Outpatient Alcohol Withdrawal Management: The Right Plan for the Right Patient

Shuchin Shukla MD MPH

North Carolina Technical Assistance Center

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Disclosures

- Chief Medical Officer for Goldie Health, Inc.

- The *North Carolina Technical Assistance Center* is a statewide initiative to provide FREE technical assistance to programs that support individuals at risk of incarceration and overdose.

AREAS OF EXPERTISE

- Harm reduction
- Reentry from incarceration
- Diversion/Deflection, including Law Enforcement Assisted Diversion (LEAD)
- Jail-based Medication for Opioid Use Disorder (MOUD)
- Naloxone access and distribution
- Program evaluation
- Data management

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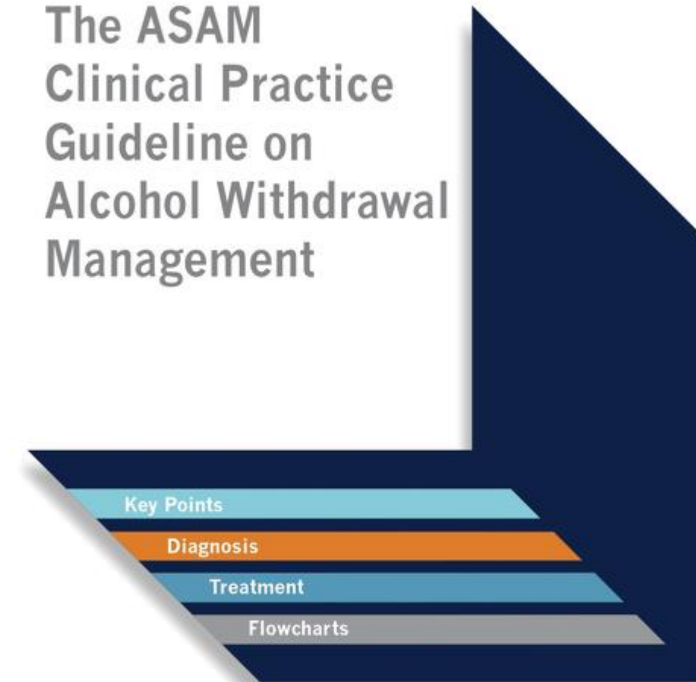
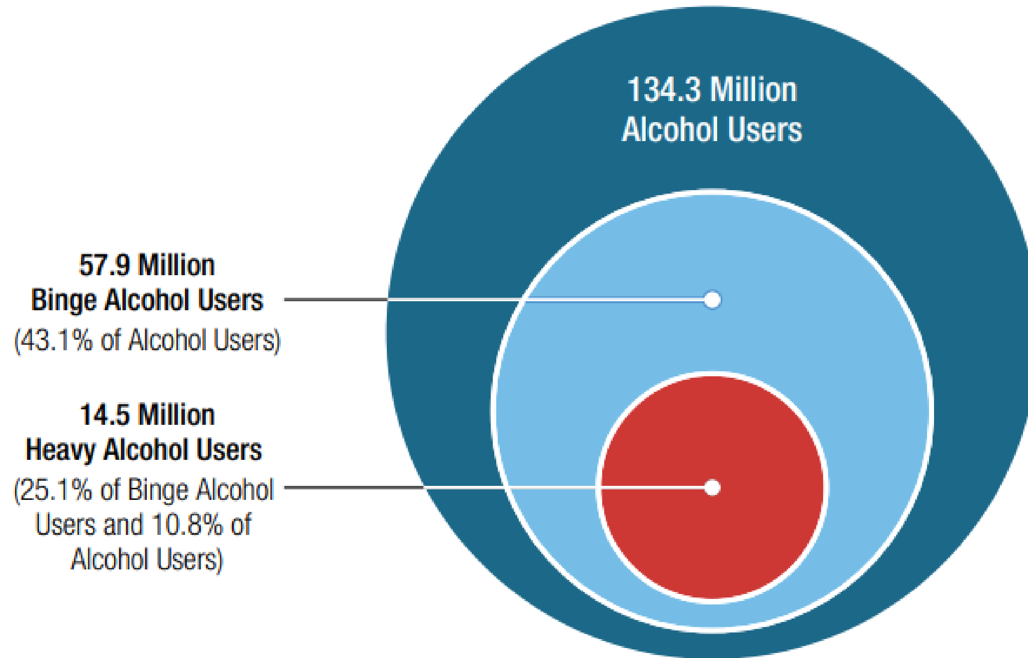
Learning Objectives

1. Use validated assessment tools and strategies to evaluate patient severity of alcohol withdrawal and appropriateness for outpatient management.
2. Discuss pharmacotherapies and supports for outpatient alcohol withdrawal management.



