Alcohol Withdrawal Management Pathway

- Use for any patient suspected of withdrawing from alcohol.
- Complete AUDIT-C and Severity of Alcohol Dependence Questionnaire (SADQ) Calculator; also available on EPR as e-forms.
- Use the scores from these tools to guide dosing of **diazepam** or **chlordiazepoxide** (see below). A fixed dose reducing regimen is indicated for SADQ scores of 16 or above.

Alcohol history – confirm the following: • Quantity, type and frequency of drinking (unit calculation) • Date and time of last drink – risks associated with withdrawal are highest within the first 96 hours after the last drink (seizure risk 6-48 hours and delirium tremens 48-96 hours post drink) • Past history of withdrawal (including seizures/delirium tremens) • Other drug use (illicit, prescribed or purchased) • Current substance misuse treatment • Desire to stop/reduce drinking • Nutritional status (malnutrition, symptoms of Wernicke's Encephalopathy [WE], weight loss, vomiting)	Consider referral to drug and alcohol services in the patient's locality

Signs of withdrawal:

- Tremor (tongue, eyelids, hands)
- Sweating
- Nausea, vomiting
- Mild hypertension
- Tachycardia (>100bpm)
- Psychomotor agitation
- Headache
- Insomnia
- Malaise or weakness

Choose a regimen from below – **always** use fixed regimen plus symptom controlled for patients with the following risk factors:

- Previous severe withdrawal or delirium tremens
- Previous alcohol withdrawal related seizure(s)
- High initial Alcohol Withdrawal Scale (AWS) score – also use clinical judgement and look for objective signs of withdrawal

Co-prescription of other benzodiazepines/z-drugs must be approved by a senior medical prescriber

Title	Alcohol Withdrawal Management Pathway	
Approved by	Drug & Therapeutics Committee	Date of approval: 28th May 2026
Reference	PHARM-0100-v3	Review date: 1st June 2029

Fixed Regimen	**Symptom triggered** use when clinical risks are low and unable to confirm alcohol history or when SADQ is <16.

Fixed titration regimens are available on EPMA for AMH and MHSOP patients under 'titrations' and are based on SADQ score – **select appropriate regimen for patient demographic.**
 	
Chlordiazepoxide regimens are for use on MHSOP wards only.
 	
Diazepam regimens should be used on AMH wards.
 	
Ensure PRN is also prescribed as appropriate:
• AWS 6-9: diazepam 4 mg or chlordiazepoxide 10 mg;
• AWS 10 or above: diazepam 8 mg or chlordiazepoxide 20 mg
• Minimum dose interval = 1-hour.
• Maximum dose in 24 hours (including regular doses):
  ○ Diazepam 100 mg
  ○ Chlordiazepoxide 120 mg (60 mg if frail)
	For AMH:
	• AWS <6: no treatment
	• AWS 6-9: give 4 mg diazepam and recheck AWS hourly until <6 then complete AWS 4-hourly
	• AWS >10: give 8 mg diazepam and recheck AWS hourly until <6 then complete AWS 4-hourly
	
	For MHSOP:
	• AWS <6: no treatment
	• AWS 6-9: give 10 mg chlordiazepoxide and recheck AWS hourly until <6 then complete AWS 4-hourly
	• AWS >10: give 20 mg chlordiazepoxide and recheck AWS hourly until <6 then complete AWS 4-hourly
	
	Review frequency of use after 24 hours and consider prescribing a fixed regimen if indicated.

Seizure management

Prescribe **buccal midazolam 10 mg PRN**, to be administered for seizures lasting >5 minutes. Dose can be repeated after 5 minutes. If this occurs, consider escalation to acute hospital.

Important notes

- Consider differential diagnosis e.g. sepsis, delirium etc.
- Treat with **thiamine** (advice on next page) – alcohol consumption reduces thiamine absorption for the diet, also it is likely if there is co-existing poor diet.
- Investigate LFT's and clotting factors to assess hepatic function. Consider using lorazepam as an alternative to diazepam or chlordiazepoxide if there is existing hepatic impairment – see EPMA for fixed schedule
- Consider using lower doses if there is severe hepatic or renal impairment and in patients aged over 65 years.

Wernicke's Encephalopathy:

Wernicke's is a **medical emergency.** It is essential that all patients with suspected alcohol withdrawal receive a full neurological examination upon clerking. Without prompt identification and appropriate management Wernicke's can lead to long lasting irreversible brain injury. Acute Wernicke's encephalopathy does not occur only when people stop drinking, and people who are malnourished or have decompensated liver disease remain at risk while they continue to drink alcohol.

Risk of Wernicke's Encephalopathy (WE) ➞	**Low risk**	**Medium to high risk**	**Diagnosed or suspected**
Risk factors	➢ Mild to moderate alcohol dependence. ➢ Eating a normal diet. ➢ No liver disease	➢ Moderate to severe alcohol dependence. ➢ Malnourished: significant weight loss, poor diet, BMI <18. ➢ Previous history of complicated alcohol withdrawal (including WE). ➢ Alcohol related Liver disease (ARLD). ➢ Long history of harmful alcohol dependence. ➢ Acute Illness	History of alcohol excess and any **ONE** of the following: ➢ Ophthalmoplegia ➢ Ataxia ➢ Encephalopathy: acute cognitive impairment or delirium
Management	Prescribe **oral thiamine 50 mg four times daily**, then to be reviewed by GP after discharge.	Prescribe **IM thiamine 250 mg once daily for 5 days;** then oral thiamine 50 mg four times daily to be reviewed by GP after discharge.	**Transfer to acute hospital for IV thiamine**

Nutrition

- All patients with suspected alcohol withdrawal should be assessed for refeeding risk at initial clerking.
- If refeeding risk is suspected, then manage the risk as per the Refeeding Syndrome Procedure
- Ensure the following investigation are completed: FBC, Magnesium, phosphate, calcium, Folate/B12, Vitamin D and U&E's.
- Replace any deficiencies of magnesium, potassium and phosphate as per the refeeding policy.
- Ward team to complete dietician referral.

Delerium Tremens (DT)

Delerium tremens is a **medical emergency**. If delirium tremens is suspected, then the patient should be transferred to the acute hospital for treatment.

Symptoms: Disorientation, agitation, hypertension (>20 mmHg rise in systolic blood pressure) tachycardia (heart rate over 120 bpm), hallucinations (auditory, olfactory, visual), insomnia, fever, marked tremor, paranoid ideation.

Risk factors for DT: previous seizures or delirium, low potassium, low magnesium, multiple co-existing physical health co-morbidities, thiamine deficiency.

Supporting relapse prevention

- Acamprosate and naltrexone are first line pharmacological interventions for relapse prevention. Both are commissioned as specialist drugs and should only be started after discussion with the specialist service that will continue prescribing it in the community.
- Although some specialist centres use acamprosate off label for neuroprotection during alcohol detoxification, this is not an approved use in TEWV or either ICB. Acamprosate should therefore only be prescribed within its product licence, with specialist team input, and in line with the commissioning position. Where a plan has been agreed between the specialist alcohol service and the patient to start acamprosate during inpatient detoxification, with the intention of long-term continuation, it may be initiated on admission while the benzodiazepine dose is being reduced.