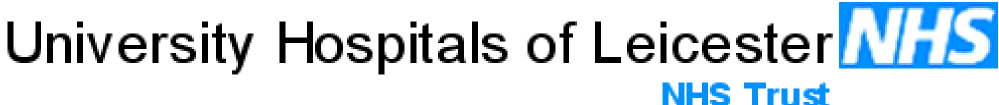

Alcohol Withdrawal UHL Policy

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Significant Changes from Version 4

Section	Change Made	Page
2.2.3	Change to reflect the existence of the new Alcohol Care Team (ACT)	4
2.2.4	The ACT can offer clinical advice around the management of alcohol-dependent patients.	4
3.2.4	Patients should now be screened using the Audit-C questionnaire	5
4.2.2	Addition of optimal reduction advice in text box.	7
4.6.1	Addition of advice around discharging patients on GMAWS, and UHL alcohol support leaflet	9
4.6.1	GMAWS 5-point Advice box rewritten and updated	9
6	Added Section on Acamprosate	10
7	Updated referral routes into ACT.	11
7.4	Inclusion of the Making Every Contact Count Assessment as referral route	11
	Removal of any reference to the defunct LEDPAT referral sheet.	
Appendix 2	Removal of additional questions following the Audit-C questionnaire	
Appendix 3	Addition of timeline graph of alcohol withdrawals.	16
Appendix 7	Rewritten to update advice around safe reduction of alcohol intake	21
Appendix 8 & 9	Removed as obsolete	

1. Introduction

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trust's policy for patients who are admitted suffering with Alcohol misuse. Alcohol misuse is a common problem resulting in 814,595 alcohol-related hospital admissions in England in 2020/21.

1.2 It is estimated that there are 602,391 people – 4% of the adult population - who are dependent on alcohol in England (PHE 2021). Patients may present to hospital either directly as a result of intoxication or following a consequence of intoxication or acute alcohol withdrawal.

1.3 All areas of the hospital may be affected. The following policy provides advice for how patients should be screened for harmful drinking as well as the management of patients who are dependent on alcohol.

2. Policy Scope and Roles and Responsibilities

2.1 This policy applies to:

Staff group(s)

- The Alcohol Care Team (ACT) / Drug & Alcohol Liaison Team (Turning Point)
- The medical team in charge of the patient's overall care
- The ward nurses
- The hospital pharmacy

Clinical area(s)

- All clinical areas across UHL where a patient with alcohol withdrawal is admitted.

Patient group(s)

- Adult patients within all clinical areas across UHL

2.2 Roles and responsibilities in managing alcohol withdrawals

2.2.1 Management of Alcohol Withdrawals requires a multidisciplinary approach and expert management

2.2.2 The responsibility of the overall management of the patient sits with the medical team in charge of the overall care. The medical team will hold responsibility for initiating the use of the GMAWS (Glasgow Modified Alcohol Withdrawal Scale), all prescribing issues and for considering the impact of the Alcohol Withdrawals on the patient's overall treatment.

Given the potential complexity of co-morbid Alcohol Dependence and other physical health conditions, care will often require regular Registrar or Consultant oversight.

2.2.3 The Alcohol Care Team (ACT), part of the wider Drug & Alcohol Liaison Team run by Turning Point, will provide advice, support and start brief interventions to the patient. They can also arrange continuing support from their community resources on patient discharge where applicable. The ACT nurses can give advice on medical interventions for the patient while an inpatient.

The ACT consists of:

- x1 Band 7 nurse
- x3 Band 6 nurses
- x4 Recovery Practitioners (non-clinical substance use workers)

2.2.4 The ward nurse will monitor and implement the use of the GMAWS, administer medication as per prescription and guidance, and offer general care and support. The ACT nurses can be consulted with on any queries around the implementation of GMAWS.

2.2.5 The pharmacist will ensure that necessary medications are supplied to the clinical setting promptly to reduce the potential for complications arising from delayed administration of medication. The pharmacist will also provide relevant pharmacological advice.

3. Confirming Alcohol consumption and identification of alcohol related problems

3.1 Taking an Alcohol History

As part of the admission assessment for all patients they should be asked about their alcohol intake. Please note the following as good practice:

- Consumption of alcohol should be documented in units (see Appendix 1 regarding the calculation of units drunk).
- There is great variation in container sizes (bottles/cans) and strength (%abv) of alcoholic drinks. It is important these variables are recorded to ascertain true intake.
- It is essential to ascertain the pattern of drinking, stating whether the number of units drunk relate to a daily or weekly consumption
- If problematic/ harmful drinking is detected (see appendix 2), the pattern of drinking and length of time the problem has been going on for should also be documented
- Is there a history of alcohol withdrawals? What symptoms the patient experienced should be documented. Has the patient previously suffered seizures?

3.2 Types of Drinkers

3.2.1 Low Risk or sensible drinkers

The recommended maximum daily limits for drinking alcohol are, for both men and women, **14 units per week**, spread across 3-5 days, with at least 2-3 days per week abstinent. People drinking at this pattern are considered to be at low risk of developing any problems as a result of their alcohol consumption.

