



**ORIGINAL RESEARCH PAPER**

**Psychiatry**

**COMPLICATED OPIOID WITHDRAWAL – A CASE REPORT**

**KEY WORDS:** Opioid Withdrawal, Delirium, Convulsions, Complicated

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**ABSTRACT**

Opioids are one of the commonly abused substances in India. Opioid dependence is a serious medical, social and legal concern in Indian society. Opioids are one of the commonly abused substances in India. Opioid withdrawal symptoms classically includes yawning, sweating, lacrimation, rhinorrhea, anxiety, restlessness, insomnia, dilated pupils, piloerection, chills, tachycardia, hypertension, nausea/vomiting, crampy abdominal pains, diarrhea, and muscle aches and pains. However, in rare cases delirium and convulsions can colour the picture of opioid withdrawal and makes it complicated. We hereby, report a case of delirium & convulsions during opioid withdrawal.

**INTRODUCTION**

Classical signs and symptoms of opioid withdrawal includes irritability, anxiety, apprehension, muscular and abdominal pains, chills, nausea, diarrhoea, yawning, lacrimation, sweating, sneezing, rhinorrhoea, general weakness and insomnia. Symptoms of the opioid withdrawal syndrome usually varies from 6 to 12 hours in case of short acting opioids such as heroin and morphine, to 36 to 48 hours for long acting opioids such as methadone (1). Opioid withdrawal syndrome is rarely life threatening (2-4). However, in rare circumstances complications like delirium & seizures can be observed, especially if the opioid withdrawal is complicated by comorbid medical illnesses (5).

**CASE REPORT**

Mr X, a 23-year-old man having opioid dependence for past 7 years, presented to the psychiatry outpatient department with history of sudden onset generalised tonic clonic seizures for past 2 days, followed by violent and agitated behavior, restlessness, not recognizing others, irritability, irrelevant speech, and decreased sleep. On examination, he was disoriented to time, place, and person, and was uncooperative for the examination. Patient was finally admitted in our deaddiction centre. Patient has been consuming opioid for past 7 years in the form of intravenous heroine. This was confirmed by his father. There was no history of any other substance use except tobacco as reported by his family members as well as his friends. The patient was abstinent on opioids for the past 4 days. There was no history of any fever, head injury or any other metabolic complications. There was no past history of any psychiatric or neurological illness. Evaluations, including CBC, liver function tests, serum electrolytes, CT head scan, EEG, blood glucose, kidney-function tests, urinalysis, ECG, and chest X-ray, were within normal limits. His personal and family histories were not significant. A diagnosis of drug-withdrawal delirium (mental and behavioral disorders due to the use of opioids; acute withdrawal with delirium) was made. Patient was started on 0.3 mg of clonidine in divided doses. He was also given symptomatic treatment in the form of paracetamol for bodyache and hyoscine for spasmodic abdominal pain. Clonidine was tapered over a period of 7 days. Finally, the patients recovered without any residual neurological deficits. Patient was given motivational enhancement therapy and cognitive behavioural therapy in the ward. On the 8th day he was finally discharged on 50 mg of naltrexone. Patient has been maintaining well for the past 4 months, with no neurological sequelae.

**DISCUSSION**

Our patient developed delirium after the abrupt discontinuation of heroin. We could not find any other reason

for delirium. Opioids have been attributed to have both convulsant and anti-convulsant properties (6). In adults, recent heroin use may be a risk factor for the development of seizures(7). Complications such as convulsions and delirium are common in alcohol withdrawal. However, these are rarely seen in opioid withdrawal (5). In rats precipitation of opioid withdrawal has been shown to be associated with increased cerebral activity that is largely unobserved in opioid withdrawal (8). This is further supported by some of the studies reporting occurrence of seizures during opioid withdrawal have been reported (5-12). Infact, Mattoo et al (12) observed the prevalence of epileptic seizures to be unusually high (12.5%) in opioid abusers.

Delirium has been reported following rapid opioid detoxification with naltrexone and clonidine in patients dependent on opioids (13,14). A significant incidence of delirium (20%) resulted from the Rapid opioid detoxification (ROD) procedure in one of the study (13). Some reports have been related to intoxication delirium or delirium after a single dose of opioid (15 -17). Sudden abstinence from opioids and use of an adulterated street variety could be a risk factor for delirium and seizures in this patient. Another factor could be concurrent use of other substances like alcohol, benzodiazepines which was denied by the patient and his caregivers.

**CONCLUSIONS**

There is dearth of literature on complicated opioid withdrawal. Since there was no other medical co morbidity or history of any other substance abuse in our patient, this case depicts rare features of opioid withdrawal. These uncommon withdrawal features can be due to presence of some street contaminants in the heroine or concurrent use of other substances like alcohol and benzodiazepines which was concealed by the patient. Opioid withdrawal can be complicated and life-threatening, in rare circumstances. Hence, one should be very careful while evaluating patients with opioid withdrawal.

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