Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-Ar) Training Tool

Alcohol withdrawal can lead to poor patient outcomes including death if not assessed and managed properly. Emergency department (ED) staff are empowered and accountable for autonomously initiating the **CIWA-Ar tool (10-item standardized scale for assessing alcohol withdrawal)** when alcohol withdrawal symptoms are assessed.

Harm and stigma reduction = Changing our language: Due to stigma and negative connotations associated with the term *alcoholic*, remember to use *alcohol use disorder (AUD)* when speaking with your patient and documenting.

PEARLS OF RECOGNIZING ALCOHOL WITHDRAWAL

This is most likely in a person that reports heavy daily alcohol consumption with a recent reduction in use. Withdrawal patterns repeat themselves. If they have had severe withdrawal before, they are likely to have it again.

Signs and Symptoms:

- Nausea and/or vomiting
- Tremors
- Anxiety and/or agitation
- Paroxysmal sweats
- Disorientation
- Tactile, auditory, and/or visual disturbances
- Headache

Always wake the patient for the assessment. Withdrawal can progress while sleeping. If not fully awake, scoring may be low while withdrawal symptoms are actually more severe.

Alcohol withdrawal **tremor** is a postural-type tremor that occurs in the hands. It is not a resting tremor, as is seen in Parkinson's. In an alcohol withdrawal tremor, with the arms extended and fingers spread, you will see a tremor that is constant and does not fatigue.

Different withdrawal treatment and reassessment recommendations are required for each scoring range:

- < 10 Mild withdrawal
- 10-19 Moderate withdrawal
- ≥ 20 Severe withdrawal

Pharmacology Treatment:

Benzodiazepines treat the symptoms of alcohol withdrawal and prevent complications of alcohol withdrawal such as seizures. Diazepam is the drug of choice because of its long half-life (96 hours). Lorazepam is preferred in cases where patients have clinical evidence of severe liver dysfunction, severe respiratory impairment, in the elderly, and those on high doses of opioids. These medications can be administered orally or intravenously, with intravenous push being the quickest route to administer medication to a patient in severe withdrawal.

ED Reassessments:

Mild Withdrawal (CIWA-Ar score less than 10)	**Moderate Withdrawal** (CIWA-Ar score 10–19)	**Severe Withdrawal** (CIWA-Ar score greater than or equal to 20)
Reassess CIWA-Ar score and vital signs **q 60–120 mins**	**Reassess** CIWA-Ar score and vital signs **q 60 mins**	**Reassess** CIWA-Ar score and vital signs **at minimum q 30–60 mins**

CIWA-Ar Category	Tips for Accurately Scoring
Nausea/vomiting (0 – 7): 0 - none; 1 - mild nausea, no vomiting; 4 - intermittent nausea; 7 - constant nausea, frequent dry heaves & vomiting	**Ask:** "Do you feel sick to your stomach? Have you vomited?" **Examples:** Score 2 – patient may rate their nausea severe, but appears comfortable and is eating/drinking well Score 5 – patient reports nausea, has a bin/bag ready in case of vomiting, and may request an antiemetic
Tremors (0 – 7): 0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended0	**Ask:** "Hold your arms out in front of you and spread your fingers apart." **Examples:** "Hold this glass of water in front of you, and then take a drink from it." Score 0 – able to complete task without tremor Score 1 or 2 – able to complete the task with fine tremor noticed Score 3 or 4 – able to complete the task with difficulty or some spilling, noticeable tremor Score 5 or 6 – difficulty completing the task, two hands used to hold the cup Score 7 – unable to complete the task, water may be spilt when holding the cup
Anxiety (0 – 7): 0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state	**Ask:** "On a scale 0 to 7, 0 being calm and 7 being a panic attack, how anxious are you feeling?" **Examples:** Score 2 – patient rates anxiety severe, but they appear calm and are cooperative, normal vital signs Score 5 – patient may be defensive and has difficulty concentrating on the conversation
Agitation (0 – 7): 0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about	*Though you may ask if they feel agitated, this is best observed in their activities.
Paroxysmal sweats (0 – 7): 0 - no sweats; 1 - barely perceptible sweating, palms moist; 4 - beads of sweat obvious on forehead; 7 - drenching sweat	*Paroxysmal means occurring periodically. If a patient is actively sweating, document the severity. If a patient is not actively sweating, document what they describe as their severity. **Examples:** Score 5 – "I was sweating on and off all night long" but not actively sweating Score 7 – Beads of sweat visible on forehead, shirt/gown drenched due to active sweating
Orientation (0 – 4): 0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days; 4 - disoriented to place and/or person	**Ask:** "Who am I? What year is it? Where are you right now?"
Tactile disturbances (0 – 7): 0 - none; 1 - very mild itch, P&N; 2 - mild itch, burning, P&N; 3 - moderate itch, P&N, burning; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations	**Ask:** "Do you have any itching, burning, numbness, pins/needles on your skin, that isn't usually there? Do you feel like bugs are crawling on/under your skin?" **Examples:** Score 2 – patient may be intermittently itching their skin Score 5 – seeing bugs on their skin, and continuously itching Score 7 – disturbed by seeing bugs on their skin and not being able to focus on the conversation
Auditory disturbances (0 – 7): 0 - not present; 1 - very mild harshness/ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations	**Ask:** "Is the sound of my voice bothering you? Are you hearing anything that you know isn't there?" **Examples:** Score 3 – patient reports sensitivity and is jumpy to noises like talking or doors shutting Score 4 – patient reports hearing things, but they are not bothered by it Score 7 – patient hears voices continuously, may respond to them, and cannot focus on the conversation
Visual disturbances (0 – 7): 0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations	**Ask:** "Are you more bothered by the light than usual? Are you seeing colours differently? Are you seeing anything that you know isn't there? Are you seeing anything that is frightening or disturbing you?" **Examples:** Score 1 – patient complains of bright lights, but appears comfortable Score 4 – patient keeps their eyes closed or covered with hat/glasses Score 7 – patient is seeing other things/people, may be interacting with them, and cannot focus on the conversation
Headache (0 – 7): 0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe	**Ask:** "Does your head feel different? Do you have a tight band around your head? Do you have a headache?" *Do not rate dizziness or light-headedness. **Examples:** Score 1 – patient rates their headache moderate, but shows no discomfort Score 5 – patient reports a severe headache, appears uncomfortable, and may hold their head Score 7 – patient reports severe headache, unable to concentrate, keeps eyes closed, appears in pain, and holds their head