Special Considerations

CHRONIC HEALTH CONDITIONS

Chronic health conditions can be a risk factor for complications of withdrawal. The severity of the health condition and associated factors that can complicate withdrawal should be used to determine the level of monitoring. Clients with uncontrolled or severe illnesses such as cardiovascular disease, liver diseases, COPD, or renal impairment should have their withdrawal symptoms managed in a hospital setting. Clients with controlled medical illness can be managed in WMS with medication protocol modification in consultation with specialists as required.

CARDIAC DISORDERS

- Initiate aggressive withdrawal treatment measures to prevent the exacerbation of cardiac disorders due to autonomic hyperactivity associated with alcohol withdrawal.

LIVER DISEASES

- Caution should be taken when prescribing to individuals with severe liver disease or dysfunction such as cirrhosis:
    - Because of diazepam's hepatic metabolism, lorazepam is the preferred benzodiazepine in these clients.
    - Gabapentin can be used when benzodiazepines are contraindicated because it has no appreciable hepatic metabolism.

CHRONIC PAIN

- Clients with high-risk prescription medications for chronic pain management (opioid and non-opioid, e.g., gabapentin) should be assessed for potential harm.
- Clients on moderate therapeutic doses of opioid or non-opioid medications for chronic non-cancer pain should be maintained on their current dose if the prescription is not causing harm.
- Clients on high opioid doses at potential risk (e.g., requiring high doses of benzodiazepines to manage alcohol withdrawal) should be tapered within safe prescribing guidelines. Consider following the Management of Chronic Non-Cancer Pain Guideline of 90 morphine milligram equivalents (MME) as a safe upper limit for opioid prescriptions.
- When there is potential harm, the benefits and risks of continued use, taper, abrupt cessation, or rotation to a different medication should be explored.

OLDER ADULTS

Older adults require specialized screening for the following unique concerns:

RENAL FUNCTION

Renal clearance declines with age and can be affected by other health conditions and medications. As many medications are renally cleared, be sure to order Cr, GFR, and calculate CrCl to adjust medications as required. Consider the use of a renal adjustment calculator to determine appropriate dose adjustments.

*Acamprosate requires dose adjustment with CrCl 30–50; 333mg TID or one tab by mouth TID.

MEDICATION INTERACTIONS

Many older adults will be on multiple medications, both prescription and non-prescription. It is important that all medications be checked for drug-drug interactions.

SEDATION AND FALL RISK

Special caution should be taken when adding medications that can cause sedation. Being on medication(s) that cause sedation increases fall risk. Ensuring that clients have access to their mobility devices will help to decrease the risk of falls. It is important to ensure an assessment of the individual's mobility needs prior to the admission.

*Diazepam has a long half-life; due to decreased hepatic metabolism, diazepam increases the risk of sedation in older adults. Consider the use of lower-dose lorazepam when benzodiazepines are required.

PREGNANCY

Substance withdrawal poses great risks during pregnancy. Some of these risks include dehydration, hypertension, miscarriage, and premature birth.

ALCOHOL WITHDRAWAL

Pregnant people with moderate to severe alcohol withdrawal (CIWA-Ar ≥ 10) should be managed in an inpatient setting where they can receive symptom-triggered treatment with close monitoring. Based on the stage of pregnancy, fetal heart rate monitoring may be warranted for early detection of fetal distress. If pregnant people with mild alcohol withdrawal are managed in a WMS, consultation with a provider specialized in addictions and obstetrical care is highly recommended.

Consider the following general guidelines for management of alcohol withdrawal in pregnancy:

- Gabapentin can be utilized when there is a low risk for withdrawal complications.
- Long-acting benzodiazepine can be used for a short duration in pregnancy except in the late third trimester; use short-acting benzodiazepine in the late third trimester to minimize benzodiazepine intoxication in the newborn.
- Naltrexone and acamprosate are both FDA pregnancy category C, with no human trials completed. We recommend contacting an addiction and obstetrics specialized clinician for further advice on anti-craving medication in pregnancy.

OPIOID WITHDRAWAL

Consultation with a provider specializing in addictions and obstetrical care is highly recommended for the management of opioid withdrawal in pregnancy.

Opioid withdrawal should be avoided during pregnancy, as it can cause fetal distress; OAT should be offered urgently to all pregnant clients in withdrawal. Buprenorphine/naloxone and methadone should be considered; choice should be based upon client presentation, history, preference, and accessibility. Consider short-term hospitalization to expedite OAT initiation and titration, and for safe monitoring of both the client and the fetus during this process.

