Special Considerations

CHRONIC HEALTH CONDITIONS

Chronic health conditions can be a risk factor for complications of withdrawal. The severity of the health condition and associated factors that can complicate withdrawal should be used to determine the level of monitoring. Clients with uncontrolled or severe illnesses such as cardiovascular disease, liver diseases, COPD, or renal impairment should have their withdrawal symptoms managed in a hospital setting. Clients with controlled medical illness can be managed in WMS with medication protocol modification in consultation with specialists as required.

CARDIAC DISORDERS

- Initiate aggressive withdrawal treatment measures to prevent the exacerbation of cardiac disorders due to autonomic hyperactivity associated with alcohol withdrawal.

LIVER DISEASES

- Caution should be taken when prescribing to individuals with severe liver disease or dysfunction such as cirrhosis:
  - Because of diazepam's hepatic metabolism, lorazepam is the preferred benzodiazepine in these clients.
  - Gabapentin can be used when benzodiazepines are contraindicated because it has no appreciable hepatic metabolism.

CHRONIC PAIN

- Clients with high-risk prescription medications for chronic pain management (opioid and non-opioid, e.g., gabapentin) should be assessed for potential harm.
- Clients on moderate therapeutic doses of opioid or non-opioid medications for chronic non-cancer pain should be maintained on their current dose if the prescription is not causing harm.
- Clients on high opioid doses at potential risk (e.g., requiring high doses of benzodiazepines to manage alcohol withdrawal) should be tapered within safe prescribing guidelines. Consider following the Management of Chronic Non-Cancer Pain Guideline of 90 morphine milligram equivalents (MME) as a safe upper limit for opioid prescriptions.
- When there is potential harm, the benefits and risks of continued use, taper, abrupt cessation, or rotation to a different medication should be explored.

COMPLICATIONS OF ALCOHOL WITHDRAWAL

SEIZURES

- The highest risk for alcohol withdrawal seizures is during the first 72 hours from last drink, though they can occur anytime in the first week after alcohol cessation. Though the onset of withdrawal is typically six to twelve hours from the last drink, clients with a history of recurrent withdrawal seizures and/or high levels of consumption can have seizures occur even earlier, while their blood alcohol level is still elevated but dropping.
- Withdrawal-related seizures are usually, but not always, proceeded by autonomic hyperactivity such as sweating and tremor, and are generalized, brief, and typically without a post-ictal phase. Withdrawal-related seizures are not a risk for chronic seizure disorder.
- Benzodiazepines are the only evidence-based prevention and treatment for alcohol withdrawal seizures, though anticonvulsants can be used as adjunct treatment for management of withdrawal.
- Clients with a history of alcohol withdrawal seizures are at risk for recurrent alcohol withdrawal seizures and should receive loading doses of benzodiazepines (e.g., diazepam 20 mg every hour for three hours or until lightly sedated with minimal to no tremor) as early as possible in their presentation as blood alcohol levels lower and they move into withdrawal. If loading doses cannot be accommodated, clients should be transferred to the emergency department for this care and can be returned to WMS once loading doses are completed.

ALCOHOLIC HALLUCINOSIS

- Alcoholic hallucinosis presents as predominantly visual hallucinations without a clouding of the sensorium. Consider other diagnoses (such as schizophrenia) for reports of auditory or command hallucinations.
- Alcoholic hallucinosis presents within twelve to 24 hours from the last drink, and typically resolves within 48 hours.
- Appropriate treatment of alcohol withdrawal will typically resolve alcoholic hallucinosis, though addition of antipsychotics can be added if required for distressing or persistent hallucinations. Caution is required when using antipsychotics while the client is in moderate to severe alcohol withdrawal, as both antipsychotics and withdrawal can cause QT prolongation; first-generation antipsychotics pose the greatest risk.

DELIRIUM TREMENS

- Delirium tremens (DTs) presents with confusion and disorientation. It is typically preceded and accompanied by autonomic hyperactivity such as tachycardia, hypertension, tremor, low-grade fever, agitation, and diaphoresis. It usually begins three to five days from the last drink, following several days of severe withdrawal.
- The mortality rate for DTs has declined over time with fast and appropriate access to treatment but can range from 1–15%, with higher risk for those with older age or concomitant conditions.
- Risk factors for DTs include a history of sustained drinking, a history of seizures or DTs, recent withdrawal seizures, older age, use of sedating medications, concurrent medical illness (such as pneumonia), and a high CIWA-Ar score (unrecognized or undertreated withdrawal).
- Clients with suspected or confirmed DTs should be transferred to the emergency department.
- Early and aggressive benzodiazepine treatment has been shown to reduce the duration of DTs and reduce the need for intubation and ICU admission.

