

# MEDICAL TOXICOLOGY

DIAGNOSIS AND TREATMENT OF HUMAN POISONING

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TABLE 33-11  
STAGES OF ACUTE ALCOHOLIC INFLUENCE/  
INTOXICATION IN NONTOLERANT INDIVIDUALS

BLOOD ALCOHOL CONCENTRATION (% w/v)	STAGE OF ALCOHOL INFLUENCE	CLINICAL SIGN/SYMPTOM.
0.01-0.05	Sobriety	No apparent influence Behavior nearly normal by ordinary observation Slight changes detectable by special tests
0.03-0.12	Euphoria	Mild euphoria, sociability, talkativeness Increased self-confidence; decreased inhibitions Diminution of attention, judgment, and control Loss of efficiency in finer performance tests
0.09-0.25	Excitement	Emotional instability; decreased inhibitions Loss of critical judgment Impairment of memory and comprehension Decreased sensory response; increased reaction time Some muscular incoordination
0.18-0.30	Confusion	Disorientation, mental confusion; dizziness Exaggerated emotional states (fear, anger, grief, etc.) Disturbance of sensation (diplopia, etc.) and of perception of color, form, motion, dimensions Decreased pain sense Impaired balance; muscular incoordination; staggering gait, slurred speech
0.27-0.40	Stupor	Apathy; general inertia, approaching paralysis Markedly decreased response to stimuli Marked muscular incoordination; inability to stand or walk Vomiting; incontinence of urine and feces Impaired consciousness; sleep or stupor
0.35-0.50	Coma	Complete unconsciousness; coma; anesthesia Depressed or abolished reflexes Subnormal temperature Incontinence of urine and feces Embarrassment of circulation and respiration Possible death
0.45 +	Death	Death from respiratory paralysis

Adapted from Dubowski KM: Alcohol determination in the clinical laboratory. *Am J Clin Pathol* 1980;74:749. Used with permission.

The plasma/whole blood ethanol ratio is approximately 1/1.18. If the blood specimen was centrifuged and the cellular elements removed, then the resultant reading for the plasma or serum must be reduced by 16%–18% to convert the value to a blood ethanol level. Proper collection technique involves the use of nonalcohol skin antiseptics, although at least one study found no significant difference between alcohol and nonalcohol preps in measurement of the blood ethanol level.<sup>58</sup> Another study also showed that performing the venipuncture through a pool of 100% ethanol on the skin did not affect ethanol results as determined with the DuPont automatic clinical analyzer.<sup>69</sup>

#### Postmortem Blood Alcohol Specimens

Blood ethanol produced by postmortem decomposition rarely exceeds 50 mg/dL.<sup>70</sup> Fluoride ion, mercuric ion, and cold storage inhibit the tissue formation of ethanol by microorganisms. Femoral and jugular veins are the best postmortem blood sampling sites. Intracardiac samples may demonstrate falsely elevated ethanol levels compared with femoral blood samples.<sup>71</sup> Because of diffusion of ethanol from the stomach, pleural or pericardial samples may contain ethanol levels up to 190 mg/dL, higher than those of corresponding femoral blood samples.<sup>72</sup>

Within 24 hours of death, little ethanol is formed even at room temperature. No blood specimen from bodies refrigerated within 4 hours of death and stored up to 28 hours contained more than 10 mg ethanol per deciliter.<sup>73</sup> The use of vitreous humor for postmortem ethanol analysis helps distinguish endogenous from exogenous ethanol sources, because bacterial infiltration occurs late in the putrefaction process.<sup>74</sup>

#### Preservation of Blood Samples

Mechanisms of ethanol decomposition in stored samples include diffusion from improperly sealed containers, ethanol metabolism by microorganisms (inhibited by sodium fluoride), and a temperature-dependent ethanol oxidation reaction. This enzymatic process varies from zero under frozen conditions to 0.29 mg/dL/d at 22°C and 43 mg/dL/d at 62°C.<sup>75</sup> Temperature, fluoride concentration, and length of storage are the most important variables in ethanol loss during storage, but very little ethanol deteriorates when the sample is stored over a month at 4°C.<sup>76,77</sup> The presence of bacterial flora and enzymes released from traumatized organs also can affect ethanol decomposition under adverse storage conditions.

