Clinical Toolkit

Clinical Tips: Alcohol Withdrawal and Management

The onset of alcohol withdrawal is usually between six and 24 hours after the last drink.

The signs and symptoms of alcohol withdrawal may be groups into three major classes – Autonomic hyperactivity, gastrointestinal, and cognitive and perceptual changes.

1. Autonomic hyperactivity

- Sweating
- Tachycardia
- Hypertension
- Tremor
- Fever (generally lower than 38^{0}C)
- Severe withdrawal complications include dehydration and electrolyte disturbance

2. Gastrointestinal features

- Anorexia
- Nausea
- Vomiting
- Dyspepsia
- Diarrhoea

3. Cognitive and Perceptual Changes

- Poor concentration
- Anxiety
- Psychomotor agitation
- Disturbed sleep
- Vivid dreams
- Severe withdrawal features include
- Seizure
- Hallucinations
- Perceptual disturbances (visual, tactile, auditory)
- delirium

Predictors of Alcohol Withdrawal Severity

In addition to the factors listed above, a predictor of increased alcohol withdrawal severity is the onset of alcohol withdrawal symptoms (such as tremor, nausea, anxiety) upon waking that are normally relieved by early morning drinking.

The following may also be used to predict the severity of alcohol withdrawal.

Past withdrawal experience. Patients with a history of severe alcohol withdrawal syndrome (such as severe anxiety, seizures, delirium, hallucinations) are more likely to experience such complications in future withdrawal episodes.

***Concomitant substance use**. Patients with heavy or regular use of other substances (such as benzodiazepines, stimulants, opiates) may experience more severe withdrawal features.* In particular, withdrawal from both alcohol and benzodiazepines may increase the risk of withdrawal complications.

Concomitant medical or psychiatric conditions. Patients with concomitant medical conditions (such as sepsis, epilepsy, severe hepatic disease, head injury, pain, nutritional depletion) or psychiatric conditions (such as anxiety, psychosis or depression) are more likely to experience severe withdrawal complications

More information on alcohol withdrawal and detoxification can be found at the YSAS website.

Management of acute alcohol withdrawal

Management of withdrawal symptoms in patients with prolonged alcohol dependence requires medical input. In situations where your client or patient is at risk of acute or severe withdrawal symptoms, it is recommended that you encourage consultation with a treating GP.

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Relapse is more likely if the patient suffers acute withdrawal symptoms; therefore ensuring that a suitable management plan is in place is essential for good clinical care. If a patient does experience withdrawal symptoms such as insomnia, panic attacks, seizure, etc. during their initial abstinence phase, it is helpful if they have an existing relationship with a GP or treating doctor who is aware of their situation – i.e., help-seeking behaviours are more likely where appropriate planning has occurred.

Admission to a medically supervised detoxification unit is recommended for the management of acute alcohol withdrawal. Severe alcohol withdrawal symptoms can be dangerous. Please see the YSAS withdrawal guidelines for more information.

Diazepam
Diazepam can be considered where prolonged regular us of alcohol has occurred. This is usually administered according to an alcohol withdrawal scale (10mg 1-4 hourly up to a total dose of 50mg daily up to 5 days) in ordered to minimise the total dose of diazepam given.

Thiamine
Alcohol consumption can cause thiamine and other deficiencies. Thiamine deficiency can precipitate Wernickes' Encephalopathy, which is characterised by the classic triad of confusion, abnormal movements of the eyes (opthalmoplegian and nystagmus) and imbalance (ataxia).

All heavy drinkers are advised to take 300md thiamine daily and ongoing while the heavy alcohol consumption is occurring, and during first five days of detox, and 100mg ongoing for at least 9 days post detox.

The other symptoms of withdrawal can be treated by specific medications. A handy table outlining these medications, their actions and dosage can be found on page 64 of the YSAS Adolescent Withdrawal Guidelines.

Management of Long-term Alcohol Dependence

Drug therapy for alcohol dependence should only be used in conjunction with a comprehensive treatment plan.

Naltrexone and acamprosate have well established efficacy and are first-line treatments. Naltrexone is recommended for patients aiming to cut down their alcohol intake and who do not have severe liver disease or an ongoing need for opioids. Acamprosate is recommended for those who have achieved and wish to maintain abstinence but is contra-indicated in pregnancy.

Disulfiram is no longer considered first-line treatment due to difficulties with compliance and toxicity.

Although baclofen and topiramate have evidence of benefit, they are not registered for alcohol dependence and should only be considered in specialist practice. Also, Baclofen is highly toxic in overdose and should be used with caution in patients with a history of overdose or other substance use, as well as those with a history of psychotic illness or renal insufficiency.

Further Information can be found at the following site:
https://www.nps.org.au/australian-prescriber/articles/long-term-drug-treatment-of-patients-with-alcohol-dependence

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