Management of alcohol withdrawal in a general hospital: Our experience from an addiction psychiatry unit.

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ABSTRACT: Alcohol abuse is a major public health problem. This brief report summarizes our experience from the management of alcohol withdrawal in patients of our hospital. We describe the alcohol withdrawal syndrome and the way we treat these patients. We stress the importance of early recognition and treatment of this syndrome, in order to prevent serious complications, such as delirium tremens and withdrawal seizures.

Key words: Alcohol abuse, general hospital, alcohol withdrawal, delirium tremens

INTRODUCTION

Alcohol abuse and alcohol dependence are major public health problems with serious consequences for the physical and mental health of the patients. It is well documented that alcohol abuse leads to physiological and psychological dependence, and its abrupt cessation may result, in many cases, in alcohol withdrawal syndrome. Furthermore, both abuse and dependence account for a variety of problems in the personal, family, social and occupational life of these patients, who are often hospitalized for medical or surgical diseases. Thus, urgent recognition and management of alcohol withdrawal are very important.

The addiction psychiatry service of our department holds the responsibility for the diagnosis and treatment of drug-related disorders in our hospital. Alcohol-related problems are among the most frequent problems encountered both in selected populations of patients with addictive and general psychiatric disorders as well as in medical/surgical patients hospitalized for a concurrent health problem.

Patients treated for alcohol withdrawal by our service fall into two broad categories:

- Alcohol-abusers or alcohol dependent patients who are followed-up by our service on an outpatient basis: we believe that a reasonable time period is important in order to motivate these patients accept their problem, gain insight into it and decide to treat it. After a satisfactory therapeutic alliance has been built, admission to a medical unit is scheduled on a regular basis in order to help them undergo detoxification.

- More often, we are called upon by physicians of other departments for patients who are treated for a medical problem. This problem can either be a medical consequence of alcohol abuse, such as liver cirrhosis, or a random, commorbid disease (e.g., admission to hospital for an elective operation). In these cases we usually face not only the denial, which is a very common and powerful defense mechanism in these patients, but also other facts as well. These include absence of prior co-operation, lack of time needed to help the patient gain insight into his problem, but also the reason for admission in the hospital, which is an area of great concern for the patient and his family.

Based on our experience, patients from the first group usually do better. They often agree to be admitted to our department in order to continue the detoxification process, to participate in psychotherapeutic groups aiming at relapse prevention and they generally show a satisfactory course in many cases. On the contrary, patients of the second group are more reluctant to follow such a programme. We attribute this difference to the fact that an important part of therapeutic work has been previously done with the patients of the first group. This work includes motivational interviewing, empathy, lack of judgemental attitude and building of therapeutic alliance, among others.

ALCOHOL-WITHDRAWAL SYNDROME

In chronic heavy drinkers a fall in the blood alcohol concentration leads to withdrawal symptoms including delirium tremens (1). Alcohol withdrawal is associated with significant morbidity and mortality when improperly managed (2). This fact underlies the importance of high clinical suspicion, early recognition and treatment of the problem. The alcohol withdrawal syndrome varies significantly in
clinical manifestations and severity. The first symptoms and signs occur within hours of the last drink (approximately 6-8 hours), peak within 24-48 hours and include restlessness, tremor, sweating, anxiety, nausea, vomiting, loss of appetite, insomnia, tachycardia and hypertension (2, 3).

The peak onset of delirium tremens is within 48 hours from the last drink and the mortality rate is estimated to be about 5%, associated with cardiovascular collapse or infection. Withdrawal seizures may also take place within 48 hours from stop drinking (1).

Detoxification can usually be conducted on outpatient basis, unless severe withdrawal effects are likely to occur, the patient’s mental state causes concern, or there are severe social problems (1). Outpatient withdrawal is safe and effective for mild and moderate alcohol dependence (4, 5). Nevertheless, we always insist that detoxification be conducted in the hospital, so as to monitor closely the patient and complete the whole process safely. This is because, although the most common effect of abrupt cessation of drinking is an uncomplicated alcohol withdrawal syndrome, severe effects also may result, including tonic-clonic seizures, hallucinations, and delirium tremens, and may even lead to death (6).

The objectives in treating alcohol withdrawal are relief of discomfort, prevention or treatment of complications, and preparation of rehabilitation (6). The identification of co-occurring medical problems, good supportive care and treatment of concurrent illnesses, fluid and electrolyte repletion, and administration of thiamine and multivitamins are important (6, 7). Attention should always be paid to the state of hydration and nutrition of the patient and if malabsorption is likely, intravenous thiamine and other B vitamins should be given in the first instance (1).

