ALCOHOL WITHDRAWAL MANAGEMENT IN THE STATE OF MONTANA

Dr. Marc Mentel DO

Family Medicine/Addiction Medicine

CASE SCENARIO

- DP is a 54yo male with Alcohol Use Disorder. He has been drinking most of his adult life. He currently drinks 750ml of Vodka Daily. He will typically need to get up in the middle of the night to have a drink and will usually need a drink first thing in the morning. He has been hospitalized many times for his alcohol use disorder and has been intubated and placed in an induced coma once in the past. He would like stop drinking and get into recovery. What are the next steps?

BOARD ANSWER

STEP 1:

- Risk Assessment: AUDIT-PC or PAWSS
- An AUDIT-PC score of 5 or more is 91% sensitive and 89.7% specific for developing AWS

AUDIT - PC

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-PC positive.

BOARD ANSWER

STEP 2:

- Risk Stratification: ASAM Appropriate Placement
  - *Level 1 WM: Ambulatory WM without extended onsite monitoring*
  - *Level 2 WM: Ambulatory WM with extended onsite monitoring*
  - *Level 3 WM: Residential/Inpatient withdrawal management*
    - *level 3.5 WM: Clinically managed residential WM*
    - *level 3.7 WM: Medically monitored inpatient WM*
  - *Level 4 WM: Medically managed intensive inpatient WM*

BOARD ANSWER

STEP 3:

- Monitor: CIWA – AR Gold Standard for monitoring/Needs trained personnel

  CIWA<10 = Mild withdrawal

  CIWA 10-18 = Moderate withdrawal

  CIWA 19 or > = Severe withdrawal

  CIWA 19 or > = Complicated withdrawal

BOARD ANSWER

STEP 4:

- Treatment: Medications protocols are based upon CIWA-AR scores. Scores 8 or more usually indicate treatment
- Medications:

  Benzodiazepines – Gold Standard

  Anticonvulsants – Gabapentin, Carbamazepine

  Phenobarbital – if experienced

  Specials- Haloperidol, Propofol, Dexmedetomidine, Thiamine, Folic Acid

REALITY CHECK IN MONTANA

AUDIENCE ?

