Alcohol Withdrawal Guidelines: Portland VA Medical Center

I. RATIONALE: The goal of these guidelines is to ensure safe W/D from ETOH, usually completed within 72-96 hours. Patients are at risk for ETOH withdrawal if they abruptly stop or reduce ETOH intake.

II. ASSESSMENT: To determine drinking pattern and risks for withdrawal, we recommend asking:
- How much do you drink?
- How much do you drink every day? When was your last drink?
- Have you ever had trouble with ETOH withdrawal?
- Any history of UGI bleed, pancreatitis, hepatitis or seizures?

III. SIGNS and SYMPTOMS:

- **Moderate**
  - Usually 6-48 hours post cessation
  - Elevated VS
  - Tremor
  - Anxiety
  - Abdominal Cramps

- **Generalized tonic-clonic seizures:** usually within 72 hours.
- **Delirium Tremens (DT's):**
  - Can be seen within 48 hours to 7 days
  - General autonomic hyperarousal
  - Visual hallucinations
  - Changes in level of consciousness
  - Nausea/Vomiting
  - Visual or Tactile Misperceptions
  - Diaphoresis

*Note: DT's are a medical-psychiatric emergency, requiring IV treatment beyond the limits of these guidelines.

IV. VITAL SIGNS:

Common signs of withdrawal include:
- Hypertension
- Tachycardia
- Tachypnea
- Fever

We recommend VS q 4 hours while awake and q2 hours after each benzodiazepine dose (see below). If VS do not improve after medications, consider dosage adjustment, or other etiology.

V. LABS:

Lab abnormalities are noted with both chronic ETOH use and ETOH withdrawal. We recommend:
- BAL – On admit to establish baseline. High levels suggest tolerance, and increased risk for withdrawal
- Urine Drug Screens – To establish presence of other medications with separate withdrawal syndromes
- Admit Panel – May see decreased potassium, glucose, and increased liver function tests (get Hepatitis Screen)
- CBC – Anemia, thrombocytopenia, leukopenia and leukocytosis can occur.
- Mg²⁺ - Levels decrease during withdrawal
- HIV Counseling and testing – if high risk behaviors present

VI. MEDICATIONS:

To prevent withdrawal symptoms, we recommend one of the following benzodiazepines:
- Chlordiazepoxide and Diazepam - Have long half lives.
- Lorazepam – Has a shorter half life, is not liver metabolized (may be safer in geriatric and liver disease patients). The main reason to use Lorazepam is due to reliable IM absorption.

We recommend the following medications for commonly associated problems:
- Thiamine – Give before IV fluid, to prevent Wernicke’s encephalopathy
- Folate and multivitamin – For poor nutritional state

VII. Disposition: If patient has an ETOH problem, begin education and consider consult by Social Work for referral to appropriate treatment resource.
ALCOHOL DETOX ORDERS: Portland VA Medical Center

1. VS Q 4 Hrs while awake, and 2° after each benzodiazepine dose.

   Call HO if:
   - SBP > 180 or < 90
   - DBP > 110 or < 50
   - Pulse > 120 or < 55
   - RR > 35 or < 10
   - Temp > 101.5 degrees or 38° C

2. Labs/Tests (if not already done, and if applicable):
   - Blood Alcohol Level (BAL)
   - UA
   - Urine drug screen
   - CBC
   - Admit Panel
   - Mg²⁺
   - Hepatitis Screen
   - Other

3. check if needed: Place PPD with controls

4. Benzodiazepine (choose one):
   - Lorazepam 0.5-2mg/PO/IM q 2-4° PRN SBP > 170 or DBP > 105 or P> 115, NTE 10 mg/24° – hold dose and call HO for oversedation.
   - Chlordiazepoxide 25-100 mg PO q 2-4° PRN SBP > 170 or DBP > 105 or P > 115, NTE 400 mg/24° – hold dose and call HO for oversedation.
   - Diazepam 5-10 mg PO q 2-4° PRN SBP > 170 or DBP > 105 or P>115, NTE 50 mg/24° – hold dose and call HO for oversedation

5. Thiamine 100 mg PO/IM q d X 3
6. Folate 1 mg PO q d
7. Multivitamin 1 PO q d
8. Social work consult for referral to appropriate treatment resources