ECHO IDAHO

Substance Use in Idaho

Best Practices in Ambulatory Alcohol Detoxification

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Learning Objectives

- By the end of this presentation, participants will be able to:
  - Describe ambulatory detoxification (AmDetox) and its role in alcohol use disorder (AUD)
  - Identify appropriate patient selection criteria
  - Describe common protocols and medications
  - Recognize risks, limitations, and safety considerations

Alcohol & Why AmDetox Matters

Alcohol is a CNS depressant

- Alcohol both downregulates the inhibitory part the brain and upregulates the excitatory part of the brain, resulting in compound CNS depressing effects
- Frequently involved in OD death and suicide cases

One standard drink

- 12 oz of "regular beer (5% w/v)" = 7-8 oz of malt liquor or craft beer = 5 oz of wine = 1.5 oz of liquor

AUD is common

- As of 2024: 1 in 10 adults in the US meet criteria for AUD yearly **(~50% will experience at least some degree of withdrawal** when they stop or reduce use)
- Incarcerated adults have rates roughly 2-3x the general US population

AUD is undertreated

Less than 10% of people with past-year AUD receive any **treatment** each year, even though untreated AUD greatly increases the risk of alcohol withdrawal and other complications

Inpatient resources are limited and costly and often not preferred by patients

Withdrawal is predictable and preventable when treated early

What is alcohol withdrawal?

A physiologic response to sudden reduction or cessation of alcohol in someone with prolonged heavy use

Symptoms = immediate and opposite of the drug effects

Results from CNS hyperexcitability due to chronic alcohol-induced GABA/glutamate imbalance

Typical signs/symptoms:

- Mild: tremor, anxiety, insomnia, nausea
- Moderate: tachycardia, hypertension, diaphoresis
- Severe: hallucinations, seizures, delirium tremens (DTs)

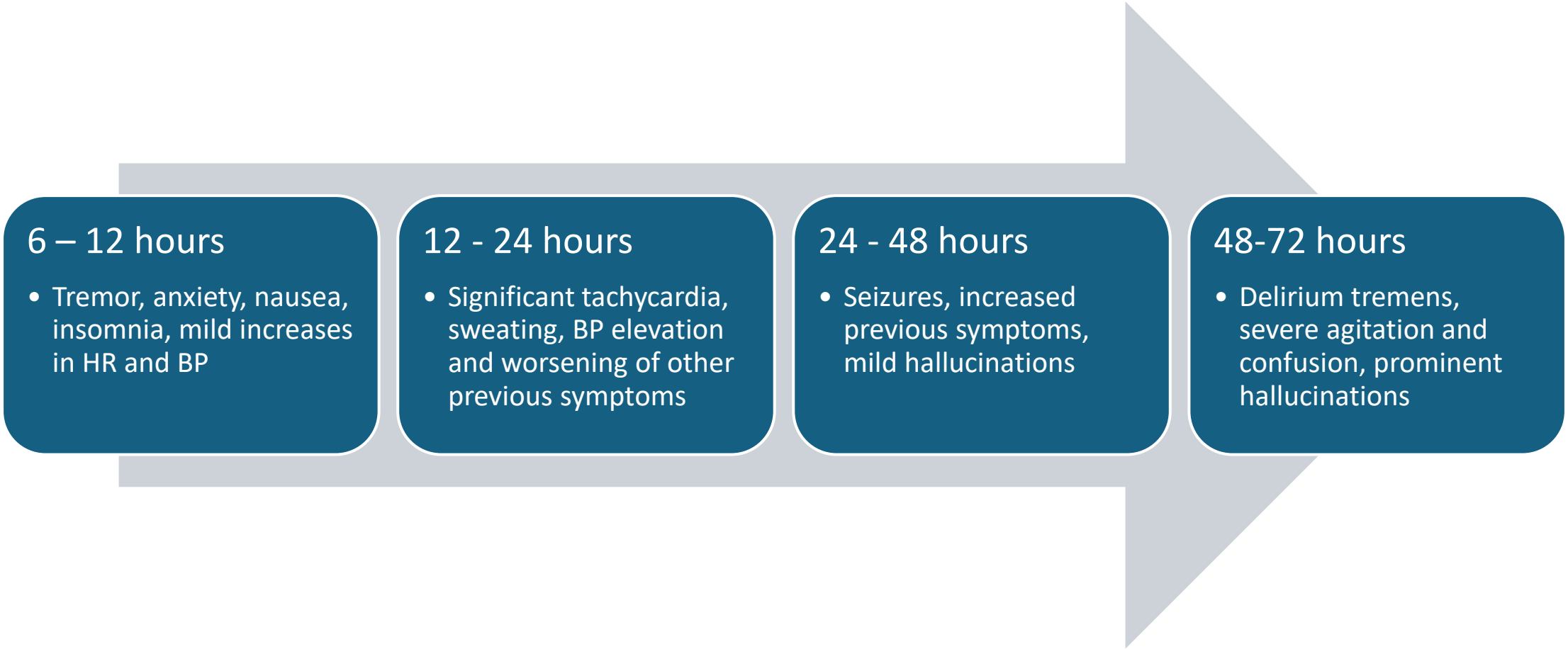
Can be fatal without proper management and should be medically guided

Clinical Food for Thought

Alcohol detoxification should be conceptualized as risk mitigation – not just symptom relief

