Most people take prescription opioids appropriately, but abuse does occur in a proportion of patients, some of whom are illicit drug users.

Many illicit drug users target GPs and pharmacists for opioid prescriptions when their regular street supply is compromised. Their drug of choice is street heroin, but some prefer prescribed opiates, because they are reliable and potent. Withdrawal symptoms from heroin occur rapidly after the drug supply has been cut off, for example in situations such as imprisonment, loss of capacity to afford heroin, hospitalisation, or a heroin drought. The effects of a short-acting opioid such as heroin will wear off in the space of 6 hours, and an uncomfortable withdrawal syndrome occurs soon after. Withdrawal is characterised by sweating, chills, cramps, diarrhoea and pilomotor activity. This is known on the street as ‘cold turkey’ or ‘hanging out’. These symptoms can last up to 5 days and users suffer extreme discomfort.

A partial solution to this unpleasant syndrome is to take oral or injectable opioids, generally prescribed for severe acute or chronic pain and terminal malignancies.

The illicit use of strong prescription opioids usually occurs within a well defined black market, amongst users who obtain supplies from factory and pharmacy robberies. Another illicit source of opioids is from the supply of dangerous drugs kept in hospitals.

Some patients who are legitimately prescribed strong opioids, by a pain clinic or for a terminal condition, will sell part, or all, of their prescription on the illicit drug market to augment their income. These patients have often had a history of illicit drug use before receiving this treatment.

‘Doctor–shopping’ data for 1999/2000 for Australia show that a total volume of 262,923 codeine compound analgesics and narcotic prescriptions were written for 87,800 known abusers. These patients saw more than 15 separate doctors in 1 year. The cost of these prescription drugs for 3,000 patients, in NSW alone, was $759,954. The problem is, however, much more widespread than these figures indicate. Many more patients avoid detection by requesting private prescriptions, and are not reflected in official government statistics. There are a large number of these white-collar drug users, adding incalculably to a huge problem.

Portrait of an opioid abuser

The majority of opioid abusers in Australia are under 50 years of age. They often have a history of heroin abuse and may also have injuries or illnesses that cause chronic pain. The crossover between drug abuser and chronic pain sufferer is often difficult to ascertain. Many users have learned to disguise their addiction as a medical condition, and provide plausible signs and symptoms for the doctor. In the USA, 2.6 million patients abused prescription opioids in 1999.

Salient points

- Many illicit drug users target GPs and pharmacists for opioid prescriptions when their regular street supply is compromised.
- The effects of a short-acting opioid such as heroin will wear off in the space of 6 hours, and an uncomfortable withdrawal syndrome occurs soon after.
- The majority of opioid abusers in Australia are under 50 years of age.
- Pethidine is the favoured injectable prescription because it has the effect of producing a rapid anxiolytic ‘rush’ before analgesia.
- When oral preparations are injected, the effect of the drug is heightened, but the duration is reduced.
- GPs should be instrumental in detecting prescription opioid abuse and proactive in trying to reduce harm to affected patients.
Drug diversion scenarios

Many patients fabricate histories to obtain an opioid prescription, claiming for example that:

- ‘I have a kidney stone, doctor’
  (blood can be added to urine in the bathroom, in order to feign signs of calculus)
- ‘I have dislocated my shoulder. I need some pethidine’
  (some patients with recurrent dislocations are able to ‘drop’ their shoulders out at will, and restore them as quickly after an injection)
- ‘I have just arrived from interstate and I need my prescription filled for morphine. The Flying Doctor usually prescribes for me but he is unavailable. I do have a letter’
  (Doctors letters are often forged)
- ‘I am on a methadone programme and have not picked up my medication for 3 days. I need something to tide me over the weekend. Please help me doc!’
- ‘I am withdrawing from heroin so I can go home for a family wedding. I need some Physeptone tablets/Doloxene tablets/morphine (sulphate) slow-release capsules to help me’
- ‘Just one script doc, and I’ll be right’
- ‘The only thing that works is …’ (insert potent opioid name)

A high level of suspicion should be maintained if a younger patient appears to know a lot about the pharmacopeia, and requests potent analgesia by name.

Opioids

Favoured prescriptions

Pethidine is the favoured injectable prescription because it has the effect of producing a rapid anxiolytic ‘rush’ before analgesia. It is used inappropriately to treat back pain and migraine in Australia.

