Management of Alcohol Withdrawal in the Critically Ill Patient: A Selected Review

To the Editor: In the article "Management of Alcohol Withdrawal in the Critically Ill Patient: A Selected Review" (Henry Ford Hosp Med J 1986;34:87-9) the authors emphasize treatment with phenothiazines, paraldehyde, benzodiazepines, barbiturates, antihistamines, butyrophenones, beta-blockers, and ethanol. Many of these agents, such as ethanol and particularly paraldehyde, have been found to be toxic to the brain of the patient and should not be used under any circumstances.

In "The Physiological Basis of the Treatment of Delirium Tremens" (1), I pointed out that the major problem in dealing with chronic alcoholics, particularly those who develop delirium tremens, concerned their electrolyte imbalance, vitamin deficiency, and liver function. Many of these patients had a diminished blood volume, and once the blood volume was restored by intravenous medication we found abnormally low levels of most electrolytes and particularly magnesium. Because many symptoms of the patients in delirium tremens and withdrawal states are similar to those of magnesium deficiency, we found it necessary and useful to restore magnesium to the normal levels. Since the Journal paper was written by a surgical team, I would expect Ms. Kantz and Dr. Horst to be especially interested and attentive to restoring the fluid, electrolyte, and vitamin balance of their patients.

It is not my point that the authors go back to my procedures and insights from 1959. I'm sure that better tools are available to measure the authors' patients' withdrawal from alcohol, we deal with people who have long neglected their intake, many of whom have gastritis, cannot keep their food down, and are subject to the many disturbances and abuses that I have described in my paper. I found that 40% of the patients had evidence of physical trauma prior to admission. Fully half of the patients had evidence of either gastritis or peptic ulcer. Therefore, these patients must be treated with special attention to the multiple and complex psychological and physiological disturbances. Their demand for sedation has to be handled with the greatest caution, because if their wishes to be heavily sedated are granted, the physicians may miss the symptoms of the multiple and potentially lethal physiological disturbances.

In addition to the proper attention of the physiological problems, it is necessary to deal psychotherapeutically with the myriad of problems these patients have in their minds and in their lives. Only then does one get beyond just securing their survival.

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Reference

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: The authors would like to thank Dr. Krystal for his comments and for bringing our attention to his article. We are in complete agreement with him. Fluid, electrolyte, nutritional, and psychological support are essential in this patient population. In our surgical ICU patient population, the symptoms of delirium tremens are superimposed on trauma or acute surgical illness. Because the symptoms of delirium tremens are similar to symptoms of postoperative complications, the diagnosis remains one of exclusion.

Replacement therapy of fluids, electrolytes, and nutritional support are routinely provided and carefully monitored. Despite this replacement therapy, many of these patients remain hyperdynamic and hypermetabolic. These patients, in our opinion, require additional medication for support during their acute illness.

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Idiopathic Bilateral Chylothorax Presenting as a Left-Sided Neck Swelling

To the Editor: I enjoyed the article "Idiopathic Bilateral Chylothorax Presenting as a Left-Sided Neck Swelling" by Tankanow et al (Henry Ford Hosp Med J 1986;34:130-1). As the authors point out, the anatomy is extremely important in understanding the drainage of the lymphatic system as it traverses the diaphragm. One of the guides used for ligation of the thoracic duct as it enters the thoracic cavity is its relationship between the aorta and the azygos vein. The thoracic duct enters the thoracic cavity through the aortic hiatus at the level of the 12th thoracic vertebra, and not through the esophageal hiatus as stated in the authors' discussion. On the other hand, the esophageal hiatus is at the level of the 10th thoracic vertebra and includes the esophagus as well as the right and left vagus nerves.

Marc J. Shapiro, MD
Assistant Professor of Surgery
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Suggested Reading

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: We appreciate Dr. Shapiro's comments. As he points out, the thoracic duct is transmitted through the aortic hiatus at the level of the 12th thoracic vertebra and not the esophageal hiatus as was stated in our article.

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Carlos Petrozzi, MD
Joseph C. Ward, MD
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