Whittington Health NHS

Alcohol withdrawal and intoxication

Subject:	Alcohol withdrawal and intoxication
Policy Number	N/A
Ratified By:	Clinical Guidelines Committee
Date Ratified:	October 2006 (v1) reviewed Jan - March 2015
Version:	2.0
Policy Executive Owner:	Divisional Director ICAM
Designation of Author:	Dr VS Wong (Consultant) Review: T Orr (Clinical Services Manager, Primary Care Alcohol and Drug Services)
Name of Assurance Committee:	As above
Date Issued:	March 2015
Review Date:	3 years hence
Target Audience:	All clinical teams
Key Words:	Alcohol, withdrawal, intoxication, misuse

Version Control Sheet

Version	Date	Author	Status	Comment
1.0	Oct 2006	Dr V S Wong	OFF LINE	New guideline approved at Clinical Guidelines Committee
2.0	Jan 2015	T Orr	LIVE	General review of content: • Changes in individuals' / organisations' contact names / details • Removal of obsolete referral pathways • Inclusion of new referral pathways None of the treatment / investigation content needed amending as is still current.

➢ Criteria for use

For use in the treatment of patients suffering from or likely to suffer from alcohol withdrawal or patients suffering from alcohol intoxication.

➢ Background/ introduction

Alcohol related deaths account for 8-18% of causes of death in males and 2-4% in females in Europe and America. An alcohol related inpatient admission costs the NHS 2- 12% of its total expenditure on hospitals. Therefore this guideline aims to provide optimal management for these patients.

➢ Acute Effects of Alcohol Misuse

Gastrointestinal: Pancreatitis, Mallory-Weiss syndrome, gastritis, oesophagitis
Cardiac: Cardiac arrhythmias
Neurological: CVA, neuropraxia
Respiratory: Aspiration pneumonia
Endocrine: Hypoglycaemia
Others: Rhabdomyolyis, acute alcohol poisoning, accidents and injury

➢ Effects of Increasing Blood Alcohol Concentrations

Amount (Units)	Blood Alcohol (mg/100ml)	Effects
2	30	Accident risk
3	50	Mood, judgement impaired
5	80	Risk taking behaviour
10	150	Loss of self control, slurring of speech
12	200	Staggering, diplopia, memory loss
25	400	Sleep, coma
30	500	Death possible
38	600	Death certain

➢ Alcohol Withdrawal Effects

- 40% of patients who are alcohol dependent develop withdrawal symptoms and 5% develop delirium tremens.
- Alcohol withdrawal start 6 - 8 hours after stopping alcohol
- Withdrawal symptoms include generalized hyperactivity, retching, tachycardia, hypertension, pyrexia, tremor, anxiety and sweating.
- Symptoms peak between 10 - 30 hours and subside by 40 - 50 hours.
- Fits can occur in the first 12 - 48hrs
- Visual and auditory hallucinations can occur and may last up to 5 - 6 days.

Delirium tremens occurs 24 - 72 hours after cessation of drinking and is characterized by:

1. Tachycardia, cardiac arrhythmias, fever
2. Agitation, profound confusion, delusions, hallucinations
3. Ketoacidosis, collapse,
4. Grand mal epileptic fit

➢ Investigations

Urgent:

- Full blood count
- Urea and electrolytes
- Blood sugar
- Alcohol level*
- Consider toxic screen or drugs level if not sure of the diagnosis.

Investigate other cause of coma if alcohol level is less than 400 mg/100ml

Non – Urgent

- Serum Amylase
- Liver function tests and gamma GT
- INR
- Thyroid function tests,
- Chest X ray, electrocardiogram

➢ Management of the intoxicated patient

Mild to moderate clinical intoxication:
(no altered level of consciousness and alcohol level less than 300 mg/100 ml) can be managed in general medical ward.

1. Correct dehydration and biochemical abnormalities

2. Vitamin supplementation (see table) and encourage oral nutrition.

3. Treat convulsions with intravenous (IV) diazepam in dose of 0.15 - 0.25mg/Kg (10 20mg) every 4 hours or lorazapam (2 - 4mg IV) as a short acting sedation.

Hallucinations treated with haloperidol 2 mg by IV injection (Max 18 mg daily or 1.5-3 mg 2-3 times daily orally)

If venous access is difficult, give rectal diazepam as rectal solution 500 mcg/Kg up to a max of 30 mg (15 mg in elderly)

Severe intoxication:
Severe intoxication will need to be treated in HDU /monitored bed to observe urine output, blood glucose, electrolytes, ABG every 4 hours. Inform outreach team via switchboard.

For all severely intoxicated patients contact the National Poisons Information Service (Toxbase) on 0844 892 0111 / www.toxbase.org

Naloxone should be used if an opioid has been co-ingested: naloxone (0.4 - 2 mg) by IV injection. Repeat every 2-3 minutes. (Maximum of 10 mg) as advised by The National Poisons Information Service www.npls.org

➢ Recommended regimens for vitamin supplement for inpatients

Patient Condition	Regimen
- Well nourished - Adequate dietary intake - No neuropsychiatric signs	Oral thiamine 100mg tds
Malnourished History of dietary neglect Peripheral neuropathy	IV Pabrinex 1 pair of ampoules daily for 3 days in 50 – 100 ml Glucose or Sodium Chloride 0.9 % over 20- 30 mins
Symptoms of Wernicke Syndrome (Ataxia, ophthalmoplegia, nystagmus, confusion, coma, hypotension)	Two pairs of IV Pabrinex, tds for 3 days. Add to 100ml Glucose 5% or Sodium Chloride 0.9 % over 30 mins

➢ Sedation (applicable to both intoxicated and alcohol withdrawal patients)

If consciousness level is decreased defer initiation of sedation unless convulsions are present.

