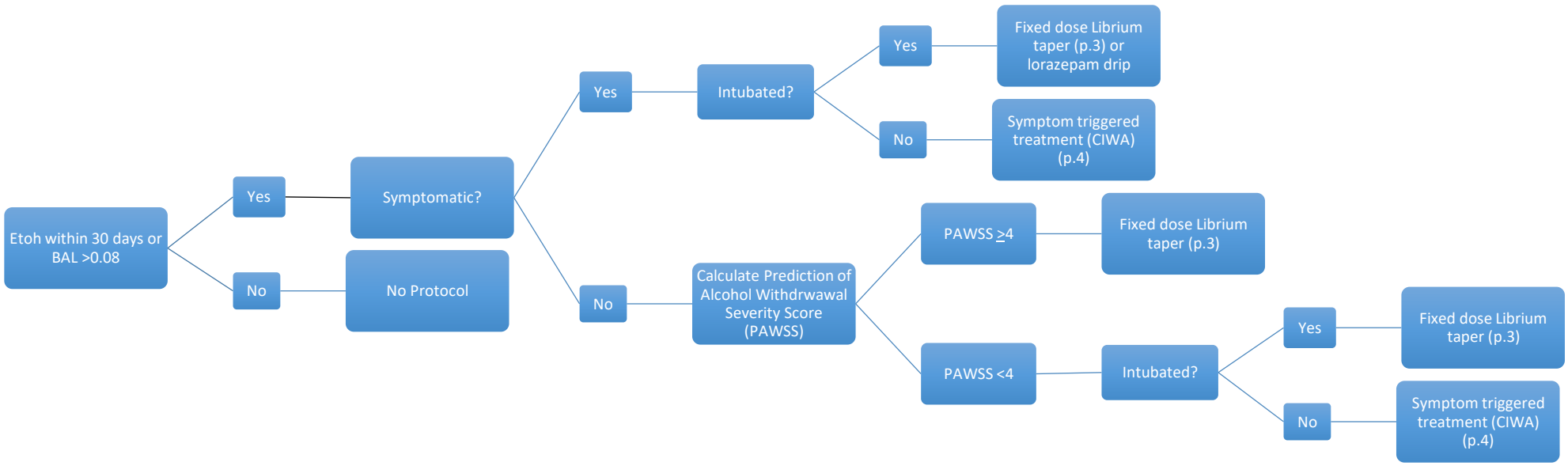


See. PAWSS on next page

Prediction of Alcohol Withdrawal Severity Score (PAWSS)

Part A: Threshold Criterion	**"Y" or "N", no point**
Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" BAL on admission? *IF the answer to either is YES, proceed with test:*	
Part B: Patient Interview	**1 point each**
1. Have you been recently intoxicated/drunk within the last 30 days?	
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance)	
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?	
4. Have you ever experienced blackouts?	
5. Have you ever experienced alcohol withdrawal seizures?	
6. Have you ever experienced delirium tremens or DT's?	
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days?	
8. Have you combined alcohol with any other substance of abuse, during the last 90 days?	
Part C: Clinical Evidence	**1 point each**
9. Was the patient's blood alcohol level (BAL) on presentation ≥ 200?	
10. Is there evidence of increased autonomic activity? (e.g., HR>120, tremor, sweating, agitation, nausea)	
Total Score:	

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS.
A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.

Risk Stratification

- **Low Risk:** PAWSS Score ≤ 3 (and clinical judgement)
  → **follow symptom triggered treatment**
- **Moderate-High Risk:** PAWSS Score ≥ 4 and persistent CIWA score > 18
  → **follow fixed dose taper**

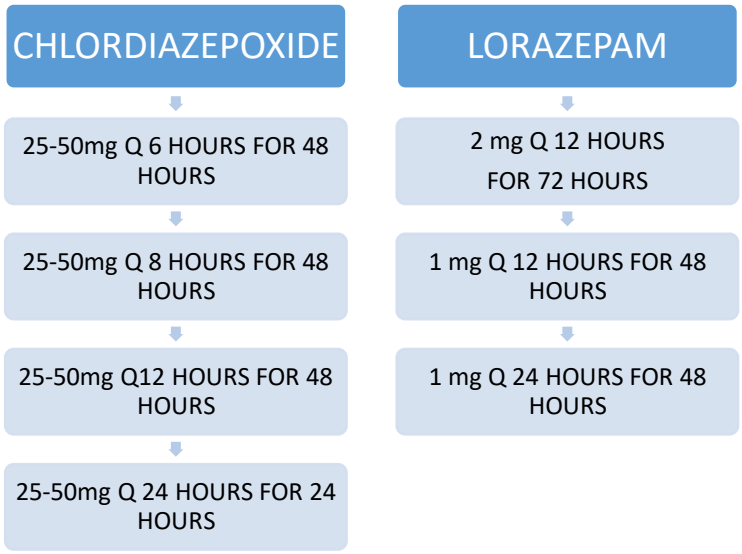
FIXED-DOSE TAPER (1 week)