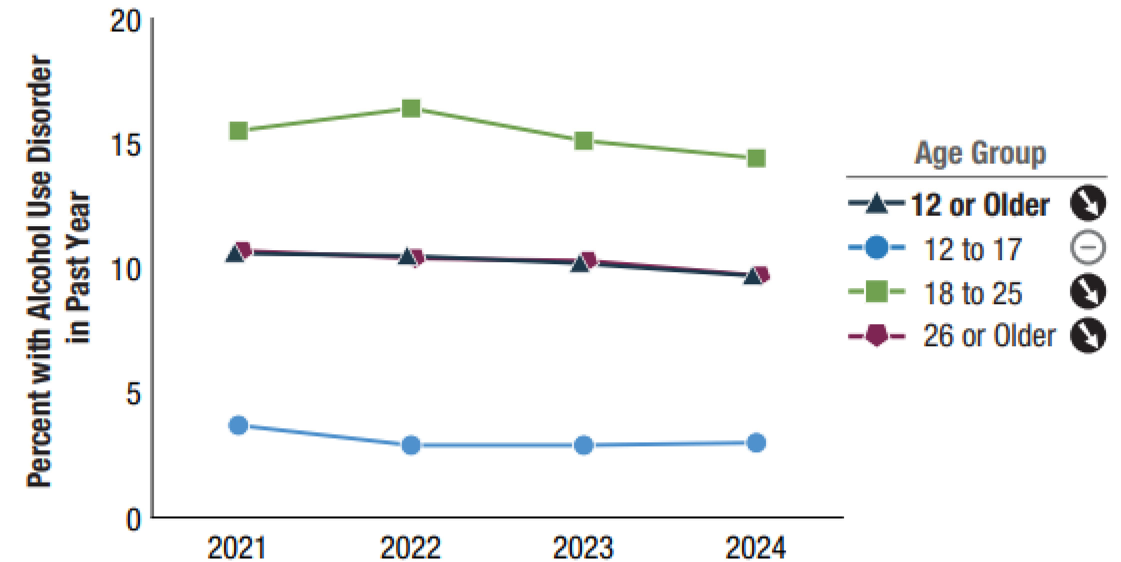
Epidemiology of Alcohol

Figure 7. Alcohol Use, Binge Alcohol Use, or Heavy Alcohol Use in the Past Month: Among People Aged 12 or Older; 2024



Note: Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion on at least 1 day in the past 30 days. Heavy Alcohol Use is defined as binge drinking on the same occasion on 5 or more days in the past 30 days; all heavy alcohol users are also binge alcohol users.

Figure 37. Past Year Alcohol Use Disorder: Among People Aged 12 or Older; 2021-2024



NSDUH 2024

Epidemiology of Alcohol Withdrawal

- Up to 50% AUD will experience alcohol withdrawal syndrome
  - ~10% of these will experience seizures
- Best predictor of severe alcohol withdrawal syndrome or seizure is prior episode
  - Platelet count, LFTs also suggestive

Day E, Daly C. Clinical management of the alcohol withdrawal syndrome. *Addiction*. 2022;117(3):804-814. doi:10.1111/add.15647

Goodson, C.M., Clark, B.J. and Douglas, I.S. (2014), Predictors of Severe Alcohol Withdrawal Syndrome: A Systematic Review and Meta-Analysis. Alcohol Clin Exp Res, 38: 2664-2677. https://doi.org/10.1111/acer.12529

Alcohol Withdrawal

- Usually after 2+ weeks heavy use
- Begins 6-24hrs after last intake
- Symptoms driven by ↓GABA and ↑NMDA glutamate receptor expression, habituation to chronic alcohol use, and subsequent decreased alpha-2 adrenergic inhibitory activity with alcohol abstinence

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TABLE 2

DSM-5 Diagnostic Criteria for Alcohol Withdrawal

A. Cessation of (or reduction in) alcohol use that has been heavy and prolonged.

B. Two (or more) of the following, developing within several hours to a few days after the cessation of (or reduction in) alcohol use described in Criterion A:

1. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 beats per minute).
2. Increased hand tremor.
3. Insomnia.
4. Nausea or vomiting.
5. Transient visual, tactile, or auditory hallucinations or illusions.
6. Psychomotor agitation.
7. Anxiety.
8. Generalized tonic-clonic seizures.

