ASAM NEWS

JULY-AUGUST 2001 VOLUME 16, NUMBER 4

NEWSLETTER OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE

INSIDE

ASAM AT WORK FOR YOU:

ALSO SEE:

ASAM Joins Forum on Parity

Dr. David Gastfriend

How can ASAM members, purchasers and beneficiaries compare addiction treatment benefits across health plans and treatment systems? At present there is no way to do this, but ASAM has joined a new federal initiative to foster common indicators for this purpose. The initiative has far-reaching implications for improving coverage and quality of care. It will permit employers to decide which plans provide the best value for benefit dollars expended. It will help consumers to decide which plans offer the most comprehensive care.

Sponsored by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the initiative is funded by three agencies: the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Prevention (CSAP). Background work supported by the three agencies was reported at a March Consensus Forum on Mental Health and Substance Abuse Performance Measures at the Carter Center in Atlanta.

ASAM has been involved in this project since its inception, with David R. Gastfriend, M.D., representing the Society in the CSAT-sponsored component, known as the "Washington Circle Group." ASAM Executive Vice President James F. Callahan, D.P.A. joined Dr. Gastfriend for the Consensus Forum meeting at the Carter Center.

In both meetings, participants agreed that multiple "consumers" have a stake in performance measures, including employers, states, managed care organizations, treatment providers, and patients. Employers and legislators want concrete measures, such as days worked and disability reduction. States want to know if programs reduce criminal justice system involvement. Providers want measurement of the range of coverage (for example, does the insurer cover residential rehabilitation, naltrexone, and wrap-around services?). Consumers want measurement of variables such as client satisfaction and respect for cultural uniqueness.

Unfortunately, data that would inform such comparisons are not available a single location. Instead, data are collected in different "silos" under the aegis of separate organizations and agencies, which complicates aggregation. For a given patient, for example, data on absenteeism is found in employer's payroll records, general hospitalization data is collected by the health insurer, and data on rehabilitation costs may be captured by a mental health or substance

▶ **PARITY FORUM** *continued on page 18*

CSAT Issues Advisory on OxyContin®

Dr. H. Westley Clark

Responding to widespread media reports about abuse of the analgesic OxyContin® [see the March-April and May-June issues of **ASAM News**], the federal Center for Substance Abuse Treatment (CSAT) has issued an advisory for treatment professionals. In an introductory note, CSAT director H. Westley Clark, M.D., J.D., M.P.H., FASAM, writes that "At the Center for Substance Abuse Treatment, we are not interested in fueling the controversy about the use or abuse of OxyContin....CSAT is instead interested in helping professionals on the front line of substance abuse treatment by providing you with the facts about OxyContin, its use and abuse, and how to treat individuals who present at your treatment facility with OxyContin concerns...."

"We need a balance between providing pain relief to cancer patients and others in dire pain and curtailing the abuse of OxyContin, which is an excellent pain medication," Dr. Clark added. "On the one hand, we have the Institute of Medicine calling for better pain management, and on the other we have increasing abuse of OxyContin."

Dr. Clark added, "I see CSAT's role as one of education. We need to educate physicians, dentists, pharmacists and other medical personnel about the street use of OxyContin and their need to be vigilant when

▶ **OXYCONTIN®** *continued on page 14*

Build Your Society: Recruit a Member Today

James F. Callahan, D.P.A.

Your Society is launching a new campaign that encourages members to reach out to their colleagues to offer them the benefits of membership in ASAM.

In explaining why members do their colleagues a favor by introducing them to ASAM, Membership Committee chair Richard E. Tremblay, M.D., FASAM, points to his own experience. Dr. Tremblay says, "I am deeply indebted to the existence of ASAM and to Dr. LeClair Bissell, who pointed me to the Society in 1982. ASAM provides the most current science of the specialty while enlightening the art of addiction medicine. ASAM offers authority, guidance, and collegiality that exists nowhere else. By recruiting new members into the Society, I'm passing on a valuable resource."

> *"Membership in ASAM opens doors to people, places and wonderful communication with what's going on in the field of addiction medicine."*
> Max A. Schneider, M.D., FASAM

Dr. Tremblay's sentiment was echoed by past President Max A. Schneider, M.D., FASAM, who said, "Membership in ASAM opens doors to people, places and wonderful communication with what's going on in the field of addiction medicine."

As part of the "Member-Get-A-Member" drive, Dr. Tremblay is asking each ASAM member to recruit at least one new member of the Society between August 1 and December 31, 2001. Those who recruit the most members are eligible for tangible rewards. The first prize, which will go to the ASAM member who recruits the most new members, is two complimentary registrations for ASAM's 2002 Medical-Scientific Conference in Atlanta (valued at $900). Second prize is one complimentary Med-Sci registration (valued at $450). Third prize is one complimentary annual membership renewal (valued at up to $425), while fourth prize is a complimentary copy of ASAM's *Principles of Addiction Medicine, Second Edition* (valued at $130) and fifth prize is a complimentary copy of ASAM's new *Patient Placement Criteria, Second Edition-Revised* (*ASAM PPC-2R*, valued at $70).

The recruitment process is simple. Nancy Brighindi, ASAM's Director of Membership and Chapter Development, urges members to "Simply share your ASAM experience with a peer and invite him or her to join ASAM. Your recruit even can join on-line through ASAM's Web site (***www.asam.org***). Just be sure he or she types in your name in the "How Did You Hear About ASAM" field. Or you can request membership brochures from the ASAM office (contact ***cpuen@asam.org***). Once you receive the brochures, write your name on each application form, so you receive credit."

For answers to your questions about the drive, e-mail ***cpuen@asam.org*** or phone the ASAM office at 301/656-3920, ext. 117. And while you're at it, don't forget to renew your own ASAM membership. We are engaged in important work, and every member contributes to our success. ■

American Society of Addiction Medicine
4601 North Park Ave., Suite 101
Chevy Chase, MD 20815

ASAM is a specialty society of physicians concerned about alcoholism and other addictions and who care for persons affected by these illnesses.

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ASAM News
is an official publication of the American Society of Addiction Medicine. It is published six times a year. Please direct all inquiries to the Editor at 703/538-2285, or Email ASAMNews@aol.com.

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For members visiting ASAM's Web Site (*www.asam.org*), entrance to the on-line Membership Directory requires the Username "asam" and the password "asam" (in lower case letters).

Physicians Divided on Prescribing Medical Marijuana

Physicians are evenly divided on the question of prescribing marijuana for medical conditions, according to a new national survey. Conducted by researchers at Rhode Island Hospital in Providence, RI, the survey found that of 960 physicians nationwide, 36% said that doctors should be able to legally prescribe marijuana as medical therapy, while 38% said they should not and 26% said they were neutral.

"We hypothesized that physicians would be more likely to support medical marijuana use in states with legislative mandates," said lead author Anthony Charuvastra. "However, we discovered that was not the case. Instead, we found that specialty, residence in a state that had ever approved medical marijuana research, and...underlying attitudes" were associated with support of marijuana use for medical purposes.

For the study, researchers surveyed physicians in five specialty areas: addiction medicine/psychiatry, general psychiatry, obstetrics-gynecology, family practice, and internal medicine. They found that obstetricians-gynecologists and internists were most likely to support medical marijuana use.

The results were presented at ASAM's annual Medical-Scientific Conference in Los Angeles.

Source: Reuters News Service, April 24, 2001.

Amendment Provides Funds for Alcohol Prevention

An amendment to the Elementary & Secondary Education Act, offered by Sen. Robert Byrd (D-WV), would provide $25 million over six years to educational agencies for use in promoting alcohol prevention among youth, particularly in low-income and rural areas.

