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Treatment of misuse of adult cold tablets: A new opening

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ABSTRACT

Background: Misuse of medical drugs to get high is a raising problem. Objective: To treat the misuse of medical drugs. Results: This study explains management of misuse of adult cold tablets. Discussion: This study discloses that some people misuse medical drugs to turn high. Conclusions: We reached to this result that buprenorphine may treat misuse of adult cold tablets. Hence, this work could substantially add to the literature.

Key words: adult cold tablets, buprenorphine, misuse

INTRODUCTION

Currently, buprenorphine as a partial mu agonist is administered for the treatment of pain and opioids withdrawals. Buprenorphine is a safe drug with little chance of overdose and low possibility of toxicity (1).

For the treatment of opioid dependence, buprenorphine is more useful than methadone (2, 3, and 4). Johnson, Jaffe, and Fudala narrated that buprenorphine 8mg/d is as effective as 60 mg of methadone considering opioids negative urines and retention rates (5).

Buprenorphine lessens the incidence of HIV and other opioids induced disorders (1, 6, 7, 8).

Most opioids are derived from opium which has been utilized as a medicine for a long time in some regions of the world (9, 10).

At the present time, mental disorders are boosting globally (11-29). Regarding psychiatric disorders, drug induced disorders, especially medications containing ephedrine, pseudo ephedrine, amphetamine, dextroamphetamine, dextromethorphan and opioids have been reported as lifting quandary. So such drugs induced psychiatric problems are an advancing dilemma and have resulted to more referrals to emergency rooms, inpatient and outpatient psychiatric centers (30-120).

Now we are explaining a single high dose of 47mg of buprenorphine for treatment of adult cold misuse.

To the best of our understanding there is not any published study on this matter,
therefore, our experience could add to the literature. We prepared a reliable and valid scale of assessment (32, 42) to measure drug craving and depression grades, including scores from 0 to 10 (0 means no craving or depression at all and 10 denotes severe craving or depression all the time).

Scale of measurement: 0-1-2-3-4-5-6-7-8-9-10.

PATIENT DISCLOSURE

Our patient was a 42 year old, married, and self-employed with high school education. He resided with his family in Shiraz city of Fars province in southern Iran. BS commenced drinking alcohol at age of 20. One year later he began smoking cigarettes and opium. BS started smoking heroin when his age was 24. Since 15 years prior to the first hospital admission he commenced misusing ephedrine 5mg tablets to turn his mood high and gradually raised the dosage to 300 tablets daily. 7 months later he stopped misusing ephedrine tablets and began misusing tramadol and also methadone 400mg/d. One year later because of tramadol misuse he advanced occurrences of convulsions. Then discontinued tramadol misuse and began using buprenorphine tablets. Since 18 months prior the first admission he commenced misusing 50 tablets of cold stop and adult cold (tablets contained acetaminophen, pseudoephedrine, chlorpheniramine and diphenhydramine) and 4mg of alprazolam per day.

He ended smoking tobacco 5 years prior to first admission. BS did not give history of IV drug abuse.

He gave history of smoking cigarettes and drinking alcohol with his father. At the time of first admission he reported misusing cold stop, adult cold, alprazolam, methadone and tramadol.

Because of irritability, anxiety, agitation, depression and insomnia he was admitted in dual diagnosis ward.

In urine drug screening tests methadone, buprenorphine and benzodiazepine were found. Serology tests for viral markers (HIV, HCV and HB Ag) were within normal limits. During physical and neurological examinations we could not detect any abnormality. In psychiatric interview and examinations he was, irritable, anxious, restless, hopeless and depressed.

Based on medical, psychiatric, and substance use history and also DSM-5 criteria he was diagnosed as substance induced depressive disorder.

Patient received venlafaxine 225mg, olanzapine 20mg and modafinil 300mg per day for the treatment of depression and anxiety. He developed severe opioid withdrawal symptoms in the first day of admission, therefore in the 2nd day of admission he took tizanidine 16 mg, clonidine 0.2 mg and ibuprofen 1200 mg per day for the treatment of opioid withdrawals.

The mean scores of opioids craving for 20 days of admission were 7 (before administration of medications), 3.7, 3, 1.3, 1.3, 0.7, 0.3, 1, 0.3, 0.7, 1.7, 0.3, 0.3, 0, 0.3, 0.3, 0, 0, 0 and 0 respectively.

