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SOMEBODY HAS A BAD EVENING

Pilar Valverde Vallejo. Jorge Palacios Castillo. M del Carmen Cabrera Martínez.
Emergency Hospital Regional de Málaga. Málaga. Spain.

HOSPITAL REGIONAL UNIVERSITARIO DE MÁLAGA

Personal history and reason for inquiry:

56 years old patient, no known drug allergies. No known toxic habits. Depressive disorder treated with Citalopram and Lorazepan, is run on public roads by mobile ICU to those who warn citizens after seeing how the patient came out of a bar with signs of drunkenness and falls to the ground suddenly.

Physical examination:

The arrival of the mobile unit found an obese patient, in a State of unconsciousness (Glasgow 3) no signs of external trauma, cyanotic and in respiratory arrest. TA: 90/40. FC: 35 BPM. 60% O2 saturation. They come to the IOT is not possible, opting for placement of laryngeal mask and intravenous atropine administration. After starting the patient oxygen saturation improved oxygenation to 94-96% and pressure above 100 mmHg systolic numbers, decided to transfer to hospital.

Attended in box of critics, the patient is sedated and painless with midazolam + fentanyl, TA: 110/50. FC: 60 BPM. O2 saturation of 95% LMA.

- Head and neck: there is no external injuries. Symmetric and palpable pulses.
- Cardiac auscultation: Rhythmic (60 BPM). No murmurs or rods.
- Respiratory auscultation: MVC. Ventilate both hemithorax.

Abdomen: globulous.

It is orotracheal intubation prior to moving to radiology and realization of TAC's skull. Extracted samples of blood and urine for analysis with ethanol and toxic urine.

Complementary tests:

- Portable chest x-ray: endotracheal tube. It is images of condensation, infiltration or pneumothorax.
- ECG: RS to 60 BPM. Unaltered driving or the Repolarization.
- Skull CT: without significant findings.
- Analytical income: Leukocytosis, neutrophilia without highlights. PCR negative and toxic in urine positive for benzodiazepines. ETHANOL in blood 320 mg/dl.

Evolution:

The patient was transferred to intensive care unit where remains hemodynamically stable to extubation and subsequent discharge from the unit with initial transfer to Department of medicine internal completion of consultation to Psychiatry: are relatives the patient when they come to hospital which inform the patient, with a prior diagnosis of depressive disorder, had noticed it something sad in recent weeks and that after having had lunch in place of taking 1 tablet 1 mg lorazepam, took 5 because he was "rather distressed". Later he decided to go out to clear it.

Conclusions:

We have a non drinker patient known alcohol that's acutely suicidal intentions taken 5 times their usual dose of benzodiazepines and subsequently decides to take alcohol compulsively in an effort to soothe his State of anxiety. As a result we have a drug and alcohol intoxication which causes decreased level of consciousness until coma and almost causes arrest if it fails to be a fast and efficient action by emergency services Hospital.