

#### Kliiniline küsimus nr 4

Kas kõiki alkoholivõõrutusseisundi kahtlusega patsiente tuleb hinnata võõrutusseisundi raskusastme täpsustamiseks hindamisvahenditega vs mitte hinnata?

#### Kriitilised tulemusnäitajad:

uuringumeetodi tundlikkus ja spetsiifilisus, positiivne ja negatiivne ennustatav väärtus

#### Ravijuhendid

##### Kokkuvõtte tõendusmaterjali kvaliteedist

Soovituse koostamiseks vaadati läbi 12 alkoholisõltuvuse ja liigkasutamise ravijuhendit. Teemakohast infot sisaldas neist kuues: NICE2011, NICE2010, NSW2008, APA2006, BAP 2012, Austraalia 2009. Ning 2 süstemaatilist ülevaadet. Uuritud kirjanduses ei käsitleta hindamisvahenditega hindamata jätmist, mistõttu sellekohast võrdlust tõendusmaterjali osas teha polnud võimalik. Kirjandus keskendub medikamentoosse ravi valimisele sõltuvalt hindamisvahendiga hindamisel saadud skoorile ning sellest tuleneva ravi kestvusele ja maksuvusele. Soovituste tegemiseks kasutatud kirjanduses ei olnud välja toodud uuringumeetodi tundlikkust, spetsiifilisust, positiivset ja negatiivset ennustatavat väärtust.

Vähesed soovitused baseerusid süstemaatilistel ülevaadetel või randomiseeritud kontrollitud uuringutel (NICE2010, Austraalia2009). APA2006, NSW2008 ning BAP2012 soovitused põhinesid sekkumisuuringutel või eksperthinnangutel.

Sekkumisuuring (Foy et al, 1988) näitas, et kui ravimisel lähtuti hindamisvahendiga hindamisel saadud skoorist, siis patsientidel, kes said skoori >15, oli suurem tõenäosus tõsisele alkoholi võõrutussündroomile, kui neid ei ravitud (RR, 3.72; 95% CI, 2.85-4.85). Mida kõrgem oli skoor, seda kõrgem oli suhteline risk. Sekkumisuuring järeldas, et objektiivse kliinilise skaala kasutamine alkoholi võõrutussündroomi määramiseks on kasulik üldhaiglas diagnoosimaks võõrutusseisundis patsientidel sündroomi varases staadiumis, vältimaks hilisemaid komplikatsioone. Alkoholi võõrutussündroomi hindamise skaalat (CIWA, AWS) saab kasutada võõrutusnähtude tugevuse hindamiseks ja medikamentoosse ravi määramiseks.

Vaatlusuuring (Foy et al, 1997) 539 juhtumi hulgas näitas, et suurim risk oli seotud hilinenud diagnoosimisega. Rohkem kui 24h hilinenud diagnoosimiste puhul pikenes hilisem voodipäevade arv keskmiselt 4 päeva võrra.

Süstemaatiline ülevaade (Williams et al, 2001) näitas, et alkoholi võõrutussündroomi diagnoosimine on oluline diagnoosimaks sündroomi esinemist, selle tõsidust ning medikamentoosse ravi vajalikkust. Hindamise kallutatuse vältimiseks on loodud diagnoosimise skaalad, mis ei hinda ainult sümptomi(te) esinemist, vaid ka tugevust. Teine süstemaatiline ülevaade (Foy et al, 2006) näitas, et lühem CIWA hindamisvorm on lihtne kasutada ning annab võrdväärseid tulemusi pika CIWA vormiga.

Kohortuuring (Kraemer et al, 2003) 284 patsiendiga kasutas 6 erinevat hindamiskriteeriumit alkoholi võõrutussündroomi hindamiseks: hommikune "peaparandamine" (adjusted odds ratio [OR], 5.6; 95% confidence interval [CI], 1.2-25.9), esialgne CIWA-Ar skoor > või =10 (OR, 5.1; 95% CI, 2.4-10.6), seerum aspartaat aminotransferaas > või =80 U/L (OR, 4.2; 95% CI, 2.0-8.8), varasem benzodiazepiinide kasutamine (OR, 3.6; 95% CI, 1.3-9.9), ise teavitatud "delirium tremens" (OR, 2.9; 95% CI, 1.3-6.2), varasem osalemine kahes või rohkemas võõrutusprogrammis (OR, 2.6; 95% CI, 1.3-5.6). Kolme või enama kriteeriumi esinemine oli seotud tõsisema alkoholi võõrutussündroomi esinemisega, seega parandab nende hindamine hilisemat ravitulemust.

