

48 - Withdrawal management

Withdrawal management

Addictions and substance misuse CHAPTER 4 GHB and GBL dependence Gamma-hydroxybutyrate (GHB) and gamma-butyrolactone (GBL, a pro-drug of GHB) are colloquially often referred to as 'G'. They reduce anxiety and produce disinhibition and sedation, primarily through actions at the GABA-B receptor. These drugs are used recreationally for socialising and occasionally to aid sleep. Among men who have sex with men (MSM) they can be used, often alongside stimulants such as mephedrone and crystal methamphetamine, to facilitate sex in the context of potential high-risk sexual behaviour ('chemsex'). Both GHB and GBL have a narrow therapeutic index and overdose is not uncommon. Dependence is rare, but in dependent users withdrawal has a rapid onset and can produce severe delirium with paranoid delusions and life-threatening complications.¹ The withdrawal syndrome^{1,2} Dependent users take doses 'round the clock' (consuming doses day and night, typically every 1–3 hours). The onset of withdrawal symptoms occurs a few hours following the last dose. This withdrawal syndrome is similar to alcohol withdrawal and may include symptoms such as tachycardia, insomnia, anxiety, sweating and fine tremors.¹ Untreated, it can progress to agitated delirium, often with psychotic features (including paranoid delusions and hallucinations) later followed by severe tremors, muscle rigidity and seizures.¹ Muscle rigidity may be so severe as to produce fever, rhabdomyolysis and acute renal failure. The requirement for medication to manage symptoms eases over 4–6 days, although there are case reports of more prolonged withdrawal. Withdrawal management The evidence base for detoxification is limited. The core principle of managing withdrawal is to treat early and so prevent the development of delirium and other complications. Once established, delirium can be difficult to control.³ Early treatment with benzodiazepines is required, and baclofen (a GABA-B agonist) and phenobarbital have also been used effectively as adjunctive medications.^{1,4} Antipsychotic drugs are used in some countries.⁵ Baclofen is freely available online and may be obtained by users for unsupervised withdrawal,⁶ something which, given the dangers involved in withdrawal, should be unequivocally discouraged. There is as yet no validated screening tool to determine when patients should receive pharmacological treatment for withdrawal symptoms. However, two case reports suggest that the CIWA-Ar scale can be used in the assessment of patients withdrawing from GHB.^{7,8} GHB itself has also been successfully used to aid withdrawal⁹ with reducing doses given every 3 hours over up to 2 weeks. Pharmaceutical GHB may be more effective than benzodiazepines in managing withdrawal.¹⁰ GHB and GBL misuse is uncommon but medically important because, in dependent users, withdrawal can proceed rapidly to life-threatening agitated delirium. Complications include

seizures, bradycardia, cardiac arrest and renal failure. Professionals in acute and psychiatric hospitals need to be able to recognise and manage acute withdrawal.

538 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Box 4.7 Management of planned elective withdrawal Setting ■ ■ All patients undergoing planned withdrawal should be medically supervised ■ ■ Ambulatory community detoxification should be attempted only where there is no history of delirium or psychosis. A responsible third party should be at home who is able to monitor and support the withdrawal process. There should be the option of transferring the patient to an in-patient unit if symptoms are not well controlled For up-to-date guidance on the management of GHB/GBL withdrawal, it is recommended in the UK that information be sought from the National Poisons Information Service (NPIS),¹¹ specifically the NPIS 24-hour telephone service and the poisons information database TOXBASE.¹² The two scenarios with which clinicians should be conversant are unplanned acute withdrawal (Box 4.6) and planned elective withdrawal (Box 4.7). Box 4.6 Management of unplanned acute withdrawal Setting ■ ■ Acute unplanned withdrawal is a medical emergency and should be managed in the acute hospital inpatient setting ■ ■ Severe withdrawal may require admission to ICU Initial pharmacotherapy ■ ■ Initiate diazepam 20mg PO as soon as withdrawal symptoms are observed ■ ■ Diazepam can be repeated at 30 minutes to 4-hourly intervals until symptoms are controlled ■ ■ Most cases of GBL withdrawal require 60–80mg diazepam in the first 24 hours ■ ■ Higher daily dosages of up to 300mg PO diazepam may be necessary ■ ■ If on assessment the patient is drowsy, withhold diazepam dose, monitor respiratory signs and review once sedation attenuates ■ ■ One-to-one nursing care may assist in managing severe cases ■ ■ If there are concerns about the level of drowsiness from treatment with benzodiazepines then early discussion with anaesthetics/ICU team is advised to consider need for airway support ■ ■ From day 2 a tapering regimen of diazepam is started based on the total diazepam administered in the first 24 hours Adjunctive pharmacotherapy ■ ■ Initiate baclofen 10mg PO tds in combination with benzodiazepine withdrawal regimen where benzodiazepines prove inadequate ■ ■ This can be titrated to 20mg PO tds in cases of continued anxiety and agitation ■ ■ In cases of severe withdrawal consider addition of phenobarbital in doses of 150–450mg/day oral or IV* (ICU only)¹³ ■ ■ In cases where severe withdrawal remains uncontrolled, IV anaesthetics such as propofol* may be required (ICU only) ■ ■ Thiopental* coma has also been used in severe resistant withdrawal¹⁰ *The respiratory depressant effects of phenobarbital, thiopental and propofol cannot be reversed; facilities for mechanical ventilation should be available. GBL, gamma-butyrolactone; ICU, intensive care unit; PO, by mouth; tds, three times a day.

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