Acute opioid detoxification revealing a unique challenge in clinical management

Alexander Sabre, Lydia Ehlenberger

ABSTRACT

Introduction: Opioid abuse in pregnancy is inherit to a multitude of adverse outcomes for both mother and fetus, with use of intra-dermal injections for drug delivery leading to systemic sequela such as endocarditis. In patients with history of drug abuse, infective endocarditis most frequently presents as a subacute disease process that requires high clinical suspicion. Case Report: We report a case of a 21-year-old caucasian female, G3P0020, who presented to the emergency department in a state of acute opioid withdraw. Initial investigation detailed a positive pregnancy test and leukocytosis. The extensive workup revealing a viable embryo and culture negative endocarditis (CNE) with vegetation on tricuspid valve and further care ensuring proper treatment for inpatient course. Conclusion: We present a clinical case of intravenous-opioid derived CNE composed of challenges that required multiple disciplines and collaboration of multiple specialties in the gravid patient along with detailed information on management in this subset of patients.

Keywords: Endocarditis, Pregnancy, Opioid dependence

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INTRODUCTION

The first successful treatment of bacterial endocarditis in the gravid patient was described by Nazarian et al. in 1976 [1]. The incidence of infective endocarditis during pregnancy as noted in literature, is 0.006%. Significant mortality for both mother and fetus has been established for this disease, with maternal mortality rate reaching 33% and fetal mortality at 29% [1].

Perinatal mortality is a significant challenge in the care of drug users. Fetal activity and oxygen demand increase during accidental withdrawal and intentional abstinence, which may coincide to hypoxic dysfunction of the placenta or labor; resulting in fetal death [2]. Ensuring that acute withdrawal from drug intoxication was minimal, placement of methadone maintenance treatment (MMT) has long been used to treat dependence in pregnancy. Although MMT can be associated with neonatal abstinence syndrome (NAS) in 60–90% of infants exposed to methadone in utero, the adverse effects of uncontrolled withdrawal highlight its practical use [3]. This standard of care endorsed by the American Academy of Pediatrics (AAP) provides many benefits which include increased fetal growth, improvements in prenatal care, and a reduction in fetal mortality [4].

We wish to present a clinical case of intravenous-opioid derived CNE encountered in obstetric practice,
provide relevant background information on opioid abuse and withdrawal in pregnancy, present the appropriate use of MMT in the pregnant patient, and to provide clinicians information on how to properly recognize, diagnose, and treat CNE in this patient population.

CASE REPORT

A 21-year old caucasian female G3P0020 presented to the emergency department with anxiety, weakness, insomnia, nausea, diarrhea, and cramps of less than 24 hours duration. The patient reports the use of a significant amount of heroin by injection daily. She reported that she wanted to undergo detox and presented to the hospital in order to “get clean”. Past medical history is significant for recreational drug abuse for nine years, asthma, and an early first trimester miscarriage at age 20. Past surgical history is significant for an abortive dilation and curettage at age 12. The patient did not take medications and had no known drug allergies. Social history revealed the patient is a current everyday smoker of half a pack of cigarettes a day, and revealed an extensive history recreational drug abuse with methamphetamine, and venous injection of 1 gram of heroin daily.

Vitals signs were blood pressure 98/50, pulse 78/min, respiratory rate 22/min, temperature 38.4ºC, room air O₂ sats 98. Physical examination revealed a young disheveled woman wrapped in a blanket in acute distress, diaphoretic, shivering, and with bilateral erythematous needle-point marks on her arms and legs. The patient was admitted for acute opioid detoxification with further evaluation and treatment.

Laboratory workup revealed a urine drug screen positive for amphetamines and heroin. A urine pregnancy screen was positive, which was followed by serum quantitative beta human chorionic gonadotropin (BHCG) with a level of 38347 IU/L. Blood work was significant for extensive leukocytosis with a white blood cell (WBC) count of 33.2×10⁹/μL. Initial treatment protocol was lorazepam 2 mg for anxiety, methadone titration started at 10 g, a nicotine patch for tobacco abuse, and social services consultation for psychosocial factors. Investigation first began by performing a pelvic ultrasound due to the elevated BHCG levels. Ultrasound examination revealed a seven-week embryo with positive fetal heart tones (FHT), a uterus of appropriate size for first trimester time period, and normal ovaries. Investigation into the leukocytosis and with patient’s recent and extensive history of intravenous drug abuse prompted a 2d trans-thoracic echocardiogram (TTE), which revealed a 3.6 mm vegetative lesion on the tricuspid valve (Figure 1). There was mild mitral regurgitation, and ejection fraction was estimated at 60-65%. Blood cultures taken peripherally from different sites did not give rise to causative organism. A diagnosis of culture negative endocarditis (CNE) prompted empirical antibiotic treatment.

