Substance use disorder Complex Cases

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Pharmacotherapy and chronic pain

Jill: Chronic pain 1

- Jill has a history of alcohol abuse and oxycontin abuse; she is discharged from an alcohol detox unit on the following:
- Lyrica 300 mg bd
- Suboxone 18 mg daily
- Acamprosate 333 mg 2 tds
-
- Jill then sustains a third degree burn on the medial aspect of her left leg. She needs a skin graft. The anaesthetist phones you up to discuss her perioperative pain management.
-
- What are the options for her peri-operative pain management?

Jill: chronic pain 2

- Jill is discharged on the same medication regime as listed. She comes to you in severe pain at the graft site. She tells you that unless you do something for the pain she is going to start drinking again.
-
- What are your treatment options?

Jill: Chronic Pain 3

- Jill recovers from her skin graft and then attends a dentist. Forty-eight hours later she is back in your surgery telling you she has the worst pain she has ever experienced at the site where a tooth was pulled.
-
- What diagnosis might explain this pain?
- What are your treatment options?

Jill: chronic pain 4

- Jill gets over the dental extraction and then travels into the bush. She then returns with a fever / arthralgia illness. Her temperature goes up to thirty-eight point five degrees. blood cultures are negative. CRP and ESR are significantly elevated. Neutrophil count is normal.
-
- What diagnoses might you consider?
-
- She complains bitterly of joint pain.
- What treatment options might you consider?

Jill: chronic pain 5

- Jill visits you one last time at the surgery and tells you she is moving to another part of Victoria. You wish her all the best and breathe a sigh of relief.
-
- What are your summary thoughts regarding the management of acute and chronic pain in the context of pharmacotherapy?

Pharmacotherapy and Occupational issues

John: occupational issues 1

- You are a GP. John is a patient stabilised on methadone 90 mg daily with four take-aways per week. He has been under your care for over five years. He always provides urine samples when asked and these have been negative for as long as you can remember. He is a model patient. One of your other less savoury patients however tells you that john has started up a taxi business on the same model as "Uber". You look at the face book page and sure enough there John is offering taxi services to your local community.
-
- What do the driving regulations say regarding opiate replacement therapy and the following?
-
- Private standards
- Commercial standards
-
- What is your ethical / medico-legal liability?

John: occupational issues 2

- John comes in to see you for a routine blood pressure check. You notice that he has put on weight. His BMI is now 45. His neck size is 44 cm. He specifically denies fatigue and daytime somnolence. He admits to loud snoring only after he has had a "skin-full."
-
- What diagnosis might be an issue here?
- Does this diagnosis impact upon his opiate replacement therapy, and if so how?
- Does this diagnosis impact upon him driving?

John: occupational issues 3

- John then gets a job working as a social worker.
-
- He gradually descends his dose to 20 mg under your medical supervision. As part of your routine care you ask him to do the "usual three-monthly urine test"
-
- What test is done?
- Is it accurate?
-
- The test comes back as positive for amphetamines. Both you and John are devastated. He protests his innocence.
-
- What medication can give a false positive for amphetamines?

John: occupational issues 4

- He repeats the test again. This time the test is clear however the creatinine concentration is < 2mml/l.
-
- What does this indicate?
-
- John admits to using a few extra pills supplied from his aunt to help him get through the day.
-
- What opiates are not tested for in routine urine screening?

John: occupational issues 5

- He admits that his methadone dose is not holding him. He agrees that he has been using illicit opiates on top of his methadone.
-
- What do you do to his methadone dose?
- What do you do with his take away regime?
-
- John loses his job as a result of your actions and continues to blame you for his deteriorating lifestyle. His frequent refrain is," if only you had left me with takeaways!"
-
- How do you respond to this charge?

Pharmacotherapy and Alcohol

Roger: alcohol 1

- Roger is on methadone 95 mg daily four take-aways per week. He presents to you for his regular three-monthly review. He smells of alcohol and is obviously inebriated.
-
- What are your initial thoughts?
- Comment on his dose of methadone and his takeaway regime.