Sen. Byrd said he drafted the amendment after seeing a report by the National Institute on Alcohol Abuse and Alcoholism that showed an increase in underage drinking. According to the report, three million 14- to 17-year-olds drink alcohol regularly. More than 100,000 children aged 12 and 13 drink every month.

Educational agencies would be eligible to apply for the funding. They would have to show that their program would work to reduce underage drinking and provide a follow-up report on its effectiveness. The Byrd amendment also calls for $5 million of the $25 million to be set aside by the Substance Abuse & Mental Health Services Administration (SAMHSA) to provide technical assistance and resources to local educational agencies that receive the grants.

Source: Substance Abuse Funding News, May 22, 2001.

Philip Morris Liable in California Case

A jury in Los Angeles has found the Philip Morris Companies guilty of fraud, conspiracy and negligence in a lawsuit brought by a 56-year-old smoker. The verdict came in the case of Richard Boeken, who suffers from brain and lung cancer. Mr. Boeken began smoking Marlboro cigarettes at age 13. His lawsuit claimed that Philip Morris failed to warn him of the health risks associated with smoking.

The jury ordered Philip Morris to pay Boeken $3 billion in punitive damages and $5.5 million in compensatory damages. Boeken was seeking $12.37 million in compensatory damages and between $100 million and $10 billion in punitive damages.

"The jury obviously had an agenda that was not to decide the case they were supposed to decide," said William Ohlemeyer, associate general counsel and vice president of Philip Morris Cos. Inc. He said the company is hopeful the verdict will be overturned on appeal, where Philip Morris will focus on instructions given by the judge to the jury and whether jurors were allowed to hear all the evidence in the case. Philip Morris claims that Boeken was aware of the health warnings on cigarette packs, but ignored them.

The case is the first smoking and health related lawsuit to reach trial in Los Angeles. It is also the largest individual punitive-damages award in a case against the tobacco industry.

Source: Reuters News Service, June 6, 2001.

Few Medical Students Learn About Addiction

Medical education on the addictions has improved over the past 25 years, but it still is relatively rare for medical students to receive comprehensive training in how to identify and manage patients with addictive disorders. So said Bud Isaacson, M.D., vice chairman of the Department of General Internal Medicine at the Cleveland Clinic, who addressed a session at ASAM's recent Medical-Scientific conference in Los Angeles.

Dr. Isaacson noted that agencies such as the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have provided funding for medical school curriculum development and faculty education. Results of these efforts have included the development of guidelines for teaching about addiction in the fields of internal medicine, pediatrics, psychiatry, family medicine, emergency medicine, and obstetrics/gynecology, and a significant expansion of elective courses on addictions offered at major medical schools. "But few require substance abuse in their [core] curricula," he said. In a survey of medical schools published in the *Journal of Studies on Alcohol* [November 2000], Dr. Isaacson reported that while 95% of programs in psychiatry required classroom training on addictive disorders, only 75% of programs for family physicians did so. Even fewer required that residents complete a rotation at an addiction treatment facility.

In spite of the pervasive presence of addiction problems in emergency departments and the fact that fetal alcohol syndrome is the leading cause of preventable birth defects, Dr. Isaacson's survey found that emergency medicine and OB-Gyn gave especially short shrift to addiction training. Only 55% of curricula for emergency medicine included any course hours for addictive disorders; for internal medicine, 51%; for osteopathic medicine, 41%; for OB/Gyn, 39%; and for pediatrics, 32%.

Even course requirements were no guarantee of an in-depth learning experience: Dr. Isaacson pointed out that programs for emergency physicians and OB/Gyns included an average of only 3 hours of addiction training, and even psychiatry programs required only 8 hours of training on addictions. "The number of hours was really quite small," he noted. Given such limitations, it's not surprising that students rarely learned more than simple screening techniques and information about detoxification, and heard little about treatment follow-up or brief interventions, he said.

Such programs stand in sharp contrast to models like the Brody School of Medicine at East Carolina University in Greenville, NC, where students not only receive extensive classroom training, but must attend local AA meetings, which count as 15% of their grade. ECU graduates have shown a "dramatic improvement" in their assessment skills, confidence in making referrals to treatment and self-help groups, and ability to overcome preconceptions of addiction as a moral weakness or issue of willpower, according to Jerome Schulz, M.D., a clinical professor at the school.

Source: Bob Curley, Join Together Online, June 1, 2001. ■

Thinking Strategically About ASAM's Future

Andrea G. Barthwell, M.D., FASAM

"If you don't know where you're going, any road will take you there." The folk wisdom captured in this old maxim poses both a caution and a challenge to us as individuals and to ASAM as an organization. It reminds us that, for organizations as well as individuals, it is easy to slip into doing things "because we've always done it this way," or "because it's always worked before," or even "because it's expected of us."

However, times are changing in the addiction field as in the rest of society, and these changes require more than acting out of habit. Indeed, they demand that we prepare for the future by thinking about *where* we want to go, and what is the best way to get there: in short, they require that we think strategically.

Your Board of Directors took a major step toward incorporating strategic thinking into its plans for ASAM's future when it commissioned a special Strategic Plan Task Force more than a year ago. The task force, whose members are broadly representative of ASAM's membership,* was charged by the Board with determining *where* ASAM ought to be five years from now and identifying the best ways to get there.

I am pleased to report that the Task Force, under the leadership of Richard E. Tremblay, M.D., FASAM, has made significant progress toward fulfilling its charge. The group has reviewed ASAM's mission, refined the statement of ASAM's goals, and developed a variety of possible objectives for achieving those goals.

Earlier this year, every ASAM member was given an opportunity to participate in this process by voting on the draft objectives prepared by the Task Force. A striking number of our members took the time to participate, and the process is better for their input.

The Task Force now is working to incorporate members' input into a final set of objectives and to develop strategies—action steps—to achieve those objectives. Our goal is to have a finished document ready for review by the Board of Directors in October.

This is difficult, challenging work—more difficult than any of us could have imagined when we began. But at every step, the Board and the Task Force are buoyed by the belief that ASAM must be very clear about where it wants to be five years from now, and careful to select the right roads to take us there. With your continued support, I am confident that our strategic plan will guide ASAM to even greater success in years to come. ■

**** Members of ASAM's Strategic Plan Task Force are:***

Richard E. Tremblay, M.D., FASAM, Olympia, WA (Chair); Andrea G. Barthwell, M.D., FASAM, Oak Park, IL; Lawrence S. Brown, Jr., M.D., M.P.H., FASAM, Brooklyn, NY; James F. Callahan, D.P.A., Chevy Chase, MD (Ex Officio); Irving A. Cohen, M.D., M.P.H., FACPM, FASAM, Topeka, KS; Christina Delos Reyes, M.D., Bedford, OH; Marc Galanter, M.D., FASAM, New York, NY; Stuart Gitlow, M.D., M.P.H., Providence, RI; Lloyd J. Gordon III, M.D., FASAM, Brandon, MS; Merrill Scot Herman, M.D., Bronx, NY; Elizabeth F. Howell, M.D., FASAM, Atlanta, GA (Deputy Chair); Lori D. Karan, M.D., San Francisco, CA; Mark L. Kraus, M.D., FASAM, Waterbury, CT; Michael M. Miller, M.D., FASAM, Madison, WI (Deputy Chair); J. Patrick Moulds, M.D., M.S., Baltimore, MD; Gail N. Shultz, M.D., FASAM, Rancho Mirage, CA; Norman Wetterau, M.D., Dansville, NY; Daniel E. Wolf, D.O., Seattle, WA; and Rebecca Zarko, M.D., Parma, OH.

