Editorials

The physical health of people who inject drugs:

complexities, challenges, and continuity

PHYSICAL CHALLENGES FACED BY PATIENTS

Patients using intravenous drugs have particular physical healthcare needs.[1] Drug-related death rates for patients using heroin and morphine have risen sharply recently.[2] Nevertheless, drug overdoses are only one of many factors that contribute to the high mortality rate. Methadone or buprenorphine treatment reduces but does not eliminate the high mortality rate. Patients in this group also experience high morbidity rates.[3]

WHAT SPECIFIC PHYSICAL PROBLEMS DO GPS NEED TO BE AWARE OF?

Infections

O'Donnell and colleagues alert us to the high prevalence of skin and groin infections. Infections in this group are complex and wide ranging. Injecting manure and other materials used in heroin production produces predictable soft-tissue infections and abscesses, as well as the occasional exotic infection such as botulism, necrotising fasciitis, or tetanus. Other relatively more common but still serious infections include subacute bacterial endocarditis (SABE) and osteomyelitis, which may be difficult to diagnose, perhaps because it is not easy to think of the diagnoses in standard consultations. Infections not directly related to injecting, such as pneumonia, are also more common than the general population and likely to be caused by poor living conditions and poor nutrition.

Hepatitis C

This group represents the major cause of hepatitis C infection in the UK; the RCGP has done much to make GPs aware of the connection and arrange appropriate testing and follow-up. There may also be opportunities for primary care to be involved in hepatitis C treatment through new commissioning routes.[4]

Deep vein thrombosis

Deep vein thrombosis (DVT) is common, and in addition to the acute dangers causes poor quality of life from chronically swollen and sometimes ulcerated legs.[5] Pharmaceutical management of DVT poses particular challenges both in terms of the choice of anticoagulant and in decisions about length of treatment. Because of venous access difficulties and unreliability of attendance for monitoring, the newer oral anticoagulant drugs such as rivaroxaban and dabigatran may be the most suitable agents. Guidance about length of treatment in the general population is not based on evidence from this particular group. Factors such as continuing injection (known to increase recurrence risk) may be more relevant. Skilled management of ulcers by nursing staff, and use of stockings and compression bandages, are also necessary but again require regular, periodic clinic attendance to be effective.

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Pain management

Pain management from DVTs is a specific example of the general difficulties of managing pain in this group. Not only is there a high prevalence of conditions causing physical pain, such as trauma from accidents or violence, but there is also some evidence of altered pain perception. The difficulties apply, not so much to the treatment of acute pain — where advice to divide the daily dose of methadone or buprenorphine and add other analgesic medications including opiates may be appropriate — but to the management of long-term pain. The usual medications for pain relief are potentially subject to 'misuse'. These include opiates, but gabapentin and pregabalin are also drugs that are now frequently used for mind-altering effects. Principles discussed in *Managing Persistent Pain in Secure Settings* are useful for managing patients with intravenous drug problems in community settings.[6] The presence of a 'medical indication' is only one relevant factor in making a judgement about whether to prescribe or not; contextual factors such as the risk of misuse or diversion, and made on an individual basis, are also important.

Other physical health issues

There is a range of other specific physical healthcare problems that may go unnoticed in general practice. Both methadone treatment and heroin use may cause hypogonadism resulting in menstrual irregularities and subfertility in women, and erectile dysfunction and possibly reduced bone density in men.[7] Female patients have a high incidence of chlamydia and pregnancy terminations. They also as a group have large numbers of children taken into care, and, as would be expected, have particular requirements for contraceptive services, though the specific type of contraception that might be most effective and appropriate might differ from other 'mainstream' patients.[8] Services need to take into account the contexts (such as sex work) in which contraceptive choices are made and to support women to take proactive control over their reproductive life choices.

Other drug use

It is also important to remember the major health problems that follow from other drug use including licit drugs. Smoking is very common, and its sequelae in an ageing cohort of heroin users is likely to become compounded by poor living conditions. Respiratory problems may also be increased by the frequent use of inhaled drugs such as cannabis and crack cocaine. The cumulative problems associated with alcohol are also common. Although some intravenous drug users do not drink at all, a subgroup drink alcohol at very high levels and deaths from alcohol are unfortunately common.

COMPLEXITIES OF SERVICE PROVISION

The same healthcare needs of the general population apply but services should be flexible to adapt to specific need. Unfortunately, a common criticism from intravenous drug users is that the standard of health care received can be affected prejudicially by their drug use. GPs have a difficult balancing act — to ensure that their approach is non-judgemental, but also to not necessarily accept everything they are told — and to recognise that intravenous

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drug users are individuals, some relatively stable and others chaotic with varying degrees of stability over time.

Mental healthcare needs

The mental healthcare needs of this group cannot be disregarded in a description of the management of physical healthcare needs. People injecting drugs have a high prevalence of psychotic illness, personality disorders, and common mental health problems such as anxiety and depression. GPs should be aware of the association between methadone and prolongation of the QT interval, which may be exacerbated by the co-prescribing of other medications for mental health illness. The crippling effects of early and repeated severe emotional trauma are often all too apparent. High levels of anxiety and poor motivation from depressive illness may contribute to failure to attend appointments. 'Needle phobia' may paradoxically aggravate the problem of venous access caused by physical damage to veins. This is understandable when one realises that most will have witnessed an overdose in others, and which is the rationale for providing naloxone injection kits. This should now be standard practice.

Health care management

Earlier research, showing a high workload in general practice in terms of consultation rates, prescribing rates, missed appointments, and emergency appointments,[9] is still likely to apply. As a group, they share the features of deprived patients in general, such as the presentation with multiple physical and mental health problems, and the need for the patient to be seen opportunistically.[10] This applies particularly to the management of long-term conditions and screening. Letter invitations are likely to be ineffectual and appointments may be missed. Flexible use of healthcare appointments can be highly effective: we demonstrated that this approach led to higher rates of cervical smear compared with the national average.[8] Automatic texting of appointments anecdotally seems to be useful in this group, provided the frequent changes of mobile telephone numbers are updated.

NEXT STEPS

The importance of developing long-term relationships with a GP and other members of the healthcare team are perhaps particularly important. Although presentations with multiple problems are commonplace, the priority of the patient may be radically different from that of the healthcare professional at a specific time. A longer-term relationship may enable important health issues to be addressed when the patient is in a position to do so.

It is important to remember that major physical events and near misses — such as spells in hospitals with SABE — can provide the opportunity for a patient to re-appraise their life and provide an opportunity to move forward positively. And, as for all patients, non-medical life events rather than interventions from medical professionals can provide the opportunity for change. Striking a balance between realism and being positive about change (a necessary attribute for positive therapeutic effect) provides one of the challenging necessary skills for the GP and other members of the primary healthcare team.

Charles Cornford,
GP, Fulcrum Medical Practice, Middlesbrough.

Helen Close,
Health Research Methodologist, Research Design Service, School of Medicine, Pharmacy and Health, Wolfson Research Institute, Durham University, Stockton-on-Tees.

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ADDRESS FOR CORRESPONDENCE

Charles Cornford
Fulcrum Medical Practice, Acklam Road, Middlesbrough TS5 4EQ, UK.

E-mail: charles.cornford@nhs.net

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