

Management of Acute Alcohol Withdrawal

Key Points

- All patients admitted to hospital should be assessed for their alcohol intake by a healthcare professional. This is by utilising the AUDIT C.
- Patients are stratified for treatment according to their alcohol intake and signs and symptoms of withdrawal using CIWA-Ar.
- The main agent for the treatment of acute alcohol withdrawal at FHFT is oxazepam.
- The goal of detoxification is to rapidly control withdrawal symptoms and achieve stability.
- Personal clinical judgement is essential to be used alongside this guideline to achieve the therapeutic target of light sedation from which the patient is easily rousable.
- Under-treatment may trigger Delirium Tremens (DTs) or withdrawal seizures, whereas overtreatment can lead to respiratory depression.
- All patients who misuse alcohol and present with Alcohol Withdrawal Syndrome (AWS) should be prescribed thiamine for prevention of Wernicke's Encephalopathy
- Patients with symptoms suggestive of Wernicke's or in high-risk groups may require intravenous thiamine.
- Patients who have high risk alcohol use should be referred to the ASN to encourage abstinence and onward referral to community alcohol services.
- *Patients should **NOT** be discharged with oxazepam except on Gastroenterology Consultant advice*

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Key words: Alcohol withdrawal, oxazepam, detoxification, CIWA-Ar

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Abbreviations

ABV	Alcohol by Volume
AWS	Alcohol Withdrawal Syndrome
CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Scale Revised
DH	Drug history
DTs	Delirium Tremens
PMH	Past medical history
WE	Wernicke's Encephalopathy
NBM	Nil by mouth
PRN	Pro re nata (when required)

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1. INTRODUCTION

Alcohol misuse can manifest as physical or psychological symptoms across a whole range of specialties.

Patients showing symptoms of acute alcohol withdrawal may pose a risk to the health and safety of other patients as well as the patient themselves.

Unplanned alcohol detoxification usually arises when a dependent drinker is admitted with intercurrent illness. It is important for all healthcare professionals to be aware of patients at risk of alcohol withdrawal so appropriate treatment can be instituted. Under-treatment may lead to delirium tremens (DT) or seizures, whereas over-treatment can lead to respiratory compromise.

2. PURPOSE OF THE GUIDELINE

To minimise the morbidity and mortality associated with withdrawal from alcohol and to facilitate long-term abstinence from alcohol.

These guidelines should be used to ascertain who is at risk and how to reduce complications of alcohol withdrawal, although clinical judgement will still need to be used alongside this.

3. PROTOCOL

Patient Assessment

Assessment of alcohol dependence should be performed by doctors and ward nurses when the patient is admitted.

It is essential that a detailed alcohol history is obtained from all patients. Failure to recognise alcohol misuse/ dependence may have significant consequences.

3.1 Identify patients at risk

- Drinking pattern: daily/continuous or episodic/binge drinking
- Establish the units of alcohol consumed per typical day/week using the calculation:
Units of alcohol = (volume (ml) x %ABV) / 1000
*ABV= alcohol by volume
- Date and time of last drink
- Behaviours to suggest physical dependence (tolerance/ morning drinking)
- Presence of withdrawal symptoms
- Previous withdrawal seizure
- PMH: epilepsy, hepatic disease, jaundice, ascites
- DH: antipsychotics, anti-epileptics, drugs for addiction, recreational or non-prescription medication (including benzodiazepines).
- Co-dependencies; previous re-attendances and engagement to local alcohol service
- Complete AUDIT – C (see appendix 1)

3.2 Alcohol withdrawal syndrome (AWS)

Patients' dependent on alcohol are at risk of developing an acute withdrawal syndrome when they abruptly stop or substantially reduce their alcohol consumption.

Most patients will manifest a 'minor symptom complex or syndrome', which may include any combination of generalised hyperactivity, anxiety, tremor, sweating, nausea, retching, tachycardia, hypertension and mild pyrexia.

Additional features include:

- Onset 6 to 8 hours after an abrupt reduction in alcohol intake.
- Symptom peak between 10 to 30 hours
- Offset 40 to 50 hours.
- Fits may occur in the first 12 to 48 hours and only rarely thereafter.
- Auditory/visual hallucinations may develop and may last for 5 to 6 days.