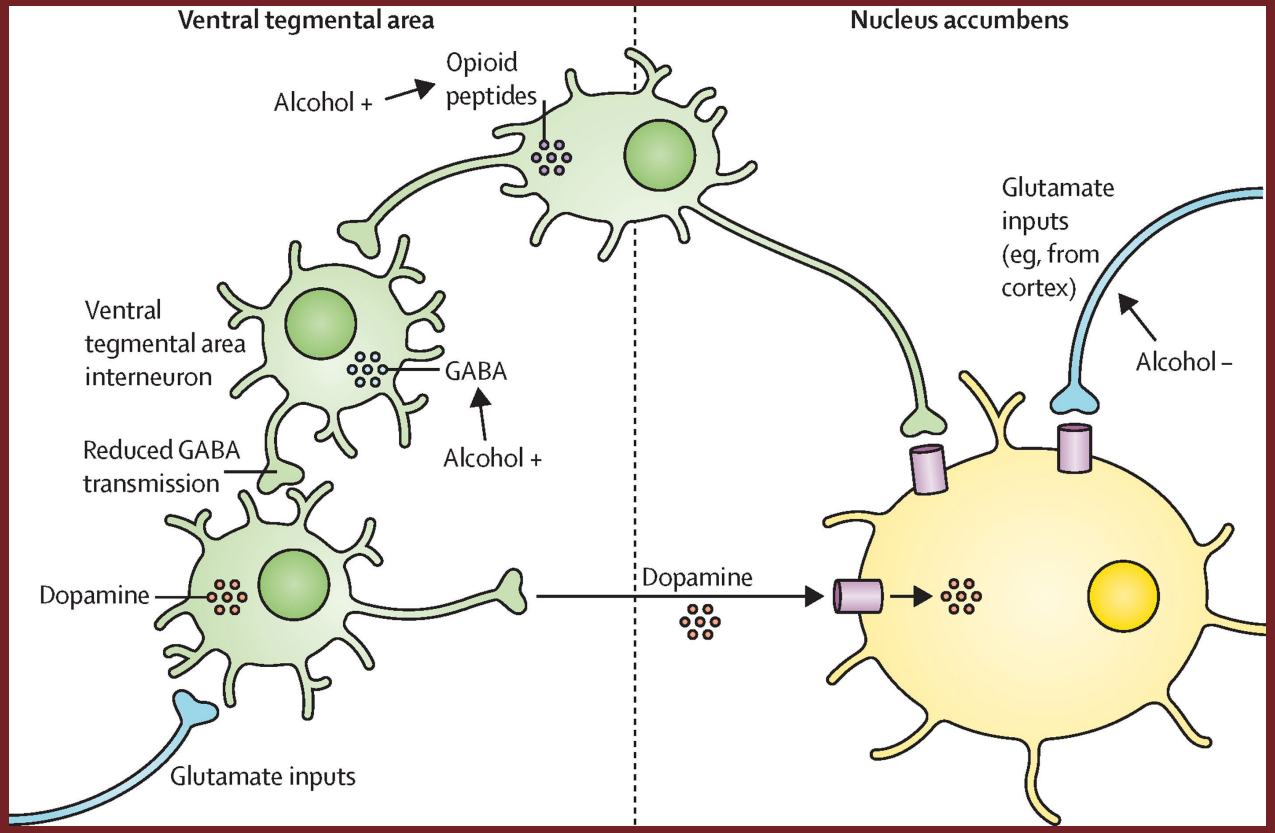
PATHOPHYSIOLOGY OF ALCOHOL WITHDRAWAL

NEUROTRANSMITTERS INVOLVED

- Dopamine
- Opioids
- GABA
- Glutamate
- Cannabinoids
- Serotonin
- CRF (Cortisol Releasing Factor)

GABA AND GLUTAMATE RELATIONSHIP

THE CHILLER AND THE THRILLER



SIGNS & SYMPTOMS OF ALCOHOL WITHDRAWAL

SIGNS

- Elevated BP, HR, Temp
- Tremor
- Diaphoresis
- Dilated Pupils
- Disorientation
- Seizure
- Hyperreflexia

SYMPTOMS

- Anxiety
- Insomnia
- Vivid Dreams
- Headache
- Loss of appetite
- Nausea
- Irritability
- Insomnia
- Hallucinations

EPIDEMIOLOGY OF ALCOHOL WITHDRAWAL

- 50% of individuals with Alcohol Use Disorder will experience AWS (50/100)
- 4% of individuals with AWS will experience Severe Withdrawal (2/100)
- 15% of individuals with Severe Withdrawal will die (0.3/100)

- Symptoms of AWS start to occur 6 hours after the last drink
- Peak incidence of seizures occur 24-36 hours after the last drink
- Peak incidence of Delerium Tremens occur 48-72 hours after the last drink

A DIFFERENT MODEL FOR MONTANA

OPINION: Same elements/Different Order

1. *Risk Assessment*
2. *Treatment*
3. *Monitoring*
4. *Risk Stratification*

OPINION ANSWER

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SCORE

OPINION ANSWER

STEP 2: Treatment

Goal: Smooth, efficient clinical course with minimal agitation and discomfort.

The patient should be able to participate in recovery programming in 2-3 days.

