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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

AMBULATORY ALCOHOL WITHDRAWAL MANAGEMENT

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AGENDA

- Intro to Alcohol Withdrawal
- Alcohol Withdrawal Management
- Risk Stratification & Ambulatory Candidate Selection
- Ambulatory Alcohol Withdrawal Protocols
- Cases / Discussion
- Summary

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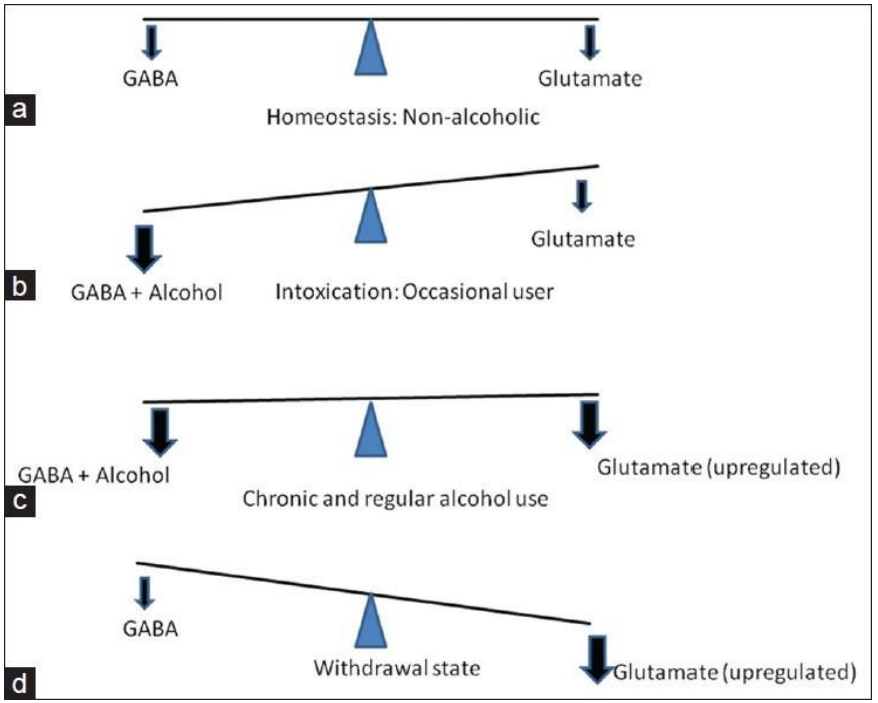
INTRO: ALCOHOL WITHDRAWAL SYNDROME (AWS)

- AWS—physical and psychological effects that occur when reducing or stopping alcohol use



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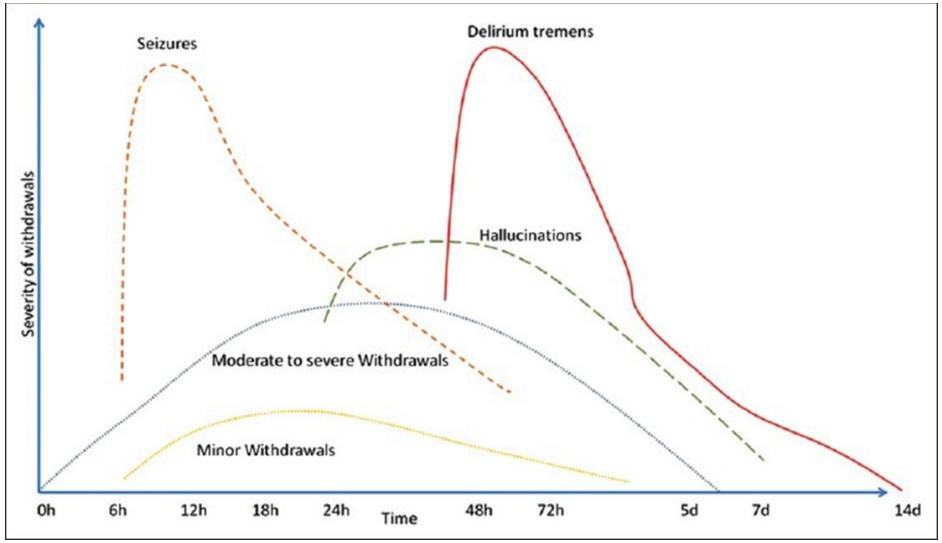
ALCOHOL WITHDRAWAL SYNDROME (AWS)

Timing of alcohol withdrawal syndromes

Syndrome	Clinical findings	Onset after last drink
Minor withdrawal	Tremulousness, mild anxiety, headache, diaphoresis, palpitations, anorexia, gastrointestinal upset; normal mental status	6 to 36 hours
Seizures	Single or brief flurry of generalized tonic-clonic seizures, short postictal period; status epilepticus rare	6 to 48 hours
Alcoholic hallucinosis	Visual, auditory, and/or tactile hallucinations with intact orientation and normal vital signs	12 to 48 hours
Delirium tremens	Delirium, agitation, tachycardia, hypertension, fever, diaphoresis	48 to 96 hours



