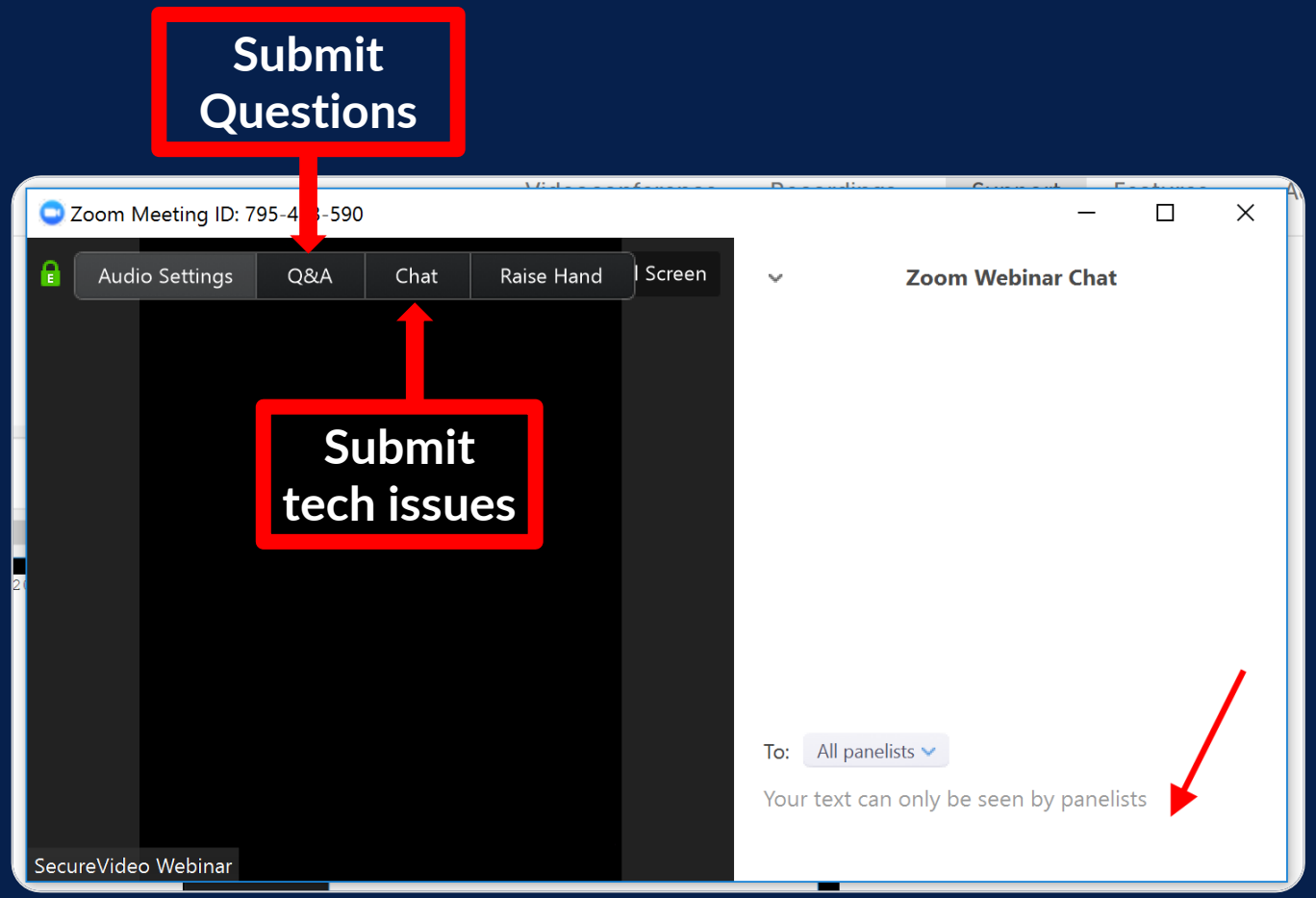
ASAM American Society *of* Addiction Medicine

ASAM Guideline on Alcohol Withdrawal Management: *Fundamentals*

Schedule

1:00 - 1:05 pm	Announcements ASAM STAFF
1:05 - 2:00 pm	Presentation and Q&A Session Dr. LEWIS NELSON
2:00 pm	Closing Remarks ASAM STAFF

Announcements



1. **Attendee Audio:** Your mics are automatically set to mute.
2. **Questions?** Type questions into the Q&A box.
3. **Technical Issues?** Use the chat box feature to submit questions to your hosts.