#### Breath Samples

Portable ethanol breath detection devices were developed as rapid, simple, and noninvasive methods that analyze arterial ethanol levels based on the blood/breath ratio of 2,100. This ratio varies between individuals and within one person over time.<sup>78</sup> Variables altering accuracy include recent use of alcohol or alcohol-containing products (within 15–30 minutes), recent belching or vomiting, inadequate end expiratory specimen (i.e., poor cooperation), presence of obstructive pulmonary disease, and poor technique. Variability in the blood/breath ratio indicates that breath ethanol concentra-

# Alcohol Determination in the Clinical Laboratory

KURT M. DUBOWSKI, Ph.D.

Dubowski, Kurt M.: Alcohol determination in the clinical laboratory. *Am J Clin Pathol* 74: 747-750, 1980. Four methods for blood-alcohol analysis—gas chromatography, enzymatic oxidation with alcohol dehydrogenase, chemical oxidation with acid dichromate, and osmometry—are briefly reviewed from the point of view of the clinical laboratory. Advantages and limitations of these methods are discussed, and their key features are tabulated. The correlation of the results of blood-alcohol analyses with stages of alcoholic influence and their corresponding signs and symptoms is presented in tabular form. (Key words: Alcohol determination; Blood-alcohol analysis.)

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THE DETERMINATION OF ALCOHOL\* in blood and other biologic specimens is a frequently requested service in clinical laboratories, and is often requested on an emergency basis in hospitals.

Breath is the preferred specimen whenever the patient is able to participate in the breath-alcohol analysis. The latter has the inherent advantages of simplicity, rapidity, and noninvasive sampling, and reflects the alcohol content of the arterial circulation, which is physiologically and clinically more significant than the venous blood-alcohol concentration, especially during active alcohol absorption. Current instrumentation includes devices employing gas chromatography, infrared absorptiometry, fuel cell catalysis, and solid-state gas sensing, as well as the older chemical oxidation devices.

All quantitative breath-alcohol instruments currently marketed employ end-expiratory breath. Features and performance of current breath-alcohol analyzers of potential applicability to clinical laboratory practice have been summarized.<sup>6,12,13</sup> Several of the newer devices are portable, battery-powered, and self-contained, and hence are especially practical for bedside or emergency-room use. When necessary or desirable, whole breath or the alcohol in a measured volume of breath can be readily stored on simple sorption columns for subsequent elution and analysis.<sup>8</sup> Measurement of alcohol in breath involves some special biologic and chemical considerations,<sup>7</sup> and requires a 15-min "deprivation" period preceding breath-sampling to ensure the absence

of contamination from recently ingested alcohol in the oral cavity.

Blood is the most useful specimen when breath is not available, with plasma or serum being physiologically more appropriate specimens than whole blood. However, for certain forensic applications (e.g., investigation of alleged traffic law violations) analysis of whole blood is required because statutory interpretations of the results of blood-alcohol analyses are universally based upon whole blood. Collection of plasma and whole blood requires the use of anticoagulants—heparin, disodium edetate, and sodium or potassium citrate or oxalate are suitable if the specimen is not to be stored. For specimens to be preserved, potassium oxalate (5 mg/ml of blood) and sodium fluoride (1.5 mg/ml of blood) are an appropriate anticoagulant and preservative combination for short-term storage at 5 C of initially sterile blood specimens.

The many methods for alcohol analysis in blood fall into about a dozen different categories, of which the four listed in Table 1 are the most obvious candidates for use in the clinical laboratory. In the author's view, osmolality measurement, while rapid and simple, is not a method of choice. Estimation of alcohol in serum requires the subtraction from the actual osmolality determination result (by freezing-point depression) of the assumed normal osmolality value.<sup>14</sup> Substantial discrepancies between the blood-alcohol concentrations (BACs) thus estimated and the actual alcohol concentrations are possible and have been documented.<sup>2</sup>

The other methods for blood-alcohol analysis listed in Table 1 are appropriate for use in clinical laboratories, and are listed in order of this author's preference. Alcohol analysis by gas chromatography can be performed with simple and relatively inexpensive instruments and is the current method of choice. Among its desirable features are rapidity, sensitivity, minimal requirements for sample manipulation or preparation, and inherently great selectivity for ethanol even with single column/single condition analyses. Essentially

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\* The unmodified term "alcohol" in this article refers to ethanol.

