Order Set for Alcohol Withdrawal

GENERAL

Supports

- ☐ Offer on-site connection with peer worker or addiction service worker if available
- ☐ Initiate hospital suicide/self-harm assessment

Monitoring[1,2]

- ☐ Temp, HR, RR, BP, and O2 saturation at baseline and q 2 H or with each CIWA-Ar assessment
- ☐ With intoxication, begin CIWA-Ar with patient's earliest recognition of withdrawal or 6 H from last drink
- ☐ Baseline CIWA-Ar, then:
  - ☐ CIWA-Ar at minimum q 30–60 min for CIWA-Ar ≥ 20 (severe withdrawal)
  - ☐ CIWA-Ar q 60 min for CIWA-Ar 10–19 (moderate withdrawal)
  - ☐ CIWA-Ar q 60–120 min for CIWA-Ar < 10 (mild withdrawal)
  - ☐ Transfer patients to a cardiac-monitored bed for CIWA ≥ 20 and/or definitive signs of severe withdrawal: SBP > 180 DBP > 110, HR > 120 bpm, T > 37.5 C, arrhythmia, profuse sweating, repeat vomiting, severe withdrawal tremor, hallucinations, psychomotor agitation, confusion, disorientation, delusions, withdrawal seizures, or DTs
  - ☐ Discontinue CIWA-Ar when CIWA-Ar < 10 x 2 consecutive reassessments at least one hour apart

Testing[3]

- ☐ ECG
- ☐ Serum ethanol, CBC, electrolytes (Na+, K+, Cl-, HCO3--, Mg2+, PO43-, Ca2+), creatinine, glucose, GGT, AST, ALT, ALP, bilirubin, albumin, INR
- ☐ Serum/urine BHCG
- ☐ Urine drug screen/serum toxicology

Fluids

- ☐ Saline lock
- ☐ IV fluids _____ at _____ ml/hr

Thiamine[4]

- ☐ Thiamine 300 mg IM x 1
- ☐ Thiamine 300 mg IV x 1

WITHDRAWAL TREATMENT

Hold any dose if the patient shows signs of sedation (frequently drowsy, rousable, but drifts off to sleep during conversation)

Benzodiazepine loading doses[5]

For patients with a previous history of withdrawal seizures or DTs AND CIWA-Ar ≥ 10 OR at least 6 H from last drink (i.e., no longer intoxicated and entering withdrawal):[6]

- ☐ Diazepam 20 mg PO q 1 H x 3
- ☐ Lorazepam 4 mg PO q 1 H x 3
- ☐ Continue with symptom-triggered treatment after loading doses are completed

If there is concern about the risk of oversedation, consider starting with a test dose of diazepam 10 mg or lorazepam 2 mg

Initial intravenous dosing[7]

For patients with initial presentation of CIWA-Ar ≥ 20 and definitive signs of severe withdrawal:

- ☐ Diazepam 10 mg IV q 10 min PRN, to max of 40 mg per hour
- ☐ Lorazepam 2 mg IV q 10 min PRN, to max of 10 mg per hour
- ☐ Continue with symptom-triggered treatment when CIWA-Ar < 20

Symptom-triggered treatment[2,6]

- ☐ Diazepam 20 mg PO q 1 H for CIWA-Ar ≥ 10 and/or definitive signs of severe withdrawal
- ☐ Lorazepam 4 mg PO q 1 H for CIWA-Ar ≥ 10 and/or definitive signs of severe withdrawal

If the patient does not yet show definitive signs of withdrawal (e.g., tremor) or is at risk for benzodiazepine toxicity, consider starting with lower doses:

- ☐ Diazepam 10 mg PO q 1 H for CIWA-Ar ≥ 10
- ☐ Lorazepam 2 mg PO q 1 H for CIWA-Ar ≥ 10
- ☐ Lorazepam 1 mg PO q 1 H for CIWA-Ar ≥ 10
- ☐ Lorazepam 0.5 mg PO q 1 H for CIWA-Ar ≥ 10

For severe withdrawal worsening or not improving despite diazepam 80 mg/lorazepam 16 mg over four hours or less, double the dose of oral benzodiazepines or move to intravenous dosing[6,8]

- ☐ Diazepam 40 mg PO q 1 H
- ☐ Lorazepam 4 mg PO q 1 H
- ☐ Lorazepam 8 mg PO q 1 H
- ☐ Diazepam 10 mg IV q 10 min PRN, to max of 40 mg per hour
- ☐ Lorazepam 2 mg IV q 10 min PRN, to max of 10 mg per hour

DISCHARGE ORDERS

- ☐ WMS referral
- ☐ Community treatment clinic referral: _____
- ☐ **Thiamine** 100 mg PO once daily x 4 weeks
- ☐ Offer **anti-craving prescription** and advise patient to attend community treatment clinic or primary care for ongoing prescription:
  - ☐ **Naltrexone** 50 mg PO once daily x 14 days, LU code 532
  - ☐ **Acamprosate** 666 mg PO three times daily x 14 days, LU code 531
  - ☐ **Acamprosate** 333 mg PO three times daily x 14 days (if CrCl 30–50 ml/min), LU code 531
  - ☐ **Gabapentin** 300 mg PO three times daily x 14 days
- ☐ Fax summary to appropriate clinic(s) and community providers