Prescriptions for morphine ampoules are also sought after and have a high street value.

Slow-release oral morphine capsules are often diverted onto the street and the capsule contents are injected.

Other highly prized prescriptions are:

- oxycodone – Endone and Oxycontin
- hydromorphone – Dilaudid and Proladone suppositories
- dextropropoxyphene – Di-Gesic and Doloxene caps
- Physeptone – 10 and 20 mg tablets
- methadone syrup diverted from official programmes
- codeine compounds – Panadeine Forte
- codeine phosphate 30mg tablets
- codeine phosphate containing cough mixtures

Effects

Prescription opioid abusers will take quantities of the drug far in excess of therapeutic standards in order to stave off withdrawal symptoms or to achieve intoxication.

Effects of these drugs vary with their onset of action and half-life. Pethidine and morphine have a 4-hour duration, whereas longer acting slow-release preparations have a 12-hour duration.

When oral preparations are injected, the effect of the drug is heightened, but the duration is reduced.

Short-term effects from abuse include blocked pain messages, drowsiness, pruritus, sweating, constipation and constricted pupils. Respiratory depression and coma are common in overdose and may lead to death. This is more likely if prescribed opioids are combined with alcohol, antihistamines, benzodiazepines or illicit street drugs such as heroin.

A long-term effect of opioid abuse is often an increased tolerance of the drug, requiring larger doses to be used in order to ease withdrawal. Physical dependence on the opioid, and consequent drug-seeking behaviour, is common in this population.

Withdrawal

Acute withdrawal occurs once the abused prescription opioids have been withheld for more than 24 hours. The withdrawal from short-acting drugs, such as pethidine and morphine, lasts from 3 to 5 days; but withdrawal symptoms can be protracted to two weeks with longer-acting drugs, such as sustained-release morphine or long half-life methadone.

Experienced GPs in a primary-care setting can usually manage withdrawal from prescribed opioids, but some cases may require the intervention of a multidisciplinary drug and alcohol service.

The doctor’s role

GPs should be instrumental in detecting prescription opioid abuse and proactive in trying to reduce harm to affected patients. Traditionally, GPs have not been keen to discuss prescription drug abuse with patients. But it is now essential for GPs and pharmacists to work collaboratively in identifying and treating this hidden epidemic. Liaison with community pharmacists can establish drug-seeking behaviour in many patients. Other strategies include:

- eliciting a formal drug history from patients, which should include alcohol, street drugs and prescribed
medications (as with all illicit drug-use, the importance of a drug history is underscored)

- inquiring about other doctors seen in the last 2 months
- contacting the Doctor Shopping Hotline on 1800 631 181 to identify patterns of prescription abuse
- checking with State Pharmaceutical Services to establish if a patient is on a methadone or buprenorphine programme – Does another doctor hold an authority for this patient to have prescribed opiates? Is the patient under the care of a pain clinic?
- suggesting a methadone maintenance, buprenorphine treatment or detoxification programme, where appropriate, for patients who are obviously heroin dependent
- becoming a methadone and buprenorphine prescriber by attending an appropriate course
- referring chronic-pain patients to a local pain clinic for an opinion and creating a care-plan to better manage their treatment

Finally, it is important not to deny adequate analgesia with strong opioids to genuine patients in real pain. There is amongst some doctors a disinclination to use such medications for fear of creating addicts. This does not happen. It is a doctor’s duty to provide adequate pain relief to such patients.

**Legal implications**

There are state regulations that prohibit doctors from prescribing opiates to a patient who is, or may be suspected of being, an addict – as is the case with benzodiazepines. Prescription of opioids to a non-addict can only continue for 2 months without gaining authority from the appropriate State body. Medical Tribunals take a dim view of doctors who flaunt the Poison’s Act regulations, and deregistration may follow such aberrant clinical behaviour.

Importantly, doctors themselves have a high rate of self-medication with strong opioids, and some practitioners do become dependent. This can lead to a finding of impairment by a medical board.

**References**

1. HIC Doctor Shopping Project. Canberra: HIC professional review division, 2000

**Useful websites**

www.nida.nih.gov/Researchreports/Prescription
www.prescriptionabuse.org
www.lindesmith.org

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