CLINICALJUDGE™ · NGN NCLEX-RN MASTER REFERENCE

SUBSTANCE INTOXICATION & WITHDRAWAL

Alcohol · Opioids · Benzodiazepines — assessment, scored withdrawal tools (CIWA-Ar & COWS), antidotes, priority interventions, and patient teaching for the high-yield psychosocial & pharmacology blueprint.

PSYCHOSOCIAL INTEGRITY | PHARM & PARENTERAL | PHYSIOLOGICAL ADAPTATION | CIWA-AR | COWS | NALOXONE | 2026 TEST PLAN

Critical / Emergency · Pathophysiology · Expected / Safe · Complication · NCLEX Trap · Medication · Patient Education

1 PATHOPHYSIOLOGY & THE CORE CONCEPT

CONCEPT CNS DEPRESSANT VS. STIMULANT DIRECTION

The single most useful mental model: **alcohol, benzodiazepines, and opioids are all CNS depressants.** When the drug is **on board (intoxication)** you see **depression** (slow, sedated, low everything). When the drug is **withdrawn**, the chronically suppressed CNS rebounds into **excitation/hyperactivity** (autonomic storm). The opioid pupil is the great exception you must memorize.

CHRONIC USE
CNS adapts: ↑ inhibitory tone (GABA) is downregulated; excitatory glutamate/NMDA upregulated to compensate.

→

DRUG STOPS
GABA brake suddenly removed; unopposed glutamate excitation floods the CNS.

→

HYPEREXCITABILITY
Autonomic storm: ↑HR, ↑BP, ↑temp, diaphoresis, tremor, seizures.

→

DTs / SEIZURE
Untreated alcohol & benzo withdrawal can be fatal. Opioid withdrawal is miserable but rarely lethal.

2 SIGNS & SYMPTOMS — INTOXICATION VS. WITHDRAWAL

ALCOHOL ALCOHOL INTOXICATION & WITHDRAWAL

INTOXICATION (CNS DEPRESSION)

- ✓ Slurred speech, ataxia, impaired coordination
- ✓ Impaired judgment, disinhibition, mood lability
- ✓ Nystagmus, drowsiness
- ✓ **Respiratory depression, stupor → coma (severe)**
- ✓ Hypotension, hypothermia, hypoglycemia
- ✓ **Aspiration risk** with vomiting + ↓LOC

WITHDRAWAL TIMELINE

- ! **6–12 hr:** tremors, anxiety, N/V, insomnia, diaphoresis, ↑HR
- ! **12–24 hr:** alcoholic hallucinosis (often visual/tactile, *sensorium intact*)
- ! **24–48 hr: withdrawal seizures** (generalized tonic-clonic)
- ! **48–96 hr: DELIRIUM TREMENS** — confusion, agitation, hallucinations, fever, severe autonomic instability
- ! DTs is a **medical emergency** (mortality if untreated)

OPIOIDS OPIOID INTOXICATION/OVERDOSE & WITHDRAWAL

INTOXICATION / OVERDOSE

- ✓ **Classic triad: ↓ respirations, pinpoint pupils (miosis)**, ↓LOC/coma
- ✓ Respiratory depression is the **killer** — hypoxia → arrest
- ✓ Bradycardia, hypotension, hypothermia
- ✓ Decreased bowel sounds, constipation
- ✓ Track marks, fresh injection sites

WITHDRAWAL (FLU-LIKE, NOT LETHAL)

- ! **Dilated pupils (mydriasis)** — opposite of intoxication
- ! Yawning, lacrimation, rhinorrhea, sneezing
- ! Piloerection ("cold turkey"), diaphoresis
- ! Muscle/bone aches, abdominal cramps
- ! N/V, diarrhea, restlessness, anxiety
- ! ↑HR, ↑BP, ↑temp — uncomfortable, dangerous mainly via dehydration

BENZOS BENZODIAZEPINE INTOXICATION

INTOXICATION (CNS DEPRESSION)

