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to countries with better provision of intensive care units. However, for the United Kingdom, non-invasive ventilation for patients with mild to moderate acidosis due to decompensated chronic obstructive pulmonary disease is a highly effective technique that improves clinical outcomes, reduces demand for intensive care, and, from the hospital’s perspective, reduces costs.

We thank Professor Christpine Godfrey, Centre for Health Economics at the University of York, for advice on methods; Amanda Farrin and Vicky Allgar for statistical advice; ResMed (UK) for the loan of the ventilators; and the consultants, junior doctors, nursing staff, and physiotherapists at all 14 centres for help in conducting the trial.

Contributors: See bmj.com


Competing interests: MWE receives research funding from ResMed (UK).

Ethical approval: The study was approved by the multicentre research ethics committee South West Thames and the local research ethics committees from the centres.


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Loss of tolerance and overdose mortality after inpatient opiate detoxification: follow up study

John Strang, Jim McCambridge, David Best, Tracy Beswick, Jenny Bearn, Sian Rees, Michael Gossop

In many countries opiate overdose remains the main source of the 10-fold excess mortality among opiate addicts, notwithstanding the effects of HIV/AIDS. Treatment reduces mortality but can sometimes increase mortality transiently—for example, during the first few weeks of methadone maintenance treatment and among former opiate addicts after their release from prison.1 2 The increase in mortality among released prisoners who were formerly opiate addicts has been attributed to loss of tolerance and erroneous judgment of dose when they returned to opiate use.3 4 We wished to investigate whether opiate addicts who have undergone inpatient detoxification might have a similarly increased mortality after treatment. We followed up patients who received inpatient opiate detoxification, looked for evidence of increased mortality, and investigated the distinctive characteristics of patients who died.

Participants, methods, and results

Over 20 months we recruited 137 consecutive opiate addicts who were receiving opiate detoxification as part of a 28 day inpatient treatment programme and who consented to be followed up. Five patients died within 12 months after their discharge from the treatment programme. We followed up 130 patients who had undergone inpatient detoxification. Values are numbers (percentage) of patients unless stated otherwise.

Predictors of mortality among patients who underwent inpatient opiate detoxification. Values are numbers (percentage) of patients unless stated otherwise.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Patients who died (n=5)</th>
<th>Other patients (n=132)</th>
<th>Statistical test results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean age in years (SD)</td>
<td>37.4 (7.3)</td>
<td>32.6 (7.3)</td>
<td>P=0.36, P=0.12</td>
</tr>
<tr>
<td>Male sex</td>
<td>5 (100)</td>
<td>99 (75)</td>
<td>Fisher’s exact, P=0.34</td>
</tr>
<tr>
<td>Previous inpatient treatment</td>
<td>4 (80)</td>
<td>92 (70)</td>
<td>Fisher’s exact, P=1.0</td>
</tr>
<tr>
<td>Ever overdosed</td>
<td>1 (20)</td>
<td>59 (45)</td>
<td>Fisher’s exact, P=0.65</td>
</tr>
<tr>
<td>Was prescribed methadone*</td>
<td>5 (100)</td>
<td>92 (70)</td>
<td>Fisher’s exact, P=0.32</td>
</tr>
<tr>
<td>Mean dose (mg) of prescribed methadone (SD)</td>
<td>51.0 (20.7)</td>
<td>29.2 (23.1)</td>
<td>t=2.08, P=0.04</td>
</tr>
<tr>
<td>Mean number of days of heroin use* (SD)</td>
<td>14.4 (14.4)</td>
<td>24.5 (10.2)</td>
<td>t=2.15, P=0.03</td>
</tr>
<tr>
<td>Living alone 3</td>
<td>4 (80)</td>
<td>27 (21)</td>
<td>Fisher’s exact, P=0.004</td>
</tr>
<tr>
<td>Physical health (MAP‡ score) (SD)*</td>
<td>38.6 (10.2)</td>
<td>29.9 (12.3)</td>
<td>t=1.59, P=0.12</td>
</tr>
<tr>
<td>Mean length of stay (days) in unit (SD)</td>
<td>24.6 (7.6)</td>
<td>15.6 (8.1)</td>
<td>t=2.44, P=0.02</td>
</tr>
<tr>
<td>Completed detoxification</td>
<td>5 (100)</td>
<td>89 (67)</td>
<td>Fisher’s exact, P=0.33</td>
</tr>
<tr>
<td>Completed full treatment programme</td>
<td>4 (80)</td>
<td>33 (25)</td>
<td>Fisher’s exact, P=0.02</td>
</tr>
</tbody>
</table>

*In the month before admission.
†Of 130 patients.
‡Maudsley Addiction Profile (see www.ntors.org.uk/map.pdf).

References


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Changing prescription patterns for lithium and valproic acid in old age: shifting practice without evidence

Kenneth I Shulman, Paula Rochon, Kathy Sykora, Geoffrey Anderson, Muhammad Mamdani, Susan Bronskill, Chau T T Tran

Over the past decade, valproic acid (prescribed as divalprox in North America) has been marketed as an alternative to lithium for treating bipolar disorders. For elderly patients, however, there is no clear evidence that valproic acid is more beneficial than lithium. Moreover, the evidence for the superiority of valproic acid in treating bipolar disorders—mixed episodes and rapid cycling—has been challenged in recent Cochrane reviews. Valproic acid has not benefited patients with manic and psychiatric symptoms in dementia, despite the growing use of the drug in the management of these conditions. Recently, the relatively rapid shift in prescription patterns has been questioned. We describe trends in the use of lithium and valproic acid in a large population of people over 65.

Methods and results

We obtained information on drug use from the Ontario Drug Benefit Program, which provides comprehensive drug benefits to all residents aged 65 or older in Ontario, Canada. We identified all patients who had been taking lithium or valproic acid between 1993 and 2001 (prevalent users) and we further identified those patients who had not previously taken lithium or valproic acid (new users). We restricted our study to patients aged 66 or more to enable us to examine their previous drug use for a minimum of one year. Using unique encrypted health card numbers, we linked data on this cohort to two other large datasets—the Canadian Institute for Health...