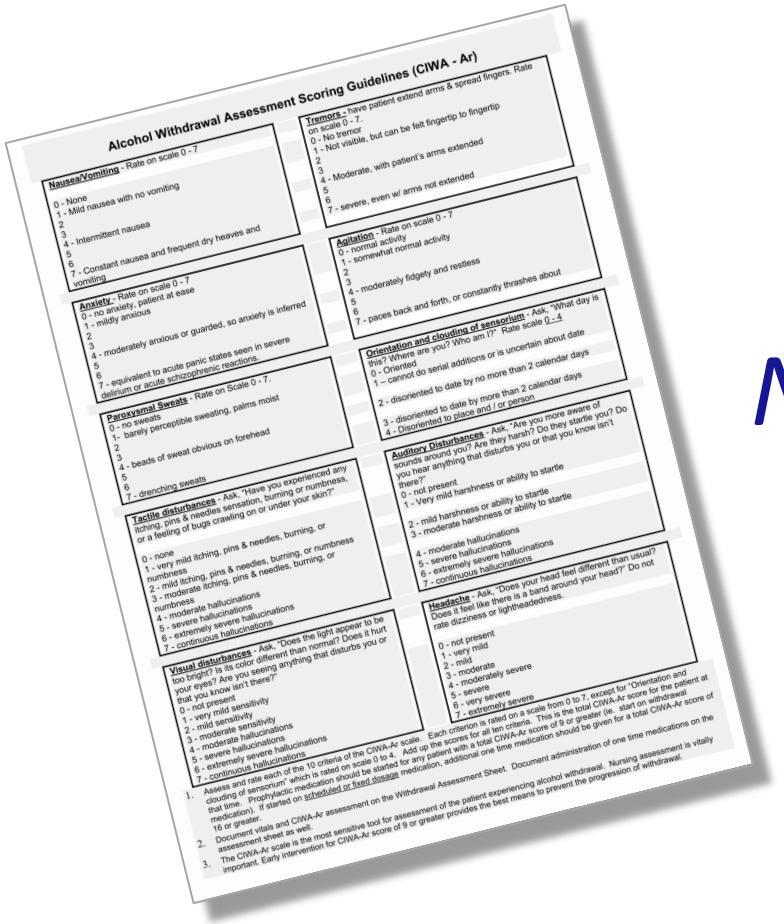

Alcohol Withdrawal Assessment Scoring Guidelines (CIWA - Ar)

Nausea/Vomiting - Rate on scale 0 - 7
0 - None
1 - Mild nausea with no vomiting
2
3
4 - Intermittent nausea
5
6
7 - Constant nausea and frequent dry heaves and vomiting

Tremors - have patient extend arms & spread fingers. Rate on scale 0 - 7.
0 - No tremor
1 - Not visible, but can be felt fingertip to fingertip
2
3
4 - Moderate, with patient's arms extended
5
6
7 - severe, even w/ arms not extended

Anxiety - Rate on scale 0 - 7
0 - no anxiety, patient at ease
1 - mildly anxious
2
3
4 - moderately anxious or guarded, so anxiety is inferred
5
6
7 - equivalent to acute panic states seen in severe delirium or acute schizophrenic reactions

Agitation - Rate on scale 0 - 7
0 - normal activity
1 - somewhat normal activity
2
3
4 - moderately fidgety and restless
5
6
7 - paces back and forth, or constantly thrashes about

Paroxysmal Sweats - Rate on Scale 0 - 7.
0 - no sweats
1- barely perceptible sweating, palms moist
2
3
4 - beads of sweat obvious on forehead
5
6
7 - drenching sweats

Orientation and clouding of sensorium - Ask, "What day is this? Where are you? Who am I?" Rate scale 0 - 4
0 - Oriented
1 – cannot do serial additions or is uncertain about date
2 - disoriented to date by no more than 2 calendar days
3 - disoriented to date by more than 2 calendar days
4 - Disoriented to place and / or person