With reference to the interview, monitoring and scoring (3 times a day) for withdrawal craving, he reported a decreasing level of craving following administration of medications (clonidine 0.2 mg, tizanidine 16 mg, and ibuprofen 1200 mg per day). After 20 days of first hospital admission BS was discharged without any craving or withdrawal symptoms.

One month later BS stopped using medications and after a few days developed craving. So he again started adult cold 30 tablets /d and buprenorphine 6mg /d. He gradually developed depressive disorder. Overall five months after hospital discharge BS was admitted again in dual diagnosis ward (2nd admission).
In second admission he complained of severe depression, anxiety, irritability, and agitation. In urine drug screening tests buprenorphine was detected. Tests of serology for viral markers (HIV, HCV and HB Ag) were normal. During complete psychiatric interview and precise examinations he was anxious hopeless and depressed. In detailed physical and neurological examinations we did not find any abnormality. With reference to DSM-5 criteria, and medical, psychiatric, and substance use history he was assumed as substance induced depressive disorder. In the 2nd day of admission, we administered venlafaxine 225mg per day for the treatment of depression and anxiety. Since he was complaining of depression (7 out of 10) craving for adult cold tablet (craving=7), and opioid (craving=6), therefore, we administered only a single high dose of 47mg of buprenorphine. Several hours after single dose of 47mg of buprenorphine, BS experienced and reported a declining level of depression (0 out of 10), craving for adult cold tablet (0 out of 10), and opioid (0 out of 10). During six days of hospital admission (after single dose of buprenorphine) his depression score and craving for adult cold tablets and opioid all were zero (0). After seven days of second hospital admission, BS was discharged without any depression and craving.

DISCUSSION

In the country of Iran illegal substances or drugs include but not limited to opium, heroin, hashish, marijuana, cocaine, ecstasy, methamphetamine, hallucinogens, alcohol, (tobacco products are legal). Based to the present Iranian drug policy if somebody is found to be misusing illegal or illicit substances, he/she must be referred to addiction treatment centers to be detoxified and treated. Our study illuminates that some people misuse tablets of adult cold (which consist of acetaminophen, chlorpheniramine, pseudoephedrine and diphenhydramine) to turn high. It is possible to treat them with a single high dose of buprenorphine. Hence, this work could considerably add to the literature.

CONCLUSIONS

Our work resulted to this issue that some people misuse tablets of adult cold or cold stop or ephedrine to get high. We could treat them with enough dosage of buprenorphine.

DISCLOSURE

Some data of this patient (which was belong to his first admission) was printed earlier somewhere else.

CONFLICT OF INTERESTS

None
REFERENCES

24. Pridmore S, Ahmadi J; Psalm 137 and Middle Cerebral Artery Infarction; ASEAN Journal of Psychiatry, 2015; 16 (2).
dose of 24 milligrams of buprenorphine for heroin detoxification: an open-label study of five

111. Kutz I, Reznik V. Rapid heroin detoxification using a single high dose of buprenorphine. J
Psychoactive Drugs. 2001 Apr-June; 33(2):191-3

112. Ahmadi J, Khoddaman AR, Kordian S, Pridmore S. Treatment of an obese opioid dependent

113. Ahmadi J, Ahmadi F, Torabi A, Ahmadi S, Ahmadi F. A single dose of 55 mg of buprenorphine


115. Ahmadi J, Sarani EM, Jahromi MS, Pridmore S. Treatment of heroin dependence with 40 mg of


117. Ahmadi J, Ahmadi F, Ahmadi F, Ahmadi S, Pridmore S. A firsthand launch: Heroin dependence
2016; February Vol 3(2): 019-022.

118. Ahmadi J. Combination of analgesics (NSAIDS), baclofen, clonidine and a single dose of
buprenorphine for heroin detoxification, International Journal of Pharma Sciences and

119. Ahmadi J. Fast Treatment of Methamphetamine Related Anxiety and Depressive Disorders: A

120. Ahmadi J. Treatment of cannabis related psychosis with electroconvulsive therapy (ECT): a
rapid approach. J. Harmoniz...Res. Med. and Hlth.Sci. 2016;3(1), 44-50

Sci. 2016. 3(1), 51-55