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CLINICAL UP-DATE

Inpatient alcohol withdrawal syndrome[☆]



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Abstract A 55-year-old man was admitted for a femur fracture; an alcohol feter was noted on admission. The following day, the patient began to experience tremors and nervousness. Intravenous haloperidol was administered. Shortly afterwards, the patient experienced two generalized seizures and then began to experience delirium and uncontrollable agitation. The patient was diagnosed with alcohol withdrawal syndrome; high doses of intravenous midazolam were prescribed and infused. A few hours later, the patient presented signs of respiratory depression, requiring a transfer to the intensive care unit. After a review of the medical history, it was determined that the patient had been admitted on three previous occasions due to alcohol withdrawal and had progressed to *delirium tremens* after experiencing seizures.

Can the risk of alcohol withdrawal syndrome and the need for prophylactic treatment be assessed on admission? Were appropriate monitoring and treatment measures employed? Would it have been possible to change his outcome?

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PALABRAS CLAVE

Delirio por abstinencia alcohólica;
Abstinencia alcohólica;
Pacientes hospitalizados;
Tratamiento

Síndrome de abstinencia alcohólica en pacientes hospitalizados

Resumen Un varón de 55 años ingresó por fractura de fémur. A su llegada presentaba feter enólico. Al día siguiente comenzó con temblor y nerviosismo, por lo que se administró haloperidol por vía intravenosa. Poco después presentó dos crisis comiciales generalizadas y posteriormente desarrolló un delirio con agresividad incontrolable. Se planteó el diagnóstico de síndrome de abstinencia alcohólica y se pautó midazolam por vía intravenosa en perfusión a dosis altas. A las pocas horas evolucionó a depresión respiratoria que obligó a su traslado a la Unidad de Cuidados Intensivos. Revisados sus antecedentes, el enfermo había ingresado en tres ocasiones previas por síndrome de abstinencia alcohólica, que tras presentar crisis comiciales evolucionó a *delirium tremens*.

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¿Se podía valorar al ingreso el riesgo de desarrollar un síndrome de abstinencia alcohólica y la necesidad de profilaxis farmacológica? ¿Se utilizaron las medidas de control y tratamiento adecuadas? ¿Hubiera sido posible modificar su evolución clínica?

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The clinical problem

Alcohol consumption was responsible for approximately 3.3 million deaths in 2012, representing 5.9% of all deaths (7.6% among men and 4% among women) and 5.1% of the overall disease cargo worldwide.¹ Although the per capita consumption of alcohol has declined, the Spanish population consumed 11.9 liters of alcohol/inhabitant/year from 2008 to 2010 and almost doubled the global mean (6.2L/inhabitant/year), remaining above the European mean (10.9L/inhabitant/year).¹ In the 2011 national survey on alcohol and drugs, 76.6% of the population acknowledged having consumed alcohol in the last 12 months, and 10.2% had done so daily in the last 30 days.² In short, alcohol consumption constitutes the most severe substance abuse problem in our country.

To develop interventions aimed at reducing alcohol consumption, it is essential that we identify hazardous drinking. In addition, the detection of patients with alcohol dependence is especially important in the hospital setting, where the abrupt discontinuation of alcohol ingestion can trigger a withdrawal syndrome. It is estimated that the prevalence of harmful alcohol consumption among hospitalized patients in our community is between 16% and 26%.³ However, this situation is frequently not properly assessed in medical records. A recently conducted study on patients hospitalized in Spanish internal medicine departments showed a 12% rate of alcohol abuse. However, the patients' antecedents on alcohol consumption had only been recorded on admission in 59% of the medical histories, and a quantitative assessment of alcohol consumption had been recorded for only 28% of the patients.⁴

The Diagnostic and Statistical Manual of Mental Disorders (4th edition, text revision, DSM-IV-TR) differentiates the concepts of alcohol abuse and dependence, with specific criteria for each (Table 1). Abuse does not involve the concepts of tolerance and withdrawal or a pattern of compulsive consumption and is defined by the negative consequences caused by its repeated consumption.⁵ The new DSM-5, published in May 2013, integrates the 2 concepts into one: alcohol use disorder, which requires meeting 2 of the 11 proposed criteria over the course of 12 months for its diagnosis (Table 1). Moreover, this disorder is classified as mild, moderate or severe depending on the number of criteria met.⁶ With regard to the criteria used by the DSM-IV-TR, the DSM-5 withdrew the criterion related to legal problems linked to alcohol use and introduced the concept of craving. In any case, patients with alcohol dependence or, according to the new classification, moderate to severe alcohol use disorders have a high risk of developing alcohol withdrawal syndrome after the abrupt discontinuation of its consumption.

Risk factors of alcohol withdrawal syndrome

The most consistently detected clinical factors associated with the risk of developing complicated alcohol withdrawal reported in the literature are the severity of the alcohol use disorder (intensity, duration, previous detoxification episodes), history of alcohol withdrawal syndrome, abstinence seizures or *delirium tremens*, the presence of acute comorbidities, the concomitant use of other toxins or benzodiazepines, signs of autonomic hyperactivity (hypertension, tachycardia) and abnormal laboratory test results (e.g., hypokalemia and thrombopenia).⁷⁻¹²

The considerable heterogeneity found in the various studies is partly due to the methodological differences between the studies, such as the settings in which they were conducted (outpatient and psychiatric or medical hospital wards), patients with or without comorbidities, selection and inclusion biases, statistical analysis and the definitions of complicated withdrawal employed (e.g., hallucinations, seizures, *delirium tremens*, the need for drug treatment). Moreover, the differences detected indicate the intrinsic difficulty inherent in identifying these patients.

The detection of patients with alcohol dependence is frequently inadequate in the day-to-day hospital setting. It would be advisable that clinicians increase their alertness to its detection. The Alcohol Use Disorders Test (AUDIT) is considered the gold standard in detecting alcohol-related disorders.¹³ A high score helps predict the development of alcohol withdrawal syndrome (AUDIT score ≥ 8 points). However, its use requires time from clinicians and is difficult to implement for patients with cognitive impairment. The Fast Alcohol Screening Test, which is based on only 4 of the 10 items of the AUDIT, is designed for faster screening. The test has also been assessed as a predictor of withdrawal (Fast Alcohol Screening Test score >10 points).¹⁴ None of these tools has been separately validated for this purpose in patients with comorbidities or for the identification of severe forms of withdrawal (e.g., seizures, *delirium tremens*).

The Prediction of Alcohol Withdrawal Severity Scale was published more recently. After performing a systematic literature review, the authors proposed a scale based on a score of 10 items that covered many of the above mentioned factors, as well as others that have also been related to the risk of severe alcohol withdrawal. This scale has since been validated in a pilot sample of patients hospitalized with acute comorbidities in medical hospital wards. In this cohort, a Prediction of Alcohol Withdrawal Severity Scale score ≥ 4 has shown excellent results (sensitivity, specificity, positive predictive value and negative predictive value of 100%) for the identification of patients

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