How to Claim CME

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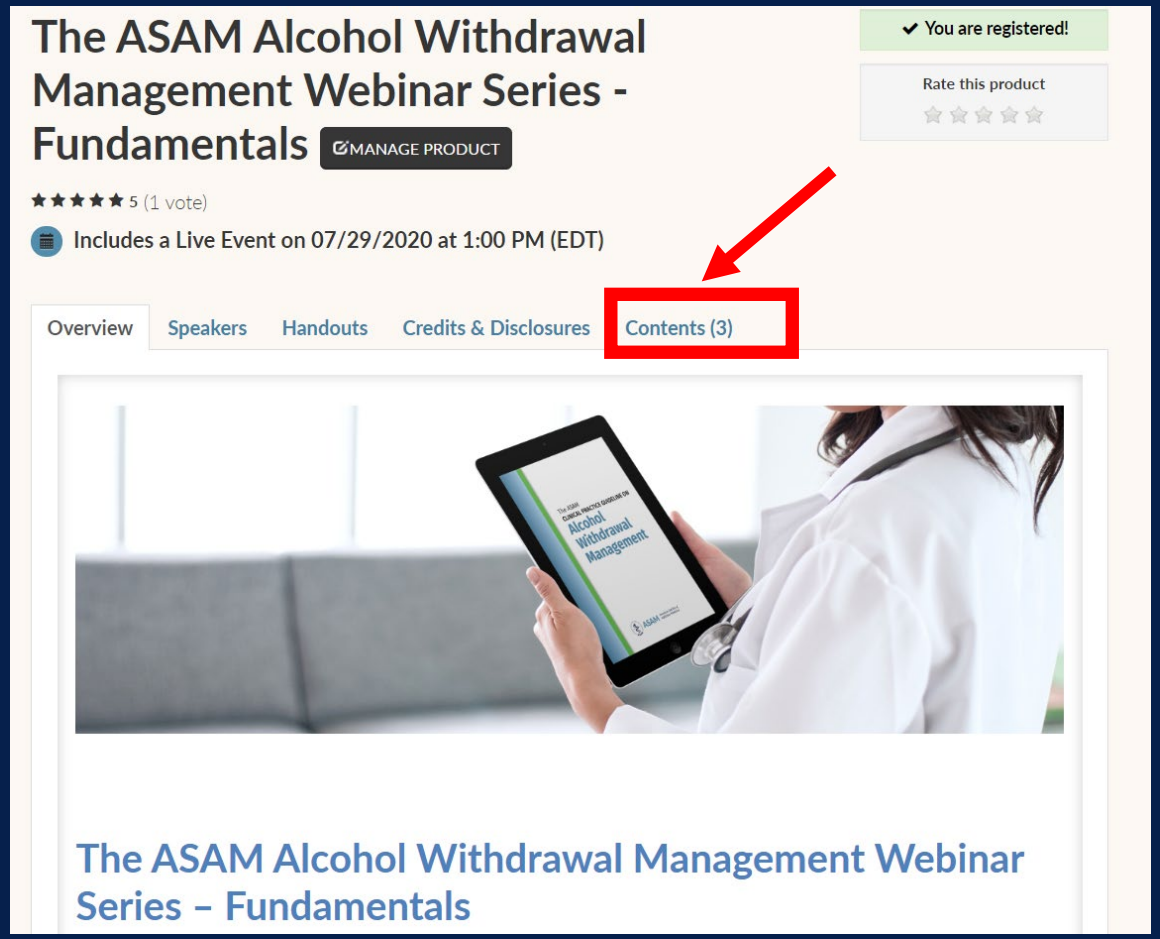
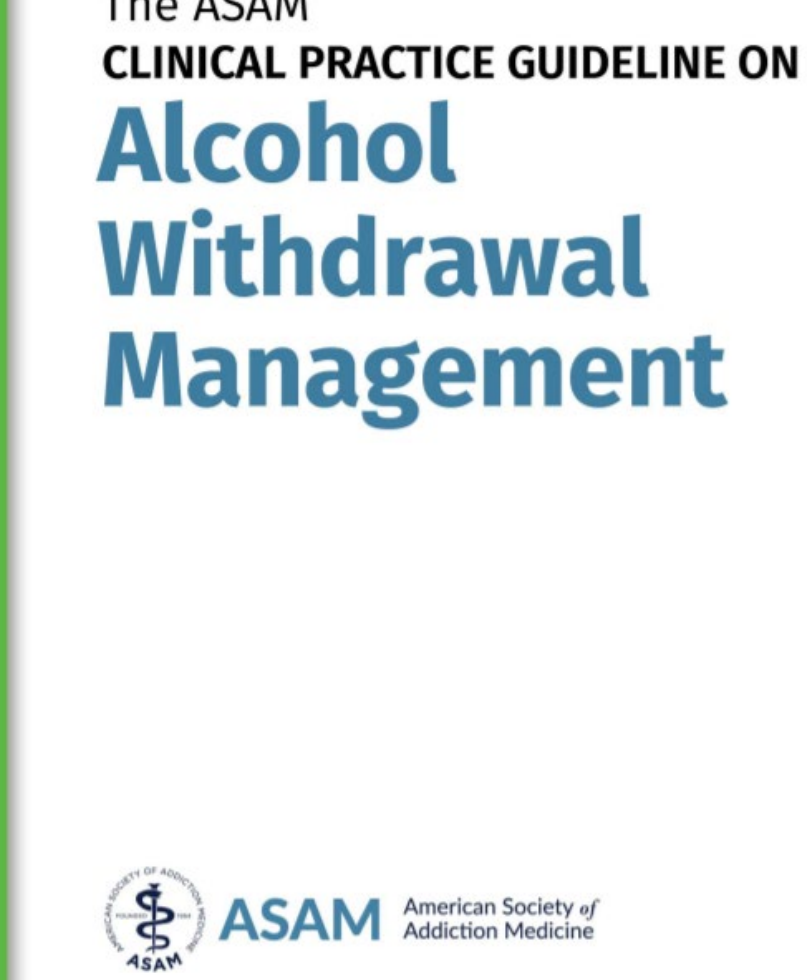


ASAM Guideline on Alcohol Withdrawal Management: *Fundamentals*



Presenter

Lewis S. Nelson, MD

- Professor and Chair of the Department of Emergency Medicine and Chief of the Division of Medical Toxicology at Rutgers New Jersey Medical School
- Member of the Board of Directors of the American Board of Emergency Medicine and a Past-President of the American College of Medical Toxicology.
- Actively involved with CDC, FDA, DHS, and with several professional medical organizations including ASAM.
- Editor of the textbook Goldfrank's Toxicologic Emergencies and on the editorial boards of several journals.
- Directs clinical care to patients in the ED
- Specific expertise include the consequences of licit and illicit opioids, emerging drugs of abuse, opioid stewardship, and alcohol withdrawal.

Disclosure Information

Lewis Nelson, MD

[No Disclosures]

The ASAM
CLINICAL PRACTICE GUIDELINE ON
Alcohol Withdrawal Management

ASAM American Society of Addiction Medicine

Outline of Content

- Objectives
- Background on Alcohol Withdrawal/Treatment
- Part 1: Identification and Diagnosis of Alcohol Withdrawal
- Part 2: Initial Assessment of Alcohol Withdrawal
- Part 3: Level of Care Determination
- Part 4: Pharmacotherapy
- Part 5: Ambulatory Management of Alcohol Withdrawal
- Part 6: Inpatient Management of Alcohol Withdrawal
- Part 7: Addressing Complicated Alcohol Withdrawal
- Part 8: Specific Settings and Populations
- COVID-19 Related Issues

Learning Objectives

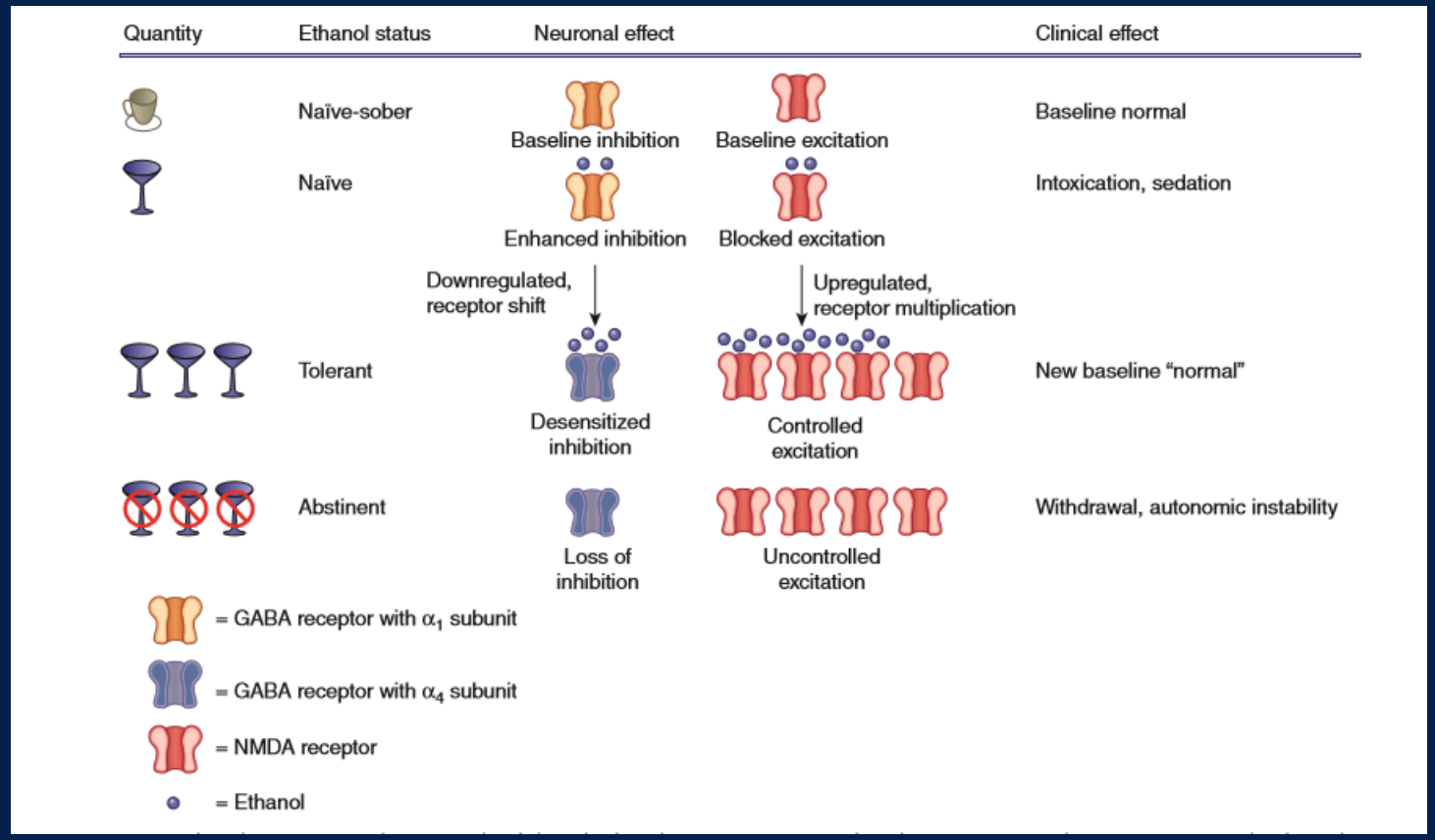
At the end of this webinar, you will be able to:

1. Summarize the guideline's treatment recommendations and discuss how they should be used in practice.
2. Address the gaps in the management of alcohol withdrawal.
3. Recognize the unique needs and recommendations during the COVID-19 pandemic.

Background on Alcohol Withdrawal/Treatment

Introduction

Ethanol Intoxication, Tolerance, and Withdrawal

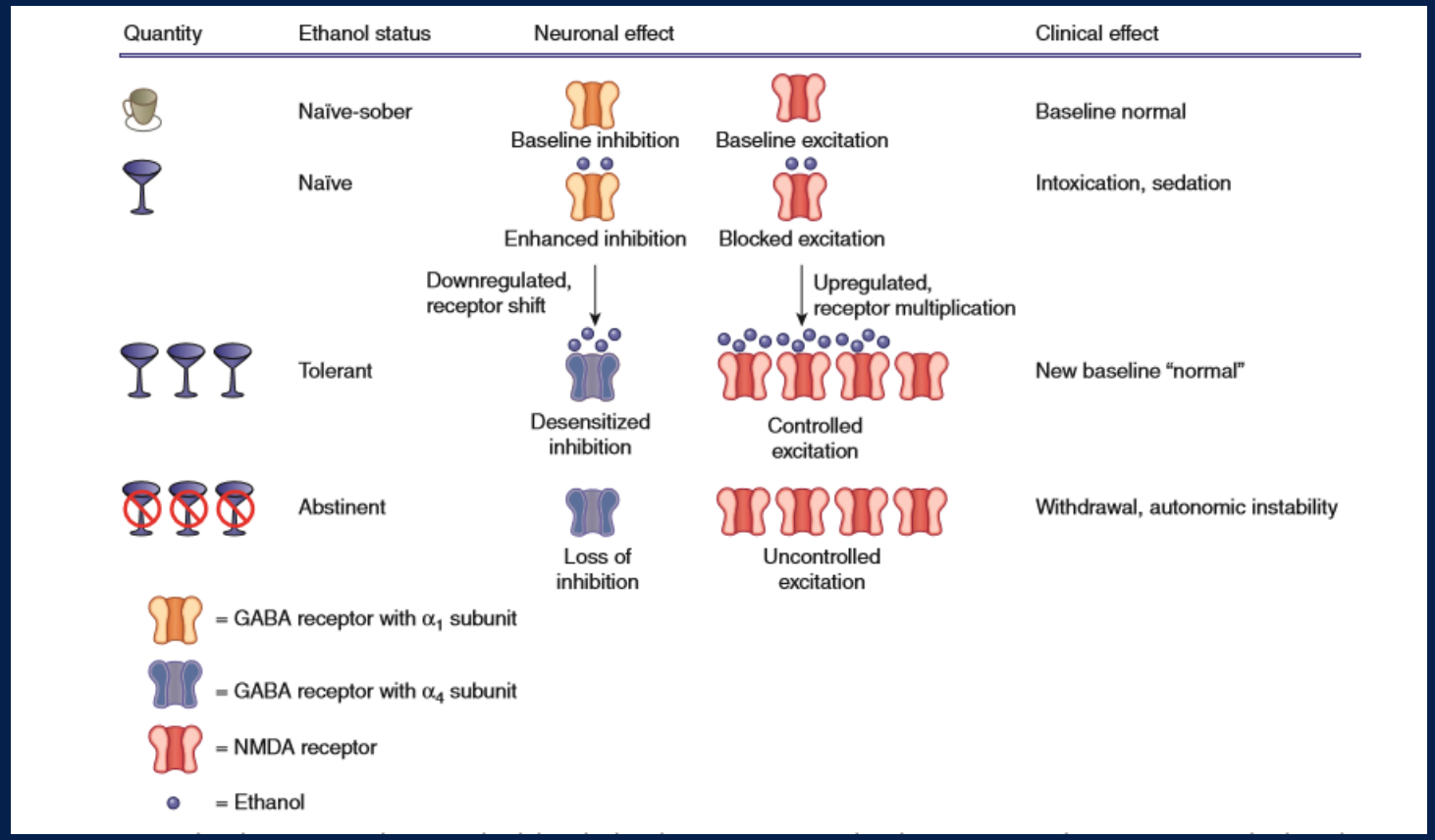


4 Key Points:

1. Ethanol consumption in an ethanol-naïve person produces intoxication and sedation by simultaneous agonism at the γ-aminobutyric acid (GABA) receptor–chloride channel complex and antagonism at the N-methyl-d-aspartate (NMDA) receptor.

Nelson LS, Howland MA, Lewin NA, Smith SW, Goldfrank LS, Hoffman RS. Goldfrank's Toxicologic Emergencies, 11th Edition. New York, McGraw Hill, 2019.

