



SMMGP CLINICAL/POLICY UPDATE December 2007

Policy

The **Central Office of Information (COI)** has produced a report for the NTA in response to a previous report that found that increased doses of methadone and buprenorphine were being given as rewards for drug free urine tests. On the positive side they did not find anything like the scale of this going on that the original report suggested (up to a third) finding only 5% of services admitting to this practice. However that fact that anyone is doing it is worrying. Also 7% of services said they decreased doses as a punishment for negative urine screens. Read the full results on

http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/docs/coi_summary_report_nov07.pdf

In response to the above the NTA has published 'definitive guidelines' on ethical prescribing for UK drug treatment providers, and committed to putting in place new monitoring procedures to ensure the guidelines are followed by all doctors. This is an addendum to the recently published clinical guidelines. The issue of using doses as a reward or punishment was not specifically addressed in the clinical guidelines because *'it should be obvious to any competent clinician that medication and dose should be determined only on the basis of clinically assessed need.'* The document clearly states *'It is inappropriate for medications to be used as a reward, or to be withheld or dose reduced solely as a punishment or sanction.'* Read the document on: http://www.nta.nhs.uk/areas/clinical_guidance/clinical_guidelines/docs/statement_on_medication_choice_and_dosing_in_drug_misuse_and_treatment_14_12_07.pdf

Printed copies of the **Clinical Guidelines** are now available to order. There is no cost and orders should be placed via the **DH publications** orderline 08701 555 455 or by email dh@prolog.uk.com, quoting the product code: UKCG07. Orders are limited to 5 copies.

Another document, which serves as an addendum to the clinical guidelines, is *'non-medical prescribing, patient group directions and minor ailment schemes in the treatment of drug misusers'* (NTA 2007). Which outlines good practice and standards for all these activities. See the 40-page document on: http://www.nta.nhs.uk/publications/documents/nta_non_medical_prescribing_1207.pdf

Clinical

Overdose Prevention

Davoli M et al 'Risk of fatal overdose during and after specialist drug treatment: the VEdette study, a national multi-site prospective cohort study.' *Addiction* 102 (12), pp 1954-1959

We have mentioned this study before when findings were given at a conference, however the results have been formally published now. It is a very significant study by its sheer size alone. It also covers an extremely important topic. It was a cohort study of 10454 heroin users in treatment between 1998 and 2001 in Italy. They were followed up for 10208 person years in treatment and 2914 person years out of treatment. **Conclusions:** A range of treatments for heroin dependence reduce overdose mortality risk. However the considerable excess mortality in the month following treatment indicates a need for more health education of drug users and implementation of relapse and overdose prevention programmes. The study calls into question the benefit of short-term therapies for opiate use in particular treatments lasting a month or less may actually do more harm than good.

Darke S et al '*comprehensive toxicology of fatal heroin overdose and morphine positive homicide victims*' *Addiction* 102 (11) pp 1793-1797

This interesting and unusual study looked at the blood morphine concentrations of overdose victims and fatalities from another cause, homicide, who also tested morphine positive. They found, fascinatingly, that morphine concentrations *per se* were not predictive of overdose but that use of alcohol was. The morphine concentrations of the two groups were not significantly different. This potentially has major implications for overdose prevention programmes.

Misc

Castells X et al '*Efficacy of central nervous system stimulant treatment for cocaine dependence: a systematic review and meta analysis of randomised controlled clinical trials.*' *Addiction* 102 (12) 2007 pp1871-1877

This is a subject that definitely needed investigating and this is one of the best explorations available. 9 RCTs were included covering 640 patients and utilising 5 replacement stimulants (mazindol, dexamphetamine, methylphenidate, modanfil, bupropion). **Results:** No CNS stimulant improved retention or Cocaine use. However exploratory analysis using indirect estimations of cocaine use showed the proportion of cocaine positive urines was lower with dexamphetamine than placebo and overall CNS stimulants suggested a significant reduction in cocaine use. Only one RCT found a significant reduction in craving versus placebo and this one favoured dexamphetamine. **Conclusions:** The study does not support the use of CNS stimulants for cocaine use, but secondary analysis provided hopeful results which encourage future research, especially regarding dexamphetamine and modanfil.

Bell J et al '*A randomised trial of effectiveness and cost effectiveness of observed versus unobserved administration of buprenorphine-naloxone for heroin dependence*' *Addiction* 102 (12) 2007 pp 1899-1907

Retention and heroin use for both groups was not significantly different. Observation was not associated with worse retention. Treatment with close clinical monitoring but no observation was significantly cheaper and therefore more cost effective.

Happy Xmas and New Year to all our members.