Alcohol Use Disorder Withdrawal Management

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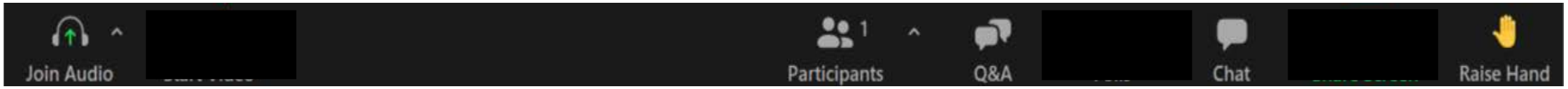
1:00 pm PDT

DISCLAIMER

- This session was conducted for members of county-based teams in CA that are working to expand access to Medications for Addiction Treatment in jails and drug courts. The project is funded through California's Department of Health Care Services with State Opioid Response funding from SAMHSA. The content is being made available to all interested parties.
- Please note this content has not been professionally edited and the session was conducted using Zoom.

ZOOM FEATURES

- The preferred audio is using “Phone Call”. Please enter your participant ID so that your name is associated with your phone number
- Use the “Q&A” and “Chat” features to type in a question or make a comment
- Use the “Raise Your Hand” feature by going to Manage Participants. You will see your name and can raise your hand
- Polling questions will be used



At the end of this section, the learner will:

- Differentiate patients who will require pharmacotherapy for alcohol withdrawal from those who won't
- List which medications should be used for outpatient management of withdrawal
- Know which patients require referral for a higher level of care for alcohol withdrawal

ASAM Clinical Practice Guideline on Alcohol Withdrawal Management 2020

Agenda

- Identify and Diagnose
- Initial Assessment
- Level of Care Determination
  - Ambulatory Management
    - Monitoring
    - Supportive Care
    - Treatment Initiation and Engagement
    - Pharmacotherapy
  - Referral for Higher Level of Care

IMPORTANCE OF MANAGING ALCOHOL WITHDRAWAL

+ PEOPLE DIE

- Although opioids have gotten a lot of press recently
- Alcohol & benzodiazepines are more likely to result in death from withdrawal than opioids
- Alcohol withdrawal is also much more common

+ CASES SETTLE

- 2010-2015 $11 million paid to families of loved ones who died during withdrawal in jails
- Save $2 million settlement with $2 medication
- ADA violation to withhold treatment for a medical condition

15 million Americans have Alcohol Use Disorder (AUD), 2 million have OUD, .6 million have benzodiazepine use disorder

WHY DO PATIENTS DIE FROM WITHDRAWAL IN JAILS?

- Failure to recognize
  - due to lack of screening
  - attribution to another disorder
  - lack of awareness of masking by medication for another disorder
- Failure to take withdrawal seriously
- Failure to closely monitor
- Failure to use appropriate medication or adequate doses

ALCOHOL WITHDRAWAL

+In the chat box, please enter:

What do you do at your facility to recognize withdrawal?

POLLING QUESTION

35yo female arrived to jail 48 hours ago on a charge of reckless driving. Officers contact you because, "she's acting crazy". There are no past medical records in your system; upon intake she denied medical, mental health or drug or alcohol issues. Her speech is incoherent, she's agitated and doesn't respond when spoken to and is picking at unseen things. How do you proceed?

1. Call a psychiatric consult
2. Take her vitals signs
3. Call non-psychiatric provider
4. Call an ambulance for transport to local ED
5. Complete a CIWA

ALCOHOL WITHDRAWAL: IDENTIFY AND DIAGNOSE

Universal Screening for unhealthy alcohol use in all medical settings using a validated tool

- Assess risk of developing withdrawal
  - History of withdrawal symptoms
  - Quantity, frequency and time of day of last use
    >8 standard drinks per day predicts withdrawal
- For those with signs and symptoms of withdrawal
  - Use information from collateral sources
  - Laboratory testing of hepatic function
  - Biological testing for substances (breath or urine)
    - **Do not rule out the risk of withdrawal, because the toxicology test is negative**

