

06 - Pharmacologically assisted withdrawal (alcohol)

Pharmacologically assisted withdrawal (alcohol detoxification)

482 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Pharmacologically assisted withdrawal (alcohol detoxification) Alcohol withdrawal is associated with significant morbidity and mortality when improperly managed. Pharmacologically assisted withdrawal is likely to be needed when: ■ ■there has been regular consumption of >15 units/day ■ ■AUDIT score >20 ■ ■there is a history of significant withdrawal symptoms. Symptom scales can be helpful in determining the amount of pharmacological support required to manage withdrawal symptoms. The Clinical Institute Withdrawal Assessment of Alcohol Scale Revised (CIWA-Ar)¹² (Figure 4.1) and Short Alcohol Withdrawal Scale (SAWS)¹³ (Table 4.3) are both 10-item scales that can be completed in around 5 minutes. The CIWA-Ar is an objective scale and the SAWS is a self-complete tool. A CIWA-Ar score >10 or a SAWS score >12 should prompt assisted withdrawal. Community detoxification is usually possible when: ■ ■There is a supervising carer, ideally 24 hours a day throughout the duration of the detoxification process. ■ ■The treatment plan has been agreed with the patient, their carer and their GP. ■ ■A contingency plan has been agreed with the patient, their carer and their GP. ■ ■The patient is able to pick up medication daily and be reviewed by professionals - regularly throughout the process. ■ ■Out-patient/community-based programmes including psychosocial support are available. Community detoxification should be stopped if the patient resumes drinking or fails to engage with the agreed treatment plan. In-patient detoxification is likely to be required if: ■ ■Regular consumption is >30 units/day. ■ ■SADQ >30 (severe dependence). ■ ■There is a history of seizures or delirium tremens. ■ ■The patient is a minor or an older adult. ■ ■There is current benzodiazepine use in combination with alcohol. ■ ■Substances other than alcohol are also being misused. ■ ■There is comorbid mental or physical illness, learning disability or cognitive impairment. ■ ■The patient is pregnant. ■ ■The patient is homeless or has no social support. ■ ■There is a history of failed community detoxification. In certain situations, there may be a clinical justification for undertaking a community detoxification

in these patients, however the reasons must be clear and the decision made by an experienced clinician.

Addictions and substance misuse CHAPTER 4 Patient: _____ Date: _____
Time: _____ Pulse or heart rate, taken for 1 minute: _____ Blood pressure: _____ NAUSEA AND VOMITING - Ask 'Do you feel sick to your stomach? Have you vomited?' Observation. 0 - no nausea and no vomiting 1 - mild nausea with no vomiting 3 4 - intermittent nausea with dry heaves 6 7 - constant nausea, frequent dry heaves and vomiting TACTILE DISTURBANCES - Ask 'Have you any itching, pins and (24 hours clock, midnight = 00:00) needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?' Observation. 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 TREMOR - Arms extended and fingers spread apart. Observation. 0 - no tremor 1 - not visible, but can be felt fingertip to fingertip 3 4 - moderate, with patient's arms extended 6 7 - severe, even with arms not extended AUDITORY DISTURBANCES - Ask 'Are you more aware of sounds 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. 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 PAROXYSMAL SWEATS - Observation. 0 - no sweat visible 1 - barely perceptible sweating, palms moist 3 4 - beads of sweat obvious on forehead 6 7 - drenching sweats VISUAL DISTURBANCES - Ask 'Does the light appear to be too bright? Is its colour 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. 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 ANXIETY - Ask 'Do you feel nervous?' Observation. 0 - no anxiety, at ease 1 - mild anxious 3 4 - moderately anxious, or guarded, so anxiety is inferred 6 7 - equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions 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 light-headedness. Otherwise, rate severity. 0 - not present 1 - very mild 2 - mild 3 - moderate 4 - moderately severe 5 - severe 6 - very severe 7 - extremely severe AGITATION - Observation. 0 - normal activity 1 - somewhat more than normal activity 3 4 - moderately fidgety and restless 6 7 - paces back and forth during most of the interview, or constantly thrashes about ORIENTATION AND CLOUDING OF SENSORIUM - Ask 'What day is this? Where are you? Who am I?' 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 Scores ≤ 10 - mild withdrawal (do not need additional medication) ≤ 15 - moderate withdrawal

“ 15 - severe withdrawal Total CIWA-Ar score _____ Rater's initials _____
Maximum possible score 67 Figure 4.1 Clinical Institute Withdrawal Assessment

of Alcohol Scale, Revised (CIWA-Ar).¹² The CIWA-Ar is not copyrighted and may be reproduced freely.

