

ASAM NEWS

American Society of Addiction Medicine

formerly American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD)

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Stanley E. Gitlow, MD Wins ASAM Award



(story on p. 7)

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New Definition for Alcoholism

ASAM/ NCADD Committee Worked for 2 Years

What is your favorite definition of alcoholism? Definitions can be found in the DSM manuals, in medical dictionaries, regular dictionaries, AA literature, and in the hundreds and hundreds of books, pamphlets, tapes and films about addictions.

Why a new definition? Because ASAM's most recent one is nearly 15 years old. A great deal has happened in the field since that definition was conceived by five physicians in 1976.

"We hope that this definition will serve to clarify what is meant by the term 'alcoholism,'" Sheila B. Blume, MD, told *ASAM NEWS*. Dr. Blume was on both the 1976 and the current definition committees. "Its purpose is different from a formal set of diagnostic criteria, which is meant to yield a specific diagnosis in individual cases. This definition updates the 1976 document; it reflects recent research and current thinking."

That is why in early 1988, a joint NCADD/ASAM committee of 27 experts was formally created to examine and, if appropriate, to revise the 1972 Criteria for the Diagnosis of Alcoholism, and the 1976 Definition of Alcoholism, both published by NCA.

The National Council on Alcoholism/ American Society of Addiction Medicine Joint Committee to Study the Definition and Criteria for the Diagnosis of Alcoholism included 15 physicians who are members of ASAM (five ASAM presidents, two NIAAA directors, three NCA medical directors, two NCA board chairmen):

Drs. Margaret Bean-Bayog, Sheila B. Blume, Jasper Chen See, Daniel K. Flavin, (staff to committee), Jean L. Forest, Stanley E. Gitlow, Enoch Gordis, James E. Kelsey, Robert M. Morse, (committee chair), Robert G. Niven, Barton Pakull, Max A. Schneider, Frank A. Seixas, David E. Smith, Robert D. Sparks.

ASAM staff members on the committee were James F. Callahan, E. M. Steindler, and Lucy Barry Ròbe.

(continued on p. 9)

◆

**ASAM is a specialty society of 3,600 physicians
who are concerned about alcoholism
and other drug dependencies
and who care for persons affected by these illnesses.**

4th AIDS Forum in Miami

"HIV is a chronic, manageable disease with early intervention now available. It's time to stop running from this illness as if it's not part of our lives, for it surely is part of the CD treatment field."

... **Mel Pohl, MD**, conference co-chair

This year: a sense of optimism not felt at the previous three conferences. Survival was increasingly discussed, albeit cautiously and conservatively, by a number of the more than 250 at ASAM's 4th National Forum on AIDS and Chemical Dependency held Feb. 22-24, 1990, in Miami.

HIV Progression and Survival

Examples of comments about survival: "From 1981-1985, survival in San Francisco after HIV/AIDS diagnoses was less than one year." But, "with the introduction of AZT, survival now averages four years," according to **Richard E. Chaisson, MD**, of Johns Hopkins in Baltimore.

What is the likelihood of a seropositive patient getting AIDS? "No risk to low risk in the first two years following infection," said Dr. Chaisson. After seven to eight years, 10% develop AIDS annually. Although 50% have AIDS ten years following infection, 50% do not. Dr. Chaisson stressed the importance of telling this to seropositive patients. "HIV/AIDS should be treated as a serious chronic illness -- like heart disease. People are surviving, longevity is improving, we cannot abandon these patients."

The median incubation time is 9.8 years. Without treatment, most infected persons will develop HIV-related illness, said **Lionel Resnick, MD**, of Mount Sinai Medical Center in Miami. "I've yet to see an individual clear his or her infection, which is why it's important to use all possible treatment: antiviral therapy interrupts HIV replication, which then permits the immune system to recover."

Larry Siegel, MD, of Key West, Florida, said, "I've seen people ten years after they tested HIV positive who are totally asymptomatic. There may be a lot more out there." Dr. Siegel, co-chair of the conference, chairs ASAM's AIDS Committee.

According to **Keith Barton, MD**, of San Francisco, "90% of people with HIV do not have AIDS after four years, two-thirds do not have AIDS after eight years." He knows some people who were infected nine to ten years ago and who have low T cells but are otherwise getting along well. He has patients with Kaposi's sarcoma who have lived more than five years. "Living two to three years with opportunistic infections is no longer rare," he said.

"This is not a new virus. We (primates) have been exposed before," declared **Omar Bagasra, MD**, of the University of Medicine and Dentistry in New Jersey. "It takes from two to 15 years for an infected person to develop AIDS. We have intrinsic defenses against the AIDS virus, which are accelerated by alcohol and cocaine." In a study "Syncytic formation before and after alcohol intake" Dr. Bagasra drew blood and isolated lymphocytes before and after 60 subjects drank alcohol "lightly, moderately or heavily." He found low concentration of HIV prior to alcohol intake, high concentration after four drinks.

CONFERENCE DIGEST

What do these cells protect, wonders Dr. Bagasra? Why are they so sensitive to alcohol that they lose control over HIV infection?

The conference began with "The Role of the Chemical Dependency Professional in the Management of HIV Disease," a day-long workshop of seven experts offered free by Burroughs Wellcome (makers of AZT). About 150 physicians attended this workshop. On the agenda: persons at risk; the spectrum of HIV (human immunodeficiency virus) Disease; AZT therapy; opportunistic infections; other complications of AIDS; concomitant drug therapy; access to care for underinsured and uninsured people, including adolescents; use of medications in pregnant HIV-positive IVDU's or alcoholics; influence of crack cocaine; compliance of CD persons with medical management; AIDS treatment team.

AZT

AZT (Zidovudine, Retrovir) was released in 1987 and has been used mainly by patients who were diagnosed with AIDS, and whose T-4 counts fall below 200. **Peter Selwyn, MD**, of New York City, said that AZT slows the progression to AIDS in asymptomatic patients, and that 100 mgs every 4 hrs seems to be as effective as the traditional 200 mgs, with less toxicity.