Source: https://www.niaaa.nih.gov/alcohols-effects-health/overview-alcohol-consumption/what-standard-drink

ALCOHOL WITHDRAWAL: IDENTIFY AND DIAGNOSE

- Case
  - Patient was pulled over for going 6 mph over speed limit. He had just dropped his children off at school. He smelled of alcohol, was tested and arrested for DUI at 9AM.
  - At jail intake he reports drinking 12-24 beers/day and that he stopped drinking at 10pm last night.
  - He is well groomed, calm, answers questions appropriately, alert, oriented, speech is normal rate, volume and amount, thoughts are well organized and linear, no hallucinations, delusions, no suicidal or homicidal ideation.
  - Per police breathalyzer was .22 at 9AM.

BAC	Time	# hours
.4	12AM	0
.38	1 AM	1
.36	2 AM	2
.34	3 AM	3
.32	4 AM	4
.30	5 AM	5
.28	6 AM	6
.26	7 AM	7
.24	8 AM	8
.22	**9 AM**	**9**
.20	10 AM	10
.18	11 AM	11
.16	12 PM	12
.14	1 PM	13
.12	2 PM	14
.10	3 PM	15
.08	4 PM	16
.06	5 PM	17
.04	6 PM	18
.02	7 PM	19
.0	8 PM	20

ALCOHOL WITHDRAWAL: CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED

CIWA-Ar is Public Domain as is CIWA-B (benzodiazepine) - anchored responses are provided

Vitals
https://www.jailmedicine.com/random-thoughts-on-alcohol-withdrawal/

1. Nausea/Vomiting: “Do you feel sick to your stomach? Have you vomited?” Observation

2. Tremor: arms extended and fingers spread apart. Observation

3. Paroxysmal Sweats: Observation

4. Anxiety: “Do you feel nervous?” Observation

5. Agitation: Observation

6. Tactile Disturbances: “Have you any itching, pins & needles, any burning, numbness or do you feel bugs crawling under your skin?” Observation

7. Auditory Disturbance: “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything disturbing you? Are you hearing things you know are not there?” Observations

8. Visual Disturbance: “Does the light appear to be too bright? Is the color different? Does it hurt our eyes? Are you seeing anything that is disturbing you? Are you seeing things you know are not there?” Observation

9.Headache or fullness in the head: “Does your head feel different? Does it feel like there is a band around your head? “ Do not rate dizziness or lightheadedness.

10. Orientation and clouding of sensorium: “What day is this? Where are you? Who am I?” Observation

ALCOHOL WITHDRAWAL: INITIAL RISK ASSESSMENT

- Risk factors for severe or complicated withdrawal
  - History of withdrawal delirium or withdrawal seizure (kindling)
  - Numerous withdrawal episodes
  - Comorbid medical or surgical illness
    - especially traumatic brain injury
    - low platelets
    - high ALT
  - Age >65
  - Long duration of heavy and regular consumption, especially recently
  - Marked autonomic hyperactivity on presentation
  - Physiological dependence on GABAergic agents (such as benzodiazepines)
  - Concomitant substance use
  - Withdrawal symptoms in presence of positive breathalyzer or urine alcohol level

ALCOHOL WITHDRAWAL: LEVEL OF CARE DETERMINATION

- Current symptoms of withdrawal AND comorbid conditions
  - Suicidal ideation or other acute psychiatric issues
  - Unable to take oral medications or other medical issues

- Alcohol withdrawal can typically be safely managed in an ambulatory setting, for those with limited or mitigated risk factors
  - 10% of patients with alcohol withdrawal require inpatient treatment
  - Treat in least restrictive environment possible

  - Consider co-horting patients likely to experience withdrawal

ALCOHOL WITHDRAWAL (W/D): AMBULATORY MANAGEMENT

Ambulatory Withdrawal Management

Level 1 without extended onsite monitoring

Level 2 with extended onsite monitoring

Organized service with the ability to provide regular medical assessments and monitor withdrawal progression

- Mild withdrawal can be treated in level 1
  - Mild psychiatric symptoms or cognitive impairment
  - Nonalcohol related seizure; abnormal labs
  - Previous severe/ complicated w/d >1y ago
  - Previous failure ambulatory w/d
  - Absence of caregiver
- Moderate withdrawal can be treated in level 1 or 2
- Severe withdrawal should NOT be managed in level 1, but can be managed in level 2

Onset of withdrawal symptoms:

6 to 36 hours after last drink

Severity	CIWA Score
Mild	<10
Moderate	10-18
Severe	≥19
Complicated	≥19

CIWA <10: when did last drink occur?