DM: A Store-Bought Dissociative?

William V. Bobo, M.D.
Shannon C. Miller, M.D.
Jonathan Jackson, B.S.

Dextromethorphan (DM) is an antitussive medication used in more than 50 over-the-counter cough remedies. At indicated doses, DM inhibits medullary cough centers to approximately the same extent as opiate alkaloids such as codeine, but without other opioid effects such as analgesia, CNS depression, and respiratory suppression. As such, its efficacy and safety for indicated use are well established. At excessive doses, however, a well-characterized toxic syndrome may emerge (despite early reports indicating a total lack of CNS effects, including abuse potential). Such effects, interestingly, are not noted only in cases of accidental overdose, but also have been identified within the context of intentional overdose and recreational use.

Sporadic reports of high-dose DM abuse have appeared over the past 30 years. Yet in spite of this lengthy history, the potential public health effects of DM abuse have not been fully appreciated. Nevertheless, there is a growing consensus that DM carries a significant abuse potential, and that abuse of this seemingly benign pharmaceutical has become increasingly popular among adolescents and young adults. As one indication of the latter, the National Clearinghouse on Alcohol and Drug Information (NCADI) recently added DM to its list of abusable dissociative agents, placing it alongside more notorious agents such as ketamine and PCP.

Dissociative Effects

Those abusing DM may experience euphoria, dissociation, and hallucinosis—similar to that encountered with well-established agents such as PCP or ketamine—within 15 to 30 minutes of ingestion. Other reported effects include increased perceptual awareness, altered time perception, hyper-excitability, pressure of thought and disorientation.

The DM "high" may last anywhere from 3 to 6 hours. Such effects require the ingestion of large amounts of the substance, with doses estimated as ranging from 300 to 1,800 mg/kg (more than 100 times the amount in a normal prescribed dose). This translates to over 4 ounces of DM-containing cough syrup, prompting some abusers to ingest the drug in a concentrated powder form (which has reportedly been available both on the street and on the Internet). DM's metabolic byproduct, dextrorphan (DOR), is similar to PCP with respect to its antagonist activity at the NMDA receptor.

In general, psychoactive effects are seen in patients who have adequate amounts of the enzyme subfamily responsible for DM's metabolic conversion to DOR, while those who lack sufficient amounts (referred to as phenotypic "poor metabolizers") are better protected against DM-induced psychomimesis.

Drug-Related Culture

As with the better-known drugs of abuse, users of DM have developed a social culture around the drug over the past 30 years. Popular street names include "DM," "DXM," "DMX," "Skittles," "Vitamin D," "Dex," "Tussin" or "Robo." Numerous internet sites dedicated to the misuse of DM further this cultural movement by answering "Frequently Asked Questions" and explaining how to acquire the drug (either directly through mail order or via simple chemical extraction). The sites also warn abusers of potential drug-drug interactions and other safety concerns. Many such sites employ a scientific lexicon and may even refer to articles from the medical literature and the established databases, thus providing an air of "scientific" legitimacy.

DM has been distributed at dance parties referred to as "raves," which are characterized by the open use and sale of psychoactive agents. At high doses, DM has been used as an adulterating agent for the club drug MDMA (as by combining DM with MDMA to enhance the latter agent's effects). Internet sites also display the artwork of artists who use DM to "enhance their creative expression" (in ways similar to the early users of LSD and other hallucinogens). Moreover, Internet sites advertise several so-called "DXM-enhanced" musical artists such as "DXM" and "Sigma" (a name chosen because of DM's activity at sigma-type opiate receptors in the brain).

Potential for Abuse

Surprisingly little empirical data are available to characterize the scope of DM abuse. The published literature consists mainly of case reports. It appears that the drug has become especially popular among adolescents, and it is likely that the social impact of the problem has yet to be fully appreciated. Reasons for this are varied and complex. Because large epidemiologic studies or trend analyses are lacking, it is not clear who is at increased risk for DM abuse or what non-demographic predisposing factors are operative in identifying potential abusers.

Also, there seem to be relatively few deterrents to abusing DM, thus furthering its appeal among prospective and active users. For example, those who experiment with DM have access to an inexpensive and licit pharmaceutical product that is available over-the-counter to any age group. Because the drug is produced by pharmaceutical companies, abusers may believe it to have a higher safety profile than the illicit drugs such as heroin or cocaine, or even legal substances such as nicotine and alcohol (both of which come with Surgeon General warnings).

Use of DM also may engender less social disapproval than, for example, abuse of crack cocaine, which has a clearly negative social connotation. DM is not among the substances routinely tested for on urinary or serologic toxicology screens, and the legal consequences of a positive drug screen for DM are questionable at best. Individuals who test positive could claim that they are simply self-medicating for a cough. In short, DM has many characteristics that make it a potentially attractive choice for adolescents who experiment with drugs.

While much remains to be accomplished in defining the scope and significance of dextromethorphan abuse, reports from clinicians and surveys of web sites suggest that its popularity as an agent of abuse is growing. This may be based in part on its availability, legality and perceived lack of adverse physical effects or social/legal consequences. The Internet seems to be a powerful tool for disseminating information to potential and active abusers. Physicians, drug and alcohol counselors, educators and parents thus are advised to educate themselves about the dangers of the intentional misuse of DM. ■

***William V. Bobo, M.D.**, is a fourth-year psychiatry resident at the National Capital Consortium Military Psychiatry Residency; **Shannon C. Miller, M.D.**, is former Director of the Tri-Service Addiction Recovery Center at the Malcolm-Grow USAF Medical Center (Andrews Air Force Base, MD); and **Jonathan Jackson** is a fourth-year medical student at the Uniformed Services University of the Health Services, Bethesda, MD. Disclaimer: The opinions expressed herein are those of the authors and do not reflect the opinion or official position of the Federal government or any of its departments.*

CHAPTER UPDATES

CALIFORNIA

President: Peter Banys, M.D., FASAM
Regional Director: Lori Karan, M.D., FASAM

Alternate Regional Director Donald Kurth, M.D., FASAM, reports that the California state senate has passed S.B.599, a substance abuse parity bill, by a vote of 23 to 12.

Speaking in favor of the bill's passage were the author, Senator Sheila Kuehl of Sanata Monica, as well as Senate Insurance Committee Chair Jackie Speier (D-Hillsborough). The only vocal opposition was raised by Senator Ray Haynes of Riverside. The support of Senator Speier—who, according to her own testimony (and HMO lobbyists) began the Insurance Committee hearing disinclined toward this "mandated benefit" legislation, was important to the bill's success on the floor.

Dr. Kurth reports that powerful testimony from physicians, researchers, treatment providers, and persons in recovery carried the day in the Insurance Committee and was central to its success on the Senate Floor. Supporters argued that voter enactment of Proposition 36 created an inequitable situation in which an arrested person has the right to treatment but most persons who have not been arrested do not. Additionally, advocates argued that private insurers should be required to pay their fair share when those with health insurance are arrested and receive treatment under Proposition 36. (To its credit, Kaiser currently does this in a manner that benefits both its enrollees and the treatment system.)

Finally, Dr. Kurth reports that a co-sponsor, Senator Chesbro, used data developed by the Kaiser health plans to demonstrate that insurers receive a financial return on an investment in substance abuse treatment within 18 months.

The California Assembly will be the next test for this important bill. CSAM and its partners plan an aggressive campaign to win approval there. (For more information on the status of this important legislation, visit www.jimgonzalez.com.)

