

Alcohol Withdrawal Syndrome - Level II
ALCOHOL WITHDRAWAL SYNDROME

Level II
 (No Level I)

Skill Level: RN

Definition: Alcohol withdrawal syndrome is a physiologic response to the sudden reduction or stopping of alcohol intake. Alcohol withdrawal syndrome includes (in order of decreasing frequency) anxiety, insomnia, tremor, tachycardia, systolic hypertension, hyper-reflexia, decreased seizure threshold, auditory and visual hallucinations and finally delirium.

MILD	
<p>Subjective:</p> <ul style="list-style-type: none"> • Alcohol usage pattern - intermittent, binging or chronic low level and onset of symptoms 6-24 hours after intake. • Sleeplessness and headache. • Nausea (usually within 48-72 hours of last drink). • Night sweats. • Anxiety, depression or irritability. • Describes visual, auditory or tactile disturbance. • No history of prior alcohol withdrawal problems 	<p>Assessment:</p> <ul style="list-style-type: none"> • Alteration in comfort: mild alcohol withdrawal symptoms. • Potential for agitation. • Potential for DT's.
<p>Objective:</p> <ul style="list-style-type: none"> • Hyperarousal, restlessness, cutaneous flushing. • Oriented to time, place and person. • May see mild hypertension 140/90 and tachycardia >100. • May see, slight fine tremor, dilated pupils. • No focal neurological deficit. • No hallucinations 	<p>Plan:</p> <ul style="list-style-type: none"> • Recheck in 4 hours. Use CIWA scale and vital signs to monitor. If CIWA scale is 15 or over, go to Moderate or Severe, below. • If CIWA scale is increasing, continue to monitor every four hours until it is decreasing. • Encourage fluid intake of one gallon or more daily.

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MODERATE																			
<p>Subjective:</p> <ul style="list-style-type: none"> • Patient history of regular and heavy alcohol use. • Patient may have prior history of one or more of the following: <ul style="list-style-type: none"> ○ Visual or auditory hallucinations during past alcohol withdrawal. ○ Cirrhosis. ○ Pancreatitis without cholelithiasis. ○ Wernicke-Korsakoff syndrome (memory loss, confusion). ○ Seizure during prior alcohol withdrawal. • Numbness of hands and feet. • Moderate agitation or anxiety. • Forgetfulness, inability to concentrate. 	<p>Assessment:</p> <ul style="list-style-type: none"> • Alteration in comfort: Moderate alcohol withdrawal. 																		
<p>Objective:</p> <ul style="list-style-type: none"> • Objective findings are similar to mild withdrawal, but signs and symptoms are more severe. • General: Restless, Agitation, Tremor. • Blood Pressure and pulse are frequently elevated. • No seizure activity • Tremors may be severe. • Patient may experience transient tactile, auditory or visual disturbances. • No history of head injury or neurological deficit. • No hallucinations or focal neurological deficits. 	<p>Plan:</p> <ul style="list-style-type: none"> • Use CIWA scale to monitor patients who have moderate withdrawal symptoms. • Consider nursing observation in the infirmary. Notify provider. • Vital signs and CIWA scale every 2 hours at minimum, until CIWA less than 10, without medications. • Check blood sugar. • If female 45 years old or under, check for pregnancy. Call provider if positive. <u>DO not issue any medications without direction from provider.</u> • Push oral fluids at least one gallon daily. After checking for allergies to medications, use:--Thiamine, 100 mg IM once daily for 5 days. --If CIWA score is over 15, call provider and ask about Librium use. The standard dose of Librium is as follows: <table style="margin-left: 20px; border: none;"> <tr> <td>Treatment Day:</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> </tr> <tr> <td>Dose (mg):</td> <td>50</td> <td>50</td> <td>25</td> <td>25</td> <td>0</td> </tr> <tr> <td>Schedule:</td> <td>q4h</td> <td>q6h</td> <td>q4h</td> <td>q6h</td> <td></td> </tr> </table> • If patient is experiencing insomnia: Librium 25 mg PO q HS, only if patient 	Treatment Day:	1	2	3	4	5	Dose (mg):	50	50	25	25	0	Schedule:	q4h	q6h	q4h	q6h	
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	<p>total daily dose has not exceeded 300 mg per 24 hours.</p> <ul style="list-style-type: none"> Refer to severe alcohol withdrawal protocol and contact provider immediately for seizures, focal neurological deficit(s), hyperthermia, diastolic BP over 110 or evidence of DT's. (e.g., visual, auditory or tactile hallucinations).
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SEVERE	
<p>Subjective:</p> <ul style="list-style-type: none"> Patient may or may not be able to describe subjective findings. 	<p>Assessment:</p> <ul style="list-style-type: none"> Alteration in comfort: Severe Alcohol Withdrawal Symptoms.
<p>Objective:</p> <ul style="list-style-type: none"> Patient appears to be hallucinating, auditory and/or visual, or delusions. Profound confusion or altered sensorium. Autonomic dysfunction (dilated pupils, fever, pulse over 120, blood pressure over 110 diastolic, severe diaphoresis and/or flushing). Seizure activity. 	<p>Plan:</p> <ul style="list-style-type: none"> Severe alcohol withdrawal or Delirium Tremens is a medical emergency. Prepare for transport to an emergency facility. Notify the provider while awaiting emergency transport. CIWA score over 40 corresponds to "severe" for the purposes of this protocol. Do not spend time doing CIWA scale if patient clearly has descriptive elements under "objective". Arrange transport.

Treatment Goals:

"The initial therapeutic goal in patients with alcohol withdrawal delirium is control of agitation, the symptom that should trigger use of the medication regime. Current evidence does not clearly indicate that a specific sedative-hypnotic agent is superior to others or that switching from one to another is helpful. Benzodiazepines are the most common drug recommended dependent on the severity of the alcohol withdrawal" (National Guideline Clearinghouse, 2004).

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Nursing Education:

1. The CIWA scale is used to monitor the seriousness of alcohol withdrawal and should be used for all patients who have moderate to severe alcohol withdrawal.
2. Alcoholism is the use of alcohol to the extent that it causes recurring interference with one or more of the following areas: personal life, health, close relationships, employment, education, the law.
3. Mortality rates for patients whose alcohol withdrawal syndrome progresses to Delirium Tremens (D.T.'s) approaches 40%.
4. Delirium tremens involves profound confusion, hallucinations, and severe nervous system hyperactivity (including seizures). This is a dangerous group of symptoms that can result in death. Alcohol withdrawal treatment seeks to prevent DT's.
5. Patients' self-reported history of frequency and amount of chronic alcohol use is usually less than the reality. Use objective observations to guide treatment.

APPROVED:

Medical Services Manager

Date

Chief Medical Officer

Date

Steve Shelton M.D.

2/24/2015

Medical Director

Date

Effective Date: 3/2015
Revised: February 2015

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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:

<p>NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.</p> <p>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</p>	<p>TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.</p> <p>0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>TREMOR -- Arms extended and fingers spread apart. Observation.</p> <p>0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient's arms extended 5 6 7 severe, even with arms not extended</p>	<p>AUDITORY DISTURBANCES -- Ask "Are you more aware of sound around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.</p> <p>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</p>
<p>PAROXYSMAL SWEATS -- Observation.</p> <p>0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p>	<p>VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.</p> <p>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</p>
<p>ANXIETY -- Ask "Do you feel nervous?" Observation.</p> <p>0 no anxiety, at ease 1 mild anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p>	<p>HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.</p> <p>0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p>
<p>AGITATION -- Observation.</p> <p>0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about</p>	<p>ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"</p> <p>0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place/or person</p>

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.