Alcohol Withdrawal for Nursing

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Learning Objectives

- Understand the withdrawal process for alcohol
- Feel competent in doing a Clinical Institute Withdrawal Assessment (CIWA)
- Identify red flags for when alcohol withdrawal may be severe and life threatening

Disclosures/ Conflicts of Interest

None

Destigmatizing language

- A person with a substance use disorder (SUD)
- Recovery/ remission (>5 years of recovery)
- Recurrence of symptoms or return to use/ drinking
- Use of a not/non prescribed substance
- Medications for Opioid Use Disorder (MOUD)

- Addictionary® – Recovery Research Institute (recoveryanswers.org)

ALCOHOL WITHDRAWAL

Epidemiology

Alcohol use disorder in about 14 percent of the population.

About 50 percent of patients with AUD will experience withdrawal if they stop drinking

20% of patients experience severe withdrawal symptoms, 5% experience DTs

? Genetic predisposition

A few weeks of heavy, consistent use can be enough

UpToDate. (n.d.). Www.uptodate.com. Retrieved February 23, 2024, from https://www.uptodate.com/contents/alcohol-withdrawal-epidemiology-clinical-manifestations-course-assessment-and-diagnosis?search=alcohol%20withdrawal&source=search_result&selectedTitle=2%7E150&usage_type=default&display_rank=2

Withdrawal Process

- Typically begin 6-24h from last drink (can be while still have + blood alcohol), typically resolved by day 5-7
- Alcohol enhances inhibitory tone and inhibits excitatory tone-
  - GABA insensitivity from chronic alcohol use helps people with AUD stay alive/ not lethargic at high alcohol levels
  - Glutatmate receptors increase in chronic alcohol use causing unregulated excess excitation
  - Dopamine affects as well
- Chronic alcohol use ends up creating a new homeostasis
- Abrupt cessation causes overactivity of the central nervous system

Risk Assessment

If no symptoms in first 24h, unlikely to develop

Prediction of Alcohol Withdrawal Severity Scale – MDCalc

Delirium Tremens and seizures can be fatal- common cause for ICU admissions

Alcohol Withdrawal Seizures

- Most likely in the first 12-48 hours after last drink, can be earlier
- Typically after long/ heavy alcohol use
- Most common onset in 40s and 50s
- Typical seizure medications not effective
- Phenobarbitol, benzodiazepines and propofol are treatments of choice
- If untreated can lead to delirium tremens

Alcoholic Hallucinations

- Typically in 12-24h since last drink and resolve by 48h
- Visual most likely but all types possible
- Can be a sign of progression to delirium tremens
- Difficult to treat- consider antipsychotics but ideally would have DTs ruled out and electrolytes corrected and consider an EKG to rule out QT prolongation first

Delirium Tremens

- Clarify diagnosis- many patients equate this with tremors!
- High risk to have again if they have had in the past or have had delirium or seizures with w/d before
- Typically starts between 48h and 96h since last drink
  - Most patients have had at least SOME withdrawal symptoms prior
- Diagnositc symptoms are hallucinations, disorientation, tachycardia, hypertension, hyperthermia, agitation, diaphoresis
  - Ultimately hyperventilation and respiratory alkalosis decrease blood flow to the brain
- Likely co-occurring metabolite abnormals (mag, potassium, phosphate)
- Risk factors: >65 yo, concurrent illness, comorbid conditions, benzo use
- Mortality risk: elevated for the elderly, if pre-existing cardiopulm disease or liver disease

Clinical Institute Withdrawal Assessment Scale for Alcohol (CIWA-Ar)

- **Take into consideration someone's baseline- the score should be related to the alcohol withdrawal**
- **< 7: minimal withdrawal**
- **8-15: moderate withdrawal**
- **>15: severe withdrawal**

Nausea

Do you feel sick to your stomach and have you vomited?

0 – No nausea and no vomiting

1 – mild nausea with no vomiting

2,3,4 – intermittent nausea with dry heaves

5,6,7 – constant nausea, frequent dry heaves and vomiting

Sensory

Do you have any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?

0 – No tactile disturbances
1 – very mild itching, pins and needles, burning or numbness
2 – mild itching, pins and needles, burning or numbness
3 – moderate itching, pins and needles, burning or numbness
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continual severe hallucinations

Tremor

Observe tremors in the patient by having the patient extend their arms and spread their fingers.

0 – no tremor

1 – not visible, but can be felt fingertip to fingertip

2,3,4 – moderate, with patient's arms extended

5,6,7 – severe, even with arms not extended

Auditory

Are you hearing things you know are not there? (And other related questions)

0 – not present
1 – very mild harshness or ability to frighten 2 mild harshness or ability to frighten
3 – moderate harshness or ability to frighten
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Sweats

Paroxysmal Sweats — Observation.

0 – no sweat visible

1 – barely perceptible sweating, palms moist

2,3,4 – beads of sweat obvious on forehead

5,6,7 – drenching sweats

Hallucinations

Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?

0 – not present
1 – very mild sensitivity
2 – mild sensitivity
3 – moderate sensitivity
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

Anxiety

Do you feel nervous?