Ethanol Intoxication, Tolerance, and Withdrawal

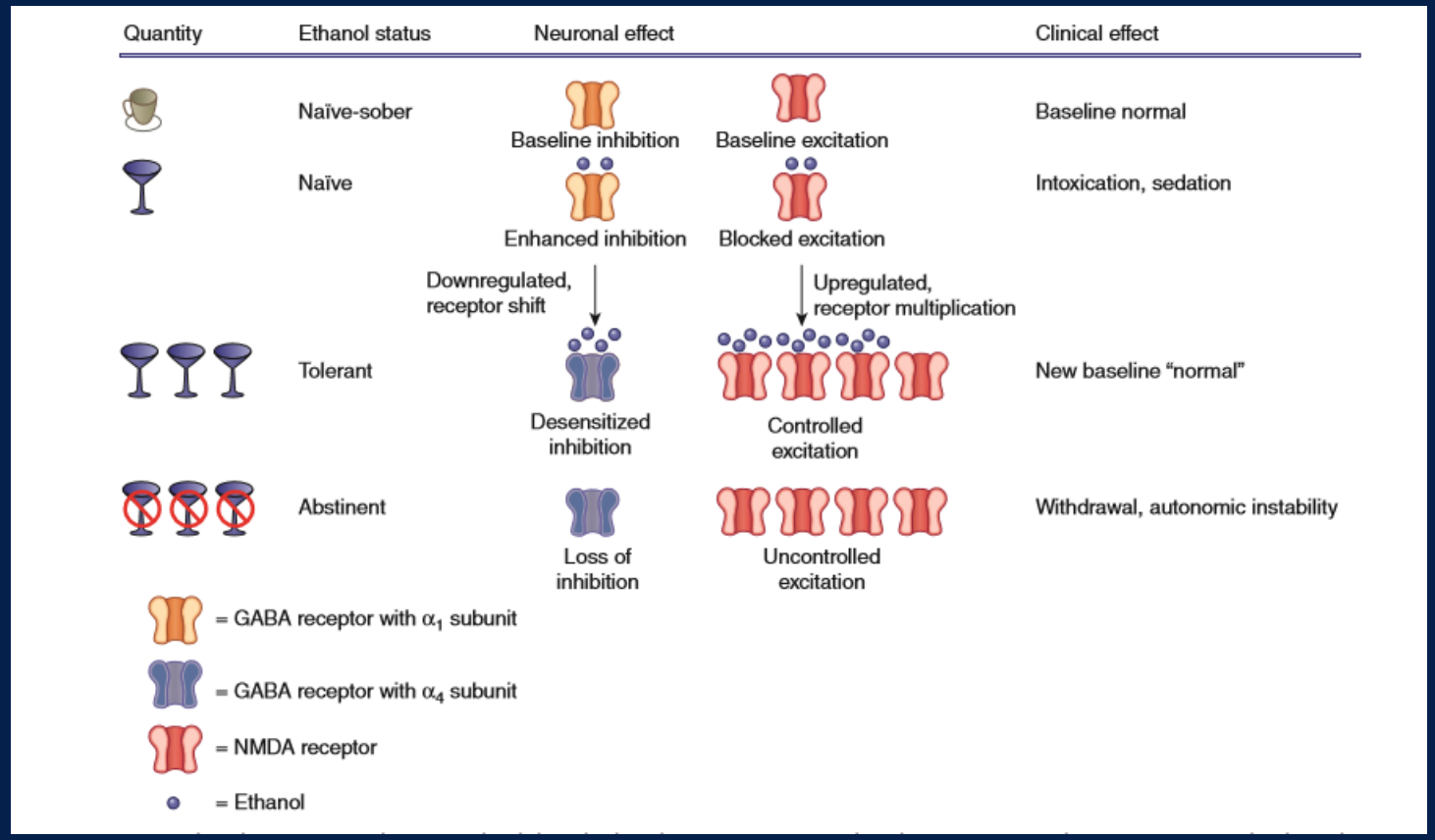


Nelson LS, Howland MA, Lewin NA, Smith SW, Goldfrank LS, Hoffman RS. Goldfrank's Toxicologic Emergencies, 11th Edition. New York, McGraw Hill, 2019.

4 Key Points Cont'd:

2. Continuous ethanol consumption leads to the development of tolerance through changes in both:
   - GABA receptor–chloride channel complex
     - Subunit shift from α 1 to α4, resulting in reduced sensitivity to the sedating effects of ethanol.
   - NMDA subtype of glutamate receptor
     - Upregulation in number, resulting in enhanced wakefulness.

Ethanol Intoxication, Tolerance, and Withdrawal



4 Key Points Cont'd:

3. Conceptually, there is a concentration at which the tolerant patient may appear clinically normal despite having an elevated blood ethanol concentration.

4. Tolerant patients who are abstinent lose the tonic effects of ethanol on these receptors, resulting in withdrawal.

Nelson LS, Howland MA, Lewin NA, Smith SW, Goldfrank LS, Hoffman RS. Goldfrank's Toxicologic Emergencies, 11th Edition. New York, McGraw Hill, 2019.

The Kindling Effect

- Repeated episodes lead to an increased severity of the withdrawal syndrome.
- Neuronal adaptations from intoxication/withdrawal cycle accumulate.
- Increased neurotransmitter imbalances occur when alcohol is stopped.
- Chronic alcohol use and repeated withdrawal may lead to permanent alterations in GABA receptors.

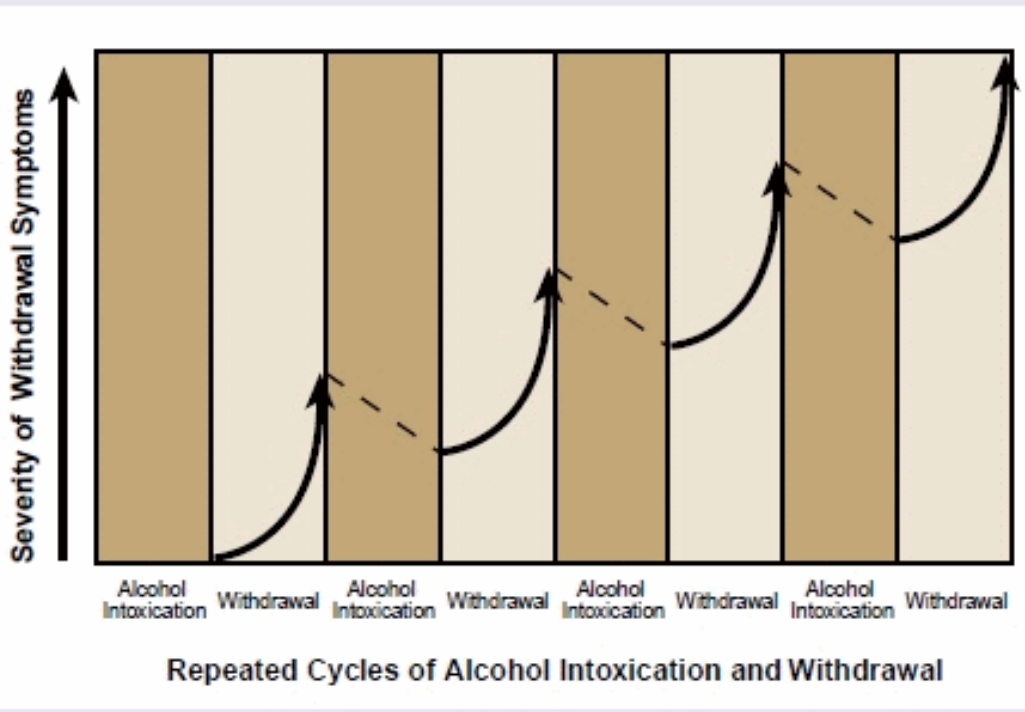


Figure 1 Graphic representation of the kindling concept during alcohol withdrawal. The term "kindling" refers to the phenomenon that people undergoing repeated cycles of intoxication followed by abstinence and withdrawal will experience increasingly severe withdrawal symptoms with each successive cycle.