If patient is still in mild withdrawal upon discharge:

- ☐ Prescribe **gabapentin**

  OR
- ☐ Prescribe tapering doses of **diazepam** or **lorazepam**

Name _____ Signature _____

Prescriber ID _____

Date _____ Time _____

NOTES

[1] Withdrawal is likely for patients with (a) a history of withdrawal, and (b) consumption of at least five standard drinks per day for at least one week consecutively. Withdrawal symptoms typically present six to twelve hours after the last drink. Starting six hours after the last drink, administer the CIWA-Ar q 2 H, and symptom-triggered treatment should be started for CIWA-Ar ≥ 10. Patients that are likely to experience withdrawal but do not have a history of withdrawal seizures or delirium tremens (DTs) can be considered for transfer to a withdrawal management service.

[2] If any of the following are present during alcohol withdrawal, they should be treated as definitive signs of severe withdrawal: SBP > 180 DBP > 110, HR > 120 bpm, T > 37.5 C, arrhythmia, profuse sweating, repeat vomiting, severe withdrawal tremor, hallucinations, psychomotor agitation, confusion, disorientation, delusions, withdrawal seizures, or DTs.

[3] Laboratory tests, ECG, and IV should be initiated in most patients in moderate withdrawal, all patients in severe withdrawal, and those who have a history of severe withdrawal, withdrawal seizures, or DTs. BHCG is recommended for people who can become pregnant; pregnant people need immediate access to treatment. Serum toxicology or point-of-care urine drug screen should be considered for patients who may be using unregulated substances, especially opioids. Potent opioids such as fentanyl, taken either before admission or after discharge, can have dangerous interactions with high doses of benzodiazepines.

[4] All patients in withdrawal should receive thiamine as prophylaxis for Wernicke's syndrome. Because of poor gastric absorption, IM and IV are the preferred route of administration. If D5W IV solution or oral glucose solution is to be given, efforts should be made to give thiamine first. Administering glucose before thiamine could trigger Wernicke's if the patient is already deficient in thiamine, as glucose metabolism requires thiamine as a co-factor. If the patient is dangerously hypoglycemic, do not delay giving glucose, but give thiamine as soon as possible afterwards.

[5] Lorazepam is preferred over diazepam for patients with cirrhosis and those who are at higher risk for benzodiazepine toxicity, i.e., the frail elderly, those on high-dose opioids, and those with respiratory or hepatic impairment. The lorazepam dose depends on the degree of risk. Lower lorazepam doses should be used for patients with decompensated cirrhosis and severe respiratory impairment. Patients requiring lorazepam should have prolonged monitoring to ensure withdrawal and risk of complications do not return as the dosing wears off.

[6] Because the course of withdrawal is predictable based on previous withdrawal presentations, loading doses should be given to those with a history of withdrawal seizures or DTs. Loading doses should be given as early as possible but should not be started until the patient is either in early withdrawal, i.e., CIWA ≥ 10, or anticipated to be in withdrawal, i.e., at least six hours after the last drink. Check on the patient after each dose to ensure that they are not sedated and that their withdrawal is resolving; discontinue loading doses if the patient is showing signs of sedation.

[7] Regardless of history, patients with CIWA-Ar ≥ 20 with definitive signs of severe withdrawal on initial presentation can be initiated on intravenous dosing, as it has a rapid onset of action and oral dosing may be challenging (e.g., in patients that are agitated or vomiting). There are benefits to the rapid onset of action in patients who have cardiovascular instability (severe hypertension, tachycardia, arrhythmia) and in patients showing early signs of DTs (agitation, confusion, delusions, hallucinations). IV dosing can continue until the patient is no longer in severe withdrawal, at which point oral symptom-triggered dosing can begin. Patients with a history of withdrawal seizures or DTs should still be provided with the cumulative dosing that would occur with loading doses.

[8] IV dosing is indicated for patients in severe or worsening withdrawal despite frequent dosing of benzodiazepines, particularly if the patient has not responded to frequent oral doses or double oral doses or if they show signs of cardiovascular instability (hypertension, tachycardia, arrhythmias) or early signs of DTs (agitation, confusion, delusions, hallucinations). Careful monitoring and frequent assessment is needed. These patients require cardiac-monitored beds with attention to respiratory rate, oxygen saturation, and sedation. If the patient shows marked improvement after an IV dose, reassess in 10–20 minutes; the patient can be switched back to oral dosing when their withdrawal is no longer severe. If the patient is at high risk for benzodiazepine toxicity, monitor closely, give lower doses, and consult with internal medicine for hospital admission. If the patient does not respond to IV dosing, consider phenobarbital.