

Alcohol Withdrawal Syndrome

PHYSICIAN Pre-Printed Orders

Check box to activate orders below if applicable.
Cross off non-applicable orders with a single line.

ALLERGIES: None Known Yes _____

- Psychiatric Consult
- “Suicide Risk Assessment Tool”** post withdrawal (required for all patients once withdrawal completed)
 1. Implement Withdrawal Syndrome Precautions. Score patient using Richmond Agitation Sedation Scale. **Desired RASS score is 0 to -1.**
 2. Thiamine 100 mg po daily x 3 days
Folic Acid 1 mg po daily x 3 days
Multivitamin 1 tablet po daily
If patient unable to take PO:
Thiamine 100 mg & Folic Acid 1 mg IV in 100 ml Normal Saline over 1 hour x 3 days
 3. 1 liter D5NS with 20meq KCL at _____/hour. (Start after first piggyback of Thiamine and Folic Acid finishes or patient has taken PO vitamins.
 4. Obtain a serum magnesium and potassium on admit and daily while on withdrawal protocol and treat per *Potassium Magnesium Replacement Protocol.*

Select either 5a or 5b and check appropriate boxes:

- 5. a. Patient at **Low Risk** for Alcohol Withdrawal Delirium: *1
(This regimen preferred for patients with COPD or respiratory illness)
 - Lorazepam 1 mg PO or IV every 1 hour PRN early withdrawal symptoms
- OR**
- b. Patient at **High Risk** for Alcohol Withdrawal Delirium: *2
 - Lorazepam 2 mg PO or IV every 4 hours x 12 doses then
Lorazepam 1 mg PO or IV every 6 hours x 6 doses then discontinue order and give
 - Lorazepam 1 mg PO or IV every 1 hour PRN early withdrawal symptoms.

For Acute Alcohol Withdrawal Delirium Treatment Regimen: *3 (Notify the attending physician and the hospitalist of acute alcohol withdrawal and inquire regarding ICU transfer.)

- 6. Lorazepam 2 mg IV every 15 minutes PRN. (If patient needs 8mg in 1 hour **OR** if severe agitation continues with Richmond score of +3 or greater contact physician for medication order that will treat delirium and transfer the patient to ICU.)

ICU ONLY

- 7. Haldol _____mg IV is for sedation every 4 hours PRN (**ICU only**) and check QTc interval prior to administration of drug, notify physician and hold Haldol if QTc 500 msec or greater.
- 8. Recheck QTc 2 hours after first dose of Haldol and every 8 hours. Notify physician if QTc is greater than 500 msec or there is a change of greater than 80 msec and discontinue Haldol.

Date/Time:	Physician Signature:
Date/Time:	Transcription Signature:

General Information

Acute Alcohol Withdrawal Syndrome occurs when early alcohol withdrawal symptoms are not promptly recognized and treated. Treatment with benzodiazepines should reduce or eliminate withdrawal symptoms.

Early alcohol withdrawal symptoms to monitor all patients for include:

GI Complaints: Nausea, vomiting, anorexia

Peripheral Nervous System Hyperactivity: Tremor, tachycardia, tachypnea, hypertension, fever, and diaphoresis

Central Nervous System Complaints: anxiety, insomnia, restlessness, light/sound sensitivity, headache

^{*1}Low Risk:

No prior history of alcohol withdrawal symptoms (“shakes”) or history of acute alcohol withdrawal, patient consumes minimal (less than or equal to 2 drinks per day) alcohol, patient is not exhibiting any signs/symptoms of early alcohol withdrawal.

^{*2}High Risk:

Prior history of acute alcohol withdrawal syndrome, history of withdrawal seizures, daily consumption of large quantities (more than 2 drinks per day) of alcohol, patient exhibits signs/symptoms of early alcohol withdrawal.

^{*3}Acute alcohol withdrawal delirium requiring physician notification:

Early alcohol symptoms (see above) **and**, dry heaves, drenching sweats, agitation, panic, seizures, visual, tactile, and/or auditory hallucinations confusion, disorientation, agitation and/or marked tremor.

All patients will be scored using Richmond Sedation Scale.

The goal of sedation will be a 0 to –1 on the scale below:

Richmond Agitation Sedation Scale

+4	Combative	Overtly combative, violent, immediate danger to staff
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive
+2	Agitated	Frequent non-purposeful movement, fights ventilator
+1	Restless	Anxious but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained awakening (Eye-opening/contact) to voice (≥ 10 seconds)
-2	Light sedation	Briefly awakens with eye contact to voice (< 10seconds)
-3	Moderate sedation	Movement or eye-opening to voice (but no eye contact)
-4	Deep sedation	No response to voice, but movement or eye opening to physical stimulation
-5	Unarousable	No response to voice or <i>physical</i> stimulation