If an asymptomatic patient refuses AZT because he or she doesn't feel ill (yet), a physician can adopt the same attitude as when prescribing drugs for an illness such as hypertension.

Some recommend taking AZT under the care of a knowledgeable physician after exposure to HIV through a needle stick accident. About one in 250 such exposures result in AIDS, according to Dr. Chaisson.

[One week after this workshop, the FDA approved AZT for HIV positive adults with no AIDS symptoms. This FDA action could make reimbursement easier for patients, since some insurance companies use FDA labeling for guidance. According to Dr. Pohl, "costs are happily coming down. AZT costs about \$2,500 a year for asymptomatic seropositive people, while the full dose for someone with AIDS runs from \$3,000 to as much as \$6,000 annually." --Editor]

Women

A high percentage of drug-using women are HIV positive, according to **Janet L. Mitchell, MD**, and 1/3 of babies born to HIV-infected mothers will themselves become HIV-infected. Only 12 states allow Medicaid dollars for abortion if HIV positive. Counseling is critical - ideally a drug treatment program would offer prenatal care, but this is not always realistic.

Dr. Chaisson said it is a fallacy that transmission involving women is low. "There is a little less risk for a man to have sex with an infected woman than for him to have sex with an infected man -- but this does not mean that sex with an infected woman is safe!"

ADAMHA, NIAAA

Beny Primm, MD, director of the Office for Treatment Improvement at ADAMHA (Alcohol, Drug, and Mental Health Administration in Washington, DC) spoke about ADAMHA's direct treatment clinical trials, and the need to improve relations

between treatment professionals and his agency. He said he hoped that his office will be able to provide some grant money for "indigents in the drug treatment populations - prisons, homeless, women of childbearing age, adolescents."

The directors of NIAAA and NIDA were conference luncheon speakers. Enoch Gordis, MD, talked about how alcohol affects the immune system, but more research is needed on the scientific role of alcohol in AIDS.

Testing for HIV

Who should be tested for HIV? Needle sharers and those who practice unsafe (unprotected rectal, vaginal or oral) sex are at risk. But all the experts agreed that counseling is *critical*.

Dr. Chaisson recommended following a formal protocol that includes: why does the patient want to know? Pretest counseling and education, post-test counseling and education, post-test treatment, outreach to others at risk (significant others and children). The wait for test results can be up to two weeks, which is a powerful trigger for CD relapse, although there are labs that will report in 48-60 hours (ELISA and Western Blot). Peter Selwyn, MD, has found that role playing about the results is particularly effective *before* the patient decides whether to be tested. Those at greater risk for relapse tend to wait to be tested, he said.

James W. Russell, MD, of St. Johnsbury, Vermont, has offered HIV testing to all patients in his 28-bed CD unit for the past two years. "Knowledge of being HIV positive caused no one to leave the program and relapse, but instead to take treatment seriously," he said.

The experts recommended that *all* staff be educated frequently, including housekeeping and maintenance, otherwise their fear and hostility will affect patients.

How to handle confidentiality problem in records of HIV positive patients? All of Dr. Siegel's patients have colored envelopes, but only HIV positives have anything in their envelopes. "No peeking is allowed without authorization."

The AIDS Forum's official opening featured Mervyn Silverman, MD, president of AmFAR (American Foundation for AIDS Research) who said, "Everybody with AIDS is somebody's child, so it doesn't matter if he or she is Black, white, gay, heterosexual, African, Haitian...."

There were five concurrent workshops: on testing, CD relapse, adolescents, safer sex, and formulating AIDS policies. ASAM NEWS covered the latter presentation by Mark Hochauer, PhD, of Golden Valley, Minnesota, who said that too many CD treatment centers still have no policy in place at the time when their first HIV positive or AIDS patient is admitted. He suggested the following basic guidelines, (taken from an article by Edward E. Bartlett, PhD, in *AIDS PATIENT CARE* magazine, Feb. 1990, p. 21).

Areas an HIV Policy Should Cover:

Purpose; background information; statement of the organization's ethical commitment; HIV testing and informed consent; sharing the results of the HIV test; ensuring confidentiality of information; infection control; procedures for employees with needle stick, puncture wound, or other exposure to blood/body fluids; procedures for employees with HIV infec-

tion; and employees caring for patients with HIV-related conditions.

The next morning, seven speakers covered major issues and controversies in the 90s: free needles, drugs & alcohol and the immune system, women with HIV, research, burnout in treatment providers, survival.

Needle Controversy

In a debate about free needles, Robert W. Wood, MD, of Seattle, argued against Beny Primm, MD, of ADAMHA. Dr. Wood said that the primary purpose of free needles is to control AIDS. Secondary is to help users stop using drugs and get needed treatment and medical care, and to reduce discarded needles in public places (parks, playgrounds and alleyways).

Dr. Primm, who used to work in Brooklyn, NY, said that needles are only part of the IV drug ritual - that many drug addicts prefer homemade syringes, made of a medicine dropper and baby pacifier nipple for tensile strength. When these are shared, they can become contaminated. And even if users have clean needles, they may share cookers and cotton, which are *not* sterile.

Afternoon workshops explored the morning topics in more detail. ASAM NEWS attended Keith Barton, MD, of San Francisco: "Survival - Myth or Reality?" who described defensive therapy (antibiotics, chemotherapy) vs. integrative therapy (improving the healing capacity to deal with infections). He believes that the two therapies can be combined, but that each HIV/AIDS case should be individually handled.

Dr. Barton recommends rigorous individual attention to nutrition, an exercise program (particularly yoga, but it's more important that the exercise program be one that the patient enjoys), psychotherapy, support groups for HIV-infected, acupuncture, various vaccinations. "Current Options - A Primer on the Treatment of HIV Infections," was included in the conference syllabus. This is a detailed 27-page description by Dr. Barton of various drug therapies and how they help or inhibit one another.

