DELIRIUM IN SMACK WITHDRAWAL: A STREET FORM OF OPIOID

Swapnil Agrawal[1], Aftab Ahmed Khan[2], Vikash Sharma[3], Rahila Qureshi[4]

[1]Senior Resident, Department of Psychiatry, NSCB Medical College, Jabalpur, Madhya Pradesh.
[2]Assistant Professor, Department of Psychiatry, NSCB Medical College, Jabalpur, Madhya Pradesh.
[3]Junior Resident, Department of Psychiatry, NSCB Medical College, Jabalpur, Madhya Pradesh.
[4]Medical Officer, Department of PH & FW, Jabalpur, Madhya Pradesh.

ABSTRACT

Delirium as a complication of substance withdrawal is mainly seen in alcohol withdrawal. Withdrawal symptoms in opioids addicts mainly include somatic symptoms. Some neurological complications have also been reported in opioid withdrawal, but no proper explanation can be given for such complications. Delirium in opioid withdrawal is rarely reported, and that too if reported was with street form of opioid (Smack). We report one such case who presented with delirium and after thoroughly ruling out all other probable causes, a diagnosis of delirium due to smack withdrawal was made. Rapid improvement in delirium with opoid drug also highlights treatment for such patients.

KEYWORDS
Opioid, Withdrawal, Delirium.

HOW TO CITE THIS ARTICLE: Agrawal S, Khan AA, Sharma V, et al. Delirium in smack withdrawal: a street form of opioid. Journal of Research in Psychiatry and Behavioral Sciences 2016; Vol. 2, Issue 1, Jan-June 2016; Page: 11-12.

INTRODUCTION

Opioids use results in severe physical dependence; likewise, its withdrawal symptoms are usually somatic complaints that classically include yawning, restlessness, muscle aches, lacrimation, rhinorrhoea, excessive sweating, inability to sleep and yawning. Later symptoms which can be more severe include diarrhoea, abdominal and muscle cramps, piloerection, nausea, vomiting, dilated pupils and possibly blur vision, palpitations, raised blood pressure and rarely seizures.(1,2)

Delirium in opioid withdrawal is a rare presentation and usually not seen in our daily practice. We hereby report a case of delirium due to opioids withdrawal.

CASE REPORT

A 40-year-old man presented to our psychiatry outpatient department referred by medicine outpatient department with a history of sudden onset agitated behaviour, restlessness, not recognizing others, irritability, irrelevant speech, abusive, incontinent and decreased sleep for the past two days.

Detailed history by his wife revealed that the patient was using "smack" (A street form of heroin) for the past 15 years. He used to take half to one gram of smack per day, majority of which he takes in evening. There was no history of any other substance use including alcohol or any other drugs, as reported by his wife and other family members. His wife stated that the patient suddenly stopped smack 10 days before after a family quarrel. He was brought to hospital on the 11th day of abstinence with symptoms as mentioned above. There was no history of fever, head injury or any history suggestive of seizures. There was no past history of any psychiatric, physical or neurological illness.

Financial or Other, Competing Interest: None.
Submission04-03-2016, Peer Review 24-05-2016,
Acceptance 31-05-2016, Published 16-06-2016.
Corresponding Author:
Dr. Aftab Ahmed Khan,
Assistant Professor,
Department of Psychiatry,
NSCB Medical College,
Jabalpur, Madhya Pradesh.
E-mail: draftab79@yahoo.com

On examination, he was not oriented to time, place and person, irrelevant speech his psychomotor activity was increased and he was uncooperative for examination.

A diagnosis of delirium was made and urgent admission advised. Urinary catheterization done and thorough investigation including CBC, blood oxygen saturation, liver function tests including blood ammonia, serum electrolytes, blood glucose, kidney-function tests, urinalysis, ECG, chest X-ray and CT head scan, were done. No abnormality detected in investigations. His personal and family histories were non-significant. A diagnosis of delirium due to opioid withdrawal was made.

The treatment started with parental tramadol 400 mg per day, along with lorazepam 4 mg/day. Gradually on 3rd day of admission, he showed marked improvement in his symptoms of delirium. A patient remains admitted for 5 days and was discharged on sixth day of admission. At the time of discharge his delirium was completely resolved. Patient advised to take medicines orally. His tramadol and lorazepam were tapered off over a period of 2 weeks. The patient reported that he only took smack and had never taken any other substances such as alcohol or benzodiazepines and he showed strong desire to quit smack. The patient was subsequently managed with motivational therapy, and was put on SSRI antidepressant fluoxetine 20 mg and lorazepam 2 mg per day. The patient is maintaining well with no residual symptoms.

