Treatment of heroin addiction

DAVID W. JOLLIFFE, MB
Trainee General Practitioner, Edinburgh
ALAN W. T. MELVILLE, MB, MRCGP
General Practitioner, Kelty, Fife

WE report a case of drug addiction dealt with in our practice. A young man returned to his parents' home requesting help for his addiction to heroin. In his mid-twenties, he had started taking 'soft' drugs while still at school and progressed to 'hard' drugs during a trip to the Middle East. He claimed to have been taking heroin on a regular basis for six to nine months, and this was later confirmed by reliable information.

On the advice of psychiatrists, we embarked on a regime of clonidine withdrawal. This treatment for outpatients was first described by Washton and colleagues.[1] Clonidine has been shown to relieve the signs and symptoms of opiate withdrawal, thereby being an alternative to the more usual treatment with methadone.[2] Initially the dosage was 0.1 mg four times daily and then increased in increments of 0.1 mg daily until the maximum effect was achieved without inducing over-sedation or postural hypotension. The maximum daily dosage was 0.8 mg (the recommended maximum is 1.2 mg daily). In addition, the patient received daytime anxiolytic treatment of 5 mg of lorazepam four times daily and night sedation of 100 mg promazine hydrochloride with 30 mg nitrazepam to counteract the agitation and insomnia accompanying withdrawal. At the time of presentation the patient had complained of aches and pains in his arms and legs and shown signs of disturbance of temperature control. These classical symptoms of heroin withdrawal were present for the next five days. On day 10 the patient was given 2.0 mg naxolone intravenously to ascertain whether or not he was still dependent on narcotic drugs. This challenge being negative, the dosage of clonidine was then slowly reduced by 0.1 mg daily. The high doses of anxiolytics and night sedatives were continued since symptoms of insomnia and anxiety were likely to be troublesome. After three weeks, night sedation was no longer required, but the anxiolytic treatment had to be continued for six weeks.

We believe that this case has some useful lessons for general practice. Psychiatric units are often unable or unwilling to admit such patients as an emergency, and the Misuse of Drugs Act 1973 forbids most practitioners from prescribing heroin for an addict. The regime of clonidine withdrawal may fill an important gap in our armamentarium for dealing with situations such as the one described. It could serve as an interim measure until a hospital admission can be arranged, or, as in this case, be the means of removing the need for hospital admission.

There were frequent home visits during the first few days of treatment. A great deal of support had to be given both to the patient and to the parents. However, the time was well spent: not only was a relationship established with the patient, but we were able also to help the parents to come to terms with the problem of addiction and then to be of help to their son. This may be of some importance in laying the foundation of rehabilitation for the patient and reducing the risk of subsequent re-addiction. Drug addiction is a problem that is on the increase and treatment in the early stages is difficult. If others were able to report similar success to ours we believe that this might be a significant step forward.

References

1. Washton AM, *et al.* Clonidine for outpatient opiate toxification. *Lancet* 1980; **1**: 1078-1079.
2. Anonymous. (Editorial.) *Lancet* 1980; **1**: 349-350.

Address for communication
Dr D. W. Jolliffe, 6c Mortonhall Road, Grange, Edinburgh EH9 2HW.

Correction

In the article on polymyalgia rheumatica by Dr R. M. Turner, which appeared in the March 1983 issue of the Journal, there is a mistake on page 169 in a reference to case 1. The penultimate sentence in the third paragraph should read:

> 'Herpes zoster occurred in three patients, in two (cases 2 and 6) while on steroids for four months and nearly two years respectively. Another patient (case 1) also developed herpes zoster nearly two years after diagnosis, never having received steroids.'