● PSYCH / MENTAL HEALTH NURSING · SUBSTANCE USE DISORDERS

NCLEX 2026 · HIGH-YIELD CLINICAL BRIEF · VOL. 01

Alcohol *Intoxication* & Withdrawal

A clinical-judgment brief for the **next-gen NCLEX** *— pathophys, priorities, pharm, & traps.*

PATHOPHYS · PHARM · RED FLAGS · TEST TRAPS

Chronic alcohol use rewires inhibitory and excitatory balance in the CNS. Abrupt cessation unmasks unopposed excitation — the pathway from tremor → seizure → delirium tremens. Recognize the timeline. Treat early. Save the airway.

DT MORTALITY (UNTREATED)

15%

"A medical emergency — not a behavior problem."

01 DEFINITION · OVERVIEW — What it is & why it matters

Alcohol is a CNS depressant. **Alcohol Use Disorder (AUD)** is a chronic, relapsing brain disorder — compulsive drinking, loss of control, and physiologic dependence.

Intoxication = acute CNS depression after recent heavy intake. **Withdrawal** = CNS hyperexcitability after abrupt cessation in a dependent drinker.

Why it matters: untreated severe withdrawal (DT) carries up to 15% mortality. Early identification and benzodiazepine therapy are lifesaving.

DSM-5-TR CATEGORY · CIWA-AR ASSESSMENT · LIFE-THREATENING IF UNTREATED

02 From chronic use to delirium tremens

PATHOPHYSIOLOGY · SIMPLIFIED

*Alcohol is a **GABA agonist** and **NMDA antagonist**. The brain adapts. When alcohol is removed, the adaptation becomes a storm.*

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
Chronic Alcohol Use	**CNS Adapts**	**Tolerance**	**Abrupt Cessation**	**Hyperexcitability**
↑ GABA inhibitory tone ↓ NMDA/glutamate excitation	Down-regulates GABA receptors Up-regulates NMDA receptors	More alcohol needed for the same effect; physical dependence develops.	GABA brake is removed. Excess NMDA receptors fire unopposed.	Tremor ▸ autonomic surge ▸ seizure ▸ **Delirium Tremens**

Key insight: Thiamine stores are depleted in chronic alcoholism because alcohol blocks GI absorption and replaces caloric intake. Giving IV dextrose before thiamine can precipitate **Wernicke encephalopathy** — confusion, ophthalmoplegia, ataxia.

03 Intoxication vs. Withdrawal

SIGNS & SYMPTOMS

Intoxication — CNS DEPRESSION

- **BAC 0.05-0.15** — **Mild:** euphoria, disinhibition, slurred speech, mild ataxia, ↓reaction time, impaired judgment.
- **BAC 0.15-0.30** — **Moderate:** nystagmus, marked ataxia, emotional lability, slowed cognition, N/V.
- **BAC > 0.30** — **Severe:** stupor → coma, **respiratory depression** AIRWAY, aspiration risk, hypothermia, hypoglycemia.
- **BAC > 0.40** — **Potentially fatal** — apnea, cardiovascular collapse DEATH RISK.

Withdrawal — CNS HYPERACTIVITY

- **6-12 hr** — **Minor:** tremors, anxiety, insomnia, N/V, sweating, ↑HR, ↑BP, headache.
- **12-24 hr** — **Alcoholic hallucinosis:** visual/tactile hallucinations — *sensorium & orientation intact.*
- **24-48 hr** — **Withdrawal seizures:** generalized tonic-clonic, often single SEIZURE.
- **48-96 hr** — **Delirium Tremens:** severe confusion, disorientation, hallucinations, fever, tachycardia, HTN, diaphoresis EMERGENCY.

WITHDRAWAL TIMELINE — LAST DRINK →

6-12 HR	12-24 HR	24-48 HR	48-96 HR
Tremors	**Hallucinations**	**Seizures**	**Delirium Tremens**
Anxiety, sweating, ↑VS	Visual/tactile, oriented	Generalized tonic-clonic	Confusion + autonomic storm

04 PRIORITY NURSING INTERVENTIONS
ABCs, safety & clinical judgment

Acute Intoxication

- ★ **Airway first:** position side-lying (lateral recumbent) to prevent aspiration.
- ★ **Monitor** RR, SpO_2, LOC continuously — watch for **respiratory depression**.
- ☐ **Check** blood glucose & core temperature (hypoglycemia & hypothermia are common).
- ☐ **Assess** for trauma / head injury — intoxication masks signs.
- ☐ **Never** leave an intoxicated patient unattended. Raise side rails.
- ☐ **Administer** IV fluids & thiamine as ordered — *thiamine before dextrose.*

Alcohol Withdrawal

- ★ **Assess** with `CIWA-Ar` scale q1–4h; score > 8 triggers medication per protocol.
- ★ **Seizure precautions:** padded side rails, suction & O_2 at bedside, low bed.
- ☐ **Administer** benzodiazepines on schedule or symptom-triggered (per CIWA-Ar).
- ☐ **Environment:** quiet, well-lit, minimal stimuli — reduces illusions & anxiety.
- ☐ **Reorient** frequently. Calm, simple speech. Same caregiver when possible.
- ☐ **Monitor** I&O, electrolytes (Mg^{2+}, K^+, PO_4^{3-}), VS q2–4h.
- ☐ **Fall precautions.** Restraints are last resort — may worsen agitation.

A **B** **C** *Always prioritize Airway · Breathing · Circulation — then Safety → Assessment → Medication → Psychosocial support.*

05 PHARMACOLOGY
Detox, deficiency repletion & maintenance

◆ ACUTE DETOX / WITHDRAWAL

Lorazepam · Chlordiazepoxide · Diazepam
BENZODIAZEPINES — GOLD STANDARD

MOA: GABA-A agonist → suppresses CNS hyperexcitability.
SE: sedation, resp. depression, amnesia, ataxia.
Nursing: taper to prevent rebound; use LOT drugs in liver disease.