Tactile disturbances - Ask, "Have you experienced any itching, pins & needles sensation, burning or numbness, or a feeling of bugs crawling on or under your skin?"
0 - none
1 - very mild itching, pins & needles, burning, or numbness
2 - mild itching, pins & needles, burning, or numbness
3 - moderate itching, pins & needles, burning, or numbness
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Auditory Disturbances - Ask, "Are you more aware of sounds around you? Are they harsh? Do they startle you? Do you hear anything that disturbs you or that you know isn't there?"
0 - not present
1 - Very mild harshness or ability to startle
2 - mild harshness or ability to startle
3 - moderate harshness or ability to startle
4 - moderate hallucinations
5 - severe hallucinations
6 - extremely severe hallucinations
7 - continuous hallucinations

Visual disturbances - Ask, "Does the light appear to be too bright? Is its color different than normal? Does it hurt your eyes? Are you seeing anything that disturbs you or that you know isn't there?"
0 - not present
1 - very mild sensitivity
2 - mild sensitivity
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4 - moderate hallucinations
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Headache - Ask, "Does your head feel different than usual? Does it feel like there is a band around your head?" Do not rate dizziness or lightheadedness.
0 - not present
1 - very mild
2 - mild
3 - moderate
4 - moderately severe
5 - severe
6 - very severe
7 - extremely severe

1. Assess and rate each of the 10 criteria of the CIWA-Ar scale. Each criterion is rated on a scale from 0 to 7, except for "Orientation and clouding of sensorium" which is rated on scale 0 to 4. Add up the scores for all ten criteria. This is the total CIWA-Ar score for the patient at that time. Prophylactic medication should be started for any patient with a total CIWA-Ar score of 9 or greater (ie. start on withdrawal medication). If started on scheduled or fixed dosage medication, additional one time medication should be given for a total CIWA-Ar score of 16 or greater.
2. Document vitals and CIWA-Ar assessment on the Withdrawal Assessment Sheet. Document administration of one time medications on the assessment sheet as well.
3. The CIWA-Ar scale is the most sensitive tool for assessment of the patient experiencing alcohol withdrawal. Nursing assessment is vitally important. Early intervention for CIWA-Ar score of 9 or greater provides the best means to prevent the progression of withdrawal.