Roger: alcohol 2

- After careful probing Roger admits to drinking two litres of vodka a day. He usually wakes up in the morning at about six am. He usually feels sweaty nauseous and vomits. he drinks some vodka and then is able to sleep till about eight a.m.; then he is able to get up and go to the shops to buy more alcohol.
-
- Re alcohol what is his diagnosis and what would be his management.
- What would you do with his pharmacotherapy if anything?

Roger: alcohol 3

- Roger comes to you on a Friday afternoon. He continues to be compliant with his methadone prescription. He tells you that he is ready to quit the booze. In fact, he has already stopped drinking. All he needs from you is enough Valium to get him through the weekend to detox.
-
- Would you give Roger Valium?
- What advice would you give Roger?

Roger: alcohol 4

- Roger agrees to be referred to an inpatient alcohol detox program.
-
- What questions would you ask roger to improve the quality of your referral?
-
- Prior to roger being admitted to the detox unit he comes to see you to ask about his detox, specifically what is going to happen to him. He is particularly interested in the medication that he will be given for his detox, and how it will affect his methadone.
-
- What would you say to Roger about an alcohol detox with simultaneous pharmacotherapy.

Roger: alcohol 5

- Roger comes out of the detox unit. he has forgotten his discharge summary. he tells you he has been started on some medication. He also tells you that his methadone dose has not changed
-
- what medication would you expect Roger to be on post discharge from an alcohol unit?
-
- One week later he presents to you confused, disoriented. You examine his cranial nerves and discover he has RAPD and diplopia.
-
- What diagnosis would you suspect and what is the management of this diagnosis?

Roger: alcohol 6

- Unfortunately, Roger relapses and falls off the radar. He is no longer taking methadone; he is discovered a year later living on the streets. He is brought to you for assessment. You find that he has developed hyperkinetic gait and apraxia of his non-dominant hand.
-
- What is your differential diagnosis?
-
- Roger fails to attend follow up appointments and two years later is brought back to your attention. He confabulates and has developed a dense amnesic gap for decades.
-
- What is your diagnosis?
- What is your management?

Pharmacotherapy and Pharmacology

Jack: pharmacology 1

- You are a young enthusiastic GP doing an outreach pharmacotherapy clinic in a rural location. You attend this clinic once a week. Jack attends your clinic. He has symptoms and signs consistent with substance use disorder. He agrees to provide urine tests. He agrees to see you again next week to "discuss the results" and to hopefully start treatment. In anticipation of smoothly starting methadone next week, today you apply for a pharmacotherapy permit to commence in a week's time. You then drive home two hours with a happy heart. The next day you discuss Jack's case with a more experienced senior GP at your usual clinic. He laughs in your face!
-
- Why?

Jack: Pharmacology 2

- You see Jack the next week and re-apply for the permit. You issue a prescription to the chemist to commence tomorrow in anticipation of receipt of the permit. You do this because your senior colleague told you that that is what he normally did when he was doing outreach clinics, and he had never ever been "knocked back by the department."
-
- Comment on the legality of these actions.

Jack: pharmacology 3

- Jack's urine test came back positive for benzodiazepines, amphetamines, and opiates. he also admits to using street Lyrica and Seroquel.
-
- What dose of methadone would you start him on.
-
- As you are writing this prescription you are reminded of a conversation you had with an addiction medicine specialist who once told you that it once was common practice to start patients on doses of 70 mg daily.
-
- Comment on this.

Jack: pharmacology 4

- Jack is keen to achieve remission from his opiate dependency as quickly as possible. He tells you he wants to go up quickly to a high dose.
-
- What is the fastest you could titrate jack?
- Is the speed of titration curtailed by your weekly attendance at the clinic?
- What minimum dose would provide jack with a release from cravings for opiates?
- What advice do you give Jack during the titration phase of his methadone program regarding his polysubstance misuse?
- When is the highest risk of fatality during treatment with methadone?

Jack: pharmacology 5

- Jack is now on 110 mg daily of methadone. He now happens to remember that his cousin dropped dead a few years ago. No cause was found for his death.
-
- What are your thoughts on this issue?
- What tests would you consider?
- What is the top dose of methadone that a GP would be reasonably expected to prescribe?