- ✓ Sedation, drowsiness, slurred speech
- ✓ Ataxia, confusion, impaired memory
- ✓ Hypotension, dizziness
- ✓ Generally **less lethal alone** than opioids
- ✓ **Profound respiratory depression when combined** with alcohol or opioids (synergy)

WITHDRAWAL (PARALLELS ALCOHOL — CAN BE FATAL)

- ! Anxiety, insomnia, tremor, diaphoresis
- ! Tachycardia, hypertension, agitation
- ! Perceptual disturbances, hypersensitivity to stimuli
- ! **Seizures & delirium** — like alcohol, taper required, never abrupt stop
- ! Onset/duration longer with long-acting agents (e.g., diazepam)

3 SCORED WITHDRAWAL TOOLS — CIWA-AR & COWS

TOOL CIWA-AR — CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT, ALCOHOL (REVISED)

FEATURE	DETAIL / NCLEX SIGNIFICANCE
`10 items`	N/V, tremor, paroxysmal sweats, anxiety, agitation, tactile / auditory / visual disturbances, headache, orientation & clouding of sensorium
`Scoring`	9 items scored 0–7; orientation scored 0–4. **Max = 67**
`< 8–10`	Minimal / mild withdrawal — typically **no medication needed**
`8–15`	Mild–moderate
`16–20`	Moderate
`> 20`	**Severe** — high risk for seizures/DTs; aggressive benzodiazepine dosing
`Purpose`	**Symptom-triggered benzodiazepine dosing** — medicate based on the score, reassess frequently. Higher score = more benzo.

TOOL COWS — CLINICAL OPIATE WITHDRAWAL SCALE

FEATURE	DETAIL / NCLEX SIGNIFICANCE
`11 items`	Resting pulse, sweating, restlessness, **pupil size**, bone/joint aches, runny nose/tearing, GI upset, tremor, yawning, anxiety/irritability, gooseflesh skin
`5–12`	Mild
`13–24`	Moderate
`25–36`	Moderately severe
`> 36`	**Severe**
`Purpose`	Quantifies opioid withdrawal severity & guides medication-assisted treatment. **Buprenorphine should only be started once COWS confirms the patient is in withdrawal** (usually moderate) to avoid **precipitated withdrawal**.

4 LABS & DIAGNOSTICS — WITH NCLEX SIGNIFICANCE

LAB / TEST	EXPECTED FINDING	NCLEX SIGNIFICANCE
Blood Alcohol Concentration (BAC)	↑ `> 0.08% legal`	Tolerance can mask severity; chronic users awake at lethal-appearing levels
Urine drug screen / tox panel	`Positive`	Confirms co-ingestion — guides antidote choice & risk of mixed OD
AST / ALT (LFTs)	↑ `AST:ALT > 2:1`	Hallmark of alcoholic liver disease
GGT	↑	Sensitive marker of chronic alcohol use
MCV (CBC)	↑ `(macrocytic)`	Chronic alcohol + folate deficiency
Magnesium / Potassium / Phosphate	↓ `all`	Hypomagnesemia lowers seizure threshold — **replace before/with benzos**
Glucose	↓ `hypoglycemia`	Give **thiamine BEFORE glucose** to prevent Wernicke's
Thiamine (B1)	↓	Deficiency → Wernicke-Korsakoff syndrome
Ammonia	↑	Hepatic encephalopathy in advanced liver disease
ABG / SpO_2	↓ `pH`, ↑ CO_2	Respiratory depression in opioid/benzo/alcohol intoxication
Lipase / Amylase	↑	Alcoholic pancreatitis

