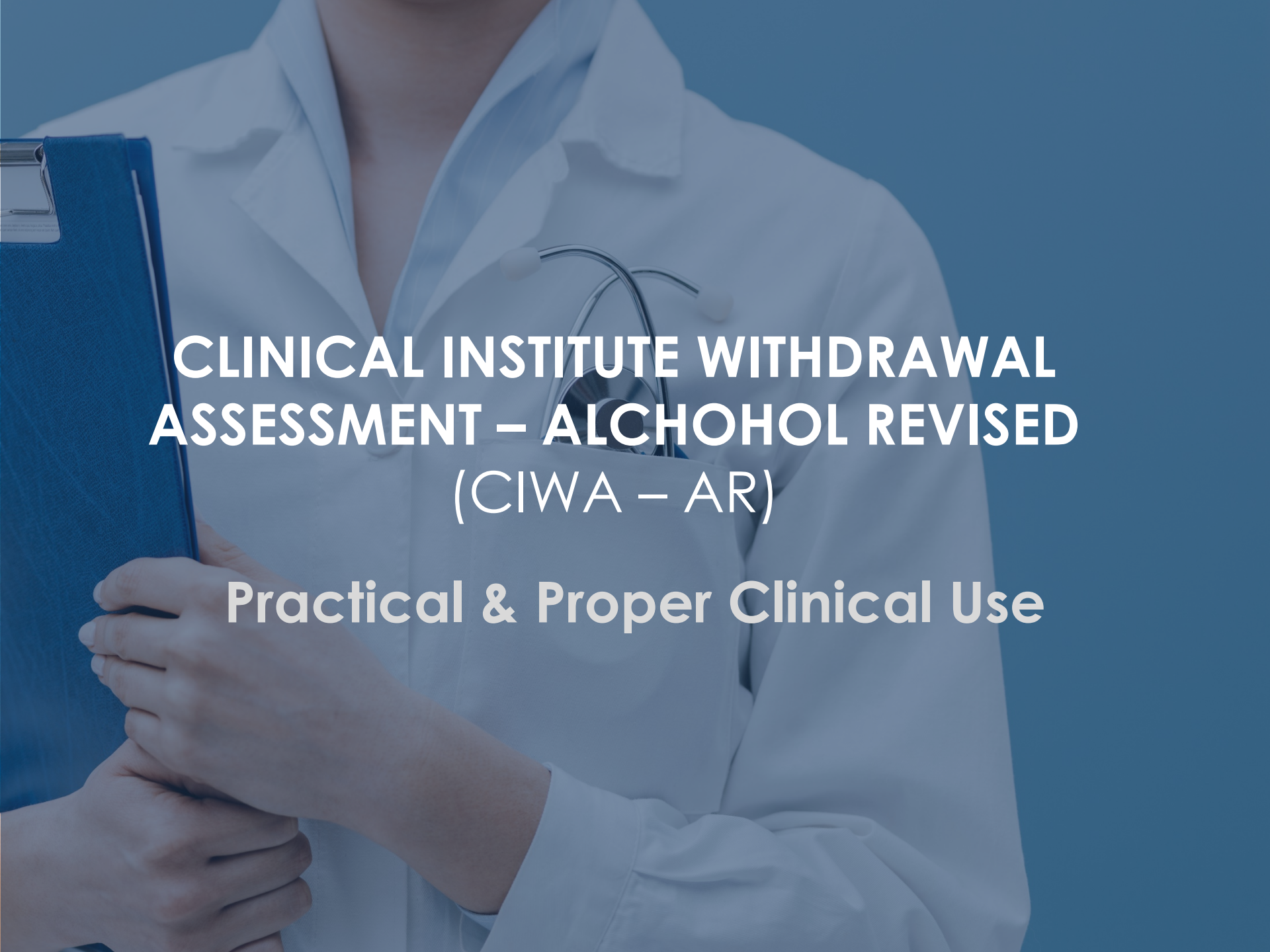

CLINICAL INSTITUTE WITHDRAWAL ASSESSMENT – ALCHOHOL REVISED

(CIWA – AR)

Practical & Proper Clinical Use

The Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-Ar) is a 10 category scale used for the assessment and management of alcohol withdrawal.

