Problems with prescribed drugs

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What Problems?

What Problems?

- Misuse
- Addiction
- Diversion

What drugs?

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- Opiates
- Benzodiazepines
- Gaba drugs
- Z drugs
- Cyclizine
- Prochlorperazine

How do patients present?

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- The cliche
  - Temporary patient with very insistent demands for a prescription for benzos or similar
  - Frequently ‘lost’ medication
  - Known IVDU with a shaggy dog story

How do patients present?

- The reality
  - Case 1:
  - 23yr old lady with tylex on repeat prescription for migraine and dysmenorrhoea
  - Suffered a badly broken wrist, requiring internal fixation.
  - Tylex use increased to 200tabs/month for 8 weeks
  - Then started to order every 3 weeks, and also order her mother's tylex early too.

How to proceed?

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- Dispensary alerted our on-call doc
- An alert was put on her notes, and she was asked to see a doctor to review her medication before a further script was issued
- When seen, she was challenged about her tylex use. She admitted overusing it, and was relieved to be able to talk about it.

How to proceed?

- Our immediate concerns were overuse of paracetamol. LFT did show some mild derangement.
- Her prescription was changed to paracetamol plus codeine as separate tablets
- With her agreement, a reduction plan was worked out, including regular reviews.
- Now codeine free

The reality:
Case 2

- 63 yr old lady with chronic pain from widespread osteoarthritis
- On high dose MST when she joined our practice – 60mg bd. Intolerant of nsaids, amitriptyline, acupuncture. Paracetamol and TENS ineffective. Using topical analgesics, and PRN oramorph (on repeat prescription)
- Oramorph use escalated until she was requesting 3-500ml every 10 days.

How to proceed?

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- Local pharmacist was relaying her requests for early medication, sometimes it had been issued in advance by locum pharmicists.
- The dose instructions were worded in such a way that didnt trigger overuse warnings
- It was apparent she had a morphine addiction, though she didnt accept that diagnosis, and felt her pain wasnt controlled despite heroic morphine doses.
- A rather confrontational consultation saw a compromise to move to an equivalent MST dose as a start (180mg bd!) with a plan to then reduce slowly and refer to pain clinic

How to proceed?

- The patient defaulted from follow-up
- She has once again started to request oramorph, which has been refused
- A colleague is now seeing her regularly to work with her reducing her morphine dose

The reality:
case 3

- 73yr old man with mild alcohol dependence and chronic anxiety, on long-term diazepam (2mg tds), not on repeat. He has never abused his prescription.
- Started requesting his diazepam more frequently. He was adamant that he wasnt overusing it, and assumed he had lost it. The council were replacing his kitchen and bathroom at the time so his house was in chaos

How to proceed?

How to proceed?

- I knew this man well, and was inclined to believe him
- I heard from a patient on methadone replacement treatment that friends of his who worked on the council houses were offering benzos they had ‘acquired’ from him
- These friends were also patients on the shared care scheme.

How to proceed?

- On questioning, he admitted some of these ‘lads’ were hanging around his house after work. He enjoyed the company.
- I referred the man to the vulnerable adult team, and got hold of a drug safe for him. I suggested that he may be putting himself and his possessions at risk
- I discussed their cases with our shared care nurse, and alerted the police to the issue.
- His ‘overuse’ stopped.

Avoiding the pitfalls

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- Prevention is better than cure!
- Be explicit about addictive risks when starting a prescription
- Have a specific and appropriate indication
- Have a treatment plan in place – duration, dose, reviews etc
- Consider non-addictive alternative, pain clinic referral etc
- Have robust oversight systems for repeat medication

Avoiding the pitfalls

- When a patient is identified as having a suspected problem, be open and frank about your concerns
- They often are quite resistant to the idea they are an ‘addict’ and can be difficult to persuade to enter treatment with substance misuse
- They need a lot of support as the initial problem may still be there as well as the addiction.