VCOM Psychiatry Online
Case H
“I know I gotta’ stop”
Chief Complaint

• John* is a 38 year old who is brought to your office by his ex-wife after she found him confused and drunk at his house.

*NOTE: Although this is a patient in your practice, he has not been seen for over 2 years. Chart is in storage…
HPI

- His wife found him lying next to a ladder leaning against their house. He told her that he was cleaning the gutters.
- She asks to speak with you alone. They are divorced, primarily because of his drinking problems. He is seeing a local counselor, but continues to drink.
- She wants you to “order him to treatment” and she is willing to answer any questions you have.
Do you need the patient’s permission to speak with his ex-wife about his condition?

a. Yes, you do  
b. No, you don’t
Sorry, this is an incorrect answer
Correct!

Any patient, unless legally incompetent to do so (i.e. children, patients with legal guardians) generally has full authority over release of any treatment information. The patient therefore would need to consent to allowing you to discuss any of his condition or treatment with any party including his wife.
How would you approach this situation?

Answer: Ask the patient for permission, explaining that you are very concerned about his condition. Corroborating information from family members is essential in this case.
Can you “order him to treatment” from your office?

a. Yes, you can
b. No, you cannot
Sorry, this is an incorrect answer
Correct!

The patient must have full psychiatric evaluation first.
What do you do next?

A. Call his counselor about the patient’s current treatment plan for alcoholism
B. Send him to the Emergency Room for evaluation to rule out head trauma
C. Ask your nurse to take some vital signs
D. Tell his wife to go home and find out how much beer is left in the house.
Sorry, this is an incorrect answer
Correct!

The most immediate problem in a patient with possible withdrawal symptoms is insuring patient safety and stability. You should therefore start with vital signs.
Further history

• The patient says he thinks his last drink was last night before he went to bed, but he is not sure.

• Patient says “Doc, I’ve tried to cut down…I’ve gotta stop drinking…I can’t even get drunk anymore. I know you said my liver is going…”

• His ex-wife notes that he has been intoxicated every time she has stopped by to let him see the children since she has full custody.

• The patient lost his job as an electrician last week after arriving at work drunk.

• Wife tells you his driver’s license has been suspended
You review the chart....

• Past Medical and Surgical History:
  – Admitted after automobile accident 2003
    • Multiple fractures, including rib, leg.
    • Required medically supervised withdrawal in the ICU
    • Charged with DUI, court ordered to treatment to retain driver’s license

• Past Psychiatric History
  – Depression, treated with buproprion X6 months without success 2002
  – Admitted for Substance Abuse Treatment 2003, left after 5 days
  – Currently seeing a counselor, occasional AA meetings

• Medications
  – Prescribed Antabuse by Court. Non-compliant
More history

• Family History
  – Father died of alcoholism 2 years ago

• Social History
  – Divorced since 2004, supervised visitation with children (boys, 10 and 14 years old) living with his mother since divorce
    • Ex-wife states the 14 year old was suspended from school for marijuana and is involved in juvenile court
  – Legal: DUI X 3, overnight in jail once
  – Education/Employment: Trade school, has held several jobs over last few years, but fired for sporadic “attendance”.
From the information you have... Does this patient meet the criteria for...?

a. Alcohol abuse
b. Alcohol Dependence
c. Neither
Sorry, this is an incorrect answer
Correct!

Alcohol Dependence

• Tolerance (increased drinking to achieve same effect)
• Drinking more than intended
• Unsuccessful attempts to cut down on use
• Impaired social or work activities due to alcohol
• Use despite physical or psychological consequences

Review the Criteria for each diagnosis
DSM-IV Alcohol Dependence

Meets 3 criteria for over 1 year

• Tolerance (increased drinking to achieve same effect)
• Alcohol withdrawal signs or symptoms
• Drinking more than intended
• Unsuccessful attempts to cut down on use
• Excessive time related to alcohol (obtaining, hangover)
• Impaired social or work activities due to alcohol
• Use despite physical or psychological consequences
DSM-IV Alcohol Abuse

