ALCOHOL WITHDRAWAL

From tremor to delirium tremens · treat early

SYMPTOM *triggered*

TIMELINE FROM LAST DRINK: tremor / anxiety 6-24 h · seizures 12-48 h · alcoholic hallucinosis 12-48 h · delirium tremens 48-96 h (can be fatal).

ASSESS

- **Score severity -** CIWA-Ar (symptom-triggered) or SEWS; predict risk with PAWSS
- **Thiamine FIRST -** give IV thiamine 200-500 mg before any glucose (prevents Wernicke)
- **Replace -** magnesium, potassium, phosphate; correct dehydration
- **Screen -** for infection, head injury, GI bleed, hypoglycaemia - they mimic withdrawal

TREAT · BENZODIAZEPINES

- **Symptom-triggered -** dose to CIWA - fewer benzodiazepines, shorter treatment
- **Agents -** diazepam / chlordiazepoxide (long-acting); lorazepam if liver disease / elderly
- **Escalate fast -** give repeated doses until lightly sedated; front-load in severe cases
- **Seizures -** treat and prevent with benzodiazepines (NOT phenytoin)

DELIRIUM TREMENS

medical emergency, ICU

- **Recognise -** agitation, confusion, tremor, fever, tachycardia, hypertension, sweating
- **First-line -** escalating IV benzodiazepines to light sedation - the mainstay
- **Add adjuncts -** phenobarbital (benzo-sparing); dexmedetomidine or propofol for ICU control
- **Support -** fluids, electrolytes, thiamine, monitor airway; treat hyperthermia

BENZO-RESISTANT?

- Escalating benzodiazepine needs (> 200 mg diazepam-equivalent early) = resistant
- Add / switch to phenobarbital (long-acting, GABA + anti-glutamate)
- Dexmedetomidine or propofol control autonomic drive - NOT as monotherapy
- Adjuncts do not treat seizures - keep a benzodiazepine on board

DRUG DOSES

adult; titrate to CIWA / sedation

Drug	Dose	Note
Diazepam	10-20 mg IV / PO, repeat	Long-acting; front-load in severe withdrawal
Chlordiazepoxide	25-100 mg PO, reducing course	Oral, ward-based symptom-triggered
Lorazepam	2-4 mg IV, repeat	Liver disease / elderly (no active metabolites)
Phenobarbital	10-15 mg/kg IV load (specialist)	Benzodiazepine-resistant / DTs
Thiamine	200-500 mg IV	BEFORE glucose; prevents Wernicke

WERNICKE'S ENCEPHALOPATHY: confusion + ophthalmoplegia + ataxia (the triad is often incomplete). Give high-dose IV thiamine (e.g. Pabrinex) BEFORE any glucose; under-treatment risks irreversible Korsakoff amnesia.

PEARLS & PITFALLS

- Give thiamine before any glucose - a carbohydrate load can precipitate Wernicke encephalopathy.
- Dexmedetomidine and propofol blunt the autonomic signs but do NOT prevent seizures - keep benzodiazepines.
- Symptom-triggered dosing (CIWA) uses less benzodiazepine and shortens treatment than fixed schedules.
- New confusion is not always withdrawal - exclude sepsis, bleeding, head injury and hypoglycaemia.

References: ASAM Alcohol Withdrawal 2020 · CIWA-Ar (Sullivan) · standard critical-care references.

Educational aid; verify doses against local protocol and patient factors.