Jack: pharmacology 6

- A locum covers the holiday absence of the usual pharmacist who dispenses to Jack. Jack comes to your surgery and falls asleep in the waiting room. At the same time, you get a panic-stricken call from the locum telling you about a drug error for Jack.
-
- What has happened? How did it happen?

Jack: pharmacology 7

- Jack recovers from this accident and continues to receive pharmacotherapy. He develops stability in his life, he gets a job, he gets a car, he gets a girlfriend. He remains on 60 mg of methadone daily with four take-aways. He has been in treatment now for 12 months. He tells you that he wants to come off the methadone as quickly as possible because his girlfriend does not like him being on it.
-
- What are your thoughts?
- How long should a methadone maintenance treatment program last?
- How quickly can you reduce methadone?
- What are the risks of reducing methadone?

Jack: pharmacology 8

- Jack is now on thirty mg daily of methadone. He tells you that he wants to switch to Suboxone because it is easier to come off Suboxone than methadone. You have just read his most recent urine test result which is positive for opiates.
-
- What are your thoughts?

Pharmacotherapy and Polysubstance misuse

Roy: substances 1

- Roy's sister comes to you asking for help. You are the pharmacotherapy doctor in the practice; you are known to be the go-to-doctor for addiction. Roy's sister tells you that Roy has an addiction problem with ice, and that he will shortly be coming to live in the village. She wants you to agree to "take him on as a patient."
-
- What is your recollection of the principles of management of ice addiction?
- What is your view on pharmaceutical intervention regarding ice addiction?

Roy: substances 2

- You meet Roy for the first time; he is obese, he suffers from metabolic syndrome, ice addiction, fibromyalgia, and he smokes. His medications as per his previous gp record include the following:
- Lexapro 30 mg daily
- Olanzapine 30 mg daily
- tramadol 200 mg b.d.
- Valium 5 mg prn quantity 50 multiple episodes of prescribing
- duloxetine 120 mg daily
- Lyrica 300 mg b.d.
-
- He tells you he is actually using 25 mg daily of Valium and he cannot sleep. He last used ice a week ago. He does not inject.
-
- How would you manage his insomnia?
- How would you manage his Valium habit?

Roy: substances 3

- You refer him to a psychiatrist who stops his Lexapro and switches him from olanzapine to risperidone 6 mg daily. The psychiatrist mentions Deralin and clonidine as adjuncts to his anxiety and sleeplessness.
-
- What are your views on the use of derail and clonidine in anxiety and insomnia?

Roy: substances 4

- Roy tells you that it is his usual routine to work as a manual labourer in his father's business during the day, then have dinner at his sister's house then go home to his own house in the evening. He tells you that when he gets home he feels anxious and nervous. He tells you that he thinks of ice at these times and is tempted to go out and buy ice.
-
- How would you deal with this apparent situational anxiety?

Roy: substances 5

- At a subsequent visit, Roy tells you that last year he was the victim of a home invasion perpetrated upon him by a dealer to whom he owed money. He was physically assaulted and tied up. He tells you that he suffers from nightmares about this and regularly wakes up in the middle of the night in a cold sweat. As a consequence, he does not sleep well, and feels tired all day. he drinks at least eight cups of coffee a day and constantly has an energy drink to hand.
-
- What is his diagnosis?
- Given that he is already taking clonidine, Deralin, and the meds listed above what group of drugs might you consider as a treatment for his nightmare and insomnia disorder?

Roy: substances 6

- A few weeks later Roy comes to see you for a scheduled review appointment. He tells you that last Saturday evening he had a knock at the door. It was a local dealer who offered him ice for free. He took it. he has not used since.
-
- How would you respond to this?

Roy: substances 7

- In February 2018 Roy comes to see you complaining of worsening fibromyalgia and back pain. CT scan demonstrates spondylolysis of L5 without spondylolisthesis. He attends a follow-up psych appointment. You see him with the results of the CT scan and the psych letter. The psychiatrist he has seen is concerned about his dose of Tramadol and the potential risk of serotonin syndrome. She recommends stopping the tramadol and a referral to pain clinic.
-
- You discuss physiotherapy and reducing the tramadol. He tells you that you are a waste of time, and that he will go back to his previous doctor who was a proper doctor who, because he helped him with his pain in the past, would help him again. He quaffs the remnant of his energy drink that he has with him, then burps in your face as he leaves the room never to be seen again.
-
- What do you think is going on?