WERNICKE'S ENCEPHALOPATHY

- Wernicke's encephalopathy presents with confusion, ataxia (slow, unsteady gait), and ocular abnormalities (double vision, nystagmus, or paralysis of ocular muscles). Diagnosis can be difficult in clients who are intoxicated or in withdrawal.
- If left untreated, this can lead to Wernicke-Korsakoff Syndrome, resulting in a chronic memory deficit usually affecting short-term memory.
- Risk factors include poor diet, poor absorption (e.g., gastric bypass), and liver disease.
- Wernicke's can be prevented by routinely administering thiamine; the usual dose is 300 mg IM or IV (to bypass poor gastric absorption). Higher doses of 500 mg IM or IV at least twice daily are needed for treatment. Clients should be prescribed oral thiamine 100 mg once daily for at least one month post-discharge.

OLDER ADULTS

Older adults require specialized screening for the following unique concerns:

ISOLATION

- Ask older adults about support and connections with family, friends, and/or community. Limited social interactions are a risk factor for mental health and substance-related concerns. Make onsite connections or offer referrals to social work, personal support work, and/or other services to help build social connections.

RENAL FUNCTION

- Renal clearance declines with age and can be affected by other health conditions and medications. As many medications are renally cleared, Cr and GFR should be ordered. Consider the use of a renal adjustment calculator to determine appropriate dose adjustments.
- Acamprosate requires dose adjustment with CrCl 30–50 ml/min to 333 mg (one tab) three times daily.

MEDICATION INTERACTIONS

- Many older adults will be on multiple medications, both prescription and non-prescription. It is important that all medications be checked for drug-drug interactions.

SEDATION AND FALL RISK

- Special caution should be taken when adding medications that can cause sedation due to the increased risk of falls. Ensuring that clients have access to their mobility devices will help to decrease the risk of falls. It is important to ensure an assessment of the individual's mobility needs prior to the admission.
- Diazepam has a long half-life; due to decreased hepatic metabolism, diazepam increases the risk of sedation in older adults. Consider the use of lower-dose lorazepam when benzodiazepines are required.

PREGNANCY

Substance withdrawal poses great risks during pregnancy. Some of these risks include dehydration, hypertension, miscarriage, and premature birth.

ALCOHOL WITHDRAWAL

Pregnant people with moderate to severe alcohol withdrawal (CIWA-Ar ≥ 10) should be managed in an inpatient setting where they can receive symptom-triggered treatment with close monitoring. Based on the stage of pregnancy, fetal heart rate monitoring may be warranted for early detection of fetal distress. If pregnant people with mild alcohol withdrawal are managed in a WMS, consultation with a provider specialized in addictions and obstetrical care is highly recommended.

Consider the following general guidelines for management of alcohol withdrawal in pregnancy:

- Gabapentin can be utilized when there is a low risk for withdrawal complications.
- Long-acting benzodiazepine can be used for a short duration in pregnancy except in the late third trimester; use short-acting benzodiazepine in the late third trimester to minimize benzodiazepine intoxication in the newborn.
- Naltrexone and acamprosate are both FDA pregnancy category C, with no human trials completed. We recommend contacting an addiction and obstetrics specialized clinician for further advice on anti-craving medication in pregnancy.

OPIOID WITHDRAWAL

Consultation with a provider specializing in addictions and obstetrical care is highly recommended for the management of opioid withdrawal in pregnancy.

Opioid withdrawal should be avoided during pregnancy, as it can cause fetal distress; OAT should be offered urgently to all pregnant clients in withdrawal. Buprenorphine/naloxone and methadone should be considered; choice should be based upon client presentation, history, preference, and accessibility. Consider short-term hospitalization to expedite OAT initiation and titration, and for safe monitoring of both the client and the fetus during this process.

YOUTH

Youth with addictions are greatly underserved in Ontario. Because of the specific criteria for substance use disorder in the DSM-5, many adolescents and young adults go undiagnosed.

- Substance use predisposes youth to relationship difficulties, trouble in school/work, and homelessness. A full biopsychosocial assessment should be completed for every youth seeking care.

- Youth are at high risk for polysubstance and binge use of their substances of choice. This complicates intoxication and withdrawal presentations and management. Toxicology can be useful in determining substances exposure and developing an appropriate care plan.
- Having a peer support worker specifically for youth can help to reduce barriers to care by meeting clients where they are at in their journey and offering appropriate harm reduction services, community connections, and accessible information..

