
This letter to the editor raises the issue of baclofen and the French experience with ‘its potentially miraculous effects’ on alcohol dependence. Much of this stems from a French cardiologist, Olivier Ameisen, who suffered from alcohol dependence and tested baclofen on himself with great success. There was a study in the Lancet in 2007 which showed some promising results but there has been little else in the way of evidence. There has, however, been considerable popular media interest and apparently an ‘overwhelming number of patients now beg their physicians’ for treatment with high dose baclofen. Sales of baclofen in France have risen 20% between 2008 and 2010.


This was a brief report from Australia presenting four cases of alcohol-dependent patients who were resistant to standard treatments and who responded to higher doses of baclofen ranging from 75 to 125mg daily. The four cases were quite different in regard to gender, age, motivations and drinking patterns. They had all been tried on lower dose baclofen of 30mg daily, alongside other anticraving drugs, without success. Baclofen was increased from a total daily dose of 30mg by 12.5-25.0mg per week as tolerated, or until craving was suppressed. All four cases achieved abstinence with higher dose baclofen. After three months stabilisation baclofen was then reduced to the lowest effective dose.


This was a retrospective open study where they looked at the level of alcohol consumption in the 12th month of treatment. The patients came from the practices of two physicians in Paris, a GP in private practice and a hospital-based psychiatrist, who both prescribe baclofen on an outpatient basis. They included 181 patients and were able to do a follow-up evaluation in 132 patients. The initial alcohol consumption of the 132 patients averaged 182+/–92 g/day. After one year 78 out of the 132 were abstinent and a further 28 were drinking at low-risk levels. The mean baclofen dose was 129mg/day.

Overall, 86% of the patients experienced adverse effects. These were described as mostly being transient and experienced during dose increases. The principal adverse effects were fatigue or somnolence, insomnia, vertigo and digestive disorders. None required hospitalisation and six patients stopped because of side effects.

**SMMGP comment:** Baclofen is an unlicensed and, largely, unproven treatment. Most of the literature involves single or short series case studies and some observational evidence. The French experience highlights the challenges when medical care is influenced by a wide range of...
factors. The pharmaceutical industry, colleagues, and politicians can all exert an influence that goes far beyond the simple facts of the medical evidence. In this case, media attention seems to have pushed baclofen into the French consciousness.

That said, the preliminary evidence from case studies and descriptive data offer much cause for optimism. That isn’t unusual with untested treatments and it is not until we strip out all the bias (or at least as much as possible) will we, perhaps, get nearer the truth. If the findings do live up to the hype then baclofen could be a formidable option to manage cravings in those with alcohol dependence. There is an urgent need for a robust clinical trial and that may well come soon, but till then, care should be taken if considering baclofen. At the moment, it seems clear, to use a hoary old cliche, that more research is needed.


This study was conducted in Scotland and evaluated a general practice-based case-finding initiative. The aim was to assess the effectiveness and acceptability of a targeted screening intervention to detect, refer and, if needed, treat former injecting drug users (IDUs) with chronic hepatitis C virus infection (HCV). They offered testing in eight Glasgow general practices in areas with high deprivation where there was also a high prevalence of hepatitis C infection and injecting drug use. They matched these practices with eight demographically similar control practices.

The intervention involved looking at the computer systems in the practice - a search protocol had been designed that looked for people aged 30-54 years and who had indicators of past injecting drug use at least six months prior to the intervention. All the people identified were informed of the intervention and provided with information leaflets. Practices were asked to offer testing to at least 20 patients over the intervention period and received £100 remuneration for each test offered.

Out of 422 eligible practice attendees, 218 (52%) individuals were offered an HCV test, and 121 (56%) accepted. Poor venous access prevented testing in thirteen and a further three didn’t turn up for their appointment. This left 105 who were tested and 74 of these were antibody positive - of these 43 were RNA positive by PCR. Out of these 43 individuals with chronic hepatitis C just over half (n=22) attended specialist care within 30 months of the study.

