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Patient Case Study

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Prescribing information is available either at the meeting where these slides are presented or available online in the link below this presentation

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Patient Profile

- Audrey was a 56 year old lady who lived with her elderly mother. She had not worked for some years due to anxiety and was reliant on benefits.
- She had a brother who was 2 years older and lived at the same address.
- She had returned to live at her mother’s property following a divorce 7 years ago.

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Patient History

- The admission in June 2020 was her first presentation to hospital and she was brought in by ambulance due to family concerns of increasing confusion, abnormal behaviour and reduced mobility.
- Other than her anxiety, she had no previous medical history of note and was not on any regular medications.
- She had a history of daily alcohol use of 3 bottles of wine daily with additional whiskey.

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Patient Situation

- She presented with acute confusion. She was not orientated to time, place or person and had poor mobility. She was deemed to be unsafe to self mobilise without assistance.
- She appeared significantly malnourished and had a BMI of 17.2
- She was pleasant in manner and there was no evidence of violence or aggression from her. She was happy to remain in hospital though she was unaware that she was in hospital for the first 48 hrs of her admission. She was ‘pleasantly confused’.
- The history of alcohol dependency and abnormal liver function tests (LFTs) meant she had been put on an alcohol withdrawal symptom triggered regimen. She was reporting to Drs on the ward that she drank 3 bottles of wine daily and sometimes whiskey as well. Due to her confusion she had been given several doses of withdrawal medication before she was seen by the Alcohol Care Team (ACT). She was on IV Pabrinex® (high potency vitamins B and C) – 2 pairs x3 daily.

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Actions and Outcome

- She was seen by the Alcohol Care Team 40 hrs into her admission. Nurses reported her confusion was worse and she was more agitated mainly due to ongoing questioning around orientation to monitor her alcohol withdrawal. Due to COVID visiting restrictions no family had been seen.
- On first examination she was clearly malnourished, was immobile so ACT were unable to assess her gait. She had a mild nystagmus to her left eye although she had poor compliance with neurological assessment and reported she had a 'terrible memory' – that was 'normal' for her.
- She did not appear to be in any level of alcohol withdrawal and couldn't tell ACT when her last drink was. She had low magnesium on admission bloods (0.58mmol/litre – normal range is 0.70 to 1.00 mmol/litre) and was on oral magnesium replacement. She wasn't prescribed a multi vitamin. Her CT scan had been performed to exclude head injury and showed nil acute of note.
- The Consultant on the admission unit had referred as URGENT to ACT as he felt it was all alcohol withdrawal related and was concerned she was getting worse.

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Action taken by ACT

ACT telephoned the family for collateral alcohol history and established she had been alcohol free for 8 days.

ACT requested that her magnesium be aggrievedly corrected with IV replacement instead of oral and re-checked.

She was increased to 3 pairs of Pabrinex TDS immediately but for 5 full day of IV Pabrinex once her magnesium had normalised.

She was started on Sanatogen A-Z complete OD.

She was for ACT review in 72 hrs.

All withdrawal medication was stopped.

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Key Learnings

Once her magnesium had been corrected there was significant improvement in Audreys presentation with ongoing, high dose, Pabrinex.
When she was reviewed 3 days later she was orientated to time, place and person and her family she felt she was back to pre-admission levels of cognition.
She did not remember seeing ACT 3 days before despite having undergone an extensive assessment.
ACT were able to go through the Alcohol Related Brain Injury (ARBI) leaflet with her in an attempt to improve compliance with vitamin replacement in the community and to re-iterate the importance of good nutrition.
GP was informed of the evidence of ARBI in her presentation and that there had been significant improvement in her symptoms with parenteral B1.
An outpatient fibroscan was booked with ACT 6 weeks later for follow up. At this scan she reported feeling much better and taking her vitamin replacement regularly. Her diet had also improved.

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