- AmDetox expands access and continuity of care

Timeline of Alcohol Withdrawal Symptoms



Blood Alcohol Impact Table

0.02	Light to moderate drinkers begin to feel relaxed	0.15	Balance and movement are substantially impaired. Difficulty walking or talking. Heavy drinkers with substantial tolerance may learn to look sober at this level. One half pint of whiskey is circulating in the blood stream. 25x more likely to cause a fatal car crash .
0.04	Most drinkers begin to feel relaxed		
0.06	Judgment is impaired. Legally drunk in some states		
0.08	Judgment is further impaired. More likely to do things that you would not do when sober. Legally drunk in all states.	0.20	Blackout and memory loss. A person driving at this level is 100x more likely to cause a fatal car crash .
0.10	Reaction time and muscle control are impaired. A person drinking at this level is 10x more likely to cause a fatal car crash. Normal social drinkers rarely reach this level.	0.30	Loss of consciousness and passing out. Being able to remain conscious at this level indicates a tolerance that is a serious risk factor for health problems
0.12	Vomiting for most people	0.40 to 0.60	FATAL - Causes paralysis to brain area that controls breathing and heart rate. This can happen when someone drinks a lot, passes out and the alcohol in the stomach continues to be absorbed into the blood stream. Drinking contests are a frequent cause of lethal overdose

Photo courtesy of: Alcohol *and Other Drug Program Initiatives at the University of Pennsylvania.*

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Who is a candidate for Alcohol AmDetox?

AmDetox is not a lower standard of care, it is a different level of care

- Stable home environment & support system
  - Just as important as medical stability
- Mild—moderate dependence
- Stable medical and psychiatric status
- Reasonable health literacy

Serious Risks / Exclusion Criteria for AM Detox

Inpatient Referrals

- H/O withdrawal seizures
- H/O delirium tremens
- H/O chronic, heavy alcohol use
- Concomitant benzodiazepine use
- Pregnancy
- Untreated/symptomatic comorbid SMI or other medical problems
- Withdrawal from numerous substances at once

Risk Stratification Tools

- PAWSS (prediction of alcohol withdrawal severity) --> use to screen for admission
- CIWA-Ar (standard of care for daily management)
  - Not a substitute for judgement
  - Useful for informing you about withdrawal and intoxication
- Clinical history is critical
  - When was your last drink?
  - What is your drink of choice?
  - How much do you consume daily?
  - What has past withdrawal been like?
  - Do you use any other substances or medications?

The CIWA-Ar

- See form here: https://www.dochub.com/fillable-form/8878-ciwa-ar

Evidence-based Protocols & Medications

Benzodiazepines (standard of care)

- Includes medications like: lorazepam, diazepam, clonazepam, chlordiazepoxide, etc.
- Inpatient vs outpatient considerations
- Use of long-acting agents in the outpatient setting is generally preferrable (e.g., chlordiazepoxide (Librium®))
- Taper vs symptom-triggered dosing
- Monitoring

Option 1: Fixed-Dose Chlordiazepoxide Taper (Common Outpatient Approach)

Day 1

- Chlordiazepoxide 25–50 mg PO every 6 hours
  (Typical total daily dose: 100–200 mg)

Day 2

- Chlordiazepoxide 25–50 mg PO every 8 hours

Day 3

- Chlordiazepoxide 25–50 mg PO every 12 hours

Day 4–5

- Chlordiazepoxide 25 mg PO once daily, then discontinue

Notes:

- Long half-life provides “self-tapering” effect
- Avoid in significant liver disease or elderly patients??
- Dispense **limited quantities**

Option 2: Symptom-Triggered Lorazepam

Dosing Based on CIWA-Ar Score

- CIWA-Ar ≥8–10:
- Lorazepam 1–2 mg PO every 4–6 hours as needed
  - Maximum typical outpatient dose: 6–8 mg/day (varies by protocol)

Advantages of lorazepam:

- Shorter half-life
- Rapid onset -> quicker relief of symptoms
- No active metabolites
- Can be safer in hepatic impairment and geriatric patients

Requirements:

- Reliable daily assessment (in-person or telehealth)
- Patient able to self-monitor symptoms

Adjunctive Medications to Always Include

- Thiamine 100 mg PO daily (before glucose if applicable)
- Folic acid 1 mg PO daily
- Multivitamin daily
- Encourage oral hydration and nutrition
- Avoid alcohol and sedating medications

Adjunctive Medications to Possibly Consider

THESE SHOULD NOT GENERALLY BE CONSIDERED A SUBSTITUTE FOR BENZODIAZEPINE THERAPY

Anticonvulsants → these do not reliably reduce the incidence of withdrawal seizures or DTs

- Gabapentin: most evidence of these options. Consider for:
  - Mild dependence, or
  - Adjunct to a benzodiazepine regimen, or
  - If benzodiazepines are contraindicated, or
  - Possibly useful for protracted withdrawal sx (i.e., anxiety, insomnia, cravings)
  - General regimen: 300 mg – 600 mg TID (titrate to prevent falls)
- Carbamazepine / Oxcarbazepine
  - May be of more use in a similar capacity for benzodiazepine use disorder but data are unclear

Monitoring / Follow - Up

- Daily Symptom check-ins
- Include use of CIWA-Ar
- What about telehealth?
- Communication Strategies (motivational interviewing)
- Peer support

Clear Escalation Criteria → Inpatient Detox

- CIWA-Ar persistently >15
- Worsening tremor, confusion, hallucinations
- Seizure activity
- Inability to adhere to regimen
- Unstable vitals or oversedation

Key Points

- Alcohol withdrawal occurs when heavy and/or prolonged alcohol use is abruptly reduced or stopped, leading to CNS hyperexcitability. Medical management is necessary.
- Ambulatory alcohol detox is a different level of care indicated primarily for people with mild-moderate alcohol dependence without medical complications
- Standard of care includes: regular use of scales (CIWA-Ar), daily symptom check-ins, clinical judgement, benzodiazepines and other potential adjunctive medications
- Alcohol withdrawal treatment should be conceptualized as risk mitigation – not just symptom reduction/management

References

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