

Addiction in Primary Care: Complications and Comorbidities

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Objectives

- Develop an approach to preventive care and health screening in the context of addiction
- Learn to assess and treat common illnesses associated with addiction
- Develop an awareness of unique cultural, social, and interpersonal issues involved in the care of people suffering from addiction

ASK

- For any Dx: Could substance use be involved in this presentation?
- Given a Dx of substance abuse / dependence / at-risk use: Is this patient manifesting any physical or psychiatric SSx associated with known complications / comorbidities?
- If a patient is using: Is she using anything else?

Addiction: Definitions

- Substance misuse
 - use not consistent with legal guidelines or medical recommendations
- Abuse
 - maladaptive pattern of use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve month period:
 - 1) failure to fulfill major role obligations at work, school, or home
 - 2) recurrent use in situations in which it is physically hazardous
 - 3) recurrent substance-related legal problems
 - 4) continued use despite social problems
 - the symptoms have never met the criteria for Substance Dependence for this class of substance

Addiction: Definitions

- Substance Dependence

- maladaptive pattern use leading to 3 (or more) of the following in a 12 month period
 - Tolerance
 - Withdrawal
 - substance taken in larger amounts or over a longer period than was intended
 - persistent desire or unsuccessful efforts to cut down or control use
 - ↑ time spent in activities necessary to obtain or recover from effects
 - ↓ important social, occupational or recreational activities
 - substance use is continued despite persistent or recurrent physical or psychological problems

Addiction: Definitions

- Control
- Compulsion
- Consequences

Setting the Tone: Rapport

- Acceptance and empathy
- Authenticity
- Fairness and consistency
- Respect re: disclosure
- Nondiscrimination
- Partnership

- *I don't have to put up with your biases, I don't have to put up with the attitude, I don't have to put up with the you know the sideways looks and when the doctor comes and they're outside the curtain and they're talking and you can hear, you overhear what they're saying and you know, this is another one, you're not treated as an equal as a human being. You're treated as a drug addict, somewhat less than. You know I'm a person.*

Setting the Tone: Rapport

- Ask permission
- Thank your patient

- “I’d like to ask you a couple questions about alcohol and other drug use, since they can affect your health”
- “Substance use, from the occasional drink right up to smoking crack and injecting heroin, can have negative effects on your health. As a healthcare provider, I’m not doing my job if I don’t ask you about alcohol or other drug use, and help you deal with any concerns.”

Screening: CAGE

- Cut down
 - Annoyed
 - Guilty
 - Eye opener
- 1: At risk
 - 2: Current problem
 - 3: Dependence until proven otherwise
- NB: consider T-ACE in women
 - Tolerance

Screening: AUDIT

- ❑ 10 item questionnaire
- ❑ Score of 8 or more indicates harmful alcohol use and possible dependence



AUDIT
questionnaire

Screening: DAST

- ❑ Long (28 item) and short (10 item) form questionnaire
- ❑ Score of 6 or greater indicates drug use problem



DAST
questionnaire

Brief Intervention: FRAMES

- Feedback
- Responsibility
- Advice
- Menu of options
- Empathy
- Self-efficacy

- “Your answers to some of these questions suggests that your [substance] use is harmful to your health and well-being and may have negative effects on your work and those around you.”
- “I’m very worried that things will go from bad to worse if something doesn’t change. What do you think?”

Case #1

- 45 year old male IDU
- Polysubstance use (opioids, EtOH, marijuana, nicotine)
- C/O fatigue
- Affective sx not prominent, px unremarkable
- Labs: CBC, TSH, FBS, creatinine, LFTs, anti-HIV, anti-HCV, HBsAg

Hepatitis C

- Fatigue is a very common (but nonspecific) complaint
- Assess carrier status (HCV RNA)
- Monitor LFTs
- Baseline U/S
- Counseling around harm reduction if unable to abstain
- Optimize housing, nutrition, mental health, pain management
- Consider referral for treatment

Infectious disease

- HIV
- Viral hepatitis
- STDs
- Febrile neutropenia (levamisole)

