WITHDRAWAL OF DRUG(S) OF DEPENDENCE ● 1/4

Table 1: Substance misuse contact numbers

Ward pager

Edward Myers Unit:
A&E pager: Leek:
Office: Newcastle:
Referrals on OrderComs Stafford/south of county:
Weekends: HALT

- Withdrawal syndromes are specific to:
  - type of drug involved
  - route of administration
  - frequency of use
  - quantity used
  - individual variation in sensitivity
  - psychological state
- Mild symptoms occurring after withdrawal of a drug do not require routine medical intervention. Explaining to patient likely course of withdrawal has been shown to reduce severity of withdrawal symptoms
- If treatment may be required suggest TAP – Test (investigations), Assess (as described below) and Phone (drug agency that will continue input following discharge acute hospital)

- Obtain **witnessed** urine sample or mouth swab for drug screen (contact alcohol liaison team for screening tests)
- Check patient's prescribed medications with GP when surgery open
  - if patient states they are taking opiate substitute, contact prescriber e.g. patient's own GP, Stoke community drug and alcohol service or One Recovery – see **Table 1** for contact numbers
- Pregnancy test, if indicated

***Pregnancy is an indication for very detailed assessment and close management of withdrawal because of risks to fetus. Refer to appropriate drug service (patients living in Stoke-on-Trent to Stoke community drug and alcohol service, patients living in the rest of Staffordshire to One Recovery) and contact on-call obstetric team** – see* **Management of a pregnant woman with a non-obstetric problem** *guideline*

- Nausea, vomiting
- Diarrhoea
- Restlessness, anxiety
- Irritability, insomnia
- Muscle and bone pains
- Running eyes and nose
- Sneezing, yawning
- Sweating, flushing
- Dilated pupils, pilo-erection
- In a hospital setting assess severity using **Table 2**

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- score **0** if not present
- score **1** if mildly present
- score **2** if strongly present

Table 2

Signs 0 1 2

Pupillary dilation

Rhinorrhea

Lacrimation

Pilo-erection

Nausea/vomiting

Diarrhoea

Yawning

Cramps

Restlessness

Subjective evaluation

· Score ≤5, no medical treatment indicated

· Score >5, treatment may be indicated

Immediate treatment

· Where withdrawal symptoms are of sufficient severity to warrant medical treatment, several options are available

Symptomatic treatment

· Nausea, vomiting and insomnia: promethazine hydrochloride 25 mg oral 12-hrly

· Somatic anxiety: propranolol 40 mg oral 8-hrly

· Diarrhoea: loperamide 4 mg single oral dose. Do not give loperamide if infective diarrhoea suspected

· Stomach cramps: hyoscine butylbromide 10–20 mg oral 6-hrly

· Pain: paracetamol 1 g oral 6-hrly or ibuprofen 400 mg oral 8-hrly if required

Opiate substitution

Discuss initiation of opiate substitution with drug agency (based on geography) that will continue input following discharge acute hospital. Do not give substitutes unless a screening test confirms presence of opiates. Drug of choice is methadone mixture (1 mg/1 mL) – do not use injectable or tablet forms of methadone. Do not give alternative forms of opiate unless discussed with relevant drug agency

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Initial dose

· Measure withdrawal symptoms using **Table 2** at 6-hrly intervals for 24 hr. If score >5, give methadone 1 mg per point (i.e. score of 5 = no dose, score of 7 = 7 mg)

· Following first four 6-hrly assessments, add up doses administered at these assessments. Sum will be the daily dose on which patient should continue

· If significant withdrawal symptoms persist and patient remaining in hospital, give the new daily dose and perform a further 24 hr cycle of 6-hrly assessments

· in order to decide dose to be given on day 3, add any extra methadone given on day 2 to the sum obtained from day 1

Maintenance dose

· Once stable dose has been achieved, give methadone as single daily dose as described above

Maximum dose in 24 hr should not exceed 50 mg without specialist advice

Subsequent management

· Aim to allow patient to stabilise on the dose of methadone reached by titration with any reductions arranged by continuing care teams once discharged

· On discharge, continuing prescription should be via Staffordshire community drug service (One Recovery) or Stoke community drug service (Lifeline)

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- Complete withdrawal table 6-hrly (**Table 2**)

Discharge and follow-up

- Contact agency that has agreed to continue prescribing; allow as much warning as possible in order for necessary arrangements to be made
- relevant agency will confirm arrangements for prescription and appointment

Do not write methadone prescription as a TTO

- Notify GP

- Benzodiazepines and other sedative hypnotic drugs
- Alcohol – see **Alcohol withdrawal** guideline

- Confusion
- Nystagmus
- Tremor
- Agitation, irritability
- Insomnia
- Pyrexia
- Hyperreflexia
- Weakness
- Convulsions

• In initial stages, treatment of sedative withdrawal is similar to that for alcohol – see **Alcohol withdrawal** guideline. Once symptoms controlled, change to long-acting benzodiazepine (chlordiazepoxide, diazepam) in an equivalent dose (**Table 3**) to maintain clinical state and discuss a longer term strategy with either Edward Myers Centre or patient's GP

Table 3: Equivalent dosages

Chlordiazepoxide 12.5 mg
Diazepam 5 mg
Loprazolam 500 microgram–1 mg
Lorazepam 500 microgram
Oxazepam 10 mg
Temazepam 10 mg
Nitrazepam 5 mg
Lormetazepam 500 microgram–1 mg

• GHB is a 'party' drug used for its euphoric effects. It may interact with other illicit or prescribed drugs (e.g. anti-convulsants or anti-psychotics)

- Headaches
- Hallucinations
- Dizziness
- Confusion
- Nausea
- Vomiting
- Drowsiness
- Agitation
- Diarrhoea
- Sexual arousal
- Numbing of legs

- Vision problems
- Tightness of chest
- Mental changes
- Combativeness
- Memory loss
- Serious breathing and heart problems
- Seizures
- Coma
- Death
- Long-term use may lead to withdrawal symptoms

• Patients may present to A&E in an intoxicated or comatose state – most wake up within a few hours but some require ventilation
• Due to short half-life, withdrawal symptoms require active management – use diazepam as indicated in **Alcohol withdrawal** guideline using CIWA-Ar assessment chart, available from Trust intranet – Clinicians>clinical guidance>clinical guidelines>alcohol. Higher doses may be required
• Refer to Stoke community drug and alcohol service or One Recovery – see **Table 1** for contact numbers

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• There are no acute symptoms of stimulant withdrawal that need medical treatment as a matter of urgency. Insomnia and anxiety can be treated symptomatically
• Advice and support are valuable
• Depressive symptoms sometimes occur as a later withdrawal effect and can be treated with an antidepressant
• Refer to Stoke community drug and alcohol service or One Recovery – see **Table 1** for contact numbers

• Commonly misused are butane, toluene, glues, petrol. As there are no physical withdrawal syndromes, it is best to discontinue use abruptly. Treatment of intoxication involves general supportive measures:
• refer to Stoke community drug and alcohol service or One Recovery – see **Table 1** for contact numbers

• Treat anxiety and insomnia symptomatically

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