

Opium Withdrawal Delirium: Two Case Reports

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ABSTRACT ~ Two patients with opium dependence developed delirium during abstinence. The delirium resolved completely within 48–58 hours of appropriate treatment. Caution needs to be exercised during opioid detoxification in timely detecting and treating potentially life-threatening condition like delirium. Psychopharmacology Bulletin. 2017;47(1):48–51.

INTRODUCTION

Opioid withdrawal symptoms are characterized by nausea/vomiting, lacrimation, rhinorrhoea, diarrhoea, yawning, sweating, insomnia, dilated pupils, piloerection, chills, dysphoric mood, and fever.¹ Opioid withdrawal delirium has been classified in DSM-5 under the chapter “Neurocognitive disorders”.²

CASE REPORT- I

A 56-year-old male was admitted to our de-addiction facility with regular opium consumption (about 3.3 grams/day) for the last 30 yrs. There was no history of any other substance use except tobacco. There was no current or past history suggestive of any psychiatric, medical including neurological illness. Family and personal history was also non-contributory. About five years back also the patient had undergone uneventful detoxification for opium however, he didn't come for follow-up thereafter. Mental state examination (MSE) on the day of admission was unremarkable. He was diagnosed as a case of opium dependence, currently abstinent. Detoxification with tramadol 200 mg/day and clonazepam 1.5 mg/day was started. His investigations such as CBC, urinalysis, fasting blood glucose, liver and kidney function tests, serum electrolytes, ECG, chest X-ray and head CT scan were all within normal limits. At 30 hours of abstinence patient had mild

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signs of opium withdrawal in the form of sweating, lacrimation, body-aches and craving for opium along with impaired immediate and recent memory. In the midnight after about 40 hours of abstinence, the patient became grossly agitated (was shouting, running out of the bed, kicking family members). On MSE he was non-cooperative, inattentive, disoriented and restless. Opium withdrawal delirium was kept the additional diagnosis now. Patient was physically restrained and given i/m lorazepam 4 mg which was repeated after 4 hours. After another three hours he was given 5 mg haloperidol with 50 mg promethazine i/m. As he was not accepting orally, therefore, i/v fluids were started and tramadol was shifted to i/m route (100 mg 12 hourly). After about 28 hours, agitation settled down but the patient was still disoriented to time and had impaired attention, concentration and recall, features of opium withdrawal were more intense. The patient was again shifted to oral tramadol 300 mg/day along with clonazepam 1mg/day. Delirium subsided completely after 56–58 hours. Drugs were tapered off over next 2 weeks and the patient was put on naltrexone 50 mg/day and quetiapine 50/day (for insomnia). Quetiapine was tapered off over next two weeks, naltrexone was continued along with psycho-social intervention for relapse prevention. The patient was maintaining abstinence three months after discharge.

CASE REPORT- II

A 38-year-old male was brought to our de-addiction facility with the complaints of confusion, restlessness, decreased sleep, irrelevant talk after abrupt cessation of opium two days back which he had been taking regularly (1.5 to 2 grams/day) for the last 14 yrs. Patient had never tried to stay abstinent from opium for more than a day in the past that too due to non-availability. There was no history of any other substance use except tobacco. There was no suggestion of any significant psychiatric and medical including neurological illness at present or in the past. Family and personal history was unremarkable. MSE revealed restlessness, disorientation, agitation and aimless picking at clothes. He was diagnosed as a case of opium withdrawal delirium and tramadol 200 mg/day, risperidone 1.5 mg/day and clonazepam 3.0 mg/day was started. His investigations including CBC, urinalysis, fasting blood glucose, liver and kidney function tests, serum electrolytes, ECG, chest X-ray and head CT scan were all within normal limits. After about 48 hours, of therapy, the delirium subsided and only opium withdrawal symptoms were evident. All the drugs were tapered off over next 2 weeks and the patient was discharged on quetiapine 50 mg/day. Quetiapine was tapered off over next two weeks

and patient was managed with psychosocial treatment alone and was maintaining abstinence six months after discharge.

DISCUSSION

Both the patients were opium dependent cases and they developed delirium after about 40 to 48 hours of abstinence. We could not find any other drug or medical including neurological cause for delirium. The delirium was quite severe in the first case where it required parenteral haloperidol and lorazepam, whereas in the second case it subsided with low dose of oral risperidone and clonazepam. Opioid withdrawal is generally thought to be uneventful but there are some reports of opioid withdrawal seizures,^{3,4} delirium⁵ and both seizures and delirium⁶ in patients undergoing opioid detoxification. A high incidence of delirium has also been reported during rapid opioid detoxification with naltrexone and clonidine in methadone-dependent patients.⁷ In our patients, we noticed only opium withdrawal delirium which was short lasting and was not associated with any seizures. Opium withdrawal has also been found to be risk factor for postoperative delirium after coronary artery bypass graft surgery.⁸ Both of our patients were in good physical health and were not suffering from comorbid medical or psychiatric disorder before admission in our hospital. Though there are some reports of opioid intoxication delirium after oral or parenteral use of opioid including tramadol,⁹⁻¹¹ such association can't be entertained in our cases as neither any patient was intoxicated with opium nor delirium started immediately after initiating tramadol. A remote possibility of using adulterated opium could be a probable risk factor in both cases. Opium is frequently adulterated with benzodiazepine class of drugs in this part of country to increase the euphoric effects of opium.¹² The abrupt abstinence could be additional risk factor in the second case for the development of delirium. A close watch should be kept while managing patients with opioid withdrawal in view of the possibility of withdrawal delirium so that this potentially life threatening complication could be detected and treated in time. Larger sample reports may throw a better light on the possible risk factors involved in the causation of opioid withdrawal delirium. ❀

50

*Sharma, Kumar,
Sharma, et al.*

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