Drug Dependence as a Chronic Medical Illness

To the Editor: McLellan and colleagues state that drug addiction should be treated as a chronic medical disease. This contradicts our experiences as a sheriff (L.A.) and an emergency department physician (D.L.S.) who regularly encounter patients who provide false histories concerning trauma or pain syndromes, insist on narcotic analgesics, and vigorously refuse nonnarcotic analgesics or follow-up with an office-based physician. Our experience has been that the overwhelming majority of such patients will not agree to enter a drug rehabilitation program or to go to Alcoholics Anonymous or Narcotics Anonymous.

Anecdotally, most patients who have been in rehabilitation experience a relapse or a loss of control of their drug dependency. Only a tiny minority of these patients will follow up with a single physician or medical office for ongoing medical management of their chronic illness. The vast majority of drug-dependent individuals do not view their condition as an illness, but rather spend tremendous resources and take great risks, including that of jail or even death, to continue their lifestyle. In our area we have discovered organized groups that travel from physician to physician for the express purpose of obtaining drugs.

Most people who use illegal drugs make a conscious decision to do so. Although we believe that treatment should be available, it must also be accompanied by consequences, such as jail or involuntary commitment, for noncompliance with detoxification. From our observations, many individuals use drugs to insulate themselves from life and its problems. It is impossible to view all drug users and addicts together, but practical experience provides insight into a world that they choose to live in.

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In Reply: Mr Amerson and Dr Smith have failed to understand 3 key points in our article: (1) that substance-dependent individuals are responsible for the onset of their illness; (2) that they are also responsible for active participation in their recovery; and (3) that they should be treated because of the demonstrated public health and safety benefits of treatment, not merely because of compassion for those affected.

Responsibility for Onset of Illness. Addiction is initiated by a voluntary act—but it is also true that this initial voluntary behavior is shaped by preexisting genetic factors. These are also brain changes that begin with the very first drug or alcohol uses, which may evolve into compulsive drug taking that is less subject to voluntary control. We are not yet able to explain the brain and cellular changes that transform the initial, voluntary drug-taking behavior into a compulsion.

Responsibility for Recovery. Drug dependence erodes but does not erase a dependent individual’s responsibility for control of their behavior. All patients, regardless of their illness, are responsible for actively participating in their recovery. Many patients with chronic illnesses fail to see the importance of their symptoms and thus may ignore physician advice, fail to comply with medication, and engage in behaviors that exacerbate their illnesses. While such patients may not be as disruptive, demanding, or manipulative as alcohol- or drug-dependent patients, the patterns of denial of symptoms, failure to comply with medical care, and subsequent relapse are not peculiar to addiction. One thing that does separate addiction from other illnesses is the waiting lists for treatment throughout the United States, which contradict assertions that addicted persons do not want treatment.

Efficacy as Basis for Treatment. Compassion or sympathy is not the basis for our argument that physicians should treat addicted individuals. Medically oriented treatments are much more effective than socially oriented responses such as incarceration. Also, addiction treatments have been combined effectively with legal sanctions (eg, drug courts and court-mandated treatments) and with civil sanctions (eg, welfare-to-work programs and involvement of child protection services).

Research has provided physicians with even more effective medications and brief interventions to address addiction problems. These new interventions should be taught in medical schools and primary care residencies. Our review suggests that if physicians develop and apply the skills available to diagnose, treat, monitor, and refer patients in the early stages of substance dependence, there will be fewer late-stage emergency department cases such as those that have frustrated and disillusioned Amerson and Smith.

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Dextromethorphan and Ecstasy Pills

To the Editor: In their Research Letter, Mr Baggott and colleagues’ report that they performed a chemical analysis of 3,4-methylenedioxymethamphetamine (MDMA) tablets, also known as “ecstasy,” and found that such tablets frequently contain dextromethorphan. The authors imply that findings of “lethargy or
hyperexcitability, tachycardia, ataxia, and nystagmus, as well as a phencyclidine-like psychosis” can occur only in dextromethorphan toxicity. Furthermore, they suggest that these findings in patients admitting ecstasy use, but in whom the results of toxicology screens are negative for MDMA and amphetamines, should lead clinicians to consider dextromethorphan toxicity. Both of these statements are misleading.

