Red drugs

"We insist on teaching medical students clinically irrelevant pharmacology theory yet they are utterly naïve to the real clinical dangers associated with drugs of diversion."

There are lots of ideas. Magazines stuffed full of gadgets you think you need: foot spas, page-turners, electric back scratchers, hoverboard shopping carts, and juicers. These are all tumbling out of cupboards across the UK. There are Big Ideas too: hot tubs (now full of green slime), conservatories (which tarnish, leak, and allow cold drafts into the house), and private schooling (only to find your next door neighbour's kids did better at the local comprehensive). The world is littered with good ideas that weren't. Medicine is just the same — just as faddish. New diagnoses such as pre-diabetes, pre-hypertension, sero-negative (with normal inflammatory indices), rheumatoid arthritis, and chronic pain are now viewed as syndromes. All seem like good ideas but aren't.

I have tried to get ideas into the public sphere too. Such as the 'i-patient effect' where the doctor's own health beliefs directly affect patient care, and explains the wide variance in GP referral rates within a locality or a practice. But none ever seems to catch on. Yet the term 'red flags', the idea that clinically there are certain symptoms that doctors should always respond to, has caught on like wildfire. Now any GP with experience knows that it is important to ignore red flags on occasion because they do not fit the clinical picture. But as an idea it rocks.

I have for a long time tried to highlight concern about 'drugs of diversion', many of them used in pain management.[1–2] Patients contrive to obtain these medications, which have a street value, on prescription, frequently purposely mispronouncing their names for dramatic effect, claiming that they have been given them by a friend 'and they really worked'. Once prescribed they can lead to dose escalation, over-ordering, and stories of lost or stolen prescriptions, and are impossible to stop. These medications are frequently prescribed in combination too.

The classic drugs of diversion are tramadol, dihydrocodeine, oxycodone, co-codamol 30/500, pregabalin, gabapentin, zopiclone, nitrazepam, temazepam, diazepam, ADHD medications, and sip feeds. But I have been spectacularly unsuccessful in raising the profile of concern, as trends are ever upwards with increases of tens of millions of scripts over the last decade. Co-codamol prescribing is up 50%, gabapentinoids 500%, tramadol up 100%, oxycodone up 500%, and even diazepam up 10% (despite decades of concern over dependence and abuse).[3] How can the physiology of pain have changed so much in a decade? It makes no sense.

Much of this prescribing is initiated in secondary care and endorsed by the pain community, who have reassured GPs that these medications are not addictive or dependence forming if used therapeutically. But the evidence is wildly inconsistent, based on the unscientific and false premise that *'pain is what the patient says it is'*.[4] These medicines are addictive and are abused. See no further than the US to witness the murderous iatrogenic harm of prescription drugs.[4] In our communities these drugs do real harm but mostly it is concealed and denied.

We insist on teaching medical students clinically irrelevant pharmacology theory yet they are utterly naïve to the real clinical dangers associated with drugs of diversion. So here's an idea: why not rebrand these drugs 'red drugs'? This is a simple and catchy way of highlighting and recognising the dangers of these medications. I hope it catches fire.

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DOI: https://doi.org/10.3399/bjgp17X689185

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