HEALTH MANAGEMENT ASSOCIATES DHCS

ALCOHOL WITHDRAWAL: PHARMACOTHERAPY

Moderate withdrawal or at risk of developing severe or complicated withdrawal: prophylactic treatment

- Benzodiazepines are first line options
- Carbamazepine or gabapentin are options

Low risk of withdrawal: single or few doses of prophylactic treatment

Benzodiazepines, carbamazepine or gabapentin are all first line options

ALCOHOL WITHDRAWAL: SUPPORTIVE CARE

- Low or no bunk
- Educate patients and staff to monitor
  - Drink fluids
  - Eat
  - Multivitamin
  - Thiamine 100mg for 3-5 days orally
  - Don’t mix with other central nervous system depressants, including alcohol
  - Reduce dose if sedated
  - Increase dose for exacerbation
- AUD treatment initiation and engagement

ALCOHOL WITHDRAWAL: MONITORING

Check in daily for 5 days with medical professional

- In person
- Video teleconference

Check in:

- **Physical condition, including hydration**
- **Vitals**
- **Sleep**
- **Psychiatric symptoms, including suicidal ideation & orientation**
- **Alcohol consumption, breathalyzer if possible**

ALCOHOL WITHDRAWAL: MONITORING

The following would indicate a need for higher level of care

- Vomiting
- Exacerbation of symptoms despite being able to take medications: utilize validated tool
- New symptoms that weren't present previously
  - Hallucinations
  - Confusion
  - Seizure
  - Syncope
- Unstable vitals
- Over sedation
- Returns to alcohol use

ALCOHOL WITHDRAWAL

+In the chat box, please enter:

What do you do at your facility to treat alcohol and benzodiazepine withdrawal?

ALCOHOL USE DISORDER TREATMENT INITIATION AND ENGAGEMENT

AUD treatment should be initiated concurrently with alcohol withdrawal

- Offer to initiate pharmacotherapy for AUD, not just withdrawal
- If you need to refer for pharmacotherapy you should still explain the options available
- Offer information about local recovery support
- Refer for psychosocial or pharmacotherapy, if needed
- Regular follow up visits monthly for 1 year

Support Groups
12 Step meetings
Non-religous alternatives

ALCOHOL WITHDRAWAL: WHO NEEDS REFERRED TO A HIGHER LEVEL OF CARE?

Severe Withdrawal

- May be treated in level 2/ observation unit
- Benzodiazepines are the first line treatment
  - Decrease risk of seizure, delirium
  - Shorten durations of delirium
- Ensure patient is responding to treatment
- Ensure patient is not over or under treated
- Ensure patient does NOT need a higher LOC
- You can switch medications
- You can augment medications
- Front loading (preferred for severe withdrawal), fixed doses or symptom triggered

Longer acting benzos are preferred due to:

- longer duration of action
- greater symptom control
- fewer rebound symptoms

If signs and symptoms of liver disease use benzo with less hepatic metabolism:

- oxazepam
- lorazepam

Prescribe small amounts
Discontinue medication when withdrawal complete

ALCOHOL WITHDRAWAL: DOSING

Chlordiazepoxide single dose regimens

- Mild withdrawal 25-50mg po
- Moderate withdrawal 50-100mg po
- Severe withdrawal 75-100mg po

Gabapentin
Loading dose of 1200mg then 600mg q6h day 1 or 1200mg for 1-3 days then 300-600mg for 4-7 days