Pharmacotherapy and Boundaries

Boundaries 1

- You run a pharmacotherapy clinic and two evenings a week you do out of hours sessions. A patient comes to you in the out of hours period requesting methadone induction. She states that she works all day and is unable to attend your clinic during the day.
-
- Would you manage her opiate dependency syndrome in this setting?

Boundaries 2

- A new patient attends your clinic at 4:45 pm Friday afternoon requesting help for his opiate dependency. He has finally seen the light and is ready to go on treatment. In fact, he has already quit. On examination he has a runny nose goose bumps pulse 95 and SBP 145.
-
- How would you manage this situation?

Boundaries 3

- A GP colleague phones you up for advice. A patient came to see her for opiate replacement therapy. She tells you that she has, in the past, paid for antibiotics for this patient via her practice account in the local pharmacy. When she told the patient the fees for suboxone the patient told her that he could not afford the fees. The GP is considering paying for the suboxone.
-
- What advice would you give the GP?

Boundaries 4

- A patient who was previously stable on 130 mg of methadone daily with four take-aways per week has now missed two appointments in a row. His prescription has another six weeks to run before it expires.
-
- How would you manage this situation?

Boundaries 5

- Two patients, husband and wife, stable on forty mg of methadone daily on four take-aways per week pick up their doses from a pharmacist across town from where they live during their lunch break at work. They have always gone to that pharmacist who knows them well. They are requesting six take-aways per week of methadone because their work is taking them away and means that they cannot access that pharmacist any more during their lunch break. They are compliant, well presented, in work, with negative urine tests. When you equivocate, they accuse you of treating them like statistics.
-
- How would you deal with this situation?

Boundaries 6

- A patient in 18 mg of suboxone six take-aways per week presents to you saying that she has run out of her take away doses. She has used them early. In the last few weeks she has been really stressed, she is being bullied at work and finding it difficult to cope with her alcoholic abusive husband. She breaks down in tears and begs you firstly to prescribe additional suboxone to tide her over till the next pickup (two days hence), and secondly to not reduce her take-aways otherwise she will lose her job.
-
- How would you respond to this?

Pharmacotherapy and Interstate travel

Travel: 1

- Richard is stable on 60 mg of methadone with four take-aways per week. His mother is dying in Perth. he needs to go and attend her death bed. He does not know How long he will need to be away for.
-
- How will you manage this situation?
- Where would you seek further guidance on this matter?

Travel 2

- Zane is new to your clinic. He has transferred from another prescriber who retired. He is on methadone 90 mg daily dispensed from the local pharmacy. As far as you are aware there are no problems with his behaviour. Recent urine drug screens have been negative. He is on two take-aways per week. He attends with his girlfriend. He tells you that his grandfather has left him some money and he has quit his job. it is his intention to buy a camper van and to go on an extended driving holiday around Victoria. He may cross state boundaries if the fancy takes him, but only for a few days because he is aware of the legal limitations of Victorian pharmacotherapy prescriptions. He wants you to give him one month's take away prescriptions to facilitate his road trip, then thereafter at various times he will contact you and let you know which pharmacy he is at, so that you can fax further scripts for him for ongoing pharmacotherapy.
-
- How would you respond to this?

Travel 3

- Vikram is stable on a dose of 22mg daily of suboxone. Recent urine drug screens have been negative and there are no issues with his dispensing pharmacy. His family lives in India. He comes in for a routine appointment to pick up his prescription for suboxone. He tells you that his father is sick, possibly dying. He asks you, in principle, about what he can do about his suboxone and travel to India, if and when his father passes away.
-
- How would you respond?

