Management of acute and postacute alcohol withdrawal in RAAM clinic settings

Meldon Kahan MD

META:PHI conference

April 4, 2025

META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Disclosures

- In November 2024, I received an honorarium from Indivior for participating in a panel discussion on Opioid Agonist Treatment
- I am Medical Director of META:PHI

Learning objectives

- Explain the rationale for treating alcohol withdrawal electively, as a therapeutic intervention.
- Discuss clinical considerations in managing alcohol withdrawal in a RAAM or outpatient setting.
- Outline a protocol for management of post-acute withdrawal syndrome.

Alcohol withdrawal treatment as a therapeutic intervention

- The prevailing view is that alcohol withdrawal is an emergency that must be treated to prevent complications
- Alcohol withdrawal management can also be viewed a therapeutic intervention (Airagnes 2019)
- Psychological withdrawal symptoms: anxiety, insomnia and craving, quickly relieved by alcohol
- These symptoms compel patients to continue drinking
  - Similar to opioid withdrawal symptoms
- Patient who no longer need to drink to relieve withdrawal symptoms will be more likely to engage in counselling and medical treatment

Elective withdrawal treatment: Is it effective in improving drinking outcomes?

- Evidence is very limited, but promising
- Retrospective chart review of 73 patients admitted electively to a short stay unit (Wyman 2025): at one month post discharge, 45/50 reported reduced drinking and improved well-being; 23 lost to follow up
- Retrospective chart review of a low barrier, outpatient clinic reported good results with elective outpatient withdrawal treatment (Peterkin 2025)

Are RAAM clinics an appropriate setting for elective withdrawal treatment?

- There is limited but promising evidence that RAAM clinics can effectively manage Alcohol Use Disorder – but no evidence on withdrawal management specifically
- Retrospective cohort study: Patients with AUD referred to the Ottawa RAAM clinic from the ED had a marked reduction in repeat ED visits at 30 days, and self-reported reduction in drinking and improved mood (Corace 2020)
- Chart review of patients with AUD attending a Toronto RAAM clinic: Increased rates of self-reported abstinence; reduced alcohol consumption (Wiercigroc 2020)

RAAM clinics versus EDs

- Patients with AUD are often reluctant to go to the ED for withdrawal treatment
- Very long waits, perceived stigma, undertreatment of withdrawal
- Retrospective cohort study of 235 patients treated for alcohol withdrawal at one ED (Libin 2022):
  - Average total dose 6 mg lorazepam equivalent (= 30 mg diazepam)
  - ED return rate within 7 days - 32%

Addressing patient's concerns about withdrawal management

- When patients in withdrawal drink alcohol, they experience rapid and marked relief of anxiety
- This causes some to believe that they will experience severe anxiety when they stop or reduce drinking
- Assure patients that benzodiazepines quickly and effectively relieve withdrawal symptoms

Addressing concerns (2)

- Explain that although alcohol is a sedative, heavy sustained drinking actually increases anxiety and insomnia by revving up the nervous system
- With abstinence/reduced drinking, medications and counselling, the nervous system returns to normal within weeks, resulting in improved mood, less anxiety less insomnia

Treating withdrawal in a RAAM clinic: Necessary supplies and services

- Health care worker (nurse, NP, MD) on site
- Open for at least 5-6 hours
- Medications (diazepam, lorazepam, thiamine) on site
- Nearby ED

Ideal candidate for RAAM treatment

- Expresses a sustained interest in reduced drinking or abstinence
- Reports frequent or daily withdrawal symptoms that are quickly relieved by drinking
- Does not have a recent history of withdrawal related seizures or ED visit or hospitalization
- Is not at high risk for benzodiazepine toxicity (eg severe COPD, on methadone)
- Agrees to go to ED or WMS if advised to by RAAM clinician
- Has social supports at home

Protocol

- Advise patient to have last drink 12 hours or so before coming to the RAAM clinic
  - If the patient comes to the clinic intoxicated they will need to be sent home
- Symptom triggered treatment while in the clinic: Diazepam 10-20 mg q 1 H for CIWA > 10 or SHOT > 1
  - Should be at least one objective sign present – tremor or sweating are most reliable signs
- Discontinue treatment when CIWA < 8 and patient comfortable

