

**MINDS Alcohol Withdrawal Scale**  
(0-46 points)

Table 1. Minnesota Detoxification Scale

Symptom	Score
Pulse (beats/min)	
< 90	0
90–110	1
> 110	2
Diastolic blood pressure (mm Hg)	
< 90	0
90–110	1
> 110	2
Tremor	
Absent	0
Visible	2
Moderate	4
Severe	6
Sweat	
Absent	0
Barely; moist palms	2
Beads visible	4
Drenching	6
Hallucinations	
Absent	0
Mild	1
Moderate, intermittent	2
Severe, continuous	3
Agitation	
Normal activity	0
Somewhat > normal	3
Moderately fidgety, restless	6
Pacing, thrashing	9
Orientation	
Oriented x 3 (person, place, time)	0
Oriented x 2 (person, place)	2
Oriented x 1 (person)	4
Total disorientation	6
Intubated	0
Delusions	
Absent	0
Present	6
Seizures	
Absent	0
Present	6

## MINDS Alcohol Withdrawal Protocol – Benzodiazepine Dosing

\*\*Hold benzodiazepines for sedation or RASS less than -2\*\*

### Mild <15

- **Check MINDS q2h**
- No midazolam infusion: lorazepam 1mg IV q1h PRN
- On midazolam infusion: decrease rate by 5mg/hr q2h as long as MINDS remains <15

### Moderate 15-19

- **Check MINDS q1h**
- No midazolam infusion: lorazepam 2mg IV q1h PRN
- On midazolam infusion: continue current rate

### Severe >19

- **Check MINDS q20min**
- No midazolam infusion and
  - <3 boluses given in 1 hour: lorazepam 4mg IV q20min PRN
  - ≥3 boluses given in 1 hour: lorazepam 4mg IV and start midazolam infusion at 5mg/hr
- On midazolam infusion: give lorazepam 4mg IV q20min PRN and increase midazolam infusion by 5mg/hr if ≥3 boluses given in 1 hour (can titrate rate q1h if needed)

## PEARLS

1. The CIWA-Ar is a validated scoring tool for alcohol withdrawal. It should be used for non-ICU patients and ICU patients who can respond to questions.
2. For patients in the ICU who are in severe withdrawal and cannot respond to questions, the MINDS protocol should be used. The MINDS protocol is an alcohol withdrawal scoring tool which has been studied in the ICU setting.
3. Check vitals signs and arousability (RASS score) q 4 hours or based on protocol.
4. Other causes for delirium and agitation must always be considered (i.e. hypoxia or sepsis).
5. Patients who require aggressive treatment of agitation and anxiety may be best treated in areas where extensive monitoring is available.
6. If seizure occurs, evaluate patient for transfer to TCU or ICU.
7. Patients who are being treated for alcohol withdrawal should not receive a neuroleptic (i.e. haloperidol) or dexmedetomidine for agitation unless they have first been aggressively treated with benzodiazepines.
8. May consider use of haloperidol in addition to lorazepam in patients experiencing hallucinations. Doses > 5mg or (20 mg/day) require cardiac monitoring of QT interval.
9. IV administration of lorazepam may be necessary in certain patients and these patients must be monitored q 1 hour for respiratory depression, especially when receiving high individual doses.
10. Patients who are belligerent when inebriated may exhibit excitation from benzodiazepines; may consider the additional use of haloperidol, beta-blockers, or clonidine for these patients.
11. Chlordiazepoxide should generally be avoided in patients with significant liver disease, renal disease, or the elderly.
12. Thiamine should be given prior to the administration of any dextrose-containing IV solutions to prevent Wernicke's encephalopathy.