1 or more criteria for over 1 year

• Role Impairement (e.g. failed work or home obligations)
• Hazardous use (e.g. Driving while intoxicated)
• Legal problems related to alcohol use
• Social or interpersonal problems due to alcohol
Substance Abuse History

- **Tobacco:** Smoking since age 12 years, currently 1-1/2 PPD. Wants to quit.
- **Marijuana:** Smoking since age 13 years, currently weekly, at work.
- **Cocaine:** Snorted at age 18 years, did not like.
- **Methamphetamine:** Denies.
- **Heroin:** Denies.
Substance Abuse History

- **Alcohol**: Drinking since age 13 years. Drank on weekends in high school. Daily drinker since age 22. Has had periods of abstinence—particularly after the birth of both of his sons. Currently drinking 18-24 beers daily.
  - He left substance abuse treatment after accident because he didn’t think he could miss work.
  - He is willing to consider treatment again, maybe

- Since the patient smells of alcohol, you ask him when his last drink was....
  - "A couple of hours before I went up on the roof, doc. I’m not stupid!"
Substance Abuse History

• Prescription Drugs
  – Admits to taking some of his Mom’s prescribed diazepam when he is really shaky in the morning
  – He remembers the doctor gave him that in the hospital so he thinks it might help.
  – Asks “Doc, can’t you just give me some of that to take at home????”
    • “I really have the shakes bad doc and need something to come off this…”
What additional Diagnosis do you now add to your list?

a. Tobacco Abuse
b. Benzodiazepine Abuse
c. History of Depression
d. History of delirium tremens/major alcohol withdrawal
Sorry, this is an incorrect answer
Correct!
List the Psychiatric Diagnosis by Axis
• Axis 1: Alcohol Dependence, Tobacco Abuse, Diazepam Abuse
• Axis 2: Deferred
• Axis 3: None
• Axis 4: Unemployment, divorce, housing problems
• Axis 5: 50
Physical Examination

- VS: HR 110, BP 145/95, RR 16, T= 100.5
- Appearance: Alert but tremulous man who appears anxious. You notice a pack of cigarettes in his pocket.
- Skin: Diaphoretic. You note spider angiomata over his nose and cheeks. Fingers with deep staining of thumb and 1st finger
- HEENT: Pupils 3-4 mm, Fundi visible and normal without papilledema. Teeth in poor repair. Neck supple, no masses, no bruits
PE

- Lungs: Clear to auscultation
- CV: RR without murmur, rub, gallop
- Abdomen: Liver 5-6 cm below right costal margin. Spleen not palpable
- GU: Normal male, testes descended bilaterally
- Musculoskeletal: Muscular mass decreased proximally.
PE

• Neurological Exam:
  – Gait unsteady
  – Reflexes increased bilaterally
  – CN2-12 intact
  – Strength decreased throughout, but particularly proximally.
  – Visible tremor of tongue
  – You ask him to put out his hands to “stop a train” and note visible tremor of hands.
Mental Status Exam

• Appearance: Alert, tremulous man who appears anxious. Complains about the child screaming in the next room, asks if you can turn off the overhead lights because his head hurts.

• Attitude toward examiner: Attentive and cooperative, seems embarrassed by some of your questions.
  – “Gee, doc, do we have to go over that again…you know my problems.”

• Mood: Patient notes that he has been down most days, particularly since losing his job and the divorce.
MSE

• Affect: Somewhat constricted, sad.
• Speech: Normal rate and quality, although answers are brief
• Thought Process and content:
  – Patient denies hallucinations, although he repeats again that the office is very noisy.
  – As the interview proceeds, the patient appears somewhat confused and is unclear about the day, date, and circumstances. He asks his ex-wife how he got to the office....
What is your differential diagnosis to explain his confusion?