Alcohol Withdrawal and the CIWA-Ar Scale

Nurse-Doctor Co-Teaching Session

Holli Murray, MSN, RN, PCCN

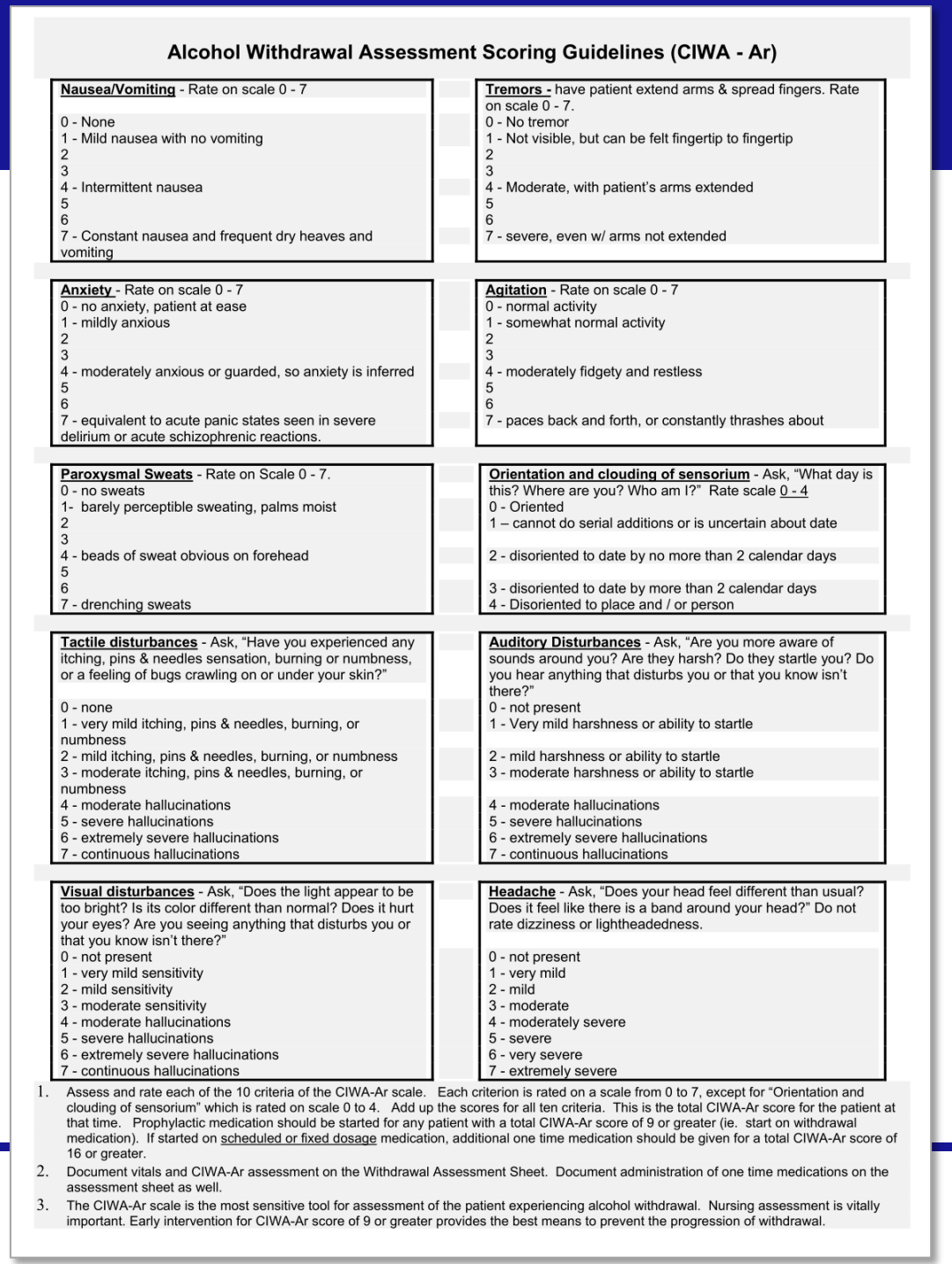
Bill Martin-Doyle, MD, MPH

Learning Objectives

1. Describe the signs and symptoms of alcohol withdrawal
2. Determine who is appropriate for a CIWA-based protocol as compared to a standing regimen
3. Utilize the CIWA scale to guide symptom-triggered management of alcohol withdrawal

What is the CIWA-Ar Scale?

- Clinical Institutes Withdrawal Assessment Scale for Alcohol (CIWA-Ar)
- “Symptom-triggered therapy”
- Studied primarily in moderate severity withdrawal (i.e., no seizures, DTs, able to take PO, no severe comorbidities…)
- Ten areas to assess and score (0-7 each), total score of 67
  - Mild: 0-8
  - Moderate: 9-15
  - Severe: > 16, higher risk seizure/DTs
- Benefits compared to standing regimen:
  - Reduced total amount of benzodiazepines administered
  - Shorter duration of treatment



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What is the CIWA Scale and What Symptoms Are Scored?

GENERAL MEDICINE FAMILY FEUD

Video Vignette - Score The CIWA Yourself!

https://www.youtube.com/watch?v=NUKigZjcGy4

CIWA Scoring

https://www.mdcalc.com/ciwa-ar-alcohol-withdrawal

VIGNETTES!

Case 1

- A 45 year old male is admitted for alcohol withdrawal and ordered for CIWA per protocol every 4 hours
- His CIWA scores following admission are:

8:00	12:00	16:00	20:00	22:00
4	5	12	15	17

- 2mg lorazepam were given for scores 12 and 15. It is now 22:00.

Do you continue the CIWA?

If the answer is no - stand up!

Case 2

- A 70 year old patient with alcohol dependence is admitted for Community Acquired Pneumonia
- Patient was initially hypotensive but is now stabilized
- PMH includes severe Parkinson's Disease.

Do you put this patient on CIWA?

If the answer is no - stand up!

Case 3

- A 25 year old American Sign Language-speaking deaf patient with alcohol use disorder and no other PMH is admitted for alcohol withdrawal

Do you put this patient on CIWA?

If the answer is no - stand up!