Oxazepam is the benzodiazepine of choice at FHFT as it has a shorter half-life than alternatives such as chlordiazepoxide. See Withdrawal Regime (section 6) for prescribing information.

3.3 Delirium Tremens (DT)

DT occurs in approximately 5% of individuals withdrawing from alcohol and is characterised by tremor, agitation, fever, tachycardia, profound confusion, delusions, hallucinations, and seizures. Severe hypophosphatemia is also a sign. Onset is usually 48 to 72 hours after cessation of drinking.

Oral lorazepam 1-2mg PRN can be offered as it has a faster onset of action than oxazepam (monitor closely for over-sedation if used in combination with oxazepam). If difficult to manage, IV lorazepam 1-2mg every 5 minutes can be used until the patient is awake but calm.

- Discuss with ICU for any of the following: CIWA-Ar score >35, >4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress

*At the time of writing this policy, lorazepam did not have UK marketing authorisation for the management of delirium tremens. Informed consent should be obtained and documented.

3.4 NBM

In patients that are NBM or with swallowing difficulties, prescribe lorazepam PRN or a lorazepam reducing dose and discuss with ASN (see Appendix 3). Oxazepam may be crushed and dispersed if oxazepam is still the most appropriate agent (unlicensed – discuss with ASN/Pharmacy).

3.5 Wernicke's Encephalopathy (WE)

WE is a neuropsychiatric complication caused by vitamin B1 (thiamine) deficiency, which is characterised by:

At least 2 of the following must be present (Caine's criteria):

- Nutritional deficiency – undernutrition and/or vitamin deficiency
- Ocular signs – nystagmus or ophthalmoplegia
- Cerebellar signs – ataxia and/or unsteadiness
- Altered mental status or mild memory impairment – disorientated, comatose, confused

WE may occur in people with chronic alcohol dependence. Early treatment with high dose parenteral thiamine can reverse WE in most patients. If inadequately treated Wernicke's can lead to permanent brain damage termed Korsakoff's Syndrome (an irreversible condition characterised by anterograde amnesia and confabulation, with relative preservation of intellectual functions) and a 10-20% increased mortality risk. It is essential that adequate parenteral and oral thiamine replacement is employed in ALL patients. For prescribing information please see section 7.

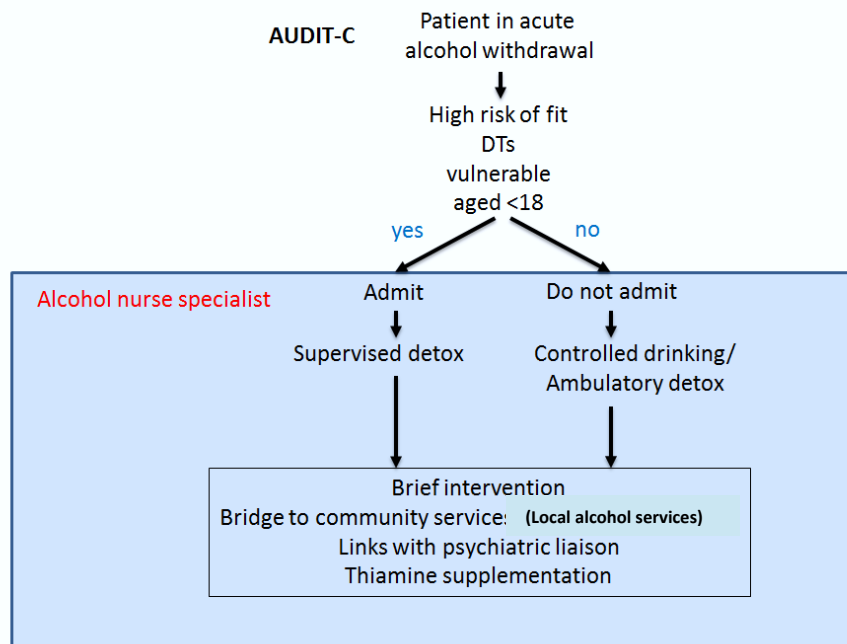
3.6 Alcohol withdrawal seizures

These usually occur within 12-48 hours of alcohol cessation and are rare beyond 48 hours. Do not prescribe phenytoin as this is not effective.

