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Alcohol Withdrawal *Syndrome*

A CNS hyperexcitability state on the spectrum from mild tremors to life-threatening Delirium Tremens (DTs) — high yield for safety, prioritization, and pharmacology items.

SYSTEM: MENTAL HEALTH · NEURO | TEST FOCUS: SAFETY · PHARM | PRIORITY: HIGH

📚 **Source note:** *This topic was not in your uploaded reference set, so content has been drawn from standard* **NGN NCLEX 2026 references** *— Saunders Comprehensive Review, ATI Mental Health, Lippincott Q&A, and CIWA-Ar protocol guidelines (ASAM/AHRQ).*

1 SECTION ONE Definition & Overview

- **Alcohol Withdrawal Syndrome (AWS)** = the cluster of CNS & autonomic symptoms that emerge when a chronic heavy drinker abruptly stops or sharply reduces intake.
- Severity ranges from **mild tremulousness** → **hallucinations** → **withdrawal seizures** → **Delirium Tremens** (DTs).
- **DTs carry a 5–15% mortality** if untreated → AWS is a true medical emergency, not just a behavioral issue.
- Risk ↑ in: long drinking history, prior withdrawal episodes, prior DTs/seizures, recent heavy use, comorbid illness, postop or trauma admissions.

2 SECTION TWO Pathophysiology

Chronic alcohol = a chronic **CNS depressant**. The brain adapts. When the depressant is gone, the brain is left in an **unopposed excitatory state**.

Chronic ETOH →

↑ GABA tone & ↓ NMDA glutamate activity

Brain adapts →

Down-regulates GABA, up-regulates glutamate

ETOH stops →

Unopposed glutamate & sympathetic surge

Result → Tremor · ↑HR · ↑BP · seizures · DTs

SECTION THREE

3 Withdrawal Timeline — Hours After Last Drink

6–12 hr — STAGE 1 · MILD

Minor withdrawal

Hand tremor ("shakes"), anxiety, insomnia, N/V, anorexia, headache, diaphoresis, mild tachycardia/HTN, hyperreflexia. **Patient is alert & oriented.**

12–24 hr — STAGE 2 · MODERATE

Alcoholic hallucinosis

Visual, auditory, or **tactile hallucinations (formication — "bugs crawling")** with **intact orientation**. Patient knows hallucinations aren't real. *Not* DTs.

24–48 hr — STAGE 3 · SEVERE

Withdrawal seizures

Generalized tonic-clonic seizures, usually brief and self-limited. Status epilepticus is possible. Implement seizure precautions *before* they occur.

48–96 hr — STAGE 4 · DTS

Delirium Tremens — life-threatening

Severe confusion, disorientation, agitation, vivid hallucinations, **autonomic instability** (HR >120, BP >180/110, fever >101°F), diaphoresis. Mortality 5–15% untreated.

SECTION FOUR

4 Signs & Symptoms — Early vs. Late

Early / Mild (6–24 hr)

- Coarse hand tremor ("the shakes")
- Anxiety, restlessness, irritability
- Insomnia, vivid dreams
- N/V, anorexia
- Diaphoresis, headache
- Mild ↑HR, ↑BP
- Hyperreflexia
- Alert & oriented × 3

Late / Severe (48–96 hr)

- Severe confusion, disorientation **RED FLAG**
- Tactile/visual hallucinations
- Withdrawal seizures (tonic-clonic) **RED FLAG**
- HR > 120, BP > 180/110
- Hyperthermia (fever > 101°F)
- Severe agitation, paranoia
- Profuse diaphoresis
- Risk of arrhythmia & death **RED FLAG**

