

Response to “Benzodiazepine misadventure in acute alcohol withdrawal: the transition from delirium tremens to ICU delirium”

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To the Editor:

We read with interest the response by Johnson et al. [1] to our article in the May issue of the *Journal of Anesthesia*, and appreciate their comments [2]. In our retrospective case series, we reported the use of dexmedetomidine for treatment of alcohol withdrawal syndrome (AWS), to avoid mechanical ventilation. We described our protocol, which uses dexmedetomidine as the primary agent for AWS. In addition, adjunctive agents are used at low doses including a benzodiazepine, lorazepam 2 mg intravenously every 6 h, and haloperidol 5 mg intravenously every 6 h.

Johnson et al. suggest a secondary benefit of dexmedetomidine is a lower incidence of delirium tremens, and subsequent less progression to ICU delirium. They also describe their experience with a case of severe AWS in a patient requiring over 1000 mg parenteral midazolam and lorazepam during her course in the ICU. After 11 days she

was placed on dexmedetomidine, with resolution of her AWS within 34 h.

We would like to address the queries in the letter. At the time of our study, we did not have use of the Confusion Assessment Method in the Intensive Care Unit (CAM-ICU) in our hospital as a validated delirium assessment tool. The CAM-ICU was recently implemented at our institution, but have not accumulated enough experience to assert that the dexmedetomidine is reducing the incidence of delirium, although the hypothesis is certainly plausible, and merits further study. We did not collect data specifically on the reduction of benzodiazepine requirements subsequent to initiation of the dexmedetomidine. However, Rayner et al. [3] have subsequently reported 61.5 % reduction in benzodiazepines with the use of dexmedetomidine in their series of AWS patients.

With experience, we have learned that the dexmedetomidine should be started earlier in these patients, and this serves to shorten the course of the AWS. We have managed cases in which the AWS patient had dexmedetomidine initiated on admission to our emergency department, continued in the SICU, and was off the dexmedetomidine and stable for floor care within 36 h. We have also broadened the use of dexmedetomidine to other withdrawal syndromes, including benzodiazepines, opioids, and cocaine. It has also been particularly effective for the polydrug abuser, a traditionally difficult patient experiencing overlapping withdrawal syndromes.

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