1. Treat with Chlordiazepoxide (Librium) according to dosing below (available as PO only)

- Longer acting than lorazepam
- Smoother taper
- Contraindicated in elderly, moderate to severe liver dysfunction or if unable to take PO

2. Lorazepam (available as IV/IM/PO) **ONLY if chlordiazepoxide is contraindicated:**

- Oral administration of lorazepam is preferred over parenteral routes of administration. However, IV administration should be considered for patients not tolerating oral administration
- Lorazepam can be administered IM if IV access is not available.
- Monitor for signs of propylene glycol toxicity (i.e. anion gap metabolic acidosis, osmolar gap) with administration of lorazepam continuous infusion



SYMPTOM TRIGGERED MANAGEMENT (CIWA)

I. Inclusion Criteria
- Patient should be in Intensive or Intermediate Care Units
- This protocol is only indicated in NON-mechanically ventilated patients

II. Exclusion Criteria
- Seizure on this admission from alcohol withdrawal
- Cannot/unable to answer questions
- Actively experiencing Delirium-Tremens (DTs)
- No history of recent alcohol intake in the last 7 days

III. PHARMACY: Inform physician that all pre-existing orders for benzodiazepines will be discontinued.

IV. DOSING: Symptom-Triggered Dosing (PO or IV - IM if no IV access)

Withdrawal Score	Lorazepam Dose	Reassessment Time
0-7	None	2 hours
8-13	1 mg	1 hour
14-18	2 mg	1 hour
19-23	3 mg	1 hour
24 or more	4 mg	30 min for up to 2 hours

- Assessment frequency can be decreased after 24 hours if, on 3 consecutive assessments, CIWA < 8
- If after 72 hours CIWA remains < 8 and no symptoms of withdrawal then CIWA can be discontinued
- Fixed dose benzodiazepines or Lorazepam drip can be ordered for up to 8mg per hour for four hours if:
    i. If patient required for doses of lorazepam every thirty minutes for a total of 32 mg over two hours and CIWA score is still greater than 18
    ii. MD is at bedside and documents the need for lorazepam drip
    iii. Patient is in ICU status or is in the ED under monitoring status
    iv. Patient must be mechanically ventilated to initiate lorazepam drip

RASS Score	Lorazepam Infusion Instructions	Assessment
>+2	Bolus 6 mg and initiate drip at 6 mg/h Bolus 4 mg for each RASS +4 Increase drip by 2mg/h if RASS >+3 after 2 hours	Q15 min until RASS Score 0-2
0-2	Continue at current rate (do not increase unless RASS >+2	Reassess q1h
<0	Decrease drip by 2mg/hr q2 hours as long as RASS <0; when drip weaned off, start (or resume) fixed dose taper	Reassess q2h

- Haldol can be considered but should have:
    i. ECG
    ii. Recent electrolytes

V. Hold benzodiazepines and contact physician for:
- BP < 110 mm Hg (Systolic)
- RR < 10 breaths per minute
- SpO2< 93
- Patient unresponsive (RASS -4 to -5)

VI. Contact physician if:
- HR>110 per minute or SBP >160 mm Hg or DBP of > 100 mg Hg after 10 minutes of administering lorazepam

VII. Vitamins/Mineral Supplementation
- Thiamine 200mg IV once, then 200mg PO/IV daily x 3 days
    i. Consider higher doses (200 – 400mg every 8 hours x 2-3 days) if suspicion of Wernicke's is high (cognitive changes, paralysis of eye muscles, ataxia)
- Folic Acid 1 mg PO or IV if no oral access daily for three days
- Multivitamin 1 tab PO daily for three days

VIII. Additional PRN Medications to Consider
- For control of persistent signs of adrenergic hyperactivity such as tachycardia and hypertension
    i. Metoprolol 5mg IV Q 6 hours PRN for SBP>160 or DBP > 100 mm Hg (hold for SBP <100 mm Hg, HR < 60 bpm)
    ii. Clonidine 0.1 mg PO Q 8 hours PRN SBP > 160 or DBP >100 mm Hg (hold for SBP <100 mm Hg, HR < 60 bpm)
- Adjunctive therapy (in addition to benzodiazepines) to improve control of agitation
    i. Haloperidol 2.5 – 5mg IM every 4 – 6 hours scheduled or PRN
    ii. Phenobarbital 130mg IV q8h prn agitation
    iii. Monitor for signs of respiratory depression (RR < 10 breaths/min) and over-sedation (unresponsive)

- For adjunctive management of severe alcohol withdrawal (not be used as monotherapy and/or in conjunction with clonidine). May consider for patients requiring lorazepam continuous infusion of >10mg/hr to control signs of adrenergic hyperactivity or prevent mechanical ventilation
    i. Dexmedetomidine - initiated at 0.2mcg/kg/hr and titrated to maintain RASS of 0 to -1 (unless otherwise ordered by provider). Titration range 0.2 – 1.5 mcg/kg/hour
        1. Hold for bradycardia (HR < 50 beats/min) and hypotension (BP < 90/60 mm Hg)
        2. Discontinue all existing orders for clonidine while utilizing dexmedetomidine