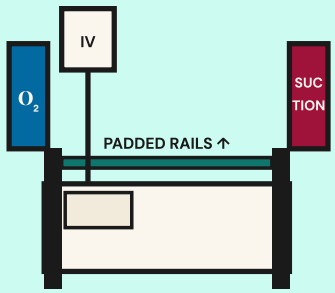
SECTION FIVE

5 Priority Nursing Interventions · ABCs First

- **AIRWAY:** Position for airway protection during seizure; suction at bedside; have oxygen ready.
- **BREATHING:** Monitor RR & SpO_2 — benzodiazepines depress respirations.
- **CIRCULATION:** Monitor HR, BP, temp Q15–30 min in severe withdrawal; ECG if HR >120.
- **Assess severity:** Use **CIWA-Ar** scale Q4–8h (score >15 = severe → aggressive treatment).
- **Seizure precautions:** Padded side rails, bed low/locked, suction & O_2 at bedside, IV access.
- **Administer benzodiazepines** per CIWA-Ar protocol (front-line treatment).
- **Give thiamine BEFORE glucose** to prevent Wernicke's encephalopathy.
- **IV fluids & electrolyte replacement** (esp. Mg, K, phosphate).
- **Environment:** Quiet, well-lit room, minimize stimulation, single private room if possible.
- **Reorient frequently;** calm, simple communication; family at bedside if helpful.
- **Restraints = LAST resort** — try environmental & pharmacologic measures first.
- **Fall & aspiration precautions** throughout.

BEDSIDE SETUP

★ Seizure-Ready Room



CHECK Q SHIFT

O_2 · Suction · Rails · IV · CIWA

SECTION SIX

6 Pharmacology — Acute & Long-Term

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS	NURSING CONSIDERATIONS
Lorazepam (Ativan) Diazepam (Valium) Chlordiazepoxide (Librium) *Benzodiazepines — 1st LINE*	↑ GABA → calms CNS hyperexcitability; prevents seizures & DTs	Sedation, respiratory depression, hypotension, ataxia	Dose per CIWA-Ar. Monitor LOC & RR. **Lorazepam preferred in liver disease** (LOT rule).
Thiamine (Vit B_1)	Cofactor for glucose metabolism in CNS	Generally well-tolerated; rare anaphylaxis IV	**GIVE BEFORE GLUCOSE** to prevent Wernicke-Korsakoff. IV/IM in acute phase.
Folic acid & Multivitamin	Replace chronic nutritional deficiencies	Minimal	Routine in all chronic alcohol users.
Magnesium sulfate	Corrects hypomagnesemia; may ↓ seizure threshold	Flushing, ↓BP, ↓DTRs if toxic	Monitor Mg level, DTRs, RR.
Clonidine / β-blockers *Adjunct only*	Blunt autonomic surge (HR/BP)	Hypotension, bradycardia	NOT a substitute for benzos — masks symptoms without preventing seizures.
Haloperidol	D_2 antagonist for hallucinations	**Lowers seizure threshold**, EPS, QT prolongation	Use cautiously; never replace benzos.
Disulfiram (Antabuse) *Long-term relapse prevention*	Blocks aldehyde dehydrogenase → severe reaction if alcohol ingested	Flushing, N/V, HA, tachycardia, hypotension with ETOH	Teach: avoid ALL alcohol — mouthwash, cologne, cough syrup, vinegar, OTC meds.
Naltrexone · Acamprosate *Long-term*	Reduce cravings & reward response	GI upset; naltrexone — hepatotoxicity	Naltrexone: avoid in opioid users / liver failure. Acamprosate: adjust in renal disease.

SECTION SEVEN

7 NCLEX Test Traps ⚠ Wrong vs. Right

✗ WRONG ANSWER LOGIC

- Giving **glucose first** in a malnourished alcohol user (can precipitate Wernicke's).
- Picking **restraints first** for agitation before trying environmental + pharmacologic measures.
- Using **diazepam** when patient has liver failure (active metabolites accumulate).
- Treating with only **clonidine or β-blockers** — they hide vitals but don't prevent seizures.
- Assuming **hallucinations = DTs**. Alcoholic hallucinosis has intact orientation; DTs do not.
- "Wait and see" when CIWA-Ar score climbs — withdrawal escalates fast.
- Placing patient in a **busy, brightly lit, high-stimulation** hallway room.

✓ CORRECT NCLEX LOGIC

- **Thiamine BEFORE glucose** — every time.
- Use CIWA-Ar score to drive dosing; treat early to prevent DTs.
- Choose a **"LOT" benzo** (Lorazepam, Oxazepam, Temazepam) in liver disease.
- Benzodiazepines are the **first-line treatment**; adjuncts are adjuncts.
- Identify DTs by the **triad**: altered mental status + autonomic instability + hallucinations.
- Place patient in a **quiet, well-lit private room**; reorient often.
- Restraints = **LAST** resort, with order & per facility policy.