SOUTH CAROLINA

President: Ronald Paolini, D.O.
Regional Director: Paul Earley, M.D., FASAM

The South Carolina Society of Addiction Medicine partnered with the state's Department of Alcohol and Other Drug Abuse to sponsor a very successful conference in June. The session focused on women's and children's issues in recovery, as well as concepts of spirituality and treatment. Also covered were recent developments in opioid treatment.

ASAM President Andrea G. Barthwell, M.D., FASAM, addressed the conference, as did Father Leo Booth and researchers Kathleen Brady, M.D., and Carrie Randall, Ph.D., both of the Medical University of South Carolina, Charleston.

Participants agreed that the conference fulfilled its purpose of bringing together medical and substance abuse prevention and treatment professionals to explore a variety of issues related to the medical aspects of addiction, as well as to share their knowledge and experiences. ■

Rx A Prescription for Defeating Stigma: CELEBRATE RECOVERY MONTH

H. Westley Clark, M.D., J.D., M.P.H., FASAM

Physicians are healers. Our patients come to us ill and implore us to make them well. This cuts across all areas of medicine. But those of us in addiction medicine carry an additional burden: our patients come to us and we have no antibiotic to end their disease, or vaccine to protect them from addiction to alcohol, cocaine, heroin, methamphetamine or even legal drugs that are diverted and abused. We have a tiny arsenal of medicines, most of them misunderstood by both the public at large and our fellow physicians.

Our patients must show courage and endurance to undergo addiction treatment in this atmosphere. Insurance coverage is spotty at best and, if they need methadone, they can be reviled for entering treatment.

So how can we, as addiction medicine professionals, help break down this stigma?

I want to urge every member of ASAM to support National Alcohol and Drug Addiction Recovery Month activities in their community this year, in September. Recovery Month forums give us the opportunity to combat the stigma that surrounds treatment for alcohol and drug abuse. As part of Recovery Month, there will be formal activities in 19 cities (see box). This year's theme is "We Recover Together: Family, Friends and Community."

These are forums that ASAM members should take part in to explain addiction to the public, to policymakers, and to other members of the medical community. If we promote the Recovery Month message that addiction treatment is effective and that recovery from addiction is possible, we can make a difference.

We need to explain the science of addiction, and that the person addicted to alcohol or other drugs suffers from a disease that presents challenges similar to those experienced by the diabetic or heart disease patient. As trusted members of the medical community, we have a unique ability to explain the need for appropriate care, the role of medications in the treatment of opioid addiction, and the need to avoid the excessive use of prescription drugs such as OxyContin®.

Addiction medicine specialists also have a special responsibility to begin educating our fellow physicians. Larry Gentilello, M.D., an emergency physician, and other physicians have found that 45% of persons who arrive in the emergency department with injuries are intoxicated with alcohol. Yet this underlying cause of their injuries is rarely addressed. With as many as 39 states having laws that allow insurers to refuse payment if the patient was intoxication at the time of injury, it has not been in the interest of most of the medical profession to address the root cause of the acute trauma—or the HIV, sexually transmitted disease, or hepatitis C that they treat.

SEPTEMBER IS
National Alcohol and Drug Addiction Recovery Month.

THIS YEAR'S THEME IS
"We Recover Together: Family, Friends and Community."

The National Association of Insurance Commissioners and the National Conference of Insurance Legislators recently revised the language of the model insurance laws to eliminate the exclusion for substance abuse. Now we, as addiction medicine specialists, need to take part in Recovery Month activities and spread the word to our colleagues and communities that it is time for states to follow the new recommendations and revise legal restrictions that prevent many in the medical profession from recognizing, diagnosing and recommending the treatment of addictive disorders.

If we are to convince insurers that they must cover the treatment of alcohol or drug addiction in the same way that they cover treatment of diabetes or heart disease or asthma, we must convince our fellow physicians that they need to observe and refer for treatment those patients with alcohol or drug problems, because they already are treating the medical problems that are consequences of untreated addiction.

Winning community support for addiction treatment is not easy. We all know about the vilification of methadone by many politicians and the rejection of methadone facilities by communities where the citizens convince themselves that drug treatment is the problem, rather than the use of drugs by citizens in the community.

We in the addiction medicine field have a special obligation to speak up for our patients, who may be too afraid of losing their jobs or the respect of their families or neighbors to speak out about the joy of recovery. The celebration of Recovery Month brings hope to millions of people and gives credit to those who have started down the road to recovery and a productive life.

For many years, we have battled together for treatment for those who suffer from addiction to alcohol or other drugs. If each of you volunteers to take part in a forum, we can use our expertise and the respect we command as physicians to break down the stigma that surrounds treatment for addictive disease. ■

National Alcohol and Drug Addiction Recovery Month activities have been scheduled during the month of September in the following cities:

Atlanta, GA
Baltimore, MD
Boston, MA
Charlotte, NC
Chicago, IL
Columbus, OH
Detroit, MI
Hartford, CT
Jacksonville, FL
Los Angeles, CA
Madison, WI
Minneapolis/St. Paul, MN
New Orleans, LA
New York, NY
Philadelphia, PA
Phoenix, AZ
Portland, OR
St. Louis, MO
Washington, DC

Please check the Recovery Month Web site at ***www.samhsa.gov*** or call CSAT at 301/443-5052 for information on how to take part in a Recovery Month Community Event.

Two-Item Screen Detects Alcohol, Other Drug Use

Current alcohol or other drug problems can be detected in nearly 80% of young and middle-aged patients by asking two questions: "In the last year, have you ever drunk or used drugs more than you meant to?" and "Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?"

Richard L. Brown, M.D., M.P.H., and colleagues at Wisconsin and at the University of Edingburgh (Scotland) tested the brief screen in two random samples of primary care patients aged 18 to 59. In both groups (of 434 and 702 participants), they found that at least one positive response to the two conjoint questions detected current substance use disorders with nearly 80% sensitivity and specificity. (A conjoint screening question is defined as one that inquires simultaneously and in the aggregate about experiences with alcohol and other drugs.) Respondents who gave 0, 1, and 2 positive responses had a 7.3%, 36.5%, and 72.4% chance of a current substance abuse disorder, respectively, the researchers reported. The screen was particularly sensitive to polysubstance abuse disorders, they said.

Dr. Brown and his colleagues developed the conjoint questions in an effort to answer the need for a brief, accurate screen for substance abuse disorders in health care settings. They point out that research shows most patients provide accurate responses to direct questions about tobacco use, but not to direct questions about use of other drugs. They speculated that conjoint screening questions might overcome this problem because they combine a legal substance (alcohol) with illicit drugs. Conjoint questions also allow clinicians to screen for alcohol and drugs as rapidly as they screen for alcohol alone, and are easy to integrate into a clinical interview.

Source: Journal of the American Board of Family Practice, May 2001. Reprint requests to Richard L. Brown, M.D., M.P.H., Department of Family Medicine, University of Wisconsin-Madison Medical School, 777 South Mills St., Madison, WI 53715.

Alcohol Problems in Older Adults Often Missed

An estimated 2.5 million older adults in the U.S. suffer serious health problems because of alcohol use. But their physicians often overlook alcohol as a cause, a group of researchers told a joint meeting of the American Society on Aging and the National Council on the Aging.

In many instances, physicians overlook alcohol as the cause for common ailments, the researchers said. For example, they may attribute sleeping problems to depression or assume that hand tremors are an early sign of Parkinson's disease, whereas the symptom actually may be a result of alcohol use.