Kontrollitud uuringu (Saitz et al, 1998) soovitus kohaselt tuleb tugeva alkoholi võõrutussündroomi tekkimise riski hinnata praeguse alkoholi tarbimise, eelnevate alkoholi võõrutuste, teiste ainete väärkasutamise ning kaasnevate meditsiinilise ja psühhiaatrilise seisundite alusel.

Randomiseeritud kontrollitud uuring (Hecksel et al, 2008) -Alkoholi võõrutussündroomi hindamise skaalat ei tohi kasutada patsientidel, kel esineb samaaegne võõrutus teistest ainetest või kaasuvaid komorbiidsusi.

Kokkuvõtte ravijuhendites leiduvatest soovitustest:

Alkoholi võõrutuse sümptomite korrektne hindamine on oluline, hindamaks ravi vajadust ja vastava raviplaani koostamiseks. Seega on kriitilise tähtsusega, et meditsiinitöötajad, kes tegelevad alkoholi võõrutusraviga, peaksid oskama näha ja ära tunda võõrutuse sümptomeid. Kliiniliste sümptomite alusel hindamine võib põhjustada kallutatust või olla ebatäpne vähese kogemusega hindaja puhul. Seega on soovitatav kasutada lisaks kliinilisele kogemusele ka mõnd valideeritud hindamisvahendit (nt CIWA).

CIWA-Ar on 10 punktiline valideeritud skaala. Skoor alla 10 loetakse kergeks võõrutuseks, 10-20 keskmiseks ning >20 tõsiseks võõrutuseks. Patsientidel, kelle skoor on >10, on ravimata jätmisel suurem riski võõrutuse komplikatsioonide tekkimiseks. CIWA-Ar monitoorimise sagedus sõltub patsiendi olukorrast ning keskkonnast, milles ta viibib. Patsiente suurema skooriga kui 10 tuleks hinnata sagedamini (vähemalt iga 4 tunni järel) ja skooriga >20 iga 2 tunni järel. CIWA-Ar sobib kasutamiseks üldhaigla tingimustes.

Alternatiivseteks hindamisvahenditeks on AWS, mis on valideerimata, aga laialdaselt kasutatav Austraalias. Selle lühem versioon SAWS on patsiendi poolt ise täidetav (sagedusega kord päevas) ning sobib eelkõige ambulatoorseks võõrutusraviks. AWS skoor kuni 4 viitab kergele võõrutusele, 5-7 keskmisele, 8-14 tõsisele ning üle 15 väga tõsisele võõrutusele. Monitoorimine on soovitatav vähemalt iga 4 tunni järel kerge võõrutusega patsientide puhul ning iga 2 tunni järel tõsise võõrutusega patsientide puhul.

Hindamisvahendiga hindamine on äärmiselt oluline vajaduspõhise ravi valimisel, mil medikamentooset ravi antakse patsiendile vaid hindamisvahendi kõrge skoori korral või siis kui skoori langus aja möödudes on väga aeglane. Võõrutusel kasutatavad ravimid omavad kõrvaltoimeid. Patsientidele, keda raviti CIWA-Ar skoori alusel, manustati ravi käigus oluliselt vähem diazepamit (keskmine kogudoos 50 mg diazepam versus 75 mg,  $p=0.04$ ) ning enamus neist said vaid väikse doosi (< 20 mg diazepam) (44/133 [25%] versus 25/117 [21%],  $p=0.05$ ), võrreldes nende patsientidega, keda CIWA-Ar alusel ei hinnatud.

Sümptomite alusel ravimisel on näidatud, et lüheneb raviaeg võrreldes fikseeritud doosiga ravimisega. Elukvaliteedi uuring näitas, et sümptomite alusel ravimine parandas patsientide füüsilist funktsioneerimist võrreldes fikseeritud doosiga ravimisega. Sümptomite alusel ravimine on seega kuluefektiivsem, kuna lüheneb raviaeg ja manustatavate ravimite kogus.

On näidatud, et komplikatsioonidega (hallutsinatsioonid, krambid) patsientidel olid CIWA skoorid kõrgemad, kui neil, kes komplikatsioone ei esinenud (mean highest score 21.8 [SD1.2] versus 15.6 [0.55], MD6.10; 95%CI 5.67 to 6.53;  $p<0.00001$ ).

