

The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management (2020)

About the Guideline

- The practice guideline was developed and updated by the American Society of Addiction Medicine's (ASAM) Quality Improvement Council on Alcohol Withdrawal Management.
- The guideline is one component in the overall treatment of alcohol use disorder, and it is intended to aid clinicians in patient management and decision-making to treat alcohol withdrawal (AW).
- The guideline was developed under ASAM's Quality Improvement Council oversight committee. A Guideline Committee moderator was chosen to act as a liaison between the Guideline Committee members and the project team and to lead the discussion during an in-person meeting of the Guideline Committee.
- This guideline provides recommendations in the following areas: identification and diagnosis of AW, initial assessment of AW, level of care determination, ambulatory management of AW, inpatient management of AW, addressing complicated AW, and specific settings and populations.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline, especially if you work in an acute care setting.

Identification and Diagnosis

- Universal screening of all patients for alcohol use using a validated scale is recommended to assess for the risk for alcohol use disorder or alcohol withdrawal (AW).
 - Patients with a recent or current history of alcohol use should be assessed for their risk of developing AW, both in the presence or absence of signs or symptoms.
- A diagnostic test (blood, breath, or urine analysis) may help identify recent alcohol use, but AW can still occur with a negative result.
- AW delirium and alcohol use disorder diagnoses should be made using the *Diagnostic and Statistical Manual, Fifth Edition* (DSM-5) criteria.
 - Alcohol withdrawal severity scales should not be used for AW diagnosis because other conditions can influence diagnostic scores. AW presence is not ruled out or based only a positive blood alcohol concentration.
- The patient's signs, symptoms, history, medication history, or other serious illnesses should be assessed since other etiologies can mimic AW.
- A neurological exam, electroencephalogram and/or neuroimaging, and recent alcohol consumption can assist in determining the causes of delirium.

Initial Assessment

- Current signs and symptoms, a validated risk assessment scale, current history and physical examination, and collateral information from family and friends should be included in the initial assessment for AW.

- Laboratory tests, polysubstance use, and pregnancy testing (if appropriate) should be part of the initial assessment, but AW treatment should not be delayed, even if results are not available.
- A mental health history and evaluation for active suicide risks should be part of the initial assessment for AW and considered when determining mental health treatment needs.

Level of Care Determination

- In addition to the current signs and symptoms, *The ASAM Criteria* Risk Assessment Matrix can be used to determine the needed level of care to prevent the development of severe withdrawal symptoms or complications of withdrawal.
- Five levels of care for AW management are defined by *The ASAM Criteria*, and settings should be utilized that are equipped to provide care for patients at active risk for suicide.

Ambulatory Management

- Patients should check in daily with a qualified practitioner for up to five days following the reduction or cessation of alcohol use.
 - Check-ins should focus on the patient's health since the last checkup, vital signs, orientation, hydration status, emotional status, suicide risk, and sleep status.
 - If available, the use of a breathalyzer to measure blood alcohol content is suggested during check-ins.
- AW severity should be measured with a validated tool. Patients may use a validated self-monitoring tool if they are able to monitor their own signs and symptoms.
- Patients with a history of or current benzodiazepine use disorder need additional monitoring in an ambulatory care setting.
- Transfer to a more intensive level of care is recommended for patients with the following indications:
 - Unresolved agitation
 - Severe tremor
 - Severe signs and symptoms
 - Worsening psychiatric condition
 - Oversedation
 - Alcohol use
 - Syncope or unstable vital signs
- Supportive care includes education for patients and family about the following:
 - What to expect during withdrawal, including signs, symptoms, and treatment.
 - Use of noncaffeinated fluids and the benefits of a daily multivitamin and oral thiamine.
 - The importance of taking medications as prescribed.
 - When transfer to a higher level of care is appropriate to ensure safe and effective treatment.
- First-line prophylactic pharmacotherapy treatment is benzodiazepines to prevent development of severe or complicated AW, including delirium and seizures.
 - Phenobarbital therapy or transfer to a more appropriate level of care can be utilized in patients with a contraindication for benzodiazepine use.
- Frontloading therapy is recommended for patients with a high risk of severe AW symptoms.
 - A minimum of a single dose of prophylactic medication is recommended for patients with the following:
 - History of complicated or severe withdrawal
 - Acute psychiatric, medical, or surgical illness

- Signs of AW concurrent with a positive blood alcohol content
- Pharmacotherapy is recommended for patients at risk of developing new or worsening signs or symptoms of AW while away from the treatment setting.
 - Appropriate monotherapy options are benzodiazepines, carBAMazepine, or gabapentin.
 - If AW risk is unknown, patients should be reassessed frequently over 24 hours for pharmacotherapy needs.
- If ongoing alcohol use disorder treatment is planned, gabapentin is the drug of choice for AW, and along with carBAMazepine or valproic acid, it can be used as a benzodiazepine adjunct.
- Oral or intravenous alcohol should not be used for the prevention or treatment of AW, and there is not sufficient evidence to support the use of baclofen or magnesium.

