Etoh within 30 days or BAL >0.08

- Yes
  - Symptomatic?
    - Yes
      - Fixed dose Librium taper (p.3) or lorazepam drip
    - No
      - Intubated?
        - Yes
          - Symptom triggered treatment (CIWA) (p.4)
        - No
          - Calculate Prediction of Alcohol Withdrawal Severity Score (PAWSS)
            - PAWSS ≥4
              - Fixed dose Librium taper (p.3)
            - PAWSS <4
              - Intubated?
                - Yes
                  - Fixed dose Librium taper (p.3)
                - No
                  - Symptom triggered treatment (CIWA) (p.4)

- No
  - No Protocol

See. PAWSS on next page
Prediction of Alcohol Withdrawal Severity Score (PAWSS)

**Part A: Threshold Criterion**

<table>
<thead>
<tr>
<th>Question</th>
<th>“Y” or “N”, no point</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td></td>
</tr>
<tr>
<td><strong>IF the answer to either is YES, proceed with test:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Part B: Patient Interview**

<table>
<thead>
<tr>
<th>Question</th>
<th>1 point each</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you been recently intoxicated/drunken within the last 30 days?</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
</tr>
<tr>
<td>3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?</td>
<td></td>
</tr>
<tr>
<td>4. Have you ever experienced blackouts?</td>
<td></td>
</tr>
<tr>
<td>5. Have you ever experienced alcohol withdrawal seizures?</td>
<td></td>
</tr>
<tr>
<td>6. Have you ever experienced delirium tremens or DT’s?</td>
<td></td>
</tr>
<tr>
<td>7. Have you combined alcohol with other “downers” like benzodiazepines or barbiturates, during the last 90 days?</td>
<td></td>
</tr>
<tr>
<td>8. Have you combined alcohol with any other substance of abuse, during the last 90 days?</td>
<td></td>
</tr>
</tbody>
</table>

**Part C: Clinical Evidence**

<table>
<thead>
<tr>
<th>Question</th>
<th>1 point each</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Was the patient’s blood alcohol level (BAL) on presentation ≥ 200?</td>
<td></td>
</tr>
<tr>
<td>10. Is there evidence of increased autonomic activity? (e.g., HR&gt;120, tremor, sweating, agitation, nausea)</td>
<td></td>
</tr>
</tbody>
</table>

**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

---

**CHLORDIAZEPoxide**

- 25-50mg Q 6 HOURS FOR 48 HOURS
- 25-50mg Q 8 HOURS FOR 48 HOURS
- 25-50mg Q12 HOURS FOR 48 HOURS
- 25-50mg Q 24 HOURS FOR 24 HOURS

**LORAZEPAM**

- 2 mg Q 12 HOURS FOR 72 HOURS
- 2 mg Q 12 HOURS FOR 48 HOURS
- 1 mg Q 12 HOURS FOR 48 HOURS
- 1 mg Q 24 HOURS FOR 48 HOURS
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)

<table>
<thead>
<tr>
<th>Withdrawal Score</th>
<th>Lorazepam Dose</th>
<th>Reassessment Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>None</td>
<td>2 hours</td>
</tr>
<tr>
<td>8-13</td>
<td>1 mg</td>
<td>1 hour</td>
</tr>
<tr>
<td>14-18</td>
<td>2 mg</td>
<td>1 hour</td>
</tr>
<tr>
<td>19-23</td>
<td>3 mg</td>
<td>1 hour</td>
</tr>
<tr>
<td>24 or more</td>
<td>4 mg</td>
<td>30 min for up to 2 hours</td>
</tr>
</tbody>
</table>

- 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 8 mg per hour for four hours if:
  - 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
  - MD is at bedside and documents the need for lorazepam drip
  - Patient is in ICU status or is in the ED under monitoring status
  - Patient must be mechanically ventilated to initiate lorazepam drip
**Lorazepam Infusion Instructions**

<table>
<thead>
<tr>
<th>RASS Score</th>
<th>Lorazepam Infusion Instructions</th>
<th>Assessment</th>
</tr>
</thead>
</table>
| >+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:
  - ECG
  - 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
    - 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
    - Metoprolol 5mg IV Q 6 hours PRN for SBP>160 or DBP > 100 mm Hg (hold for SBP <100 mm Hg, HR < 60 bpm)
    - 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
    - Haloperidol 2.5 – 5mg IM every 4 – 6 hours scheduled or PRN
    - Phenobarbital 130mg IV q8h prn agitation
    - 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