Although the recognition of FASD is important, its prevention is essential. Given that no safely established level of alcohol consumption in pregnancy exists, recommendations suggest that pregnant women maintain abstinence. In addition, women who are considering pregnancy or are already pregnant must be counseled about the effects of alcohol on the fetus.

Medical Management of Alcohol Withdrawal and Delirium Tremens

For the patient with probable alcohol withdrawal, comorbid conditions that may coexist or mimic the symptoms of withdrawal (e.g., infection, trauma, hepatic encephalopathy, drug overdose, gastrointestinal bleeding, and metabolic derangements) should be excluded. Once this has been accomplished, the patient should be placed in a quiet and protective environment and should receive parenteral thiamine and multivitamins to decrease the risk of Wernicke encephalopathy or Korsakoff amnestic syndrome.

The Revised Clinical Institute for Withdrawal Assessment for Alcohol (CIWA-Ar) scale (available at https://umem.org/files/uploads/1104212257_CIWA-Ar.pdf), a measure of withdrawal severity, is useful in guiding symptom-triggered therapy in medically stable (i.e., non ICU or postoperative) patients. Benzodiazepines are the only medications proved to ameliorate symptoms and to decrease the risk of seizures and DTs in patients with alcohol withdrawal. Typically, diazepam (5 to 20 mg), chlordiazepoxide (50 to 100 mg), or lorazepam (1 to 2 mg) is administered intravenously every 5 to 10 minutes until symptoms subside, with the last of these medications preferred in patients with advanced cirrhosis, considering that the liver minimally metabolizes it. All benzodiazepines appear to be similarly efficacious in treating alcohol withdrawal, but long-acting agents may be more effective in preventing withdrawal seizures and are associated with fewer rebound symptoms. Conversely, short-acting agents may offer a lower risk of oversedation. For the patient who is resistant to benzodiazepines, intravenous phenobarbital (130 to 260 mg administered intravenously every 15 minutes until symptoms are controlled) may be given.

PRESCRIPTION DRUG ABUSE

According to the National Survey on Drug Use and Health, an estimated 6.1 million Americans aged 12 years or older used prescription-type psychotherapeutic drugs nonmedically in the past month (Fig. 126-3). This estimate represents 2.4% of the population aged 12 years or older. In 2011, the illicit drug category with the largest number of recent initiates was marijuana use (2.6 million), followed by nonmedical use of pain relievers (1.9 million) and nonmedical use of tranquilizers (1.2 million). More people in the United States now die of prescription drug overdose (i.e., the nonmedical use of prescription-type pain relievers, tranquilizers, stimulants, and sedatives) than accidental vehicular trauma.

Sedatives and Hypnotics

Benzodiazepines and barbiturates are the major sedative-hypnotic drugs among the commonly abused agents that are listed in Table 126-4. The patient with sedative-hypnotic intoxication may have slurred speech, incoordination, unsteady gait, impaired attention or memory, stupor, and coma. The psychiatric manifestations of intoxication include inappropriate behavior, labile mood, and impaired judgment and social functioning. On physical examination, the person may have respiratory depression or even arrest, nystagmus, and hyper-reflexia. Although benzodiazepines rarely depress respiration to the extent that barbiturates do (and, as a result, have a much wider margin of safety), the effects of these drugs are additive with those of other CNS depressants, such as ethanol. Chronic use may produce physical and psychological dependence and a potentially dangerous withdrawal syndrome.

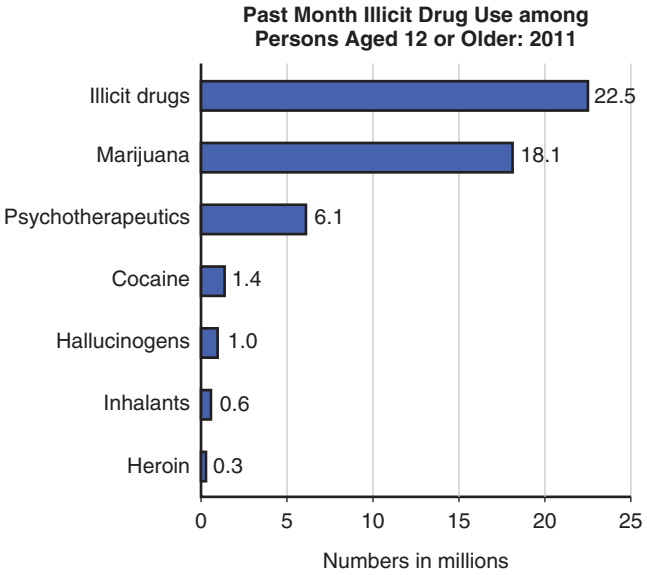

FIGURE 126-3 Past-month illicit drug use among persons aged 12 or older, according to the National Survey on Drug Use and Health (2011). (From Substance Abuse and Mental Health Services Administration: Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-44, HHS Publication No. [SMA] 12-4713, Rockville, Md., 2012, Substance Abuse and Mental Health Services Administration.)

Benzodiazepines potentiate the effects of GABA, which inhibits neurotransmission. They are available as short-acting agents (temazepam [Restoril] and triazolam [Halcion]), intermediate-acting agents (alprazolam [Xanax], chlordiazepoxide [Librium], estazolam [ProSom], lorazepam [Ativan], and oxazepam [Serax]), and long-acting agents (clorazepate [Tranxene], clonazepam [Klonopin], diazepam [Valium], flurazepam [Dalmane], halazepam [Paxipam], Prazepam [Centrax], and quazepam [Doral]). Flunitrazepam (Rohypnol, also known as *roach, roofies, circles, Mexican valium,* or *rope*) is a popularly abused benzodiazepine that is not legally available in the United States but is often smuggled here from other countries. It has been implicated in cases of date rape and is known as a club drug because adolescents and young adults often use it at nightclubs and bars or during all-night dance parties called raves.

In persons with an acute benzodiazepine overdose, respiratory depression is the major danger. Flumazenil (Romazicon), a competitive antagonist of benzodiazepines, can be given intravenously for acute overdose. Although it reverses the sedative effects of benzodiazepines, flumazenil may not completely reverse respiratory depression, and it may cause seizures in patients with