Each of the above symptoms may arise from MDMA use. Effects of MDMA include tachycardia, hypertension, hyperthermia, hepatitis, myocardial ischemia, elevated antiduretic hormone levels, serotonin syndrome, cerebral hemorrhage, and psychosis. In those who use pure MDMA, lethargy may represent a postictal state caused by hypotension, hyperthermia, or cerebral hemorrhage. Tachycardia, hyperexcitability, tremor, ataxia, nystagmus, and seizures arise from the hyperadrenergic state produced by the drug. Cerebral hemorrhage may also produce seizures as well as focal neurologic findings, and psychosis may arise from chronic amphetamine use. Contrary to the authors’ views, these symptoms may arise not from an adulterant, but from the intended drug.

Urine toxicity screens vary in their ability to detect MDMA. A recent survey assessed the proficiency with which the intended drug. Contrary to the authors’ views, these symptoms may arise not from an adulterant, but from the intended drug.

Urine toxicity screens vary in their ability to detect MDMA. A recent survey assessed the proficiency with which clinical laboratories detected MDMA in standardized samples. Approximately one third of the 2734 laboratories evaluated did not detect MDMA, irrespective of method used. The results of urine immunoassay toxic screens, therefore, may be negative in individuals taking MDMA. Consequently, such results may lead to an incorrect diagnosis of dextromethorphan toxicity in patients who actually have MDMA poisoning. The management of toxicity for MDMA is different than that for dextromethorphan. Clinicians should continue to suspect MDMA toxicity even in the presence of a negative urine screen result.

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5. Poklis A. American Association for Clinical Chemistry/College of American Pathologists Urine Drug Testing (Screening) Survey Set UDS-C. Final Critique, 1999, Northfield, Ill.

In Reply: We described another potential complication of MDMA abuse. It is not logical to suggest that by describing possible dextromethorphan toxicity we somehow minimize the dangers of illicit MDMA. The adverse effects of MDMA are well-documented and well-known to medical personnel. We reluctantly omitted an explicit comparison of MDMA and dextromethorphan toxicity due to space constraints but strongly agree that both drugs may produce toxic syndromes with similar signs and symptoms. We also agree that currently available qualitative urine toxicology screening systems may not detect MDMA in as many as one third of samples.

Our point is that dextromethorphan, which may be ingested with or instead of illicit MDMA, is not detected using any available urine screening techniques or by clinical examination. Because people who take ecstasy are unlikely to know exactly what they ingested, physicians may make an incorrect diagnosis and provide less than optimal treatment. We feel that it is better for physicians to be aware of possible dextromethorphan toxicity, even if this makes treatment decisions more difficult. Shannon1 made the same point in a recent review on MDMA toxicity: “Because other street drugs are referred to as Ecstasy, including ephedrine, Ma-Huang (herbal ecstasy), caffeine, and gammahydroxybutrate (GHB), clinical and laboratory assessment should be thorough to correctly diagnosis MDMA ingestion.” We would now add dextromethorphan to that list.

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Health Insurance Status of Recent US Immigrants

To the Editor: Dr Ayanian and colleagues1 state that a significant number of uninsured adults in the United States forgo needed medical attention. However, many of these uninsured persons are not US citizens. A recent Kaiser Family Foundation report states that immigrants make up about 10% of the population, yet account for 20% to 25% of the uninsured population. A significant fraction of these immigrants are in the United States illegally. Legal immigrants are ineligible for Medicare for 5 years. Each legal immigrant must have a sponsor who pledges to provide support for 5 years so that the immigrant does not become a public charge. Even then, Medicaid still provides support for emergency situations.

The insurance problems will only increase as more people immigrate legally and illegally to the United States. A significant part of the problem of adults not being insured in this country can be traced directly to US immigration policy. Illegal immigration must be controlled. Sponsors should be held to their pledges and provide for the health needs of the legal immigrants they sponsor. Immigration should not be a...