AIRWAY MONITORING

Thiamine (Vitamin B_1)
VITAMIN REPLETION — IV/IM

MOA: cofactor for glucose metabolism in CNS neurons.
Prevents: Wernicke encephalopathy (confusion, ataxia, ophthalmoplegia) & irreversible Korsakoff psychosis.
Nursing: give BEFORE dextrose. Continue with folate & multivitamin.

BEFORE GLUCOSE · ALWAYS

Folate · Magnesium · Multivitamin
NUTRITIONAL SUPPORT

Why: chronic alcoholics are deficient — corrects anemia, tremor threshold, seizure risk.
Nursing: monitor Mg^{2+}, K^+, PO_4^{3-} (refeeding syndrome risk).

Haloperidol (adjunct)
ANTIPSYCHOTIC — SEVERE AGITATION

Use only when benzodiazepines inadequate for severe hallucinations/agitation.
Caution: lowers seizure threshold, ↑QT, EPS.
Nursing: never as first-line for withdrawal.

NOT FIRST-LINE

◆ MAINTENANCE · RELAPSE PREVENTION

Disulfiram (Antabuse)
AVERSION THERAPY

MOA: inhibits aldehyde dehydrogenase → acetaldehyde accumulation.
Reaction: flushing, N/V, tachycardia, HA, hypotension.
Teach: avoid ALL alcohol — mouthwash, cough syrup, vanilla, aftershave, hand sanitizer.

48 H BEFORE / 14 D AFTER

Naltrexone
OPIOID RECEPTOR ANTAGONIST

MOA: blocks μ-opioid receptors → ↓reward & ↓cravings.
SE: nausea, headache, hepatotoxicity.
Nursing: check LFTs; hold opioid analgesics.

Acamprosate
GLUTAMATE MODULATOR

MOA: restores GABA/glutamate balance → ↓post-acute cravings.
Safe in liver disease.
Nursing: caution in renal impairment; monitor for diarrhea.

06 NCLEX TEST TRAPS
What students confuse — priority vs. non-priority

1. **"Give D50 for confusion"** — ~~dextrose first~~. **Thiamine first, then glucose**. Glucose without thiamine can precipitate Wernicke encephalopathy.
2. Withdrawal ≠ intoxication care. Withdrawal needs **benzodiazepines**, ~~not antipsychotics~~ as first-line.
3. Hallucinations with **intact orientation** = **alcoholic hallucinosis**, not DT. DT requires **disorientation + autonomic instability**.
4. DT peaks **48–96 hr** after the last drink — not immediately. A "sober for 3 days" pt can still crash.
5. Disulfiram reaction can be triggered by **mouthwash, cough syrup, aftershave, hand sanitizer, vanilla extract** — educate early.
6. **Wernicke** encephalopathy is **reversible** with thiamine. **Korsakoff** psychosis (amnesia, confabulation) is ~~not~~.
7. Priority in DT = **safety & seizure precautions** — not restraints. Restraints ↑ agitation & injury.
8. In liver failure use **LOT** benzos: **L**orazepam, **O**xazepam, **T**emazepam — no hepatic phase-I metabolism.

07 PATIENT EDUCATION
Recovery, safety & teaching points

- ✓ **Never stop cold-turkey** without medical supervision if physically dependent — withdrawal can be fatal.
- ✓ **Join AA / 12-step** or similar peer support. Sobriety is a *lifelong* commitment, not an event.
- ✓ **On disulfiram**, avoid all alcohol-containing products: mouthwash, OTC cough syrups, aftershave, vanilla, hand sanitizer.
- ✓ **Take daily** thiamine, folate, multivitamin. Eat thiamine-rich foods — pork, legumes, fortified grains.
- ✓ **Identify triggers** (people, places, emotions). Build coping skills & relapse-prevention plan with a counselor.
- ✓ **Include family** in recovery. Consider Al-Anon for loved ones. Rebuild trust gradually.
- ✓ **Know warning signs:** tremor, anxiety, insomnia, hallucinations after cutting back → seek care *immediately*.
- ✓ **Naltrexone** — take with food to ↓ nausea. Notify MD of yellowing skin / dark urine (hepatotoxicity).

MEMORY BOOSTERS

08 Mnemonics & pattern recognition

◇ "SWEATING" — DELIRIUM TREMENS

S	**S**weating & diaphoresis
W	**W**ide-awake (insomnia)
E	**E**levated temp / HR / BP
A	**A**gitation / anxiety
T	**T**remors — coarse, bilateral
I	**I**llusions & hallucinations
N	**N**ausea / vomiting
G	**G**rand-mal seizure risk

◇ WITHDRAWAL TIMELINE — 6·12·24·48

6	**hr:** Shakes (tremors, anxiety, autonomic)
12	**hr:** Hallucinations (oriented)
24	**hr:** Seizures (tonic-clonic)
48	**–96 hr: Delirium Tremens**

◆ WERNICKE TRIAD — "COA"

Confusion · **O**phthalmoplegia · **A**taxia. Reversible with IV thiamine.

Korsakoff = Can't remember (amnesia + confabulation, **irreversible**).

◆ "LOT" — BENZOS SAFE IN LIVER DISEASE

Lorazepam · **O**xazepam · **T**emazepam.
No hepatic phase-I metabolism — safer in cirrhosis / hepatic failure.

◆ GOLDEN RULE

Thiamine BEFORE Glucose. Always. Every single chronic alcoholic. Every single NCLEX question.