Managing physical health problems in people who inject drugs

INTRODUCTION

GPs have an important role in addressing the physical health complications of illicit drug use and in particular in people who inject drugs (PWID). Managing these morbidities is within the remit of every GP and does not require any special interest or knowledge.¹ A balance will need to be struck between trying to accomplish too much in a single visit and the common problem of arranging adequate follow-up.

MANAGING SKIN INFECTIONS

Skin infections are common in PWID. A study in Glasgow found that 60% of drug injectors reported some kind of skin problems.² In the Public Health England report *Shooting Up*, 28% of those injecting psychoactive drugs in 2013 reported that they had experienced an abscess, sore, or open wound during the last year.³ One in 10 PWID are admitted to hospital with a related infection each year and there are frequently delays in seeking healthcare advice. Clinicians should assess common sites of injection such as arms and groin. If there is infection present, then superficial infections without systemic involvement should be treated according to local antibiotic guidelines. Groin infections should be assessed carefully as these can track into deeper structures and may require admission to establish their full extent.

It is advised to watch closely for systemic infection. Typical symptoms of tachycardia, hypotension, and reduced capillary refill might, at a glance, be dismissed as withdrawal related by both user and clinician, but people who inject drugs are at higher risk of developing cellulitis and associated septicaemia. Make sure to check for the presence of a fever. Although very rare, PWID can acquire unusual and serious infections: bacteraemia can cause osteomyelitis that may present atypically and infective endocarditis is well recognised in PWID; cases of botulism have also been documented; and there have been cases of 'injectional anthrax' in North West England and Glasgow.³

GROIN INJECTING AND VENOUS HEALTH

One study of groin injecting in three English cities found that 53% of PWID had used their groin as a site at some time. More importantly, 41% of injectors had used their groin within the past month.⁴

Groin injecting leads to damage of the lower venous system and users are more likely to have problems with chronic venous insufficiency leading to considerable morbidity (Figure 1). Coull and colleagues found that 25% of their sample of young Glaswegian PWID had problems with leg ulcers and 15% of their sample had suffered a leg ulcer that had persisted for >4 weeks.² The risk of deep vein thrombosis is 100 times greater than in the general population and a prevalence of around 14% has been found in illicit drug users with a rising incidence for older patients, females, and people who injected drugs.⁵ End-stage venous disease carries a high tariff and, in those who inject drugs in their groin, it can affect relatively young people. Early treatment with close involvement of primary care professionals is essential.

CONTRACEPTION

Females who use illicit drugs are far less likely to use planned (non-condom) contraception, have more frequent pregnancy terminations, and have a higher annual incidence of Chlamydia when compared with age-matched population data.⁶ Although they tend to have slightly higher rates of injectable contraceptives they have a much lower use of oral contraceptives and intrauterine contraceptive devices (IUCDs).⁶ There is an urgent need for better contraceptive services in females who are drug using, and every opportunity to discuss contraception should be taken.

LIVER HEALTH AND BLOOD-BORNE VIRUSES

Hepatitis C is known to have deleterious effects across a range of domains with a reduction in overall quality of life; its effects

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Figure 1. A 45-year-old man with bilateral chronic venous disease and ulceration as a consequence of groin injecting.

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Competing interests

Euan Lawson is paid by SMMGP (www.smmgp.org.uk) to write a bi-monthly summary of current evidence for substance misuse. He is Deputy Editor of the *BJGP* and Editor of the *Harm Reduction Journal*.

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are not limited to the liver. There are two priorities for primary care when it comes to hepatitis C. These are: to find cases and to get the current cases into treatment. There is no consensus on how often a person who is actively injecting should have blood-borne virus testing carried out, but in general testing every 6–12 months is advised. Many addiction services now offer dried blood spot testing and will offer regular checks for blood-borne viruses.

VACCINATION

Do not miss an opportunity to immunise people who inject drugs. Given the difficulties with attending for appointments, the rapid schedule of hepatitis B vaccines has been shown to work better than the usual schedule. The hepatitis A vaccine is also indicated for drug users and can be given separately or in combination with the hepatitis B vaccine. There is a significantly increased risk of pneumonia in PWID. Other vaccines that should be considered include influenza, tetanus, and pneumococcus.

PHLEBOTOMY

Taking bloods to investigate physical problems or to screen for disease may not be easy. Over two-thirds of people who inject drugs into their groin have run out of veins elsewhere. Many people who inject drugs will regard themselves as expert in their own veins; this does not necessarily imply that self-phlebotomy is appropriate but a careful, collaborative approach can help reduce stigma and emotional conflict.

MANAGING PHYSICAL HEALTH: PRESCRIBING CONCERNS

Co-prescribing with methadone

Commonly, the prescribing of opioid substitution therapy (OST) will occur at community drug clinics. Methadone can cause prolongation of the QTc interval in a dose-dependent manner. Be wary of prescribing other QT-prolonging drugs, as interactions with these may be easily missed given that methadone is not prescribed on the practice system.

Prescribing for pain relief

PWID have a high prevalence of chronic pain and this is a complex area that may require specialist input. Chronic leg ulceration can be exceedingly painful. Methadone in once-daily dosing regimens will not provide adequate pain relief. Anyone on buprenorphine OST for doses of more than 8–12 mg will be blocked to other opioids. There is no value, and some risk, in prescribing opioid analgesia to people on buprenorphine. Non-opioid options should be explored, but if stronger analgesia is needed then this may require a change in OST and will need to be discussed with the OST prescriber.

BEFORE FINISHING

Not all of these will necessarily be completed in a single brief consultation but may be appropriate depending on the discussion and interventions:

- confirm the patient's contact details; most will have mobile phones but numbers change frequently and these are crucial for follow-up;
- discuss follow-up and how test results should be made available;
- discuss how often the patient should have repeat blood testing;
- enquire about contraception;
- provide contact details of local harm-reduction and needle exchange services; and
- if not already engaged then refer to local treatment services for further assessment.

Patient consent

The patient consented to the publication of these images.

Provenance

Freely submitted; externally peer reviewed.