SMMGP comment: The pool of people who are infected with hepatitis C but are no longer injecting and, perhaps, no longer in any drug treatment services is often discussed but few studies have looked at methods to access them. So, this is an important issue. One problem with this study is that there could be something of a Hawthorne effect here - the finding that people who know they are being studied change their behaviour for that reason alone. There is clearly an increase in uptake of testing and case finding in this study - but how do we translate that into an effect across the whole of general practice and not just practices that are being studied? We need to look further at the intervention in this case.
The payments to practices are a significant issue - initially it may appear that it is not simply a token sum: one practice tested 25 patients and will have received £2500. However, one of the factors noted by the authors was that the whole process of offering testing and getting a sample was even more time-consuming than anticipated, with multiple appointments needed.

On one level, it could be suggested that this study demonstrates that paying GPs and practice nurses improves testing. That may be money well-spent and it could be used as an argument for incentivising HCV testing through the usual mechanisms - but it is far from clear if it will have a lasting impact on clinical case-finding.

The problem of multiple appointments is a major issue to address when it comes to HCV testing. Every additional appointment in the process is a barrier - they mean more people get lost to follow-up or don’t even get as far as blood testing. Poor venous access is an important issue - one wonders how many of those who didn’t accept the offer of an HCV test at the start of this study were aware of the problems there might be with venous access. Clinical experience would suggest it is a source of anxiety for many - this study would be interesting to repeat with the offer of dried blood spot testing.

Finally, consider the amount of HCV testing in the eight demographically similar control practices. These practices, with nearly 38,000 patients, have the same problems with injecting drug use and a high prevalence of HCV. Yet just 36 people were tested in the study period. This study is a welcome addition but there remains much work to improve HCV testing and get people into treatment.


This study in the Irish Republic wanted to assess the effectiveness of brief interventions in those on methadone. Initially they screened the participants using the Alcohol Use Disorders Identification Test (AUDIT). They then used a World Health Organisation (WHO) protocol for a single clinician-delivered brief intervention. The full AUDIT questionnaire was used at baseline to fully assess participants and they also excluded those with scores of ≥20. (These individuals went on to have further assessments for alcohol dependence but they weren’t included in this study.) The abbreviated AUDIT-C was used at the 3-month follow-up and the AUDIT-C scores before and after the intervention from baseline to 3 months follow-up were the primary outcome.

They trained 48 clinical staff, including pharmacists, GPs, nurses, counsellors, and outreach workers across three clinical sites to deliver the brief intervention. The main elements of the brief intervention included presentation of the screening results, identification of risks and discussion of associated consequences, solicitation of the person’s commitment to change and identification of a goal related to alcohol intake reduction or abstinence. This was achieved using a non-judgemental motivational interviewing style.

They screened 710 (82%) of the 863 eligible methadone-maintained people within three urban treatment clinics. A total of 160 were ‘AUDIT-positive’ and the results showed that there was a statistically significant reduction in AUDIT-C scores.
from baseline to 3 months in the intervention group. The proportion of men who were AUDIT-C positive dropped but there was no significant decrease in the women.

**SMMGP comment:** In this particular sample nearly one-quarter of these screened required a brief intervention to be delivered. This is rather indicative of the importance of this issue - particularly given the high prevalence of co-existent hepatitis C infection and the combined deleterious effect on liver health.

It's a real strength of this study that it was done over such a range of staff, including different professions. The study couldn't find any difference in effectiveness between professions. It is also notable that, even with a relatively small sample, it seems to have had an impact. There was clearly a considerable amount of time and effort put into training staff - but this study suggests it would be time well spent. The evidence for the effectiveness of brief interventions continues to grow - this is the first study looking at its use in a population on methadone and the results are very encouraging.


**Commentary on Kurdyak et al. (2012):**


This study in Addiction looked at the extent to which other opioids are prescribed to patients receiving methadone. They studied people aged 15-64 years who had been on methadone for at least 30 days. They measured the proportion of people who received more than 7 days of a non-methadone opioid during the time they were on methadone. A secondary analysis looked at whether the prescriptions came from physicians or were dispensed by pharmacies who were not involved the methadone maintenance.

In total they looked at 18,759 patients who were given methadone. Out of these, 3456 (18.4%) received at least one prescription for non-methadone opioids of at least 7 days duration. In this group the median number of scripts per year was 11.9 and the most frequently prescribed medications were codeine and oxycodone. Out of a total of 73,520 non-methadone opioid prescriptions nearly half (45.8%) came from non-MMT prescribers and pharmacies.

