5mg
Nitrazepam	5mg
Temazepam	10mg

### Example Lorazepam withdrawal regimen

	Low risk plus CIWA $\geq 8$	Medium risk plus CIWA $<15$	Medium risk plus CIWA $\geq 15$ or High Risk
<b>Lorazepam Stabilisation Dose Day 1 / A&amp;E</b>	0.5mg qds + 0.5mg 2-hourly PRN	1mg qds + 1mg 2-hourly PRN	2mg stat Repeat hourly up to 3 doses or CIWA-Ar $<8$ Then 2mg qds + 2mg hourly PRN
<b>Stabilisation dose Day 2</b>	0.5mg tds + 0.5mg 2-hourly PRN	1mg qds + 1mg 2-hourly PRN	1-2mg qds + 1mg 4-hourly PRN
<b>Day 3</b>	0.5mg bd	0.5mg qds	1mg qds
<b>Day 4</b>	0.5mg bd	0.5mg tds	1mg tds
<b>Day 5</b>	0.5mg nocte	0.5mg bd	1mg bd
<b>Day 6</b>		0.5mg nocte	0.5mg bd
<b>Day 7</b>			0.5mg nocte

At the time of writing this policy, Lorazepam did not have UK marketing authorisation for the management of delirium tremens. Informed consent should be obtained and documented.

## Steps for managing alcohol withdrawal using diazepam:

- **If low risk category:**
  - Monitor using CIWA every hour
  - Write up for prn diazepam 10mg dosages, up to 40mg in 24 hrs
  - Review after 1 hour
  - If CIWA < 8 – nil    If CIWA ≥ 8 give 10mg diazepam stat
  - Review after 1 hour
  - If CIWA < 8 – nil    If CIWA ≥ 8 give 10mg diazepam stat
  - If 2 consecutive CIWA scores of < 8 probably OK to stop formal monitoring
  - If > 2 prn doses required review clinical picture, consider re-categorising patient and consider commencing fixed dose diazepam regimen starting from 10mg qds (*Day 3 - see below*)
  
- **If medium risk category + initial CIWA < 15:**
  - Give 15mg diazepam stat
  - Write up for prn diazepam 15mg dosages, up to maximum 100mg in 24 hrs
  - Review after 1 hour
  - If CIWA < 8 - nil    If CIWA ≥ 8 – give further 15mg diazepam stat
  - Review after 1 hour
  - CIWA < 8 - nil    If CIWA ≥ 8 – give 15mg diazepam stat
  - Continue hourly reviews until 2 consecutive CIWA < 8 then start fixed dose regimen from 15mg / 10mg / 10mg / 15mg (*Day 2 - see below*)
  - If > 2 consecutive 15mg stat doses needed review clinical picture and consider transfer to high risk pathway
  
- **If high risk category or medium risk + initial CIWA ≥ 15**
  - Give 20mg diazepam stat
  - Write up for prn diazepam 20mg dosages, up to maximum 100mg in 24 hrs
  - Review after 1 hour
  - If CIWA < 8 - nil    If CIWA ≥ 8 – give further 20mg diazepam stat
  - Review after 1 hour
  - If CIWA < 8 - nil    If CIWA ≥ 8 – give 20mg diazepam stat
  - Continue hourly reviews until 2 consecutive CIWA < 8 then start fixed dose regimen from 15mg qds (*see below*)
  - If > 3 doses at 20mg look at policy on difficult to stabilise patients (*see section 8.1*)

**Fixed dose diazepam reducing regimen:**

Day 1	15mg qds
Day 2	15mg / 10mg / 10mg / 15mg
Day 3	10mg qds
Day 4	10mg tds
Day 5	5mg qds
Day 6	5mg bd

- Community detoxes generally start on Day 2 (i.e. 5 day reducing course).
- Hospital detoxes have the initial stabilisation period which is essentially 'front loading' the patient before the fixed dose reducing regimen begins.
- Having comparable reducing regimens in hospital and in the community allows for ease of communication if patients are admitted or discharged.



## Appendix 8: Dependence: ICD-10 Diagnostic guidelines

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

## Appendix 9: Standard Alcohol Detoxification Management Flowchart

Evidence of heavy alcohol use / dependence / potential need for detox



Determine risk category \*

### Low

- patients with high risk but non-continuous alcohol use and / or low level dependence
- neither recent withdrawal symptoms nor recent drinking to prevent withdrawal symptoms
- no alcohol on breath test and no significant withdrawal signs / symptoms (CIWA <8)
- typical consumption < 15u /day
- drinking pattern 3-4 days / week only
- recent detox within last 2/52
- SADQ <15