Protocol (2)

- Send to ED if:
- Patient's withdrawal is not improving or worse despite several doses of diazepam
- Patient has signs of cardiovascular instability eg marked tachycardia, hypertension
- Patient shows signs of impending delirium eg confusion, disorientation, hallucinations
- Patient shows signs of benzo toxicity ie drowsiness
- Patient has repeated vomiting and/or profuse sweating

Discharge

- If still in mild withdrawal on discharge, give a script for:
- Diazepam 10 mg qid day 1, tid day 2, bid day 3, OD day 4
- Gabapentin is another option
- Prescribe anticraving medication if not already on it (see next slides)
- Check on patient daily for a few days – virtually or telephone if more convenient for patient
- Have a formal appointment in a week

Gabapentin for acute withdrawal

- Gabapentin has been used as an alternative to diazepam: Less sedating, less likely to be misused
- Less effective than benzodiazepines in preventing seizures; should not be used as monotherapy for modrate-severe alcohol withdrawal (Qu 2024)

Elective management of patients with a history of moderate-severe withdrawal: Role of WMS

- WMS can help patients with moderate-severe AUD who have a history of withdrawal-related seizures or hospitalizations
- RAAM clinician can work with WMS Nurse Practitioner to develop a plan for elective admission to WMS
- Patient should come to WMS in the morning when the NP starts work
- NP will initiate symptom triggered treatment
- WMS can keep the patient for a day or two, provide counselling, connection to treatment and adjustment of anticraving medications, and refer the patient to the ED if necessary

”Home detox”

- Prescribe scheduled doses of benzodiazepines to take home
- Eg diazepam 10 mg six times per day on day 1, taper by one tab/d
- This approach is more convenient for the patient, but:
  - Is not as effective symptom triggered treatment (20 mg per hour)
  - Tapering doses of diazepam can be sedating when patient is no longer in acute withdrawal
  - Patients may combine diazepam with alcohol
  - Patients may find that they like diazepam, creating a potential problem
- CAMH has had a successful pilot of home symptom triggered treatment with careful monitoring

Discharge counselling

- You no longer need to drink to relieve withdrawal symptoms
- Over the next few days and weeks, if you remain abstinent or markedly reduce your drinking, your mood, sleep and energy level will continue to improve and your cravings will diminish
- Take steps to prevent relapse (next slide)
- Arrange frequent follow-up

Advice to patient: Reducing risk of relapse

- Don’t keep alcohol in the house
- Don’t engage in activities that will expose you to alcohol
- Spend time with positive supports who don’t drink – family, friends
- Have a strategy to cope with cravings:
  - 30 minute time out
  - Mindfulness
  - Call a support person
  - If intense, leave the house

Advice to patient (2)

- Connect the patient to RAAM clinic counsellor and other community services: AA, other self-help groups, outpatient and residential counselling programs, mental health services
- Advise the patient to contact the RAAM clinic if they resume drinking – don’t give up

Subacute or post acute withdrawal

- Subacute or post-acute withdrawal is characterized by insomnia, anxiety, depression, irritability, cognitive dysfunction (eg poor concentration), craving for alcohol (Bhaji 2022)
- Symptoms start after resolution of acute withdrawal and can last for several months or longer, gradually lessening over time
- Subacute withdrawal likely a major cause of relapse

Acamprosate for post-acute withdrawal

- Controlled trials have found that acamprosate are effective for post acute withdrawal symptoms, particularly insomnia (Perney 2018)
- Acamprosate is not effective while the patient is drinking, but can be started on the first day of elective withdrawal management
- Dose 666 mg tid (333 mg tid if renal insufficiency)
- LU code 531
- Generally well tolerated; GI side effects