Michael C. Gordon, MD, of Georgia, said in that workshop: "When I break the bad news to my patients that they are HIV positive, I stress that *they do not have AIDS*. While they are in my office, I make them repeat several times: 'I do not have AIDS. I do not have AIDS. I do not have AIDS.'"

Tapes of the presentations are available from Infomedix, 12800 Garden Grove Blvd, Ste F, Garden Grove, CA 92643. Phone: (714) 530-3454.

Proceedings of this conference will be published in the August 1990 issue of *AIDS PATIENT CARE--A Magazine for Health Care Professionals*. Publisher: Mary Ann Liebert, Inc., 1651 Third Ave, New York, NY 10128. Phone: (212) 289-2300.

Meanwhile, copies of the 31- chapter, 160-page, conference syllabus *AIDS and Chemical Dependency* are available from the New York office for \$20 (includes postage and handling).

Co-chairs of next year's AIDS & CD Forum (mid-February) are Drs. Mel Pohl and Stephan Sorrell..

Nearly 30 committees will meet during the Medical-Scientific Conference in Phoenix. Times and locations are listed in ASAM's conference program. Info also available at ASAM Booth (#14) in Exhibit Hall, Phoenix Civic Plaza.

COMMITTEE NEWS

No More PMP's on ASAM Exam

The 1990 ASAM certification examination will have around 300 multiple choice questions, and no patient management problems, according to **Sidney H. Schnoll, MD, PhD**, chair of the Exam Committee. Dropping the PMP's is consistent with actions by certifying boards and the National Board of Medical Examiners.

To pass the 1990 exam, the minimum will again be 1.2 standard deviations below the mean. After this year, however, the committee plans to grade on an absolute number of correct answers (criterion scoring), rather than on a curve (normative scoring). Those who have passed ASAM certification exams have answered from 75% to 78% of the questions correctly, according to Dr. Schnoll.

The Exam Committee also decided that an ASAM exam should be offered no more than every two years, and that Type K Questions will be phased out over the next few years. (Type K questions are those with more than one correct answer. They are worded "Choose A if 1, 2 and 3 are correct, B if 1 and 3 are correct, C if 2 and 4 are correct, D if 4 is correct, and E if all are correct.")

"A good test taker can rapidly figure out the answers, which means that K Type Questions are no longer a good test of knowledge, but of ability to take an exam," Dr. Schnoll told the ASAM Board of Directors in February. The National Board of Medical Examiners has decided to drop K questions from its exams.

The ASAM Examination Committee has discussed with the National Board of Medical Examiners how its consultation could assist ASAM in developing addiction medicine exams this year and in the future. One suggestion has been clinical vignettes followed by an MCQ (multiple choice question).

ASAM needs volunteers who have been certified by ASAM to field test questions in Phoenix, on Thursday April 26 at 5:00 PM, or Friday April 27 at 5:00 PM, or Sat. April 28 at 6:00 PM. Light dinner will be served. Two hours Category I CME credits. Anyone who has not reserved a place can sign up in the ASAM registration area in Phoenix.

Child /Adolescent

"We are planning the First National Conference on Adolescent Addiction Medicine for 1991. We are looking for groups and organizations that would like to help sponsor the conference."

Contact: Peter D. Rogers, MD, Edwin Shaw Hospital, Ambassador House, 1621 Flickinger Rd, Akron, OH 44312-4495. Phone: (216) 666-7645...Chair: **Peter D. Rogers, MD**

Credentialing

"Credentialing: that which entitles one to confidence, credit, or authority." -
-American Heritage Dictionary

There were nearly 600 new applications for the 1990 ASAM Certification Exam. Of these, nearly half were new ASAM members.

How does ASAM's credentialing process work?

The Credentialing Committee includes eight lead reviewers, three consultant members, and a chair. This year, the eight lead reviewers appointed 34 primary reviewers.

The Credentialing Department in the New York office of ASAM checks each exam application for completeness and compliance. Next, two primary reviewers separately evaluate each application, under the guidance of a lead reviewer. Any application believed not to comply with requirements is sent to another team of reviewers for an independent reevaluation. Along the way, the applicant may be asked for further information.

No request to sit for the certification exam is refused without a review at a Credentialing Committee meeting during the ASAM Annual Meeting, or during a conference call. Finally, any refusal to sit by this process remains subject to appeal to the ASAM Board of Directors...Chair: **H. Blair Carlson, MD**

Cross-Cultural Clinical Concerns

Will anyone interested in joining this committee please send name, address, phone number, and area of interest to: **Andrea G. Barthwell, MD**, Interventions, 1234 S. Michigan Ave., Chicago, IL 60605.

The committee presently has four major areas of concern:

- To network with other organizations that represent specific special interest groups, and which have substance-related use/abuse issues (Indians, Blacks, Hispanics, etc.) and need education and/or exposure to ASAM.

- To insure that ASAM positions are sensitive to special interest groups.

- To provide for cross-fertilization with other ASAM committees (Hispanics on the AIDS Committee, Blacks on the Membership Committee, etc.).

- To look towards the development of an annual ASAM-sponsored meeting on cross-cultural clinical issues....Chair: **Andrea G. Barthwell, MD**

DUI

New Driving Under the Influence (DUI) Committee will meet for the first time in early September in San Diego, during the ASAM Nicotine Conference. Chair: **Ernest B. Leibov, MD**. Anyone interested in joining this committee can contact Dr. Leibov at Newton Memorial Hospital, 175 High St, Newton, NJ 07860. Phone: (201) 813-1880.

Dr. Leibov will hold a preliminary organizational meeting in Phoenix in April. Information about this will be available in conference registration area.

Fellowship

At a January meeting jointly sponsored by ASAM, AMERSA, and AAPAA, and attended by Dolores Burant, MD, committee chair, 17 members of 11 medical societies adopted the name "The Consortium for Medical Fellowships in Alcoholism and Drug Abuse." These individuals (as distinct from their organizations) plan a survey which will "gather, validate and publish information about all training programs" and will prepare requests for federal support for fellowship training.

Fellowship listings in *ASAM NEWS* (there have been several) have not indicated any review or comment by the Fellowship Committee or by ASAM.

