EMERGENCY CARE BC
Provincial Health Services Authority

Navigating Alcohol Use Disorders in the ED

Panelists: Isabelle Miles, Brighid Cassidy, Aron Zuidhof

Moderator: Julian Marsden

St. Paul's Emergency Medicine Update
Whistler, Sept 20, 2025

4x alcohol related ED visits
vs
opioids and cannabis combined

[DAWN 2023 estimates]

2-4x increase in alcohol-related visits
vs
overall ED visits
in last 10 years

Alcohol related hospital admissions
>
CAD related admissions

[CIHI]

Individuals with AUD and frequent care visits =
1:10 mortality within 1 year of index visit

[36997435]

Navigating Alcohol Use Disorders in the ED

In the Top 10 of preventable cause of death:
2.6M annually

[WHO, 36997435, 36997435, 30146330, 38539681, 40115759]

Risk factor for 200+ diseases

[WHO, 36997435, 36997435, 30146330, 38539681, 40115759]

Estimated prevalence of AUD:
up to 1 in 10!

[DAWN, WHO]

St. ate

Disclaimer

EMERGENCY CARE BC
Provincial Health Services Authority

In alignment with PHSA fiscal responsibilities regarding travel,
no PHSA funding was used to support
Emergency Care BC participation at this conference.

Emergency Care BC looks forward to
increased in-person presence at future events.

Notice of Recording

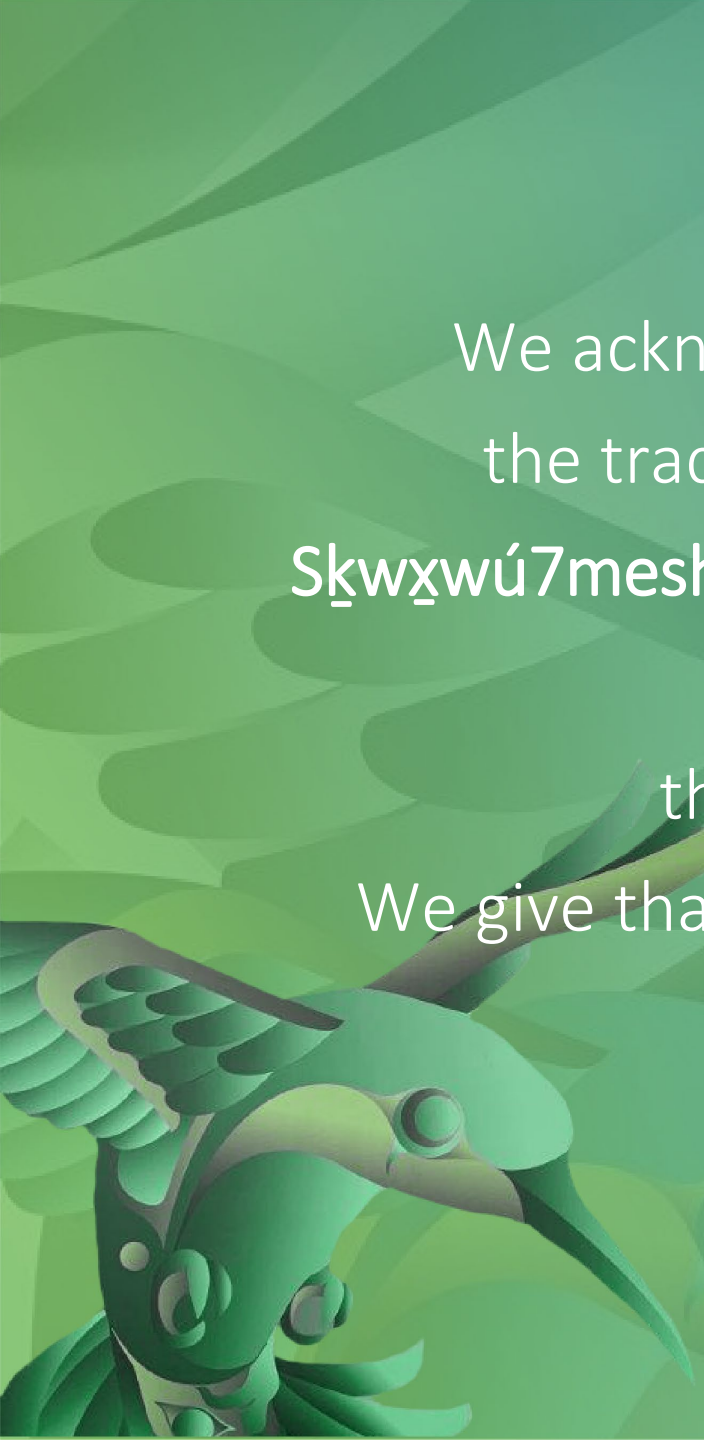
EMERGENCY CARE BC
Provincial Health Services Authority

This session is being recorded
to explore AI's role in increasing
the efficiency of knowledge translation.