Case #2

- Crack cocaine user
- Longstanding 1ppd cigarette habit with associated morning cough
- Presents to community clinic with increased sputum production / cough and SOB.
- Temp 38C, sats 92%RA
- CBC, CXR

AECB

- Remember nicotine, even when harder drugs are on board
- Lower threshold for admission
- Broaden DDx
- Arrange for baseline PFTs / CXR
- BMD if extensive need for prednisone

Respiratory

- COPD
- TB
- Talcosis
- Pneumonia (chemical / aspiration / infectious)
- Empyema (aspiration)
- Cancer

Case #3

- Pleasant elderly gentleman with longstanding atrial fibrillation, hypertension, and CHF
- BP 170/95 on 3 different meds
- INR unpredictable, 2.5-6.5
- No new meds or dietary changes

EtOH dependence

- Underdiagnosed in elderly
- Can cause and exacerbate HTN, dysrhythmias, and CHF
- Use Coumadin with caution; consider risk vs benefit, alternative rx

Cardiovascular

- Atrial fibrillation
- CAD
- Cardiomyopathy
- Endocarditis
- Hypertension
- Bleeding diatheses

Case #4

- 25 yo male, cocaine / meth, C/O pruritus
- “I think I have scabies”
- Exam: multiple scratch marks / scabs, abscess right forearm
- I&D, given rx for Cloxacillin
- Preliminary culture: MRSA
- Eventually shows up in ED with rip-roaring cellulitis

Dermatologic

- Formication
- Abscesses / cellulitis
- Poor wound healing / superinfection
- Infestations

Case #5

- 18 yo woman with abdo pain, vague hx otherwise, maybe irreg. menses and urinary frequency
- Px: Firm abdopelvic mass, SFH 25cm???
- BHCG +ve, syphilis EIA +ve, Pap HSIL
- Routine use of amphetamines
- Sexually assaulted 7 months ago

Gynecologic

- Unplanned pregnancy
- STDs
- Contraception
- Cervical cancer

GI

- Altered bowel habits
- Liver disease
- Bleeding
- Gastritis
- Pancreatitis
- Cancer

Case #6

- New pt, old WCB back injury
- Escalating oxycodone use, cut off by former MD
- In “severe pain”, baseline 8/10 with exacerbations 10/10

Chronic Pain

- Addictive substances can exacerbate pain
- Address addiction first
- Less rewarding medications (nonopioid, long acting opioid, methadone)
- More frequent dispensing
- Avoid preferred opioid
- Urine Drug Testing
- Consider chronic pain clinic referral
- DDx: Pseudoaddiction

Case #6 continued

- Pt slipped on ice and broke ankle
- Requesting something for pain

Acute Pain

- Treat pain
- Treat withdrawal from nonopioids
- Provide baseline dose + additional analgesia consistent with source of pain
- Consider unresolved / undiagnosed physical issue for persistent pain

Case #7

- Chronically depressed elderly woman, husband just dx'd with dementia, c/o reactive decreased mood
- EtOH 26oz every other day since dx
- Need to address both issues in tandem

Mental health

- Schizophrenia
- Bipolar disorder
- Depression
- Anxiety
- ADHD
- PTSD
- Personality disorder
- Sleep disturbance
- Sexual dysfunction

Case #8

- Poorly controlled diabetic
- Active use of tobacco, alcohol, and benzodiazepines
- Advised repeatedly to modify lifestyle, i.e. increase activity, improve diet, quit smoking
- Repeated no shows to clinic and lab
- Deemed “poorly compliant”

Socioeconomic

- Housing
- Income
- Violence / abuse
- Nutrition
- Disability

Addressing barriers to care

- Opportunistic screening
 - Use EMR or other prompts
 - Don't rely on the periodic health exam!
- One-stop shopping
 - Addiction services within primary care setting
 - Optimize linkages locally
- Explore patient's priorities, vulnerabilities, and strengths
- Be patient....

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If you don't ASK,
you won't find out!