Image Source: Becker 1998

Signs & Symptoms: The Short List

- **H**allucinations
- **A**gitation
- **T**remor
- **E**levated pulse

- **S**weating
- **I**nsomnia
- **N**ausea and vomiting
- **S**eizures

Signs and Symptoms of AWS

Signs and Symptoms	Typical Onset	Other
Mild Withdrawal • Mild anxiety, tremor, insomnia, headache, gastrointestinal upset, palpitations; still coherent.	6 – 24 hours	Symptoms generally resolve in 24–48 hours if no progression
Alcoholic Hallucinosis • Hallucinations (predominately tactile, can be visual or auditory), sensorium otherwise maintained.	12 – 24 hours	Symptoms generally resolve in 24–48 hours if delirium does not emerge
Moderate & Severe Withdrawal • Increased severity signs and symptoms; marked agitation and diaphoresis; increased systolic blood pressure, tachypnea, tachycardia, mild hyperthermia; confusion may be present.	24 – 72 hours	Duration usually 5–7 days
Withdrawal Seizures • Generalized tonic-clonic seizures	8 – 48 hours	Peak occurrence at 24 hours
Alcohol Withdrawal Delirium • Hallucinations (predominately visual) and disorientation; autonomic instability: severe tachycardia, hypertension, agitation, diaphoresis, low-grade fever.	72 – 96 hours	Symptoms can last for a few hours, but usually last 2–3 days

Categorizing Signs and Symptoms of AWS

Source: The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management Pocket Guide

Table 1. Alcohol Withdrawal Severity

Severity Category	Associated CIWA-Ar Range[a]	Clinical Findings
Mild	CIWA-Ar <10	Mild or moderate anxiety, sweating and insomnia, but no tremor
Moderate	CIWA-Ar 10–18	Moderate anxiety, sweating, insomnia, and mild tremor
Severe	CIWA-Ar ≥19	Severe anxiety and moderate to severe tremor, but not confusion, hallucinations, or seizure
Complicated	CIWA-Ar ≥19	Seizure or signs and symptoms indicative of delirium – such as an inability to fully comprehend instructions, clouding of the sensorium or confusion – or new onset of hallucinations

[a] Throughout this document, we provide examples for withdrawal severity using the CIWA-Ar, although other scales can be used. Regardless of the instrument used, there is a wide variety in the literature and in practice as to which scores best delineate mild, moderate and severe withdrawal. Classification of withdrawal severity is ultimately up to the judgment of clinicians and the choice of reference range may be based on their particular patient population or capabilities.

AWS Epidemiology

- Up to 50% of AUD patients experience clinically significant withdrawal symptoms
- For up to 90% of patients, AWS is mild or moderate
- Hallucinosis in 8% of AWS patients
- Seizures in 11% of *placebo-treated* patients enrolled in studies of BZD effectiveness
- AWD in 5% of AWS patients
- AWD fatal in 5-20% of *untreated* patients, most due to arrhythmias or MI
- AWD mortality reduced to less than 1% if *properly treated*

Driessen 2005 Alcohol & Alcoholism; Mirijello 2015 Drugs; Wartenberg 2014 ASAM Principles

Part 1. Identification and Diagnosis of Alcohol Withdrawal

Diagnosing Alcohol Withdrawal Syndrome (AWS)

- Use diagnostic criteria
- Do not use an AWS symptom severity instrument

Rationale

- Standard diagnostic criteria such as DSM-5 provide a common, reliable method to label and categorize signs and symptoms
- Symptom severity instruments are non-specific to etiology of the symptoms

Differential Diagnosis

- Assess patient's signs, symptoms, and history.
- Rule out other serious illnesses that can mimic AWS.
- Rule out medications that can mask AWS.

Rationale

- Many conditions share signs and symptoms with AWS.
- Medications such as beta-adrenergic antagonists (beta-blockers) mask signs and symptoms of AWS.

Part 2. Initial Assessment of Alcohol Withdrawal

Initial Assessment Goals

- Orient initial assessment towards **evaluating risk of**:
  - **Severe** AWS
  - **Complicated** AWS: Seizure/AWD
  - Complications of AWS: Potentially life-threatening exacerbation of existing condition
- Also assess severity of presenting signs and symptoms.

Rationale

- Signs and symptoms can escalate quickly.
- The trajectory of AWS can vary considerably among patients who are:
  - older.
  - using sedative hypnotics.
- Seizure and hallucinosis may occur in the absence of other clinically prominent signs or symptoms.

Risk Factors: Alcohol Use Pattern

- High dose
- Long duration
- Regular frequency

Rationale

These factors are predictive of greater physiological dependence.

Other Possible Risk Factors

- Use of other addictive substances
  - Depends on substance type and use pattern
- Positive BAL in presence of signs and symptoms
- Active signs and symptoms of co-occurring psychiatric disorder

Rationale

Indicates high degree of physiological dependence and other interacting issues

Choosing A Tool

- There is not one preferred tool. Use one appropriate for your setting and patient. If risk factors are present:
  - Interpret results with caution
  - Use a scale that relies on signs rather than symptoms

Rationale

Scores can be falsely elevated due to comorbid conditions or falsely suppressed due to certain medications.

Risk Level Tools

There are many risk factors to assess; consider using a tool:

- ASAM Criteria Risk Assessment Matrix
- Prediction of Alcohol Withdrawal Severity Scale (PAWSS)
- Luebeck Alcohol-Withdrawal Risk Scale (LARS)

Rationale

Because there are several risk factors to consider, using a consistent, standardized tool to measure risk is helpful.

AWS Severity Tools

- Clinical Institute Withdrawal Assessment for Alcohol, Revised (CIWA-Ar)
- Brief Alcohol Withdrawal Scale (BAWS)
- Short Alcohol Withdrawal Scale (SAWS)
- Richmond Agitation-Sedation Scale (RASS)

Part 3. Level of Care Determination

Ambulatory Withdrawal Management

Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring

- **Primary care office**
- Least disruptive to patient life
- May help patients avoid stigma

Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring

- **Intensive outpatient, day hospital setting**
- Daily clinic contact
- Often co-located with outpatient AUD treatment
- Access to other support services

Inpatient Withdrawal Management

Level 3.2-WM: Clinically managed residential withdrawal management

- **Residential setting withdrawal management program**
- Clinical (but not medical) staff, competent to implement physician-approved protocols
- On-call medical services
- Staff may supervise patients as they self-administer medications

Level 3.7-WM: Medically monitored inpatient withdrawal management

- **Freestanding facility with inpatient beds**
- Medical and nursing staff
- Provides 24-hour observation, monitoring, and treatment in a permanent facility with inpatient beds

Level 4-WM: Medically managed intensive inpatient withdrawal management

- **Acute care or psychiatric hospital inpatient unit**
- Staffed by physicians, who are available 24 hours a day, who medically manage the care of the patient

Primary Level of Care Considerations

Level of Care (LOC) is determined by:

- Current signs and symptoms
- Level of risk for severe, complicated AWS
- Other dimensions such as recovery capital and environment

Rationale

- In accordance with *The ASAM Criteria*, patients should be treated in the least restrictive setting that is safe.
- The greater the risk, the greater the need for intensive monitoring.

