Patients with certain co-morbidities, such as use of high-dose opioids for chronic pain, or severe liver or respiratory disease, are at higher risk for benzodiazepine-related complications such as aspiration pneumonia, encephalopathy, and opioid overdose.

Research also recommends the use of thiamine, magnesium, multivitamins, and supportive care if indicated (Mayo-Smith, 1997; Kraemer et al., 1999; Lingford-Hughes et al., 2004; Naegle, 2012; DiBartolo & Jarosinski, 2017).

RECOMMENDATION #17:

As a harm reduction strategy for older adults in controlled environments, where medical withdrawal is not available or deemed appropriate, it is recommended that a managed alcohol taper be considered. Individualize the taper by 1 standard drink every 3 days (aggressive tapering), weekly (moderate tapering), or every 2–3 weeks (mild tapering) with CIWA-Ar monitoring to keep the withdrawal symptom score < 10. The approach should be individualized, incremental, and with an indeterminate timeline. [Consensus]

If a medical withdrawal program is not available or is deemed inappropriate, a transition from home to a controlled living environment presents an opportunity for a more gradual, individualized taper through a controlled reduction in alcohol intake to avoid precipitous withdrawal. A clinical consensus recommends the trial of an alcohol taper with the use of CIWA-Ar to monitor withdrawal symptoms and maintain a low, single-digit score.

A baseline of daily alcohol consumption, in standard drinks, that avoids both acute intoxication and withdrawal symptoms is required. Alcohol should be provided in a measured amount, spread out over the day. The alcohol taper may range from more aggressive at 1 standard drink every 3 days, to a more moderate taper at 1 standard drink per week, or mild tapering at one standard drink every 2–3 weeks, as tolerated. Tolerance of the taper is determined by individual neuroadaptation to the reduced alcohol and is difficult to predict. It therefore requires a slow, individualized approach.

The end point may vary with the care facility's willingness to provide any alcohol on an ongoing basis to its residents, balanced with the risk of harm due to concurrent medication use or co-occurring health conditions. A discussion with the client or their proxy, exploring potential risks and benefits, is required for informed consent.

This recommendation requires further research on indications, environment, and tapering protocols. No evidence could be found to support this recommendation beyond unpublished clinical reports. Wernicke's encephalopathy use stable alcohol dosing as a harm reduction approach to engage, house, and care for people with a severe, chronic AUD. This may or may not involve a taper over time (Podymow et al., 2006; Pauly et al., 2018)

RECOMMENDATION #18:

To prevent the development of Wernicke's encephalopathy during withdrawal, at least 200 mg of parenteral thiamine (IM or IV) should be administered daily for 3–5 days. [GRADE: Evidence: Low; Strength: Strong]

Wernicke-Korsakoff syndrome (WKS) is a brain disorder caused by thiamine or vitamin B1 deficiency. It is characterized by the onset of ophthalmoplegia, ataxia, and confusion. Patients can go on to develop permanent memory impairment and WKS can result in fatality. Excessive alcohol use in combination with dietary thiamine deficiency or reduced absorption are the primary causes of WKS. Thiamine supplementation as treatment for WKS is well supported (Phillips et al., 1952; Victor & Collin, 1989; Wood & Currie, 1995; Cook et al., 1998; National Clinical Guideline Centre for Acute and Chronic Conditions (NCGCACC), 2017).

Recommendations about dosage and duration of thiamine treatment are extrapolations from basic science and clinical reports (Thomson & Marshall, 2006; Lingford-Hughes et al., 2012; NCGCACC, 2017), however a recent systematic review determined that there is insufficient evidence for recommendations of the dose, frequency, route, and duration of thiamine treatment (Day et al., 2013). One randomized controlled trial found significant improvement with doses of 200 mg intramuscularly daily compared to a lower dose (Ambrose et al., 2001). Due to decreased absorption of thiamine in patients with AUD, parenteral administration is recommended (Cook et al., 1998). This is an area that requires further study.