Hindamata jätmine on seotud riskidega. Patsiendi hindamise viibimine rohkem kui 24 tundi suurendab riski võõrutusel komplikatsioonide tekkimiseks:

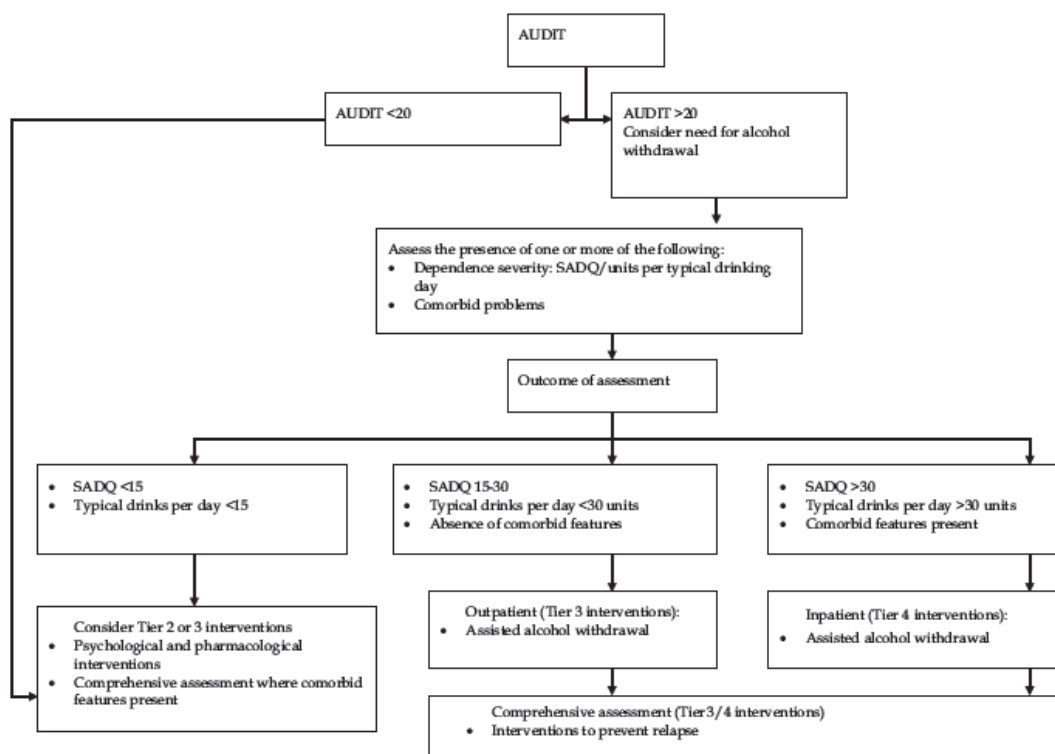
- igasuguse komplikatsiooni tekkimine (25/52 [48%], OR [adj.] 4.0; 95%CI 2.7 to 7.6)
- deliiriumi tekkimine (20/52 [38%], OR [adj.] 8.1; 95%CI 3.7 to 17.7)
- hallutsinatsioonide tekkimine (18/52 [35%], OR [adj.] 3.2; 95%CI 1.6 to 6.0)

Korduvalt võõrutusel viibivad patsientidel on hindamisvahendiga hindamine ja selle alusel ravimine ja jälgimine väga oluline, kuna võõrutussümptomid on neil tugevamad ning nad vajavad agressiivsemat ravi (*sensitization effect*).

