Hepatic encephalopathy in special situations [Alcohol: Withdrawal/Intoxication/Wernicke’s]

Aim: To discuss the manifestations of alcohol withdrawal and management of the same in patients with and without hepatic impairment. Content of the presentation: Alcohol withdrawal syndrome is often seen in persons who continuously drink heavily and then either stop using alcohol or reduce the amount of alcohol intake. Alcohol withdrawal syndrome can vary from mild anxiety to severe complicated withdrawal which is characterised by alcohol withdrawal delirium tremens (DTs), withdrawal seizures, Wernicke’s encephalopathy (WE) and Korsakoff psychosis. DTs during the withdrawal phase understood as a form of hepatic encephalopathy. DTs usually begin after 2 to 5 days of sudden unmedicated abstinence from alcohol or even with sudden reduction in the amount of alcohol in patients whose degree of alcohol dependence is very high. Delirium tremens may also be triggered by infection, illness, or head injury in people with a history of alcohol abuse. Risk factors for developing DTs include coexisting acute illness, long duration of alcohol intake, large volume of alcohol intake, severe withdrawal symptoms at presentation, prior DTs, and preceding withdrawal seizures. DTs mostly appear suddenly, although close enquiry may reveal a prodromal stage of restlessness, anxiety and insomnia. It is characterized by usual alcohol withdrawal symptoms, plus reduced level of consciousness, disorientation in time, place and person (non-recognition of close family and friends), impairment in recent memory, disruption of the sleep-wake cycle with insomnia or daytime sleepiness, transient perceptual disturbances and evening worsening of symptoms, with severe agitation and coarse tremors of limbs and body. The perceptual disturbances may include misinterpretation of sensory stimuli and hallucinations. The affected person may see terrifying sights [visual hallucinations of smaller (Lilliputian) or of normal size], smell horrifying smells (olfactory hallucinations), feel all sorts of distressing touching (tactile hallucinations) or hear threatening or frightening sounds, including language (auditory hallucinations). Ordinary conversation is misinterpreted in a suspicious manner. In addition to the above the patient may have ataxia, autonomic disturbances and mild pyrexia. Withdrawal seizures (‘rum fits’) occur within 12 to 72 hours of alcohol cessation, usually precedes delirium and are characterized by major motor (generalized tonic clonic) seizures that occur during withdrawal in patients who normally have no seizures and have normal EEGs. In 60% of patients, the seizures are multiple (in burst of 2 to 6), but only 3% of patients go on to develop status epilepticus. About 30-40% of patients with alcohol withdrawal seizures progress to DTs. WE is characterised by acute mental confusion, ataxia, and ophthalmoplegia. Korsakoff amnestic syndrome is a late neuropsychiatric manifestation of WE with memory loss and confabulation. These manifestations occur as a result of thiamine deficiency. Management of complicated alcohol withdrawal requires use of supportive measures, benzodiazepines, thiamine and prevention of secondary complications.
Corresponding Author Detail

Name: Sandeep Grover  ISHEN Member: ISHEN Member  Country: India
State: Chandigarh  City: Chandigarh  E-mail: drsandeepg2002@yahoo.com
Mobile: 9316138997/7087009807
Address: Department of Psychiatry PGIMER, Chandigarh

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