Age-related diagnostic problems have been noted before. A 1992 study of patients in alcohol treatment programs found that primary care physicians accurately diagnosed alcoholism about two-thirds of the time in young persons, but only one-third of the time in older adults.

Resource: Alcohol and Aging

An "Alcohol Alert" summarizing current research on alcohol and aging is available from the National Institute on Alcohol Abuse and Alcoholism.

Download this publication from NIAAA's Web site at *www.niaaa.nih.gov/publications/aa* or order a print copy from the NIAAA Publications Distribution Center P.O. Box 10686 Rockville, MD 20849-0686

According to University of Michigan researcher Frederic C. Blow, M.D., alcohol-related illnesses place as many older adults in the hospital as heart attacks. As the body ages, he said, alcohol metabolizes more slowly, so older persons no longer can safely drink as much as they once did.

"People say, 'That's just Grandma enjoying her cocktails; they make her happy.' But it's not," adds Dr. Blow. "This is a serious medical problem. We need to recognize it as something that's treatable and can really impact the quality of people's lives."

Source: St. Petersburg (FL) Times, March 13, 2001.

10,000 Take Alcohol Screening Test On-Line

AlcoholScreening.org, a new Web site that helps laypersons understand the effects of alcohol on personal health and well-being, successfully screened more than 10,000 users in its first 30 days of operation, developers say. The site allows visitors to take a confidential self-test to assess their alcohol use patterns and receive personalized feedback. Visitors then find out whether their alcohol consumption appears to be within safe limits, risky, or harmful to their health. The Web site is a free service of Join Together, a project of the Boston University School of Public Health, and is underwritten by a grant from the Robert Wood Johnson Foundation.

AlcoholScreening.org also features answers to frequently asked questions about alcohol and health, links to on-line and off-line support resources, and a database of more than 12,000 local treatment programs throughout the U.S.

"Our premise was that ordinary people who may have concerns about their own alcohol consumption would welcome the opportunity to learn in a confidential and convenient setting on the Internet," said David Rosenbloom, director of Join Together. "The fact that more than 10,000 people have completed the online questionnaire in such a short time shows that our prediction was right: there is a demand for accurate and succinct information on alcohol and health," he added. "About 15% of the users go on to find more information after completing the screening.

The site launched April 2, during national Alcohol Awareness Month, when the public is encouraged to learn more about alcohol. Users are attracted to the site in a variety of ways. Traditional media releases were employed, as well as announcements in Join Together's e-mail newsletter service, which has 11,000 subscribers. Other Web sites that focus on alcohol and drug problems have linked to the site, including those of the Center for Substance Abuse Treatment, the Higher Education Center for Alcohol and Other Drug Prevention and About.com's alcohol section.

Source: Join Together, May 7, 2001.

Addicts in Treatment Need Regular Medical Care

Addicted persons need regular medical care in addition to treatment of their addictive disorder in order to effectively manage their health problems, a new study shows. The

▶ **CLINICAL REPORTS** *continued on page 9*

PEOPLE IN THE NEWS

John Slade, M.D., FASAM

John Slade, M.D., FASAM, is one of only 100 physicians nationwide to receive the Pride in the Profession Award Program of the American Medical Association. The award recognizes Dr. Slade's leadership in public health efforts related to reducing use of tobacco products. The award was established by the AMA to honor "those unsung heroes who have exhibited the qualities of leadership, excellence and ethical behavior that reaffirm our commitment to our profession and the improvement of patient care."

Dr. Slade is affiliated with the Program in Addictions at the School of Public Health of the University of Medicine and Dentistry of New Jersey. His many contributions to ASAM include service as a member of the Board of Directors, chairmanship of the Committee on Nicotine Dependence, and countless hours given to shaping ASAM policy statements and *amicus* briefs on tobacco-related issues.

Stanley E. Gitlow, M.D., FACP, FASAM

Dr. Stanley Gitlow is the 2001 honoree of the 14th Annual Angel Ball sponsored by the Long Island (NY) Council on Alcoholism and Drug Dependence (LICADD). In announcing his selection, LICADD cited Dr. Gitlow's pioneering work in addiction medicine over a period of 50 years.

Dr. Gitlow began his private practice of addiction medicine in 1951, while working with Dr. Ruth Fox. Since that time, he has published over 200 scientific papers and book chapters, and is the author of a standard textbook on alcoholism.

A founding member of ASAM, Dr. Gitlow has served the Society as President, committee chair, and organizer of the annual Ruth Fox Course for Physicians. He also sits on the editorial boards of three journals and has been an expert consultant on addiction to the U.S. Department of State and the American Medical Association. ■

▶ **CLINICAL REPORTS** *continued from page 8*

study, led by Dr. Barbara J. Turner of the University of Pennsylvania, involved more than 58,000 drug users enrolled in the New York State Medicaid program.

In examining data on hospitalization rates among drug-dependent individuals, researchers found that in 1997, more than half of the HIV-positive users and nearly 40% of the HIV-negative users had been hospitalized at least once, staying an average of 25 to 30 days. On the other hand, HIV-negative and HIV-positive drug users who received either regular drug addiction care or regular medical care had the lowest rates of hospitalization. HIV-negative and HIV-positive drug users who received both regular drug treatment and regular medical care were 25% less likely to be hospitalized. (For the study, regular addiction care was defined as six months in a treatment program, while regular medical care was defined as receiving more than one third of care from one clinic, group practice, or individual physician.) "Our study affirms the enormous demand by users of illicit drugs for hospital care but also sheds light on possible solutions to this problem," Dr. Turner concluded.

The researchers recommended providing regular outpatient drug treatment and medical services to drug users. "Our data suggest that sufficient drug treatment slots need to be available to treat drug users, drug users must be linked to this care for at least six months, and these individuals must receive regular medical care," Dr. Turner said. "Thus, resources devoted to the outpatient care for this population have the potential to reduce the many millions of dollars spent on inpatient care. Consumers need to understand that we all pay for ignoring and/or not addressing the health care needs of drug users."

Source: Journal of the American Medical Association, May 9, 2001. ■

COMMITTEE REPORTS

Cross Cultural Concerns Committee Seeks New Members

Louis E. Baxter, Sr., M.D., FASAM
Committee Chair

The Cross Cultural Clinical Concerns Committee invites ASAM members to consider joining our active group. The committee's mission is to offer a forum for the identification and discussion of cultural issues that may affect treatment outcomes, as well as the development of programs to educate addiction medicine professionals about those issues.

If you are interested in these issues, please send a short letter (containing your name and degree, street address, e-mail address and telephone number) to me at the following address: Louis E. Baxter, Sr., M.D., FASAM, Chair, Cross Cultural Clinical Concerns Committee, 2 Princess Road, Lawrenceville, NJ 08648. We look forward to welcoming you! ■

Neurotoxic Effects of Methamphetamine Clarified

Two studies by researchers at the U.S. Department of Energy's Brookhaven National Laboratory shed light on the mechanisms through which methamphetamine use damages the brain.

In one study, Norah D. Volkow, Ph.D., and colleagues used positron emission tomography (PET) to determine the specific brain regions that are damaged by methamphetamine. The PET scans of 15 detoxified methamphetamine abusers were compared with the scans of 21 healthy subjects. Overall brain metabolism was 14% higher in the methamphetamine users than in the healthy subjects, investigators found. This increase was most pronounced in the parietal cortex. On the other hand, the methamphetamine users demonstrated significantly lower metabolism in the thalamus and the striatum than did the healthy subjects.