3.2.2 Increasing risk or hazardous drinker

These are people who drink 14-35 units weekly. They are considered to be at risk of developing significant physical or mental health problems due to their drinking. This group also includes binge drinkers. Binge drinkers are defined as those who consume twice the recommended daily limits, about 6 units daily, over a short period of time (1-5 days) .

This group of drinkers is harder to detect when they present as they often attend sober and usually appear to have a normal lifestyle. However early detection allows for brief interventions to be offered, which is more likely to result in a reduction in the amount consumed, and lessen any future impact on services.

3.2.3 Higher risk or harmful drinkers

These are people that show signs of clear alcohol-related harm due to their drinking pattern.

This constitutes drinking at 35+ units weekly.

3.2.4 Alcohol Dependent Patients

Alcohol dependence starts at an intake of around 10+ units daily (although it could be less). Alcohol dependent patients are individuals who show a cluster of physiological, behavioural and cognitive problems as a result of their drinking. Alcohol takes on a much higher priority, often with a strong desire to drink despite awareness of harmful consequences.

According to the WHO International Classification of Diseases-10, a definitive diagnosis of dependence should usually be made if three or more of the following are present or have been present at any time within the previous year:

1. A strong desire or sense of compulsion to take alcohol
2. Difficulty in controlling drinking in terms of its onset termination or level of use
3. A physiological withdrawal state when drinking has ceased or been reduced or drinking to avoid alcohol withdrawal symptoms

4. Evidence of tolerance, such that increased doses of alcohol are required in order to achieve effects originally produced by lower doses
5. Progressive neglect of other interests
6. Persisting with alcohol use despite awareness of overtly harmful consequences.

Most patients would present to hospital as a result of complications with point 3 above - a physiological withdrawal state.

All admitted patients should be screened for alcohol dependence by using the Audit-C questionnaire on NerveCentre. This also forms part of the Making Every Contact Count (MECC) assessment.

ADVICE:

Use Audit-C (appendix 2) to help identify types of drinkers. Please note that a score of 11-12 indicates possible dependency. Dependency here relates to physical dependency characterised by alcohol withdrawals as opposed to alcohol dependency syndrome

4. Alcohol Withdrawal Management

4.1 What causes Alcohol Withdrawals?

Abrupt cessation of or reduction in, long-term high dose alcohol consumption produces well defined symptoms collectively described as alcohol withdrawal syndrome (AWS). The intensity of alcohol withdrawal is variable between individuals ranging from mild to its most severe manifestation that include seizures, hallucinations and delirium.

Within the WHO International Classification of Diseases-10, for a diagnosis of AWS to be made there must be clear evidence of:

- Recent cessation or reduction of alcohol intake after repeated, and usually prolonged and / or high-dose use.
- Symptoms and signs which are compatible with the known features of the AWS, and
- Symptoms and signs that cannot be accounted for by an alternative medical, mental or behavioural disorder unrelated to alcohol

ADVICE:

High alcohol use could be patients that drink over 15 units of alcohol per day, and/ or who score 11-12 or more on the AUDIT-C (NICE, CG115)

4.2 Does this patient require medical admission for alcohol withdrawal?

4.2.1 Patients at high risk of alcohol withdrawal seizures, delirium tremens (DTs), individuals aged under 16 with alcohol withdrawal problems or vulnerable adults with alcohol withdrawal problems should be admitted to hospital and offered medically assisted alcohol withdrawal.

Patients not in these groups may be suitable for treatment in the community. For more information see **Appendix 4**. (They should be advised to either stabilise or slowly reduce their alcohol intake as outlined in **Appendix 7**).

4.2.2 It is important to avoid either under-treatment, which may lead to DTs or seizures, or over-treatment, associated with sedation and/or benzodiazepine dependence.

DTs are fatal in 15-20% of patients whilst early detection and prompt initiation of treatment usually prevents onset and reduces mortality to around 1%.

Patients most at risk are those with high fever, tachycardia, and dehydration, an associated illness (pneumonia or pancreatitis) or where diagnosis is delayed. These patients will also be at risk of developing Wernicke's Encephalopathy and Korsakoff's Psychosis (See Section 5)

ADVICE: **Please note that patients who are physically dependent on alcohol and not admitted to hospital should be advised to gradually reduce their intake at a rate of not more than 5 units per day. Optimal advice is to reduce by 10% every 2-3 days, or to drink minimally only when experiencing withdrawals.** **(See Appendix 7 for information on the gradual reduction of alcohol intake)**

4.3 Managing Alcohol Withdrawals for patients admitted to hospital

4.3.1 Oral benzodiazepines are the group of drugs recommended for the routine management of alcohol withdrawals. The most appropriate approach to the management of alcohol withdrawals is considered to be symptom triggered dosing. Within UHL we have chosen the Glasgow Modified Alcohol Withdrawal Scale (section 4.6 and **Appendix 5**) to help manage alcohol withdrawals in a symptom-triggered fashion.