Treat with:

- IV lorazepam 4mg stat, over 2 minutes (max rate is 2mg/min). This can be repeated ONCE after 10 minutes if necessary. Please discuss with ICU if any concerns.
- The patient should then be started on the oxazepam withdrawal pathway starting with STAT dose according to CIWA-Ar score (See Day 1 of Withdrawal Regime, section 6).

3.7 Deciding who to admit: (adapted from NICE guideline CG100)



- Offer admission to patients who are at high risk of alcohol withdrawal seizures: delirium tremens, aged <18 and/or features of Wernicke's.
- Admission should also be considered if there are concerns about the patient's safety/ vulnerability, e.g., lives alone, psychiatric problems, learning difficulties.
- Patients with persistent vomiting who are unable to sustain regular oral intake should strongly be considered for admission.

Alcohol dependent individuals who are aged 18 years and older, and who are not considered high risk of DTs/ seizures or vulnerable, might not require inpatient detox. In this case:

- Refer to the ASN for alcohol support in the community.
- Recommend gradual reduction (not abrupt cessation) of alcohol consumption.

4. TREATMENT OF ALCOHOL WITHDRAWAL SYNDROME

- According to the CIWA-Ar score prescribe STAT dose oxazepam (20-40mg), a stat dose may not be required.
- Assess CIWA-Ar score EVERY 2-4 hours and give oxazepam as per CIWA-Ar (see protocol below).
- If the patient is NBM lorazepam 0.5-1mg SL/IV PRN for NBM (see Appendix 3 for reducing regime).
- DT is a medical emergency and must be managed promptly. Give Lorazepam IV as stated above. (Please note Lorazepam IV can only be given by a doctor.)
- For acute behavioural disturbance, please see Rapid Tranquilisation Policy from the Intranet.
- Thiamine replacement – see section 7:
- Consider IV fluids 4-6 hourly. N.B. If high-risk Wernicke's give thiamine before IV dextrose.
- All patients need the following investigations: U & E's, Mg²⁺, PO₄⁻, Ca²⁺, Folate/B12, LFT's, FBC, Clotting Screen, Blood glucose. Watch for hyponatraemia.

5. DISCHARGE

- Prescribe PO thiamine 100mg BD for 8 weeks or indefinitely if ongoing chronic alcohol problems or dietary deficient. (Pharmacy will supply up to 4 weeks at discharge, pre-packs are available in ED and other relevant wards).
- Ensure TTA states treatment length.
- Patients must not be discharged on oxazepam except on Gastroenterology Consultant advice.
- Refer to community Alcohol liaison services.
- Refer for outpatient FibroScan (as recommended in NICE Guidelines)
- If cirrhosis suspected or confirmed, please request outpatient hepatology clinic review

6. WITHDRAWAL REGIME

Use the EPIC prescribing panel

DAY 1 (first 24 hours)

- Based on a clinical judgment of the severity of clinical signs and symptoms, (alongside CIWA-Ar Scale) prescribe the initial **STAT** dose oxazepam: 20mg or 40mg.

MILD CIWA score 0-9	MODERATE CIWA score 10-20	SEVERE CIWA score >21
No STAT dose required	STAT dose 20mg oxazepam	STAT dose 40mg oxazepam

- Prescribe the following **PRN** regime on the drug chart (when required section):

MILD CIWA score 0-9	MODERATE CIWA score 10-20	SEVERE CIWA score >21
NO dose required. Monitor every 2 to 4 hours	Oxazepam 20mg every 2 hours PRN	Oxazepam 40mg every 2 hours PRN

- Assess CIWA-Ar every 2-4 hours and give oxazepam as per PRN prescription

DAY 2 (after first 24 hours)

- Prescribe 5-day reducing regime based on total dose of oxazepam required in first 24 hours. See chart below and prescribe using the EPIC panel.
For example, if the patient has needed 100mg of oxazepam in the previous 24 hours, the prescription will be started as follows:
 - Oxazepam 20mg QDS (in the variable dosing section of the drug chart).

Continue CIWA-Ar every 2 to 4 hours and top up with oxazepam PRN as needed. There is a 200mg max dose PRN on top of fixed dose.

