Alcohol Withdrawal Protocol

Give Thiamine 100mg IV initially and qd (po, IM/IV), Folate 1mg qd, MVI qd. Assess current state of withdrawal with CIWA-Ar scoring sheet, attached.

<table>
<thead>
<tr>
<th>CIWA &lt;8 and Low Risk</th>
<th>CIWA &gt;8 OR Moderate Risk</th>
<th>CIWA &gt;15 or High Risk</th>
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</thead>
<tbody>
<tr>
<td>Monitor CIWA q shift for 2 days</td>
<td>Ativan 1-2mg IV or 2-4mg PO x1 stat Ativan 1mg IV or 2mg PO q4-6h standing Ativan 1 mg IV or 2mg PO q2h pm CIWA&gt;8, HR&gt;100 or DBP&gt;100 Hold dose for RR&lt;10, or if patient is unresponsive to voice (or decreased oximetry, or other signs of intoxication) - HOLD dose until no toxicity, resume at lower dose After first 24 hours, total up 24-hour Ativan requirement, then split into q4h or q6h standing dose for the next 24 hours. Day 3: Begin slow taper of Ativan dose, usually no more than 15-20% per day. If frequent prn doses needed, consider stopping taper, raising dose, achieving stability, resuming at slower rate</td>
<td>Consider transfer to ICU. Ativan 2-4mg IV q15 minutes until stable, then use that dose of Ativan that achieved stability IV q2-3h standing Hold dose for RR&lt;10, or if pt. is unresponsive to voice (or decreased oximetry, or other signs of intoxication) - HOLD dose until no toxicity, resume at lower dose Goals of treatment: CIWA&lt;8, HR&lt;100, DBP&lt;100 If this is achieved, total up 24-hour Ativan requirement and split into q4h or q6h standing dose for the next 24h. Then begin slow taper of Ativan dose (10-15%/day)</td>
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</table>

A. CIWA <8 and Low Risk
- Monitor CIWA q shift for 2 days
- If CIWA >8, go to B.

B. CIWA >8 OR Moderate Risk
- Ativan 1-2mg IV or 2-4mg PO x1 stat
- Ativan 1mg IV or 2mg PO q4-6h standing
- Ativan 1 mg IV or 2mg PO q2h pm
- CIWA>8, HR>100 or DBP>100
- Hold dose for RR<10, or if patient is unresponsive to voice (or decreased oximetry, or other signs of intoxication) - HOLD dose until no toxicity, resume at lower dose
- After first 24 hours, total up 24-hour Ativan requirement, then split into q4h or q6h standing dose for the next 24 hours.
- Day 3: Begin slow taper of Ativan dose, usually no more than 15-20% per day. If frequent prn doses needed, consider stopping taper, raising dose, achieving stability, resuming at slower rate

C. CIWA >15 or High Risk
- Consider transfer to ICU.
- Ativan 2-4mg IV q15 minutes until stable, then use that dose of Ativan that achieved stability IV q2-3h standing
- Hold dose for RR<10, or if pt. is unresponsive to voice (or decreased oximetry, or other signs of intoxication) - HOLD dose until no toxicity, resume at lower dose
- Goals of treatment: CIWA<8, HR<100, DBP<100
- If this is achieved, total up 24-hour Ativan requirement and split into q4h or q6h standing dose for the next 24h.
- Then begin slow taper of Ativan dose (10-15%/day)
Acknowledgments - Dr. Phyllis Grable
FOR ALLOWING ME TO STEAL PART OF THIS PRESENTATION

Sources: ALCOHOL


Sources- Opioids

- General Sources (Texts)