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Case Report: A Case of Confusion with Review of Sedative-Hypnotic Alprazolam Use

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Abstract : A 52-year-old male with unknown psychiatric and medical history was brought to the Psychiatric Emergency Room by ambulance directly from jail. He had been detained for three weeks for possession of a firearm while intoxicated. On initial evaluation, the patient was unable to provide a reliable history. He presented with odd jerking movements of his extremities and catatonic features, including mutism and stupor. His vital signs were stable. Patient was transferred to the medical emergency department for work-up of altered mental status. Due to suspicion for opioid overdose, the patient was given naloxone (Narcan) with no improvement. Laboratory work-up included complete blood count, comprehensive metabolic panel, thyroid stimulating hormone, vitamin B12, folate, magnesium, rapid plasma reagin, HIV, blood alcohol level, aspirin, and Tylenol blood levels, urine drug screen, and urinalysis, which were all negative. CT head and chest X-Ray were also negative. With this negative work-up, the medical team concluded there was no organic etiology and requested inpatient psychiatric admission. Upon re-evaluation by psychiatry, it was evident that the patient continued to have an altered mental status. Of note, the medical team did not include substance withdrawal in the differential diagnosis due to stable vital signs and a negative urine drug screen. The psychiatry team decided to check California's prescription drug monitoring program (CURES) and discovered that the patient was prescribed benzodiazepine alprazolam (Xanax) 2mg BID, a sedative-hypnotic, and hydrocodone/acetaminophen 10mg/325mg (Norco) QID, an opioid. After a thorough chart review, his daughter's contact information was found, and she confirmed his benzodiazepine and opioid use, with recent escalation and misuse. It was determined that the patient was experiencing alprazolam withdrawal, given this collateral information, his current symptoms, negative urine drug screen, and recent abrupt discontinuation of medications while incarcerated. After admission to the medical unit and two doses of alprazolam 2mg, the patient's mental status, alertness, and orientation improved, but he had no memory of the events that led to his hospitalization. He was discharged with a limited supply of alprazolam and a close follow-up to arrange a taper. Accompanying this case report, a qualitative review of presentations with alprazolam withdrawal was completed. This case and the review highlights: (1) Alprazolam withdrawal can occur at low doses and within just one week of use. (2) Alprazolam withdrawal can present without any vital sign instability. (3) Alprazolam withdrawal does not respond to short-acting benzodiazepines but does respond to certain long-acting benzodiazepines due to its unique chemical structure. (4) Alprazolam withdrawal is distinct from and more severe than other benzodiazepine withdrawals. This case highlights (1) the importance of physician utilization of drug-monitoring programs. This case, in particular, relied on California's drug monitoring program. (2) The importance of obtaining collateral information, especially in cases in which the patient is unable to provide a reliable history. (3) The importance of including substance intoxication and withdrawal in the differential diagnosis even when there is a negative urine drug screen. Toxidrome of withdrawal can be delayed. (4) The importance of discussing addiction and withdrawal risks of medications with patients.

Keywords : addiction risk of benzodiazepines, alprazolam withdrawal, altered mental status, benzodiazepines, drug monitoring programs, sedative-hypnotics, substance use disorder
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