Pharmacotherapy Options for Alcohol Withdrawal

<table>
<tr><th></th><th>Benzodiazepines</th><th>Gabapentin</th></tr>
<tr><td rowspan="2">Usage</td><td colspan="2">Inpatient management is recommended for all pregnant patients. However, if inpatient service is not an option due to patient preference or lack of availability, outpatient treatment with close daily monitoring may be offered to those who are at low risk of severe complications. See outpatient resource for details.</td></tr>
<tr><td>PAWSS ≥ 4 or patient is high risk for severe withdrawal complications.</td><td>PAWSS < 4 or patient is low risk for severe withdrawal complications.</td></tr>
<tr><td>Dosing</td><td>Prescriptions should be short-term and tapered. Adjust doses daily for outpatients or more frequently for inpatients (q 1h) based on symptoms (CIWA-Ar or SAWS). If higher doses are required, consult an addiction medicine specialist and consider inpatient admission.

<u>Diazepam (Valium)</u>
<table><tr><td></td><td>Day 1</td><td>Day 2</td><td>Day 3</td><td>Day 4</td></tr><tr><td>Symptom-based (in or outpatient)</td><td>5-10mg q4-6 h</td><td>5-10mg q6-8 h</td><td>5-10mg q12 h</td><td>5-10mg HS</td></tr><tr><td>Fixed schedule for outpatients</td><td>5-10mg QID</td><td>5-10mg TID</td><td>5-10mg BID</td><td>5-10mg HS</td></tr></table>
<u>Lorazepam (Ativan)</u>

Preferred in late 3rd trimester over diazepam due to shorter-acting effects and potentially less impact on neonate

<table><tr><td>Day 1-2</td><td>1-2mg q4 h</td></tr><tr><td>Day 3-4</td><td>0.5-1mg q4 h</td></tr></table>
If medication is needed beyond day 4, continue to taper dose down to q2d.</td><td>For immediate-release tablets
<table><tr><td>Symptoms</td><td>Regular Dose</td><td>PRN</td><td>HS</td></tr><tr><td>If CIWA-Ar is 10-14 or SAWS ≥ 12</td><td>300mg TID. Titrate up to 600mg TID if symptoms are not responding</td><td>300mg PRN - leave 2 hrs btwn regular and PRN doses</td><td>300-600mg HS PRN</td></tr><tr><td>If CIWA-Ar is < 10 or SAWS < 12</td><td></td><td>300mg q4 h PRN</td><td>300-600mg HS PRN</td></tr><tr><td colspan="4">When acute symptoms resolve and CIWA < 10 or SAWS < 12 consistently (e.g., 3 measurements), taper over 3-5 days, reducing dose by 600mg each day

Max daily dose is 3600mg
Hold doses if patient shows drowsiness, ataxia, or slurred speech</td></tr></table></td></tr>
<tr><td>Contra-indications</td><td>1. Severe respiratory insufficiency
2. Sleep apnea
3. Myasthenia gravis
4. Narrow angle glaucoma
5. History of allergy or hypersensitivity</td><td>1. History of allergy or hypersensitivity</td></tr>
</table>

	Benzodiazepines	Gabapentin
Cautions	1. Hepatic impairment 2. Renal impairment	1. Renal impairment
Safety	**A careful assessment of benefits of medication vs. risks of continued alcohol use should inform decision-making.** Frequent monitoring of fetus or infant is advised.	
	If used with alcohol, can lead to serious safety risks, incl. over sedation, falls, delirium, respiratory depression	If used with alcohol, risk of additive CNS-depressive effects
	<u>Pregnancy</u> Controversial evidence to suggest an increased risk for cleft lip and palate and “floppy infant syndrome” in human studies. Risk of neonatal withdrawal syndrome <u>Breastfeeding</u> Present in breastmilk. Can cause sedation and inability to suckle. Shorter-acting lorazepam preferred and has better outcomes than diazepam. Monitor infant for drowsiness, decreased feeding, or low weight gain	<u>Pregnancy</u> Limited data indicates minimal adverse effects <u>Breastfeeding</u> No adverse effects reported. Monitor infant for drowsiness, low weight gain, gastrointestinal side effects, and developmental milestones
Side Effects	Drowsiness, dizziness	Doses greater than avg therapeutic levels may cause ataxia, slurred speech, or drowsiness
Other Considerations	Risk for non-medical use, diversion, and dependence. Risk for drug-drug interactions leading to excess sedation, impaired psychomotor and cognitive functioning Lorazepam is the preferred option for patients with advanced liver disease Use cautiously in outpatients. Consider blister packing or daily dispensing	Risk for non-medical use, diversion, and dependence Toxicity profile parallels that of alcohol Easy to transition from WDM to long-term relapse prevention
	Thiamine: Thiamine deficiency is common. For patients planning withdrawal management, offer 100-200 mg oral or parenteral thiamine daily. For patients with suspected Wernicke’s encephalopathy, offer 200-300 mg parenteral thiamine for 3-5 days followed by oral therapy.	

Abbreviations: WDM – withdrawal management, PRN – as needed/when necessary, QID – four times per day, TID – three times per day, BID – two times per day, HS – at bedtime