Unfortunately, there are limited residential withdrawal management centers in Ontario that admit youth. Each facility should assess their resources and make every attempt to safely accommodate youth when they are able to do so.

POLYSUBSTANCE WITHDRAWAL

Clients may present with concurrent substance use disorders and polydrug withdrawal. There is commonly overlap in withdrawal symptoms from different substances, and this overlap can increase the severity of withdrawal experienced. This overlap also means that withdrawal monitoring scales, such as the CIWA-Ar, should not be solely relied upon, as their accuracy decreases (e.g., tremor can be from opioid or alcohol withdrawal if occurring concurrently). For this reason, closer monitoring of clients with polydrug withdrawal is needed; they may require transfer to a higher-care facility such as the hospital. The inaccuracy of monitoring scales decreases the effectiveness of symptom-triggered regimens, and fixed dosing regimens with increased monitoring is recommended.

It is important to prioritize withdrawal from the substance with the greatest risk for complications and severe withdrawal. This usually means prioritizing alcohol withdrawal, as it presents with risks such as withdrawal seizures, delirium tremens, and Wernicke's encephalopathy.

The experienced clinician may initiate treatment for non-prioritized substances (e.g., methadone, buprenorphine/naloxone, NRT, or benzodiazepines) while managing the prioritized substance. However, caution should be taken when combining two substances with the risk of sedation and respiratory depression such as methadone and benzodiazepines (e.g., start and remain at methadone 10–20 mg while benzodiazepines are provided for alcohol withdrawal).

ALCOHOL AND OPIOIDS

- Clients are at increased risk of sympathetic stimulation and dehydration from excessive vomiting/diarrhea.
- Management of opioid use disorder requires OAT; relief of opioid withdrawal may help to reduce alcohol consumption.
- Caution should be taken when combining two medications with the risk of sedation and respiratory depression such as methadone and benzodiazepines.
- Management considerations:
  - Clients on opioids or OAT should not be started on naltrexone as an anti-craving medication for alcohol use, given the risk for precipitated withdrawal. Consider acamprosate as an alternative.
  - Benzodiazepines enhance the respiratory suppressing effect of opioid medications; therefore, caution is needed when treating alcohol withdrawal in clients who are taking opioid analgesics, OAT, or unregulated opioids. Shorter-acting benzodiazepines and/or lower doses should be considered.
  - Any ongoing OAT prescriptions should be continued. For clients not already on OAT, consider initiating after management of acute alcohol withdrawal; of the available options, buprenorphine has the best safety profile and is usually the treatment of choice when concurrent withdrawal is being managed.

ALCOHOL AND STIMULANTS

- Clients are at increased risk of severe and protracted withdrawal, anorexia, insomnia, and agitation.
- Management considerations:
  - Higher doses of benzodiazepines may be needed to manage acute withdrawal.

ALCOHOL AND BENZODIAZEPINES

- Clients are at increased risk of delayed alcohol withdrawal onset due to the presence of benzodiazepines, increased severity of symptoms, prolonged course of withdrawal, and increased risk of seizures.
- Management considerations:
  - Higher doses of benzodiazepines may be needed to manage acute withdrawal.
  - Acute withdrawal management should smoothly transition into a benzodiazepine taper. For example:
    - Excessive alcohol use and clonazepam 0.5 mg BID
    - Equivalent to ~15 mg diazepam once daily
    - Provide diazepam 10–20 mg q1h until diminished tremor and/or light sedation
    - Then begin diazepam 5 mg TID–QID for one week and organize an outpatient taper

BENZODIAZEPINE USE

- Clients on moderate, therapeutic doses of benzodiazepines for sleep or anxiety should be maintained on their current dose while in withdrawal management, if the prescription is not causing harm.
- Clients with suspected benzodiazepine use disorder should be offered a medically supervised benzodiazepine taper, with the knowledge that the taper will need to be finalized during the outpatient phase of treatment over weeks or months.
- Clients with concurrent benzodiazepine use disorder experiencing alcohol withdrawal are likely to require higher doses of benzodiazepines for the management of alcohol withdrawal. Benzodiazepine taper can begin once acute alcohol withdrawal is managed.
- Clients with concurrent benzodiazepine dependence and opioid withdrawal will require lower starting doses of opioid replacement therapy (e.g., buprenorphine/naloxone starting dose of 2 mg and methadone starting dose of 10–20 mg) and closer monitoring for respiratory depression and sedation.