5 PRIORITY INTERVENTION LADDER

1. **Airway, Breathing, Circulation first — always**
   Any intoxication: assess airway patency & respiratory rate. Position lateral/recovery to prevent aspiration if ↓LOC. Have suction and bag-valve-mask ready.
2. **Reverse the immediate threat (antidote when indicated)**
   Opioid OD → **naloxone**. Benzo OD → flumazenil only with extreme caution. Support ventilation while the antidote works.
3. **Thiamine before glucose (alcohol)**
   Prevents precipitating Wernicke's encephalopathy. "Banana bag": thiamine, folate, magnesium, multivitamin in IV fluids.
4. **Treat withdrawal by severity score**
   CIWA-Ar → symptom-triggered **benzodiazepines** for alcohol/benzo withdrawal. COWS → methadone/buprenorphine/clonidine for opioids.
5. **Seizure & safety precautions**
   Pad rails, suction at bedside, quiet low-stimulation room, frequent reorientation, fall precautions. One-to-one if DTs.
6. **Continuous monitoring & reassessment**
   VS, LOC, SpO_2, cardiac monitor. Watch opioid patients for **re-sedation** after naloxone wears off.
7. **Correct electrolytes & hydration**
   Replace magnesium, potassium, phosphate; IV fluids for withdrawal losses (vomiting/diarrhea/diaphoresis).
8. **Psychosocial care & referral**
   Nonjudgmental approach, treat co-occurring conditions, referral to MAT program, AA/NA, counseling once stabilized.

6 IF → THEN CLINICAL DECISION RULES

`IF pinpoint pupils + RR 6 + ↓LOC`
THEN opioid overdose → support ventilation & give **naloxone**; titrate to respirations, not full alertness.

`IF naloxone given & patient improves then re-sedates`
THEN opioid outlasted the antidote → **repeat dose / start infusion** & keep monitoring (esp. long-acting opioids).

`IF chronic alcohol use + altered LOC + needs dextrose`
THEN give **thiamine FIRST** (or together) — glucose alone can trigger Wernicke's encephalopathy.

`IF CIWA-Ar score > 20 with tremor, fever, hallucinations`
THEN impending/active DTs → **aggressive benzodiazepines**, 1:1, ICU-level monitoring.

`IF opioid-dependent patient and you give naloxone`
THEN expect **precipitated acute withdrawal** — anticipate agitation, vomiting; reassure, support.

`IF benzo overdose suspected with seizure history or TCA co-ingestion`
THEN **avoid flumazenil** — it can provoke refractory seizures; support airway instead.

`IF patient wants to stop chronic benzodiazepines`
THEN **gradual taper** — never abrupt discontinuation (seizure/death risk, like alcohol).

`IF starting buprenorphine for opioid withdrawal`
THEN wait until COWS confirms moderate withdrawal — early dosing causes **precipitated withdrawal**.

7 THE 8 NCLEX TRAPS

TRAP 1
`MYTH:` Opioid and alcohol withdrawal are equally dangerous.

TRAP 2
`MYTH:` Pupils are dilated in opioid overdose.
`TRUTH:` Overdose = `pinpoint (miosis)`. Dilated pupils = opioid `withdrawal`.

TRUTH: Alcohol & benzo withdrawal can be fatal (seizures/DTs); opioid withdrawal is miserable but rarely lethal.

TRAP 3

MYTH: Give glucose first to the hypoglycemic alcoholic.

TRUTH: Thiamine first — dextrose without thiamine can precipitate Wernicke's encephalopathy.

TRAP 4

MYTH: Titrate naloxone until the patient is fully awake.

TRUTH: Titrate to adequate respirations; full reversal causes severe withdrawal & agitation.

TRAP 5

MYTH: Flumazenil is the routine antidote for benzo overdose.

TRUTH: Used rarely — can trigger seizures, especially in chronic users / mixed OD. Supportive care first.

TRAP 6

MYTH: CIWA-Ar gives benzos on a fixed schedule.

TRUTH: It is symptom-triggered — dose to the score and reassess; higher score = more medication.

TRAP 7

MYTH: Alcoholic hallucinosis means the patient is disoriented.

TRUTH: In hallucinosis the sensorium is intact; clouded sensorium & disorientation point to DTs.

TRAP 8

MYTH: One naloxone dose fixes a long-acting opioid OD.