Please note: If a patient's CIWA-Ar is less than 10 for the first 24 hours, it would be prudent to continue monitoring of CIWA-Ar for a minimum of 3 days after the last reported alcohol consumption. This does not apply to patients who are deemed medically stable for discharge (please refer to section 7).

Patients requiring more than 200mg oxazepam on Day 1 (first 24h) to be reviewed by the Medical Team on Day 4 to assess if longer reducing regime or hospital stay is required

Day 1 TOTAL (STAT + PRN) dose in first 24hours	Day 2 (mg)				Day 3 (mg)				Day 4 (mg)				Day 5 (mg)			
	8am	12pm	6pm	10pm	8am	12pm	6pm	10pm	8am	12pm	6pm	10pm	8am	12pm	6pm	10pm
200mg or more*	40	40	40	40	30	30	30	30	20*	20*	20*	20*	10	10	10	10
150mg -190mg	30	30	30	30	20	20	20	20	10	10	10	10	10	0	10	0
100mg -140mg	20	20	20	20	10	10	10	10	10	0	10	0				
50mg -90mg	10	10	10	10	10	0	10	0								
40mg	10	0	10	0												

7. THIAMINE PRESCRIBING

Treatment of suspected Wernicke's Encephalopathy	Intravenous Thiamine 300mg – 500mg TDS for 3 to 5 days with daily review If pt is still symptomatic at day 5, continue 300mg – 500mg once daily if there is continued improvement. If there is no improvement re-review for alternative causes of symptoms.	Thiamine IV 300-500mg TDS (round to nearest whole ampoule) or Pabrinex IV 2 pairs TDS
Prevention of Wernicke's Encephalopathy	PO Thiamine 100mg BD OR where required e.g., high-risk patients*/NBM without neurological symptoms: IV Thiamine 200mg to 300mg OD (converting to PO thiamine 100mg BD as soon as possible) (If neurological symptoms develop, step-up as above immediately).	PO Thiamine 100mg BD or IV Thiamine 200mg-300mg OD (round to nearest whole ampoule) or IV Pabrinex ONE pair OD
*high risk patients defined as chronic alcoholics with severe malnourishment (BAPEN high-risk criteria for malnourishment)		

Where possible PO thiamine should be used to preserve stocks and avoid risks of anaphylaxis with IV products. Suspected Wernicke's ALWAYS requires prescription of an IV thiamine and should not be delayed.

Pabrinex® is prescribed in pairs of ampoules. A pair of Pabrinex® ampoules provides 250mg thiamine.

Each presentation (carton) contains pairs of 5 ml ampoules. Each pair of ampoules to be used in treatment is labelled Pabrinex No 1 and Pabrinex No 2.

Each No 1 ampoule contains:	5 ml ampoule
Thiamine Hydrochloride	250 mg
Riboflavin (as Phosphate Sodium)	4 mg
Pyridoxine Hydrochloride	50 mg
Each No 2 ampoule contains:	5 ml ampoule
Ascorbic Acid	500 mg
Nicotinamide	160 mg
Glucose (as Monohydrate)	1000 mg

8. CONTACTS

Alcohol Team

Alcohol Specialist Nurses

Frimley Park: 07918 375605 / 07918 375512 (urgent)

fhft.alcoholnursesfph@nhs.net (non-urgent).

Inpatient referral via EPIC.

Wexham Park: Ext. 153905 or 07393 243072

Inpatient referral via EPIC

Pharmacy Team

Frimley Park: Gastro bleep 5487, in alternative ext. 134724.

Wexham Park: Gastro bleep 4872.

9. REFERENCE

Hoffman et al. (2021) Management of moderate and severe alcohol withdrawal syndromes. Uptodate, accessed online

Royal Free Hospital: Acute alcohol withdrawal guideline (2020).

