SCENARIOS IN SUBSTANCE MISUSE

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ALCOHOL SCENARIOS

- DON’T PRESCRIBE LIBRIUM AS YOU ARE CONTRIBUTING TO A SECOND ADDICTION WITHOUT TREATING THE MAIN ONE!!!!

ALCOHOL ASSESSMENTS

- Most important is to assess the amount of consecutive dry days!!! – if they cannot manage dry days – better to diagnose dependence than diagnose non dependence.
- Stopping alcohol causes autonomic rebound with upward spike of BP and HR

If NON DEPENDENT

- Nalmafene- gives sense of fullness and reduces urge to drink
- prn

SCENARIO 1

- Pt brought in by relative and disoriented in time. BP and P elevated – not smelling of alcohol

SOLUTION

- Treat as acute confusional state – A&E attendance – do not treat yourself as you will not monitor him.
- A&E will refer to medics to admit for medical detox , usually starting librium at 100mg in 4 divided doses and reducing at a rate of 10mg per day(oxazepam if liver failure)

SCENARIO 2

- The same patient gets admitted for his DT's on a medical ward. He self discharges after 1 day feeling confused and comes to your office. He states he does not want to go back to the hospital and asks you for medication as he is shaking.

SOLUTION 2

- Again, do NOT prescribe anything. He must re-attend A&E for consideration He is still in danger from DT's and the ambulance may need to be called.
- No role for mental health team as diagnosis is alcohol withdrawal still

SCENARIO 3

- This same patient tolerates 3 days of hospital treatment and self discharges. He comes to the clinic stating that the librium is working and can he have some more?

SOLUTION 3

- Treat as incomplete detox but at least he is out of danger from DT's.
- Again don't prescribe librium as you are contributing to a new addiction
- Refer to CRI who will re-assess his motivation for a planned detox

SCENARIO 6

- 45M presents to surgery stating that they stopped drinking 2 days ago and wants something to stop him shaking-he states he has fits

SOLUTION

- Do NOT give him Librium or diazepam script. Librium to be given only under trusted supervision and decision taken by specialist

- If he is intoxicated, he is unlikely to be in DT's
- He can engage with CRI in normal way

SCENARIO 6

- 32 yo male brought in by relative disoriented and c/o double vision. Not oriented.

- Discuss diagnosis and management

SOLUTION 6

- Wernickes encephelopathy likely
- Mamillary body infarct-affects optic chiasma
- Needs Vitamin B1 (Pabrinex) to reverse osmotic flow

SCENARIO 7

- 43 yo male confused and convinced that someone is spreading malicious gossip about him. He appears very frightened and threatening to hurt the next person who annoys him. Not smelling of alcohol.

SOLUTION

- Derogatory and persecutory beliefs – Think psychosis – needs psychiatric admission as risk to others. May need mental health act to enforce treatment and police help.

- Will respond to anti-psychotics

OPIATE PROBLEMS

- Buprenorphine if habit < 0.5 gms (<£40 per day)
- Easier to come off, harder to start
- Recovery

- Methadone if chaotic as good for harm minimisation but less good for recovery

SCENARIO 8

- 22M
- Has been smoking 0.4 gms of Heroin
- Spends £15-30 per day
- Using for 6 months
- Wants abstinence

SOLUTION

- Motivated
- Under 0.5 gm daily use
- Abstinence achievable
- Plan
- For Subutex substitute prescribing with a view to reductions and detox
- Happens in Out Patients

SCENARIO 9

- 28M smoking 1gm Heroin
- Spends £30-£50 daily
- Long standing use
- History of treatment episodes with relapses
- Wants abstinence

SOLUTION

- Abstinence more ambitious for now
- Plan
- For Stabilisation on Methadone in order to reduce/stop use of street opiates
- This usually happens in Out Patients over longer time

SCENARIO 10

- 30F on 50mls prescribed Methadone
- Drinking more alcohol steadily
- Becoming more dependent on alcohol
- Unpredictable and Unstable
- Her alcohol use is preventing her getting her methadone

SOLUTION 10

- Risky Situation as this person may get opiates from ‘outside sources’
- Individual more agitated
- Plan
- Need alcohol detox – Inpatient or otherwise
- Stabilise on Methadone afterwards
- Provide aftercare package/Rehab

SCENARIO 11

- 36M on 180 mls prescribed Methadone daily
- Admits to using 0.4 gm (£20) on top I/V Heroin
- Risk of precipitating Opiate toxicity/OD with high consumption of opiates
- Dr fearful about prescribing more methadone

SOLUTION

- Plan
- Need to manage risk of overdose/toxicity
- Admit in order to stabilize on methadone & stop I/V use as on ward. Aim is to get patient stable on a lower dose of methadone – ideally 60-100 mg daily

SCENARIO 12

- 25F pregnant 14/40
- I/V use of 0.8 gm day Heroin
- Wants opiate abstinence to protect foetus

SOLUTION

- Abstinence unrealistic
- Fear of sending neonate into opiate withdrawal
- Premature Labour risk
- Plan
- To Stabilise on Methadone to mitigate withdrawal
- Minimise risk of I/V use

SCENARIO 13

- A Pt arrives to your practice stating he ‘forgot his methadone’ and is in withdrawal

SOLUTION

- Do NOT prescribe him any opiate as you may send him in overdose. You have no way of confirming this.