TRUTH: Naloxone is short-acting — watch for re-sedation; repeat dosing or infusion may be required.

8 NCLEX QUESTION PATTERNS TO RECOGNIZE

ANTIDOTE MATCH

"Which drug for opioid OD?" → **naloxone**. Benzo → flumazenil (caution). Acetaminophen co-ingestion → acetylcysteine.

PRIORITY / FIRST ACTION

Almost always **airway/breathing** or position to prevent aspiration before giving any medication.

TIMELINE RECOGNITION

"48–72 hr after last drink + confused, febrile, tachycardic" → **delirium tremens**.

PUPIL DISCRIMINATION

Pinpoint = opioid OD; dilated = opioid withdrawal/stimulants. The fastest tell on a stem.

SCORED-TOOL LOGIC

High CIWA → more benzo; COWS confirms withdrawal before buprenorphine.

ORDER OF OPERATIONS

Thiamine before glucose; taper not abrupt stop; titrate naloxone to RR.

THERAPEUTIC COMMUNICATION

Nonjudgmental, reflect feelings, avoid "why" questions, set limits on manipulation.

SAFETY PRIORITY

Seizure & fall precautions, suction at bedside, low-stimulation environment for DTs.

RE-SEDATION WATCH

Post-naloxone monitoring is a frequent "which response indicates further teaching/monitoring" stem.

9 NGN BOW-TIE SUMMARY

BOW-TIE: SUSPECTED WITHDRAWAL EMERGENCY

CONDITION / CLIENT PROBLEM

ACUTE SUBSTANCE WITHDRAWAL WITH AUTONOMIC INSTABILITY

◄ ACTIONS TO TAKE

- Maintain airway / give O_2
- Administer benzodiazepine per CIWA-Ar
- Thiamine before dextrose
- Initiate seizure & fall precautions
- Naloxone if opioid involvement

PARAMETERS TO MONITOR

- Vital signs & temperature
- LOC & orientation
- SpO_2 / respiratory rate
- CIWA-Ar or COWS score trend
- Electrolytes (Mg, K, glucose)

CONDITIONS TO CONSIDER ►

- Delirium tremens
- Withdrawal seizure
- Wernicke encephalopathy
- Opioid re-sedation
- Mixed / poly-substance OD

10 PATIENT & FAMILY TEACHING CHECKLIST

TEACHING Discharge & Recovery Education

- [x] **Never stop alcohol or benzodiazepines abruptly** after chronic use — life-threatening seizures can occur; taper under provider supervision.
- [x] **Take and store naloxone** if at risk for opioid OD; teach family how to recognize OD (pinpoint pupils, slow breathing) and administer intranasal naloxone, then **call 911** — effect wears off.
- [x] **Do not combine** CNS depressants — alcohol + benzos + opioids together dramatically raise respiratory-depression and death risk.
- [x] **Tolerance drops after abstinence** — a previously "normal" opioid dose can now be fatal after a period of not using.
- [x] **Adhere to MAT** (methadone, buprenorphine/naloxone, naltrexone) and keep follow-up appointments; do not skip or double doses.
- [x] **Nutrition & thiamine/folate** supplementation supports recovery and prevents neurologic damage.
- [x] **Disulfiram caution:** avoid all hidden alcohol (mouthwash, sauces, OTC cough syrups) — severe reaction.
- [x] **Connect to support:** AA/NA, counseling, sponsor; identify triggers and a relapse-prevention plan.
- [x] **Recovery is a chronic process** — relapse is common and is a reason to re-engage care, not a moral failure. Nonjudgmental support improves outcomes.

SAVE / PRINT THIS GUIDE AS PDF

1. Press `Ctrl + P` (Windows) or `⌘ + P` (Mac).
2. Set **Destination** to "Save as PDF".
3. Open **More settings** → set **Scale** to **65–70%** so each section fits cleanly.
4. Enable **"Background graphics"** so the color-coding and cards print.
5. Set margins to **Default** or **None**, then **Save**. Works best in Chrome or Edge.