Each item on the scale is scored independently and the summation of the scores provides a total value that correlates to the severity of alcohol withdrawal. The total score is thus typically used to guide the treatment and management of alcohol (aka EtOH) withdrawal.

The maximum score is 67. Mild alcohol withdrawal is defined as a score of less than or equal to 10, moderate withdrawal scores are 11 to 16, and severe withdrawal is reflected by any score equal to or greater than 17.

Properly and carefully applied, CIWA-Ar scoring is readily reproducible between different practitioners and quite reliable regarding the degree of withdrawal and need for treatment of such withdrawal.

Pre- and Post-treatment assessments are both very important to capture AND should be recorded accordingly. The pre-treatment assessment guides both the need for treatment as well as the degree of treatment (level of monitoring, medication dosage, etc.). The post-treatment assessment provides feedback on the efficacy of the chosen treatment regimen.

Assessing and recording ONLY post treatment CIWA-Ar scores is dangerous as an inaccurate understanding of the patient's risks of withdrawal complications is likely.

CIWA-Ar Categories

1. Nausea & Vomiting
2. Tremor
3. Paroxysmal (sudden, intermittent) Perspiration
4. Anxiety
5. Tactile Disturbances
6. Auditory Disturbances
7. Visual Disturbances
8. Head Discomfort
9. Agitation
10. Alertness & Orientation

NOTE: Red color indicates rating primarily by observation

Nausea & Vomiting

This is a *subjective* assessment. The evaluator should ask the patient: "Do you feel sick to your stomach, nauseous, queasy, or have you vomited?"

Scoring is then graded using these values:

0) No related symptoms at all
1) Minimal discomfort with no vomiting
2) Very mild discomfort with no vomiting
3) Mild discomfort with no vomiting
4) Intermittent or moderate discomfort with any dry heaves
5) Repeated episodes of dry heaves
6) Significant or severe discomfort or regular dry heaves
7) Severe discomfort, frequent dry heaves or vomiting

Note: Discomfort refers to feeling stomach sickness, nausea, abdominal pain or queasiness. Cultural equivalents should be considered.

Tremor

This is an *objective* assessment. The evaluator should ask the patient to extend both arms forward with the fingers spread and the palms down. The patient should be asked to slowly rotate the arms until the palms face up.

Scoring is then graded using these values:

0) No tremor
1) Not visible, but evaluator is able to feel
2) Very mild with arms extended
3) Mild with arms extended
4) Moderate with arms extended
5) Moderate in any position
6) Severe with arms extended
7) Severe in any position

Note: Patient safety mandates to score higher, if unsure.

Paroxysmal Perspiration

This is an *objective* assessment. The evaluator observes the patient for perspiration and skin moisture. Intermittent bouts of skin moisture are common.

Scoring is then graded using these values:

0) No moisture
1) Moist skin including palms with no visible moisture
2) Any visible moisture on skin
3) Mild perspiration (beading sweat)
4) Perspiration beads visible on forehead
5) Diffuse moderate sweating
6) Heavy sweating
7) Very heavy or drenching sweats

Note: Patient safety mandates to score higher, if unsure. Ambient temperature and recent physical activity should be considered.

Anxiety

This is a *subjective* assessment. The evaluator should ask the patient: "Do you feel nervous, anxious, uneasy or apprehensive?"

Scoring is then graded using these values:

0) No anxiety
1) Minimal anxiety (background symptoms)
2) Slight anxiety
3) Moderate anxiety
4) Moderate symptoms of anxiety
5) Severe anxiety that alone may require medication
6) Very severe anxiety alone would require medication
7) Panic

Note: Patient safety mandates to score higher, if unsure.

Tactile Disturbances

This is a *subjective* assessment. The evaluator should ask the patient: "Do you feel itching, needles, burning, pain, bugs crawling, numbness or abnormal sensations on your skin?"

