Summary of Recommendations on the Management of Selected Alcohol-Related Presentations in the Emergency Department

Alcohol-related emergency department (ED) visits are increasingly common, and patients visiting the ED for an alcohol-related reason are at high risk for death. Screen for alcohol use disorder (AUD) or high-risk drinking in patients with common alcohol-related ED presentations: Alcohol intoxication, withdrawal (including seizures), trauma (e.g., accident, assault), cardiac issues (such as chest pain or arrhythmias), hepatic and extra-hepatic sequelae (e.g., ascites), gastro-intestinal issues (such as pancreatitis or gastritis), psychiatric conditions (such as self-harm or suicidal ideation), "feeling unwell", or repeat ED visits.

DISPOSITION FOR PATIENTS SEEKING ALCOHOL CESSATION

An intoxicated patient with a history of seizures or DTs seeking alcohol cessation should be held until they can safely be provided with loading doses before discharge. Ideally, withdrawal management will start in the ED for all patients; however, intoxicated patients without a history of seizures or DTs and without major medical comorbidities can be transferred to a withdrawal management unit once the reason for their ED visit has been addressed. If considering a discharge home for a low-risk patient, ensure they have a reliable support person to monitor them.

MONITORING

The **CIWA-Ar** is a well validated scale that can be used to monitor alcohol withdrawal in a frequency that matches the severity of the patient's symptoms:

- CIWA-Ar < 10 (mild withdrawal): q 60–120 min
- CIWA-Ar 10–19 (moderate withdrawal): q 60 min
- CIWA-Ar ≥ 20 (severe withdrawal): At minimum q 30–60 min

Definitive signs of severe withdrawal:

- Signs of autonomic hyperactivity: Profuse sweating, severe tremor, repeat vomiting, SBP > 180 DBP > 110, HR > 120 bpm, arrhythmia, T > 37.5 C
- Hallucinations, psychomotor agitation, confusion, disorientation, delusions, withdrawal seizures, DTs

EFFECTIVE TREATMENT OF WITHDRAWAL

Oral loading doses should be given to patients with a history of withdrawal seizures or DTs:

- Diazepam 20 mg PO OR lorazepam 4 mg PO every 1 hour x 3

Patients should be managed with **symptom-triggered treatment:**

- For CIWA ≥ 10 give diazepam 20 mg PO
- Patients presenting with severe withdrawal should be started with IV dosing
- Lorazepam 2–4 mg PO should be used in those with cirrhosis and when there is a higher risk for benzodiazepine toxicity, including the frail elderly, those on high doses of opioids, and those with liver or respiratory impairment
- Patients with decompensated cirrhosis or severe respiratory impairment require even lower lorazepam doses (i.e., 0.5–1 mg PO per dose)
- Lower oral doses can be used with clinical judgment (e.g., no definitive signs of alcohol withdrawal such as tremor are yet present)

If no response after diazepam 80 mg or lorazepam 16 mg, consider the following:

- Double the oral dose: Diazepam 40 mg PO per dose or lorazepam 8 mg PO per dose
- IV dosing: Diazepam 10 mg IV or lorazepam 2 mg IV every 10 minutes
- Phenobarbital

Lower IV doses of lorazepam should be used if the patient is at high risk for benzodiazepine toxicity.

DISCHARGE PRESCRIPTIONS FOR WITHDRAWAL

If CIWA-Ar < 10 on 2 consecutive assessments, an outpatient script for withdrawal management is not needed as diazepam has a long duration of action.

If patient is still in mild withdrawal on discharge, consider gabapentin 300 mg PO three times daily for 14 days.

If diazepam or lorazepam is prescribed, consider a short prescription (i.e., 2–3 days) with daily dispensing or dispensing to a support person.

ANTI-CRAVING MEDICATIONS

Offer all patients **naltrexone**, **acamprosate**, and/or **gabapentin**.

Naltrexone is indicated for most patients. Acamprosate is useful when a patient has liver dysfunction or opioid use. Gabapentin is useful when there is no medication coverage or if the patient has ongoing withdrawal at discharge.

BRIEF INTERVENTIONS FOR ALCOHOL USE

Engage in a brief negotiated interview (**BNI**) with patients with alcohol-related presentations:

1. Establish rapport and ask permission to discuss alcohol consumption and its possible consequences.
2. Provide feedback on the patient's drinking levels and make a connection to the ED visit.
3. Enhance motivation to reduce drinking by asking how ready on a scale of 1–10 the patient is to change any aspect of their drinking.
4. Negotiate goals and advise a plan of action.

Connection to community addiction services

Connect the patient to a peer support worker, social worker, substance use navigator, addiction service worker, mental health counselor, or health promotion advocate if available.

Arrange follow-up care: RAAM clinic, primary care, withdrawal management, psychiatric services, etc.