- Symptomatic relief only – eg loperamide NSAIDS

SCENARIO 15

- A patient on a weekly pick up of 90 mls methadone states that he vomited up his doses on 3 separate occasions. He tells this to you and you advise him to attend CRI. You cannot prove or disprove this.

SOLUTION

- Difficult to call. You have no means of confirming his story but not prescribing him may precipitate a heavy withdrawal. Prescribing at original dose may cause overdose as you dont know how much has been consumed. I will take in other factors eg use on top history.

SCENARIO 16

- A 65M arrives with a private script of injectible methadone ampoules 100mg bd, diazepam 40mg od and dexamphetamine 15mg

- How should this be managed

SOLUTION

- If this script has been ratified, then dispensing supervised better.
- Allow scripting at this dose for 2 weeks but reductions necessary after that.
- His private doctor also worried about that level of scripting

BENZO SCENARIOS

- Get patient on diazepam as most long acting
- (oxazepam if liver disease)
- Reduce by 10% every 1-3 weeks

- Remember that 10mg diazepam =
- 1mg lorazepam, 0.5mg clonazepam, 30mg librium

NON BDZ ALTERNATIVES

- Trazadone – anxiolytic antidepressant, particularly useful in elderly,nursing homes

- Pregabalin – longer acting anxiolytic
- + massive dose range 25-600mg per day
- -Expensive, needs slow reduction plan
- Antipsychotic prescribing is off-label

SCENARIO 17

- 33 yo new patient , on a diazepam script of 40mg from previous GP practice-You obtain evidence from old GP letters. You are not happy with this dose but patient insistent.

SOLUTION

- Explain the need to reduce in terms of recovery ethos. Give patient initial script for 2 weeks only and then explain that he will be reduced at a rate of 10% every 2-3 weeks .
- Refer for psychosocial work
- Aim that next script will be at 36mg.

SCENARIO 18

- You try reducing to 36mg, patient then comes in for a new script and states that he can't cope and used illicit diazepam this morning-he describes irritability and anxiety.
- What are your treatment options?

SOLUTION

- If he used today, then script him from the next day.

- Start at 39mg and explain that the next script in 2/52 time will be 36 mg. Explain the need for engaging in recovery work.Reinforce recovery agenda.

SCENARIO 19

- The same patient receives his 2 weekly script of 36mg diazepam. He rings in 1 week later demanding to see a Dr stating that he has used all his diazepam as he heard bad news and he could not cope.

- What are the options?

SOLUTION 19

- Dangerous scenario-Patient could be trading medications and should not be given large take outs.
- Establish other drug/etoh use
- Rescripting will create problems in the future
- After KW feedback on attendance , explore coping strategies

SCENARIO 20

- A patient who was recently admitted to a psychiatric ward following a crisis and discharged after 3 days over the weekend. He was given 1 weeks worth of lorazepam at 1mg tds and has no CMHT follow up. He attends your practice requesting more lorazepam.

SOLUTION

- Lorazepam very addictive. Work out that he has had 3mg lorazepam daily
- Equivalent to 30mg diazepam
- Get patient on 30mg diazepam script
- Consider daily pick up
- Weekly scripting
- Refer for psychosocial recovery work.

SCENARIO 21

- A patient who is alcohol dependent was recently admitted to General Hospital following a chest infection. Whilst in hospital he was placed on a librium detox starting at 120mg in divided doses.
- His infection resolves in 4 days and he is discharged and is given librium 20mg qds as a take out script for 4 days
- He attends wanting continuation

SOLUTION

- Dangerous practice as librium needs to be reduced
- However patient only been on short course
- Pt less likely to develop DT's
- Hospital admission deemed not necessary
- Possible to do home detox by reducing librium at a rate of 10mg reduction per day in 4 divided doses

SCENARIO 21

- Same scenario as above but patient given librium 20mg qds take out for 2 weeks
- Patient attends requesting further continuation at this dose

SOLUTION

- More common than expected
- Dangerous practice as patient has a new iatrogenic addiction!
- Too late for librium detox
- Convert to diazepam (3:1) ratio
- Thus 80mg librium is equivalent to approximately 27mg diazepam.
- Put in bd divided doses and reduce by 10%

SCENARIO 22

- A recently referred patient has a neurological disorder but discharged by neurology team on 30 mg diazepam daily and 60 mg DH Codeine qds. You speak to the neurologist who confirms that there is no medical reason for these high doses.

- How do you proceed

SOLUTION

- Patient has 2 addictions.
- Reducing the diazepam is the more difficult
- The Codeine can be managed like any other opiate
- Engaging in recovery work essential for psycho-social interventions
- Health psychology for CBT an option