• Head trauma, un-witnessed
• Alcoholic intoxication
• Alcohol withdrawal, minor
• Alcohol withdrawal, major
• Acute alcoholic hepatitis
• Acute depressive episode
What is your next step?

a. Send the patient immediately to the outpatient community treatment center for treatment of alcohol withdrawal.

b. Send the patient home with diazepam for the treatment of alcohol withdrawal.

c. Admit the patient to the hospital for treatment of alcohol withdrawal.

d. Prescribe antidepressant medication and disulfiram at 100 mg/day
Sorry, this is an incorrect answer
Correct!

The patient, as described, does meet criteria for minor alcohol withdrawal, a life threatening condition if untreated. If treated immediately, early, minor alcohol withdrawal is less likely to progress to major alcohol withdrawal. The patient needs immediate admission for careful monitoring and detoxification.
Patient is admitted to the hospital
What are your admitting orders to treat his alcohol withdrawal?
Stabilize alcohol withdrawal

• VS q 2 hours X 2 shifts, then q 4 hours
• Phenobarbital 60 mg po every 8 hours with 30 mg po every 3 hours for T>100.5, HR> 100, BP Diastolic >90.

OR

• Lorazepam 2-4 mg po every 4 hours with 1 mg every 1-2 hours for T>100.5, HR> 100, BP Diastolic >90.
• BP, HR, Temperature and sensorium normalizes, patient is oriented after 24 hours
• AND nicotine patch 21 mg q day
At 48 hours…

• Patient has required 360 mg of phenobarbital each day.
• BP= 135/70, HR 65, T=98.4
• You initiate a taper of phenobarbital by approximate 20% each day, keeping his dosage interval at 8 hours
• You arrange for the Social Worker to explore treatment options.
• The patient goes to substance abuse treatment at discharge.
Fast Forward

• Your patient responded well to treatment with phenobarbital, has completed intensive treatment through the Community Service Board, and is now back in your office for follow-up.

• What will you suggest as a treatment plan?
  – If the treatment program has not sent you a discharge summary, ask your staff to procure and release from the patient and procure
  – Many patients will have a copy of their treatment plan since they were involved in the creation.
Treatment Plan

• Continue attending AA meetings, select a sponsor.
• Continue his “aftercare plan” as outlined in the report.
• Encourage any individual counseling suggested in the treatment plan.
• What are the medications you would consider prescribing to support his abstinence?
  – Lab work?
  – Mechanisms of action?
NIAAA Clinicians Guide to Helping Patients who Drink too much

• Follow this link to the guide:

• The guide contains an excellent summary of medications used in the treatment of alcoholism
On first page, scan to find:

“Brief Intervention Support Materials”

• Approach to Brief Intervention
• U.S. Adult Drinking Patterns
• click here → Prescribing Medications for Alcohol Dependence
• Referral Resources
• Alcohol Screening Forms: Baseline and Followup

• The table of medications, dosages, lab monitoring is located on the second page.
Medication Assisted Treatment

• Acamprosate (Campral): 333 mg po q 8 hours
  – Action: Works through glutamatergic and gaba-ergic receptors.
  – CAUTION: Check renal function prior to prescribing.

• Disulfram (Antabuse): 250 mg po q day
  – Action: Blocks alcohol dehydrogenase causing flushing, nausea, and vomiting if individual drinks alcohol while prescribed
  – CAUTION: Must monitor liver function.

• Naltrexone (Revia): 12.5 mg q day, increase to 50 mg q day.
  – Action: Mu receptor blockade. Will cause withdrawal in opiate dependent patients
  – CAUTION: Must Monitor liver function.
Summary

Your patient presented at your office with exacerbation of alcoholism secondary to life stressors. He was in minor alcohol withdrawal. He was treated with a cross tolerant sedative hypnotic, either phenobarbital or lorazepam, and did not progress to major withdrawal. After intensive substance abuse treatment, you will encourage him to follow his after care plan and prescribe a medication to support his recovery efforts. As his primary care physician, you are a key member of the treatment team and one of his main supports.