A 33-year-old male presented to the hospital for recurrent syncope for one week. His past medical history was significant for opioid use disorder on methadone, and a historical diagnosis of bulimia due to purging behaviors. While in the emergency department, the patient had a witnessed syncopal episode. Telemetry indicated that the patient was in tachycardia and he was immediately loaded with magnesium with resolution of his arrhythmia. He was admitted to the Intensive Care Unit for further management. His workup was notable for a significantly prolonged QTc of 680, and multiple electrolyte and metabolic abnormalities. Concern was brought up for the patient’s eating disorder being the cause of his presentation; thus, psychiatry was consulted. The patient reported substantial weight loss of about 120 lbs over the preceding two years due to his purging behaviors but denied other symptoms of bulimia such as concerns with weight or body dysmorphia. Further questioning revealed that for the last two years, the patient had persistent sensations of bloating, belching, indigestion that was only relieved by purging which ultimately became compulsive. History revealed that as his dose of methadone had increased, so too did his upper gastrointestinal symptoms and purging behaviors. In the two weeks prior to admission, his dose had been increased to 160 mg coinciding with nearly continuous purging. GI was consulted for endoscopy and referred to outpatient. Methadone was tapered, a PPI and carafate were started for suspected gastritis, and Remeron was initiated. The patient was ultimately placed on NG tube feeds and Stomach X-rays and CT scans were unremarkable. While being evaluated in ED, the patient had a witnessed syncope. Rapidly titrated to 160mg daily methadone, he became unresponsive. Telemety showing torsades de pointes, and he was immediately given empiric IV magnesium. He was admitted to ICU for close monitoring. Given BMP hypokalemia, ketosis, ECG: sinus tachycardia and torsade de pointes, the patient was placed on magnesium and magnesium was administered 5mg daily. He was stabilized on methadone and a historical diagnosis of bulimia was made. He was referred to eating disorder and bulimia treatment. The patient reported a witnessed syncopal episode. Telemetry indicated that the patient was in tachycardia and he was immediately loaded with magnesium with resolution of his arrhythmia. He was admitted to the Intensive Care Unit for further management. His workup was notable for a significantly prolonged QTc of 680, and multiple electrolyte and metabolic abnormalities. Concern was brought up for the patient’s eating disorder being the cause of his presentation; thus, psychiatry was consulted. The patient reported substantial weight loss of about 120 lbs over the preceding two years due to his purging behaviors but denied other symptoms of bulimia such as concerns with weight or body dysmorphia. Further questioning revealed that for the last two years, the patient had persistent sensations of bloating, belching, indigestion that was only relieved by purging which ultimately became compulsive. History revealed that as his dose of methadone had increased, so too did his upper gastrointestinal symptoms and purging behaviors. In the two weeks prior to admission, his dose had been increased to 160 mg coinciding with nearly continuous purging. GI was consulted for endoscopy and referred to outpatient. Methadone was tapered, a PPI and carafate were started for suspected gastritis, and Remeron was initiated. The patient was ultimately placed on NG tube feeds and Stomach X-rays and CT scans were unremarkable. While being evaluated in ED, the patient had a witnessed syncope. Rapidly titrated to 160mg daily methadone, he became unresponsive. Telemety showing torsades de pointes, and he was immediately given empiric IV magnesium. He was admitted to ICU for close monitoring. Given BMP hypokalemia, ketosis, ECG: sinus tachycardia and torsade de pointes, the patient was placed on magnesium and magnesium was administered 5mg daily. He was stabilized on methadone and a historical diagnosis of bulimia was made. He was referred to eating disorder and bulimia treatment. The patient reported a witnessed syncope.

**REFERENCES**

- Cases opioid prescribers or opioid treatment centers.

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