YOUTH

Youth are greatly underserved in addictions in Ontario. Because of the specific criteria for substance use disorder in the DSM-5, many adolescents and young adults go undiagnosed. Youth are at high risk for polysubstance and binge use of their substances of choice. This predisposes them to relationship difficulties, trouble in school/work, and homelessness. A full biopsychosocial assessment should be completed for every youth seeking care.

Unfortunately, there are limited residential withdrawal management centers in Ontario that admit youth. Each facility should assess their resources and make every attempt to safely accommodate youth when they are able to do so.

POLYSUBSTANCE WITHDRAWAL

Clients may present with concurrent substance use disorders and polydrug withdrawal. There is commonly overlap in withdrawal symptoms from different substances, and this overlap can increase the severity of withdrawal experienced. This overlap also means that withdrawal monitoring scales, such as the CIWA-Ar, should not be solely relied upon, as their accuracy decreases (e.g., tremor can be from opioid or alcohol withdrawal if occurring concurrently). For this reason, closer monitoring of clients with polydrug withdrawal is needed; they may require transfer to a higher-care facility such as the hospital. The inaccuracy of monitoring scales decreases the effectiveness of symptom-triggered regimens, and fixed dosing regimens with increased monitoring is recommended.

It is important to prioritize withdrawal from the substance with the greatest risk for complications and severe withdrawal. This usually means prioritizing alcohol withdrawal, as it presents with risks such as withdrawal seizures, delirium tremens, and Wernicke's encephalopathy.

The experienced clinician may initiate treatment for non-prioritized substances (e.g., methadone, buprenorphine/naloxone, NRT, or benzodiazepines) while managing the prioritized substance. However, caution should be taken when combining two substances with the risk of sedation and respiratory depression such as methadone and benzodiazepines (e.g., start and remain at methadone 10–20mg while benzodiazepines are provided for alcohol withdrawal).

ALCOHOL AND OPIOIDS

Clients are at increased risk of sympathetic stimulation and dehydration from excessive vomiting/diarrhea.

Management considerations:

- Consider maintaining a stable dose of OAT until alcohol withdrawal is managed.
- Higher doses of benzodiazepines may therefore be needed until OAT can be titrated to effect.
- Clients on opioids or OAT should not be started on naltrexone as an anti-craving medication for their alcohol use, given the risk for precipitated withdrawal. Consider acamprosate as an alternative.

ALCOHOL AND STIMULANTS

Clients are at increased risk of severe and protracted withdrawal, anorexia, insomnia, and agitation.

Management considerations:

- Higher doses of benzodiazepines may be needed to manage acute withdrawal.

ALCOHOL AND BENZODIAZEPINES

Clients are at increased risk of delayed alcohol withdrawal onset due to the presence of benzodiazepines, increased severity of symptoms, prolonged course of withdrawal, and increased risk of seizures.

Management considerations:

- Higher doses of benzodiazepines may be needed to manage acute withdrawal.
- Acute withdrawal management should smoothly transition into a benzodiazepine taper. For example:
    - Excessive alcohol use and clonazepam 0.5mg BID
    - Equivalent to ~15mg diazepam once daily
    - Provide diazepam 10–20mg q1h until diminished tremor and/or light sedation
    - Then begin diazepam 5mg TID–QID for one week and organize an outpatient taper

BENZODIAZEPINE USE

- Clients on moderate, therapeutic doses of benzodiazepines for sleep or anxiety should be maintained on their current dose while in withdrawal management, if the prescription is not causing harm.
- Clients with suspected benzodiazepine use disorder should be offered a medically supervised benzodiazepine taper, with the knowledge that the taper will need to be finalized during the outpatient phase of treatment over weeks or months.
- Clients with concurrent benzodiazepine use disorder experiencing alcohol withdrawal are likely to require higher doses of benzodiazepines for the management of alcohol withdrawal. Benzodiazepine taper can begin once acute alcohol withdrawal is managed.
- Clients with concurrent benzodiazepine dependence and opioid withdrawal will require lower starting doses of opioid replacement therapy (e.g., buprenorphine/naloxone starting dose of 2mg and methadone starting dose of 10–20mg) and closer monitoring for respiratory depression and sedation.