INTOXICATED PATIENTS AND DETOXIFICATION

Patients often present for evaluation of substance use and possible detoxification. There are certain decisions that the on-call resident will have to make regarding disposition of these patients. The following points should help as you attempt to decide whether or not to admit a patient for detoxification, and (if they need admission) whether to admit to Medicine or Psychiatry.

SCENARIO: Patient presents to Iowa City VAMC requesting admission for issues related to alcohol or detoxification. This person does not have active medical or psychiatric issues that would require admission independent of the intoxication or request for “detoxification” (e.g., they are not acutely suicidal, and they are not suffering from acute pancreatitis or other serious medical problem).

1) Does patient meet one of the following criteria for inpatient detoxification on a Medical floor?
   a. Prior credible history of alcoholic withdrawal seizures
   b. Seizure disorder that is poorly controlled or a patient that is noncompliant with medications
   c. Prior history of Delirium
   d. Medical problems severe enough to satisfy Utilization Review Criteria for Medical Inpatient treatment
   e. Active medical disease that would be deleteriously affected by alcoholic withdrawal or increases the risk of Delirium Tremens (e.g. uncontrolled diabetes, pneumonia)

Answer:
Yes: Admit to Medical Service for inpatient detox and management of medical issues.
No: Patient will not be admitted to Medicine for detoxification. Go to next question.

2) Is this the first time patient has requested detoxification and treatment for substance abuse disorder, or did they have prior substance abuse treatment greater than 1 year ago?

Answer:

Nights, Weekends and Holidays:
1. If the patient meets criteria for detoxification (see Attachment A), and there are concerns regarding outpatient detoxification therapy, then admit to inpatient Psychiatry for detoxification. Document detoxification criteria in the admission note.
   NOTE: DO NOT USE THE LAST OPEN BED FOR DETOX ONLY.
2. If medically stable, can institute outpatient detoxification with follow up in OSATP the following day (see Attachment B).

3. In all cases these issues are relative and not absolute. This should not be a substitute for good clinical judgment.

No: Go to next question.

3) Does the patient have friends or family that can be contacted to pick up the patient, or is the patient local?

Answer:
Yes: Contact the friends or family to pick up the patient, or provide a taxi voucher to deliver patient to family or friends.

No: Contact the VA Police. VA police will work with local law enforcement to provide disposition of patient to local jail if necessary. Patient is not to “sleep it off” in the VA facility or on VA grounds.

4) Is the patient attempting to leave the facility by operating a motor vehicle while intoxicated?

Answer:
Yes: Contact the VA Police or local law enforcement agency and notify them of the intoxicated driver.

[Reference: PCSAP 02-11 dated 3/02]

Attachment A: Serious Symptoms That May Require Inpatient Detoxification

Clinical Findings:

Planned Detoxification AND high risk for severe withdrawal, (≥ one)¹
- Chronic medical conditions
- Delirium tremens
- Dependence of Alcohol
- Failed outpatient treatment
- Heavy prolonged alcohol use with high degree of physical tolerance²
- Intractable vomiting
- Pregnancy
- Seizures/hallucinations/myoclonic contractions during previous withdrawal
Severe alcohol related medical conditions (e.g. hepatitis, encephalopathy, bleeding, pancreatitis)

Withdrawal syndrome, (≥ one)
   Delirium tremens
   Hallucinations/delirium/delusions/stupor
   Homicidal threat/ideation with plan
   Polysubstance abuse
   Seizures/myoclonic contractions
   Suicide attempt
   Suicidal threat/ideation with plan
   T > 101°F (38.0°C)
   P > 110 bpm
   BP > 160/100

Laboratory Findings
   Blood alcohol > 0.3g% (65 mmol/L)
   Blood alcohol > 0.1g% (22 mmol/L) and withdrawal syndrome present

1 mild to moderate withdrawal syndrome includes gastrointestinal distress, anxiety, irritability, elevated BP, tachycardia, and autonomic hyperactivity. Severe withdrawal syndrome includes clouding of consciousness difficulty in maintaining attention, disorientation, grand mal seizures, respiratory alkalosis, and fever.

2 defined as daily ingestion of large quantities of alcohol to achieve the same effect formerly attained by less. Individuals will experience withdrawal when they discontinue or decrease their substance use.

Further information about “InterQual Criteria for Admission” can be found on VAMC Intranet.

Attachment B: Outpatient Alcohol Detoxification Evaluation

1. Physical Examination and Vital Signs
2. Labs (these labs are suggested, and do not have to be done “stat” unless needed for some other medical reason): CBC, LFTs, blood alcohol content (BAC), urine drug screen, electrolytes
3. Determination of the patient’s ability to return to clinic in 24-48 hours for OSATP appt
4. Assessment of competent psychosocial supports, and assessment of transportation
options
5. Assessment of the severity of previous withdrawal episodes
6. Assessment of alcohol consumption, and other illicit drug use

**OPTIONS (remember that patient must be medically stable!)**

**Option 1:**
**NO** previous severe withdrawal symptoms (no seizures, no DTs, no previous need for medications to control withdrawal symptoms).

Typical alcohol consumption **below** 12 beers/day, or 5th wine/day, or 1 pint of spirits/day.

[REMINDER: Less than 5% of patients with Alcohol Dependence develop severe withdrawal symptoms requiring pharmacological intervention beyond vitamins.]

1. Prescribe Thiamine 100 mg #30, one PO daily; multivitamin #30, one PO daily.
2. Refer to OSATP for evaluation.

**Option 2:**
**PREVIOUS or PRESENT** moderate withdrawal symptoms (significant vital sign elevation, visible tremor, past need for medications for detox, but **no** seizures, and **no** history of DTs) with no contraindication to benzodiazepine use.

Typical alcohol consumption **above** 12 beers/day, or 5th wine/day, or 1 pint of spirits/day.

Person must have adequate liver function, and no severe respiratory disorder.
Person must have favorable social environment (e.g. someone can watch the patient, transport them, and can recognize benzodiazepine intoxication), no significant history benzodiazepine abuse, ability to get back to clinic by **NOT** driving themselves.

1. Prescribe Thiamine 100 mg #30, one PO daily; multivitamin #30, one PO daily.
2. Begin Librium 50 mg PO Q 6 hrs X 48 hrs. Dispense enough to last until the next business day, and arrange follow-up in OSATP clinic with PA or with COC provider.
3. **INSTRUCT PATIENT OR CAREGIVER TO HOLD THE DOSE IF PATIENT IS OVERLY SEDATED, UNSTEADY IN GAIT, OR SLURRED IN SPEECH.**
4. **HOLD DOSE IF ASLEEP – DO NOT WAKE THEM UP TO GIVE A DOSE!**

**Option 3:**
**PREVIOUS or PRESENT** moderate withdrawal symptoms as above, but **CONCERNS ABOUT BENZODIAZEPINE CONTRAINDICATIONS** (history of benzo misuse, or elderly patient) **OR** **SIGNIFICANT LIVER IMPAIRMENT OR SEVERE RESPIRATORY SYMPTOMS.

1. Prescribe Thiamine 100 mg #30, one PO daily; multivitamin #30, one PO daily.
2. Begin Depakote 250 mg PO Q 6 hrs as tolerated. Dispense #20, and arrange follow-up in OSATP clinic with PA the next business day or with COC provider. Continue Depakote for 7-10 days.
3. **Patient should still **NOT DRIVE HIMSELF** for the follow-up appointment.**