DISCUSSION

Delirium is a common and serious acute neuropsychiatric syndrome with core features of inattention and global cognitive dysfunction. The aetiologies of delirium are diverse and multifactorial and often reflect the pathophysiological consequences of an acute medical illness, medical complication or drug intoxication. Delirium can have a widely variable presentation, and is often missed and underdiagnosed as a result. At present, the diagnosis of delirium is clinically based and depends on the presence or absence of certain features. Management strategies for delirium are focused on prevention and symptom management.(3)

Delirium as a complication due to drug intoxication is mainly seen in alcohol withdrawal. The hallmark of alcohol withdrawal is a continuum of signs and symptoms ranging from simple tremulousness to delirium tremens which is not seen in opioids withdrawal. The spectrum varies greatly, and symptoms overlap in time and duration. Opioids withdrawal delirium is rarely reported.[4,5,6,7] In our case, the patient developed delirium after an abrupt discontinuation of smack. No other reason for delirium was found. Improvement in delirium with tramadol, an opioid analgesic also favours opioid withdrawal as the cause of delirium.

Although the majority of opioid withdrawal symptoms are somatic in nature, various neurological conditions have also been described in patients with opioid dependence. Two unusual cases of opioid dependence who developed neurological complications have been detailed by Celius.[8] One patient developed rhabdomyolysis, bilateral cortical infarctions and convulsions after an intravenous injection of heroin, while the second patient developed an acute disabling cerebellar ataxia after intra-arterial injection of heroin. Rhabdomyolysis presenting as mononeuropathy, plexus lesions and transverse myelitis has been reported in heroin addicts.[9,10] De Gans et al. concluded that an allergic or toxic reaction to heroin or impurities was more likely to be the cause of these complications.[10] However, none of these conditions were observed in our patient.

Though our patient denied any other co-morbid substance dependence, the reliability of an addict's history is questionable. The caretales are also usually oblivious to the nature of the substance taken.[11] In view of the lack of literature linking delirium and opioid withdrawal, and also because our patient belongs to low socioeconomic status and using street variety of smack; delirium in our patient might be attributed to presence of a contaminant or impurities, which we are unable to confirm. Thus, more studies are required to find prevalence of opioid withdrawal delirium and its risk factors. Nonetheless, Opioid withdrawal can be complicated and life-threatening, as alcohol withdrawal. The life threatening nature of delirium in opioid withdrawal warns that patients primarily with opioids withdrawal be carefully monitored by psychiatrist and physicians.

REFERENCES

1. Basu D, Banerjee A, Harish T, et al. Disproportionately high rate of epileptic seizure in patients abusing dextropropoxyphene. Am J Addict 2009;18(5):417–21.
2. Mattoo SK, Singh SM, Bhardwaj R, et al. Prevalence and correlates of epileptic seizure in substance-abusing subjects. Psychiatry Clin Neurosci 2009;63(4):580–2.
3. Fong TG, Tulebaev SR, Inouye SK. Delirium in elderly adults: diagnosis, prevention and treatment. Nature reviews Neurology 2009;5(4):210–20.
4. Aggarwal A, Jain M, Jiloha R. Catatonia as the initial presenting feature of subacute sclerosing panencephalities. J Neuropsychiatry Clin Neurosci 2011;23(1):E29-31.
5. Parkar SR, Seethalakshmi R, Adarkar S, et al. Is this "complicated" opioid withdrawal? Indian J Psychiatry 2006;48(2):121–2.
6. van Rijswijk R, van Guldener C. A delirious patient with opioid intoxication after chewing a fentanyl patch. J Am Geriatr Soc 2006;54(8):1298–9.
7. Agrawal A, Diwan SK, Mahajan R. Severe delirium following single dose of tramadol. Indian J Med Sci 2009;63(2):80–1.
8. Celius EG. Neurologic complications in heroin abuse: illustrated by two unusual cases. Tidsskr Nor Laegeforen 1997;117(3):356–7.
9. Yang CC, Yang GY, Ger J, et al. Severe rhabdomyolysis mimicking transverse myelitis in a heroin addict. J Toxicol Clin Toxicol 1995;33(6):591–5.
10. de Gans J, Stam J, van Wijngaarden GK. Rhabdomyolysis and concomitant neurological lesions after intravenous heroin abuse. J Neurol Neurosurg Psychiatry 1985;48(10):1057–9.
11. Desai NG, Gupta DK, Khurshid KA. Substance use disorders. In: Vyas JN, Ahuja N, editors. Textbook of postgraduate psychiatry. New Delhi: Jaypee Publications 1999:76–140.