Signs	Symptoms
Elevated blood pressure	Anxiety
Tachycardia	Insomnia
Elevated body temperature	Illusions
Sweating	Hallucinations
Tremulousness of body/increased hand tremor	Paranoid ideas
Dilated pupils	Nausea
Disorientation	Irritability
Hyper arousal	
Grand mal seizure	

+Cravings

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DIAGNOSING ALCOHOL WITHDRAWAL SYNDROME

- Clinical diagnosis

CIWA-Ar Score estimates severity:

- 1-9 = **MILD**
- 10-15 = **MODERATE**
- 16+ = **SEVERE**

- Complicated withdrawal: hallucinations, sz, DT

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ALCOHOL WITHDRAWAL MEDICAL ASSESSMENT

- History:
  - Confirm AUD dx, Duration, Drinking Pattern, Last Drink, Withdrawal Hx/Tx
  - Medical Hx
- Physical Exam w/VS
- Labs: CBC w/dif, liver fn, renal fn, electrolytes, UDAS or BAL
- CIWA-Ar

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RISK FACTORS FOR SEVERE & COMPLICATED WITHDRAWAL

- Hx of complicated AWS (hallucinations, seizures, DTs)
- Numerous prior withdrawal episodes (KINDLING)
- Long duration of regular heavy EtOH consumption
- Concurrent heavy use or w/d from multiple substances
- Other acute medical or surgical illness
- Traumatic brain injury
- Unstable seizure disorder
- Age >65

ADDITIONAL RISK STRATIFICATION

- Reliable means of communicating w/patient
- Ability to attend clinic daily if needed for up to 5 days
- Supportive person to assist / monitor
- Physical Safety
- Ability to take adequate PO

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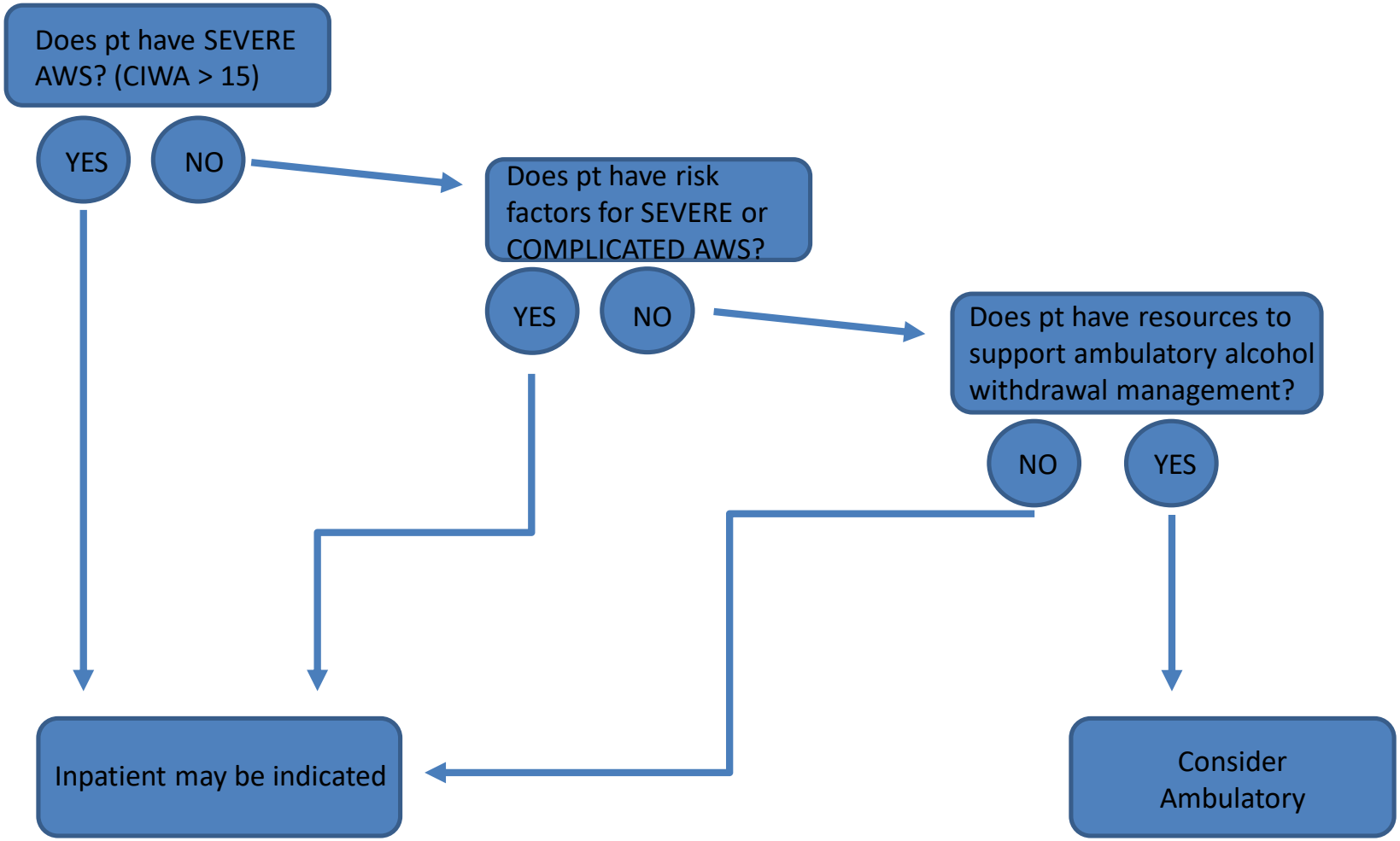