Members-In-Training

The second issue of the M-I-T newsletter, now edited by Shelly Rose Clark, 3rd year medical student at UCLA, was mailed in early February to the 165 medical students, residents, and fellows who belong to ASAM. The newsletter included three fine articles: Clark's experience in the 5-day Professional in Residence experiential program at the Betty Ford Center; description of being in the 8-week Substance Abuse InterActive Teaching Service at UCLA by 2nd year medical student Agnes Soraino Wallbom; a report by Allan James McCorkle, 4th year medical student at Texas Tech in Lubbock, about helping to start a student assistance program serving all health professions in a health sciences center.

Copies of the M-I-T newsletter are available from the ASAM New York office.

The ASAM Board voted to lower registration fees for members-in-training to \$50 for an entire ASAM conference, (or \$20 per day,) and to \$25 for the Ruth Fox Course....Chairs: David Gastfriend, MD, and Daniel Glatt.

MRO

The MRO committee is greatly concerned about the apparent extension of its responsibilities to determine "fitness for duty," rather than simply deciding the medical status of a positive urine. The committee wants to alert the membership to the vastly increased liability that this might cause.

A letter has been sent to responsible government officials outlining these problems, in hopes that this situation will be altered.... Chair: Max A. Schneider, MD

Publications

New policy for advertising in *ASAM NEWS*: 10% discount will apply only to exact duplication of ads, not to company or organization affiliations.

(Former policy: 10% discount for one or more ads run consecutively or within one calendar year, by a company or organization.)...Chair: Stanley E. Gitlow, MD.

Review Course

The revised *ASAM Review Course Syllabus* will be ready for the 1990 Review Course. (Chicago: Oct. 11-13; New York: Oct. 25-27; San Francisco: Nov. 8-10; Atlanta: Nov. 15-17.)

Meanwhile, the current syllabus, which has been used as a textbook in the society's Review Courses since 1987, is still on sale for \$15 at the New York office. Previous price: \$35 members, \$45 nonmembers.

The 1991 ASAM Review Course will be held in Orlando, Florida, Oct. 24-27.... Chair: Anne Geller, MD.

Ruth Fox Memorial Endowment Campaign

As of the end of February, 100% of the ASAM Board had contributed a total of \$100,000, which is 10% of the campaign's goal.

Chair Lynn Hanks, MD, reports that the nine regional chairs will now choose coordinators for their regions; a planning meeting will be held in Phoenix in April.

Specialty Status

Reminder: ASAM members are invited to an open meeting or hearing in Phoenix on

"...a hearing for ASAM members about the specialty of addiction medicine."

Thurs., April 26, from 6:00 to 7:00 PM, to express their opinions and concerns about the status of ASAM and the

specialty of addiction medicine....Chair: Anne Geller, MD

Standards & Economics of Care

- The committee plans to distribute a reaction draft of adult and adolescent admission, continued stay, and discharge criteria for levels of care, at the ASAM annual meeting in Phoenix.

- It is working on a draft statement on "Managed Care and Addiction Medicine."

- Reimbursement Subcommittee will seek guidance from the AMA Current Procedural Terminology (CPT) Editorial Panel on how to develop, modify, or better use CPT codes that fit addiction medicine needs".... Chair: David Mee Lee, MD

New State Chapter: Pennsylvania

With seven times as many "yesses" as "noes" on its official vote, Pennsylvania is the latest ASAM state chapter.

President: Bruce Branin, DO, of Waverly.

ASAM now has six official state chapters: California, Florida, Georgia, Maryland, Ohio, and Pennsylvania.

Trauma

This committee welcomes new members who are interested in issues relative to substance abuse and trauma. Contact: Carl A. Soderstrom, MD, chair, MIEMSS, 22 S. Greene St, Baltimore, MD 21201. Phone: (301) 328-5537.

CHEMICAL DEPENDENCY UNIT
MEDICAL DIRECTOR Charter Retreat Hospital is now in need of CD Director. Hospital is in scenic mountain lakes region of N. Alabama + offers excellent income potential. Call David Causey at 1-800-937-3873 or mail CV to: David Causey, Assistant Admin, PO Box 2240, Decatur, AL 35609.



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112 Chestnut St, Danville, PA 17821

MEMBERS IN THE NEWS

Gitlow Wins ASAM Award

Stanley E. Gitlow, MD, of New York City, will receive the 1990 ASAM Award at the society's annual luncheon in Phoenix on Saturday, April 28.

An ASAM member since it was called the New York Medical Society on Alcoholism and met at Ruth Fox's apartment in the 1950s, Dr. Gitlow was twice president: from 1963-65, and from 1971-73. He has frequently been a board member, served on a good dozen committees, is currently chair of the Publications Committee, and is also on the Exam and Nomenclature Committees, the Specialty Status Task Force, and the NCADD/ASAM Definition and Criteria Committee.

IoM Treatment Report

The media showed great interest in the Institute of Medicine's Report to Congress, *Broadening the Base of Treatment for Alcohol Problems*, released in early March. When committee chair Robert Sparks, MD, guested on *Good Morning America* March 13, Joan Lunden quizzed him about the necessity of abstinence. *USA Today* reported that 1/3 of inpatients "for alcohol problems would do just as well with less expensive outpatient or in residential programs;" quoted Dr. Sparks that up to 50,000 people in the USA are in inpatient programs which cost \$10,000 to \$25,000 for a typical 28-day stay; and added that residential and outpatient programs cost 1/3 to 1/2 of that.

ASAM's executive director Dr. James F. Callahan notified the media Mar. 13 that the society "strongly agreed" with the IoM report on the "inexcusable lack of systematic research" on alcohol problems, and supports "systematic screening for alcohol problems" in hospitals, courts, and human service agencies that is followed by evaluation and referral for treatment.

ASAM also endorsed the report's proposals for "improved, nondiscriminatory health insurance coverage" for alcoholism treatment; for increased national support for research, particularly on youth, minorities, women, homeless, multiple substance abusers, and alcoholics with mental illness; and cautioned that any changes in the current approach to treatment should be introduced gradually, evaluated carefully, and be based on research evidence.

