

2.6.3 Self-medication

Self-medication presents a risk during alcohol withdrawal, particularly when there is minimal supervision (low level and medium level 1 settings). Inform patients of the risk of self-medication (e.g., overdose, undiagnosed complications, failure to complete withdrawal).

Self-medication is more likely if the treatment is inadequately explained to the patient or supportive care is inadequate.

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2.6.4 Medication for withdrawal syndrome

Benzodiazepines (usually diazepam) are the treatment of choice for alcohol withdrawal. Benzodiazepines are effective because they are cross-tolerant with alcohol.

Typically, diazepam is required when there is:

- mild to severe withdrawal (CIWA-AR > 10 or AWS > 5)
- a history of withdrawal seizures.

In general, diazepam should not be required for:

- very mild withdrawal (CIWA-AR < 10 or AWS < 5), and
- no previous withdrawal history of seizures.

Diazepam loading regimens are best suited to settings where the nurses have specific expertise in withdrawal management.

A fixed dosage regimen, with additional dosing as required, is preferred in settings where nurses do not have specific expertise in managing withdrawal.

Further details of the use of diazepam are given in subsection 2.6.6 (for ambulatory detoxification), subsection 2.6.7 (for managing moderate to severe withdrawal in a residential setting) and subsection 2.7.2 (for managing delirium tremens).

Other symptomatic treatments

For headache consider paracetamol.

For nausea or vomiting consider metoclopramide (Maxolon[®]) 10 mg every 6 hours or prochlorperazine (Stemetil[®]) 5 mg every 6 hours orally or intramuscularly.

For diarrhoea consider Lomotil[®], Kaomagma[®].

Never give alcohol to relieve withdrawal symptoms.

Prevention of dehydration

There can be significant fluid loss in alcohol withdrawal through diuresis (increased urination) caused by alcohol, sweating, vomiting and diarrhoea. In some cases dehydration may be serious and require aggressive fluid replacement.

- Assess and record nutritional intake, fluid intake and output.
- Encourage oral rehydration.
- Monitor carefully for signs of dehydration.

In severe withdrawal:

- Intravenous rehydration of up to 2–5 L per day may be required.
- Consider monitoring of urea, electrolytes and creatinine.

2.6.5 Routine prevention of Wernicke's encephalopathy

All people being treated for alcohol withdrawal should routinely receive prophylactic thiamine.

Recommended doses are:

- 100 mg orally, up to three times per day for at least one week.
- 100 mg IV or IM if Wernicke's encephalopathy is suspected. Then continue IM for three days. Oral doses should then be continued indefinitely.

Wernicke's encephalopathy is a form of brain injury resulting from thiamine (Vitamin B₁) deficiency. If not treated early it can lead to permanent brain damage and memory loss.

Wernicke's encephalopathy was common in Australia in people who were alcohol dependent before the introduction of thiamine supplementation of food, but is now uncommon.

Clinically, the patient with Wernicke's encephalopathy presents with confusion, eye signs (nystagmus with or without ophthalmoplegia) and ataxia. However, it is uncommon for all three to be present. Peripheral neuropathy is present in up to 80% of people with Wernicke's encephalopathy.

Wernicke's encephalopathy can be particularly difficult to diagnose in an intoxicated patient as the signs of ataxia, confusion and nystagmus may also be attributed to intoxication.

The absorption of thiamine is erratic while the gastrointestinal tract is affected by alcohol. Accordingly, thiamine should be given IM or IV initially if possible.

Administer thiamine before giving glucose, including food or sweet drinks. A carbohydrate load in the presence of thiamine deficiency runs the risk of precipitating Wernicke's encephalopathy.

2.6.6 Ambulatory withdrawal treatment

The standard therapeutic regimen involves regular doses of diazepam over two to six days. The dose is usually tapered over the latter days. For most cases of withdrawal, diazepam should not continue past the sixth day.

When a patient is suitable for withdrawal from alcohol at home, consult with him/her to choose a date for commencing detoxification. The date will be determined by the availability of the patient, the doctor, and the carer who will be with the patient during the day.

Take some time to explain to the patient and the carer:

- expected withdrawal symptoms and course of withdrawal
- possible complications and measures that should be taken if complications do arise
- the medication (diazepam) to be used, its side effects (mainly sedation) and the risks of combining it with alcohol (i.e., incoordination, disinhibition, respiratory depression).

Between the initial consultation and commencing withdrawal it is safest to recommend that the patient not stop drinking suddenly until the night before the planned treatment begins. Should the patient stop drinking earlier, withdrawal symptoms may appear before they can be properly managed.

On the first morning, see the patient to assess early withdrawal symptoms. Ensure that the patient is not intoxicated and has not been drinking within the last eight hours. Prescribe 5–10 mg (depending upon body mass and tolerance) of diazepam six hourly to begin after the patient arrives home from attending this consultation.

If the patient has a history of high tolerance to alcohol or benzodiazepines, it is prudent to give a further two 10 mg doses to use as required during the first day.

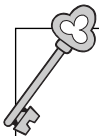
The patient or carer should contact the medical practitioner later that day to enable a brief (10 minute) discussion of symptom control, medication side effects, use of additional (PRN) doses, and to deal with any other concerns.

See the patient each day for the first three or four days, with telephone contact in the afternoons for the first one or two days. Tailor the diazepam dose to the patient's needs — the aim is to control withdrawal symptoms without oversedation.

Begin by providing medication for one day at a time. If there is confidence in the progress of withdrawal and the carer is willing to be involved in monitoring the patient, after Day 2 more than one day's medication could be provided.

The medical practitioner should continue daily or second daily contact with the patient until withdrawal is completed.

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An example of a diazepam regimen for alcohol withdrawal in an ambulatory setting

Days 1 & 2 diazepam 10 mg six hourly with up to two additional 10 mg doses PRN

Day 3 diazepam 10 mg six hourly

Day 4 diazepam 5 mg morning and night

Tapering doses may be required over the next two days.

PRN = taken as required for symptom relief.