The finding of brain hypermetabolism in the methamphetamine abusers was unexpected, the researchers wrote, since most studies have shown decrements in brain metabolism in abusers of other drugs. They speculate that methamphetamine is more damaging to the brain than other abused drugs because "brain disease states for which higher metabolism has been reported, such as head trauma and radiation damage, usually involve inflammation and gliosis."

While studies in animals have shown that methamphetamine is toxic to dopamine cells, the metabolic pattern observed in the current study indicates that it is also affecting non-dopamine innervated regions, the authors point out.

In another study, the same investigators used a different PET scan contrast agent to measure dopamine transporter levels in the brains of 15 detoxified methamphetamine abusers and 18 healthy subjects. In addition, all subjects underwent neuropsychological testing to assess motor and cognitive function.

Dopamine transporter levels were significantly reduced in the striatum of abusers compared with the striatum of healthy subjects. Moreover, this reduction correlated with motor slowing and memory impairment, the authors note.

Dr. Volkow's team emphasized that "there is an urgent need to alert methamphetamine users to the consequences of their abuse and to develop treatments for these patients." The public must also be warned and educated about the drug's neurotoxic effects, the researchers added.

Source: American Journal of Psychiatry, March 2001.

Single Exposure to Cocaine Can Alter Brain Function

Scientists have found that a single use of cocaine can modify neural connections in the brain, which may help explain at a cellular level how occasional drug use can progress to compulsive use. The researchers, from the University of California at San Francisco, reported that a single injection of cocaine induced a long-lasting (5- to 10-day) increase in excitatory synaptic transmission in the ventral tegmental area of the brain in rats and mice. The increase in synaptic currents that were activated by cocaine had many similarities to the changes in neural activity involved in learning and memory processes in many areas of the brain.

"The significance of this finding," explained lead investigator Dr. Antonello Bonci, "is that the single dose of cocaine 'usurped' a cellular mechanism involved in a normally adaptive learning process, which may help to explain cocaine's ability to take control of incentive-motivational systems in the brain and produce compulsive drug-seeking behavior."

The researchers added that the changes that were observed in the brains of rats and mice may be important not just for the early stages of addiction, but also may help explain the neural basis for relapse, where a single exposure to cocaine after a period of abstinence can induce renewed drug-seeking behavior. "These findings on the impact of cocaine on the memory and learning circuits of the brain may help explain the switch from occasional drug use to addiction. This study emphasizes the dangers of even experimenting with cocaine and other illicit drugs," said Alan I. Leshner, Ph.D., Director of the National Institute on Drug Abuse (NIDA), which funded the study.

Source: Nature, May 31, 2001.

Cocaine-Related Brain Process Identified

Researchers have identified a process that plays a key role in brain changes involved in cocaine addiction. Dr. James Bibb, Dr. Paul Greengard, and colleagues at the Rockefeller University in New York City, together with Dr. Eric Nestler at the University of Texas Southwest Medical Center in Dallas, reported their findings in the March 15 issue of the journal *Nature*.

The researchers found that repeated exposure to cocaine causes a change at the level of gene expression that leads to altered levels of a specific brain protein called cyclin-dependent kinase 5 (Cdk5).

The same group of researchers previously found that Cdk5 regulates the action of dopamine, a chemical messenger in the brain associated with the cocaine's pleasurable "rush" and with addiction to cocaine and other drugs. The Cdk5-related process leads to changes in brain cells that are thought to play a key role in cocaine addiction.

"This research provides a valuable insight into the step-by-step molecular adaptations that the brain makes in response to drugs," said Alan I. Leshner, Ph.D., Director of the National Institute on Drug Abuse. "These adaptations result in long-term changes at the cellular level that are involved in the development of addiction."

Source: Press release, National Institute on Drug Abuse, March 14, 2001.

Images of Alcohol Stir Craving in Alcoholics

Images of alcohol activate specific areas of the brain in problem drinkers but not in moderate drinkers. Researchers say the finding offers some insights into the mechanics of craving.

Using functional magnetic resonance imaging (fMRI) equipment, researchers from the Medical University of South Carolina (MUSC) found that alcohol images stimulated the prefrontal cortex and the anterior thalamus regions of the brain in alcoholics, but not in moderate drinkers. These regions are associated with attention, regulating emotion, and craving, according to Enoch Gordis, M.D., director of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), which funded the study.

"We saw clearly that certain brain regions in alcoholics activated in response to viewing pictures with alcohol-specific content," said Raymond F. Anton, M.D., scientific director of the MUSC Alcohol Research Center. "It appears the alcoholics paid greater attention to the alcohol images."

The researchers next plan to measure craving in real time to determine if there is a correlation between craving and increased activities in specific areas of the brain.

Source: Archives of General Psychiatry, May 2001.

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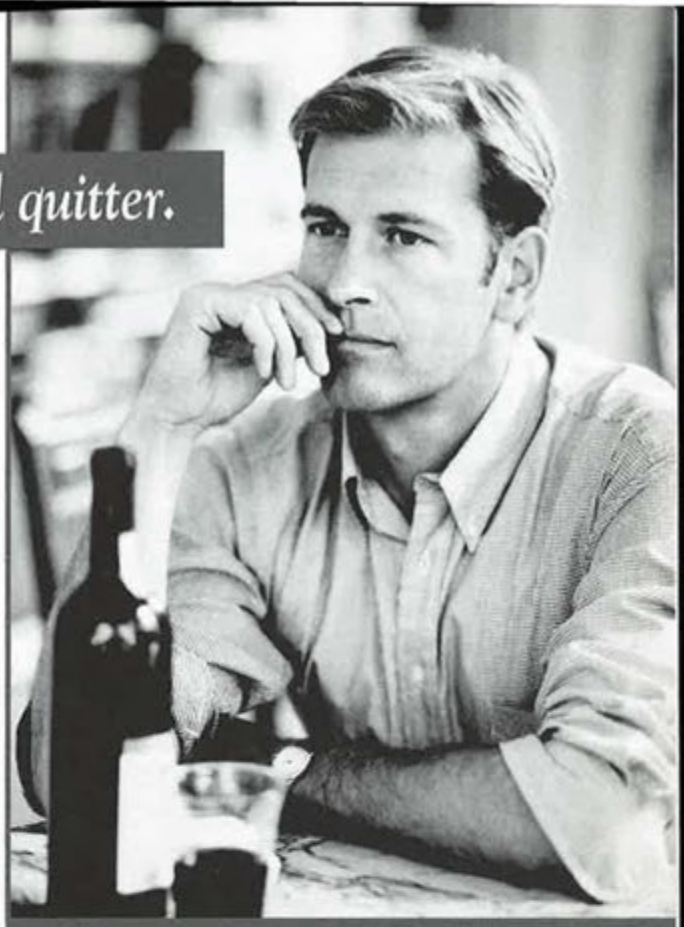

Now, for alcoholism, from Odyssey Pharmaceuticals — Antabuse, an integral part of an integrated system of support for the patient with chronic alcoholism.

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Disulfiram should *never* be administered to a patient who is in a state of alcohol intoxication or without their full knowledge. Relatives should be instructed accordingly.

Patients who have recently received metronidazole, paraldehyde, alcohol or alcohol-containing products should not receive Antabuse. Antabuse is contraindicated in severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram. Antabuse should be used with caution in patients receiving phenytoin and its congeners. Please see complete prescribing information on next page for more information.

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WARNING:
Disulfiram should *never* be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge.
The physician should instruct relatives accordingly.