Report will be available in early May for \$45 prepaid. Contact: National Academy Press, 2101 Constitution Ave N.W., Washington, DC 20418.

Phone: (202) 334-3313 or 800-624-6242.

Sullivan Still on Cigarette Warpath

HHS Secretary Louis Sullivan, MD, has vowed to make the U.S. smoke-free by the 21st century. In a Feb. 21 cover story in *USA Today*, Dr. Sullivan declared of cigarette advertising that "It is morally wrong to promote a product which, when used as intended, causes death."...Louis Sullivan, MD

"It is morally wrong to promote a product which, when used as intended, causes death."...Louis Sullivan, MD

The latest government report, *Smoking and Health*, estimates that smoking causes 390,000 deaths annually.

Smoking has dropped from 40% of USA adults in 1965, the year of the first Surgeon General's report on it, to 27% in 1990. Estimate for 2000: 20%.

After Dr. Sullivan's attack on *Uptown*, R. J. Reynolds' proposed cigarettes targeted at blacks, RJR withdrew the product (*ASAM NEWS* Jan.-Feb. issue). Next: RJR plans a brand called *Dakota*, targeted at young women ("virile females" according to a confidential memo leaked to the media). *U.S. News & World Report* said on Mar. 5 that Dr. Sullivan called to-bacco companies "immoral and irresponsible" for targeting vulnerable youths. Fate of *Dakota* is undecided.

Halikas Uses Anticonvulsant for Cocaine, Crack Addicts

Carbamazepine or CBZ (anticonvulsant) is used by James Halikas, MD, of the University of Minnesota, to control craving for cocaine and crack. "We believe CBZ, whose brand name is Tegretol, can eliminate or significantly reduce kindling, [thus] curbing the craving for cocaine," Dr. Halikas told *People Magazine* for a Jan. 22 article. "With his craving curbed, and by involving himself in therapy groups, the recovering addict can begin to control his cocaine use." Dosage: "typically 1/3 to 1/2 less than that prescribed for epileptic seizures." Duration: "three months to as long as a year."

Dr. Halikas is chair of ASAM's CME Committee.

Smith, Payte, Testify on Methadone Maintenance

Drs. J. T. Payte, chair of ASAM's Methadone Treatment Committee, and board member David E. Smith of San Francisco, testified Feb. 28 at the FDA on its "Interim Methadone Maintenance Proposal."

ASAM is in opposition to this regulation, believing that quality treatment -- getting patients well -- is the best goal.

ASAM NEWS

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1990 Definition of Alcoholism from ASAM and NCADD

Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic: impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

Explanatory Text

1. "Primary" refers to the nature of alcoholism as a disease entity in addition to and separate from other pathophysiologic states which may be associated with it. "Primary" suggests that alcoholism, as an addiction, is not a symptom of an underlying disease state.

2. "Disease" means an involuntary disability. It represents the sum of the abnormal phenomena displayed by a group of individuals. These phenomena are associated with a specified common set of characteristics by which these individuals differ from the norm, and which places them at a disadvantage.

3. "Often progressive and fatal" means that the disease persists over time and that physical, emotional, and social changes are often cumulative and may progress as drinking continues. Alcoholism causes premature death through overdose, organic complications involving the brain, liver, heart and many other organs, and by contributing to suicides, homicides, motor vehicle crashes and other traumatic events.

4. "Impaired control" means the inability to limit alcohol use or to consistently limit on any drinking occasion the duration of the episode, the quantity consumed, and/or the behavioral consequences of drinking.

5. "Preoccupation" in association with alcohol use indicates excessive, focused attention given to the drug alcohol, its effects, and/or its use. The relative value thus assigned to alcohol by the individual often leads to a diversion of energies away from important life concerns.

6. "Adverse consequences" are alcohol-related problems or impairments in such areas as: physical health (e.g. alcohol withdrawal syndromes, liver disease, gastritis, anemia, neurological disorders); psychological functioning (e.g. impairments in cognition, changes in mood and behavior); interpersonal functioning (e.g. marital problems and child abuse, impaired social relationships); occupational functioning (e.g. scholastic or job problems); and legal, financial, or spiritual problems.

7. "Denial" is used here not only in the psychoanalytic sense of a single psychological defense mechanism disavowing the significance of events, but more broadly to include a range of psychological maneuvers designed to reduce awareness of the fact that alcohol use is the cause of an individual's problems rather than a solution to those problems. Denial becomes an integral part of the disease and a major obstacle to recovery.

New Definition (continued from p. 1)

Other [non-ASAM] committee members, all active nationally: Daniel J. Anderson, PhD, Henri Begleiter, MD, PhD, Nancy K. Mello, PhD, Roger E. Meyer, MD, Ann Noll, Katherine Pike, Marc Schuckit, MD, Boris Tabakoff, PhD, George Vaillant, MD.

The committee has met in person and by mail all over the country for well over a year, carefully and laboriously working out a new definition of alcoholism.

Sentence by sentence, phrase by phrase, word by word, they wrote, they examined, they argued, they discussed; they edited, they rewrote, they argued again, they discussed some more, they edited again. Finally, this past winter, the definition was approved by the boards of directors of both ASAM and NCADD, along with the descriptive material ("explanatory text"). (See column at left)

The joint committee will now turn its attention to criteria for diagnosing alcoholism.

Abbreviated Definition

The committee suggests the following short form of the 1990 definition:

**Alcoholism is a disease
characterized by continuous or periodic:
impaired control over drinking,
preoccupation with the drug alcohol,
use of alcohol despite
adverse consequences, and
distortions in thinking,
most notably denial.**

Previous Definition

Fourteen years ago, five physicians representing AMSA and NCA (now ASAM and NCADD) prepared the definition of alcoholism that was first published in the *Annals of Internal Medicine*, Vol. 65, No. 6 (December 1976) and has been widely quoted since.

