**Case Study: Mark**

You are the intake clinician at a large acute inpatient psychiatric facility, which includes a sizable detoxification unit. It is an unusually busy day and the lobby is full of patients seeking treatment. Half an hour before lunch, you pick up another clipboard from the *“pending*” rack and quickly scan the intake information filled in by the prospective patient and receptionist. Mark is a 45-year-old male who has been waiting since 8:15 AM. He is requesting alcohol detox. You notice that Mark has been waiting for over three hours and you are frustrated because you will have to begin yet another interview with an apology for the long wait. You notice that the blood pressure assessed by the receptionist is somewhat elevated you make a mental note to inform the nurse: BP = 149/97, pulse 104, respiration rate 18. You invite Mark into one of the free interview rooms and you notice that he appears much older than his 45 years. He’s dressed casually and is a bit disheveled; his skin looks old/tanned and flushed; in his right hand, he holds an emesis bag. He apologizes and he states that he has been having dry heaves since yesterday evening but he tells you that he is able to keep down some fluids.

You observe that Mark does not look too good and since he’s been waiting in your lobby for three hours, you think it’s a good idea to assess another set of vitals. The receptionist obliges and reports the new vital signs as BP = 154/103, pulse 114, respiration rate 20, oxygen saturation 98% at room air. You become a little concerned by the increase in blood pressure and pulse and you note that while previously Mark’s shirt was dry, he now has sweat stains on his back and chest; visible sweat beads are also noticeable on his forehead and neck. You noticed that Mark speaks softly now when the door to the interview room is closed to cut down on the noise from the hallway. He asks you if you can turn off the bright ceiling lights and to keep on only the lamp on your desk. You oblige. Mark tells you that he started drinking at the age of 16 simply because it was popular and the fun thing to do on the weekends in high school. His social drinking increased somewhat in his 20s but it became problematic in his early 30s.

Mark works as a plumber, and along with his older brother, he owned his own plumbing business. Somewhat embarrassed, he tells you that for the past 15 years, he has been more drunk than sober. His longest period of sobriety was seven years ago, after a detox and rehab program he managed to stay clean for nine months. Slowly he relapsed into drinking, believing that he is one of the few who can only drink socially. For the past 15 years, he has had several DUIs. Several times, his wife of 20 years threatened divorce; now they have come to a truce of sorts, but he describes a disengage relationship. His brother continues to be very loyal to him, but Mark tells you that this is both a blessing and a curse. On one hand, his brother has “covered” for him when his drinking and the hangovers made him an unreliable worker. On the other hand, he regrets the fact that had his brother been stricter with him he may have sought serious help a long time ago. Mark tried to quit drinking several times on his own. He reports that on one such occasion when he went “cold turkey” after a religious conversion of sorts, he experienced a grand mal seizure and had to be taken to the emergency room. The ER doctor strongly advised him to never stop drinking abruptly or you have another seizure. The past two years, Mark has been averaging a six-pack of beer and a pint of vodka every day. This is enough to lead to intoxication. He starts with the beers in the morning and after work, he switches to the vodka. On the weekends, he can drink up to a gallon of vodka per day. Those binges lead to blackouts because he often cannot remember most of his Sundays. He often goes out with his brother to a local casino where he gambles $500 to $1000 each weekend. His wife stopped nagging him about it when he insisted that he works hard for his earned money and that he always pays the bills first. Mark has decided to stop drinking because during a routine doctor’s visit, his liver enzymes were significantly elevated. His primary care physician warned him seriously about liver cirrhosis. On several occasions during the interview, Mark quickly turns away from you and leans into his emesis bag heaving heavily. He apologizes. You offer him a bottle of water and he takes small sips occasionally. You ask Mark to stand up and to stretch out his arms: you notice visible tremors in both his arms and his shoulders. He reports a headache of 5 out of 10 (subjective units of distress) and he tells you that normally a few Advils help. His last full drink was yesterday morning before going to his doctor’s office and he had only a sip of beer at lunch. You calculate that by now he has been without any alcohol for approximately 24 hours. He reports mild anxiety, but you observe him to fidget during the interview. You complete the CIWA scale (attached) and you observed that with a score of 25 he is in severe alcohol withdrawals. You notify the nurse immediately, urging her to come and have a look at Mark and to call the doctor for admitting orders.