DESCRIPTION: CHEMICAL NAME:
bis(diethylthiocarbamoyl) disulfide.
STRUCTURAL FORMULA:

$C_{10}H_{20}N_2S_4$ M.W. 296.55

Disulfiram occurs as a white to off-white, odorless, and almost tasteless powder, soluble in water to the extent of about 20 mg in 100 mL, and in alcohol to the extent of about 3.8 g in 100 mL.

Each tablet for oral administration contains 250 mg disulfiram, USP. Tablets also contain colloidal silicon dioxide, anhydrous lactose, magnesium stearate, microcrystalline cellulose, sodium starch glycolate, and stearic acid.

CLINICAL PHARMACOLOGY: Disulfiram produces a sensitivity to alcohol which results in a highly unpleasant reaction when the patient under treatment ingests even small amounts of alcohol.

Disulfiram blocks the oxidation of alcohol at the acetaldehyde stage. During alcohol metabolism following disulfiram intake, the concentration of acetaldehyde occurring in the blood may be 5 to 10 times higher than that found during metabolism of the same amount of alcohol alone.

Accumulation of acetaldehyde in the blood produces a complex of highly unpleasant symptoms referred to hereinafter as the disulfiram-alcohol reaction. This reaction, which is proportional to the dosage of both disulfiram and alcohol, will persist as long as alcohol is being metabolized. Disulfiram does not appear to influence the rate of alcohol elimination from the body.

Disulfiram is absorbed slowly from the gastrointestinal tract and is eliminated slowly from the body. One (or even two) weeks after a patient has taken his last dose of disulfiram, ingestion of alcohol may produce unpleasant symptoms.

Prolonged administration of disulfiram does not produce tolerance; the longer a patient remains on therapy, the more exquisitely sensitive he becomes to alcohol.

INDICATIONS: Disulfiram is an aid in the management of selected chronic alcohol patients who want to remain in a state of enforced sobriety so that supportive and psychotherapeutic treatment may be applied to best advantage.

Disulfiram is not a cure for alcoholism. When used alone, without proper motivation and supportive therapy, it is unlikely that it will have any substantive effect on the drinking pattern of the chronic alcoholic.

CONTRAINDICATIONS: Patients who are receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations, e.g., cough syrups, tonics and the like, should not be given disulfiram.

Disulfiram is contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, and hypersensitivity to disulfiram or to other thiuram derivatives used in pesticides and rubber vulcanization.

WARNINGS:

Disulfiram should *never* be administered to a patient when he is in a state of alcohol intoxication, or without his full knowledge.
The physician should instruct relatives accordingly.

The patient must be fully informed of the disulfiram-alcohol reaction. He must be strongly cautioned against surreptitious drinking while taking the drug, and he must be fully aware of the possible consequences. He should be warned to avoid alcohol in disguised forms, i.e., in sauces, vinegars, cough mixtures, and even in aftershave lotions and back rubs. He should also be warned that reactions may occur with alcohol up to 14 days after ingesting disulfiram.

The Disulfiram-Alcohol Reaction: Disulfiram plus alcohol, even small amounts, produce flushing, throbbing in head and neck, throbbing headache, respiratory difficulty, nausea, copious vomiting, sweating, thirst, chest pain, palpitation, dyspnea, hyperventilation, tachycardia, hypotension, syncope, marked uneasiness, weakness, vertigo, blurred vision, and confusion. In severe reactions there may be respiratory depression, cardiovascular collapse, arrhythmias, myocardial infarction, acute congestive heart failure, unconsciousness, convulsions, and death.

The intensity of the reaction varies with each individual, but is generally proportional to the amounts of disulfiram and alcohol ingested. Mild reactions may occur in the sensitive individual when the blood alcohol concentration is increased to as little as 5 to 10 mg per 100 mL. Symptoms are fully developed at 50 mg per 100 mL, and unconsciousness usually results when the blood alcohol level reaches 125 to 150 mg.

The duration of the reaction varies from 30 to 60 minutes, to several hours in the more severe cases, or as long as there is alcohol in the blood.

Drug Interactions: Disulfiram appears to decrease the rate at which certain drugs are metabolized and therefore may increase the blood levels and the possibility of clinical toxicity of drugs given concomitantly.

DISULFIRAM SHOULD BE USED WITH CAUTION IN THOSE PATIENTS RECEIVING PHENYTOIN AND ITS CONGENERS, SINCE THE CONCOMITANT ADMINISTRATION OF THESE TWO DRUGS CAN LEAD TO PHENYTOIN INTOXICATION. PRIOR TO ADMINISTERING DISULFIRAM TO A PATIENT ON PHENYTOIN THERAPY, A BASELINE PHENYTOIN SERUM LEVEL SHOULD BE OBTAINED. SUBSEQUENT TO INITIATION OF DISULFIRAM THERAPY, SERUM LEVELS OF PHENYTOIN SHOULD BE DETERMINED ON DIFFERENT DAYS FOR EVIDENCE OF AN INCREASE OR FOR A CONTINUING RISE IN LEVELS. INCREASED PHENYTOIN LEVELS SHOULD BE TREATED WITH APPROPRIATE DOSAGE ADJUSTMENT.

It may be necessary to adjust the dosage of oral anticoagulants upon beginning or stopping disulfiram, since disulfiram may prolong prothrombin time.

Patients taking isoniazid when disulfiram is given should be observed for the appearance of unsteady gait or marked changes in mental status, the disulfiram should be discontinued if such signs appear.

In rats, simultaneous ingestion of disulfiram and nitrite in the diet for 78 weeks has been reported to cause tumors, and it has been suggested that disulfiram may react with nitrites in the rat stomach to form a nitrosamine, which is tumorigenic. Disulfiram alone in the rat's diet did not lead to such tumors. The relevance of this finding to humans is not known at this time.

Concomitant Conditions: Because of the possibility of an accidental disulfiram-alcohol reaction, disulfiram should be used with extreme caution in patients with any of the following conditions: diabetes mellitus, hypothyroidism, epilepsy, cerebral damage, chronic and acute nephritis, hepatic cirrhosis or insufficiency.

Usage in Pregnancy: The safe use of this drug in pregnancy has not been established. Therefore, disulfiram should be used during pregnancy only when, in the judgement of the physician, the probable benefits outweigh the possible risks.

PRECAUTIONS: Patients with a history of rubber contact dermatitis should be evaluated for hypersensitivity to thiuram derivatives before receiving disulfiram (see CONTRAINDICATIONS).

It is suggested that every patient under treatment carry an *Identification Card* stating that he is receiving disulfiram and describing the symptoms most likely to occur as a result of the disulfiram-alcohol reaction. In addition, this card should indicate the physician or institution to be contacted in an emergency. (Cards may be obtained from ODYSSEY PHARMACEUTICALS upon request.)

Alcoholism may accompany or be followed by dependence on narcotics or sedatives. Barbiturates and disulfiram have been administered concurrently without untoward effects; the possibility of initiating a new abuse should be considered.

Baseline and follow-up transaminase tests (10-14 days) are suggested to detect any hepatic dysfunction that may result with disulfiram therapy. In addition, a complete blood count and a sequential multiple analysis-12 (SMA-12) test should be made every six months.

Patients taking disulfiram tablets should not be exposed to ethylene dibromide or its vapors. This precaution is based on preliminary results of animal research currently in progress that suggest a toxic interaction between inhaled ethylene dibromide and ingested disulfiram resulting in a higher incidence of tumors and mortality in rats. A correlation between this finding and humans, however, has not been demonstrated.

ADVERSE REACTIONS: (See CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS.)

OPTIC NEURITIS, PERIPHERAL NEURITIS, POLYNEURITIS, AND PERIPHERAL NEUROPATHY MAY OCCUR FOLLOWING ADMINISTRATION OF DISULFIRAM.

