Managing Alcohol Withdrawals in Acute Inpatient Psychiatry

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Guidelines for Acute Psychiatric Wards managing alcohol withdrawals

• Taking an alcohol history
• Identify those at risk of/ developing alcohol withdrawal syndrome (AWS)
• Achieve safe physical withdrawal from alcohol
• Prevent development severe alcohol withdrawal syndrome (AWS)
• Prevent onset of Wernicke-Korsakoff syndrome
• Manage withdrawal seizures and delirium tremens if they emerge
• Optimise physical healthcare
• Enhance continued maintenance of abstinence
Alcohol History /Assessment

- Screening tools
  - AUDIT 20+ indicates severe dependence
  - Alcohol Dependence SADQ score 15-30 moderate, >30 severe
- Consumption – historical and recent units
- Previous history of escalating severity, withdrawals seizures, delirium tremens
- Withdrawals with medically assisted withdrawals
- Physical health inc signs/ symptoms of liver disease, frailty, WKS
- Other drug misuse inc over the counter
- Cognitive function
- Readiness to change
- Risk assessment
- Investigations LFT, GGT, FBC, U&E, PT/INR, Mg
- **Breathalyzer** *
ICD-10 Alcohol Withdrawal

Clear evidence recent cessation/reduction alcohol

Three or more of following:
1. Tremor
2. Sweating
3. Nausea/Vomiting
4. Tachycardia/Hypertension
5. Psychomotor agitation
6. Headache
7. Insomnia
8. Malaise
9. Transient hallucination/illusion
10. Grand mal convulsions
Benzodiazepine treatment regimes

FRONT LOADING

FIXED DOSING SCHEDULE

SYMPTOM - TRIGGERED THERAPY

COMPLICATIONS

UNCONTROLLED WITHDRAWALS

DELIRIUM TREMENS

SEIZURES

ELDERLY / LIVER DISEASE
Elderly/ Liver disease

• In those who are elderly or with severe liver disease there are problems with metabolising long acting benzodiazepines and a risk of benzodiazepine toxicity due to accumulation.

• In individuals who are elderly and frail or those with significant liver disease (jaundice, bilirubin > 50, Childs Pugh B) the following regime should be followed

• Oxazepam Hourly CIWA triggered PRN dose of Oxazepam 30mg for first 24 hours no standard regime. Alternative Lorazepam 1mg CIWA triggered

• After 24 hours identify dose required to control symptom this is the starting dose for the detoxification or continue PRN Symptom triggered
NICE Headline Recommendations

Selection for inpatient admission
High risk delirium/ seizures
Avoid sudden cessation drinking in dependent individuals
Lower threshold for admission e.g. elderly, frail, cognitive impairment, comorbidity, under 16

Treatment of Withdrawal
Offer benzodiazepine or clomethiazole or carbamazepine
Hepatology advice required with decompensated liver disease requiring detoxification
In-patient Symptom-triggered regimen if 24 hour assessment and monitoring available
Frontloading regime
Assisted withdrawal from alcohol

**Steps**

1. Identify high risk withdrawal patients at assessment interview. (See later)

2. Admission breathalyzer and CIWA-Ar record on proforma/ ICIS

3. Breathalyzer reading (BAC) > 200mg% (BrAC 87mcg%) and CIWA-Ar < 10 repeat breathalyzer and CIWA-Ar in 1 hour

4. If BAC > 200mg% (BrAC 87mcg%) and CIWA-Ar > 10 give 20mg Chlordiazepoxide and repeat BAC and CIWA Ar in 1 hour N.B Likely to be high risk detoxification

5. If CIWA Ar > 10 commence detoxification Chlordiazepoxide 20mg qds
Assisted withdrawal from alcohol (cont.)

6. If BAC < 200mg% (BrAC 87mcg%) and CIWA-Ar > 10 commence detoxification Chlordiazepoxide 20mg q.d.s. (standard detoxification).

7. Continue standard detoxification (unless high risk) Hourly CIWA Ar ratings.

8. Every occasion CIWA Ar > 10 give PRN dose of Chlordiazepoxide 20mg.

9. Greater than 5 doses of PRN in 48 hours contact SHO or on call to increase standard detoxification.

10. CIWA Ar scores and detoxification regime to be reviewed by doctor at 48 hours
Delirium Tremens

Severe complication of alcohol withdrawal (Victor and Adams 1953)

Symptoms emerge several hours- days after cessation or reduction in alcohol

Symptoms peak 48-72 hours

Tremor

Hallucinations (auditory, visual, olfactory)

Confusion

Associated delusions, insomnia, agitation

Tachycardia, hyperthermia, hypertension, tachypnoea
# Risk factors for DTs

<table>
<thead>
<tr>
<th>Predisposing</th>
<th>Positive predictors</th>
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<tr>
<td>various authors</td>
<td>Palmstierna T, 2001; Sweden</td>
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<tr>
<td>Severe dependency, High BAC when withdrawals occur Drinking pattern Abrupt cessation of intensive drink Kindling processes eg prev DTs Recent epileptic seizure Concurrent medical problems Metabolic abnormalities Use of sedative-hypnotic drugs Older age Male sex</td>
<td>Infectious disease Tachycardia at admission &gt;120 Withdrawals with BAL &gt; 1g/L=7 units History of epileptic seizures History of delirious episodes Lee J et al, 2004; Korea 59/ 147 patients developed DT History of delirium tremens Tachycardia &gt;100 bpm • 20% dev DTs if no risk factors • 46% dev DTs if one factor present • 100% if both factors present</td>
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Management of delirium tremens