**Table 15: Characteristics of assessment tools included in narrative review**

Assessment instrument	Number of items & format	Time taken to administer and by whom	Time to score and by whom	Copyright and cost of test
	Scale and cut-offs	Training required for administration		
Alcohol Problems Questionnaire (APQ)	44 items (eight subscales), pencil and paper self-administered	3 to 5 minutes; respondent	Minimal; minimally trained technician	No; free to use
	Maximum score = 23	No training		
Alcohol Use Disorders Identification Test (AUDIT)	Ten items (three subscales), pencil and paper or computer self-administered	2 minutes; trained personnel	1 minute; trained personnel	Yes; test and training manual free to use, training costs \$75
	Scale: 0 to 40. Cut-offs: 8 to 15 = hazardous; 16 to 19 = harmful, mild or moderate dependence; $\geq 20$ = severe dependence	Minimal training		
Clinical Institute Withdrawal Assessment (CIWA-Ar)	Eight items, observation format	2 minutes; trained personnel	4 to 5 minutes; trained personnel	Yes; free to use
	Total score ranges from; 0 to 9 = minimal/absent withdrawal; withdrawal	Training required for administration		
Leeds Dependence Questionnaire (LDQ)	Ten items, paper and pencil self-administered	2 to 5 minutes; respondent or personnel	Half a minute; non-trained personnel	No; free to use
	Scale: 0 to 30. Cut-offs: 0 = no dependence; 1 to 10 = low/moderate dependence; 11 to 20 = moderate/high dependence; 21 to 30 = high dependence	No training		
Readiness to Change Questionnaire – Treatment Version (RCQ-TV)	15 items (three subscales). Most up-to-date version has 12 items, pencil and paper self-administered	2 to 3 minutes; respondent	1 minute; non-trained personnel	Yes; free to use
	Original total score range: -10 to +10; current version total score range: -8 to +8	No training		
Severity of Alcohol Dependence Questionnaire (SADQ)	20 (five subscales), pencil and paper self-administered	5 minutes; respondent	1 minute; trained personnel or clinician	No; free to use
	Scale: 0 to 60; Cut-offs: $<15$ = mild dependence; 16 to 30 = moderate dependence; $\geq 31$ = severe dependence	No training		

**Figure 6: Care pathway: withdrawal assessment**



**Table 2-12. Relative risks for untreated patients according to CIWA score.**

	Complicated	Uncomplicated	RR untreated versus treated	95%CI
Score < 15				
Untreated	5	73	1.92	0.27 to 13.6
Treated	0	15		
Score 16 to 20				
Untreated	9	12	2.74	1.06 to 7.05
Treated	5	17		
Score 21 to 25				
Untreated	7	1	5.46	2.14 to 13.9
Treated	4	21		
Score > 25				
Untreated	5	1	7.50	3.87 to 29.07
Treated	2	15		

## Alcohol withdrawal: patient assessment and treatment planning

Recommendation	Strength of recommendation	Level of evidence
5.1 The risk of severe alcohol withdrawal should be assessed based on current drinking patterns, past withdrawal experience, concomitant substance use, and concomitant medical or psychiatric conditions.	B	II
5.2 Successful completion of alcohol withdrawal does not prevent recurrent alcohol consumption and additional interventions are needed to achieve long-term reduction in alcohol consumption.	A	Ia
5.3 Realistic goals of clinicians, patients and their carers for withdrawal services include: interrupting a pattern of heavy and regular alcohol use, alleviating withdrawal symptoms, preventing severe withdrawal complications, facilitating links to ongoing treatment for alcohol dependence, providing help with any other problems (such as accommodation, employment services).	D	IV
5.4 Ambulatory withdrawal is appropriate for those with mild to moderate predicted withdrawal severity, a safe 'home' environment and social supports, no history of severe withdrawal complications, and no severe concomitant medical, psychiatric or other substance use disorders.	D	IV
5.5 Community residential withdrawal is appropriate for those with predicted moderate to severe withdrawal, a history of severe withdrawal complications, withdrawing from multiple substances, no safe environment or social supports, repeated failed ambulatory withdrawal attempts, and with no severe medical or psychiatric comorbidity.	D	IV
5.6 Inpatient hospital treatment is appropriate for those with severe withdrawal complications (such as delirium or seizures of unknown cause), and/or severe medical or psychiatric comorbidity.	S	—
5.7 Hospital addiction medicine consultation liaison services should be accessible in hospitals to aid assessment, management and discharge planning.	S	—

## Monitoring alcohol withdrawal severity

Recommendation	Strength of recommendation	Level of evidence
5.8 Patients withdrawing from alcohol should be regularly monitored for physical signs, severity of alcohol withdrawal and general progress during withdrawal.	S	—
5.9 Alcohol withdrawal scales (CIWA-Ar,AWS) can be used to assess withdrawal severity, to guide treatment (such as symptom-triggered medication regimens) and to aid objective communication between clinicians; but should not be used as diagnostic tools.	A	Ia
5.10 Alcohol withdrawal scales should not be used to guide treatment in patients concurrently withdrawing from other substances, or with significant medical or psychiatric comorbidity. Health professionals should consult a specialist drug and alcohol clinician about monitoring and management needs.	B	Ib
5.11 Scores on alcohol withdrawal scales are not always reproducible and should be checked before using them to make management decisions.	S	—

