



SMMGP CLINICAL UPDATE JULY 2008

Firstly, a paper that is another useful addition to the European literature on **diamorphine/heroin prescribing**; it's topical with the UK Randomised Injectable Opioid Treatment Trial (RIOTT) study going on at the moment and the drug strategy's endorsement of it (should it be successful):

Uwe Verthein et al *Long-Term Effects of Heroin-Assisted Treatment in Germany*. *Addiction* 103 960-966 (2008)

This prospective cohort study describes the association between 2 years of heroin assisted treatment (HAT) and improvements in health and social stabilization, as well as the association between HAT and illicit drug use. A total of 515 patients were assigned to diamorphine treatment and 278 patients remained in treatment for the entire period of 24 months (54.8%). This is a low figure but compares favourably with other HAT trials

Measurements: The results on physical (Opiate Treatment Index Health Symptoms Scale) and mental (Symptom Checklist 90–Revised Global Severity Index) health and illicit drug use (number of days with drug use within the last month—European Addiction Severity Index) were examined by repeated-measures analyses.

Findings: Symptoms of physical and mental health improved during treatment. Street heroin use declined rapidly as did cocaine use

Conclusions: HAT is associated with improvements in mental and physical health in the long term.

A commentary on this paper by **Nick Lintzeris**, also in *Addiction*, suggests this does make a case for the expansion of HAT but there are various issues that must be considered: **1** Ways to make this treatment less expensive. **2** Ways to make it more accessible to patients than a clinic that must be attended three times a day. **3** Maintaining safety for individuals and the community. The first two issues may explain the relatively low retention figures in HAT trials

With **brief interventions** coming to the fore in treating **alcohol** problems, this next paper has concerning findings regarding their efficacy for men.

Reinhardt s et al *Gender Differences in the Efficacy of brief interventions with a Stepped Care Approach in General Practice Patients with Alcohol Related Disorders* *Alcohol and Alcoholism* vol. 43 (3) 334-341 (2008)

Part of "**Stepped Interventions for Problem Drinkers**," in which 10,803 patients from 85 general practitioners were screened using alcohol related questionnaires; 408 patients were randomised (32% were female) to a control (booklet only) or to two different intervention groups: stepped care (feedback, manual, and up to three counselling sessions depending on the success of the previous intervention); and fixed care (four sessions). Response rate at 12 months follow-up was 91.7%. **Results:** Regression analysis revealed a significant effect size only in women. Among the patients in stepped care who, by the first assessment point, had reduced drinking to within safe-drinking limits, there was a tendency for females to have achieved this more often than males. **Conclusions:** In a heterogeneous sample, the intervention was only effective for women. Women tended to profit more from the first, less intensive intervention than men. When analysis was limited to those reporting "at risk" average daily consumption and "alcohol abuse," the gender differences in efficacy appeared to be less, but the study was not sufficiently powered to affirm that.

With the increasing use of **Suboxone** in the UK it is useful to look at the experience of its introduction elsewhere. Here's a paper from **Finland** and a US case study that may or may not have practice implications.

Simojoki J et al *A retrospective evaluation of patients switched from buprenorphine (Subutex) to the buprenorphine/naloxone combination (Suboxone)* Substance Abuse Treatment, Prevention, and Policy 2008, (3): 16-7

Due to concerns about abuse of buprenorphine, many clinics transferred their patients to buprenorphine/naloxone (Suboxone). A retrospective study involving five different treatment centers examined the effects of switching patients to Suboxone, gathering data from 64 opioid dependent patients. **Results:** Most patients (90.6 %) switched to Suboxone at the same dose of buprenorphine that they had been receiving as Subutex. During the first 4 weeks, 50 % of the patients reported adverse events and, at the four-month time point, 26.6 % reported adverse events. However the adverse events caused only one patient to discontinue Suboxone during the 4-week period, and five after four months. Suboxone was misused intravenously once by 4 of the patients and twice by 1 patient; these 5 patients all reported that injecting Suboxone was like injecting “nothing”, or that it was a bad experience.

Conclusion: When patients are transferred, dose adjustments may be necessary especially in the later phase of the treatment. A transfer from Subutex to Suboxone should be carefully discussed and planned with the patients in advance and after the transfer adverse events should be regularly monitored. With regard to IV use, the combination product seems to have less abuse potential than buprenorphine alone.

Welsh C et al *A Case of Heroin Overdose Reversed By Sublingually Administered Buprenorphine/Naloxone (Suboxone)* Addiction 103 1226-1228 (2008).

This case study describes how a 28 year old male patient had resuscitated an ‘acquaintance’ from overdose by crumbling up one of his Suboxone tablets and putting it under his acquaintance’s tongue along with a touch of water. The authors note that this appears to be almost exclusively down to the partial agonist properties of the buprenorphine and its high Mu receptor binding capacity – not to the naloxone. Because of this there is no reason why the buprenorphine mono product (Subutex) would not work in the same way. **Conclusions:** Although certainly not approved for this indication, it might be useful for public health programmes related to opioid use to be aware of this potential use of buprenorphine for the reversal of opioid overdose in life-threatening situations where no other option is available.

With UK pilots underway and the approach being discussed on radio 4 recently the following is another paper on the use of **Contingency management**.

Hanson T et al *Contingency Management Reduces Drug-related Human Immunodeficiency Virus Risk Behaviors in Cocaine-abusing Methadone Patients* Addiction 103 1187-1197 (2008)

Data was analysed from a subset of participants in a combined data set of 3 published RCTs. 165 cocaine using methadone maintenance patients were studied. Participants receiving contingency management (CM) significantly decreased overall HIV risk behaviours and IV drug use risk behaviours. CM participants also achieved longer durations of abstinence during treatment. **Conclusion:** The title of the paper is correct.

D Ferguson, J Boden *Cannabis Use and Later Life Outcomes* Addiction 103 969-976 (2008)

This interesting and concerning study from New Zealand adds to the growing body of knowledge (much from New Zealand) regarding the adverse consequences of heavy cannabis use. This was a longitudinal Study of a Birth Cohort Studied to Age 25. It aimed to examine the association between the extent of cannabis use during adolescence and young adulthood and later education, economic, employment, relationship satisfaction and life satisfaction outcomes. **Findings:** There was a statistically significant association between increasing cannabis use aged 14-21 and: lower levels of degree attainment aged 25; lower income at 25; higher levels of welfare dependence; higher unemployment; and lower levels of relationship and life satisfaction. The association remained significant after adjusting for potentially confounding factors (e.g. socio-economic background, child abuse, early academic achievement).