1976 Definition

Alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both—all the direct or indirect consequences of the alcohol ingested.

On that committee were Drs. Frank A. Seixas, Sheila B. Blume, Luther A. Cloud, Charles S. Lieber, and R. Keith Simpson.

◆

ASAM NEWS would be interested in readers' reactions to this definition. Please send your comments (short have a better chance of being published) to the Editor.

ASAM Exam

In preparing the examination that certifies its members, the ASAM Exam Committee continually explores new ways to test knowledge and skills. One that we are investigating is called the "clinical vignette."

The clinical vignette describes a clinical situation, then asks one or more questions about it. Exam Committee members go through many questions before choosing those that appear on the examination. Some questions are innovative, others less so. The following vignette was developed by Dr. David Altman of our Chicago Test Development Committee.

I believe you will find this vignette to be a unique contribution to the addiction literature and a novel approach to testing. I hope you will enjoy it as much as did members of the Chicago Test Development and Exam Committees.

Due to our concern for the confidentiality of exam materials, the following vignette will not appear on any future examination, but it might stretch your test taking skills and your imagination.

Sidney H. Schnoll, MD, PhD, Chair
ASAM Exam Committee
Richmond, VA

Are You Ready for Recertification?

by David B. Altman, MD

It all happened because I didn't take the stairs.

I was in my office with my feet on my desk, meticulously, mentally dismembering the Chairman of the Department of Psychiatry. Oh, don't let me leave out that he is also the Chairman of the Utilization Review Committee. And on the Board of Directors. Isn't it wild the way his name is Dr. Badder? Rather like a soap opera name with intrinsic meaning.

Only the day before, I had presented at psychiatry grand rounds. (That sure is great - bring in the addiction specialist - bring in the cannon fodder!) I was discussing referrals to AA and Al-Anon when Dr. Badder stood up. Where was my control group, he asked me? That was the high point, followed by an extensive description of how I give people an excuse to drink when I tell them that they are powerless over alcohol and drugs.

I decided to go down to the cafeteria. Why worry about missing a call? There would be no referrals after yesterday.

I rang for the elevator, complimenting myself on my ability to avoid feeling resentful, when the elevator door slid open.

Dr. Badder leaped out. He was no longer meticulously dressed, was haggard, and unshaven. We were alone. "My son's had a psychotic break," he told me in a halting voice. "He was admitted this morning. I've got the best analyst on the staff -- Dr. Overhead -- to handle him. My son's had a little problem with drugs, so I'd like you to see him. But don't worry, Dr. Overhead will handle everything."

I couldn't believe it. My mind raced back to the last 24 hours, but I pulled myself together and said:

Question 1. (pick the best answer)

1. "I would be happy to see your son."
2. "I would like to see your son, but I'd really need to be

in charge of his care."

3. "You're obviously distraught. I think that you need more support than your son at this point."

4. "I would be glad to see your son. Let me first speak to Dr. Overhead, so there is no confusion."

5. "I'm glad you finally came crawling to me. It confirms my faith in eventual justice."

Soon I was on the psychiatric unit, my first visit there. The nurse let me into Dr. Badder's son's room. He was 23 and very frightening. You know, one of those patients where you spend half the time studying the patient and the other half the path to the door.

When I walked into the room, he gave me a crazed look, as if there were more than one of me. He was hypervocal, and complained that "they had done this" to him.

My attempts to gain any clear history were fruitless. I knew that I'd better come up with *something*. If I didn't, I could forget having an office with a window - or any office.

Question 2. If it was a drug-induced problem it could include: (pick best answer)

1. Amphetamine, or cocaine
2. Amphetamine, or cocaine, or scopolamine
3. Amphetamine, or cocaine, or heroin
4. Amphetamine, or cocaine, or cannabis
5. Amphetamine, or cocaine, or botulism

At the nurse's station, the secretary was putting a urine toxicology report in the chart (it must have been ordered by some resident that I trained). The result was clear: amphetamine metabolites.

The key turned in the door to the unit. In walked Dr. Overhead and Dr. Badder. What a study in contrasts! Yesterday, they had been a matched pair. I've always wondered how some people know how to exude haughtiness. Dr. Overhead's suit transmitted power, confidence, and money. On the other hand, the Chairman looked even worse than before. Dr. Badder's eyes were red and his clothes looked like he had slept in them.

Right after they saw the urine toxicology result, Dr. Overhead's pager went off and he rushed away to talk privately (no doubt to his broker).

I took the chairman into the head nurse's office, where we could have some privacy. I knew time was running out. I would have one chance to engage Dr. Badder. I could only make one intervening move and it had better be good. So I focused on:

Question 3: (pick the best answer)

1. How the neuropharmacologic effects of amphetamine explained his son's condition.
2. How his son definitely had a good prognosis.
3. How only I was qualified to handle his son's case.
4. The pain and shame he was experiencing.
5. The different approaches in the literature to increase the rate of clearing of amphetamine from the body.

It worked. He shook my hand, and now we were clearly operating on a different plane (thank God analysts aren't into hugging). Just then Dr. Overhead walked in. I told him:

Question 4: (pick the best answer)

1. I was happy to tell him that I was taking over the case.
2. Although the diagnosis was not certain, there appeared to be good reason to believe that I could help, and I was eager to work with him in treatment planning.
3. It would be helpful to have an NA volunteer see the patient tonight.
4. I would write orders to increase the amphetamine clearance.
5. We ought to have a session today with the patient, Dr. Badder, myself and him (Dr. Overhead) in order to clarify boundary issues (who will be in charge of what).

It worked again! Two in a row. I thought, maybe I'll even be good enough to pass the test to be a certified addictionologist; that is, if I can memorize the important things like the average serum level of the thiamine in men who die of Wernicke's encephalopathy.

But now I faced the greatest challenge of them all. Yes, I had dealt with Dr. Badder, Chairman of the Department. Yes, I had successfully engaged Dr. Overhead. But now came the hard part: talking to a member of the nursing staff.