4.3.2 NICE guidelines (2010) recommend that symptom triggered dosing of medication is associated with decreased complication and better patient outcomes. Symptom triggered dosing consists of prescribing benzodiazepines (Diazepam) on an 'as and when' basis, with the dose to be administered being guided by the symptoms that the patient presents with.

4.3.3 This allows more flexibility in dose administration and reduces the potential for inadequate or excessive dosing. It can also help avoid unnecessary use of medications, over sedation and other side effects, and has the added benefit of reducing length of stay.

ADVICE: **Alcohol withdrawal hallucinations typically occur within the first 2 days after stopping or reducing alcohol intake. For some patients this will not progress to delirium tremens (DTs) and will occur in the presence of a clear sensorium. However the presence of hallucinations is a significant indicator that progression to DTs is more likely and this indicates the need for closer monitoring.**

4.4 Signs and Symptoms of Alcohol Withdrawals: see Appendix 3

4.4.1 Considerations for the management of patients undergoing alcohol withdrawal:

- During alcohol withdrawal management, it is essential to closely monitor for signs of over-sedation or break through withdrawals.
- Exceptional patient groups, patients with severe withdrawals and patients requiring intravenous or intramuscular sedation, require close monitoring with an early warning score (EWS). Ideally 1 hourly care is required in an appropriately monitored area (such as Liver HDU or ACB).
- Observe for dehydration or any electrolyte imbalance (all patients should have their

electrolytes checked including magnesium, calcium and potassium concentrations)

- Treat any concurrent conditions. Many patients presenting with alcohol abuse may also have other conditions associated with self-neglect.
  - **Reassure patients**

4.5. Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

4.5.1 The GMAWS aims to assist staff in selecting treatment pathways for Alcohol Withdrawal Symptoms (AWS). It is a five- variable assessment tool aimed at managing AWS in acute hospitals.

These AWS are:

- Tremor
- Sweating
- Hallucinations
- Orientation
- Agitation

4.5.2 The scoring allows for withdrawing risk to be assessed and managed through a suggested diazepam dose. It also allows for high risk patients to be assessed and dealt with in both a fixed and symptom triggered fashion. Patients that present with severe withdrawals (DTs) can be managed through parenteral administration of benzodiazepines.

4.6 How to use the Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

4.6.1 After ascertaining physical dependency either through use of the AUDIT-C tool (**Appendix 2**: Score 11-12 signifying possible dependency), patients with recent history of drinking about 15 units/day or presenting with alcohol withdrawal, the GMAWS approach to alcohol withdrawal management should be adopted.

The following procedure should be used in conjunction with the flow-chart set out in **Appendix 5**:

1. Ensure patient details are documented correctly
2. Identify whether the patient is high risk or otherwise. If high risk and not an exceptional patient (see box 2 appendix 5) then admitting doctor to start on a fixed dose oral diazepam regime and symptom triggered as required (PRN) doses.
3. If patient is not high risk then please start on symptom triggered treatment. Also assess if patient is an exceptional patient as they may need PRN lorazepam instead of diazepam.
4. Diazepam or Lorazepam PRN doses to be guided by the Alcohol Withdrawal Scale and the assessment of the following withdrawal symptoms: Tremor, Sweating, Hallucinations, Orientation and Agitation as per the GMAWS scoring system. Each symptom is scored from 0-2
5. The amount of diazepam to be given and the frequency of assessments is dependent on the score as below:
   - Score 0 = No diazepam Repeat score in 2 hours and discontinue if score remains 0 on 4 consecutive occasions, except if during the first 48 hours after cessation of alcohol
   - Score 1 - 3 = 10mg diazepam. Repeat score in 2hours
   - Score 4 – 8 = 20mg diazepam. Repeat score in 1hour
   - Score 9 – 10 = 20mg diazepam. Repeat score in an hour and discuss with medical staff regarding management of severe withdrawal as per regime.
6. All patients who are scoring on the GMAWS system require referral to the ACT / Turning Point for review and further support on 07734694857.
7. Seek senior review if high doses of diazepam (over 120mg) or Lorazepam (12mg) are needed (See Appendix 5, Box 3). Some patients may require doses over 120mg

diazepam in 24 hours. Please seek senior review if exceeding these doses

8. Discontinue scoring after patient scores 0 (zero) on 4 consecutive occasions, except if during the first 48 hours after cessation of alcohol.
9. If patient is medically fit for discharge but still scoring on GMAWS (i.e. still alcohol dependent), discharge should not be delayed. If patient cannot be reviewed by the ACT prior to discharge, patient should be advised to drink minimally to control any residual withdrawal symptoms they may have. **NB. It is not part of this policy to prescribe any diazepam TTO.**
10. Ensure that patient is given a copy of the UHL Advice leaflet “Advice and Support if you are drinking too much alcohol” - https://yourhealth.leicestershospitals.nhs.uk/library/emergency-specialist-medicine/emergency-department/1631-advice-and-support-if-you-are-drinking-too-much-alcohol/file

