NICE National Institute for Health and Care Excellence

NICE Pathways

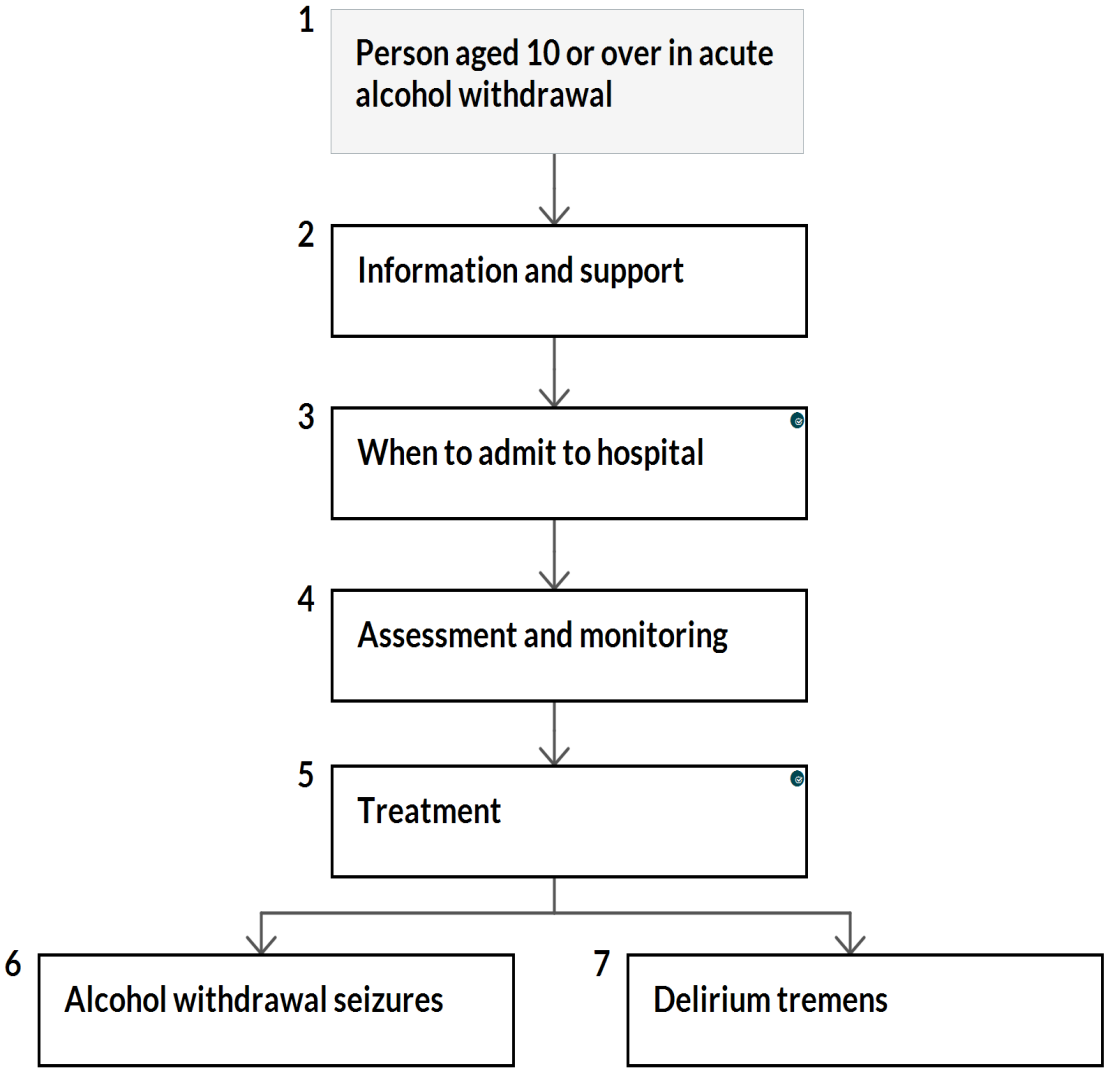
Acute alcohol withdrawal

NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

http://pathways.nice.org.uk/pathways/alcohol-use-disorders
NICE Pathway last updated: 31 March 2021

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person aged 10 or over in acute alcohol withdrawal

No additional information

2 Information and support

For people who are alcohol dependent [See page 8] but not admitted to hospital, offer advice to avoid a sudden reduction in alcohol intake[1] and information about how to contact local alcohol support services.

People with decompensated liver disease who are being treated for acute alcohol withdrawal should be offered advice from a healthcare professional experienced in the management of patients with liver disease.

Offer information about how to contact local alcohol support services to people who are being treated for acute alcohol withdrawal.

3 When to admit to hospital

For people in acute alcohol withdrawal with, or who are assessed to be at high risk of developing, alcohol withdrawal seizures or delirium tremens, offer admission to hospital for medically-assisted alcohol withdrawal.

For young people under 16 years who are in acute alcohol withdrawal, offer admission to hospital for physical and psychosocial assessment, in addition to medically-assisted alcohol withdrawal.

For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically-assisted alcohol withdrawal.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

[1] While abstinence is the goal, a sudden reduction in alcohol intake can result in severe withdrawal in dependent

drinkers.

Alcohol-use disorders: diagnosis and management

8. Medically assisted alcohol withdrawal – setting

4 Assessment and monitoring

Healthcare professionals who care for people in acute alcohol withdrawal should be skilled in the assessment and monitoring of withdrawal symptoms and signs.