Level of Care Determination Tools

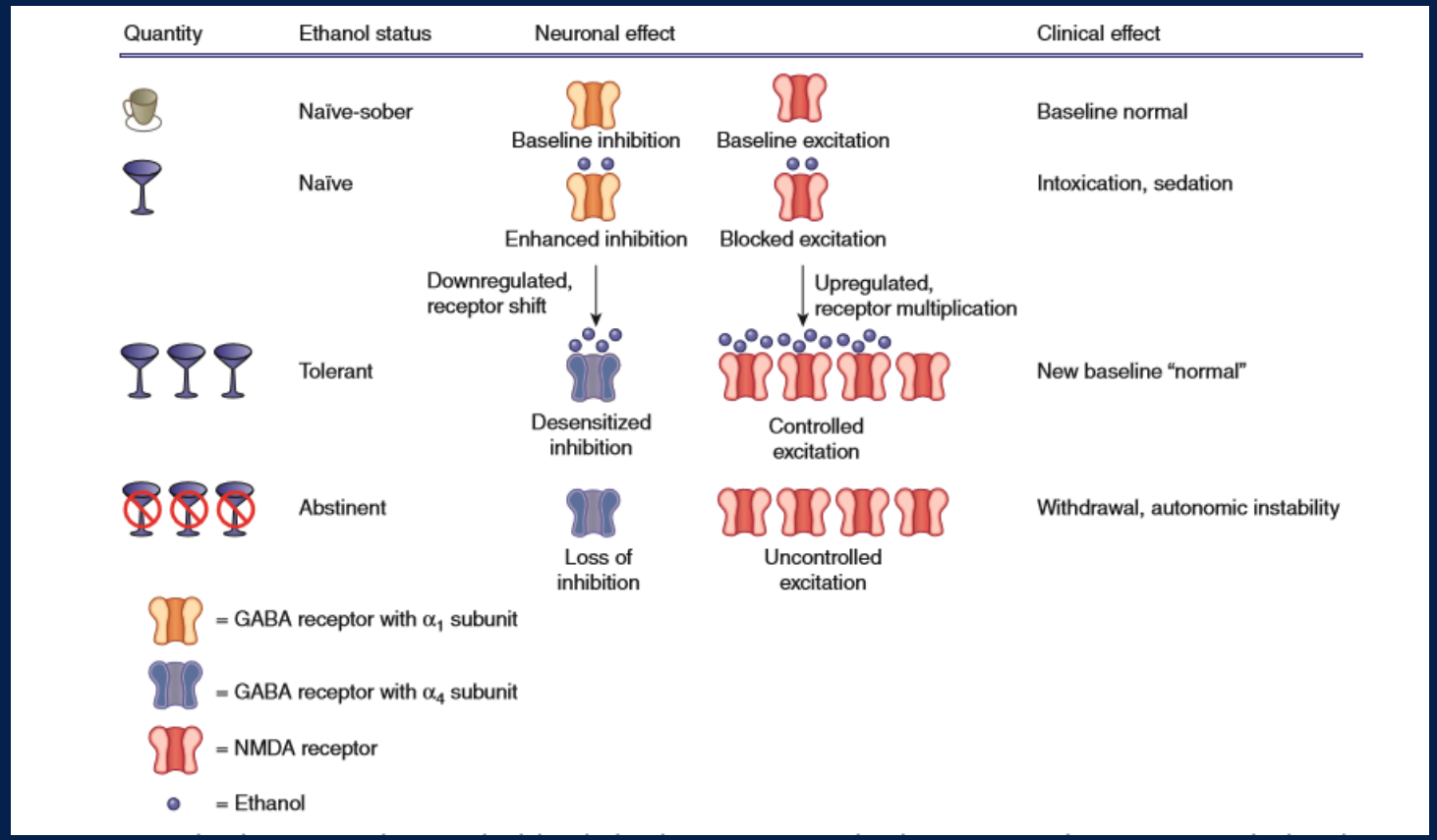
- *The ASAM Criteria* Risk Assessment Matrix
- AWS severity scales (partial information)
- Note, these tools should not be used alone to determine level of care.

Rationale

- Because there are a number of risk and protective factors to consider, using a tool is helpful.
- Most withdrawal severity scales reflect current signs and symptoms, not risk.

Part 4. Pharmacotherapy

Medications Used for AWS Monotherapy



- Target the GABA and/or glutamate system
- Benzodiazepines
- Phenobarbital
- GABA sensitive anticonvulsants (primarily carbamazepine & gabapentin)

Nelson LS, Howland MA, Lewin NA, Smith SW, Goldfrank LS, Hoffman RS. Goldfrank's Toxicologic Emergencies, 11th Edition. New York, McGraw Hill, 2019.

Benzodiazepines

Benzodiazepines (BZDs) are the medication of choice for most forms of AWS. They are appropriate for most patients in all settings.

BZDs are preferred for:

- Prophylaxis
- Severe AWS
- Seizure
- AWD

Rationale

- BZDs have the **most** empirical evidence of efficacy and safety in reducing signs and symptoms of AWS, incidence of seizure and AWD.
- The effectiveness of BZDs is well-documented in reducing the signs and symptoms of AWS and the incidence of seizure and AWD.
- Note, there is a risk of over-sedation and respiratory depression.

Phenobarbital

Phenobarbital (PHB) is appropriate for:

- Prophylaxis
- Severe or complicated AWS

Especially if:

- BZDs contraindicated
- The patient is not responding to BZDs

But only if:

- Clinicians have training and experience using it for AWS
- Patients are observed (Not Level 1-WM)

Rationale

- PHB has no evidence of better efficacy than BZDs.
- PHB has more side effects than BZDs.
- PHB has a relatively narrow therapeutic window and long half-life (up to 7 days), making it difficult to dose accurately without significant training.
- PHB is the next best alternative to BZDs for severe and complicated AWS.
- PHB acts on GABA and glutamate signaling, whereas BZDs only augment GABA.

Anticonvulsants: Carbamazepine & Gabapentin

Carbamazepine (CBZ) and Gabapentin (GBP) are appropriate for:

- Mild or moderate AWS

Especially if:

- BZDs contraindicated
- Plan to use GBP for ongoing AUD treatment

Rationale

- CBZ and GBP have sufficient evidence of efficacy and safety for mild to moderate AWS.
- Compared to BZDs and PHB, CBZ and GBP have a:
  - better safety profile
  - less sedating
  - lower risk of drug-drug interaction
- There is not enough evidence for treating AWS-related seizure or AWD.

Anticonvulsants: Valproic Acid (Depakene, Depakote)

- **Valproic acid (VPA)** is appropriate only as an adjunct to BZDs.
- VPA is **NOT** appropriate for patients with:
  - Childbearing potential
  - Liver disease

Rationale

- VPA has sufficient evidence of efficacy and safety as an adjunct
- VPA has significant teratogenic risk – and should not be used by any person with childbearing potential
- CBZ and GBP are as effective as VPA and have lower risk

Alpha2-Adrenergic Agonists & Beta-Adrenergic Antagonists

Alpha2-Adrenergic Agonists (A2AAs) and Beta-Adrenergic Antagonists (Beta-Blockers) are appropriate for:

- Only as an adjunct to BZDs
- A2AAs: Autonomic hyperactivity and anxiety
- Beta-Blockers: Persistent hypertension or tachycardia

Rationale

- A2AAs and Beta-Blockers reduce the signs of sympathetic activation.
- A2AAs and Beta-Blockers do not treat the underlying syndrome.
- A2AAs and Beta-Blockers may mask signs of worsening syndrome.