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MANAGING ALCOHOL WITHDRAWAL SYNDROME

1. Daily Contact w/Clinic (up to 5 days)
   - Physical assessment, VS, safety, substance use

2. Medication Regimen:
   - Gabapentin (scheduled), Monotherapy
   - Gabapentin (scheduled) + Lorazepam PRN
   - Librium taper (scheduled)
   - Lorazepam taper (scheduled)

3. Supportive Tx Measures:
   - Nutrition, Hydration
   - MVI, Thiamine

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AMBULATORY WITHDRAWAL MEDICATION REGIMENS

Gabapentin monotherapy:

- Day 1: 300mg TID
- Day 2: 600mg TID
- If tolerated, continue at 1800mg TDD for protracted withdrawal

Gabapentin w/PRN lorazepam:

- Same as monotherapy, PLUS
- Lorazepam 1mg Q6h PRN for breakthrough w/d sx (#10)

If moderate/severe withdrawal AND safe for outpatient benzo rx:
-establish first day dosing of chlordiazepoxide or lorazepam (w/d controlled, not overly sedated)
-ex: chlordiazepoxide 50mg Q6hrs OR lorazepam 2mg TID
-taper 25% per day for 4 days

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INDICATIONS FOR ESCALATION OF CARE

- Agitation or severe tremor that is not resolving w/medication
- Persistent vomiting
- Confusion
- Hallucinations
- Seizures
- Worsening of medical or psychiatric condition
- Over-sedation
- Unstable VS
- Return to alcohol use

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CASE 1

- 50yo married, domiciled, employed F with T2DM on metformin, social anxiety disorder and alcohol use disorder presents to family medicine clinic accompanied by her wife requesting help withdrawing from alcohol. The pt has been drinking about 2 – 6-packs of 12oz beers daily for the past 20 years, with no prior attempts at cessation, no known withdrawal history, and no previous medication trials for AUD. She does not use any other substances besides marijuana recreationally. Physical exam, VS, labs are all WNL. Last drink was ~ 2 hours prior to arrival and CIWA is currently 0.

CASE 2

- 25yo single, homeless, M disabled 2/2 bipolar disorder is seen in the psychiatry clinic for routine med check. On review of substance use history, patient reveals that he has been drinking & using drugs again for the past 4 months, including snorting fentanyl and drinking a pint of whiskey + 3 tall boys daily. He has tried to stop drinking and using several times in the past month, but has been unsuccessful. He was hospitalized for alcohol withdrawal one time several years ago after he "might've had a seizure" and says benzos are the only thing that work for his withdrawal. His last drink was ~12 hours ago, CIWA currently a 10; last fentanyl use was immediately before this appointment, so COWS was not assessed. He is not currently taking his lithium and would like to get restarted on that as well as he feels his mood has been more down lately. He denies current SI but does have a hx of psychiatric hospitalization for SA in the setting of prior mood episodes.

SUMMARY

- AWS affects about 1/3 to ½ of patients dependent on alcohol, and most cases are mild or moderate
- Ambulatory alcohol withdrawal management is appropriate for medically uncomplicated pts with mild to moderate symptoms, who have limited or mitigated risk factors, and who can accommodate daily visits or remote check ins for up to 5 days after last drink
- Ambulatory AWS treatment consists of close monitoring, withdrawal medication and supportive care including nutrition, hydration, MVI and thiamine
- Escalation of care is indicated for severe or worsening w/d sx, inability to take PO, unstable VS, syncope, hallucinations, confusion
- Medically supervised alcohol withdrawal by itself is not sufficient treatment for AUD

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