My heart pounded as I walked into the charting area. The nurse who was there looked like a mean one. Then I saw her name: I. Savage, RN. How should I come across, I wondered?

Question 5: (pick the best answer)

1. Make it clear that I am in charge, and it's my way or the highway for the nursing staff. After all, I've got the heavy hitters on my side.
2. Tell them (the nurses) that they certainly know a lot about what is going on, and I want to work with them.
3. Ask what they know about conflicts between Dr. Badder and his son.
4. Explain the disease concept and the role of confrontation in chemical dependence treatment.
5. Ask them directly if they have any preconceived ideas about drug addicts.

You'll never believe it! This issue worked out well, too. I'm going to go see him (Dr. Badder's son) after lunch.

Are you hungry? Shall we take the stairs? Just let's stop at the mailbox, I have to send my application for a continuing ed course, "Becoming Neurotic: The Advanced Course."

If the doctor who told you this story was your patient in a chemical dependency program, what issue would be likely to come up in group therapy?

Question 6: (pick the best answer)

1. Difficulty identifying feelings.
2. Defocusing through humor.
3. Difficulty stopping resentments from spilling over and contaminating relationships.
4. Difficulty expressing himself in groups.
5. Difficulty identifying the feelings of others.

Commentary

The common feedback I hear from certified ASAM members is that the exam is too easy, and especially that the clinically oriented questions are either so esoteric as to be worthless, or the answers are totally obvious. The only way I

can think of to respond to this criticism is by asking the examinee to maintain his/her focus despite a number of distracters. This question has numerous distracters, including examples of humor and irony from many perspectives. The narrator would not be an appealing colleague with whom to go into group practice. However, an addiction medicine specialist needs to be able to deal with people who are less than appealing, and still maintain a clinical focus.

The key point of this question is, how does an addictionist who is drawn into a genuine mess not lose track of the boundary issues, while integrating himself or herself into the treatment team?

Question 1: The answer is No. 4. This recognizes that Dr. Badder is the father, not the attending physician. Answers No. 1, 2, and 5 negate that point by usurping the role. No. 3 is incorrect because the shame Dr. Badder feels is so intense that the reaction to this statement would be anger. He is worried about his son. This is where the focus needs to be at the beginning.

Question 2: The answer is No. 2. In a normal MCQ, we would be expected to give more clinical information, i.e. pupils, etc., but given the structure of this story, we can give very little data.

Question 3: The answer is No. 4. He is a family member, and his emotional status is the issue. To lecture him on neuropharmacology, the prognosis, how to clear amphetamine, misses the point. Also, these approaches will probably injure his pride even more and result in a negative reaction. As for answer No. 3, it is poor clinical practice to "steal a patient."

Question 4: The answer is No. 2. The diagnosis is not certain. A lab test does not equal a diagnosis. Notice that we know no past history. Answer No. 1 again represents an attempt to usurp the attending physician role. No. 4 does the same thing in a more subtle way, by him saying that *he* would write orders. He needs to discuss with Dr. Overhead if he is going to write orders, or if these orders will even be written. Regarding No. 5, clarifying boundary issues is a good idea, but a session that involves three other people, with a patient who is hallucinating, is not. No. 3 is wrong for the same reason, and also, hold off on the NA volunteer until the patient's psychosis clears.

Question 5: Focuses on integrating into the treatment team. The correct answer is No. 2. Expressing respect for the nursing staff is critical. Remember, this is the first time he has been on this unit. The macho stance of No. 1 will only generate resentments and undermine treatment. No. 3 is not a critical issue with an hallucinating patient. Also, it borders on gossiping. No. 4 is wrong because confrontation now would be a disaster. No. 5 is wrong because the timing is terrible. You need to establish trust before you expect people to say something which will make them appear less than professional and impartial.

Question 6: Requires the individual to again shift frame of reference and have a knowledge of the defenses which patients use to avoid confrontation. This man uses humor to defocus, thus the answer is No. 2. I do not feel there is evidence in the story to support the other answers.

I hope you enjoyed these questions and would appreciate feedback.

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FOR YOUR PATIENT

Letter a Patient on Methadone Maintenance Can Give to a Physician

This letter comes from Drug Dependence Associates,
3701 West Commerce St, San Antonio, TX 78207.
Phone: (512) 434-0531.

Dr. J. Thomas Payte, who is chair of ASAM's Methadone Treatment Committee, is medical director of Drug Dependence Associates. He suggests giving this letter to patients who are on methadone maintenance. "These are my views based on my 20 plus years of experience with addictions and methadone treatment. I don't represent any position of ASAM nor of the methadone committee or its individual members."

Dear Doctor:

The bearer of this letter is a patient in a methadone maintenance treatment program for addictive disease.

Methadone patients frequently need treatment for other medical, surgical, and dental conditions. But too many health professionals are unfamiliar with methadone maintenance. They tend to react to these patients with fear, anger, prejudice, disgust, and other negative subjective responses. And, in turn, because of previous bad experiences, many patients are reluctant to disclose their methadone treatment to health professionals.

The purpose of this brief letter is to mention the most common problems, and to offer any assistance that I can.

Methadone has been used to treat opioid dependence for over 20 years, and is both effective and safe in chronic administration. The methadone maintained patient develops **complete tolerance to the analgesic, sedative, and euphorogenic effects** of the maintenance dose of methadone. Tolerance **does not** develop to methadone's capacity to prevent the onset of abstinence syndrome. With a half-life of over 24 hours, methadone has a relatively flat blood plasma level curve that will prevent the onset of abstinence syndrome for over 24 hours *without* causing any sedation, euphoria, or impairment of function.

The most common problem we encounter in a methadone maintained patient is the management of pain. Since the patient is fully tolerant to the maintenance dose of methadone **no** analgesia is realized from the regular daily dose of methadone. Relief of pain thus depends on maintaining the established tolerance threshold with methadone, and then providing additional analgesia.

When pain is not severe, non-narcotic analgesics should be used.

