CLINICAL GUIDELINE

Glasgow Assessment and Management of Alcohol (GMAWS) Adult Inpatients

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Medicines Utilisation Subcommittee of ADTC

Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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Glasgow Assessment and Management of Alcohol

Please Attach Patient Label
CHI:_____

Name:_____

DoB:_____

Address:_____

Postcode:_____

GUIDE TO ALCOHOL UNITS	
Alcohol By Volume (ABV%)	Approximate Units
Strong Lager 9% (440mls)	4 Units
Beer/ Lager 4% (Pint /Can)	2 Units
Wine (e.g.Buckfast) 15% (750mls)	11 Units
Wine (Table) 12% (750mls)	9 Units
Alcopops 5% (330mls)	2 Units
Spirits 40% (Litre)	40 Units
Spirits 40% (700mls)	28 Units
Cider 4% (Litre)	4 Units
Cider 4% (440mls)	2 Units
White Cider 8% (Litre)	8 Units

Estimated Weekly Alcohol Units:_____ **Estimated Date / Time Of Last Drink: _____**

(Daily Units x Number of Days per Week) (If ≥ 5 Days, Re-consider Alcohol Withdrawal Status

Presents with or has had previous alcohol withdrawal seizures or severely agitated withdrawal within 6 months: YES: ☐ NO: ☐

IS IT ALCOHOL WITHDRAWAL?

Consider alternative diagnoses such as delirium, encephalopathy, traumatic brain injury especially if symptoms atypical or prolonged (≥5 days since last alcohol)

Fast Alcohol Screening Tool - FAST:

1. MEN: How often do you have EIGHT or more units on one occasion?
   WOMEN: How often do you have SIX or more units on one occasion?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

3. How often during the last year have you failed to do what was normally expected of you because of drinking?

   Never ☐0 Less than monthly ☐1 Monthly ☐2 Weekly ☐3 Daily or almost daily ☐4

4. In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

   No ☐0 Yes, on one occasion ☐2 Yes, on more than one occasion ☐4

Score of 3 or more: FAST Positive

Total ☐

FAST Positive?
Yes ☐ **No** ☐

FAST 0-2:	Negative: No action required.
FAST 3-4:	Hazardous Drinking: Advise safe drinking levels and offer information leaflet / advice.
FAST 5-16:	Probable Dependent Drinking: Advice as above and consider referral to Addiction Liaison Service.

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

Be aware of Patients with Co-morbidities presenting with features of Alcohol Withdrawal, especially:

- Patients with evidence of advanced liver disease (cirrhosis) especially with jaundice (bilirubin >80µmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head Injury; pregnancy)

REFER TO SECTION 3 (PAGE 3) FOR MANAGEMENT ADVICE

PLEASE INSERT IN PATIENT'S CASE RECORD ON COMPLETION OF TREATMENT

Order Number GGC0169

Prophylaxis and Treatment of Wernicke-Korsakoff Syndrome

The guidance applies to all alcohol use disorders; hazardous, harmful and dependent.

ASSESS FOR WERNICKE'S ENCEPHALOPATHY

Does the patient have any of the following signs/ symptoms?

● Confusion ● Nystagmus ● Ataxia ● Opthalmoplegia

● Otherwise unexplained decreased consciousness, hypothermia or hypotension

SYMPTOMS MAY EVOLVE AFTER ADMISSION; continued assessment required

YES

Presumptive diagnosis of Wernicke's Encephalopathy

This requires URGENT treatment

Days 1-3

IV VITAMINS B&C SOLUTION FOR INFUSION: 2 pairs of vials (provides 500mg thiamine) three times a day.

Magnesium:
Check Serum Magnesium URGENTLY and give intravenous replacement if deficient.