Follow locally specified protocols to assess and monitor patients in acute alcohol withdrawal. Consider using a tool (such as CIWA–Ar scale) as an adjunct to clinical judgement.

People in acute alcohol withdrawal should be assessed immediately on admission to hospital by a healthcare professional skilled in the management of alcohol withdrawal.

5 Treatment

Offer pharmacotherapy to treat the symptoms of acute alcohol withdrawal as follows:

- Consider offering a benzodiazepine[1] or carbamazepine[2].
- Clomethiazole[3] may be offered as an alternative to a benzodiazepine or carbamazepine. However, it should be used with caution, in inpatient settings only and according to the SPC.

People with decompensated liver disease who are being treated for acute alcohol withdrawal should be offered advice from a healthcare professional experienced in the management of patients with liver disease.

Offer information about how to contact local alcohol support services to people who are being treated for acute alcohol withdrawal.

Follow a symptom-triggered regimen [See page 8] for drug treatment for people in acute alcohol withdrawal who are:

- in hospital **or**
- in other settings where 24-hour assessment and monitoring are available.

[1] Benzodiazepines are used in UK clinical practice in the management of alcohol-related withdrawal symptoms. Diazepam and chlordiazepoxide have UK marketing authorisation for the management of acute alcohol withdrawal symptoms. However, at the time of writing (May 2010), alprazolam, clobazam and lorazepam did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. In addition, the

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

Alcohol-use disorders: diagnosis and management

9. Medically assisted alcohol withdrawal – drug regimens

6 Alcohol withdrawal seizures

In people with alcohol withdrawal seizures, consider offering a quick-acting benzodiazepine (such as lorazepam[1]) to reduce the likelihood of further seizures.

If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.

Do not offer phenytoin to treat alcohol withdrawal seizures.

7 Delirium tremens

In people with delirium tremens, offer oral lorazepam[2] as first-line treatment. If symptoms persist or oral medication is declined, offer parenteral lorazepam or haloperidol[3].

If delirium tremens develops in a person during treatment for acute alcohol withdrawal, review their withdrawal drug regimen.

SPC for alprazolam advises that benzodiazepines should be used with extreme caution in patients with a history of alcohol abuse. The SPC for clobazam states that it must not be used in patients with any history of alcohol dependence [See page 8] (due to increased risk of dependence). The SPC for lorazepam advises that use in individuals with a history of alcoholism should be avoided (due to increased risk of dependence).

[2] Carbamazepine is used in UK clinical practice in the management of alcohol-related withdrawal symptoms. At the time of writing (May 2010), carbamazepine did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented.

[3] Clomethiazole has UK marketing authorisation for the treatment of alcohol withdrawal symptoms where close hospital supervision is also provided. However, at the time of writing (May 2010), the SPC advises caution in prescribing clomethiazole for individuals known to be addiction prone and to outpatient alcoholics. It also advises against prescribing it to patients who continue to drink or abuse alcohol. Alcohol combined with clomethiazole, particularly in alcoholics with cirrhosis, can lead to fatal respiratory depression even with short-term use. Clomethiazole should only be used in hospital under close supervision or, in exceptional circumstances, on an outpatient basis by specialist units when the daily dosage must be monitored closely.

[1] Lorazepam is used in UK clinical practice in the management of delirium tremens. At the time of writing (May 2010), lorazepam did not have UK marketing authorisation for this indication. Informed consent should be obtained and documented. In addition, the SPC advises that use in individuals with a history of alcoholism should be

avoided (due to increased risk of dependence).

[2] Although lorazepam is used in UK clinical practice in the management of delirium tremens, at the time of publication (April 2017), it did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. In addition, the SPC advises that use in individuals with a history of alcoholism should be avoided (due to increased risk of dependence).

[3] Although haloperidol is used in UK clinical practice in the management of delirium tremens, at the time of publication (April 2017), it did not have a UK marketing authorisation for this indication. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. In addition, the SPC advises caution in patients suffering from conditions predisposing to convulsions, such as alcohol withdrawal.

A symptom-triggered regimen involves treatment tailored to the person's individual needs. These are determined by the severity of withdrawal signs and symptoms. The patient is regularly assessed and monitored, either using clinical experience and questioning alone or with the help of a designated questionnaire such as the CIWA–Ar. Drug treatment is provided if the patient needs it and treatment is withheld if there are no symptoms of withdrawal.

Alcohol dependence is a cluster of behavioural, cognitive and physiological factors that typically include a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol-dependent may persist in drinking, despite harmful consequences. They will also give alcohol a higher priority than other activities and obligations. For further information, please refer to: 'Diagnostic and statistical manual of mental disorders' (DSM-IV) (American Psychiatric Association 2000) and 'International statistical classification of diseases and related health problems – 10th revision' (ICD-10) (World Health Organization 2007).

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Glossary

CIWA–Ar

(the Clinical Institute Withdrawal Assessment – Alcohol, revised (CIWA–Ar) scale is a validated 10-item assessment tool that can be used to quantify the severity of the alcohol withdrawal syndrome, and to monitor and medicate patients throughout withdrawal)

SPC

summary of product characteristics

Sources

Alcohol-use disorders: diagnosis and management of physical complications (2010, updated 2017) NICE guideline CG100

Your responsibility

Guidelines

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to

have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.