Management of Resistant Alcohol Withdrawal
Alcohol Withdrawal Consultation Service at Bellevue Hospital

The initial goal is a dose of diazepam that controls [DEFINE BELOW] the patient for at least 1 hr. [ADD CIWA OR RICHMOND SCORE? OR WETTERLING SCORE? VITAL SIGNS? NATE’S RECS? HOW TO TREAT PERSISTENT TACHY [RISK OF OVERSEDATION?]]

The dose of diazepam should be progressively increased after each failed dose until a maximum of 100 mg is administered as a single dose. For example:
- Diazepam 10 mg. May be repeated three times after 5-10 minutes, PRN.
- Diazepam 20 mg. May be repeated three times after 5-10 minutes, PRN.
- Diazepam 40 mg. May be repeated three times after 5-10 minutes, PRN.
- Diazepam 100 mg. Repeat until alternative therapy needed.

**Failure to respond to:**
- 200 mg of IV diazepam in the initial 3 hours **or**
- 400 mg in the first 8 hours **or**
- Requiring > 40 mg per PRN dose for control
(see below for disposition decision-making)

**EW**
- Notify both the EW Pulm and Med Tox Fellows
- Continue bolus diazepam dosing and add Phenobarbital (65-130 mg IV q 30 min, up to 390 mg)
- If unable to control AWS with diazepam 500 mg and phenobarb 390 mg:
- Propofol, 5mg/min IV, intubation likely [intub has downside but controls pt]

**MICU or EW (if possible)**
- Notify both the ICU and Med Tox Fellows
- Continue bolus diazepam dosing and add Phenobarbital (65-130 mg IV q 30 min, up to 390 mg)
- [IS THERE A FAILURE DOSE OF DIAZ?] All attempts to avoid intubation should be made

**Decision regarding admission location**

**Detox unit:** Pre-withdrawal and low-risk with near normal vital signs
**Floor:** Active withdrawal easily managed in ED with less than 40 mg diazepam, with or without a low-acuity co-morbid condition. If checked, the BAC = 0 mg/dL (or very low).
Mildly intoxicated patient requesting detox without h/o complicated or significant withdrawal
Single AWS seizure but otherwise meets above criteria

**Med obs:**
Moderate withdrawal and/or agitation that was responsive to ED therapy
No more than mildly depressed level of awareness after medication
Mild or moderate withdrawal in ED, responsive to therapy, but risk for more serious withdraw (personal/family history of severe AWS) or BAC > 0 mg/dL
Withdrawal + comorbid illness requiring closer observation or serial exams (abdominal pain, minor trauma, hyperglycemia, vomitting,etc.)

**EW:**
Continued significant VS abnormality despite diazepam dose > 40 mg (“resistant”) or BAC > 50 mg/dL
Significantly depressed LOC +/- Airway concerns
Multiple AWS seizures
Significant comorbid condition and moderate-severe withdrawal (cardiac disease, uncontrolled DM, electrolyte abnormalities (risk for arrhythmia), sepsis, trauma, etc)

**MICU:**
Similar to EW, although the most severe AWS patients should be put in the MICU