Clinical Pathway for Medical Management of Alcohol Withdrawal in WMS

Client presents with alcohol use disorder

Are loading doses required?
Does the client have a history of withdrawal complications such as seizures or delirium tremens, hallucinations or hospitalization for severe withdrawal?

Withdrawal typically begins 6-12h after the last drink. A protocol should typically begin within 6h of intake.

YES / NO

Are skilled staff available for monitoring and managing potential complications?

***In people who drink heavily, complications can occur as alcohol levels decrease. Aim to begin loading doses between intoxication and withdrawal.**

YES / NO

- Oral diazepam **20mg** (lorazepam **2-4mg**) q1–2h x3 or until lightly sedated and has minimal to no tremor.
- Consider following this with symptom-triggered or fixed dosing as needed.

Send client to ED for stabilization

Is a symptom-triggered regimen possible?
- Skilled staff is available to implement a symptom-triggered regimen

YES / NO

Complete CIWA-Ar q1–2h
- Administer diazepam **10-20mg/lorazepam 1-2mg** when CIWA-Ar ≥ 10 or client presents with definite tremor or profuse sweating
- Continue until CIWA < 8 x 2 consecutive assessments AND minimal to no tremor

*If unsure if withdrawal is fully resolved, this can be followed by 1-2 days of diazepam **10mg** (lorazepam **1mg**) q4h PRN for tremor

Use a fixed-dose tapering regimen
- Only use if staff skilled in implementing a symptom-triggered regimen are not available

YES

Diazepam **10mg** QID (lorazepam **1-2mg** QID) on day 1. Taper over 4-5 days. Hold any dose if sedated/drowsy.

*See alcohol withdrawal order set for example regimens

*Consider starting with diazepam **20mg** QID with a history of severe withdrawal, or known high tolerance to benzodiazepines

To prevent Wernicke-Korsakoff Syndrome, provide thiamine:
- **300mg** IM/IV for 3-5 days (**100mg** PO TID for 3-5 days if IM/IV are unavailable)
- THEN **100mg** PO OD-TID for 2-3 weeks

MONITORING PROTOCOL

Complete the initial assessment and then assess according to symptoms & scoring:

Severe withdrawal **Monitor q1h**
CIWA-Ar ≥ 20, severe tremor, or profuse sweating

Moderate withdrawal **Monitor q2h**
CIWA-Ar 10-19, moderate tremor or sweating

Mild withdrawal **Monitor q4h**
CIWA-Ar 0-9, mild tremor
BP, HR, T, RR, Sp02 with each assessment

TRANSFER TO EMERGENCY DEPARTMENT IF:

- Tremor not improving/worsening despite **80mg** diazepam (**8mg** lorazepam)
- Tachycardia (HR > 120bpm) or hypertension (elevation of systolic or diastolic BP 20-30mmHG above baseline)
- Repeated vomiting or profuse sweating
- Seizures, confusion, hallucinations, delusions, or agitation

USE LORAZEPAM IF:

- Taking opioids/sedating medications
- Severe liver dysfunction (cirrhosis, severe hepatitis)
- Low serum albumin
- Respiratory failure or distress (severe asthma, COPD, pneumonia)
- Age 60+

GABAPENTIN

Consider gabapentin in place of benzodiazepines when the client is taking opioids/sedating medications, has severe liver dysfunction, low serum albumin, respiratory failure or distress, or is 60+. Gabapentin is **not proven** to be effective against alcohol withdrawal seizures. Use this protocol only when low risk of seizures, DTs, or severe withdrawal.

Gabapentin for acute withdrawal:
Days 1-3: **300mg** QID +/- **300-600mg** hs
Day 4: **300mg** TID +/- **300mg** hs
Day 5: **300mg** BID
Day 6: **300mg** hs

When benzodiazepines are utilized, consider switching to gabapentin from day 3 on, as a benzodiazepine-sparing method, for management of post-acute withdrawal and as an anti-craving medication.

Gabapentin for post-acute withdrawal:
Day 3: **300mg** hs
Day 4: **300mg** BID
Day 5: **300mg** TID
Continue to titrate to effect, max recommended dose **1800mg**/day