Days 4-5

Reassess diagnosis of Wernicke's Encephalopathy

If no alternative cause, continue **IV VITAMINS B&C SOLUTION FOR INFUSION :** 1 pair of vials (provides 250mg thiamine) three times a day

Day 6 onwards

Change to **oral Thiamine** 50mg four times a day **or** continue IV Vitamins B&C solution for infusion at the discretion of Medical Team or the advice of Alcohol Liaison team

NO

Assess Risk of Wernicke's Encephalopathy

Risk Factors

Weight loss (MUST≥1)
Minimal oral intake for >3 days
Vomiting for >2 days
Alcohol-related Liver Disease
Presents with Seizure
Age ≤18 or ≥65
Previous Wernicke's Encephalopathy
Unexplained peripheral neuropathy

Risk Factors Present

IV VITAMINS B&C SOLUTION FOR INFUSION : 1 pair of vials (provides 250mg thiamine) three times a day for **48** hours then change to **oral Thiamine** 50mg four times a day

No Risk Factors

Oral Thiamine 50mg four times a day

INTRAVENOUS (IV) THIAMINE PREPARATIONS

Thiamine is ideally administered using an IV high strength multivitamin preparation ('Vitamins B & C solution for infusion' on HEPMA).

If the multivitamin preparation is not available, consult the GGC supply problem page for further advice: https://scottish.sharepoint.com/sites/GGC-ClinicalInfo/SitePages/Medicines-Supply-Problems-and-Shortage.aspx?csf=1&web=1&e=cdjivI&CID=d6557ffd-30ac-4559-9f99-ee3b00812d6e

CHECK MAGNESIUM IN ALL PATIENTS AND CORRECT DEFICIENCY

BOTH Magnesium and Thiamine are co-factors for the enzyme function required to prevent Wernicke's Encephalopathy

PATIENTS WITH ALCOHOL USE DISORDER MAY HAVE OTHER NUTRITIONAL DEFICIENCIES WHICH SHOULD BE ASSESSED AND SUPPLEMENTED

Important notes

- If a patient cannot swallow oral thiamine consider NG administration or intravenous 'Vitamins B & C solution for infusion'. Consult ward pharmacist for advice on NG administration.
- Intravenous 'Vitamins B & C solution for infusion' should be administered over 30 minutes.
- Anaphylaxis is a rare complication of 'Vitamins B & C solution for infusion' administration. Monitor patient for wheeze, tachycardia, breathlessness and skin rash. Resuscitation facilities should be available.
- Discontinuation of oral thiamine should be considered for patients who have been abstinent for 6 weeks and who have established an adequate dietary intake.
- In at risk patients re-admitted within 7 days of a previous admission when intravenous replacement with thiamine or a vitamins B&C solution was given, continued oral therapy can be given rather than a further course of intravenous thiamine.

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Management of Alcohol Withdrawal Syndrome

1. SUSPECTED DEPENDENT DRINKING (FAST ≥5)

EXCEPTIONAL PATIENT GROUP WITH CO-MORBIDITY?

- Patients with evidence of advanced liver disease (cirrhosis)
- Patients with other co-morbidity (ie COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly >70, head injury; pregnancy)

See Section 3

YES

NO

RISK OFSEVERE ALCOHOL WITHDRAWAL

Any 2 of the following:

- Presents with or has had previous withdrawal seizures or severely agitated withdrawal **within 6 months**
- High screening score (FAST ≥12)
- High initial symptom score (GMAWS ≥4)

YES

FIXED DOSE TREATMENT (Section 2)
PLUS
SYMPTOM TRIGGERED TREATMENT (GMAWS)

NO

SYMPTOM TRIGGERED TREATMENT (GMAWS)

2. FIXED DOSE TREATMENT REGIME: Oral Diazepam (see **Section 5** for patients unable to tolerate oral):

INITIAL DOSE: 20mg Diazepam 6 hourly

REDUCE DOSE: If after 24 hours no additional symptom triggered treatment has been required

OR

If after ≥48 hours of treatment GMAWS less than 4

REDUCING DOSE: (Do not prescribe in advance; only step down dose if GMAWS remains less than 4)

15mg Diazepam 6 hourly for 24 hours
10mg Diazepam 6 hourly for 24 hours
5mg Diazepam 6 hourly for 24 hours
5mg Diazepam 12 hourly for 24 hours

3. EXCEPTIONAL PATIENT GROUPS: SYMPTOM TRIGGERED TREATMENT ONLY

- All patients with evidence of advanced liver disease (cirrhosis) should have symptom triggered treatment only. Patients with evidence of liver dysfunction: jaundice (bilirubin >80µmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy: use symptom triggered Lorazepam: 1-2 mg
- Patients with COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury: use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose
- In pregnancy use Diazepam at 50% of standard GMAWS dose with senior medical review if more than 30mg required in 24 hours