Table 1. Summary of Methods for Blood-alcohol Analysis

Method	Required Sample Treatment/ Separation	Specificity for Ethanol	Apparatus Requirements	Final Measurement	Limitations
Gas chromatography	Dilution or headspace equilibration	Selective for ethanol; multiple columns/conditions greatly increase selectivity	Gas chromatograph, water bath (for headspace), strip chart recorder or integrator	Electrical voltage or current, via strip chart recorder or integrator	Requires calibration at time of analysis
Enzymatic oxidation with alcohol dehydrogenase	Dilution (for plasma or serum) or deproteinization	Selective for ethanol; some interference by isopropanol and methanol	Ultraviolet spectrophotometer, visible photometer, or some automatic analyzers	Photometric/spectrophotometric reading	Potential interference by higher alcohols, some enzyme inhibitors
Chemical oxidation with acid dichromate	Distillation, diffusion, dialysis, or aeration	None	Distillation or diffusion apparatus, photometer or spectrophotometer, or titration device, water bath	Titration or photometric/spectrophotometric reading	Time consuming; nonspecific
Osmometry	None for plasma or serum	None	Freezing-point depression osmometer	Osmolality measurement	Nonspecific; only plasma or serum specimens usable; poor correlation with blood-alcohol concentration

complete specificity for ethanol is achieved by using multiple columns and analysis conditions. Analysis of the "headspace" vapor above a blood or other liquid specimen saturated with sodium chloride, after equilibration at 50 C or other controlled temperature, is a simple and desirable gas chromatographic technique. It is usually preferable to direct injection into the chromatograph of a diluted whole blood specimen because it obviates problems of inlet and column contamination and syringe plugging. Direct injection of a diluted liquid sample,<sup>5</sup> however, may be preferable for emergency tests because it eliminates the 15-30-min head-

space equilibration period. When many blood specimens are to be analyzed for alcohol and analyst time is limited, automated gas chromatographic headspace analysis<sup>10</sup> or the use of automatic liquid sampling attachments is indicated and yields excellent results in routine use. The principal variants of gas chromatographic methods for blood-alcohol analysis are listed in Table 2 in order of the author's preference. As indicated in Table 1, gas chromatography requires the use of simultaneous reference standards.

Enzymatic oxidation with alcohol dehydrogenase (ADH) is a sensitive and simple method for alcohol measurement. It is a practical method for occasional or infrequent use because elaborate preparation is not needed, and for the same reason, it serves well as a back-up procedure for gas chromatography. The two principal variations are measurement of the change in ultraviolet absorbance at 260 or 340 nm, and visual photometry of a secondary indicator reaction. Several commercial kits are available for ADH methods; the characteristics and performances of four of these were reported by Redetzki and Dees.<sup>15</sup> The principal features of the ADH methods are given in Table 3. Several instrumental variations have been reported, including the use of rapid centrifugal analyzers,<sup>11</sup> rapid electrochemical measurement using a membrane oxygen-sensing electrode,<sup>3</sup> and adaptation to the DuPont Automatic Clinical Analyzer<sup>16</sup>. All ADH-based enzymatic

Table 2. Principal Variants of Gas Chromatographic Methods for Blood-alcohol Analysis

Detectors
Flame-ionization detector
Thermistor detector
Appropriate packed columns
Solid phase (Porapak®, Chromosorb®, etc.)
Liquid phase (Carbowax®, Hallicomid®, etc.)
Analysis techniques
Headspace sampling after equilibration
Direct injection of diluted blood
Protein precipitation and direct injection
Options: internal standard vs. direct procedures
Quantitation
Electronic integration/printout of peak areas
Measurement of strip-chart recording of detector response: peak heights or peak areas

