

ETOH Intoxication

Management:

- Ensure airway, adequate respiratory drive, and management of secretions/emesis
- Thiamine, consider folate/MVI, D5NS (for volume and glycogen/NAD+ depletion - will not enhance elimination)
- Check FSBG. Hypoglycemia is caused by impaired gluconeogenesis in poorly nourished patients with depleted or low glycogen stores.
- Search for other causes if mental status not clearing in 3 to 4 hours.
- Alcoholic ketoacidosis: Volume repletion, thiamine, and supplemental glucose
- Start CIWA protocol for all suspected chronic alcoholics

Symptoms:

1. Tremulousness (6-12 hours after last drink)

- Pt irritable, hypervigilant, agitated. coarse tremor of hands and tongue
- Thiamine 100mg IV, MVI, Folate 1 mg IV/PO. Give thiamine before glucose
- Mg replacement, watch for drop in phosphate
- Valium 5-10 mg IV q5-10min until stops or Librium 25-100 mg PO hourly. Monitor closely for oversedation

2. Seizures

- If no past h/o seizure, work up to r/o head trauma, meningitis, brain abscess, etc.
- If past h/o EtOH seizure, treat as other seizures but loading with anticonvulsants not indicated

3. Delirium Tremens - autonomic instability with fluctuating mental status. 2-7 days after last drink, usually with visual hallucinations, perspiration, fever, tachycardia, hypertension. This is a medical emergency. mortality is approx. 5%

- Valium 5-10 mg IV every 5 to 10 minutes until appropriate sedation is achieved.
- Librium 25-100 mg PO at presentation, repeat as needed hourly. Monitor respirations.
- Thiamine, folate, MVI iv/po
- Replete Mg, K, Ca, PO4
- Rule out infection, pneumonia
- Admit to monitored setting

Other toxic alcohols:

- Send ethanol level to calculate corrected osmole gap in the case of suspected concurrent ethylene glycol or methanol ingestion.
- Toxic alcohol panel (ethylene glycol, methanol, isopropyl alcohol) can be sent but do not delay treatment if clinical suspicion is high.
- Most common differential diagnosis is alcoholic ketoacidosis, which can cause severe anion gap acidosis and moderate osmolar gap. Send a beta hydroxybutyrate level, which is more reliable than standard ketone test (acetoacetate).

References:

Kraut JA, Kurtz I. Toxic alcohol ingestions: Clinical features, diagnosis, and management. Clin J Am Soc Nephrol 2008 Jan;3(1!):208-25.

Goldfrank's Toxicology Emergencies, 9th ed 2010.

Poisoning and Drug overdose, 6th ed. 2012.

UpToDate. (2022). <https://www.uptodate.com/contents/management-of-moderate-and-severe-alcohol-withdrawal-syndromes>.

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