Specialist Pharmacy Service (2024) Using and prescribing thiamine in alcohol dependence. Available online at: <https://www.sps.nhs.uk/articles/using-and-prescribing-thiamine-in-alcohol-dependence/>

APPENDIX 1. SAMPLE OF ALCOHOL SCREENING TOOL

Alcohol Screening Tool (AUDIT-C)



Frimley Health
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Alcohol Screening

Questions	Scoring system					Your score (0, 1, 2, 3 or 4)
	Score 0	Score 1	Score 2	Score 3	Score 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 have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL	

A total of:

0-4 shows lower risk drinking

5 or more can indicate increasing or higher risk drinking

APPENDIX 2: CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE, REVISED (CIWA-AR)

CIWA-Ar Scale

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

Using descriptions below, rate each withdrawal symptom then add scores together.

Nausea and Vomiting		
<i>Observe, ask 'Do you feel sick?'</i>		
No nausea or vomiting		0
Mild nausea, no vomiting		1
Intermittent nausea with dry heaves		4
Constant nausea, frequent dry heaves, vomiting		7
	N&V Total	
Tremor		
<i>Observe, arms extended, fingers spread apart</i>		
No tremor		0
Not visible, but can be felt fingertip to fingertip		1
Moderate, with patient's arms extended		4
Severe, even with arms not extended		7
	Tremor Total	
Paroxysmal sweats		
<i>Observe</i>		
No sweating visible		0
Barely visible sweating, palms moist		1
Beads of sweat obvious on forehead		4
Drenching sweats		7
	Paroxysmal sweats Total	
Anxiety		
<i>Observe, ask 'Do you feel nervous?'</i>		
No anxiety, at ease		0
Mildly anxious		1
Moderately anxious/guarded		4
Equivalent to acute panic states in severe delirium		7
	Anxiety Total	

Agitation*Observe*

Normal activity	0
Somewhat more than normal activity	1
Moderately fidgety and restless	4
Paces back and forth or constantly thrashes about	7
Agitation Total	

Orientation*Ask 'What day is it? Where are you? Who am I?'*

Orientated	0
Uncertain about date	1
Disorientated for date by no more than 2 calendar days	2
Disorientated for date by more than 2 calendar days	3
Disorientated for place or person	4
Orientation Total	

Tactile disturbances*Ask 'Any itching, pins and needles, burning, bugs crawling on skin?'*

None	0
Very mild itching, pins and needles, burning or numbness	1
Mild	2
Moderate	3
Moderately severe hallucinations	4
Severe hallucinations	5
Extremely severe hallucinations	6
Continuous hallucinations	7
Tactile disturbances Total	

Auditory disturbances*Observe, ask 'Are you more aware of sounds around you? Are you hearing things you know are not there?'*

Not present	0
Very mild harshness or ability to frighten	1
Mild	2
Moderate	3
Moderately severe hallucinations	4
Severe hallucinations	5
Extremely severe hallucinations	6
Continuous hallucinations	7
Auditory disturbances Total	

Visual disturbances *Ask 'Does the light appear too bright? Are you seeing anything that is*

<i>disturbing you? Are you seeing things you know are not there?’</i>		
Not present		0
Very mild sensitivity		1
Mild		2
Moderate		3
Moderately severe hallucinations		4
Severe		5
Extremely severe		6
Continuous hallucinations		7
	Visual disturbances Total	
Headache Ask ‘Does it feel like there is a band around your head?’ Do not rate for dizziness or light-headedness		
None present		0
Very mild		1
Mild		2
Moderate		3
Moderately severe		4
Severe		5
Very severe		6
Extremely severe		7
	Headache Total	
	Combined Total Score	

NURSING OBSERVATION SHEET

USE THIS SHEET TO ASSESS THE NEED FOR THE PRN OXAZEPAM DURING THE FIRST 24 HOURS

Date:		Patient name:		DOB:		Hospital no:		NEEDS CLINICAL REVIEW. PLEASE CONTACT ALCOHOL SPECIALIST NURSES (133208/133209)									
Clinical Institute Withdrawal Assessment of Alcohol Scale Revised (CIWA-Ar) For PRN Medication																	
Date																	
Time 24 h clock 2 hourly (increase frequency if CIWA-Ar >9)																	
Respiratory Rate (breaths per minute) if <10, inform medical team.																	
BEWARE OF over-sedation, if asleep do not wake patient (mark S)	Document full observations on TRP chart																
Nausea/Vomiting (0-7)																	
Tremor (0-7)																	
Sweats (0-7)																	
Anxiety (0-7)																	
Agitation (0-7)																	
Tactile Disturbances (0-7)																	
Auditory Disturbances (0-7)																	
Visual Disturbances (0-7)																	
Headache (0-7)																	
Orientation (0-4)																	
Total Score (max 67)																	
PRN oxazepam given as per drug chart																	
CIWA-Ar= 10-20= oxazepam 20mg CIWA-Ar >20= oxazepam 40mg																	
Initials																	

