Patient was a 35 year- old male who was admitted to Hospital 4919 for alcohol detox with ethanol levels of 432 mg/dL. On the same day, he was transferred to Hospital 3 for suspected delirium tremens, a rapid onset of confusion usually caused by withdrawal from alcohol. Upon transfer his medication list was as follows: Ativan as needed, Thiamin, 100 mg , Vitamin C, Trazodone 50 g, Folate 1mg, 65 mg of Methadone, Depakote 500 mg, Paxil 40 mg, and Seroquel.

In the Emergency Department of Hospital 3, the patient was given Ativan as needed throughout the night and four liters of IV fluids. He was sedated in the emergency department with visible tremors. Upon physical examination, his heart rate was in the 110s and blood pressure 168/100. Patient was tachycardic with no murmurs and Pulmonary was clear to auscultation. His abdomen was soft and nontendor Upon medical history examination, it was discovered the patient had history with Alcoholism, Opiate dependence (Methadone), Hepatitis C, and PTSD. With laboratory data on admission a urine tox indicated positive for methadone. CT scans were negative.

Patient was later transferred to the Medical Intensive Care Unit (MICU) at 2:30 am. Patient was lethargic, diaphoretic and in 4pt restraints. According to the MICU nurse, ac round 5:30 pm his Clinical Institute Withdrawal Assessment for Alcohol (CIWA) was scale 26. More Ativan was given, and patient eventually awakened with constant fluids until his electrolytes were replete. He was started on a liquid diet which was eventually increased, and he was able to tolerate full intake. He was given a total of 100 mg of Valium while sedated. Around 7 am, through seeing his brother in the room he began yelling out and experienced heavy sweating and tremors. Another 2 mg of Ativan was given to him and his conditioned ameliorated. Throughout the rest of the night the head of his bed was kept at an angle of 30 degrees.

The Patient was discharged to residential based care after seen by the psychiatric team for suicidal intentions at one point. Suicidal ideation precautions were in place and patient intermittedly followed commands. Around this time, his abdomen was soft. Nothing was allowed by mouth as he was under aspiration precautions. Bed angle was increased to an angle of 45 degrees. The patient stayed overnight and CIWA scores were continued to be taken every two hours by the overnight nurse with shift from 7pm to 7am. His score ranged between 10-14. As the night progressed he became more oriented, his eyes opened to stimuli when asleep and both his pupils were reactive. He moved all extremities and followed commands, denying and pain or discomfort. He called for his girlfriend in his sleep and stated he wanted to go home.

Upon a following physical examination, normal sinus rhythm was in the 70s, BP was 150/100, and lungs were course throughout. He was able to swallow water without any issue, and abdomen was still soft non-tender.

Upon discharge, patient was given 100 mg of Thiamin by diagnosis, 1 mg of Folic Acid, Multivitamins and Methadone.