### Medium

- continuous pattern to alcohol consumption
- consuming 15 - 30 units / day
- drinking to relieve withdrawal symptoms
- evidence of significant alcohol withdrawal
- no evidence or history of severe withdrawals (seizures / DTs)
- 15 - 30 SADQ

### High

- current high alcohol intake (>30 units/day) for at least 5 days consecutively
- history of severe withdrawal, DTs or withdrawal seizures
- signs suggestive of Wernicke's
- high medication requirement during previous detoxifications
- multiple substance addiction e.g. heavy regular or chronic benzodiazepine use in particular
- high levels of agitation / confusion
- evidence of visual or auditory hallucinations
- hyperpyrexia or profuse sweating
- significant withdrawal symptoms / signs at blood alcohol level >100mg/100ml
- SADQ score > 30



Initial CIWA score / Prescribe Thiamine / Review electrolytes



Start **stabilisation** stage of detox (see below when to start detox)

### Low risk

- Monitor / consider using CIWA every hour
- Write up for prn chlordiazepoxide (CDZ) 20mg dosages, up to 80mg in 24 hrs
- Review after 1 hour
- If CIWA < 8 – nil If CIWA > 8 give 20mg CDZ stat
- Review after 1 hour
- If CIWA < 8 – nil If CIWA > 8 give 20mg CDZ stat
- If 2 consecutive CIWA scores of < 8 probably OK to stop formal monitoring
- If > 2 prn doses required review clinical picture, consider re-categorising patient and consider commencing fixed dose regimen **from 20mg qds**

### Medium Risk plus CIWA <15

- Give 30mg CDZ stat
- Write up for prn CDZ 30mg dosages, up to maximum 250mg in 24 hrs
- Review 1 hr
- If CIWA < 8 - nil If CIWA > 8 – give further 30mg CDZ stat
- Review 1 hr
- CIWA < 8 - nil If CIWA > 8 – give 30mg CDZ stat
- Continue hourly reviews until 3 consecutive CIWA <8 then start fixed dose regimen **from 30mg qds**
- If > 2 consecutive 30mg stat doses needed review clinical picture and consider transfer to high risk pathway

### Medium Risk plus CIWA ≥ 15 or High Risk

- Give 40mg CDZ stat
- Write up for prn CDZ 40mg dosages, up to maximum 250mg in 24 hrs
- Review 1 hr
- If CIWA < 8 - nil If CIWA > 8 – give further 40mg CDZ stat
- Review 1 hr
- If CIWA < 8 - nil If CIWA > 8 – give 40mg stat
- Continue hourly reviews until 3 consecutive CIWA < 8 then start fixed dose regimen **from 40mg qds**
- If > 3 doses at 40mg look at policy on difficult to stabilise patients



### Fixed dose Chlordiazepoxide reducing regimen:

Day 1 40mg qds	Day 4 20mg tds
Day 2 30mg qds	Day 5 10mg qds
Day 3 20mg qds	Day 6 10mg bd

### Omit doses:

- If patient is asleep or appears over-sedated omit prescribed dose and then review when next dose due
- Consider re-using breathalyser if any suspicion of alcohol consumption on ward

### When to start detox:

- Ideally 6-8 hours after last drink
- Blood ethanol level should ideally <100mg/100ml and falling
- Some people who are severely alcohol dependent can experience significant withdrawal with a blood alcohol concentration of 100mg per 100ml or more.
- Medication may then be required but use caution with dosages and consult with senior doctors.

### Difficult to stabilise – consider

higher dose CDZ, change to Lorazepam  
Section 8.1

### DTs / Seizures / Severe agitation / Behavioural disturbance

Section 8.2 – 8.3

**Vulnerable groups** – elderly, young, Liver D, pregnant, benzodiazepine dependent  
Section 9

\* Extra caution and dose adjustment may be needed if patient is on other sedating medications