ADVICE:

1. **The GMAWS symptom-triggered protocol is a dynamic weaning regime. As time goes on the scores and the diazepam dosing should be reducing. If neither is the case, then the patient’s physical dependence will remain unchanged, which may cause complications around discharge. Referral to the ACT should be made is scoring/dosing is not decreasing.**
2. **Caution should be exercised to obtain an *objective* assessment of withdrawal symptoms. Diazepam is a drug of abuse, and may be sought after by some patients, especially those with a history of addiction. Some symptoms (tremor, orientation, agitation) can be simulated, any may be affected with the intention of receiving higher doses of diazepam than clinically necessary. Where possible, assessment of symptoms should be undertaken conservatively and without patient’s awareness.**
3. **Sleeping patients should not be awakened to undertake GMAWS scoring. A sleeping patient is not in acute withdrawal.**
4. **The maximum duration of diazepam for GMAWS is 7-days. If diazepam is required beyond this, please refer to the ACT.**
5. **Discharging patients on high doses of diazepam runs the risk of potentially dangerous benzodiazepine withdrawal.**

5. Wernicke’s Encephalopathy (WE)

Every patient who appears to have signs of alcohol withdrawal and / or started on GMAWS management regime must be assessed for WE.

5.1 What is Wernicke’s Encephalopathy (WE)

WE is a neurological disease caused by thiamine (Vitamin B1) deficiency. If untreated it can lead to Korsakoff’s syndrome, characterised by chronic amnesia or death

WE is a medical emergency that is reversible with timely administration of appropriate treatment. Chronic alcohol users are at particular risk of WE because:

- They are more likely to have a lower level of self-care and poor diet
- Their absorption of thiamine is reduced by both alcohol and /or malnutrition
- They have increased metabolic demands in relation to glucose utilisation and alcohol metabolism
- They have reduced hepatic storage of thiamine
- Ethanol neurotoxicity causes impaired utilisation of thiamine

5.2 Signs and Symptoms of WE

5.2.1 Traditionally there has been mention of observing for the classic triad of symptoms:

- Oculomotor abnormalities
- Cerebellar dysfunction (Ataxia)
- Confusion

However: only 16.5% of patients exhibit all 3 signs (the triad of symptoms). Focusing on identifying the triad of symptoms will lead to under diagnosis of WE which can be fatal to 20% of patients if they progress to develop Korsakoff's psychosis

5.2.2 Therefore **clinicians are advised to make a presumptive diagnosis of WE** should any patient present with a history of alcohol misuse and any of the signs stated below:

I. Acute Confusion / Disorientation
II. Ataxia
III. Unexplained hypotension with hypothermia
IV. Nystagmus
V. Decreased consciousness level
VI. Ophthalmoplegia

5.3 Prevention and Treatment of WE

Patients presenting with potential signs of WE require urgent treatment with intravenous vitamin B complex (Pabrinex®). Treatment should be given as laid out in Appendix 6. Patients who remain symptomatic should continue to receive intravenous vitamin B therapy.

6. Acamprosate

6.1 Acamprosate is an effective and generally well-tolerated treatment for relapse prevention in patients with moderate or severe alcohol dependence. Acamprosate does not prevent the harmful effects of continuous alcohol abuse, therefore the patient must have successfully completed medically assisted withdrawal before considering Acamprosate TTO.

It should only be used as part of an integrated programme including psychotherapy and counselling during rehabilitation, when it is considered by the ACT to be beneficial to the patient. Therefore, patients must agree to onward referral to Turning Point in the community and be motivated both to engage with this support and to maintain abstinence.

6.2 Acamprosate is contraindicated in patients known to be hypersensitive to the drug, pregnancy, lactation, renal insufficiency (serum creatinine >120 micromol/L) and severe hepatic impairment. Before starting treatment conduct a comprehensive medical assessment (baseline urea and electrolytes and liver function tests including gamma-glutamyl transferase [GGT]).

6.3 Commencement Dose

Adults (18 to 65 yrs) weighing 60kg or more: 666mg three times a day Adults (18 to 65 yrs) weighing under 60kg: 666mg in the morning, 333mg at noon and 333mg at night Acamprosate should be taken with or after food and the tablets should be swallowed whole.

If assessed as appropriate, it can be commenced as an inpatient if GMAWS has been completed.

6.4 A 28-day course should be supplied on discharge. This should be continued by the patient's GP if the patient remains in psychosocial treatment with Turning Point.