The patient was followed by obstetrics/gynecology, internal medicine, and infectious disease, with the pregnancy considered viable throughout the time in hospital. After the initial presentation of acute detoxification, the patient remained afebrile and did not have any incidences of acute withdrawal symptoms for remainder of stay. The titration of MMT was decreased from initial 10 g to 5 g and maintained at this level for the rest of hospital stay. The patient was followed in hospital for a period of four weeks with no problems. After this time period, the patient was transferred to a skilled nursing facility for continuation of empiric IV antibiotics and 5 g of MMT for outpatient treatment.

DISCUSSION

The most significant cause of non-obstetric maternal death during pregnancy are diseases of the heart accounting for 10% of mortality during gestation [1]. Literature of infective endocarditis is an uncommon occurrence in obstetric and gynecological patients although it is being reported in greater incidence.

The use of heroin and benzodiazepines are associated with complications commonly following intravenous administration and the associated lifestyle that it leads. Needle use can cause localized infection including cellulitis, phlebitis, and superficial thrombosis, with systemic sequelae including endocarditis, septic osteomyelitis, and septicemia [2]. Opioid abuse during
gestation is associated with multiple adverse outcomes for both the fetus and mother including intrauterine growth restriction, placental abruption, preterm births, risk of fetal demise, and neonatal abstinence syndrome (NAS) [5]. There is also increased risk for partaking in high-risk behaviors to support the addiction, which may place the woman at risk for acquiring sexually transmitted diseases, and becoming the victim of violence and legal ramifications [6].

Medication therapy is the standard of care to effectively manage addiction in the gravid patient. Since its use in the 1970’s, methadone has been the first line therapy for gravidus women as it achieves the goal of stopping uncontrolled narcotic withdrawal and the associated secondary adverse outcomes [7]. Administered in a controlled setting once a day, methadone is effective at suppressing maternal cravings due to its long half-life. Based upon the relative efficacy and safety compared to other opioid medications, a 2012 report by the American Academy of Pediatrics (AAP) clinical report suggests that either morphine or methadone is the preferred opioid to prevent and treat NAS [8].

Right sided inflammation of the endocardial tissue and valves can be from IV derived infectious organisms which is due to the anatomical relevance of venous flow to the heart. Prior to the availability of antimicrobial therapy, infective endocarditis (IE) was invariably fatal. Although approximately 80% of patients now survive these infections, one in every six do not survive initial hospitalization, with up to one-third of patients infected with highly virulent organisms (such as Staphylococcus species) dying as direct or indirect result of valvular infection [9]. In contemporary times, IE presents more frequently as an acute disease rather than chronic state. Pertinent investigations combine thorough exploration of history and physical, echocardiography, blood cultures and other select laboratory studies to lead to an expeditious diagnosis [10].

A subset of IE patients present with serological studies that fail to identify causative organisms, known as culture negative endocarditis (CNE). Subacute presentations of endocarditis may present with leukocyte counts at normal or elevated values in patients [11]. Echocardiography should be performed on all patients with a moderate or high suspicion of endocarditis, this allows direct detection and characterization of vegetations on valves or other sites.

Treatment options exclusively include bactericidal categories for effective treatment in IE, avoiding bacteriostatic agents which only hinder growth. In general, therapy should target the organism isolated from blood cultures. For subacute presentation without causative microbial agent, standard of care dictates the administration of empirical therapy. Specific antibiotic regimens will not be discussed, but in general empirical care should include antibiotics for minimum of four to six weeks covering gram negative and gram positive bacteria [12].

CONCLUSION

This case reports an incidence of culture negative endocarditis (CNE) in obstetric practice derived from intravenous heroin abuse and how important multidiscipline collaboration is necessary in the clinical management of CNE in the gravid patient. This case highlights an important pathology that is part of the spectrum of disease being reported in greater incidence and a cause of significant mortality in obstetric patients. This presentation and review of appropriate diagnosis and management is beneficial for the education of physicians for this disease.

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Author Contributions

Alexander Sabre – Substantial contributions to conception and design, Acquisition of data, Drafting the article, Revising it critically for important intellectual content, Final approval of the version to be published

Lydia Ehlenberger – Analysis and interpretation of data, Drafting the article, Final approval of the version to be published

Guarantor

The corresponding author is the guarantor of submission.

Conflict of Interest

Authors declare no conflict of interest.

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