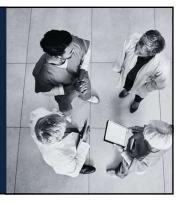
SAM REVIEW COURSE 2023

Interesting Cases: Applying Concepts to Unexpected Real-Life Scenarios

Edwin A. Salsitz, MD, DFASAM Associate Clinical Professor Mount Sinai Beth Israel New York, NY





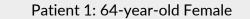


### **Financial Disclosure**

Edwin A. Salsitz, MD, DFASAM

No relevant disclosures





- Admitted to rehab for treatment of AUD following a "detox" protocol. MMTP 60mg for many years-OUD in Remission
- Married: Spouse no SUD
- F: +EtOH M: No EtOH 4S: No EtOH 2Children: No EtOH
- HS Graduate: Employed in Sales
- Social, Occasional EtOH until age 56
- ? Event  $\rightarrow \uparrow \uparrow$  EtOH one year after event  $\rightarrow$  AUD
- PE: unremarkable
- Labs: Normal CMP, CBC, Lipids
- UDT: + Methadone

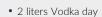
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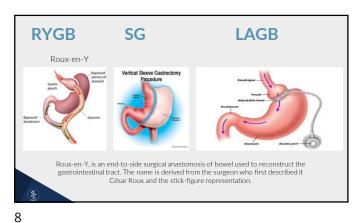




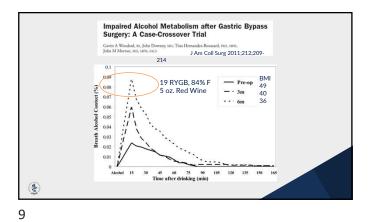






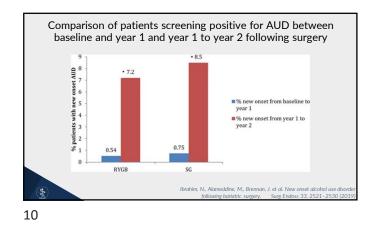




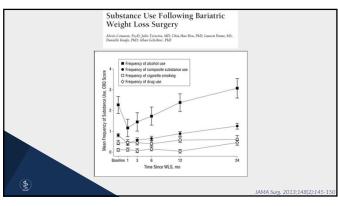




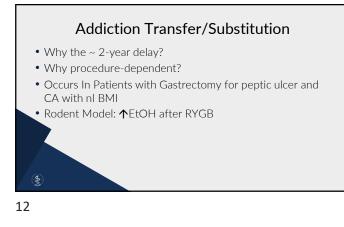












### Pharmacokinetics/Pharmacodynamics

- Explains Difference RYGB, SG, LAGB
- $\downarrow$  Gastric ADH (Cimetidine H2 Blocker)
- $\downarrow Weight \rightarrow \uparrow$  Socialization
- $\uparrow$  Absorption,  $\uparrow$  Cmax, earlier Tmax
- Feeling More Intoxicated
- AUD>> Other SUDs
- Cocaine Analogy: I.N.  $\rightarrow$  Smoked (Crack Cocaine)

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# Predictors of AUD Post WLS

- Type of Weight Loss Surgery
- Male: Women More WLS
- Younger Age, FH
- EtOH use Pre-Op
- Tobacco, Illicit Drug Use
- ADHD
- Lower Sense of Belonging, Depression
- More Weight Loss  $\rightarrow \uparrow$  Socialization  $\rightarrow \uparrow$  EtOH

-

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# Key Takeaways

- New Onset EtOH related problems occur in ~ 10% of WLS Pts.
- More likely with RYGB & SG than with LAGB.
- Some WLS patients  $\downarrow$  EtOH intake.
- EtOH problems increase over time. Usually begins ~2 years after WLS.
- Inform and Monitor all WLS patients about the risk of AUD/SUD over time.
- Special Thanks to Allan Geliebter PhD, for alerting me to the relationship between Bariatric Surgery and Alcohol

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### Sudden Death IVDU

- 26 yo male
- 8 year hx of OUD
- Prescription Opioids  $\rightarrow$  IN Heroin  $\rightarrow$  IV Heroin last 12 months
- 3 non-fatal ODs last 8 months
- Non compliant with Bupe Rx and Psychosocial Tx
- Argued with his Mother: Went up to his Room: Mother heard a loud thud, found him on floor, unresponsive, with syringe and needle in his arm 5 minutes later.
- Naloxone Nasal Spray 4mg administered X2–No Response
- Patient could not be resuscitated by EMS

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# What Happened?