484 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Table 4.4 summarises common interventions used in alcohol withdrawal. Benzodiazepines are the treatment of choice for alcohol withdrawal. They exhibit cross-tolerance with alcohol and have anticonvulsant properties. Their use is supported by NICE guidelines,^{2,14} a Cochrane systematic review⁷ and British Association for Psychopharmacology guidelines.⁹ Parenteral thiamine (vitamin B1) and other vitamin Table 4.4 Alcohol withdrawal treatment interventions - a summary. Severity Supportive/medical care Pharmacotherapy for neuroadaptation reversal Thiamine supplementation Setting Mild CIWA-Ar ≤ 10 Moderate- to high-level supportive care, little if any medical care required Little to none required Simple remedies only (see below) Oral likely to be sufficient if patient is well nourished Home Moderate CIWA-Ar ≤ 15 Moderate- to high-level supportive care, little medical care required Little to none required Symptomatic treatment only Intramuscular thiamine should be offered if the patient is malnourished followed by oral supplementation Home or community team Severe CIWA-Ar > 15 High-level supportive care plus medical monitoring Symptomatic and substitution treatment (chlordiazepoxide) probably required Intramuscular thiamine should be offered followed by oral supplementation Community team or hospital CIWA-Ar > 10 + comorbid alcohol-related medical problems High-level supportive care plus specialist medical care Symptomatic and substitution treatments usually required Intramuscular thiamine followed by oral supplementation Hospital Table 4.3 Short Alcohol Withdrawal Scale (SAWS).¹³ None (0) Mild (1) Moderate (2) Severe (3) Anxious Sleep disturbance Problems with memory Nausea Restless Tremor (shakes) Feeling confused Sweating Miserable Heart pounding

Addictions and substance misuse CHAPTER 4 replacement is an important adjunctive treatment for the prophylaxis and/or treatment of Wernicke-Korsakoff syndrome and other vitamin-related neuropsychiatric conditions. In the UK, chlordiazepoxide is the benzodiazepine used for most patients in most centres as it is considered to have a relatively low dependence-forming potential. Some centres use diazepam. A short-acting benzodiazepine such as oxazepam or lorazepam may be used in individuals with impaired liver function or those who potentially may metabolise medication more slowly, such as older people. There are three types of assisted withdrawal regimens: fixed-dose reduction (the most common in non-specialist settings), variable-dose reduction (usually results in less benzodiazepine being administered but best reserved for settings where staff have specialist skills in managing alcohol withdrawal) and finally front-loading (infrequently used, and reserved for severe alcohol withdrawal).^{2,9} Assisted withdrawal regimens should never be started if the blood alcohol concentration is very high or is still rising. Monitor patients for oversedation/respiratory depression. Fixed-dose reduction regimen Fixed-dose regimens can be used in community or non-specialist in-patient/residential settings for uncomplicated patients. Patients should be started on a dose of benzodiazepine selected after an assessment of the severity of alcohol dependence (clinical history, number of units per drinking day and score on the SADQ). With respect to chlordiazepoxide, a general rule of thumb is that the starting dose can be estimated from current alcohol consumption. For example, if 20 units/day are being consumed, the starting dose should be 20mg four times a day. The dose is then tapered to zero over 5–10 days. Alcohol withdrawal symptoms should be monitored using a validated

instrument such as the CIWA-Ar¹² or SAWS.¹³ Mild alcohol dependence usually requires very small doses of chlordiazepoxide or else may be managed without medication. For moderate alcohol dependence, a typical regimen might be 10–20mg chlordiazepoxide four times a day, reducing gradually over 5–7 days (Table 4.5). This duration of treatment is usually adequate and longer treatment is rarely helpful or necessary. It is advisable to monitor withdrawal and BAC daily before providing the day's medication. This may mean that community pharmacologically assisted alcohol withdrawals should start on a Monday and last for 5 days. Table 4.5 Moderate alcohol dependence: example of a fixed-dose chlordiazepoxide treatment regimen.

Day	Dose	Total daily dose (mg)
1	20mg four times a day	80
2	15mg four times a day	60
3	10mg four times a day	40
4	5mg four times a day	20
5	5mg twice a day	10

486 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Severe alcohol dependence usually requires in-patient treatment for assisted withdrawal because of the significant risk of life-threatening complications. However, there are rare occasions where a pragmatic community approach is required. In such situations, the decision to undertake a community-assisted withdrawal must be made by an experienced clinician. Intensive daily monitoring is advised for the first 2–3 days. This may require special arrangements over a weekend. Prescribing should not start if the patient is intoxicated. In such circumstances, they should be reviewed at the earliest opportunity when not intoxicated. The dose of benzodiazepine may need to be reduced over a 7–10-day period in this group (occasionally longer if dependence is very severe or there is a history of complications during previous detoxifications) (Table 4.6). Symptom-triggered regimen This should be reserved for managing assisted withdrawal in specialist alcohol in-patient or residential settings. Regular monitoring is required (e.g. pulse, blood pressure, temperature and level of consciousness). Medication is only given when withdrawal symptoms are observed as determined using CIWA-Ar, SAWS or an alternative validated measure. Symptom-triggered therapy is generally used in patients without a history of complications. A typical symptom-triggered regimen would be chlordiazepoxide 20–30mg hourly as needed. The total dose given each day would be expected to decrease from day 2 onwards. It is common for symptom-triggered treatment to last only 24–48 hours before switching to an individualised fixed-dose reducing schedule. Occasionally (e.g. in delirium tremens) the flexible regimen may need to be prolonged beyond the first 24 hours. Table 4.6 Severe alcohol dependence: example of a fixed-dose chlordiazepoxide regimen.

Day	Dose	Total daily dose (mg)
1 (first 24 hours)	40mg four times a day + 40mg when necessary	160
2	40mg four times a day	160
3	30mg four times a day	120
4	25mg four times a day	100
5	20mg four times a day	80
6	15mg four times a day	60
7	10mg four times a day	40
8	10mg four times a day	40
9	5mg four times a day	20
10	10mg at night	10

Example of a symptom-triggered chlordiazepoxide regimen² ■ ■ Days 1–5: 20–30mg chlordiazepoxide as needed, up to hourly, based on symptoms

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