Approach to ED Patients With Alcohol-Related Presentations

Patient presents to ED with alcohol use disorder/presentation associated with high-risk alcohol use:

- Alcohol intoxication
- Alcohol withdrawal (including seizures)
- Trauma (e.g., accident, assault)
- Chest pains/arrhythmias
- Hepatic and extra-hepatic sequelae (e.g., ascites)
- GI issues (e.g., pancreatitis, gastritis)
- Psychiatric conditions (e.g., self-harm, suicidal ideation)
- "Unwell"
- Repeat ED visits

- Treat presenting condition(s)
- Perform **brief negotiated interview**: Is the patient's presenting condition likely connected to their alcohol use?

Does the patient have a current goal of alcohol cessation OR will be in the ED long enough that they will experience alcohol withdrawal?

YES

Consider the appropriate **treatment and discharge setting**:

- ED: History of seizures, DTs, withdrawal requiring hospital admission, comorbidities (concurrent unstable or complex medical or psychiatric conditions, pregnancy)
- Home: Patient has a safe space, capable of self-care or has a support person available
- WMS: Patient does not have a safe space, requires additional support or monitoring

NO

Offer on-site connections or community referrals for AUD or high-risk drinking

ED WITHDRAWAL MANAGEMENT

Does the patient have a history of withdrawal seizures/DTs?

YES

- Initiate oral benzodiazepine loading doses when CIWA-Ar ≥ 10 OR at least 6 hours after last drink:
  - Patients at risk for benzodiazepine toxicity/sedation or without definitive signs of withdrawal: Diazepam 10 mg OR lorazepam 2 mg
  - All other patients: Diazepam 20 mg OR lorazepam 4 mg q 1 H x 3
  - Monitor for sedation before each dose
- Initiate symptom-triggered treatment after loading doses are administered

NO

- Initiate symptom-triggered treatment for CIWA-Ar ≥ 10:
  - Patients at risk for benzodiazepine toxicity/sedation or without definitive signs of withdrawal: Diazepam 10 mg OR lorazepam 1–2 mg PO q 1 H
  - All other patients: Diazepam 20 mg OR lorazepam 4 mg PO q 1 H
- Discontinue protocol when CIWA-Ar < 10 x 2
- For withdrawal worsening OR not responding after diazepam 80 mg/lorazepam 16 mg over 4 H or less:
  - Double the oral benzodiazepine dose (diazepam 40 mg/lorazepam 4–8 mg q 1 H) OR move to IV dosing as per severe withdrawal

Is the patient in severe withdrawal?

NO

YES

- Initiate IV benzodiazepines:
  - Diazepam 10 mg OR lorazepam 2 mg q 10 min
- Initiate cardiac monitoring and correct electrolyte imbalances
- When no longer in severe withdrawal, initiate symptom-triggered oral treatment
- For severe withdrawal not responding to IV benzodiazepines, consider phenobarbital and initiate referral for admission

For all patients:

- Connect with ED substance use navigator/peer worker if available
- Provide thiamine 300 mg IM or IV
- Discharge prescriptions:
  - **Anti-craving medication** (**naltrexone**, **acamprosate**, and/or **gabapentin**)
  - **Thiamine** 100 mg OD x 30 days
  - Consider outpatient **gabapentin** or **benzodiazepine** if withdrawal is expected to last after ED treatment
- Recommend follow-up with primary care provider and/or community substance use clinic
- Send **naltrexone**, **acamprosate**, and/or **gabapentin** discharge information for primary care
- Provide **patient handout**

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