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## Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
<p>This retrospective cohort study sought to identify clinical variables that independently correlate with severe alcohol withdrawal and to quantify risk in a clinically useful manner. The records of 284 inpatients admitted to an acute detoxification unit at a Veterans Affairs teaching hospital were reviewed. Clinical data were recorded on standardized forms at the time of admission and abstracted by a physician reviewer. Alcohol withdrawal severity was prospectively measured with the revised Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale. Seventy-one patients (25% of cohort) had severe withdrawal. We identified six independent correlates of severe withdrawal: use of a morning eye-opener (adjusted odds ratio [OR], 5.6; 95% confidence interval [CI], 1.2-25.9), an initial CIWA-Ar score <math>\geq 10</math> (OR, 5.1; 95% CI, 2.4-10.6), a serum aspartate aminotransferase <math>\geq 80</math> U/L (OR, 4.2; 95% CI, 2.0-8.8), past benzodiazepine use (OR, 3.6; 95% CI, 1.3-9.9), self-reported history of "delirium tremens" (OR, 2.9; 95% CI, 1.3-6.2), and prior participation in two or more alcohol treatment programs (OR, 2.6; 95% CI, 1.3-5.6). Significantly higher risk was observed in subjects with three or more independent correlates. In conclusion, several readily available clinical variables correlate with the occurrence of severe alcohol withdrawal. Ascertainment of these variables early in the course of alcohol withdrawal has the potential to improve triage and treatment decisions.</p>	<p>Independent clinical correlates of severe alcohol withdrawal.</p> <p>Kraemer KL, Mayo-Smith MF, Calkins DR. 2003</p>
<p>A shortened 10-item scale for clinical quantitation of the severity of the alcohol withdrawal syndrome has been developed. This scale offers an increase in efficiency while at the same time retaining clinical usefulness, validity and reliability. It can be incorporated into the usual clinical care of patients undergoing alcohol withdrawal and into clinical drug trials of alcohol withdrawal.</p>	<p>Assessment of alcohol withdrawal: the revised clinical institute withdrawal assessment for alcohol scale (CIWA-Ar).</p> <p>Sullivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. 1989</p>
<p>The Treatment of Alcohol Problems: a Review of the Evidence. 2003, Canberra: Australian Commonwealth Department of Health and Ageing</p>	<p>The Treatment of Alcohol Problems: a Review of the Evidence. 2003, Canberra: Australian Commonwealth Department of Health and Ageing</p> <p>Shand, F., et al.</p>
<p>Investigators have found a relationship between the number of previous alcohol withdrawals (AWs) and severity of withdrawal. We evaluated patients with multiple previous AWs, as compared to those with 0-1 previous withdrawals, in an outpatient detoxification trial comparing lorazepam (LZ) to carbamazepine (CBZ). A mixed model analysis of covariance was used to analyze Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) scores as a function of detoxification history (0-1 vs. 2 or more), drug group (CBZ vs. LZ), assessment day, and hours since last drink. The mixed model analysis of covariance (ANCOVA) indicated a significant detoxification history by assessment day interaction (<math>P &lt; 0.03</math>). Least square means associated with this interaction suggested that the CIWA-Ar</p>	<p>Malcolm R, Roberts JS, Wang W et al. Multiple previous detoxifications are associated with less responsive treatment and heavier drinking during an index outpatient detoxification. <i>Alcohol</i>. 2000; 22(3):159-164.</p>