7. Referrals to the Alcohol Care Team (ACT) / Turning Point

7.1 All patients admitted with an alcohol related issue as outlined in this policy should be referred to the ACT, part of the wider Drug & Alcohol Liaison Team, run by the national charity Turning Point. The ACT is available **7 days a week 8am-5pm** . However, referrals to the team can be made outside of these hours by voicemail, email, ICE, or on NerveCentre as the Task "ED Referral Alcohol Care Team":

7.2 We operate with any of the following referral routes:

- **07734694857**
- **07535658329**
- **X17285**
- **Email** TurningPointReferral@uhl-tr.nhs.uk
- **NerveCentre** task "ED Referral Alcohol Care Team"
- **eReferrals where available**
- **ICE**

7.3 The following information is required to accept a referral:

- Patient name and ward location. An **S** number is preferable. (Please specify if patient already discharged) However, do not delay the discharge of a patient who is medically fit for discharge, the ACT can arrange out-patient follow up with Turning Point
- Rough alcohol intake ideally in units per day or per week
- Has the patient consented to being seen by the ACT? This consent is essential if the patient has been discharged

7.4 Please undertake the Making Every Contact Count (MECC) Assessment on NerveCentre. This can trigger an automatic referral to the ACT if dependence threshold is met.

The ACT accepts referrals for patients who are being discharged, or who have already been discharged. As Turning Point operates in the community, patients can be followed-up at home. Please therefore do make referrals outside usual operating hours.

7.5 **In the case of Alcohol Related Liver Disease**, please contact the Gastro Registrar for the week or the in-reach consultant via switch board

8. Teaching and Training

8.1 A comprehensive training package will be provided by the ACT / Drug & Alcohol Liaison Team on the medical and other wards within UHL where patients with alcohol withdrawal symptoms are frequently admitted.

8.2 Training is available for other areas (e.g. illicit drug use) upon request - contact the ACT on **07734694857** or **07535658329** or email: TurningPointReferral@uhl-tr.nhs.uk

9. Monitoring and Audit Criteria

Following implementation of this policy the policy will become part of the audit cycle performed by the Acute Medical Unit at the Leicester Royal Infirmary.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Leads for recommendation

Review relevant procedure followed	Drug & Alcohol Liaison Team	See attached appendices	Annual audit by AMU team in conjunction with ACT	Local meetings	Via audit lead

10. Keywords

Alcohol, Alcohol withdrawal, Wernicke's Encephalopathy, Acamprosate, WE, WKS, Delirium Tremens, DTs

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Appendix 1: Information on Units of Alcohol

A unit of alcohol is a beverage containing 8g or 10mls of ethanol (pure alcohol). This can be calculated as follows

% ABV x Volume (Litres) = Units

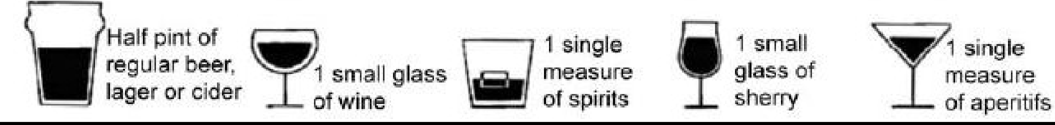
e.g. a 2 litre bottle of 7.5% cider will contain 15 units of alcohol
7.5% x 2 Litres = 15 units

…and each of these is more than one unit

Summary: Units are essential in giving a clear indication of amounts consumed and types of drinkers. Current advice is to drink no more than 14 units per week on a regular basis, spread throughout, with at least two days off a week.

