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▶ Alcohol use disorders: diagnosis and clinical management of alcohol-related physical complications.

National Clinical Guidelines Centre
Royal College of Physicians, 2010.

Clinical guidance developed for the National Institute for Health and Clinical Excellence (NICE) on the medical care of patients suffering acute alcohol withdrawal or alcohol-related lack of thiamine, liver disease, or inflammation of the pancreas.

The featured document is clinical guidance funded by the UK National Institute for Health and Clinical Excellence (NICE) on the medical care of people aged 10 or over suffering acute alcohol withdrawal or alcohol-related lack of thiamine, liver disease, or inflammation of the pancreas.

The next sections of this entry summarise only the findings and recommendations in relation to alcohol withdrawal, focusing on those possibly of general interest. The guidelines focused on what from the point of view of the health service provider is an unplanned withdrawal – a patient presenting with symptoms which can occur when patients who are physically dependent on alcohol abruptly stop drinking or substantially cut down. Planned withdrawal as part of a treatment programme for alcohol dependence is dealt with in Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

Main findings on alcohol withdrawal

The experts who developed the guidance noted there was no reliable evidence that repeated unplanned medically assisted withdrawals from alcohol caused harm – the so-called 'kindling' effect. Though not disproved, there was not enough clinical evidence in favour of the hypothesis to support a recommendation.

No studies evaluated hospital admission for unplanned withdrawal versus planned withdrawal. Nevertheless, opinion based on experience within the expert group was that unplanned withdrawal in isolation is rarely an effective long-term treatment for alcohol dependence. Patients were likely to get better long-term benefits by undergoing a

planned withdrawal through addiction services, with relevant and appropriate follow-up. The risks of sudden withdrawal from alcohol should be made clear to patients and advice should be given about how best to engage with the most appropriate local addiction services. Advice about reducing and stopping drinking was outside the scope of this guidance, but if the patient does not require admission, will usually involve drinking and then slowly reducing consumption or undergoing a planned medically assisted withdrawal of alcohol.

The consensus was that individuals may need admission due to the severity or predicted severity of the syndrome. More specifically, if a person presents following or in a withdrawal seizure or delirium tremens they should be admitted for medical care. In addition the evidence was examined to identify which factors confer a high risk of the withdrawal episode progressing to either seizure or delirium tremens. These were a history of alcohol withdrawal seizures or DTs, and signs and symptoms of autonomic over-activity with blood ethanol concentration greater than 100mg/100ml.

As to what medically assisted withdrawal should consist of, the experts assessed the evidence on the safety and efficacy of various benzodiazepines and of clomethiazole or carbamazepine as ways of controlling withdrawal symptoms. They found benzodiazepines to be more effective than placebo for the prevention of alcohol withdrawal seizures, but no other significant differences within and across the agents considered. In particular, there was no evidence to support the widely held view that clomethiazole is less safe than the other agents, although there was concern about use of this agent outside a closely monitored inpatient setting. If patients are discharged form hospital to finish their withdrawal in the community, it is very important to coordinate care with the care giver in the community.

There are three ways of administering these medications. *Fixed dose* regimens start with a standard dose which is then reduced over the next several days. *Symptom-triggered* regimens tailor treatment to the severity of withdrawal signs and symptoms which are regularly assessed and monitored. Pharmacotherapy is provided if the patient needs it and treatment is withheld if there are no symptoms of withdrawal. *Front-loaded* regimens provide a large dose of long-acting pharmacotherapy at the start and then 'as required'. There was insufficient evidence on front-loading. Compared to fixed dose regimens, symptom-triggered dosing involves significantly lower doses of benzodiazepines over a shorter period without an increase in the incidence of seizures or delirium tremens or in the severity of withdrawal symptoms. However, most studies were of mainly men admitted to specialist addiction services; only one was set in a general medical ward. Also, symptom-triggered dosing requires patients to be closely monitored and health care workers with the specialist clinical knowledge needed to identify signs and symptoms that imply a change in severity of withdrawal. In the experience of the expert group, acquiring the required skills was not a major task.

Another issue addressed by the guidance was the identification of patients at risk of or actually experiencing alcohol withdrawal. One study confirmed the experts' experience that late recognition of withdrawal leads to a more severe syndrome and a greater risk of alcohol withdrawal complications. The implication is that hazardous and harmful drinkers should be assessed for dependence (and therefore risk of withdrawal) as soon as possible. Patients in alcohol withdrawal should be assessed by an appropriately skilled health worker for the severity of their symptoms and the need for pharmacotherapy.

Selected recommendations

For people in acute alcohol withdrawal with, or who are assessed to be at high risk of developing, alcohol withdrawal seizures or delirium tremens, offer admission to hospital for medically assisted alcohol withdrawal.

For young people under 16 years who are in acute alcohol withdrawal, offer admission to hospital for physical and psychosocial assessment, in addition to medically assisted alcohol withdrawal.

For certain vulnerable people who are in acute alcohol withdrawal (for example, those who are frail, have cognitive impairment or multiple comorbidities, lack social support, have learning difficulties or are 16 or 17 years), consider a lower threshold for admission to hospital for medically assisted alcohol withdrawal.

For people who are alcohol dependent but not admitted to hospital, offer advice to avoid a sudden reduction in alcohol intake and information about how to contact local alcohol support services.

Offer pharmacotherapy to treat the symptoms of acute alcohol withdrawal. Consider a benzodiazepine or carbamazepine. Clomethiazole may be offered as an alternative, but should be used with caution, in inpatient settings only and according to the summary of product characteristics.

Offer information about how to contact local alcohol support services to people who are being treated for acute alcohol withdrawal.

Follow a symptom-triggered dosing regimen for drug treatment for people in acute alcohol withdrawal who are in hospital or in other settings where 24-hour assessment and monitoring are available.

Healthcare professionals who care for people in acute alcohol withdrawal should be skilled in the assessment and monitoring of withdrawal symptoms and signs.

People in acute alcohol withdrawal should be assessed immediately on admission to hospital by a healthcare professional skilled in the management of alcohol withdrawal.

FINDINGS Other related NICE guidance documents are listed below.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence Assessment of what evaluation research means for alcohol dependence treatment in Britain, featuring reviews of the literature on the topics it covers.

Alcohol-use disorders: preventing the development of hazardous and harmful drinking Prevention guidelines which prioritised population-wide changes like price rises and outlet restrictions which affect everyone, independent of the choices they make.

Alcohol dependence and harmful alcohol use quality standard Concise statement of 13 practices which constitute high quality health care for problem drinkers and good practice in identifying and advising hazardous drinkers. The standards may be used to assess and reward providers and health service commissioning authorities.

Services for the identification and treatment of hazardous drinking, harmful drinking and alcohol dependence in children, young people and adults Guidance for commissioners on how to organise and procure alcohol treatment and brief intervention services in an area which implement related national clinical guidance and satisfy policy requirements.

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Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence DOCUMENT 2009

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence REVIEW 2011

Pharmacotherapies for the treatment of opioid dependence: efficacy, cost-effectiveness and implementation guidelines REVIEW 2009

Alcohol-use disorders: Preventing the development of hazardous and harmful drinking REVIEW 2010

Prescription of heroin for the management of heroin dependence: current status REVIEW 2009

Defeating DTs OLD GOLD 2002

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