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<p>scores for the multiple detox patients declined more slowly than those with 0-1 previous detoxifications. Patients with multiple detoxes were 150% more likely to experience a heavy drinking day during treatment (<math>P &lt; .03</math>). The multiple detox group drank more each drinking day (<math>P = .001</math>) and a greater proportion of this group had early heavy drinking (<math>P = .0002</math>). In the present study, intensity of AW symptoms and early heavy drinking were independent of treatment medications and were more common in patients who had previously undergone multiple treatments for AW.</p>	
<p>We report on a pilot double-blind study on the effectiveness of divided doses of chlordiazepoxide and a single daily dose of diazepam in the treatment of the alcohol-withdrawal syndrome. While a variety of drugs (chlormethiazole, propranolol and clonidine) have been used for treatment of alcohol-withdrawal symptoms, benzodiazepines remain the drugs of choice for alcohol detoxification (Mayo-Smith, 1997). Diazepam and chlordiazepoxide are both longer-acting benzodiazepines, and preferred for detoxification (Williams and McBride, 1998). Traditionally, chlordiazepoxide has been the benzodiazepine of choice due to its lower dependence and abuse potential, whereas diazepam has been used in patients with a history of alcohol-withdrawal seizures.</p>	<p>Jauhar P. Is daily single dosage of diazepam as effective as chlordiazepoxide in divided doses in alcohol withdrawal - A pilot study. <i>Alcohol &amp; Alcoholism</i>. 2000; 35(2):212-214.</p>
<p>Heavy drinkers who suddenly decrease their alcohol consumption or abstain completely may experience alcohol withdrawal (AW). Signs and symptoms of AW can include, among others, mild to moderate tremors, irritability, anxiety, or agitation. The most severe manifestations of withdrawal include delirium tremens, hallucinations, and seizures. These manifestations result from alcohol-induced imbalances in the brain chemistry that cause excessive neuronal activity if the alcohol is withheld. Management of AW includes thorough assessment of the severity of the patient's symptoms and of any complicating conditions as well as treatment of the withdrawal symptoms with pharmacological and nonpharmacological approaches. Treatment can occur in both inpatient and outpatient settings. Recognition and treatment of withdrawal can represent a first step in the patient's recovery process</p>	<p>Saitz, R 1998, Introduction to alcohol withdrawal. <i>Alcohol Health Res World</i> 22(1): 5-12.</p>
<p>Two dose regimens of diazepam, conventional dose and loading dose, were randomly given for the treatment of alcohol withdrawal state in 21 and 20 male subjects, respectively. Total dose of diazepam in conventional and loading dose groups were 200 mg and 67 <math>\pm</math> 9.3 mg, respectively. Clinical response was comparable in both the groups. None of the subjects developed diazepam related side effects.</p>	<p>Manikant S, Tripathi BM, Chavan BS. Loading dose diazepam therapy for alcohol withdrawal state. <i>Indian Journal of Medical Research</i>. 1993; 98:170-173.</p>
<p>A modified version of the Clinical Institute Withdrawal Assessment Scale (CIWA) was used in the management of alcohol withdrawal in a general hospital. Patients who developed seizures or confusion were noted to score higher on the scale, even before these complications, than patients who remained uncomplicated (<math>21.7 \pm 1.2</math> compared to <math>15.6 \pm 0.55</math>). When the score was used as a guide for treatment, it was found that patients scoring <math>&gt;15</math> were at significantly increased risk of severe alcohol withdrawal if they remained untreated (RR, 3.72; 95% confidence interval, 2.85-4.85). The higher the score the greater this relative risk. Some patients however, still suffered complicated withdrawals although their scores were low or they were apparently adequately treated. It is concluded that the use of an objective clinical scale of alcohol withdrawal is valuable in a general hospital to identify those patients in early withdrawal who need sedation to avoid complication. There will however, be a small group of patients whose clinical course will be difficult to</p>	<p>Foy A, March S, Drinkwater V. Use of an objective clinical scale in the assessment and management of alcohol withdrawal in a large general hospital. <i>Alcoholism: Clinical &amp; Experimental Research</i>. 1988; 12(3):360-364.</p>