Convulsions are treated with IV lorazepam (into large vein) 2 - 4 mg (0.7mg/Kg, max 4mg).
If patient is not settling ITU should be involved for continuous IV sedation or intubation.

Close supervision may be required for a short period of time until the medication is effective.

NON-URGENT SEDATION **- Chlordiazepoxide is the preferred drug, and it should be tailored to individual patients. They must be assessed daily to adjust dose.**

A typical reducing program for an average sized male to avoid withdrawal:

Chlordiazepoxide:

- 30mg qds for 2 days
- 20mg qds for 2 days
- 10mg qds for 2 days
- 5mg qds for 2 days
- THEN STOP

An average sized female would start at 20mg qds.

➢ Discharge Arrangements

Average length of stay is 5 days

Chlordiazepoxide ideally should not be supplied on the TTA. An exception to this instruction is discharge to complete alcohol detox as an out-patient via Ambulatory Care.

Note: discharge to out-patient alcohol detox can only be made following assessment and acceptance of the patient by the Alcohol Liaison Team (see Clinical Guideline Alcohol Detoxification In Ambulatory Care Following Inpatient Admission).

➢ Community Care

All patients should be referred to Alcohol Liaison Nurse (ALN) Whittington (via internal bleep 2634).

If ALN not available, (i.e. on leave), advice can be obtained from the Whittington Health Primary Care Alcohol and Drug Service 020 3316 8778 (Mon-Fri, 9-5: answer machine service after hours).

ALN can provide brief interventions for patients during their hospital stay as well as referrals to specialist agencies in the community. Patients drinking in excess of 21 units / week for men and 14 units / week for women are appropriate referrals. It is preferable, that patients are asked if they would like to be referred to ALN before referral is made.

➢ Contacts

Trust contacts:

- Dr. Wong/ Dr Suri for advice (via switch or x 5410)
- Gastroenterology SpR (bleep 3036/3113)
- Alcohol Liaison Nurse (ALN) Whittington (bleep 2634)
- Whittington Health Primary Care Alcohol and Drug Service (020 3316 8778)

External contacts:

- National Poisons Information Service (Toxbase) on 0844 892 0111
- Haringey Alcohol Services (HAGA) on 020 8800 6999
- Hackney Alcohol Recovery Centre on 020 8985 3757
- Islington Specialist Alcohol Treatment Service (ISATS) on 020 3317 6650

➢ References

(Alcohol-can the NHS Afford it) Royal College of Physicians website - Feb 2001 http://www.rcplondon.ac.uk/.

The Management of Alcohol Withdrawal and Delirium Tremens - A Good Practice Statement (1994), CRAG/SCOTMEG Working Group on Mental Illness, Pub. Scottish Office.

Harrison - Principles of Internal Medicine. P&G. McGrew-Hill, (2004). Intravenous Chlormethiazole - British Journal of Hospital Medicine, Vol 48, No. 11(1992)

Alcohol and Health, Marsha Morgan, E Bruce Ritson (2005)

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval

		Yes/No	Comments
1.	**Does the procedural document affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
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5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the procedural document without the impact?**	N/A	
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If you have identified a potential discriminatory impact of this procedural document, please refer it to the Director of Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Human Resources.

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any procedural document when submitted to the relevant committee for consideration and approval.

	Title of document being reviewed:	Yes/No	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is it clear that the relevant people/groups have been involved in the development of the document?	Yes	
	Are people involved in the development?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
5.	**Evidence Base**		
	Are key references cited in full?	N/A	
	Are supporting documents referenced?	N/A	
6.	**Approval**		
	Does the document identify which committee/ group will approve it?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	

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9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Executive Sponsor Approval			
If you approve the document, please sign and date it and forward to the author. Procedural documents will not be forwarded for ratification without Executive Sponsor Approval			
Name		Date	
Signature			
Relevant Committee Approval			
The Director of Nursing and Patient Experience's signature below confirms that this procedural document was ratified by the appropriate Governance Committee.			
Name		Date	
Signature			
Responsible Committee Approval – only applies to reviewed procedural documents with minor changes			
The Committee Chair's signature below confirms that this procedural document was ratified by the responsible Committee			
Name		Date	
Name of Committee		Name & role of Committee Chair	
Signature			

Tool to Develop Monitoring Arrangements for Policies and guidelines

What key element(s) need(s) monitoring as per local approved policy or guidance?	Who will lead on this aspect of monitoring? Name the lead and what is the role of the multidisciplinary team or others if any.	What tool will be used to monitor/check/observe/Asses s/inspect/ authenticate that everything is working according to this key element from the approved policy?	How often is the need to monitor each element? How often is the need complete a report ? How often is the need to share the report?	What committee will the completed report go to?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**
All elements	**Clinical Teams**	**DATIX reporting**	**Ongoing**	**Departmental meetings**