Click the QR to access session tools and resources.

Watch for a summary of this session supported by AI coming soon.

We acknowledge with gratitude, that we are gathered on
the traditional, ancestral and unceded territories of the
Sḵwx̱wú7mesh Úxwumixw (Squamish), and Lilwat7úl (Lil'wat) Nations
who have nurtured and cared for
the lands and waters around us for all time.
We give thanks for the opportunity to live, work and learn here.



EMERGENCY CARE BC
Provincial Health Services Authority

Panelist Introductions

EMERGENCY CARE BC
Provincial Health Services Authority

Brighid Cassidy - No conflict of interest

Isabelle Miles - Honorarium from SAEM for GRACE-4

Aron Zuidhof - No conflict of interest

Julian Marsden - No conflict of interest

Learning Objectives

EMERGENCY CARE BC
Provincial Health Services Authority

Discuss a case-based approach to the management of AUD in the ED including alcohol withdrawal management

EMERGENCY CARE BC
Provincial Health Services Authority

Case #1

“Feels Like My Rectum is Falling Out”

EMERGENCY CARE BC
Provincial Health Services Authority

Triage: 42 M, tile layer, presenting with severe rectal pain. Worried about kidney failure because of his swollen legs.

- **VS:** HR 121, BP 145/86, Temp 36.8, 97% RA, RR 20
- **CTAS 2** for severe pain and vitals, nurse-initiated labs

"Coping with Alcohol"

EMERGENCY CARE BC
Provincial Health Services Authority

History

- 24hr onset of severe rectal pain and a mass coming from his ass, intermittent BRBPR
- Managing pain with alcohol
- Notice mild swelling of his ankles last few days, ROS otherwise neg

Substance Use History

- Heavy binge alcohol use, 3-4 days a week
- Consumes about 26oz vodka and 12-14 beers a week
- No hx of severe withdrawal or seizures

Physical Exam

- Looks uncomfortable, VS (Triage)
- Chest/Abdo exam normal
- Rectal exam – 2 large thrombosed external hemorrhoids
- Mild pedal edema

PMhx: Transient kidney injury, GERD

Meds: No meds

How do you approach a conversation about alcohol use in the ED?

Medications for AUD (MAUD)

EMERGENCY CARE BC
Provincial Health Services Authority

Management

- Analgesics – Hydromorphone 2 mg SC
- Procedure – Hemorrhoids lanced under local anesthetic and clot evacuated

Investigations

- Slightly elevated lipase, normal renal and liver function

Impression/Assessment

- Thrombosed external hemorrhoids
- Meets DSM 5 criteria for Alcohol Use Disorder
- Does not feel he needs withdrawal support, but interested in trying a medication to help reduce his heavy drinking

Does everyone with AUD need MAUD?

Are labs required?

How do you decide which MAUD to prescribe?

What are some of the barriers to MAUD and or counselling? Time, access, resources?

Management and Discharge Plan

EMERGENCY CARE BC
Provincial Health Services Authority

Hemorrhoid Management

- Analgesia, sitz baths, stool softeners, avoid straining

AUD Management

- Initiate outpatient pharmacotherapy with naltrexone
- Follow-up with counselling:

❑ 811

❑ 1-800-663-1441
(Alcohol and Drug Information Referral Services)

❑Virtual Addiction Medicine Clinic in IH

Care for AUD is more than medications

How do you support patients with AUD on discharge? ...in the midst of a busy shift!

EMERGENCY CARE BC
Provincial Health Services Authority

Case #2

EMERGENCY CARE BC
Provincial Health Services Authority

You are working an evening shift over the weekend.

Triage: 37 M worried about alcohol withdrawal, prior history of seizures

- VS: HR 115, BP 143/81, Temp 36.1 98% on R/A, RR 16

What are key features on history and physical exam to identify alcohol withdrawal and guide management?

History

- Pattern of use
  - Binge pattern (2-3 days/week) → daily x 8 months after stressor in family
  - 26 oz of vodka daily - wakes up in AM with 1 shot for anxiety
- Last use: 10 hours ago
- Previous cessation attempt: tried stopping for ½ day last week, but became to nauseated, anxious and tremors “all over”
- Other history
  - PMhx: ?anxiety
  - Meds: none
  - Other substances: weekly cannabis use

EMERGENCY CARE BC
Provincial Health Services Authority

Physical Exam

- VS: HR 115, BP 143/81, Temp 36.1 98% on R/A, RR 16
- H+N: pupil size normal for ambient light, mild sheen to forehead, mild tongue tremor
- CVS/Resp: WNL
- Abdo: RUQ/epigastric tenderness. No peritonitis. No murphy.
- Ext: mild tremor to extremities. No diaphoresis. No piloerection

Investigations (nurse initiated)

- Etoh <2,
- GGT 100, ALP 160, AST 51, ALT 25, Tbili 3, INR 1

EMERGENCY CARE BC
Provincial Health Services Authority

Seizure History

Unwitnessed after 12 hours without alcohol, they were feeling shakes and sweats, then woke up with tongue laceration and incontinent of urine (2 months ago)

How would you manage this case?