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<p>predict and further work is needed to determine the reasons for this.</p>	
<p>We conducted an observational study of 539 episodes of alcohol withdrawal in a general hospital, to determine the natural history, the incidences of seizures, hallucinations and delirium, and the risk factors for these events. The reaction began soon after arrival, at a median time of 5 h, and resolved at a median time of 22 h. Patients with a blood alcohol level of zero were in withdrawal on arrival, and only four patients had reactions lasting 120 h or longer. Complications were observed in 113 patients (21%) during the admission. Seizures occurred on arrival, hallucinations usually in the first 24 h and delirium in the first 48 h. No mortality was associated with alcohol withdrawal itself, but complications did extend length of stay by a median of 4 days, with delirium contributing most to the increase. Patients over 70 years of age or admitted with seizures had an increased risk of complication, but the greatest risk was associated with a delay in assessment of &gt; 24 h. We conclude that in general hospitals, the alcohol withdrawal reaction becomes established very early, and detection and monitoring of patients within the first 24 h is the most important element in management.</p>	<p>Foy A, Kay J, Taylor A. The course of alcohol withdrawal in a general hospital. <i>QJM</i>. 1997; 90(4):253-261.</p>
<p>The measurement of alcohol withdrawal symptoms is important for the assessment of the alcohol withdrawal syndrome and for the evaluation of the effectiveness of withdrawal treatment interventions. There continues to be a need for an instrument for the measurement of alcohol withdrawal severity which is short, easy to understand (especially by respondents who may feel anxious, confused or physically ill) and easy to administer (for example, within clinical services with limited time and resources). This paper describes the development and psychometric properties of the 10-item Short Alcohol Withdrawal Scale. The SAWS includes five items which represent psychological symptoms (anxious, confused, restless, miserable, memory problems) which accounted for 47% of the variance. A further five items represent physical symptoms (tremor, nausea, heart pounding, sleep disturbance, sweating) and accounted for 11% of the variance. The procedures leading to the development of the scale are described and results are presented showing that the SAWS has high internal consistency, and good construct and concurrent validity.</p>	<p>Gossop, M, Keaney F, Stewart D et al. 2002, Short Alcohol Withdrawal Scale (SAWS) development and psychometric properties. <i>Addict Biol</i> 7(1): 37-43.</p>
<p>Approximately 11 to 15 million persons in the United States report current heavy use of alcohol or alcohol abuse and dependence, costing almost \$100 billion each year. Almost one half of these persons meet <i>Diagnostic and Statistical Manual of Mental Disorders</i> (DSM-IV) criteria for alcohol dependence, and almost 400,000 persons are in treatment for alcoholism at any one time. The lifetime prevalence of alcohol abuse is 14% and of alcohol dependence is 8%, and there are more than 1 million discharges with an alcohol-related diagnosis, mostly alcohol dependence, from U.S. short-stay hospitals each year. The prevalence of alcohol use disorders is high in the general population and is higher in general hospitals and in outpatient medical practices.</p> <p>Clearly, physicians are in frequent contact with persons with alcohol problems. Physicians have the opportunity to intervene in a variety of ways, including prevention, recognition of the diagnosis, brief intervention, appropriate referral, management of withdrawal, and relapse prevention. This article focuses on the pharmacologic management of alcohol withdrawal and dependence.</p>	<p>Saitz, R and SS O'Malley 1997, Pharmacotherapies for Alcohol Abuse: Withdrawal and Treatment. In: Samet. JH, Stein. MD and O'Connor. PG (eds) <i>The Medical Clinics of North America: Alcohol and Other Substance Abuse</i>. 81(4), pp 881-907, WB Saunders Company Pennsylvania</p>



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<p><b>Abstract</b></p> <p><b>OBJECTIVE:</b></p> <p>To determine if hospitalized medical and surgical patients were placed inappropriately on symptom-triggered therapy (STT) for alcohol withdrawal syndrome (AWS) and if certain conditions were more likely to be associated with inappropriate STT use or adverse events.</p> <p><b>PATIENTS AND METHODS:</b></p> <p>We randomly selected 124 (25%) of the 495 Mayo Clinic inpatients who received STT according to the Revised Clinical Institute for Withdrawal Assessment for Alcohol (CIWA-Ar) protocol in 2003 and assessed them for STT appropriateness, defined as having both intact verbal communication and recent alcohol use. Adverse events, including delirium tremens, seizures, or death, were correlated with CIWA-Ar appropriateness.</p> <p><b>RESULTS:</b></p> <p>Of the 124 randomly selected patients, only 60 (48%) met both inclusion criteria. Of the remaining 64 patients, 9 (14%) were drinkers but could not communicate, and 35 (55%) could communicate but had not been drinking. Twenty (31%) met neither criterion. Univariate analysis identified a significant association between inappropriate initiation and chronic heart failure, postoperative status (POS), liver disease (LD), nonmetastatic cancer, and chemical dependency consultation. On multivariate analysis, only LD (P equals .02) and POS (P equals .01) retained significance, with LD more and POS less likely to predict appropriateness. Seven of 11 patients who experienced adverse events had received STT according to the CIWA-Ar protocol (P equals .05). Univariate analysis identified a significant association between adverse events and a history of alcohol dependence or AWS. Multivariate analysis showed significance only for a history of alcohol dependence (P equals .049).</p> <p><b>CONCLUSION:</b></p> <p>Fewer than half of the randomly selected patients met both of the inclusion criteria for the CIWA-Ar instrument, leading us to conclude that more stringent evaluation is needed. Particularly postoperatively, alternative explanations for putative AWS should be sought. Health care professionals should more aggressively seek information on recent alcohol use from medical records, family members, and patients themselves</p>	<p>Hecksel KA et al (2008)</p> <p>Inappropriate use of symptom-triggered therapy for alcohol withdrawal in the general hospital. Mayo Clinic Proceedings; 83: 3, 274-279.</p>
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## Süsteematilised ülevaated