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### Sudden Death IVDU

? Typical Opioid Induced Respiratory Depression Fatal Overdose
 Time Frame: ≥ 1 hour: Naloxone Reversal Effectiveness Evidence

- Post Mortem Toxicology: +Fentanyl, -Norfentanyl, +Heroin, -6-MAM, +Morphine
- Fentanyl Induced Chest Wall Rigidity ("Wooden Chest")
   Fentanyl Induced Respiratory Muscle Rigidity & Laryngospasm

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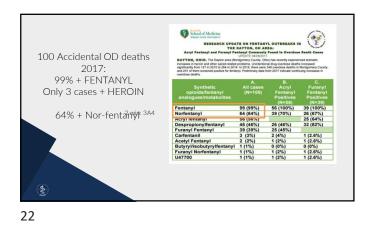
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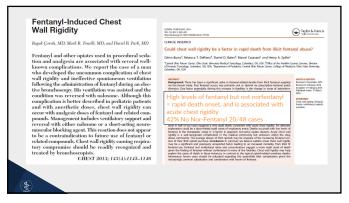
### Fentanyl Chest Wall Rigidity

- First Reported in 1953 in anesthesia literature
- Skeletal Muscle Rigidity: Chest Wall Most Common
- Most common with fentanyl and its congeners (lipid solubility)
- Most common with rapid IV administration
- ? Activation of the coerulospinal noradrenergic pathway, following mu receptor activation in LC
- ? dose related
- +/- Reversal with naloxone (IV route in literature): succinylcholine in OR
- Ventilatory SupportLow or Absent Nor-fentanyl (appears in 2 minutes: CYP3A4)

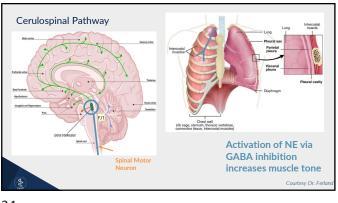
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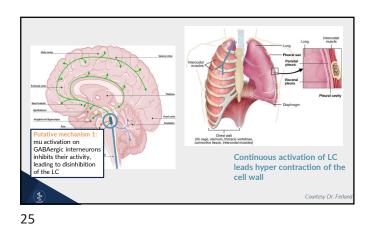




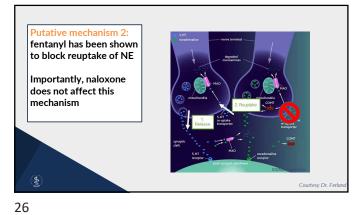


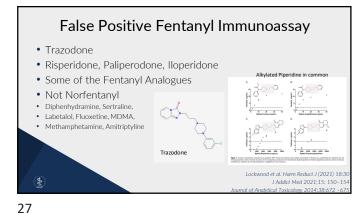
#### Slide 24

**FJ1** Ferland, Jacqueline-marie, 3/16/2021



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### 38 yo Female with AUD

- Admitted to inpatient rehab following alcohol "detox" with chlordiazepoxide Sept 2016
- Never felt happy—anxious, low self esteem
- Father physically abused patient: mother ignored
- Raped on street by stranger while intoxicated with EtOH: age 20
- EtOH, THC in H.S.: IN cocaine D/C'd 10 yrs ago: heroin IN X4 did not like: never IV. EtOH preferred: Benzos last few years

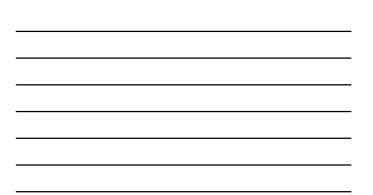
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# 38 yo Female with AUD

- Rehab is a locked unit, with visitors 1xweek--Sunday. Pt. had visitor on  $3^{\rm rd}$  day of rehab
- Started on Gabapentin 300mg tid on admission for MAT for AUD
   On 4<sup>th</sup> day of rehab, 9AM, patient had altered mental status, and rapid response called. Patient was somolent: O2 Sat=91%, Glu=64, BP-125/70, P=60, Pupils=nl. After DW50 and IV hydration MS improves. Remains on Rehab unit.
- UDT: Negative -opiate, cocaine, THC, benzo, PCP, MTD, Bupe Blood Alcohol Level: 312mg/dl
- What Happened?? • Where did the Alcohol come from?

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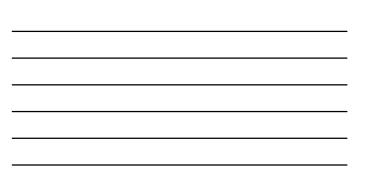






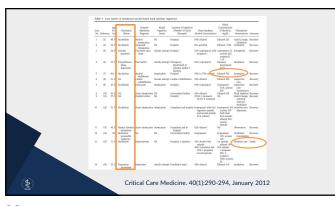






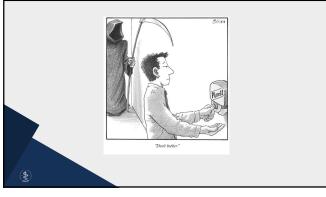
# 38 yo female with AUD

- 5 year hx of drinking hand sanitizer in health care facilities; like Vodka—but stronger
- Would drink Sanitizer to alleviate withdrawal
- No hangovers
- Also drank Listerine
- Required ICU and intubation in the past















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