**Table 3. Principal Features of Enzymatic (ADH) Oxidation Methods for Blood-alcohol Analysis**

Reactions
Basic Reaction: $C_2H_5OH + NAD^+ \xrightleftharpoons{ADH} CH_3CHO + NADH + H^+$
Conditions: pH 8.7-9.6; $CH_3CHO$ (trapped with semicarbazide or aminoacetic acid)
Diaphorase: $INT + NADH + H^+ \xrightarrow{Diaphorase} \text{Red Formazan} + NAD^+$
Oxygen Depletion: $NADH + H^+ + \frac{1}{2}O_2 \xrightarrow[Mn^{++}]{Peroxidase} NAD^+ + H_2O$
Catalyst NAD oxidoreductase (alcohol dehydrogenase; EC 1.1.1.1)
Preparation of plasma, serum, or blood Dilution with saline solution or deproteinization with perchloric or trichloroacetic acid or $Ba(OH)_2 + ZnSO_4$
Final measurement Ultraviolet spectrophotometry Δ Absorbance at 260 nm ( $NAD^+$ absorbs) Δ Absorbance at 340 nm ( $NADH$ absorbs) Visible photometry: measurement of stable red formazan color at 500 nm Amperometric measurement with $O_2$ electrode Fluorometry

oxidation methods are subject to potential interference by methanol and, especially, isopropanol to varying extents.<sup>15,16</sup> Reference standards must be analyzed in parallel with the biologic samples and controls, as they should be irrespective of the alcohol analysis method employed.

In view of the advantages of other methods, chemical oxidation with potassium dichromate in sulfuric (or nitric) acid solution is now one of the less preferable methods. It requires substantial sample treatment and separation of the alcohol from its matrix before reaction with the acid-dichromate reagent. It is time-consuming in the usual method variations, in addition to being essentially nonspecific for ethanol unless combined with complex chemical manipulations. Stability of the reagent and simplicity of the final measurement do not sufficiently counterbalance these disadvantages for use in the general clinical laboratory. The method may be useful for back-up purposes for the gas chromatographic or ADH methods, since a negative result conclusively eliminates the presence of alcohol in the specimen, and potential chemical interferants can be detected by simple tests on the same distillate.<sup>4</sup>

Table 4 correlates BACs with alcoholic influence stages and the corresponding clinical signs and symptoms. Great caution should be exercised in correlating BACs with presumed alcohol dosage, and speculative

**Table 4. Stages of Acute Alcoholic Influence/Intoxication**

Blood-alcohol Concentration (% w/v)	Stage of Alcohol Influence	Clinical Signs/Symptoms
0.01-0.05	Sobriety	No apparent influence Behavior nearly normal by ordinary observation Slight changes detectable by special tests
0.03-0.12	Euphoria	Mild euphoria, sociability, talkativeness Increased self-confidence; decreased inhibitions Diminution of attention, judgment, and control Loss of efficiency in finer performance tests
0.09-0.25	Excitement	Emotional instability; decreased inhibitions Loss of critical judgment Impairment of memory and comprehension Decreased sensory response; increased reaction time Some muscular incoordination
0.18-0.30	Confusion	Disorientation, mental confusion, dizziness Exaggerated emotional states (fear, anger, grief, etc.) Disturbance of sensation (diplopia, etc.) and of perception of color, form, motion, dimensions Decreased pain sense Impaired balance; muscular incoordination; staggering gait, slurred speech
0.27-0.40	Stupor	Apathy; general inertia, approaching paralysis Markedly decreased response to stimuli Marked muscular incoordination; inability to stand or walk Vomiting; incontinence of urine and feces Impaired consciousness; sleep or stupor
0.35-0.50	Coma	Complete unconsciousness, coma, anesthesia Depressed or abolished reflexes Subnormal temperature Incontinence of urine and feces Embarrassment of circulation and respiration Possible death
0.45+	Death	Death from respiratory paralysis

retrograde extrapolation of an experimentally determined BAC to an earlier time should be avoided because of its many pitfalls.<sup>4</sup>

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