Benzodiazepines are the drugs of choice for the treatment of alcohol withdrawal. Diazepam and chlordiazepoxide are most commonly used. In case impaired liver function exists, oxazepam and lorazepam are used instead (6), due to their short half-lives, most commonly in a reducing regimen. Antipsychotics are not indicated for the treatment of withdrawal, except when hallucinations or severe agitation are present, in which case they should be added to a benzodiazepine (6, 7).

Benzodiazepines can be given in “front-loading”, as symptom-triggered therapy or as a tapering dose regimen (2).

OUR EXPERIENCE

We present our experience, based on the patients we examine each year in our service. For example, according to our statistical data for the year 2012, we made 149 psychiatric evaluations in the medical/surgical departments of our hospital. Of these, 25 (16.8%) were women (average age 42.5 years) and the rest 124 (83.2%) were men (average age 53.1 years). Furthermore, in the outpatient clinic of our service, we examined 364 patients, of which 227 (62.4%) were men and the rest 137 (37.6%) were women (8).

Approaching the patient with alcohol-related problems is a demanding task. Patients almost always deny that there exists a problem about alcohol drinking, despite the serious consequences this has caused. Empathic listening without authoritarian style helps establish some therapeutic alliance. Motivational interviewing may help, even if the patient keeps rejecting the possibility of alcohol-related problems. A clear explanation of what is going to be done helps both the patient and his relatives co-operate in managing alcohol-withdrawal. We always inform our patients that when a heavy drinker is admitted to a hospital for a concurrent medical/surgical disease or for detoxification, problems may arise as a consequence of the abrupt discontinuation of alcohol drinking. We tell patients and their relatives that sedatives will be used because they mimick the mode of action of alcohol, and that they will be administered in a regimen that allows gradual reduction of their dose.

Medical and psychiatric history are always taken and emphasis is given on comorbidity and medications. The patient is always asked about the history of alcohol drinking pattern, amount and frequency, and the amount and time period of last drink. We also always ask if he/she has undergone any other attempt of alcohol withdrawal previously, if there is a history of delirium tremens or withdrawal seizures. Physical examination and use of Clinical Institute Withdrawal Assessment of Alcohol Scale Revised help us to make a more accurate evaluation. Finally, the laboratory examinations are screened, particularly to check for the status of renal and liver function.

The mainstay of alcohol withdrawal management is the use of benzodiazepines, most often chlordiazepoxide. We usually administer diazepam adjunctively in case of severe clinical manifestations. If there is a history of alcohol withdrawal seizures, we prefer to administer diazepam instead of chlordiazepoxide, due to the fact that diazepam has potent anticonvulsant properties. If liver function is compromised, the drug of choice is lorazepam. We use benzodiazepines in order to help treat the excitability state of the brain after the abrupt discontinuation of alcohol. Nevertheless, the pharmacological regimen always includes the use of folic acid, fluids and complex B vitamins, which are given intravenously for the first few days. We may add antipsychotics only if severe agitation, hallucinations (more often visual or tactile) or delusions ensue. Selection
and administration of antipsychotics need careful consideration due to the danger of decrease of seizure threshold. Patients are usually treated for alcohol detoxification in a medical unit, but a psychiatrist from our service delivers a thorough clinical examination every day, in order to be sure about the sufficiency of the effects of benzodiazepines administered. Apart from this, daily examination helps strengthen a sense of trust between the patient and his relatives and build a therapeutic alliance.

**CONCLUSIONS**

Alcohol-related problems are frequently encountered in a general hospital. Early recognition and treatment of alcohol withdrawal are very important in order to prevent serious consequences, such as delirium tremens or withdrawal seizures, and secure the safety of the patients.
Αντιμετώπιση του στερητικού συνδρόμου από αλκοόλ, σε ασθενείς Γενικού Νοσοκομείου.

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ΠΕΡΙΛΗΨΗ: Η κατάχρηση αλκοόλ αποτελεί ένα μείζον πρόβλημα δημόσιας υγείας. Σε αυτή τη βραχεία αναφορά συνοψίζουμε την εμπειρία μας από την αντιμετώπιση του στερητικού συνδρόμου από αλκοόλ στους ασθενείς του νοσοκομείου μας. Περιγράφουμε αυτό το σύνδρομο και τους τρόπους που αντιμετωπίζουμε τους ασθενείς. Δίνουμε έμφαση στη σημασία της έγκαιρης αναγνώρισης και αντιμετώπισης αυτού του συνδρόμου, με στόχο την πρόληψη σοβαρών επιπλοκών, όπως είναι το τρομόδες ντελίριο και οι σπασμοί.

Λέξεις κλειδιά: Κατάχρηση αλκοόλ, γενικό νοσοκομείο, στερητικό σύνδρομο από αλκοόλ, τρομόδες ντελίριο

REFERENCES