Chlordiazepoxide front loading

- 50-100mg po q 1-2 h for 3 doses (fixed dosing) or until CIWA < 10 (symptom triggered)

Chlordiazepoxide symptom triggered

- 25-100mg po q4-6h CIWA >10

Chlordiazepoxide fixed dose- taper by 25-50% daily

- Day 1 25-100mg po q4-6h
- Day 2 25-100mg po q6-8h
- Day 3 25-100mg po q8-12h
- Day 4 25-100mg po at bedtime

Carbamazepine 600-800mg/ day tapered to 200-400mg/ d over 4-9 days

POLLING QUESTION

55yo male arrived to jail 4 days ago on a charge of reckless driving. The patients report a man down incident. Upon arrival of nursing staff the patient is seizing. There are no past medical records in your system. Upon intake he denied mental health or drug or alcohol issues; however, he reported taking clonazepam for "seizures". He states he has not seen a prescriber since moving to San Diego and had been getting them off the streets for the past 2 months since arriving. How do you proceed?

1. Call a psychiatric consult
2. Take his vitals signs
3. Call non-psychiatric provider
4. Call an ambulance for transport to local ED
5. Administer lorazepam or diazepam

ALCOHOL WITHDRAWAL: INPATIENT TREATMENT

- Can’t get control of symptoms on outpatient basis
- Require admit for medical or psychiatric issue other than withdrawal
- Pregnant persons should be offered inpatient treatment
- Patients presenting with complicated withdrawal
  - Alcohol Withdrawal Seizures
  - Alcohol Withdrawal Delirium
  - Alcohol Induced Psychosis

IMPLEMENTATION ISSUES

- Determine if you are going to use the anchors only or all the numbers
- Training of nursing staff on withdrawal scales, recognition and timing of withdrawal
- Training of custody staff on recognition of withdrawal scales, recognition and timing of withdrawal
- Have multiple nurses score the same patient at the same time to determine interrater reliability
- Have a standard approach such as, if in question err on the higher score
- ? Standing orders; nursing protocols?

Remember the vitals and the risk assessment

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

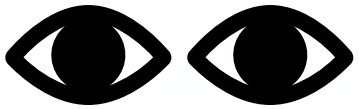
Patient:_____ **Date:** _____ **Time:** _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ **Blood pressure:**_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
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

TACTILE DISTURBANCES -- Ask "Have you any itc needles sensations, any burning, any numbness, or do yo crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbne
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbne
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

SUMMARY



Observation

Intervention

More important than the CIWA score is history, vitals and change in score

Clinical Judgement

REVIEW OF LEARNING OBJECTIVES

+ In the chat box, please enter:

Who will require pharmacotherapy for alcohol withdrawal?

REVIEW OF LEARNING OBJECTIVES

+ In the chat box, please enter:

List a medication that is appropriate for treatment of alcohol withdrawal

REVIEW OF LEARNING OBJECTIVES

+In the chat box, please enter:

List an indicator that a patient treated for withdrawal at the jail who needs a higher level of care…

QUESTIONS AND DISCUSSION

Send your questions to the host via the chat window in the Zoom meeting.

Q+A is now open.

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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KEY RESOURCES:

ASAM POCKET GUIDE

http://eguideline.guidelinecentral.com/i/1254278-alcohol-withdrawal-management/0?

HEALTH MANAGEMENT ASSOCIATES

DHCS

UPCOMING EVENTS

Webinar: Behavioral Interventions For Stimulant Use Disorders

April 27, 2021

Office Hours – All Team Members

1st Thursday of the Month at 12:00 pm

Office Hours – Prescribers

2nd Thursday of the Month at 12:00 pm

Jail MAT Quarterly Learning Collaborative

June 17, 2021

Evaluation for today's webinar

1. **Overall, today's webinar was:**
   - A. Very useful
   - B. Somewhat useful
   - C. Not very useful
   - D. Not useful at all

2. **The material presented today was:**
   - A. At the right level
   - B. Too basic
   - C. Too detailed

REFERENCES

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A guide to developing and revising alcohol and opioid detoxification

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