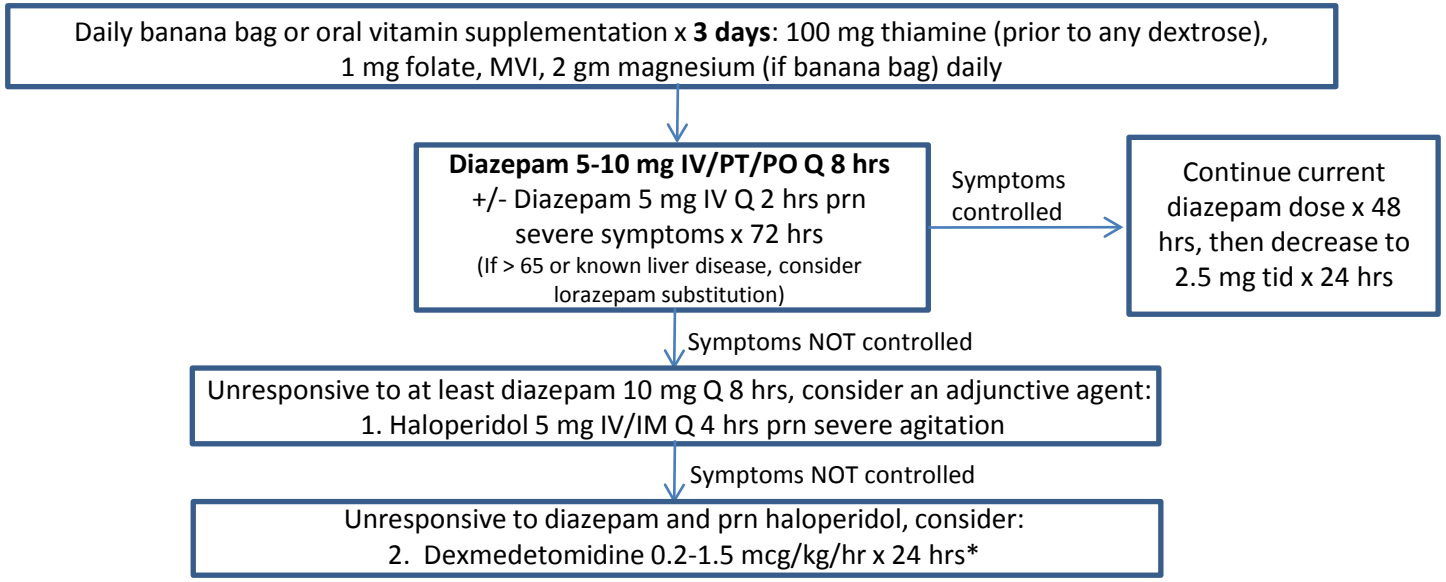
TICU Substance Abuse Guidelines

Alcohol Withdrawal:

- For INTUBATED patients, if receiving a propofol or midazolam infusion, NO ADDITIONAL therapy required while on these infusions.
- For patients who are not intubated or not receiving the above medications, DT prophylaxis may be initiated in patients who have 1) a history of delirium tremens or 2) a history of heavy alcohol use AND are demonstrating ≥ 2 of the following symptoms:
  - Nausea/vomiting
  - Tremor
  - Paroxysmal sweats and tachycardia (> 100 BPM)
  - Anxiety/agitation
  - Visual, tactile, or auditory disturbances
  - Clouded sensorium
  - Seizures
- The above symptoms of withdrawal may present within 6-48 hrs after cessation of alcohol and may progress to DTs if untreated.
- 5% of patients will develop DTs. This typically presents 48-72 hrs after the last drink, but has been reported up to 96 hrs later.
- Symptoms of DTs include tachycardia, hypertension, fevers, increased respiratory rate/respiratory alkalosis, visual/auditory hallucinations, and marked agitation. These symptoms may last up to 5 days. The untreated mortality rate may be up to 15%, largely due to the risk of aspiration. As a result, the need for a secure airway should be discussed in patients experiencing DTs.

Treatment Algorithm



* Start olanzapine (Zyprexa) 5 mg PO/PT Q 6 hrs if dexmedetomidine is started. Dexmedetomidine continuation > 24 hrs requires attending approval.

** The addition of clonidine 0.1-0.3 mg PO/PT TID may also be used adjunctively and may facilitate transitioning off dexmedetomidine.

*** Electrolyte disturbances are common in withdrawal. Potassium, magnesium, and phosphorus should be monitored daily. Consider the need for cardiac monitoring.

Opioid Withdrawal:

- Opioid withdrawal is typically not life-threatening, in contrast to alcohol withdrawal.
- Opioids may be detected on a urine drug screen.
- Symptoms may include hypertension, tachycardia, vomiting, mydriasis, excessive lacrimation and salivation.
- Symptoms may be alleviated by central alpha-2 adrenergic blockade:
    - Clonidine 0.1-0.3 mg PO/PT TID preferred
    - Clonidine 0.1-0.3 mg/24 hrs patch (TTS 1-3) TD Q week (may require 24 hrs enteral overlap)
- Benzodiazepines are not required as they have no cross-reactivity with opioid receptor agonists.

- Other substance abuse syndromes may be best treated by alleviating symptoms, according the sedation and analgesia protocol.
- Patients with a history of regular benzodiazepine use may be restarted on their home medication or managed according to the alcohol withdrawal protocol.

References:

-Sarff M, Gold JA. Alcohol withdrawal syndromes in the intensive care unit. *Crit Care Med*. 2010; 38 (suppl.): S494-S501.
-Mayo-Smith MF, Beecher LH, Fischer TL, et al. Management of alcohol withdrawal delirium. *Arch Intern Med*. 2004;164:1405-1412.
-Mayo-Smith MF. Pharmacological management of alcohol withdrawal: a meta-analysis and evidence-based practice guideline. *JAMA*. 1997;278:144-151.

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