

It's Just the Flu...or Maybe NOT!

Recognizing alcohol and narcotic withdrawal syndromes

Joan M. Kolodzik, MD
Director of Education/EMS
Premier Health Care Services, Inc.

A 53 year old male who is a well-known alcoholic was found unresponsive by his family. He was covered in emesis and incontinent of urine and stool. EMS noted a GCS of 10. Family reported that he had been “trying to stop drinking” and has had no alcohol for about 72 hours. There is an odor of ketones on his breath, but no ethanol can be detected.

A 26 year old female presents with nausea, vomiting, and diarrhea for 24 hours. She has a history of chronic back pain and is on a Fentanyl patch. She also takes Vicodin “whenever I can get hold of it”, but has had none in three days. She lost her job last week and ran out of medication, including Fentanyl, three days ago. This is her second transport to the emergency department in 24 hours. Yesterday she received an injection of Toradol (Ketorolac) for pain and a prescription for Phenergan tablets.

Not all vomiting associated with substance abuse relates to excess. In fact, in the cases above both patients had toxicology screens which were negative for alcohol, narcotics, and other substances of abuse. The metabolic consequences of withdrawal can be severe, even life threatening, and treatment requires aggressive intervention that goes beyond re-hydration.

Early symptoms of narcotic withdrawal include yawning, excessive tearing, runny nose, sweating, and restless sleep. This progresses over 12 to 24 hours to nausea, muscle twitching, and abdominal cramps. After about 36 hours patients become restless, anorexic and begin having profuse vomiting and diarrhea. Fever and hypertension may occur. The exact timing of symptoms depends on the opiate. Although narcotic abstinence symptoms are unpleasant, narcotic withdrawal is rarely life-threatening.

The alcohol withdrawal syndrome develops 6 to 24 hours after last ethanol intake and lasts 2 to 7 days. Mild symptoms include insomnia and irritability, to fever, vomiting and diarrhea, disorientation, seizures, and hallucination. Signs include tremor, tachycardia, hypoglycemia, hypertension, reduced seizure threshold, visual and auditory hallucinations, and finally delirium. Delirium tremens usually appears the third post-abstinence day and is characterized by severe tremors, confusions, fever, and hallucinations. Hepatic encephalopathy may be irreversible. Mortality associated with DTs is about 15 to 20%. Remember that chronic alcoholics are also at increased risk of occult trauma and bleeding, such as subarachnoid bleeds.

Initial management of both types of withdrawal patients begins with assessment of the ABC's. A good history may or may not include a known period of abstinence. A carefully performed neurological exam is essential. Anti-nausea medicines are helpful along with IV fluids to treat and prevent dehydration and correct metabolic abnormalities. It is tempting to give IV narcotics to opiate addicts to rescue them from withdrawal syndrome, but long term this does little to help them with their addiction recovery. Be alert for occult trauma, especially in alcoholic patients who are at increased risk for bleeding. Check for hypoglycemia, especially in patients who have experienced seizures.

We have been trained to recognize acute intoxication, and we often know well the patient who is addicted, but we are less attuned to recognized withdrawal syndromes. When you are tempted to treat nausea, vomiting, and diarrhea as "just the flu" think about the possibility of withdrawal syndromes. Early recognition, evaluation, and stabilization result in improved long term outcome for the patients.

For more information on this or other clinical topics or EMS Education opportunities, call Wanda Blackford at 937- 312-3640. Premier Health Care Services is a Dayton, Ohio based emergency department physician group staffing forty hospital emergency departments in seven states.