Dexmedetomidine & Propofol

Dexmedetomidine (DEX) and Propofol are appropriate for:

- As an adjunct to BZDs
- For patients with AWD or Resistant Alcohol Withdrawal (RAW) being treated in the ICU and who already require intubation

Rationale

- DEX and Propofol can reduce the agitation and delirium associated with AWD and RAW through sedation.
- DEX does not treat the underlying syndrome.

AWS Medication Considerations

- Need to prevent serious, life-threatening clinical effects
- Need to ameliorate current signs and symptoms, prevent return to alcohol use
- Side effect and safety profiles
- Available routes of administration (PO, IM, IV)

AWS Medication Considerations Cont'd

- To prevent or treat AWS, do **NOT** use:
  - Alcohol
  - Baclofen
  - Magnesium (to treat AWS)

Rationale

- Administration of oral or intravenous alcohol has no proven efficacy and known toxicity.
- There's not enough evidence yet for baclofen.
- There is evidence magnesium is not effective at treating AWS signs and symptoms.

Part 5. Ambulatory Management of Alcohol Withdrawal

Ambulatory: Monitoring Frequency

- Check in with a qualified health provider **daily** for **up to five days** following cessation of (or reduction in) alcohol use.
- If they cannot attend clinic daily, **some** patients can alternate in-person visits with remote check-ins via phone/internet.

Rationale

While daily monitoring is desirable, occasional telehealth check ins might be sufficient, especially for patients in mild withdrawal or who are nearing completion of withdrawal.

Part 6. Inpatient Management of Alcohol Withdrawal

Inpatient: AWS Prevention

- Patients at risk of developing severe, complicated, or complications of AWS should get **preventative** medication regardless of their current signs and symptoms
  - BZDs are first-line
  - PHB if BZDs are contraindicated and provider experienced with its use
  - If high risk, in settings with close monitoring, can add PHB adjunct to BZDs

Rationale

- These medications can prevent the development of life-threatening signs and symptoms
- BZDs have well-documented effectiveness in reducing the incidence of seizure and AWD
- PHB is effective, but has more side effects and requires experience to dose for AWS
- PHB is synergistic with BZDs and their combination increases risk of over sedation and respiratory depression

Part 7. Addressing Complicated Alcohol Withdrawal

AWS Seizure: Pharmacotherapy

- Following a withdrawal seizure, patients should be immediately treated with a medication effective at preventing seizure.
- BZDs are the first-line treatment.
- A fast-acting agent such as diazepam is preferred. Lorazepam is acceptable.
- PHB can also be used.

Rationale

- Following an alcohol withdrawal seizure, a patient is at increased risk for another seizure and progression to AWD.
- BZDs are effective in reducing the incidence of seizure and AWD
- PHB is also effective in treating seizure and preventing AWD, but have more side effects than BZDs. Their half life and therapeutic window make accurate dosing difficult without extensive training.

Scales Appropriate for AWD

- Confusion Assessment Method for ICU Patients (CAM-ICU)
- Delirium Detection Score (DDS)
- Minnesota Detoxification Scale (MINDS)
- Richmond Agitation-Sedation Scale (RASS) 1-item scale
  - 4 Combative
  - 3 Very agitated
  - 2 Agitated
  - 1 Restless
  - 0 Alert and calm
  - -1 Drowsy
  - -2 Light sedation
  - -3 Moderate sedation
  - -4 Deep sedation
  - -5 Unarousable

AWD: Supportive Care

- May use existing institutional/hospital-associated delirium protocols for supportive care.
- Provide immediate intravenous access for drug and fluid administration.
- Only use restraints to prevent injuries and in compliance with state laws.

Rationale

- Institutional/hospital-associated delirium protocols optimize patient safety and may already be familiar to staff.
- IV fluids to correct potential electrolyte imbalances (e.g. hypomagnesemia) ass ociated with AWD.
- Restraints can prevent patients from removing peripheral lines, but may contribute to confusion and agitation.

AWD: Pharmacotherapy

- Therapeutic target: Sedation to point of light somnolence.
- BZDS are first-line agents.
- Clinicians should not hesitate to provide large doses of BZDs to patients to control agitation.
- PHB can be used, but is not preferred to BZDs.

Rationale

- Medication goal is to control agitation in AWD.
- Very large doses may be needed, much larger than typically seen in other patient populations.
- PHB has more side effects than BZDs including bradycardia, bradypnea, hypothermia, hypotension, pulmonary edema, acute renal failure and Steven-Johnson syndrome.

AWD: Phenobarbital Adjunct

- When AWD is not adequately controlled by BZDs, one can add phenobarbital as an adjunct in settings with close monitoring.

Rationale

PHB acts on GABA as well as glutamate signaling. It is synergistic with BZDs and increases therapeutic effect. It also increases the risk of over-sedation and respiratory depression.

Resistant Alcohol Withdrawal

- RAW: Severe or complicated AWS despite having received high doses of BZDs.
- For supportive care, can use existing institutional/hospital-associated delirium protocols.
- Add an adjunct medication. **Can use:**
  - Phenobarbital in settings with close monitoring.
  - Propofol in the ICU if already require mechanical ventilation.
  - Dexmedetomidine in the ICU.

Rationale

- Institutional/hospital-associated delirium protocols optimize patient safety.
- Evidence that adjunct PHB reduces need for mechanical ventilation and length of stay in patients experiencing RAW.
- Evidence that adjunct propofol and dexmedetomidine are effective at reducing the signs and symptoms of AWS in patients experiencing RAW.

Part 8. Specific Settings and Populations

Medical Conditions: Hepatic Disorders

- For patients with impaired hepatic function, if prescribing medication for AWS:
  - Reduce medication dose, or
  - Use a medication with low dependence on hepatic metabolism.

Rationale

Impaired hepatic function is associated with an increase in the accumulation of BZD metabolites leading to over-sedation and respiratory depression.

Medical Conditions: Cardiovascular Disorders

- For patients with cardiovascular disorders:
  - Aggressive treatment of AWS is indicated
  - Prevent even mild signs and symptoms of AWS

Rationale

Risk of harm from AWS-related autonomic hyperactivity.

Patients Who Take Opioids

- For patients with a co-occurring opioid use disorder:
  - Stabilize opioid use disorder (e.g. with methadone or buprenorphine) and treat AWS concomitantly.

Rationale

- Committee agreed AWM and initiating medication of OUD can be done alongside.
- Consider that patients should be placed in the level of care appropriate to their most acute problem.

Patients Who Are Pregnant

- BZDs and PHB are the preferred AWS medications for pregnant patients.
- Valproic acid should not be used by pregnant patients.
- If using a BZD and at risk for pre-term delivery or in the late third trimester, use a short-acting BZD.

Rationale

- Risk of teratogenicity from BZDs and PHB during the first trimester outweighed by risk of harm should severe AWS develop, or alcohol consumption continue.
- Valproic acid has high teratogenic risk.
- Shorter onset and duration of action **reduces** the risk for neonatal BZD intoxication.