APPENDIX 3: LORAZEPAM DOSE REDUCING REGIME

Lorazepam is used as an alternative to oxazepam when patients are on NBM (nil by mouth) or has impaired swallowing. This can be given via IV, IM and sublingually. Caution is required with any fixed dose regime and should be monitored for oversedation.

Example Lorazepam withdrawal regime

	Low risk CIWA-Ar ≥ 8	Medium risk plus CIWA-Ar ≤ 15	Medium risk plus CIWA-Ar > 15 or High risk
Lorazepam Stabilisation dose Day 1	0.5 mg QDS + 0.5mg 2 hourly PRN	1mg QDS + 1mg 2 hourly PRN	2mg stat Repeat hourly up to 3 doses or CIWA-Ar <8 then 2mg QDS + 2mg hourly PRN
Stabilisation dose Day 2	0.5mg TDS + 0.5mg 2 hourly PRN	1mg QDS+ 1mg 2 hourly PRN	1-2mg QDS+1mg 4 hourly PRN
Day 3	0.5mg BD	0.5mg QDS	1mg QDS
Day 4	0.5mg BD	0.5mg TDS	1mg TDS
Day 5	0.5mg at night	0.5mg BD	1mg BD
Day 6		0.5mg at night	0.5mg BD
Day 7			0.5mg at night

APPENDIX 4: GMAWS (GLASGOW MODIFIED ALCOHOL WITHDRAWAL SCALE (GMAWS)) FOR SYMPTOM-TRIGGERED TREATMENT

Please note that this tool is only used to patients who are aphasic, cannot speak English or unable to communicate. GMAWS can only be utilised with the recommendation and supervision of ASNs or Gastro Consultant. CIWA-Ar should be the default tool to monitor acute withdrawal syndrome.

SYMPTOMS	Scoring
Tremor	0 No tremors 1 On movement 2 At rest
Sweating	0 No sweat visible 1 Moist 2 Drenching sweat
Hallucinations	0 Not present 1 Dissuadable 2 Not dissuadable
Orientation	0 Orientated 1 Vague, detached 2 Disorientated, no contact
Agitation	0 Calm 1 Anxious 2 Panicky

NURSING OBSERVATION SHEET (GMAWS)

USE THIS SHEET TO ASSESS THE NEED FOR THE PRN OXAZEPAM DURING THE FIRST 24 HOURS

Date:		Patient name:				DOB:				Hospital no:			
GMAWS (Glasgow Modified Alcohol Withdrawal Scale (GMAWS) for symptom-triggered treatment)													
Date													
Time 24 h clock 2 hourly (increase frequency if CIWA-Ar >9)													
Respiratory Rate (breaths per minute) if <10, inform medical team.													
BEWARE OF over-sedation, if asleep do not wake patient (mark S)	Document full observations on TRP chart												
TREMORS													
SWEATING													
HALLUCINATIONS													
ORIENTATION													
AGITATION													
TOTAL SCORE													
PRN oxazepam given as per drug chart													
Score 1-3 give 20mg oxazepam													
Score 4-8 give 40mg oxazepam													
Score 9-10 give 40mg oxazepam.													
Initials													

**NEEDS CLINICAL REVIEW. PLEASE CONTACT ALCOHOL SPECIALIST NURSES
(133208/133209)**

FULL VERSION CONTROL RECORD

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	October 2022	Hepatology Consultants	Final	Guideline to support new medication for patients in alcohol withdrawal
2.0	October 2023	Hepatology Consultants	Final	Update before launch date, added FibroScan in section 5, amended contributor list
2.1	June 2024	David Lang, Senior Pharmacist	Interim	Changes in practice due to the Pabrinex shortage 2024-26
2.2	March 2025	David Lang, Senior Pharmacist	Interim	Minor changes to the thiamine wording IV thiamine first line.