V. Sample Medication Regimens

Medication	Regimen	Description, Examples
Benzodiazepines (*doses in Chlordiazepoxide*)	Typical single dose	Mild withdrawal (CIWA-Ar < 10): 25–50 mg PO Moderate withdrawal (CIWA-Ar 10–18): 50–100 mg PO Severe withdrawal (CIWA-Ar ≥19): 75–100 mg PO
	Symptom-triggered	25–100 mg PO q4–6h when CIWA-Ar ≥10. Additional doses PRN.
	Fixed-dose	Taper daily total dose by 25–50% per day over 3–5 days by reducing the dose amount and/or dose frequency. Additional doses PRN. Day 1: 25–100 mg PO q4–6h Day 2: 25–100 mg PO q6–8h Day 3: 25–100 mg PO q8–12h Day 4: 25–100 mg PO at bedtime (Optional) Day 5: 25 to 100 mg PO at bedtime
	Front loading	*Symptom-triggered:* 50–100 mg PO q1–2h until CIWA-Ar < 10. *Fixed-dose:* 50–100 mg PO q1-2h for 3 doses.
Phenobarbital	Typical single dose	10 mg/kg IV infused over 30 minutes or 60-260 mg PO/IM.
	Monotherapy	*Symptom-triggered in the ICU:* 130 mg IV q30m to target a RASS score of 0 to -1. *Fixed dose in the ED:* Loading dose 260 mg IV, then 130 mg IV q30m at physician's discretion. *Fixed dose in ambulatory management:* Loading dose 60–120 mg PO. Then 60 mg PO q4h until patient is stabilized. Then 30–60 mg PO q6h tapered over 3–7 days. Additional doses PRN.
	Adjunct therapy	*Single dose in the ED:* 10 mg/kg IV infused over 30 minutes. *Escalating dose in the ICU:* After maximum diazepam dose (120 mg), if RASS ≥1, escalating dose of 60 mg → 120 mg → 240 mg IV q30m to target RASS score of 0 to -2.
Carbamazepine (Tegretol)	Monotherapy	600–800 mg total per day tapered to 200–400 mg/d over 4–9 days.
	Adjunct therapy	200 mg q8h or 400 mg q12h.
Gabapentin (Neurontin)	Monotherapy	Loading dose 1200 mg, then 600 mg q6h on Day 1 or 1200 mg/d for 1–3 days, tapered to 300–600 mg/d up to 4–7 days. Additional doses PRN.
	Adjunct therapy	400 mg q6–8h.
Valproic acid (Depakene)	Monotherapy	1200 mg/d tapered to 600 mg/d over 4–7 days or 20 mg/kg/d.
	Adjunct therapy	300–500 mg q6–8h.

CIWA-Ar, Clinical Institute Withdrawal Assessment for Alcohol, Revised; ED, Emergency Department; h, hour(s); ICU, Intensive Care Unit; IM, intramuscularly; IV, intravenously; m, minute(s); mg, milligrams; PO, by mouth; PRN, as needed; q, every; RASS, Richmond Agitation Sedation Scale.

MY BENZODIAZEPINE RECIPE

DAY#1 Lorazepam 2mg Q6hrs + 2 extra doses if needed

DAY#2 Lorazepam 2mg Q8hrs

DAY#3 Lorazepam 2mg Q12hrs

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DAY#5 Lorazepam 1mg QHS

OPINION ANSWER

STEP 3: MONITORING ADDICTION SPECIALIST

- Make sure the client is not left alone
- Check in once or twice daily with a CIWA (phone/zoom)
- Adjust the Benzodiazepine taper based upon the CIWA score

STEP 3: MONITORING THE PATIENT

- Confusion
- Vomiting
- Visual/Auditory Hallucinations
- Worsening agitation/Discomfort
- Unable to be roused

OPINION ANSWER

CARE LEVEL AMBULATORY

- CIWA 18 or <
- Minimal agitation and discomfort
- Able to eat and drink
- Ability to wake

CARE LEVEL HOSPITAL

- CIWA > 18
- Disorientation
- Hallucinations
- Seizures
- Vomiting/Diarrhea
- Inability to wake

QUESTIONS?


After listening to his owner drone on for hours, Ralph suddenly realized he was NOT cut out to be an emotional support dog after all.
ifunny.co

THANK YOU

Marc C Mentel DO

406-219-7233

Marc.Mentel@406Recovery.care