Alkoholi võõrutussündroomi hindamine on oluline diagnoosimaks sündroomi esinemist, selle tõsidust ning medikamentoosse ravi vajalikkust. Hindamiseks kasutatakse erinevaid meetodeid ning hetkel ühtne süsteem puudub. Williams et al poolt läbiviidud kirjandusülevaade näitas, et diagnoosimisel kasutatakse erinevaid näitajaid, millele antakse skoor (näiteks ärevus, iiveldus, hallutsinatsioonid jne). Enamasti kasutatakse näitajate grupeeringuid üldskoori andmiseks. Sellise hindamise puhul tuuakse peamiseks probleemiks hindamise kallutatust (kasutatakse näitajaid, millede puhul on teada seos AWS-iga ning olemas ravim). Kallutatuse vältimiseks on loodud diagnoosimise skaalad, mis ei hinda ainult sümptomi(te) esinemist, vaid ka tugevust. **TSA** (*Total Severity Assessment Scale*) on 30 küsimusest koosnev ning mõeldud teaduslikuks kasutamiseks, selle lühendatud versioon **SSA** koosneb 11 küsimusest ja on mõeldud kliiniliseks kasutamiseks. CIWA (*Clinical Institute Withdrawal Assessment*) loodi SSA põhjal ning on mõeldud kindlate intervallide järel kasutamiseks (mitu korda päevas). CIWA-Ar koosneb 15 küsimusest, ülevaadatud versioon CIWA-AD 8 küsimusest. Suurema riskiga patsientidele on loodud AWS (*Alcohol Withdrawal Scale*). Kasutatavate skaalde rohkuse tõttu ei leitud

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kirjandusülevaates uuringuid erinevate skaalade valiidsuste ja usaldusväärsuste võrdlemise kohta. CIWA valiidsust ja usaldusväärsust on hinnatud Shaw (1981) poolt.

## Viited

Kokkuvõtte (abstract või kokkuvõtlikum info)	Viide kirjandusallikale
<p>Background: Multi-item scales for monitoring alcohol withdrawal reactions have been used since the 1970s, and since 1985 we have used a modified version of the Clinical Institute Withdrawal Assessment (CIWA) in our general hospitals. This study was conducted to determine whether a shorter version of the scale would prove easier to use without loss of accuracy.</p> <p>Methods: A simultaneous 'crossover' clinical audit using two hospitals. The shortened scale was developed from the existing one, and had 10 items as opposed to the previous 18. The patients were followed throughout their course and the incidences of complication, the frequency of sedation, the delay in initiating monitoring and the ease of use were recorded.</p> <p>Results: There were 106 patients managed with the old scale and 96 with the new. The rate of complication was not different, being 16% in patients managed using the old scale and 14.5% using the new scale; the rates of sedation were 49 and 48%, respectively. Patients managed with the new scale had a shorter course with a median duration of 27.6 h compared with 40 h. The time from admission to first recording of a score was 5.4 h for the new scale and 4.8 h for the old, which is not a significant difference. Both scales were used according to instructions, but staff reported that the shortened scale was easier to use.</p> <p>Conclusions: We conclude that a shortened form of the CIWA alcohol withdrawal scale works as well as the original and is simple to use.</p>	<p>Clinical use of a shortened alcohol withdrawal scale in a general hospital A. Foy, S. McKay, S. Ling, M. Bertram and C. Sadler. 2006</p>
<p>This paper reviews the literature on the use of rating scales within the treatment of the alcohol-withdrawal syndrome. A computer-assisted literature search identified trials of therapy for and rating scales used in alcohol-withdrawal states. Eighteen rating scales were identified. There is a wide variation in symptom items included in these scales. Scales also vary in their length and ease of application. We conclude that it is important to use validated and reliable assessment scales in research if proper comparisons of treatments for the alcohol-withdrawal syndrome are to be made.</p>	<p>A Comparison of rating scales for the alcohol-withdrawal syndrome. Williams D., Lewis J, McBride A. 2001</p>