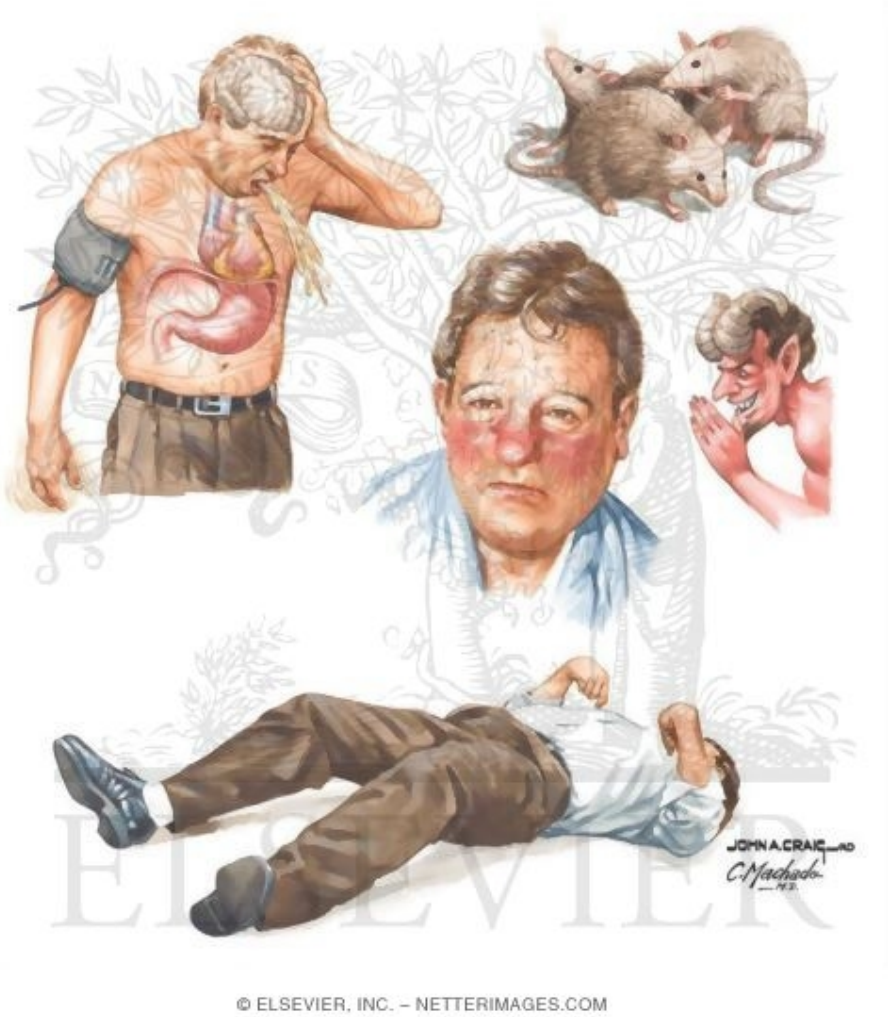
SLIDES!

Complications of Alcohol Withdrawal

~80% mild-to-moderate

~20% severe / complicated:

- Hallucinations
- Seizures
- Delirium Tremens



Saitz et al. Med Clin North Am. 1997;81(4):881

Timeline of Alcohol Withdrawal

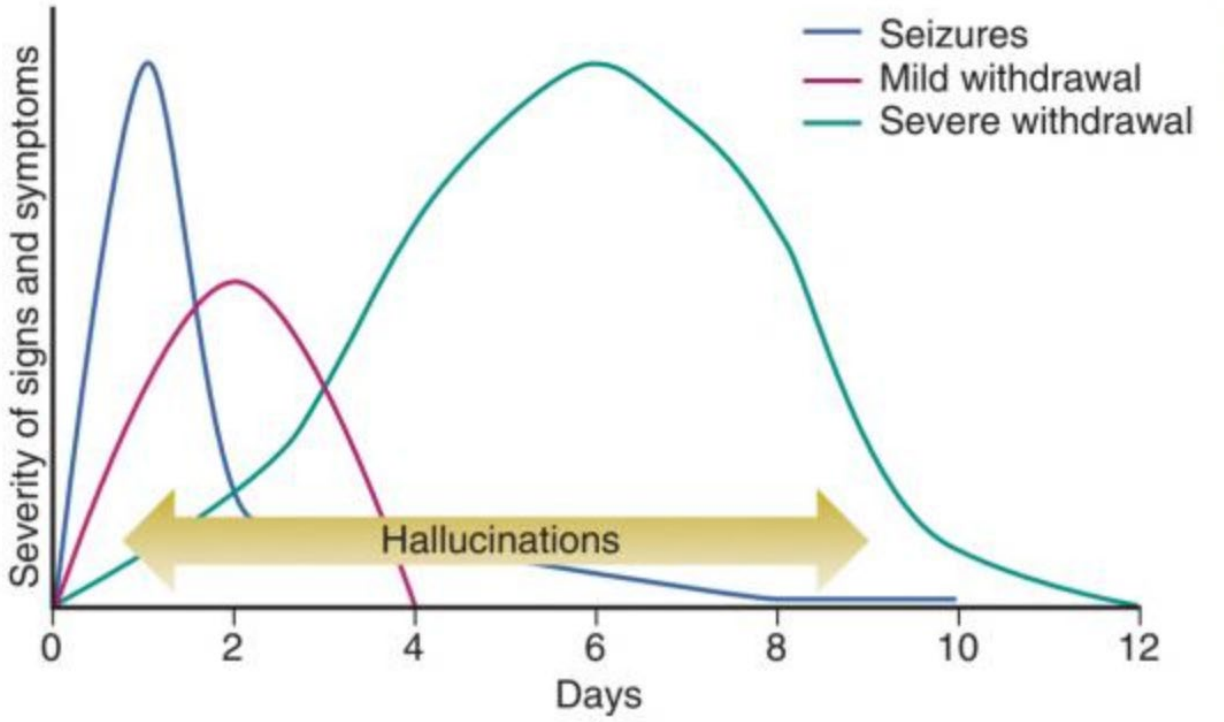
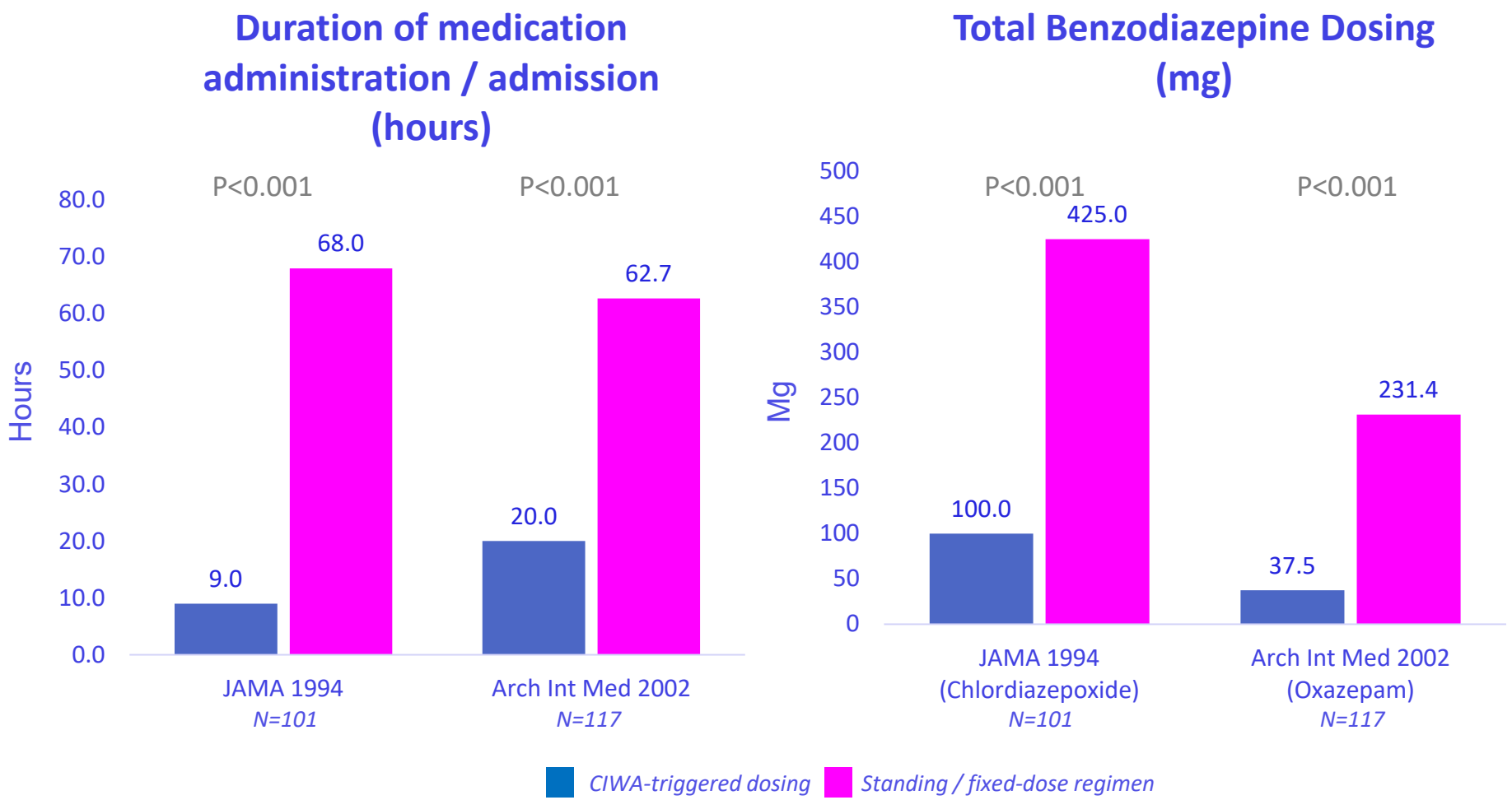