**CIWA scale for Mark**

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| **Assessment Protocol**  a. Vitals, Assessment Now.  b. If initial score ≥ 8 repeat q1h x 8 hrs, then  if stable q2h x 8 hrs, then if stable q4h.  c. If initial score < 8, assess q4h x 72 hrs.  If score < 8 for 72 hrs, d/c assessment.  If score ≥ 8 at any time, go to (b) above.  d. If indicated, (see indications below)  administer prn medications as ordered and  record on MAR and below. | | **Date** | **Today’s date** |  |  |  |  |  |  |  |  |  |
| **Time** | **11:30am** |  |  |  |  |  |  |  |  |  |
| **Pulse** | **114** |  |  |  |  |  |  |  |  |  |
| **RR** | **20** |  |  |  |  |  |  |  |  |  |
| **O2 sat** | **98%** |  |  |  |  |  |  |  |  |  |
| **BP** | **154/103** |  |  |  |  |  |  |  |  |  |
| **Nausea/vomiting** (0 - 7)  0 - none; 1 - mild nausea ,no vomiting; 4 - intermittent nausea;  7 - constant nausea , frequent dry heaves & vomiting. | | | **7** |  |  |  |  |  |  |  |  |  |
| **Tremors**  (0 - 7)  0 - no tremor; 1 - not visible but can be felt; 4 - moderate w/ arms extended; 7 - severe, even w/ arms not extended. | | | **4** |  |  |  |  |  |  |  |  |  |
| **Anxiety** (0 - 7)  0 - none, at ease; 1 - mildly anxious; 4 - moderately anxious or guarded; 7 - equivalent to acute panic state | | | **1** |  |  |  |  |  |  |  |  |  |
| **Agitation** (0 - 7)  0 - normal activity; 1 - somewhat normal activity; 4 - moderately fidgety/restless; 7 - paces or constantly thrashes about | | | **4** |  |  |  |  |  |  |  |  |  |
| **Paroxysmal Sweats** (0 - 7)  0 - no sweats; 1 - barely perceptible sweating, palms moist;  4 - beads of sweat obvious on forehead; 7 - drenching sweat | | | **4** |  |  |  |  |  |  |  |  |  |
| **Orientation**  (0 - 4)  0 - oriented; 1 - uncertain about date; 2 - disoriented to date by no more than 2 days; 3 - disoriented to date by > 2 days;  4 - disoriented to place and / or person | | | **0** |  |  |  |  |  |  |  |  |  |
| **Tactile Disturbances** (0 - 7)  0 - none; 1 - very mild itch, P&N, ,numbness; 2-mild itch, P&N, burning, numbness; 3 - moderate itch, P&N, burning ,numbness; 4 - moderate hallucinations; 5 - severe hallucinations;  6 – extremely severe hallucinations; 7 - continuous hallucinations | | | **0** |  |  |  |  |  |  |  |  |  |
| **Auditory Disturbances** (0 - 7)  0 - not present; 1 - very mild harshness/ ability to startle; 2 - mild harshness, ability to startle; 3 - moderate harshness, ability to startle; 4 - moderate hallucinations; 5 severe hallucinations;  6 - extremely severe hallucinations; 7 - continuous.hallucinations | | | **1** |  |  |  |  |  |  |  |  |  |
| **Visual Disturbances** (0 - 7)  0 - not present; 1 - very mild sensitivity; 2 - mild sensitivity; 3 - moderate sensitivity; 4 - moderate hallucinations; 5 - severe hallucinations; 6 - extremely severe hallucinations; 7 - continuous hallucinations | | | **1** |  |  |  |  |  |  |  |  |  |
| **Headache** (0 - 7)  0 - not present; 1 - very mild; 2 - mild; 3 - moderate; 4 - moderately severe; 5 - severe; 6 - very severe; 7 - extremely severe | | | **3** |  |  |  |  |  |  |  |  |  |
| Total CIWA-Ar score: | | | **25** |  |  |  |  |  |  |  |  |  |
| PRN Med: (circle one)  Diazepam Lorazepam | **Dose given (mg):** | |  |  |  |  |  |  |  |  |  |  |
| **Route:** | |  |  |  |  |  |  |  |  |  |  |
| **Time** of PRN medication administration: | | |  |  |  |  |  |  |  |  |  |  |
| Assessment of response (CIWA-Ar score 30-60 minutes after medication administered) | | |  |  |  |  |  |  |  |  |  |  |
| RN Initials | | |  |  |  |  |  |  |  |  |  |  |

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| **Scale for Scoring:**  Total Score =  0 – 9: absent or minimal withdrawal  10 – 19: mild to moderate withdrawal  **more than 20: severe withdrawal** | **Indications for PRN medication:**  a. Total CIWA-AR score 8 or higher if ordered PRN only (Symptom-triggered method).  b. Total CIWA-Ar score 15 or higher if on Scheduled medication. (Scheduled + prn method)  Consider transfer to ICU for any of the following: Total score above 35, q1h assess. x more than 8hrs required, more than 4 mg/hr lorazepam x 3hr **or** 20 mg/hr diazepam x 3hr required, or resp. distress. |