0 – no anxiety, at ease

1 – mild anxious

2,3,4 – moderately anxious, or guarded, so anxiety is inferred

5,6,7 – equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

Headache

Does your head hurt or feel different? Does it feel like there is a band around your head?

0 – no present
1 – very mild
2 – mild
3 – moderate
4 – moderately severe
5 – severe
6 – very severe
7 – extremely severe

Agitation

Observation.

0 – normal activity

1 – somewhat more than normal activity

2,3,4 – moderately fidgety and restless

5,6,7 – paces back and forth during most of the interview, or constantly thrashes about

Orientation

What day is this? Where are you? Who am I?

0 – oriented and can do serial additions

1 – cannot do serial additions or is uncertain about date

2 – disoriented for date by no more than 2 calendar days

3 – disoriented for date by more than 2 calendar days

4 – disoriented for place/or person

Treatment

- Typically with benzodiazepines or phenobarbital
- Benzodiazepines most frequently given based on CIWA score- for diazepam starting dose is 5-10mg and escalates with CIWA score
- Benzo sparing protocols can include a scheduled gabapentin taper
- Can be done outpatient with close monitoring if low risk for severe symptoms

Symptomatic Treatment

- Nausea: ondansetron, promethazine
- Anxiety: hydroxyzine, clonidine
- Insomnia: trazodone, melatonin
- Pain: acetaminophen, ibuprofen
- Diarrhea: loperamide
- Abdominal cramps: dicyclomine, simethicone
- Reflux: OTC famotidine, omeprazole, calcium carbonates

Possible need for escalation of care:

- Uncontrolled vomiting
- Unstable vital signs
- Hemoptysis
- Hallucinations/ tactile sensations
- CIWA reflecting severe score
- Medications ineffective

Re-eval of Treatment Given

- CIWA score worsening/ no improvement
- Persistent nausea
- Anxiety/ restlessness without improvement
- Threatening to leave/ return to drinking

Why aren't the medications working?

- Dehydration?
- Underlying/ chronic illnesses with poor control?
- Unknown liver disease
- Severe withdrawal

Alcohol Withdrawal in Pregnancy

- Assume symptoms are alcohol withdrawal related
- Consider inpatient strongly- risk of preterm delivery, abruption, fetal distress or demise
- Consult with OB if possible- may require fetal monitoring
- Benzos are med of choice- low fetal risk but some, less risk than continued alcohol use or uncontrolled withdrawal
- Consider reporting requirements
- Link to wrap around services as possible

the_asam_clinical_practice_guideline_on_alcohol-1.pdf (windows.net)

Multi-Substance Use

- Can complicate monitoring withdrawal given similar symptoms to other substance withdrawals
- High risk if also has benzo withdrawal risk
- If significant benzo history may have some benzodiazepine tolerance
- Relief seeking behavior

Withdrawal with Comorbid Medical Conditions

- Diabetes:
  - Depending on fragility and type can see massive fluctuations in normal trend
- Mental Health/ Insomnia
- Gastrointestinal diseases
- Cardiopulmonary disease
- Malnutrition

Withdrawal with Comorbid Medical Conditions **Hypertension**

- Recheck if within 30 minutes of smoking
- Need to be seated for 5 minutes prior
- Consider caffeine intake
- Significantly elevated BP is >180 systolic and/or >120 diastolic
  - Monitor for- chest pain, nausea/vomiting, shortness of breath, neuro changes/ mental status changes
- Pregnancy
- Consider baseline/ re-eval after d 5

Withdrawal with Comorbid Medical Conditions- **Cirrhosis**

- May need to consider alternate benzodiazepine if in protocol
- May make it more challenging to treat withdrawal
- Is arguably even more important to get through withdrawal and maintain recovery!

Pyschosocial Withdrawal Management

- Counseling
- Motivational interviewing
- Group meetings
- Peer Support
- Positive medical experience

AFTER WITHDRAWAL

Wernicke's Encephalopathy
&
Korsakoff Syndrome

Wernicke's Encephalopathy:

- Acute condition from thiamine (B1) deficiency
- Symptoms: confusion, gait ataxia, oculomotor dysfunction
- Difficult to dx with laboratory studies
- Treatable with IV thiamine
- Residual effects common
- Oral supplement for prevention

Korsakoff Syndrome:

- Long term memory loss as a result of #1
- Often other cognitive and social processing intact
- Confabulation common
- Irreversible and no medical treatments known

Post Acute Withdrawal Syndrome

- The following 4-6 months
- possible changes in sleep, appetite, gastrointestinal processes, mood
- Likely to improve
- More research needed
- Symptomatic treatment

Long Term AUD Treatment

70% of people return to heavy drinking after psychosocial treatment alone!

Naltrexone

- not if taking opioids or acute hepatitis/ liver failure (>3-5x nml)
- IM or oral
- most common side effects are nausea, headache, dizziness
- can be taken while still drinking
- is effective!

Acamprosate

- alternate first line for folks with liver disease or on opioids

2nd line agents: topiramate, disulfram, off label gabapentin