Part 9. COVID-19 Related Issues

COVID-19 Related Issues

Coronavirus

N.J. liquor store reopens after being overrun by Pennsylvania shoppers after coronavirus shutdown

Updated Mar 30, 2020; Posted Mar 30, 2020

With coronavirus closures looming, Pennsylvanians run to the liquor stores

Updated Mar 17, 2020; Posted Mar 17, 2020

COVID-19 Related Issues

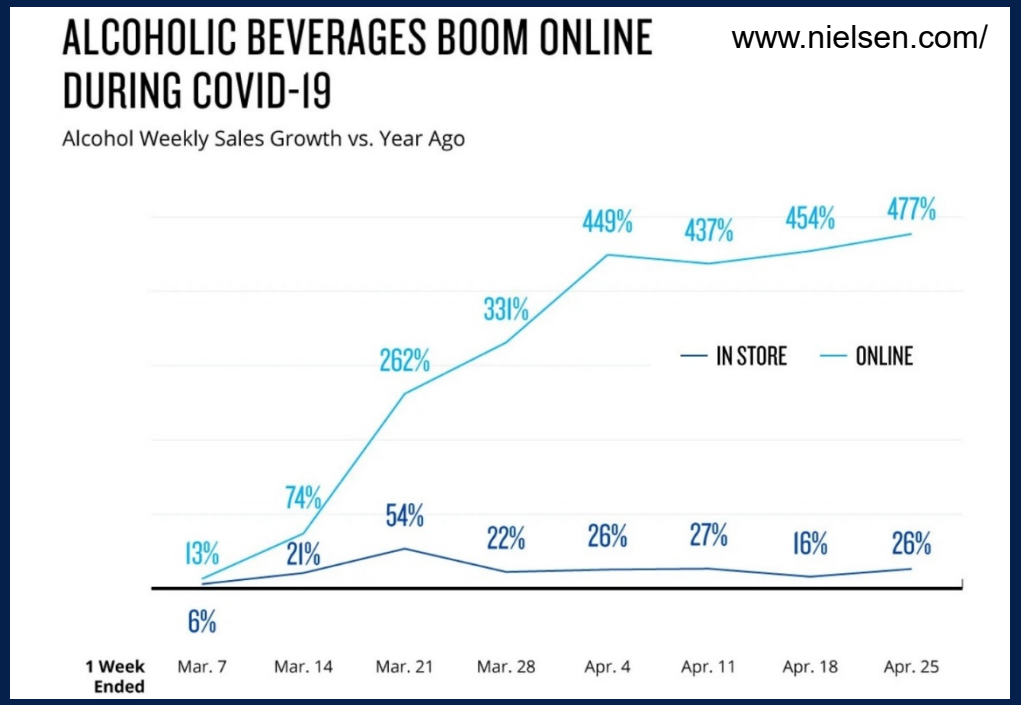
NIAAA

- For people who have been drinking heavily over long periods of time, quitting abruptly can lead to deadly withdrawal.
- More than 850 people die from alcohol withdrawal each year and more than 250,000 are treated at emergency departments.

ASAM

For those with severe alcohol use disorder (AUD), particularly those who experience alcohol withdrawal, closure of bars and liquor stores could resort in decreased access to alcohol and significant increase in episodes of alcohol withdrawal and its associated complications, which if untreated can in some instances be fatal.

COVID-19 Related Issues



CDC Healthy Ways to Cope with Stress:

https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html

COVID-19 Related Issues

- Chronic alcohol use impairs the pulmonary (lung) immune responses.

- Thus, those with chronic heavy alcohol use and AUD may be at increased risk for infection with the novel coronavirus and increased risk for related morbidity, such as Acute Respiratory Distress Syndrome (ARDS).

Simou M, et al. The Effect of Alcohol Consumption on the Risk of ARDS: A Systematic Review and Meta Analysis 2018;154:58-68

COVID-19 Related Issues

- Research suggests that telehealth can be effective for reducing drinking and staying sober.
  - See the NIAAA Alcohol Treatment Navigator: http://ow.ly/znLw50z8Zr1
- ASAM Statements:
  - Recognizing that patients are likely to need increased support during this very stressful time, providers are encouraged to use telehealth to increase the frequency of their contact with their patients. Phone calls, video visits, and video groups are all ways to connect with patients.
  - As treatment providers we can increase the frequency of contact with existing patients, provide patients with online and smartphone recovery support resources, connect patients with peer support, and partner with family members and close friends to extend support and monitoring. We can also continue to accept new patients.

Considerations for AWM during COVID-19

When treating in an outpatient setting with home monitoring, consider…

- A dosing protocol that includes higher doses of alcohol withdrawal medications
- Using the short alcohol withdrawal scale (SAWS) which can be self-administered
- Communities should consider launching an "on-call' line for urgent SUD and withdrawal management services where patients can be triaged to determine if they need inpatient care
- Developing standard protocols for specific settings where alcohol withdrawal management may be needed. Examples:
  - Protocols for management of low acuity alcohol withdrawal in emergency shelters for people experiencing homelessness
  - Protocols for COVID-19 quarantine sites staffed by nurses which may be able to handle more moderate acuity patients

For more guidance, visit: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-alcohol-use-disorder-and-alcohol-withdrawal-treatment

Considerations for AWM during COVID-19

When patients are treated for alcohol withdrawal, the provider should work to engage the patient in treatment for alcohol use disorder.

- Naltrexone 50-100mg oral once daily (must ensure opioid abstinence for at least 7 to 10 days)
  - Liver function tests should be considered when 100mh doses are prescribed
- Naltrexone ER 380mg IM once every 28 days intramuscular (gluteal) injection (must ensure opioid abstinence for at least 7 to 10 days)
- Acamprosate 333-666mg oral TID
- Disulfiram 125-500mg oral once daily

For more guidance, visit: https://www.asam.org/Quality-Science/covid-19-coronavirus/access-to-alcohol-use-disorder-and-alcohol-withdrawal-treatment

AUDIENCE Q & A

UPCOMING EVENTS

THE ASAM ALCOHOL WITHDRAWAL MANAGEMENT SERIES

❑ The ASAM Alcohol Withdrawal Management Webinar: Identification, Diagnosis, and Initial Assessment	Kurt Kleinschmidt, MD, FASAM & Dazhe Cao, MD	Monday, Aug. 24 @ 1:00 p.m. EST
❑ The ASAM Alcohol Withdrawal Management Webinar: Monitoring, Levels of Care, and Inpatient/Ambulatory Treatment	George Kolodner, MD, DLFAPA, FASAM	Tuesday, Sept. 15 @ 1:00 p.m. EST
❑ The ASAM Alcohol Withdrawal Management Webinar: Pharmacotherapy	Michael Weaver, MD, DFASAM	Tuesday, Oct. 20 @ 12:00 p.m. EST
❑ The ASAM Alcohol Withdrawal Management Webinar: Complicated Withdrawal and Special Populations	Darius Rastegar, MD, DFASAM	Tuesday, Nov. 17 @ 12:00 p.m. EST

ASAM American Society *of* Addiction Medicine

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THANK YOU.