Appendix 2: # Audit C Questionnaire

This is one unit of alcohol…

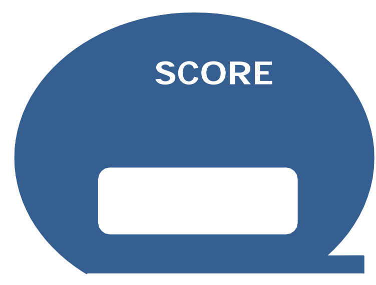


…and each of these is more than one unit

AUDIT – C

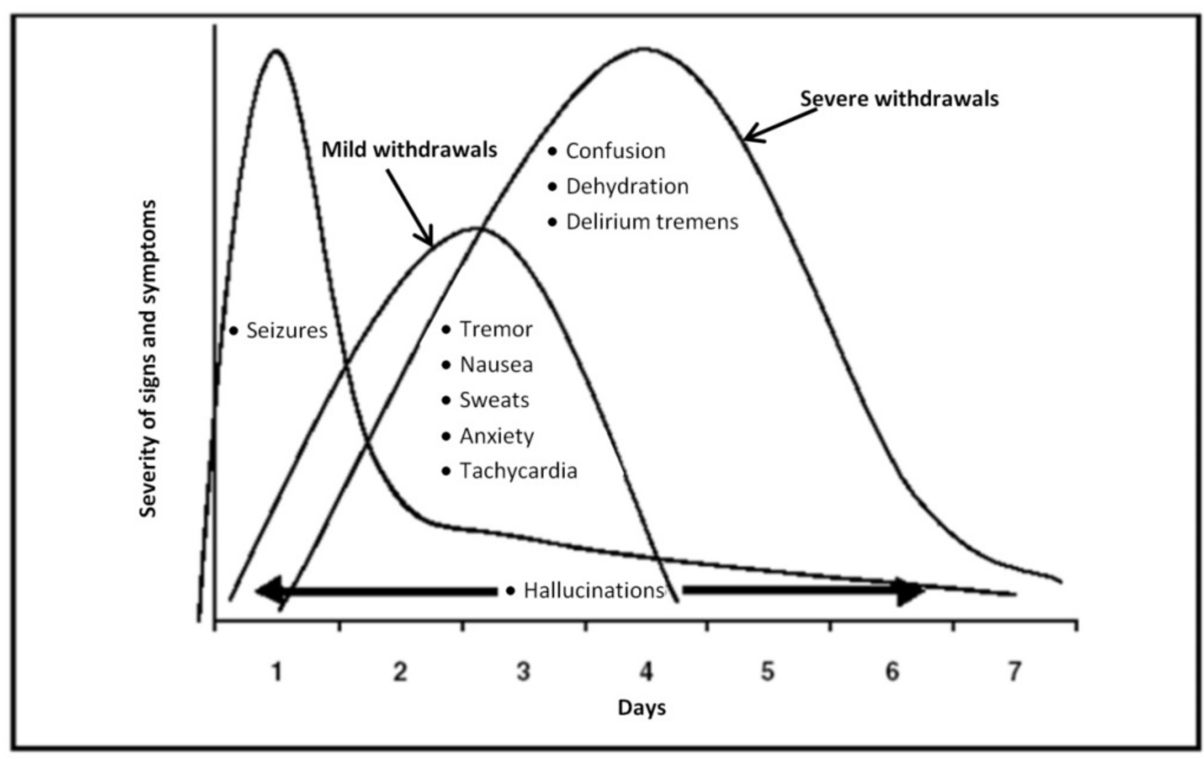
Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive.
If scoring 5+ Continue AUDIT



Appendix 3: Alcohol withdrawal features

Time after alcohol cessation	Symptoms
6- 12 hours	**Minor Withdrawal Symptoms:** tremulousness (hand, tongue, eyelids), diaphoresis, fever (with or without infection), anxiety, agitation, nausea, vomiting and retching.
12- 24 hours	**Alcoholic hallucinosis:** visual and auditory (usually accusatory orderogatory voices) hallucinations, tactile disturbances. These occur in otherwise clear sensorium.
12- 48 hours	**Withdrawal seizures:** these can manifest as early as 2hours after cessation of alcohol consumption and even before the blood alcohol level has fallen to zero. Fits are rare beyond 48 hours followingcessation of alcohol consumption.
48- 72 hours	**Delirium Tremens (DTs):** auditory and visual hallucinations, confusion and disorientation, hypertension, agitation, tachycardia >100/min, fever (with or without infection), severe tremor in hands and body. **DTs represent a medical emergency**. DTs occur in only about 5% of patients undergoing alcohol withdrawal but have a mortality rate of 15- 20%. If a patient presents with DTs consider admission for 24 hours minimum to treat withdrawals and monitor. **Patient may need observation for 72 hours after cessation of drinking**. Risk factors of developing DTs: concurrent acute medical illness, heavy daily alcohol use (60+ units), history of DTs and alcohol withdrawal symptoms, older age and abnormal LFTs. (May require Diazemuls see Appendix 2, box 3)



Appendix 4:

Alcohol withdrawal algorithm based on the NICE Clinical Guideline 100.

Person in acute alcohol withdrawal:

- Initial assessment including risk of developing delirium tremens or seizures
- Offer thiamine for the prevention or treatment of Wernicke's encephalopathy (see section 5)

Person with or at high risk of alcohol withdrawal seizures or delirium tremens

Young person under 16years in acute alcohol withdrawal

Vulnerable person in acute alcohol withdrawal (for example, people who are frail, have cognitive impairment or multiple co-morbidities, lack social support, have learning difficulties or are aged 16 or 17years)

Person who is alcohol dependent **and**

- 16 years or over
- Not at high risk of delirium tremens or seizures
- Not considered vulnerable

Offer admission to hospital

Assess immediately by a healthcare professional skilled in the management of alcohol withdrawal (**Refer to ACT - 07734695867**)

- Offer medically assisted alcohol withdrawal; to include use of GMAWS (Appendix 2)
- Offer physical and psychological assessment to all young people under 16years and as needed to those over 16years
- Offer advice from a healthcare professional experience in the management of patients with liver disease to people with decompensated liver disease

Do not admit to hospital

Advise not to suddenly reduce alcohol intake (See appendix 7)

Offer Referral to the ACT / Turning Point – 07734695867.

Appendix 5: Glasgow Modified Alcohol Withdrawal Scale

University Hospitals of Leicester NHS Trust

Caring at its best

Patient ID Label
or write name and number

Unit No.: ....

Name: ....

Address: ....

....

D.O.B.: ....

Ward: ....

