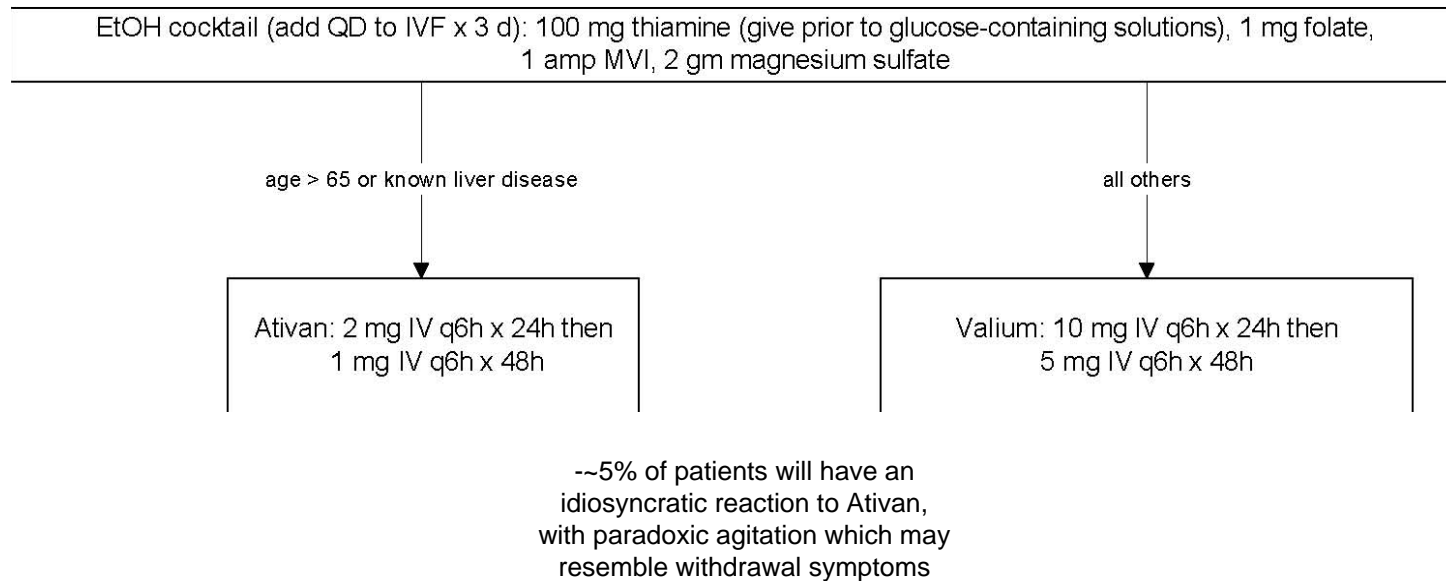


Substance Abuse Practice Guidelines

ALCOHOL WITHDRAWAL:

Initiate DT prophylaxis for all patients with: -gross intoxication at admission, or at physician discretion -h/o heavy EtOH or chronic benzodiazepine use -h/o withdrawal or DT's



Symptoms of EtOH withdrawal:

within 6-48 hours of cessation of intake: autonomic hyperactivity characterized by tremors, seizures, tachycardia; may progress to full-blown delirium tremens (typically 3-5 days after cessation of intake), with visual hallucinations, marked agitation, hypertension, hyperthermia; mortality of DT's 2-10%

IF SYMPTOMATIC DESPITE APPROPRIATE PROPHYLAXIS:

-supplement scheduled benzodiazepines with prn Haldol and/or benzodiazepine (Ativan in elderly or chronic liver disease; Valium for all others) for symptomatic control
-add clonidine 0.1-0.3 mg SL/PO BID-TID if necessary to control hypertension (do not use clonidine in severe CHI or known increased ICP)

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-continuous cardiac monitoring

-daily measurement of serum potassium and magnesium

-consider intubation, with attending approval

-check phosphorous

-continuous cardiac monitoring -daily measurement of serum potassium and magnesium -consider intubation, with attending approval -check phosphorous

09/05

Substance Abuse Protocol, continued

OPIOD (e.g., heroin) WITHDRAWAL:

-typically not life-threatening, as opposed to EtOH withdrawal

-manifested on urine drug screen as 6-monoacetyl morphine (6-MAM)

-symptoms are those of autonomic hyperactivity: hypertension, tachycardia, vomiting, mydriasis,

excessive lacrimation and salivation

-treat symptomatically with alpha-blockade (clonidine 0.1-0.3 mg SL/PO BID-TID)

-no role exists for BDZ prophylaxis, as there is no cross-tolerance with benzodiazepines

No physical dependence syndromes exist for **marijuana, PCP, or cocaine** withdrawal; treat agitation as per **Analgesia/Sedation protocol**

-**VITA consult** (call 7-7000) for patients >18 YO amenable to in- or outpatient rehab

-consult **trauma social worker** (George Belton, MSW, pager 835-4032) for:

-BAL > 200 at admission

-heroin or PCP use (either admitted or on urine drug screen)

References:

1. Wise MG, Cassen NH. Behavioral disturbances. In: Civetta JM, ed. Critical Care. Philadelphia: Lippincott; 1997: 2017-2029.
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3. Spies CD, Rommelspacher H. Alcohol withdrawal in the surgical patient. Anesthesia and Analgesia. 1999; 88: 946-954.
4. Mayo-Smith M. Pharmacological management of alcohol withdrawal: a meta-analysis and evidence-based practice guideline. JAMA. 1997; 278: 144-151.