**SMMGP comment:** The authors suggest that these scripts could be duplicitous and that this prescribing pattern points towards drug-seeking behaviour - perhaps for personal use or for diversion and financial gain. These are certainly possibilities but the authors offer no further evidence for this and no alternative interpretation.

It’s an interesting study on a couple of levels - firstly, as the authors comment, there is the ongoing concern about the rising problem of prescription opioid medication abuse; diversion of these amongst a population on methadone is an important area to consider. There is a second possibility - populations on methadone have a high prevalence of chronic pain problems and they may well need opioids for effective control. There is clearly a potential tension here in clinical practice. The provision of a methadone script may, if anything, unmask pain in some individuals. People coming into treatment may be more likely to go on and seek appropriate treatment for chronic pain issues - rather than relying on illicit drugs it would
be entirely reasonable to manage their pain with the full range of options. Treatment services need to ensure that they assess and discuss pain, or people will seek help elsewhere.

The commentary does mention this issue of pain and calls for the careful coordination of prescribing. One major risk of co-prescribing opioids is the increased potential for fatal overdose. Some of this issue is North American - the commentary points out that Canada and the USA now consume 87% of global oxycodone. However, few would dispute that we have a growing prescription opioid issue in the UK too. Effective coordination seems entirely reasonable and, in the UK at least, this can be relatively easily achieved when all the prescribing is within general practice. It’s a strong argument for a key role for primary care in managing substance misuse. It also highlights the dangers of fragmentation in substance misuse services where multiple providers don’t have clear sight of all the prescribing.


This paper is a descriptive study of a cohort of 82 injecting drug users (IDUs) recruited in the summer months of 1985 from a deprived Dublin community. They were followed-up over a 25-year period with two formal interviews held in 1995 and 2010.

The majority of the cohort were single, unemployed males aged 20 to 29 years who had served a prison sentence. Fifty one of the cohort (62%) had died by 2010. The mean age of death was 35.9 years (standard deviation 4.1 years) with 52 (63%) testing positive for HIV and 58/82 (71%) testing positive for hepatitis B between 1985 and 2010.

The median survival of those who were HIV positive was 17 years. In total 32 (39%) individuals were diagnosed with HCV but testing wasn’t done in 1985 at the start of the study - testing was not routine in the Republic of Ireland until 1992. The median survival time for those with who were HCV positive was 21 years - significantly lower than for those who were HCV negative.

SMMGP comment: This Irish cohort had a mortality rate eleven times that of the non-using cohort (62% compared to 5.5%). While all this might be regarded as historical there is also an issue for the present - those that have survived carry a considerable burden; something we are recognising in the ‘older user’. This Dublin cohort represents a single group and their experience over 25 years. Of the 31 who survived till 2010 there were 11 on methadone and, notably, not a single one of those still alive reported any ongoing injecting drug use.

A major limitation to this study is the lack of full data for hepatitis C. The authors report that typically one would expect 62-81% of IDUs attending general practice in Ireland to be infected. This study is a rip-roaring example of the potential for general practice to follow up and conduct longitudinal studies with marginal groups. It is also a good reminder, should we need it, of the powerful effect harm reduction measures such as needle exchange can have - HIV infection rates in Ireland linked to IDUs now account for only 6.6% of newly diagnosed cases compared with 61% back in 1985. We've come a long way - but we now need to turn our attention to hepatitis C infection.

The aim of this paper was to establish a link between methadone dose, concentrations, and Fridericia rate-corrected QT (QTcF) interval prolongation. It used computer modelling and simulation to assess the data from five clinical trials with patients on methadone maintenance treatment. The results showed that QTcF was increased by a mean of 17ms (90% CI 12 to 22) per 1000ng/ml of methadone. In real terms this means that doses of >120mg/ml would increase the QTcF by >20ms. The model predicted that 0.3%-2.0% of patients would have QTcF >500ms at doses of 160-200mg/day which fits with observational data.

SMMGP comment: Overall, the authors suggested that their predictions were consistent with the observational data and supported the need for ECGs in people receiving more than 120mg methadone per day. Although this was a rather technical piece of work the end-result has clear and direct clinical implication. Establishing a dose associated with an increased risk is a useful clinical endpoint and these data suggest a threshold of 120mg. It’s worth bearing in mind that this is the risk associated with methadone alone - it makes no attempt to consider other varied factors such as gender, structural heart disease, electrolyte imbalances, other medications or cocaine use.