Scoring is then graded using these values:

0) No tactile disturbances
1) Minimal pains, itching, needles, numbness or burning
2) Mild pains, itching, needles, numbness or burning
3) Moderate pains, itching, needles, numbness or burning
4) Moderate tactile hallucinations or severe discomforts
5) Severe tactile hallucinations
6) Very severe and frequent tactile hallucinations
7) Continuous tactile hallucinations

Note: Patient safety mandates to score higher, if unsure. Tactile hallucinations refers to feeling sensations that do not exist such as insects crawling on the skin. This evaluation may require in-depth questioning.

Auditory Disturbances

This is a *subjective assessment*. The evaluator should ask the patient: "Do noises seem to be bothering you or are you hearing things that you are not sure are there?"

Scoring is then graded using these values:

0) No auditory disturbances
1) Minimal sound sensitivities
2) Mild sound sensitivities
3) Moderate sound sensitivities or startles easily to sounds
4) Moderate auditory hallucinations or severe discomforts
5) Severe auditory hallucinations
6) Very severe and frequent auditory hallucinations
7) Continuous auditory hallucinations

Note: Patient safety mandates to score higher, if unsure. Auditory hallucinations refers to hearing things or voices that do not exist such as voices, ticking, rumbling, water and wind. This evaluation may require in-depth questioning.

Visual Disturbances

This is a *subjective* assessment. The evaluator should ask the patient: "Do lights seem to be bothering you, do lights seem too bright, do colors seem wrong, are patterns on things moving or are you seeing things that you are not sure are there?"

Scoring is then graded using these values:

0) No visual disturbances
1) Minimal photophobia
2) Mild photophobia or slight visual misperceptions
3) Moderate photosensitivity or visual misperceptions
4) Moderate visual hallucinations or severe sensitivities
5) Severe visual hallucinations
6) Very severe and frequent visual hallucinations
7) Continuous visual hallucinations

Note: Patient safety mandates to score higher, if unsure. Visual hallucinations refers to seeing things that do not exist. Visual misperceptions refers to objects appearing in an inaccurate form. This evaluation may require in-depth questioning.

Head Discomfort

This is a *subjective* assessment. The evaluator should ask the patient: "Does your head feel different or full? Do you feel dizzy or lightheaded? Do you have a headache or pain in your head?"

Scoring is then graded using these values:

0) No discomfort
1) Minimal discomfort
2) Mild discomfort
3) Mild but worsening discomfort
4) Moderate discomfort
5) Severe discomfort
6) Very severe discomfort
7) Incapacitating discomfort

Note: Patient safety mandates to score higher, if unsure. A value of 5 or greater is typically when a person would definitely take medication of some type. A value of 7 would typically motivate a person to seek help, professional or otherwise.

Agitation

This is an *objective assessment*. The evaluator should take the patients vital signs, body posture and movements into consideration.

Scoring is then graded using these values:

0) Normal movements and baseline vital signs
1) Minimal increase in activity or slight elevation in pulse rate
2) Mild fidgeting or mild restlessness or mild tachycardia
3) Mild restlessness with any moderate increase in vital signs
4) Moderate fidgeting or restlessness or moderate tachycardia
5) Severe fidgeting and very restless
6) Severe restlessness with any tachypnea or tachycardia
7) actively pacing or thrashing

Note: Patient safety mandates to score higher, if unsure. Close observation and in-depth questioning regarding medical history may be required. Pulse-lowering or antihypertensive medication especially beta blockers can be considered in this assessment. Pressured speech should be equated with restlessness and evaluated as such.

Orientation and Sensorium

This is an *objective assessment*. Standard orientation questions regarding person, place, time/date, and simple math are used.

Scoring is then graded using these values:

0) Oriented to person, place, time and able to do simple math
1) Only unable to do simple math or disoriented to exact date
2) Disoriented to date by no more than 2 days
3) Disoriented to date by more than 2 days
4) Disoriented to person and place

Note: Patient safety mandates to score higher, if unsure. Mild adjustments for situation are acceptable.

CIWA-Ar

Accurate CIWA-Ar assessments are critically important to ensure good patient care and to provide for optimal safety during detoxification. The performance of CIWA-Ar is a practiced diagnostic art that requires attention, patience and effort. The practitioner must learn to appreciate certain subtle variations in human behavior that are readily missed. Listen and observe and probe further as required.