Symptom-Triggered Alcohol Detoxification: A Guideline for use in the Clinical Decisions Unit of the Emergency Department.

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Summary

- This method of detoxification is an alternative to the fixed-dose treatment strategy in standard use currently. It is of potential benefit as the duration of detoxification is reduced although there is a requirement for more monitoring of withdrawal symptoms.
- With this method patients with overt or suspected alcohol withdrawal are objectively assessed for presence of significant withdrawal at regular intervals. Severity of withdrawal is assessed using a standardised scale (the CIWA-Ar).
- If found to have significant withdrawal, the patient is given a stat dose of a benzodiazepine (diazepam 20mg). This procedure of standardised assessment and treatment is repeated every ninety minutes until the patient is no longer in withdrawal and detoxification is complete.

1. What patients are suitable for symptom-triggered detoxification?

- Use in alcohol-dependent adult patients for the treatment of withdrawal in CDU only.
- Patients with a history of previous alcohol-withdrawal seizures or delirium tremens are also suitable.

2. What patients are not suitable for symptom-triggered detoxification?

- Patients with dependency on other drugs in addition to alcohol.
- Patients with severe liver impairment or other major physical illness.
- Patients who are non-verbal/ unable to communicate.

3. When to use the CIWA-A scale

The CIWA-A is a standardised assessment scale for symptoms of alcohol withdrawal. The scale should be administered when:

- the patient reports withdrawal symptoms or shows signs of withdrawal
- the patient's history indicates a likelihood of withdrawal reaction:
  - drinking large amounts of alcohol over a long period of time,
  - history of withdrawal symptoms
  - last drink within the past 12 hours.

If such a history is not evident, observe informally for signs of withdrawal as many people with dependent drinking will deny it.

4. How to use the CIWA-A scale

- Take the scale with you when assessing the patient. Ask each question as it appears on the CIWA-A and assign a score to each item. Speak slowly and clearly and reword questions, if necessary. Do not verbally contradict what the patient tells you.
- Adjust the score based on the subjective and objective signs and symptoms. Add up the number of points and assign a total score.
- Take the vital signs. These are not factored into the overall scoring but they provide important clinical information. Slight elevation of these signs is common. Please Record Vital Signs and Neurological Observations separately every 90 minutes

5. What to do next

- If CIWA-A score >10, give diazepam 20mg po stat (See Drug chart for prescription of Diazepam)
- If the CIWA-A score is = 11 give no medication
- After 90 minutes, reassess symptoms of withdrawal, using the CIWA-A again. If CIWA-A score >10 give diazepam 20mg po stat
- Repeat the above process every 90 minutes until CIWA-Ar score <11 on 3 consecutive occasions. At this point formal detoxification is complete and CIWA-Ar assessments may be stopped.
- Continue then to monitor informally to ensure there is no re-emergence of symptoms.

6. What to expect

Expect a large minority may not require diazepam at all as CIWA-A score will be <11 from the outset. Expect a median duration of detoxification of 8 hours.

7. What to do when CIWA-Ar score remains >10 after 24 hours

Some patients may remain symptomatic despite prolonged (i.e. >24 hours) CIWA-Ar monitoring and Benzodiazepine treatment. In such cases, the diagnosis of Alcohol Withdrawal should be reviewed. Look for other causes (ie benzodiazepine dependency, drug seeking behaviour, organic agitation as part of delirium or other cause). Discontinue CIWA-Ar detoxification, consider other drug treatment strategies and if necessary investigate further.

8. What about Pabrinex?

Wernicke-Korsakoff Syndrome (WKS) is a neurological syndrome of Vitamin B deficiency that may have serious sequelae.

- Prophalaxis against Wernicke-Korsakoff Syndrome should be given to all alcohol dependant patients in CDU as follows: Pabrinex (Ampoules I & II) iv once daily for 3 days. Pabrinex should be diluted in 100ml saline or dextrose (infused over 30 minutes).
- In patients with signs of possible WKS, (ie acute delirium, ataxia, gaze palsy), give 2 pairs of Pabrinex (Ampoules I & II) three times daily and continue for as long as symptoms are improving.

CIWA-Ar Scale (CLINICAL INSTITUTE WITHDRAWAL ASSESSSMENT FOR ALCOHOL)

1. Nausea & Vomiting:
Ask "Do you feel sick to your stomach? Have you vomited?"
Observation
0 no nausea / vomiting
1
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves & vomiting

2. TREMOR:
Observation. Arms extended and fingers spread apart
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patients arm extended
5
6
7 severe, even with arms not extended

3. 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

4. ANXIETY:
Observation. Ask: "Do you feel nervous?"
0 no anxiety
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic as seen in severe delirium or acute schizophrenic reactions

5.Agitation:
Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderatedly fidgety and restless
5
6
7 paces back and forth during most of interview, or constantly thrashes about

6. Tactile Disturbances
Observation. Ask: "have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?
0 none
1 very mild itching, pins and needles, burning or numbness.
2 mild itching, pins and needles, burning or numbness.
3 moderate pins and needles, burning or numbness.
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

7. AUDITORY DISTURBANCES:
Observation. Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing you? Are you hearing things you know are not there?
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

8. VISUAL DISTURBANCES:
Observation. Ask: " Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing 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

9. HEADACHE, FULLNESS IN HEAD:
Observation. Ask " Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

10. ORIENTATION & CLOUDING OF SENSORIUM:
Observation. Ask: "What day is this? Where are you? Who am I?"
0 orientated and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disorientated for date by no more than 2 calendar days
3 disorientated for date by more than 2 calendar days
4 disorientated for place and / or person

Date & Time	CIWA Total Score	Signed

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