(1) Monitoring and location in department
(2) Medications

8 Hours Later…

EMERGENCY CARE BC
Provincial Health Services Authority

- You are called to bedside for CIWA 27 and nurse is worried about severe withdrawal.
  - Total: 8mg lorazepam/40mg diazepam
  - Last dose: 30 minutes (IV)

What are your next steps?

Upon Reassessment

EMERGENCY CARE BC
Provincial Health Services Authority

- Headache, lights bother him.
- Epigastric discomfort with nausea.
- Some intermittent itching of the skin.
- Very worried about developing withdrawal and requesting more medications.
- Agitation settles with distraction

Physical Exam

- VS: HR 100, BP 140/90. Otherwise VSS.
- H+N: mild sheen to forehead. No tongue tremor. Pupils normal to large for ambient light.
- Ext: tremors to hands only, settles with distraction
    - No diaphoresis, including palms. No piloerection.

CIWA Score	RN Score
Nausea/vomiting	4
Tremor	3
Diaphoresis	3
Anxiety	5
Agitation	5
Auditory Disturbances	0
Visual disturbances	3
Tactile disturbances	3
Headache	4
Orientation	0

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.
0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning ornumbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 no present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Objective symptoms improved, but subjective persistent despite medications

Case Summary

- Hx: daily 26 oz vodka x 3-4 months, am consumption for anxiety
  Unmanageable symptoms with cessation x few hours
  - "Sz hx": possible seizure
- HR 90-115, BP 140-143/81-90
  - Total benzo: 10mg lorazepam/50mg diazepam
  - Peak CIWA 27, last CIWA 10
- Social hx: lives alone, no supports

What is your disposition?

(A) Bonus Case : Patient Returns

- You're working an overnight shift
- They've achieved prolonged abstinence up until 3 months ago, relapsed due to stressful event
- Since then – several visits to the ED for withdrawal management
  - Today – 6th visit, worried about going into withdrawal and wants to stop
- LD: 2 hours prior
- Etoh level 85

How do you approach withdrawal management in this case?
What is the risk of repeated withdrawal episodes?

EMERGENCY CARE BC
Provincial Health Services Authority

(B) Bonus Case

EMERGENCY CARE BC
Provincial Health Services Authority

You are working in a rural emergency department.

37 YO pending transfer to ward for alcohol withdrawal.

Called to bedside due to new onset confusion and tachycardia.

What is your differential?

What is your approach?

(B) Bonus Case

EMERGENCY CARE BC
Provincial Health Services Authority

1. On assessment: confused but redirect-able, several doses of benzos for subjective symptoms
    - Physical exam: HR 100-110, Pupils normal to large for ambient light, intermittent tremor to hands
2. On assessment: progressive diaphoresis, agitation, and tremors to all four extremities despite several doses of benzos. Pulling at IVs.
    - Physical exam: HR 120, pupils normal for ambient light. Diffuse diaphoresis, tremors at rest to ext and tongue tremor. Severe agitation.

Take Home Points

EMERGENCY CARE BC
Provincial Health Services Authority

Case #1: Medication for AUD

- People with AUD are likely to seek care in an ED for non-alcohol related concerns
- We can make a difference with evidence-based MAUD
- Simply ask permission to open the conversation
- Consider the Importance of trauma-informed care in your interactions and clear pathways for transition of care
- Consider barriers and identify possible solutions in your practice settings

Case #2: Complicated Withdrawal

- Alcohol withdrawal literature is mostly low-level evidence → significant variability in practice
- Always treat the patient in front of you! Not the numbers – recognize the nuances of withdrawal scales
- Consider benefits and harms of each medication individually to each patient and clinical setting
- Disposition is based on both assessment of risk of complicated withdrawal and risk of complication in withdrawal, guided by risk tolerance and local resources
- Repeated episodes of alcohol withdrawal can lead to harm

EMERGENCY CARE BC
Provincial Health Services Authority

Interested in more learning and engagement for AUD in the ED?

Click the QR to access session tools and resources.

For AUD in ED follow up tools, sessions and more:

ECBC@PHSA.ca

Thank you