For more severe pain, the use of opioid agonist drugs is quite appropriate with the following provisions:



Dr. Payte

- Possible need to increase the dose of an opioid agonist drug due to the cross tolerance to methadone.
- Duration of analgesia may be less than usual.
- The methadone tolerant patient should never be given opioid agonist/antagonist drugs such as Talwin, Stadol, and

"The methadone tolerant patient should never be given opioid agonist/antagonist drugs such as Talwin, Stadol, and Nubain."

Nubain. Severe opiate abstinence syndrome can be precipitated by drugs of this type.

- Closely supervise the quantity and duration of opioid agonist drugs.
- Avoid prescribing for self-administration by the patient, but if this is absolutely necessary, the amount should be for no more than 24 hours and refills carefully controlled.

Similar precautions are indicated in prescribing sedative/hypnotic and CNS stimulant drugs. The abuse potential of all benzodiazepines is quite high.

The admitting physician may be tempted to treat the opioid dependence itself, usually by doing a methadone graded reduction of dose. If successful, the graded reduction may result in a reduction or elimination of the physiologic dependence, but has no effect on the disease itself. Even after discontinuing methadone, significant signs and symptoms of abstinence may persist for four or more weeks. The relapse rate associated with detoxification alone approaches 100%. A relapse to street/illicit drugs increases risk of overdose, hepatitis, AIDS, and a host of other biomedical, psycho-social, and other complications.

Under some circumstances, an intervention can be accomplished during a hospital stay for other conditions. Any intervention should involve experienced professionals, and place strong emphasis on continuity of care upon discharge.

If you have any questions or concerns about our mutual patient in relation to methadone or drug dependency, please call me. I would be delighted to hear from you.

Sincerely,
J. Thomas Payte, MD
Drug Dependence Associates
San Antonio, TX

Do other readers have 'Dear Doctor' letters they would like to share? Please send for consideration to Editor, ASAM News (address on masthead, p. 8).

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Dear Editor:

Perhaps ASAM members would be interested in our recent experience at Danbury Hospital. We all know how many alcoholics are admitted to trauma services, either intoxicated or for alcohol-related illness, only to have their alcoholism ignored while its sequelae are skillfully treated.

Accordingly, our Department of Surgery started a policy requiring BAC's and drug screens to be performed on all trauma admissions. A quality assurance

procedure would see if the tests were performed and if such patients were identified and assessed.

A Trauma ETOH/Drug Study, conducted for six months in 1989, found that of 124 trauma cases, 59 (48%) had alcohol/drug screens. Of these 59, 47% had positive BAC's, and 19 of these 28 individuals were indeed referred for assessment.

Nine patients did not receive follow-up. Three died in the hospital.

LETTERS TO THE EDITOR

Letters were written to the physicians caring for the remaining six, asking why there had been no follow-up. One stopped me in the hall to thank me for the letter (although I hadn't written it) because he'd forgotten about the policy!

The emergency department that ordered admission tests had a different policy, therefore not all patients were tested. Now, however, more patients will be screened because the Emergency/Primary Care Department has seen the wisdom in the Surgery Department policy and has adopted it.

Subsequently, the Connecticut State Medical Society's Public Health Committee approved an even more thorough policy. This includes ongoing QA evaluations, to be performed every six months. Testing for BAC and other drugs is the clinical standard, and the physician is expected to address the issue of a positive test in the trauma patient "through appropriate treatment, consultation, or referral for an underlying medical condition of alcoholism."

A few suggestions for anyone who wants to start this process in a hospital:

- Begin the education and persuasion with the department chief or trauma subcommittee person, then meet with the whole committee (usually less than six people). A small group is easier to work with.

- Don't rush the process. The longer the deliberations, the more support you'll find you have.

- Involve other ASAM members. John Melbourne, MD, and I became a team at some of the meetings; his words helped to produce a unanimous vote of approval.

Perhaps other ASAM members, working at their own hospitals or through the ASAM Trauma and/or Standards of Care Committees, can develop testing and assessment standards which will lead many more patients into meaningful CD treatment.

Peter Rostenberg, MD
Danbury, CT - Connecticut State Chair

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EOE/M-F

ASAM CALENDAR

Meetings sponsored or co-sponsored by ASAM) (one-time listing for co-sponsored conferences).

For conference listing on this calendar, please send information directly to Lucy B. Robe, editor, at least three months in advance.

- ❑ **Soberfest: Sobering Issues of the Decade: May 10-11, Statesboro, GA.**
Willingway Hospital, 311 Jones Mill Rd, Statesboro, GA 30458.
☎ Phone: (800) 235-0790. (Georgia: 800-242-4040)
- ❑ **Therapeutic Drugs & Drugs of Abuse: May 18-19, San Francisco.**
Haight Ashbury Free Clinics, PO Box 27127, San Francisco, CA 94127
☎ (415) 759-6150; 800-432-5585; FAX: 415-566-9882
- ❑ **NECAD 90 - Northeastern Conference on Alcoholism and Drug Dependence: May 20-23, Newport, RI.**
Edgehill Newport, 200 Harrison Ave, Newport, RI 01840.
☎ (401) 849-5700, Ext. 304.
- ❑ **Rutgers Summer School of Alcohol Studies: June 17-29, New Brunswick, NJ.**
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ASAM NEWS
American Society of
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12 West 21st Street
New York, NY 10010

For information about ASAM co-sponsorship of conferences, contact Claire Osman, ASAM-New York.

- ❑ **ASAM Annual Medical-Scientific Conference:**
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ASAM Board Meeting: Apr. 25.
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ASAM Annual Breakfast: Apr. 27
ASAM Annual Luncheon: Apr. 28
- ❑ **IDAA 1990 Convention: Aug. 1-5, Boca Raton, FL.**
IDAA 1990 Convention, 100 East Sample Rd, Suite 300, Pompano Beach, FL 33064.
☎ (305) 785-7003
- ❑ **ASAM 3rd National Conference on Nicotine Dependence:**
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Hermese Bryant, 6429 West North Ave, Ste 102, Oak Park, IL 60302.
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- ❑ **ASAM 1990 Review Courses:**
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