Highlighting the Importance of a Comprehensive Workup for Altered Mental Status on the Detox Floor: A Case Report

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Background: Often on the detox wing, the symptom of altered mental status (AMS) has a presumed etiology: the detox process. However, providers must also remain vigilant when AMS does not follow the expected clinical course. In this case report, we discuss hypovolemia, a rare cause of AMS on the detox unit. Our patient's hypotension expected from hypovolemia was masked by the hypertension typical of the alcohol withdrawal process.(1, 2) This case report highlights the differential for atypical AMS on the detox floor and the steps of evaluation.

Case Presentation: A 52-year-old man with a history of severe alcohol abuse was transferred to the emergency department (ED) from another detox facility due to worsening mental status. He had been consuming large amounts of alcohol daily and had several medical conditions: alcohol use disorder, alcoholic hepatitis, alcoholic cirrhosis, tobacco dependence, psoriasis, anemia, hypertension, and GERD.

Upon arrival at the ED, the patient was disoriented, lethargic, and had a cerebellar tremor. Lab results obtained on admission revealed Hemoglobin (Hgb) 8.4 g/dL (13.8-17.2g/dL), B12 1424 pg/mL (160-950pg/mL), Folate 34 ng/mL (2-20ng/mL). Vitals were BP 110/70, Pulse 76 beats/min, respiration rate 16 breaths/min. He was evaluated for alcohol withdrawal and received lorazepam per the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar).

On the second day, the patient's condition did not follow the usual course of alcohol detoxification. A neurology consult was requested due to ongoing delirium, and the patient was found to have myoclonic jerks and hyperreflexia. He was transferred to the medical Intensive Care Unit (MICU) for multifactorial encephalopathy, including acute anemia of 6.1 g/dL.

Further investigation revealed a hematoma located between the left gluteus maximus and the proximal left femur with extensive adjacent soft tissue edema, likely caused by falls in the previous detox facility. The patient underwent surgical evacuation and received hemoglobin raising his levels to 8.4g/d. The patient's AMS markedly improved and he was oriented to person place and time.

Conclusion: This case highlights the complex medical issues associated with chronic alcohol abuse and the importance of a multidisciplinary approach to treating complicated patients on the detox floor. This case also shows how conditions such as hypovolemia may be masked by the psychological withdrawal process.(1) In this case we propose that the hypertension classically seen in alcohol withdrawal assisted in masking the hypovolemia associated with blood loss causing the patient to present as normotensive. (3)The complexity of this case shows the importance of a thorough workup including physical exam, comprehensive labs, and imaging, in working up AMS.

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