Alcohol by volume and units		
Strong Lager (9%)	– 440 ml	= 4 units
Beer / Lager (4.5%)	– 500 ml	= 2.2 units
Wine (12%)	– 175 ml	= 2.1 units
Spirits (40%)	– 25 ml	= 1 unit
Cider (4%) Litre		= 4 units
Strong White Cider (8%) Litre		= 8 units

Management of Alcohol Withdrawal Syndrome

Dependant drinking on screening - High Risk

Any 2 of the following (tick):

- Presents with or has had previous withdrawal seizures ☐
- Previous severely agitated withdrawal (D.T.s) ☐
- High initial symptom score (GMAWS >8) **(PTO)** ☐

Yes →

Exceptional Patient Group
Yes ☐ No ☐

Yes →

Symptom Triggered Treatment on Lorazepam (see Box 2)

No →

Fixed Dose Oral Diazepam

Initial 24 hours: 20 mg /6 hourly

REDUCE as follows:

15mg Diazepam	6 hourly	for 24 hours
10mg Diazepam	6 hourly	for 24 hours
5mg Diazepam	6 hourly	for 24 hours
5mg Diazepam	12 hourly	for 24 hours

(Max 120 mg Diazepam in 24 hours before requesting senior medical review)

AND

- **Symptom Triggered Treatment, as per GMAWS (Box 1)**
- **If unable to take oral give 50% of the oral dose as IV**
- **In case of DTs please see Box 3**

No →

Symptom Triggered Treatment as per GMAWS (PTO)
(Also consider Box 2 if exceptional group)
Please tick to confirm this treatment option ☐

Please consider **Pabrinex** for **all patients** for the prevention and treatment of Wernicke's Encephalopathy.
Please see full Alcohol Withdrawal guidelines on INsite

10 mg Diazepam = 1 mg Lorazepam = 30 mg Chlordiazepoxide

Box 1 GMAWS
Tremor
Sweating
Hallucination
Orientation
Agitation

(GMAWS PTO)

Box 2 Exceptional Patient Group:
1. Elderly >80 Y
2. Head injury
3. Encephalopathy
4. Jaundice
5. COPD / pneumonia
6. Low GCS

Consider use of Lorazepam in a symptom-triggered fashion 1-2 mg (to a max of 12 mg/24hr period before senior review

Box 3 Special Circumstances: Severe Withdrawal
(Delirium Tremens) with (agitation/aggression)
- Give 5-10 mg IV diazemuls initially followed by a maximum of 10 mg every 5 mins, increasing to a maximum of 40 mg diazepam over 30 mins (assessing response) only to be given by FY2/higher grade or trained nurse
- Adjunct Haloperidol 2-10 mg PO/IM up to 18 mg in 24 hrs at 2 hourly intervals
- Flumazenil should be available on ward
- Seek senior review

(Kashif)1148456KR

Completed by: .... Signature: .... Date: ....

Glasgow Modified Alcohol Withdrawal Scale (GMAWS)

Treatment options: GMAWS only ☐ GMAWS & Fixed Dose ☐

Date																				
Time																				
Tremor 0 No tremor 1 On movement 2 At rest																				
Sweating 0 No sweat visible 1 Moist 2 Drenching sweats																				
Hallucination 0 Not present 1 Dissuadable 2 Not dissuadable																				
Orientation 0 Orientated 1 Vague, detached 2 Disorientated, no contact																				
Agitation 0 Calm 1 Anxious 2 Panicky																				
Score																				
Treatment																				
Staff Signature																				

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink)

- **0** Repeat score in 2 hours (discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)
- **1-3** Give 10mg Diazepam: Repeat score in 2 hours
- **4-8** Give 20mg Diazepam: Repeat score in 1 hour
- **9-10** Give 20mg Diazepam: Repeat score in 1 hour and discuss wih medical staff regarding management of severe withdrawal as per guideline

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over-sedation Regular MEWS/SEWS - Frequency 1-4 hrs (GCS, Respiration Rate, Oxygen Saturation, Pulse, Blood Presssure)