SECTION EIGHT

8 Patient & Family Education

- **Do NOT stop alcohol abruptly** at home after heavy use — withdrawal can be fatal. Seek medical detox.
- Attend **AA / SMART Recovery** or other peer support consistently; sponsorship reduces relapse.
- Identify and plan around **triggers** (people, places, stress, emotions).
- **Disulfiram teaching:** avoid ALL alcohol-containing products — mouthwash, cologne, aftershave, cough syrups, vanilla extract, sauces, OTC liquid meds — for up to 14 days after the last dose.
- Take **thiamine, folate, multivitamins** daily; eat a balanced diet.
- Carry a **medical alert** if on disulfiram/naltrexone.
- Family education: signs of relapse, when to call 911 (seizure, severe confusion).
- Continue **counseling/CBT**; treat comorbid depression, anxiety, PTSD.
- Avoid CNS depressants & OTC sleep aids without provider approval.

SECTION NINE

9 Memory Boosters & Mnemonics

CIWA

The **C** linical **I** nstitute **W** ithdrawal **A** ssessment for Alcohol — drives benzo dosing. **>15 = severe.**

LOT

L orazepam · **O** xazepam · **T** emazepam — safer benzos in **liver disease** (no active metabolites).

T B G

T hiamine **B** efore **G** lucose — every alcohol patient, every time. Prevents Wernicke's.

1·2·3·4

Timeline: **12h** tremors → **24h** hallucinations → **48h** seizures → **48–96h** DTs.

A·T·M

DT triad: **A** utonomic instability + **T** remor + **M** ental status change.

SHAKES

S weats · **H** allucinations · **A** nxiety · **K** inetic tremor · **E** levated VS · **S** eizures.

10 Section Ten · NGN Clinical JudgmentNCJMM Six-Step Scenario

SCENARIO: *A 58-year-old male is post-op day 2 after a laparoscopic cholecystectomy. History: 1 pint of vodka daily for 20+ years; last drink the evening before admission. The nurse responds to a call light and finds the client tremulous and pulling at his IV.*

Assessment: *HR 128, BP 178/98, T 100.8°F, RR 22, SpO_2 95%, profusely diaphoretic, restless, oriented to person only, states "there are spiders crawling on the wall." CIWA-Ar score = 22.*

STEP 1
Recognize Cues

Tachycardia (128), HTN (178/98), low-grade fever, diaphoresis, coarse tremor, disorientation, visual/tactile hallucinations, ~48 hr since last drink, CIWA-Ar 22.

STEP 2
Analyze Cues

Cues cluster as the AWS triad: **autonomic instability + tremor + altered mental status** at the 48-hour mark. Pattern fits **severe alcohol withdrawal progressing to DTs.**

STEP 3
Prioritize Hypotheses

#1 priority: Delirium Tremens — life-threatening. Rule-outs: post-op infection/sepsis, hypoxia, electrolyte imbalance, ICU delirium, hypoglycemia.

STEP 4
Generate Solutions

Notify provider · IV lorazepam per CIWA protocol · IV thiamine *before* any glucose · seizure precautions · IV fluids/electrolytes · quiet private room · VS Q15 min · labs (CMP, Mg, glucose, ABG).

STEP 5
Take Action

Administer Lorazepam IV per order · give Thiamine 100 mg IV · raise padded rails · place suction & O_2 at bedside · dim lights, reduce noise · reorient calmly · stay with client · continuous monitor.

STEP 6
Evaluate Outcomes

CIWA-Ar trending down (<10) · HR <100 · BP <140/90 · T normalizing · oriented ×3 · resting quietly · no seizure activity · skin warm/dry. If no improvement → escalate to ICU.

48–96	>15	5–15%	B_1
HOURS TO DT ONSET	CIWA = SEVERE	UNTREATED DT MORTALITY	THIAMINE BEFORE GLUCOSE