Figure 26-5. Progress of alcohol withdrawal syndrome. *(From Frank L, Pead J.* New concepts in drug withdrawal: a resource handbook. *Melbourne, 1995, University of Melbourne.)*

Stern TA, et al. Massachusetts General Hospital - Comprehensive Clinical Psychiatry, Second Edition. Elsevier 2016

CIWA Scoring Reduces Duration of Medication Administration and Benzodiazepine Dosing



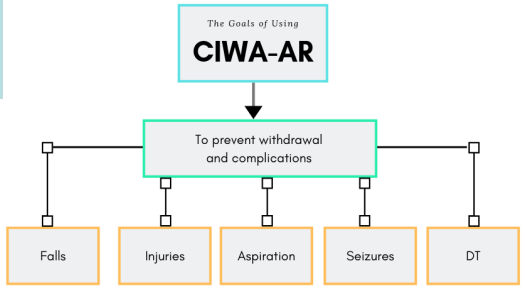
JAMA. 1994;272:519-523)
Arch Intern Med. 2002;162:1117-1121

BWH CIWA-Ar Best Practices

Holli Murray and Bill Martin-Doyle

CIWA-Ar stands for **Clinical Institute Withdrawal Assessment for Alcohol scale**

The CIWA-Ar is a **subjective scale** that is used for **symptom-triggered therapy** and must be **interpreted carefully**.



Symptoms of Withdrawal include:

6 – 12 Hours
- Anxiety
- Diaphoresis
- Headache
- Nausea/vomiting
- Tremor

12 – 24 Hours
- Hallucinations

24 – 48 Hours
- Seizures

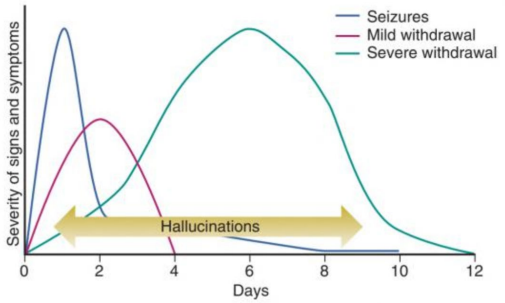
48 – 72 Hours
- Agitation
- Disorientation
- Delirium tremens
- Hypertension
- Tachypnea
- Tachycardia

Timeline of Alcohol Withdrawal

Note: Seizures occur in the first 24 – 48 hours after cessation of drinking.

Both CIWA-based and Fixed-dose protocols **require constant reassessment** and **collaboration** between the RN and Clinician.

Contraindications for CIWA protocol include *delirium*, *inability to communicate*, and *severe alcohol withdrawal*.



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Produced by Emily Piper-Vallillo, M.Ed., Marina Zambrotta, M.D., and Helen Shields, M.D.

Questions?

THANK YOU!!!