Travel 4

- You are an addiction medicine specialist. A local GP has contacted you about Sarah who has been prescribed methadone forty mg daily with four take-aways per week for a number of years. Her mother who lives in England and is terminally ill. The GP wants your advice as to whether or not he can prescribe a month's supply of Physeptone 40 mg tablets to facilitate Sarah travelling back to the UK to visit her dying mother. You ask for a urine drug screen. It unfortunately comes back as positive for methadone and also positive for benzodiazepines. Sarah admits to feeling stressed and having used a friend's Valium for a few nights to get some sleep. She is very worried about her mother. The GP is now pressing you for advice on whether or not he should prescribe Physeptone 40 mg daily, one month take-away, for Sarah.
-
- How would you respond?

Travel 4

- Taylor is a new patient to your surgery. he presents requesting pharmacotherapy, in particular suboxone. Your name has been given to him by one of your other pharmacotherapy patients. He wants you to stabilise him on suboxone for two weeks' worth of suboxone take-aways to allow him to go to Thailand to detox off opiates.
-
- How would you respond?
- Would you initiate him on suboxone?

Travel 5

- John is stable on forty mg of methadone with four take-aways. His mother is dying in Tasmania. he wants to go there to tend her bedside. He wants you to prescribe two month's takeaways of Physeptone for him because he has found out that in Tasmania there are no take away doses dispensed for methadone, and the village in Tasmania where his mother lives does not have a dispensing chemist.
-
- How would you respond?

Travel 6

- John's brother, Nathan, is also on your books receiving pharmacotherapy. He is on 140 mg daily of methadone with four take-aways. He regularly sees an addiction medicine specialist and regularly complies with requests for urine drug screens which have all been consistently negative for anything other than methadone. He has tried to reduce his dose of methadone in the past with disastrous results. He too is requesting advice about travelling to Tasmania to visit his dying mother. Remember the village wherein she lives does not have a dispensing pharmacy.
-
- What are the issues of this case?

Travel 7

- You are an experienced pharmacotherapy GP. One of your more junior colleagues bemoans the state of confusion surrounding interstate transfers for pharmacotherapy. He asks you if there is any state in the rest of Australia that does not require any specific paperwork for a Victorian pharmacotherapy prescription to be dispensed.
-
- How would you respond?

Pharmacotherapy and Special circumstances

Specials 1

- Janet is stable on 32 mg of suboxone two take-aways per week. Her attendance at your clinic is erratic, but she has stopped injecting. She comes in to tell you that she is 6 weeks pregnant. She wants advice on the suitability of suboxone in pregnancy.
-
- How would you respond?
- What are the risks of ort in pregnancy?

Specials 2

- Janet then falls off your radar. She has missed multiple appointments and has ignored recalls. She then attends your clinic just as you are thinking of packing up and going home on a Friday evening at 4:30 pm. She is now twenty-three weeks pregnant. She tells you that she is injecting heroin and wants help to come off it. She is sick of it and no longer wants to take any more. Her last injection was ten hours ago. she wants help to stay off the drugs. You examine her and can see now objective signs of withdrawal.
-
- What are the signs of withdrawal from opiates?
- What are the risks of opiate withdrawal in pregnancy?
- How would you manage this situation?

Specials 3

- Janet, whilst on sixty mg of methadone, delivers her baby boy (Joshua), and is discharged early from the hospital within six hours of delivery. The next day she brings Joshua to see you, because he is not feeding and is continually crying.
-
- What is your diagnosis?
- What is your management?
- Would you advise Janet to breast feed?

Specials 4

- Janet's methadone requirement eventually goes up to 120 mg daily. Unfortunately, she then goes on to develop nephrotic syndrome and then end stage renal disease and has become dialysis dependent. Janet asks you whether or not her methadone dose needs to be changed because of her kidney failure.
-
- How do you respond?

Specials 5

- En-route to a dialysis session Janet vomits her dose of methadone. She phones her drug worker in a panic, who then phones you requesting an authorisation of another dose of methadone.
-
- How do you respond?

Specials 6

- Kevin is stable on suboxone 32 mg daily. You have recently diagnosed him with hepatitis C. Unfortunately, during your diagnostic work-up you also diagnose hepatocellular carcinoma. He asks you whether or not his dose of suboxone should change.
-
- How would you respond?

Specials 7

- Kevin then develops decompensated liver failure.
-
- What are the clinical signs of decompensated liver failure?
-
- Would this change your prescribing of 32 mg of suboxone and if so why?
-