Gabapentin for post-acute withdrawal

- Meta-analysis of RCTs: Gabapentin is an effective anti-craving medication (Ahmed 2019)
- Gabapentin may be particularly effective for patients experiencing daily withdrawal symptoms
- RCT: Gabapentin up to 1200 mg/day improved drinking outcomes in those with high alcohol withdrawal scores (Anton 2020)
- Gabapentin relieves insomnia in post-acute withdrawal (Hoffman 2024)

Gabapentin prescribing

- RCT, 1800 mg/day gabapentin more effective at reducing drinking than 900 mg/day, which was more effective than placebo (Mason 2014)
- Start at 300 mg bid and titrate up
- Side effects: Dizziness, sedation, rarely depression
- Gabapentin can be started while the patient is drinking
- Gabapentin can be combined with naltrexone, acamprosate
- Both gabapentin and pregabalin may be effective for comorbid anxiety and alcohol use disorders (Gimeno 2017)

Counselling and follow up

- See patients frequently in the first few weeks
- Advise patients that subacute withdrawal symptoms (cravings, insomnia, low mood) get better over time; people generally feel and function much better after several weeks of abstinence or reduced drinking
- Encourage positive social supports and activities
- Avoid triggers to drinking – people, places, things
- Connect patients to community addiction and mental health services and self help groups

Case 1: A patient who is “ready”

- 45 year old woman drinking one bottle of wine per day x 1 year, since death of her mother
- Reports anxiety and slight tremor in the morning, relieved by alcohol
- On leave from work; supportive partner
- No benefit from naltrexone or counselling
- Expresses strong desire to quit alcohol
- **How would you manage this?**

T

Case 2: A patient who presents to RAAM clinic in withdrawal

- 35 year old man, presents with tremor, sweating
- Has a two year history of heavy drinking, after break-up of a long-term relationship and loss of job
- Lives alone, not working, no supports
- Two weeks ago attended the ED for alcohol withdrawal treatment, remained abstinent for three days, then resumed drinking – 12 standard drinks/day
- States he would like to quit drinking and go back to his family
- **What else would you like to know about him?**
- **How would you manage this?**

Case 3: A patient on benzodiazepines

- 27 year old woman, lives alone but close to family
- Four year history of heavy binge drinking – one week on, several weeks off
- Binges are becoming more frequent and severe
- Has had two withdrawal seizures

Case 3: A patient on benzodiazepines (2)

- Given outpatient scripts for diazepam in the ED
- Family doctor has continued to prescribe, as withdrawal seizure prophylaxis
- Dose has escalated over past year; now on diazepam 10 mg qid + one tab OD PRN
- Sometimes uses more when anxious, and relapses to alcohol use if doesn't get renewal right away
- **What are the possible diagnoses?**
- **How would you manage her withdrawal and her diazepam use?**

References

Ahmed S, Stanciu CN, Kotapati PV, Ahmed R, Bhivandkar S, Khan AM, Afridi A, Qureshi M, Esang M. Effectiveness of Gabapentin in Reducing Cravings and Withdrawal in Alcohol Use Disorder: A Meta-Analytic Review. Prim Care Companion CNS Disord. 2019 Aug 22;21(4):19r02465. doi: 10.4088/PCC.19r02465. PMID: 31461226.

Airagnes G, Ducoutumany G, Laffy-Beaufils B, Le Faou AL, Limosin F. Alcohol withdrawal syndrome management: Is there anything new? Rev Med Interne. 2019 Jun;40(6):373-379. doi: 10.1016/j.revmed.2019.02.001. Epub 2019 Mar 7. PMID: 30853380.40

Anton RF, Latham P, Voronin K, Book S, Hoffman M, Prisciandaro J, Bristol E. Efficacy of Gabapentin for the Treatment of Alcohol Use Disorder in Patients With Alcohol Withdrawal Symptoms: A Randomized Clinical Trial. JAMA Intern Med. 2020 May 1;180(5):728-736. doi: 10.1001/jamainternmed.2020.0249. PMID: 32150232; PMCID: PMC7063541.