REVIEW PRESCRIPTION if patient is excessively drowsy
SENIOR MEDICAL REVIEW (FY2 or above) REQUIRED for diagnostic review and possible adjunctive therapy (Section 4): - If patient requires more than 120mg Diazepam (or 12mg lorazepam) in 24 hours
- If patient still requiring full dose treatment 96 hours after last alcohol ingestion

4. SEVERE WITHDRAWAL (aggressive/ uncontrollable/ dangerous behaviour; high benzodiazepine requirement).

- Reassess diagnosis and consider alternative causes of severe symptoms.
- CONSIDER **Lorazepam**, 1-2mg IM (or IV) and/or adjunctive therapy with **Haloperidol** 2.5 – 5mg IM: assess response (note contraindications to Haloperidol such as prolonged QTc: see GGC Handbook).
- If continued severe behavioural disturbance, refer to local guidelines for escalation of treatment.

5. PARENTERAL BENZODIAZEPINES

- If unable to tolerate oral medication, parenteral therapy at 50% of the oral dose can be given and response assessed.
- Intravenous benzodiazepines should be administered by staff with suitable competencies.

6. MONITORING

- All patients should be closely observed for signs of over-sedation with regular observations
- Consider escalation to High Dependency/ Critical Care management for Exceptional Patient Groups **(Section 3),** patients with Severe Withdrawal **(Section 4)** and patients requiring parenteral sedation **(Section 5)**.

Glasgow Modified Alcohol Withdrawal Scale (GMAWS) **Treatment Option: GMAWS Only ☐ GMAWS & Fixed Dose ☐**

Date																			
Time																			
Tremor 0) No tremor 1) On movement 2) At rest																			
Sweating 0) No sweat visible 1) Moist 2) Drenching sweats																			
Hallucination 0) Not present 1) Dissuadable 2) Not dissuadable																			
Orientation 0) Orientated 1) Vague, detached 2) Disorientated, no contact																			
Agitation 0) Calm 1) Anxious 2) Panicky																			
Score																			
Treatment																			
Staff Signature																			

Score: (Do not use scoring tool if patient intoxicated, must be at least 8 hours since last drink.)

0 :Repeat Score in 2 hours (Discontinue after scoring on 4 consecutive occasions, except if less than 48hrs after last drink)

1 – 3 :Give 10mg Diazepam: Repeat Score in 2 hours

4 – 8 :Give 20mg Diazepam : Repeat Score in 1 hour

9 – 10 :Give 20mg Diazepam: Repeat Score in 1 hour; discuss with medical staff; may need adjunctive treatment (see Section 4).

EXCEPTIONAL PATIENT GROUPS: SYTMPTOM TRIGGERED TREATMENT

Patients with evidence of advanced liver disease and liver dysfunction: jaundice (bilirubin >80µmol/l), coagulopathy (INR/ Prothrombin time ratio >1.5) or history of hepatic encephalopathy: use **Lorazepam** 1-2mg

Patients with other co-morbidity (i.e. COPD, pneumonia, cerebrovascular disease, reduced GCS, elderly (>70), head injury): use Lorazepam as above **OR** Diazepam at 50% of standard GMAWS dose.

In pregnancy use Diazepam at 50% of standard GMAWS

PATIENTS MAY REQUIRE TO BE WOKEN FOR CONTINUING ASSESSMENT

CO-EXISTING ILLNESS MAY AFFECT SCORE: SEEK MEDICAL ADVICE IF IN DOUBT

FIXED DOSING & SYMPTOM TRIGGERED DOSING MUST BE NO LESS THAN 1 HOUR APART

All patients should have regular observations documented. Patients receiving high doses of Diazepam should be assessed regularly for over sedation. If a patient requires more than 120 mg of diazepam or 12 mg of lorazepam in 24 hrs a senior medical review and consideration of adjunct therapy (Section 4) is required

APPROXIMATE ORAL BENZODIAZEPINE EQUIVALENCE: 10mg Diazepam = 1mg Lorazepam = 25mg Chlordiazepoxide

PATIENTS SHOULD NOT BE DISCHARGED ON REGULAR BENZODIAZEPINE

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