Question: Referral from a psychiatrist to you: A 38-year-old with 12-year history of daily alcohol use (AUDIT score 28), currently on alprazolam 3mg/day prescribed by a general practitioner for "anxiety" for the past 4 years, recent urine drug screen positive for cannabis. He uses cannabis once a week or fortnight. He is now presenting with auditory hallucinations, full-body tremors, and sleeplessness after abruptly stopping alcohol three days ago. He has no prior psychiatric diagnosis history. He has attempted suicide a week back by taking 10 tablets of Alprazolam. MMSE is 24/30. Liver enzymes (AST, ALT, GGT) are 3times the upper limit of normal. He is a daily wage labourer, lives in a rural area, and has poor family support.

(500-1000 words)

Discuss:

(a) Provisional diagnosis, stepwise clinical management in the first 72 hours, including risk stratification; 10 marks

(b) The pharmacological management specific to managing concurrent alcohol withdrawal, benzodiazepine use disorder (?), and recent onset hallucinations; 10 marks

(c) Your long-term treatment plan integrating evidence-based pharmacotherapy for AUD, use of alprazolam, and psychosocial interventions, with attention to his socioeconomic constraints and access to care. 10 marks

Answer

The three conditions must be managed simultaneously with careful sequencing. For alcohol withdrawal, Lorazepam in symptom-triggered doses is the cornerstone, given liver disease. For benzodiazepine dependence,{substitution and tapering} alprazolam 3 mg daily is approximately equivalent to diazepam 30 mg. This equivalent dose is incorporated into the total benzodiazepine dose during the acute phase and then tapered gradually at a rate of 5 to 10 percent per week once the patient is stable. Abrupt alprazolam discontinuation risks severe benzodiazepine withdrawal including seizures and must be avoided. This slow structured taper continues over three to six months even after discharge.

For hallucinations, adequate benzodiazepine dosing is the primary treatment, as auditory hallucinations in alcohol withdrawal typically resolve with withdrawal control. If they persist beyond 48 to 72 hours despite adequate sedation, low-dose Haloperidol 2.5 to 5 mg orally or intramuscularly is cautiously added. Antipsychotics lower seizure threshold and must never replace benzodiazepines as the primary agent. In liver disease, antipsychotics are kept at the minimum effective dose with hepatic monitoring. Magnesium sulphate is given intravenously if serum levels are low, as deficiency worsens tremors and lowers seizure threshold independently. Thiamine, B-complex, and folic acid are continued throughout hospitalisation.

Gen AI score is 75-85%