**Appendix 10: Useful contacts for people with alcohol / drug problems**

<b><u>AA</u></b>	<b><u>02890434848</u></b>
SELF REFERRAL	
<b><u>ALCOHOL DETOX NURSES</u></b>	
WOODLEA:	<b><u>07740761312</u></b>
OMAGH:	<b><u>07940598037</u></b>
ENNISKILLEN:	<b><u>07769302385</u></b>
<b><u>ALCOHOL LIAISON NURSES</u></b>	
ALTNAGELVIN:	<b><u>02871345171</u></b>
SWAH:	<b><u>02866382000 ext 252042</u></b>
<b><u>ALCOHOL AND DRUG SERVICE, WOODLEA HOUSE, GRANSHA PARK</u></b>	<b><u>02871865237</u></b>
<b><u>ADDICTION TREATMENT UNIT, T and F, OMAGH</u></b>	<b><u>02882835443/5365</u></b>
1-1 COUNSELLING SERVICES FOR ALCOHOL AND DRUG USERS 18 – 65 YRS	
SUBSTITUTE SUBSCRIBING FOR OPIATE USERS	
COMMUNITY DETOX	
ACCESS TO IN-PATIENT PROGRAMME	
HIDDEN HARM SOCIAL WORKERS	
REFERRAL VIA GP / SS / ALN / PROBATION	
<b><u>DAISY, 29 STRAND ROAD / OPPORTUNITY YOUTH</u></b>	<b><u>02871371162</u></b>
SERVICE FOR YOUNG PEOPLE FROM TEENAGE TO 26YRS	
DEALS WITH ALCOHOL AND DRUGS / SELF REFERRAL / OPEN REFERRAL	
<b><u>DAMIAN HOUSE</u></b>	<b><u>02871361156</u></b>
MENS HOSTEL. COMMUNITY DETOX FACILITY.	
ACCESS VIA GP / WHSCT	
<b><u>DOMICILLARY OUTREACH PROGRAMME FOR OLDER PEOPLE</u></b>	<b><u>02871314239</u></b>
65 YEARS +	
REFERRAL GP / WHSCT	
CONTACT EVELYN BRETT	
<b><u>FOYLE HAVEN</u></b>	<b><u>02871 865259</u></b>
DROP IN CENTRE FOR ALCOHOL USERS / STREET DRINKERS.	
ADDRESSES PRACTICAL ISSUES / DROP IN CENTRE	
OPEN REFERRAL / SELF REFERRAL. 9AM – 10PM	
<b><u>FOYLE VALLEY HOUSE</u></b>	<b><u>02871362689</u></b>
14 BEDDED HOSTEL FOR WOMEN WITH SEVERE ALCOHOL PROBLEMS	
<b><u>GATEWAY TEAM</u></b>	<b><u>02871314090</u></b>
FIRST POINT OF CONTACT FOR CHILDCARE CONCERNS	
<b><u>HOUSE IN THE WELLS</u></b>	<b><u>02871266392</u></b>
25 BEDDED HOSTEL FOR MEN WITH SEVERE ALCOHOL PROBLEMS	

**HURT HAVE YOUR TOMORROWS**

**02871369696**

LISTENING EAR / ALTERNATIVE THERAPIES FOR YOUNG PEOPLE WITH ALCOHOL  
OR DRUG PROBLEMS  
FAMILY / USER SUPPORT  
SELF REFERRAL / CONTACT SADIE

**LIFELINE**

**0808 808 8000**

CRISIS SUPPORT  
CONFIDENTIAL COUNSELLING  
SIGNPOSTING TO ALTERNATIVE SERVICES

**NEEDLE AND SYRINGE EXCHANGE SCHEME**

LLOYDS PHARMACY, EBRINGTON TERRACE, DERRY  
SUPERDRUG, FERRYQUAY STREET, DERRY  
LLOYDS, BELMORE STREET, ENNISKILLEN

**NORTHLANDS**

**02871313232**

ADVICE AND COUNSELLING  
IN PATIENT PROGRAMME  
SELF REFERRAL

**OAKS DROP IN CENTRE MAIN STREET LISNASKEA**

**02867751913**

**RAMONA HOUSE**

**02882252730**

RESIDENTIAL FACILITY / COMMUNITY DETOX FACILITY FOR MALE / FEMALE  
GP / WHSCT

**SAMARITANS**

**08457909090**

**SR CONCILLIOS, NEWRY**

**02830262429**

IN PATIENT PROGRAMME / GP REFERRAL

**SOLACE, IRVINESTOWN**

**02868628737**

COMMUNITY SERVICE TO SUPPORT INDIVIDUALS AND FAMILIES EFFECTED BY THE  
MISUSE OF ALCOHOL

**ST VINCENT DE PAUL**

**02871265489**

PROVIDE CLOTHING / PARCTICAL AID

**SUBSTITUTE PRESCRIBING FOR OPIATE USERS**

DERRY

**02871865239**

CONTACT LORNA FOREST / JENNIFER HEGGARTY  
OMAGH / ENNISKILLEN

**02882835852**

CONTACT JOSEPHINE MULLAN

SERVICE PROVIDED BY LOCAL TRUST ALCOHOL AND DRUG SERVICE

**SUPPORTING WOMEN ALCOHOL PROJECT OMAGH AREA (Bernie Kerlin) 07590353384**



Western Health  
and Social Care Trust

**TYRONE & FERMANAGH HOSPITAL, OMAGH**

**02882833100.**

**WHITE OAKS CENTRE, CO.DONEGAL**

**0035374938440**

ADVICE AND COUNSELLING

IN PATIENT PROGRAMME / GP REFERRAL / SELF REFERRAL  
RING FOR UP TO DATE INFO

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