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

Specify if:

With perceptual disturbances: This specifier applies in the rare instance when hallucinations (usually visual or tactile) occur with intact reality testing, or auditory, visual, or tactile illusions occur in the absence of a delirium.

DSM-5 = *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders. *5th ed. American Psychiatric Association; 2013:499-500.*

Tiglao SM, Meisenheimer ES, Oh RC. Alcohol Withdrawal Syndrome: Outpatient Management. *Am Fam Physician*. 2021;104(3):253-262.

Severity Categories

- Mild: anxiety, diaphoresis, insomnia, no tremor
- Moderate: moderate sx, plus mild tremor
- Severe: more severe symptoms, mod tremor
- Complicated: seizures, confusion, new hallucination

TABLE 3

Expected Symptoms of Alcohol Withdrawal Syndrome after Cessation of Alcohol Use

Symptoms	Time of appearance after cessation of alcohol use
Anorexia, diaphoresis, gastrointestinal upset, headache, insomnia, mild anxiety, palpitations, tremulousness	6 to 12 hours
Alcoholic hallucinosis: auditory, tactile, or visual hallucinations	12 to 24 hours*
Withdrawal seizures: generalized tonic-clonic seizures	24 to 48 hours†
Alcohol withdrawal delirium (delirium tremens): agitation, diaphoresis, disorientation, hallucinations (predominantly visual), hypertension, low-grade fever, tachycardia	48 to 72 hours‡

*—Symptoms generally resolve within 48 hours.
†—Symptoms reported as early as 2 hours after cessation.
‡—Symptoms peak at 5 days.

Information from references 8-10.

Severity Assessment

- Done by provider: Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar)
- Done by patient: Short Alcohol Withdrawal Scale (SAWS)
- Consider: CMP, CBC, UDS, serum alcohol… especially if risk factors for severe or complicated withdrawal

Item	None (0 points)	Mild (1 point)	Moderate (2 points)	Severe (3 points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with memory				
Tremor (shakes)				
Nausea				
Heart pounding				
Sleep disturbance				
Sweating				

Short Alcohol Withdrawal Scale to assess severity of alcohol withdrawal. Mild symptoms: score < 12; moderate to severe symptoms: score > 12.

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RISK Assessment

- **Step 0: universal screening: AUDIT-C, single question screen**
- **Step 1: Criteria for alcohol withdrawal syndrome? If Y, continue**
- **Step 2: Risk factors for severe or complicated withdrawal? if Y, consider inpatient**
  - >8 drinks/d
  - Unstable psychiatric disorder, risk of suicidality
  - Severe withdrawal in past year
  - History of failed outpatient care
  - No caregiver support
  - Unstable housing/transportation
  - Other substance use disorder
  - Unstable medical condition, head injury, known cardiovascular disease
  - Cannot tolerate PO
  - High relapse risk, low motivation
  - Abnormal LFTs, BUN/cr, electrolytes, UDS, serum alcohol
  - Pregnancy
  - Withdrawal AND positive BAC
  - numerous previous withdrawal episodes
- Can use "Prediction of Alcohol Withdrawal Severity Scale"
- **Step 3: Severity Assessment**
- **Step 4: Decide on Location of Care**

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Prediction of Alcohol Withdrawal Severity Scale (PAWSS)

Maldonado et al, 2015

Part A: Threshold Criteria:

("Y" or "N", no point)

Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR did the patient have a "+" BAL on admission? ______

IF the answer to either is YES, proceed with test:

Part B: Based on patient interview:

(1 point each)

