Alcohol Withdrawal Assessment Scale (AASS)

Blood Pressure (Systolic)	Heart Rate	Temperature	Hallucinations
0= SBP < 139 mm Hg	0= HR < 89 bpm	0= T < 99.9 °F	0= None
1= SBP 140-149 mm Hg	1= HR 90-99 bpm	1= T 100-100.9 °F	1= Tactile only, visual only, auditory only; not agitated by them
2= SBP 150-159 mm Hg	2= HR 100-109 bpm	2= T 101-101.9 °F	2= Two types, not related (e.g. what is seen is not heard)
3= SBP >160 mm Hg	3= HR >110 bpm	3= T > 102 °F	3= Two types that are related (e.g. what is seen is also heard)

Diaphoresis	Nausea/Vomiting	Confusion, Delirium	Agitation, Restlessness
0= Absent	0= No nausea or vomiting	0= Absent, Oriented x 3	0= At ease
1= Barely visible	1= Nausea without vomiting	1= Oriented x 2	1= Anxious
2= Beads of sweat obvious	2= Vomiting □ once every 8 hrs.	2= Oriented x 1	2= Irritable, fidgety
3= Clothes or bedding drenched	3= Freq. vomiting or "dry heaves"	3= Oriented x 0	3= Thrashing, pacing

Delusions	Insomnia, Nightmares	Tremor	Seizure
0= None	0= Absent	0= Absent	0= Absent
1= Idea of reference (maintains some insight)	1= Difficulty settling, up frequently	1= Not visible, but can be felt	
2= Delusion, no resulting action	2= Awake half the night	2= Visible with arm extended	
3= Delusion, resulting in action	3= Completely sleepless	3= Visible even when arm not extended	3= Present

Pearls

1. Check vitals signs and arousability (RASS Assessment) q 4 hours.
2. Other causes for delirium and agitation must always be considered such as hypoxia or sepsis.
3. If need to give lorazepam, start with least dose and adjust upward for breakthrough withdrawal or decrease for over sedation.
4. Patients who require aggressive treatment of agitation and anxiety may be best treated in areas where extensive monitoring is available. As a general guideline, if patient scores > 8 x 2, consider transferring to ICU or TCU.
5. If seizure occurs, evaluate patient for transfer to TCU or ICU.
6. Patients who are being treated for alcohol withdrawal should not receive a neuroleptic (i.e. Haldol) for agitation unless they have first been aggressively treated with benzodiazepines.
7. Consider use of haloperidol in addition to lorazepam in patients experiencing hallucinations. Doses > 5mg or (20 mg/day) require cardiac monitoring of QT interval.
8. IV administration of Ativan may be necessary in certain patients and these patients must be monitored q 1 hour for respiratory depression, especially when receiving high individual doses.
9. Patients who are belligerent when inebriated may exhibit excitation from benzodiazepines; consider the additional use of haloperidol, beta-blockers or clonidine for these patients.
10. Magnesium sulfate 1-2 Grams IV has been shown to diminish the severity of withdrawal symptoms and decrease need for benzodiazepines.
11. Librium is not recommended for routine use due to its long half-life.
12. Patients in alcohol withdrawal are prone to hypoglycemia.
13. IV solutions of D5W should be started after first dose of thiamine to prevent precipitating Wernicke's encephalopathy.

Richmond Agitation Sedation Scale (RASS) *

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* **(≥10 seconds)**	Verbal Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* **(<10 seconds)**	Verbal Stimulation
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**	Verbal Stimulation
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice or physical* stimulation	Physical Stimulation

Procedure for RASS Assessment

1. Observe patient
   a. Patient is alert, restless, or agitated. **(score 0 to +4)**
2. If not alert, state patient's name and *say* to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. **(score –1)**
   c. Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   d. Patient has any movement in response to voice but no eye contact. **(score –3)**
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.
   e. Patient has any movement to physical stimulation. **(score –4)**
   f. Patient has no response to any stimulation. **(score –5)**

* Sessler CN, Gosnell M, Grap MJ, Brophy GT, O'Neal PV, Keane KA et al. The Richmond Agitation-Sedation Scale: validity and reliability in adult intensive care patients. Am J Respir Crit Care Med 2002; 166:1338-1344.

* Ely EW, Truman B, Shintani A, Thomason JWW, Wheeler AP, Gordon S et al. Monitoring sedation status over time in ICU patients: the reliability and validity of the Richmond Agitation Sedation Scale (RASS). JAMA 2003; 289:2983-2991.