Bahji A, Crockford D, El-Guebaly N. Neurobiology and Symptomatology of Post-Acute Alcohol Withdrawal: A Mixed-Studies Systematic Review. J Stud Alcohol Drugs. 2022 Jul;83(4):461-469. doi: 10.15288/jsad.2022.83.461. PMID: 35838422; PMCID: PMC9798382.

Corace K, Willows M, Schubert N, Overington L, Mattingly S, Clark E, Leduc N, Hutton B, Hebert G. Alcohol Medical Intervention Clinic: A Rapid Access Addiction Medicine Model Reduces Emergency Department Visits. J Addict Med. 2020 Mar/Apr;14(2):163-171. doi: 10.1097/ADM.0000000000000559. PMID: 31403977.PMID: 31403977 [Indexed for MEDLINE]

References (2)

Gimeno C, Dorado ML, Roncero C, Szerman N, Vega P, Balanzá-Martínez V, Alvarez FJ. Treatment of Comorbid Alcohol Dependence and Anxiety Disorder: Review of the Scientific Evidence and Recommendations for Treatment. Front Psychiatry. 2017 Sep 22;8:173. doi: 10.3389/fpsyt.2017.00173. PMID: 29018367;PMCID: PMC5614930

Hoffman M, Voronin K, Book SW, Prisciandaro J, Bristol EJ, Anton RF. Sleep as an Important Target or Modifier in Alcohol Use Disorder Clinical Treatment: Example From a Recent Gabapentin Randomized Clinical Trial. J Addict Med. 2024 Sep-Oct 01;18(5):520-525. doi: 10.1097/ADM.0000000000001316. Epub 2024 May 31 PMID: 38828963; PMCID: PMC11446662

Lebin JA, Mudan A, Murphy CE 4th, Wang RC, Smollin CG. Return Encounters in Emergency Department Patients Treated with Phenobarbital Versus Benzodiazepines for Alcohol Withdrawal. J Med Toxicol. 2022 Jan;18(1):4-10. doi: 10.1007/s13181-021-00863-2. Epub 2021 Oct 25. PMID: 34697777; PMCID: PMC8758850.

Mason BJ, Quello S, Goodell V, Shadan F, Kyle M, Begovic A. Gabapentin treatment for alcohol dependence: a randomized clinical trial. JAMA Intern Med. 2014 Jan;174(1):70-7. doi: 10.1001/jamainternmed.2013.11950. PMID: 24190578;PMCID: PMC3920987.

Perney P, Lehert P. Insomnia in Alcohol-Dependent Patients: Prevalence, Risk actors and Acamprosate Effect: An Individual Patient Data Meta-Analysis Alcohol Alcohol. 2018 Sep 1;53(5):611-618. doi: 10.1093/alcalc/agy013. PMID: 29617889.

Qu L, Ma XP, Simayi A, Wang XL, Xu GP. Comparative efficacy of various pharmacologic treatments for alcohol withdrawal syndrome: a systematic review and network meta-analysis. Int Clin Psychopharmacol. 2024 May 1;39(3):148-162. doi: 10.1097/YIC.0000000000000526. Epub 2023 Dec 27. PMID: 38170803.

References (3)

Peterkin AF, Laks J, Farrell N, Weisenthal K, Taylor JL. Outpatient Alcohol Withdrawal Management in a Substance Use Disorder Bridge Clinic: An Opportunity for Low-barrier Engagement and Shared Decision-making. J Addict Med. 2025 Feb 17. doi: 10.1097/ADM.0000000000001463. Epub ahead of print. PMID: 39961087.

Wiercigroch D, Sheikh H, Hulme J. A rapid access to addiction medicine clinic facilitates treatment of substance use disorder and reduces substance use. Subst Abuse Treat Prev Policy. 2020 Jan 13;15(1):4. doi: 10.1186/s13011-019-0250-1. PMID: 31931831; PMCID: PMC6958640.

Wyman J, Castro-Arteaga M, Hum S, Dagher M, Wu W, Kahan M. Elective Admission for Management of Alcohol Withdrawal in a Short-stay Medicine Unit in Toronto: Outcomes and Opportunities. Submitted for publication, CJA, March 2025