The Many Faces of Gabapentin Withdrawal

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Background

- Despite numerous case reports of gabapentin withdrawal, no risk stratification or consensus guidelines have been established.
- With a rise in gabapentin prescriptions, partly due to expanded off-label use, prompt identification of gabapentin withdrawal and appropriate pharmacologic intervention could avoid significant medical costs and prolonged hospitalization.

Case

- AA is a 55-year-old male with a past medical history of CAD, HTN, DM2, neuropathy, hepatic steatosis, and OSA who was admitted to medicine with encephalopathy and hypoglycemia.
- While initial workup was largely unremarkable, AA remained nonverbal, refusing food, prompting a psychiatry consult.
- Provisional diagnoses included catatonia with equivocal response to lorazepam and hypoactive delirium.
- A medication reconciliation revealed that AA was prescribed **gabapentin 600 mg PO TID outpatient, which was not taken in the days prior to, nor continued upon, admission.**
- Gabapentin was resumed on day 8, with significant patient response.
- Within 24 hours, AA was engaging meaningfully and began eating.
- Following resolution of encephalopathy, the patient was discharged on hospital day 11, with a diagnosis of **catatonia secondary to gabapentin withdrawal.**
- But wait, there's more..

Discussion

- Common symptoms of gabapentin withdrawal: agitation, confusion, diaphoresis, gastrointestinal upset, headache, and tachycardia (1), more severe complications of akathisia, catatonia, and seizures have been reported (2)
- two case reports - catatonia in patients with gabapentin withdrawal (3, 4), this case, to our knowledge, is unique in that it involves two distinct withdrawal manifestations within a short time span in the same patient.
- chronicity of use, high dose regimens, and underlying psychiatric - when assessing risk of more severe complications associated with abrupt discontinuation of gabapentin.
- While treatments varied across documented cases of gabapentin withdrawal, patients prescribed benzodiazepines failed to respond, whereas resolution of symptoms was observed after reinstitution of gabapentin (2).

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Conclusion

This case emphasizes the **challenges of identifying lesser-known presentations of gabapentin withdrawal,** highlights delayed time to resolution following subsequent withdrawal episodes, and **stresses the importance of ensuring access to medication and appropriate education to ensure safe transitions of care.**

Case continued

- AA returned to the ED 2 days later with altered mental status. and OSA who was admitted to medicine with encephalopathy and hypoglycemia.
- Patient's son reported not filling gabapentin following discharge, resulting in abrupt discontinuation.
- AA was readmitted to Medicine however improvement was limited upon resumption of gabapentin.
- Medical work up again was unremarkable, which prompted a transfer to the Behavioral Health Unit on day 6.
- Patient demonstrated waxing and waning attention and global disorientation consistent with **delirium secondary to gabapentin withdrawal.**
- AA was managed with supportive care and ultimately discharged home when orientation status improved; cumulative length of stay was 22 days.

References

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