Inpatient Management

- Patients should be monitored for symptoms of AW, suicidal thoughts, stable vital signs, hydration, orientation sleep, emotional status, oversedation, and respiratory depression. Patients taking medications should be monitored every 1 to 4 hours for 24 hours until stable, and then every 4 to 8 hours for 24 hours.
- Supportive nursing care should include the following:
 - Frequent reassurance and orientation
 - Care in a quiet, well-lit room
 - Education about the signs and symptoms of withdrawal
 - Information about how signs and symptoms will be treated
 - Use of delirium protocols
- Other supportive care should include the following:
 - Thiamine supplementation to prevent Wernicke encephalopathy (requiring ICU admission)
 - Magnesium, phosphorus, and/or folate supplementation, if needed
 - Proper nutrition
- Patient engagement in alcohol use disorder treatment should be initiated during AW management.
- Benzodiazepines are the first-line pharmacotherapy treatment for patients at risk for developing severe or complicated AW, including delirium and seizures.
 - Phenobarbital may be used when there is a contraindication to benzodiazepines, or with moderate AW, with signs of liver disease, when no test results are available, and for patients at risk for developing new or worsening AW while away from an ambulatory setting.
- Patients on benzodiazepines should be monitored for over sedation and respiratory depression; they should be educated about the medication, and the drug should be discontinued following AW treatment.
- If needed, an alpha2-adrenergic agonists or a beta-adrenergic antagonists can be used as an adjunct to benzodiazepines.
- Phenobarbital can be used as an adjunct to benzodiazepines if monitoring can occur in settings such as ICU or CCU.
- Oral or intravenous alcohol should not be used for the prevention or treatment of AW, and there is not sufficient evidence to support the use of baclofen or magnesium.

Addressing Complications

- Patients should be monitored for AW seizures.

- Following a seizure, monitoring and reassessment should occur every 1 to 2 hours for 6 to 24 hours using available delirium protocols; IV fluids should be administered, if needed.
- After an AW seizure, benzodiazepines and agents such as LORazepam or diazePAM, rather than alpha2-adrenergic agonists or beta-adrenergic antagonists, should be given parenterally in a highly supervised setting such as an ICU or CCU.
- When delirium is present, close nursing observation, monitoring, use of delirium protocols, sedation, and IV benzodiazepines via an individualized dosing regimen are required.
- For patients with delirium that lasts longer than 72 hours, barbiturates or antipsychotic agents, as an adjunct to benzodiazepine treatment, should be used rather than alpha2-adrenergic agonists.
- For patients with alcohol-induced psychotic disorder, delirium protocols should be used for supportive care along with psychiatric consultation, the addition of antipsychotics and diazePAM if needed.
- For patients with resistant alcohol withdrawal, delirium protocols can be used for supportive care along with PHENobarbital as an adjunct to benzodiazepines; and dexmedetomidine can be used as an adjunct for patients in the ICU requiring mechanical ventilation due to resistant alcohol withdrawal.

Specific Settings and Populations

- Patients experiencing severe AW should be referred to the nearest emergency department.
- Patients in a primary care setting with mild withdrawal may receive a few doses of benzodiazepine but must have regular follow-up visits at least monthly for a year.
- Patients presenting to the emergency department experiencing severe AW must be assessed for delirium and other etiologies; they must have laboratory testing completed and can be discharged to an ambulatory setting when criteria are met. They should be given only 1 to 2 days of medications until follow-up with a provider.
- Patients admitted to the hospital, including those admitted for elective surgery, should be screened for the risk of severe or complicated AW and monitored for vital sign changes, fluid intake and output, and electrolytes.
 - If AW is suspected and no history is available, treatment should be more aggressive.
- In patients with a reduced level of consciousness who have a risk for developing AW, monitoring should occur for signs and symptoms of AW.
- ICU patients with signs and symptoms of Wernicke encephalopathy should receive thiamine and prophylactic treatment for AW if there is physiological dependency on alcohol.
- In patients with comorbidities, specialists should be consulted, and intravenous or intramuscular medications should be used, if needed. Medication doses should be adjusted if the patient has hepatic function impairment or a cardiovascular disorder, or if aggressive withdrawal treatment is indicated.
- Patients on chronic opioid medication or with opioid use disorder should be closely monitored for appropriate dose and stabilization.
- Patients with alcohol use disorder and who are pregnant require inpatient assessment and treatment for AW and an obstetrician consultation.
 - Short-acting benzodiazepine and barbiturates are the medications of choice for treatment of patients who are pregnant and experiencing AW.
 - Avoid the use of valproic acid in patients who are pregnant.

- Newborns should be assessed for benzodiazepine intoxication, sedative withdrawal, Fetal Alcohol Spectrum Disorder, and Fetal Alcohol Syndrome, and parents should be educated about services to assist them with their newborn's needs.
- State laws must be followed regarding child abuse and neglect, including reporting and plans of care for newborns with in-utero alcohol exposure.

Reference

American Society of Addiction Medicine. (2020). The ASAM clinical practice guideline on alcohol withdrawal management. *Journal of Addiction Medicine*, 14(35), 1–71. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/quality-science/the_asam_clinical_practice_guideline_on_alcohol-1.pdf?sfvrsn=ba255c2_0