1. Use of prediction rating scales to identify high risk individuals
2. Physical examination; tachycardia >120 whilst positive breathalyser reading >0.5 with severe withdrawals on CIWA-Ar
3. Active investigation of causes of confusion, pyrexia, raised WBC, CRP, MSU, sputum, ?CXR, Mg levels, BM, serum anticonvulsants (day 1 and 3)
4. If high risk group, commence CDZ 50mg qds + serial CIWA-Ar; if severe range give an additional 20mg PRN
5. Correct Magnesium levels with MgAsparate or MgSO4
Management of established delirium tremens

1. Continued assessment delirium
2. Fluid balance; daily U/E, Mg, bone profile
3. IV Pabrinex extended for further 3 days and reviewed
4. Administer oral Lorazepam 2-4mg. If symptoms severe or oral medication is declined, give IM/IV Lorazepam or IV Diazepam 30 – 60 minutes until sedated
5. Prominent psychotic symptoms Haloperidol 1 – 5 mg orally or IM 8 hourly or Olanzapine 10mg orally
6. Rapid tranquillisation policy
7. MHA
8. Criteria for transfer to the medics
Withdrawal Seizures

Generalised Tonic-Clonic Seizures
7-48 hours after cessation alcohol
Often several seizure rarely status
Role of Electrolytes K, Mg
History of previous seizures in withdrawal/ history epilepsy

TREATMENT
- Increased dose CDZ/ DZP 40mg/ 20mg
- Continue anticonvulsant if treatment for epilepsy
- ? Role CBZ as effective as CDZ at preventing seizures

Current practice treatment seizures rectal diazepam/ buccal midazolam/IM lozazepam
NICE Clear guidance to use oral/ parenteral lorazepam to treat and prevent further seizures
Kindling

1. Severity of withdrawals correlates:
   • Amount alcohol consumed
   • Duration of consumption
   • Number of withdrawal episodes *

2. Withdrawal seizure correlate with number previous withdrawals

3. Effects on GABA, Glutamate and neuronal death
Kindling- clinical implications

1. Careful withdrawal history >5 may need inpatient treatment.
2. To detox or not detox- maximise the chance of success (information, stage of change, practical issues, detox support, follow-up arrangements, activities and prescribing).
3. Limiting detoxifications.
5. Cognitive dysfunction and brain damage.
6. Neuroprotective strategies -alternatives to benzodiazepines, acamprosate?
NICE Headline Recommendations

**Delirium Tremens**
If delirium tremens develops review management
Oral lorazepam as first line 2nd line parenteral lorazepam, haloperidol or olanzapine

**Seizures**
If seizures develop review management
Use quick acting benzodiazepine such as lorazepam to reduce likelihood of further seizures
Prevention

ASSESSMENT OF AT RISK GROUPS
- ALL PATIENTS REQUIRING INPATIENT DETOXIFICATION

i] INCIPIENT OR ESTABLISHED WERNICKE ENCEPHALOPATHY
CONFUSION + / - ATAXIA, MEMORY DISTURBANCE, OPHTHALMAPLEGIA, COMA,
OFTEN PRESUMPTIVE DIAGNOSIS

ii) AT RISK GROUP
HISTORY/CURRENT SEVERE WITHDRAWALS
VERY HEAVY CONSUMPTION
POOR DIET WEIGHT LOSS
PERIPHERAL NEUROPATHY

iii) LOW RISK GROUP
WELL NOURISHED LOWER LEVEL CONSUMPTION
NO HISTORY SEVERE WITHDRAWALS
WKS Treatment

1. INCIPIENT WERNICKE'S
   2 PAIRS PABRINEX AMPOULES (≥ 500 MG THIAMINE) TDS BY IV INFUSION FOR 3 DAYS
   FOLLOWED BY 1 PAIR PABRINEX AMPOULES OD BY IM FOR FURTHER 3 - 5 DAYS

2. AT RISK GROUP
   1 PAIR PABRINEX AMPOULES (≥ 250 MG THIAMINE) OD BY IM FOR 3 - 5 DAYS
   N.B. IV ROUTE MAY BE USED e.g. BLEEDING DIATHESIS

3. LOWER RISK GROUP
   THIAMINE 50 MG ORAL QDS
   VITAMIN B COMPLEX STRONG 2 TABLETS TDS
Maintaining abstinence

• Referral to local Community Alcohol Services
• Support AA, NA
• Support activities on line support advice
• Medications always consider prescribing drugs to help maintain abstinence, e.g. Acamprosate, Naltrexone, Disulfiram, Baclofen.