Patients may require to be woken for continuing assessment

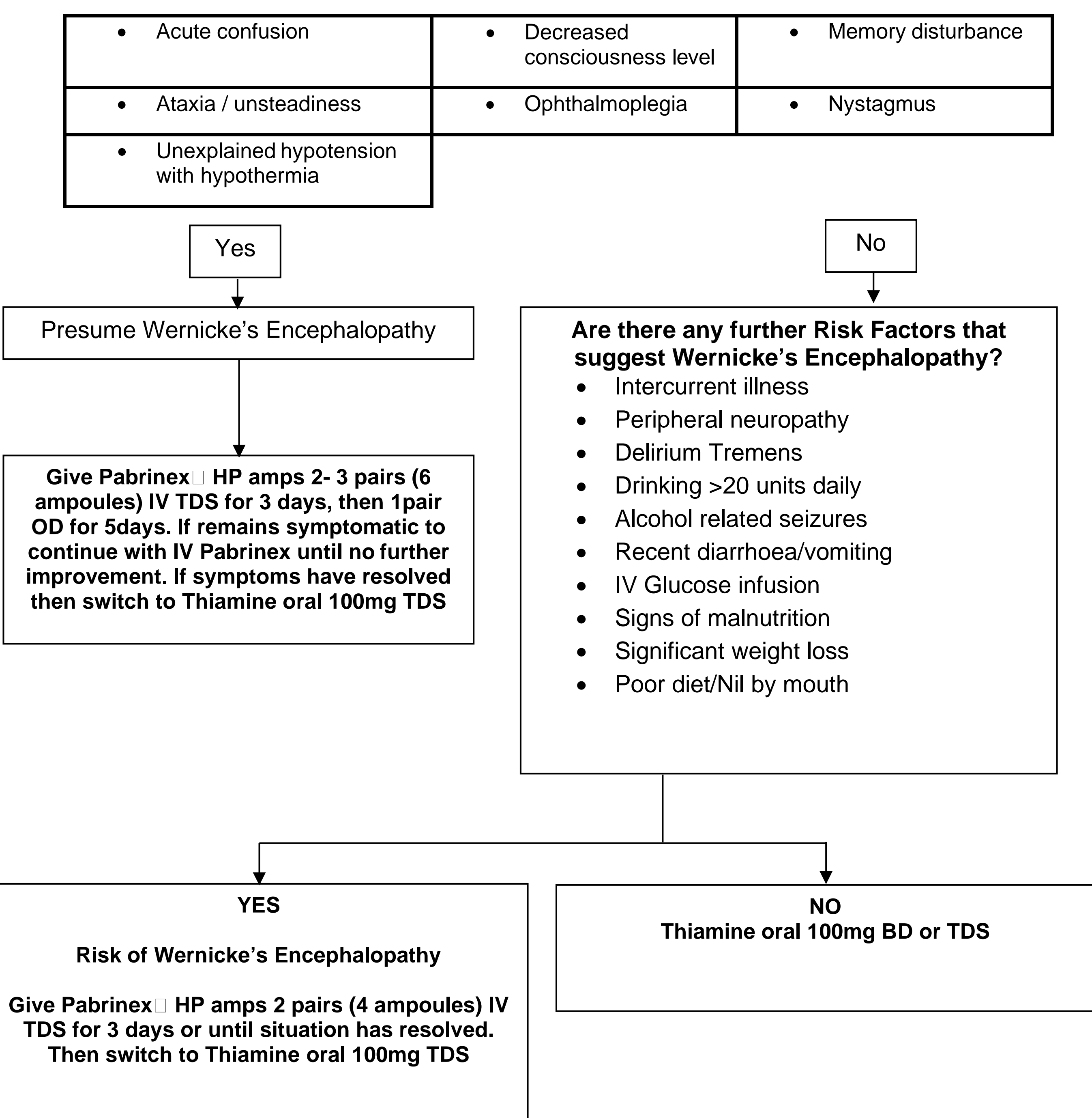
Co-existing illness may affect score: seek medical advice if in doubt

Fixed dosing and symptom triggered dosing must be no less than 1 hour apart

Developed by the Alcohol Screening and Withdrawal Management Guideline Group. Chaired by Dr Ewan Forrest, Consultant Physician and Gastroenterologist, Glasgow Royal Infirmary. Copyright: This is the property of NHS Greater Glasgow and Clyde.

Appendix 6:

Guidelines for vitamin supplementation and prevention and/or treatment for Wernicke's Encephalopathy



Appendix 7: Gradual Reduction of Alcohol Intake

How to Reduce Your Daily Drinking Safely

- Work out how many units you normally drink a day. This is your staring point.
- From your starting point, a sensible approach is to try to reduce by around a tenth every 2-3 days.
- Remember, you are drinking to control withdrawal symptoms, not to get intoxicated.
- Do not assume you have to have a drink straight away after waking up. Try drinking nothing until you notice withdrawal symptoms.
- Try to drink only when you start to feel yourself withdraw and then drink approximately 2 units at a time (e.g. one can of 4% cider). Wait 20 – 30 minutes for the alcohol to take effect and repeat this process each time you get withdrawal symptoms.
- If you experience disturbed or disrupted sleep due to withdrawal symptoms, you could try a double dose before bed.
- Remember, as you successfully reduce your daily alcohol intake, you should find your withdrawal symptoms become less severe, although in the short term your sleep could suffer.
- Keep a daily record of what and when you drink and what withdrawal symptoms you get. This will help you keep track of your progress. Use the Drink Diary on the next page.
- Remember to eat little but often. Your blood sugar levels could get too low if you don't.
- If you are having withdrawal symptoms which are making you feel unwell, you may have cut down too quickly. Drink a little more, or seek medical attention if you are very unwell.
- Reducing intake using wine or spirits is hard. If you can, swap to a lower-strength drink, e.g. 4-5%abv cider or beer, even if this means you're drinking more fluid than you're used to. It is much easier to reduce this way.

Disclaimer

The above is not clinical advice. Alcohol withdrawal can make physical demands on the body which may put some people at increased risk. If you are unsure, you should discuss your general health and plans for cutting down with an alcohol worker or your GP.