1. Have you been recently intoxicated/drunk, within the last 30 days? ______
2. Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcoholism? (i.e., in-patient or out-patient treatment programs or AA attendance) ______
3. Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity? ______
4. Have you ever experienced blackouts? ______
5. Have you ever experienced alcohol withdrawal seizures? ______
6. Have you ever experienced delirium tremens or DT's? ______
7. Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days? ______
8. Have you combined alcohol with any other substance of abuse, during the last 90 days? ______

Part C: Based on clinical evidence:

(1 point each)

9. Was the patient's blood alcohol level (BAL) on presentation ≥ 200? ______
10. Is there evidence of increased autonomic activity? (e.g., HR > 120 bpm, tremor, sweating, agitation, nausea) ______

Total Score: ______

Notes: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of AWS.
A score of ≥ 4 suggests HIGH RISK for moderate to severe (complicated) AWS; prophylaxis and/or treatment may be indicated.

Medical Management of Alcohol Withdrawal

- Goal = reduce symptoms, prevent seizures/delirium, and 1st step toward AUD treatment
- For mild/moderate, outpatient management can be effective with shorter duration, reduced cost of care, but maybe lower completion rate
- Severe/complicated -> inpatient

- PREMANAGEMENT: consider motivational interviewing, shared decision making around management plans, practicing partial control over intake

ASAM Levels

Level 1 Outpatient Withdrawal Management

- Typical outpatient clinic
- Mild withdrawal syndrome, SAWS <12, CIWAS <10
- Under age 65, no comorbidities, no previous complicated withdrawal, no previous multiple withdrawal episodes, no heavy alcohol use, no current dependence on GABAergic meds

Level 2 Outpatient Withdrawal Management

- Outpatient with extended on-site monitoring (multiple hours/day), can easily escalate care
  - Day hospital
  - Specialty clinics
- Mild or moderate syndrome, CIWS <19
- No unstable medical or psychiatric comorbidities that require hospitalization, can tolerate PO

Management: Supportive Care for All Levels

- Educate patient and caregivers on symptom time course, treatment plan, medication risks, relapse risk, “plan B” plan
- Monitor for severe withdrawal
- Stay hydrated, avoid high-stimulation environment, avoid caffeine
- MVI with 400mcg folic acid daily
- Thiamine 100mg daily x 3-5d

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Level 1 Management: Withdrawal Meds

- Gabapentin 1200mg loading dose, then 600mg-1200mg daily for next two days, then 300mg-600mg daily for next 4days
  - Can continue for Alcohol Use Disorder maintenance treatment
- Or Carbamazepine 600mg-800mg total daily dose tapered to 200mg-400mg over 4-9days
- These meds do not reliably prevent withdrawal seizures or delirium!

Level 2 Management: Withdrawal Meds

- Benzodiazepines are first-line:
  - Chlordiazepoxide: load 25-100mg per severity, then 50-100mg Q4-6hrs prn symptoms vs fixed taper over 5days
  - Diazepam 10-20mg Q6-12hrs for first 24hrs, then 5-10mg Q6-12hrs for next 3-5days
  - Lorazepam 0.5-1mg Q6-8hrs scheduled PLUS 1mg Q4 for mild symptoms or 2mg Q2hrs for moderate symptoms
- Carbamazepine or gabapentin are options as well; Phenobarbital is option for experienced providers
- Benzos reduce but do not eliminate risk of seizure/delirium
- Long-acting benzos preferred unless liver disease
- Caution for sedation, respiratory depression
- Consider front loading few doses Q1-2hrs until CIWAS<10 if high risk

Level 2 Management: Withdrawal Meds

- **Adjunctive meds: can use on top of benzos**
  - **For cravings:**
    - **Gabapentin 400mg Q6-8h**
    - **Carbamazepine 200mg Q8 or 400 Q12**
    - **Valproate 300mg-500mg Q6 (avoid in pregnancy or liver disease)**
  - **For autonomic hyperactivity**
    - **Metoprolol 25mg-50mg Q12**
    - **Clonidine 0.2mg**

Unclear evidence

- Baclofen
- Levetiracetam
- Lamotrigine
- Dextromethorphan

Monitoring

- **Depends on symptom severity, risk factors, social factors**
- **Usually daily evaluations x 5days**
  - **Can be with support staff, some can be telehealth**
- **Evaluate symptoms (CIWAS or SAWS), substance use, sleep, suicidality, hydration, mood, vitals if possible**
- **Higher Level of Care:**
  - **Worsening or persistent symptoms despite adequate dosing (if not oversedated and no other contraindications, can consider increased dosing or adjunctive meds)**
  - **Oversedation**
  - **Unstable vitals or psychiatric symptoms**
  - **Persistent symptoms beyond expected duration**

