

The basic principles of detoxification are as described in section C4, page 25. In-patient detoxification should be a 'planned for' process wherever possible, in order to increase the chance of completion of detoxification and maintenance of abstinence following detoxification.

### IN-PATIENT ALCOHOL DETOXIFICATION

The rationale of using medication in patients with alcohol withdrawal is to provide relief of subjective symptoms, to prevent serious complications of withdrawal such as seizures and delirium tremens, and to achieve this with the minimal use of medication. Over-prescription of medication has potential hazards (such as the precipitation of an episode of hepatic encephalopathy or development of a new drug dependency), in particular because of the combination of use of long half-life drugs in patients with poor hepatic function. In addition, over-prescription of medication unnecessarily extends the duration of detoxification decreasing the cost-effectiveness of the process, blocking hospital bed-space, and causing inconvenience to the patient.

Fixed dosing schedules are commonly prescribed for alcohol withdrawal, but run the risk of both over and under medicating the patient. **'Symptom-triggered'** prescribing is now recommended as the dosing schedule of choice in in-patient alcohol detoxification (Mayo-Smith M, 1997). This involves the use of a standardised alcohol withdrawal scale to direct the administration of medication and has been clearly demonstrated to minimise over and under-medication of the patient (Sullivan J et al, 1997 & Saitz R et al, 1994). The most widely used scale for this purpose is the Clinical Institute Withdrawal Assessment for Alcohol Revised (CIWA-Ar [appendix 10, page 130]). The results of trials of symptom-triggered prescribing are impressive with four-fold differences in dosage and duration of stay described (Sullivan J et al, 1997 & Saitz R et al, 1994).

Before instituting symptom-triggered regimes it is imperative that ward medical and nursing staff are trained in the use of the scale and the associated monitoring protocol. Adherence to the protocol must be tightly managed in order to avoid the occurrence of unnecessary and potentially life-threatening complications of alcohol withdrawal.

Example protocols and scales are to be found in appendix 10, page 130.

- In-patient alcohol detoxification should routinely make use of symptom-triggered regimes which minimise the use of medication and the duration of hospitalisation. It is imperative that ward medical and nursing staff are trained in the use of the associated protocols in order to avoid the occurrence of unnecessary and potentially life-threatening complications of alcohol withdrawal.
- In-patient opiate detoxification should routinely use lofexidine as the agent of choice. Rapid opiate-antagonist assisted detoxification remains an experimental technique.
- In-patient sedative-hypnotic detoxification can be effectively shortened by the use of phenobarbital as the agent of choice.

### IN-PATIENT OPIATE DETOXIFICATION

The use of opiate-antagonists to reduce the duration and enhance the outcome of detoxification is a developing but contentious area of practice. Details are to be found in Section E7, page 79. Such methods should currently only be employed in a research context or in other exceptional circumstances (Gowing L et al, 2001). Current best practice will involve the use of lofexidine and adjunctive medication as described above in section C4, page 25. An example in-patient opiate detoxification protocol and the associated scales are to be found in appendix 10, page 130.

### IN-PATIENT SEDATIVE-HYPNOTIC DETOXIFICATION

Withdrawal from benzodiazepines or barbiturate drugs in dependent persons, is usually best managed by a slow tapering in the community. However in some cases, (for example polydrug misusers undergoing detoxification before admission to drug-free residential rehabilitation, patients who have repeatedly failed to complete an out-patient reduction regime) in-patient detoxification may be indicated. The main practical difficulty here is the duration of admission required which is usually longer than with an alcohol or opiate detoxification. For this reason, substitution and detoxification using phenobarbital may be the treatment of choice for in-patient sedative-hypnotic detoxification. Phenobarbital has been demonstrated to adequately suppress withdrawal symptoms and to shorten hospitalisation (Ravi N et al, 1990; Smith D & Landry M, 1990).