Sloan ME, Ngoy A, Xiao KB, et al. Symptom-Triggered Alcohol Withdrawal Management Delivered Over Telemedicine. *J Addict Med*. 2025;19(6):708-715. doi:10.1097/ADM.0000000000001491

Transition to AUD Management

- Interventions should start as soon as patient is able
- Mutual aid groups, peer support, psychotherapy
- First-line meds: acamprosate 666mg three times daily (lower dose in moderate renal dz) and/or naltrexone PO 50-100mg daily (or Q4wk IM 380mg)
- Second-line, off label: gabapentin and topiramate
  - More effective if more withdrawal symptoms, more sleep disturbance

Anton RF, Latham P, Voronin K, et al. Efficacy of Gabapentin for the Treatment of Alcohol Use Disorder in Patients With Alcohol Withdrawal Symptoms: A Randomized Clinical Trial. *JAMA Intern Med*. 2020;180(5):728-736. doi:10.1001/jamainternmed.2020.0249

CASE #1

- Mr. J is a 42-year-old man presenting to clinic asking for help to stop drinking. He says he has been drinking about 8 to 10 beers nightly for the last 4 years, with heavier use on weekends. His last drink was 10 hours ago.
- He reports feeling shaky, anxious, sweaty, and nauseated. He has not had hallucinations, seizures, or confusion. He has never been hospitalized for alcohol withdrawal and has never had delirium tremens or withdrawal seizures. He has no opioid or benzodiazepine use. He denies other substance use.
- Past medical history includes hypertension, well controlled on lisinopril. No cirrhosis, no seizure disorder, no major psychiatric instability, and no suicidal ideation.
- He lives with his spouse, who is supportive, can stay with him over the weekend, and can help monitor symptoms. He has reliable transportation, a phone, and is able to return for daily follow-up. He wants to stop drinking and is motivated for treatment.
- Vitals: BP 148/92, HR 104, Temp 98.7°F, RR 18
Exam: alert and oriented, mild tremor, mildly diaphoretic, no agitation, no hallucinations
CIWA-Ar: 8

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CASE #2

- Ms. T is a 57-year-old woman who presents to clinic with her brother because she wants to "detox at home." She has been drinking a fifth of vodka daily for the past several months. Her last drink was early this morning, about 6 hours ago.
- She reports tremor, sweating, anxiety, nausea, and poor sleep. Her brother says that during a prior attempt to stop drinking last year, she became confused and "saw bugs on the wall." He also thinks she may have had a seizure during a different quit attempt 8 months ago, although she was never evaluated.
- Her history includes alcohol related liver disease, recurrent pancreatitis, depression, and intermittent alprazolam use that she gets from a friend. She lives alone, has missed several recent appointments, and is unsure whether she can come back tomorrow. She says she wants help but is also not sure she can avoid drinking tonight because there is alcohol at home.
- Vitals: BP 168/102, HR 118, Temp 99.4°F, RR 20
  Exam: marked tremor, anxious, intermittently distracted, appears ill
  CIWA-Ar: 17

CASE #3

- Ms. A is a 29-year-old pregnant patient at 24 weeks' gestation presenting to clinic asking for help stopping alcohol. She reports drinking 6 to 8 drinks daily for the past year, with escalation over the past 2 months. Her last drink was 12 hours ago.
- She now feels shaky, anxious, nauseated, and sweaty. She has no prior withdrawal seizures and no known delirium tremens. She denies opioid use. She says she was hoping she could "just do this from home" because she does not want anyone to judge her.
- Past medical history is otherwise unremarkable. She has had inconsistent prenatal care. She reports fetal movement.
- Vitals: BP 146/88, HR 110, Temp 98.8°F, RR 18
Exam: alert, anxious, mild to moderate tremor, no hallucinations, no confusion
CIWA-Ar: 10

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ANY QUESTIONS?

THANKS!

Shuchin@email.unc.edu

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