Multiple cases of hepatitis, including both cholestatic and fulminant hepatitis, have been reported to be associated with administration of disulfiram.

Occasional skin eruptions are, as a rule, readily controlled by concomitant administration of an antihistaminic drug.

In a small number of patients, a transient mild drowsiness, fatigability, impotence, headache, acneform eruptions, allergic dermatitis, or a metallic or garlic-like aftertaste may be experienced during the first two weeks of therapy. These complaints usually disappear spontaneously with the continuation of therapy, or with reduced dosage.

Psychotic reactions have been noted, attributable in most cases to high dosage, combined toxicity (with metronidazole or isoniazid), or to the unmasking of underlying psychoses in patients stressed by the withdrawal of alcohol.

DOSAGE AND ADMINISTRATION: Disulfiram should never be administered until the patient has abstained from alcohol for at least 12 hours.

Initial Dosage Schedule: In the first phase of treatment, a maximum of 500 mg daily is given in a single dose for one to two weeks. Although usually taken in the morning, disulfiram may be taken on retiring by patients who experience a sedative effect. Alternatively, to minimize, or eliminate, the sedative effect, dosage may be adjusted downward.

Maintenance Regimen: The average maintenance dose is 250 mg daily (range, 125 to 500 mg), it should not exceed 500 mg daily.

Note: Occasionally patients, while seemingly on adequate maintenance doses of disulfiram, report that they are able to drink alcoholic beverages with impunity and without any symptomatology. All appearances to the contrary, such patients must be presumed to be disposing of their tablets in some manner without actually taking them. Until such patients have been observed reliably taking their daily disulfiram tablets (preferably crushed and well mixed with liquid), it cannot be concluded that disulfiram is ineffective.

Duration of Therapy: The daily, uninterrupted administration of disulfiram must be continued until the patient is fully recovered socially and a basis for permanent self-control is established. Depending on the individual patient, maintenance therapy may be required for months or even years.

Trial with Alcohol: During early experience with disulfiram, it was thought advisable for each patient to have at least one supervised alcohol-drug reaction. More recently, the test reaction has been largely abandoned. Furthermore, such a test reaction should never be administered to a patient over 50 years of age. A clear, detailed and convincing description of the reaction is felt to be sufficient in most cases.

However, where a test reaction is deemed necessary, the suggested procedure is as follows:

After the first one to two weeks' therapy with 500 mg daily, a drink of 15 mL (1/2 oz) of 100 proof whiskey, or equivalent, is taken slowly. This test dose of alcoholic beverage may be repeated once only, so that the total dose does not exceed 30 mL (1 oz) of whiskey. Once a reaction develops, no more alcohol should be consumed. Such tests should be carried out only when the patient is hospitalized, or comparable supervision and facilities, including oxygen, are available.

Management of Disulfiram-Alcohol Reaction: In severe reactions, whether caused by an excessive test dose or by the patient's unsupervised ingestion of alcohol, supportive measures to restore blood pressure and treat shock should be instituted. Other recommendations include: oxygen, carbogen (95% oxygen and 5% carbon dioxide), vitamin C intravenously in massive doses (1 g) and ephedrine sulfate. Antihistamines have also been used intravenously. Potassium levels should be monitored, particularly in patients on digitalis, since hypokalemia has been reported.

HOW SUPPLIED: Disulfiram Tablets, USP:
250 mg - White, round, unscored tablets in bottles of 100.
Debossed: OP 706
Dispense in a tight, light-resistant container as defined in the USP.
Store at controlled room temperature 15°-30°C (59°-86°F).

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MRO Course to Address New Federal Rule

Dramatic changes in the federal Part 40 rule that is the standard for most drug-free workplace programs will be the focus of the next ASAM-sponsored Medical Review Officer (MRO) training course, scheduled for November 30-December 2 at the Westin Fairfax Hotel in Washington, DC. As in the past, the course offers advanced preparation for the MRO examination, as well as sessions designed to help all MROs keep up with recent regulatory changes.

Course organizers Donald Ian Macdonald, M.D., FASAM, and James L. Ferguson, D.O., describe the course as combining scientific updates, policy reviews and practical advice. Specifically, the course will involve:

- Discussion of the new Part 40 rule and its impact on drug-free workplace programs and MRO practice.
- A clinical review of addiction and relapse, and their relevance to drug-free workplace programs.
- Examination of issues in fitness-for-duty testing in programs designed for the prevention of illicit drug use.
- Interpretation of positive opiate tests, split-sample testing, alcohol testing, and passive inhalation of cocaine and marijuana.
- Practice-oriented discussions of actual cases.
- An update on the status of MRO certification.

Fees for the three-day course are $575 for ASAM members and $650 for non-members. Each registrant will receive a copy of the course manual, *The Medical Review Officer 2001*. Conference registration and information requests should be directed to the ASAM Conference and Meetings staff at 301/656-3920, or consult the ASAM Web site at ***www.asam.org***.

Hotel reservations for the November course should be made by November 7 to receive the conference rate of $159 single or double. Phone the hotel directly at 202/293-2100 or call the Westin central reservation office at 1-800/WESTIN-1.

MROCC Examination

The Medical Review Officer Certification Council (MROCC) will offer the MROCC Certification Examination on Sunday, December 2, immediately following the ASAM MRO Training Course. Candidates who wish to sit for the examination must obtain a separate application and eligibility form from the MROCC at 1821 Walden Office Square, Suite 300, Schaumburg, IL 60173. The phone number is 847/303-7210 and the Web site is ***www.mrocc.org***.

Forensic Issues in Addiction Medicine

Preceding the MRO Training Course on November 29, a one-day course on Forensic Issues in Addiction Medicine has been designed to increase the knowledge and improve the professional skills of addiction medicine specialists who encounter forensic issues in their practices. Course organizer Robert DuPont, M.D., FASAM and his committee have planned a highly interactive mix of lectures, panel discussions, and a moot court session to give participants an opportunity to survey the entire scope of practice possibilities in forensic addiction medicine.

Registration fees for the course are $175 for ASAM members and $200 for non-members. Consult the ASAM Web site at ***www.asam.org*** for additional details. ■

Role of Recovering Persons in Helping Others Documented

The beneficial role of recovering persons in treatment settings long has been an accepted practice in addiction treatment programs. Now the practice is supported by a research study demonstrating that contact with recovering persons helped hospitalized alcoholics by encouraging them to quit drinking and enter counseling. "A recovering alcoholic can help alcoholics who are still suffering from the disease, because the patients relate to them," said study author Richard D. Blondell, M.D., an addiction medicine specialist at the University of Louisville School of Medicine in Kentucky. "The patients credited the visitor as the main thing that motivated them."

The study involved 140 patients who were hospitalized for alcohol-related incidents. One group received standard medical care, a second group received medical care plus a 15-minute intervention by a trained addiction specialist, and the third group received medical care, intervention and an in-depth talk with a recovering alcoholic.

The researchers found that 59% of those who met with a recovering alcoholic abstained from drinking for six months after the encounter, compared to 44% of those who received addiction counseling alone and about 33% of those who received medical care alone.

In addition, half the patients who met with a recovering alcoholic had entered some form of treatment, compared with only 15% of those who received medical treatment and counseling by an addiction specialist.

Source: Journal of Family Practice, May 2001.

▶ **OXYCONTIN®** *continued from page 1*

patients 'lose' their medications or move from physician to physician seeking medication. We need to educate consumers that this is a potent prescription drug that can be very dangerous when used non-therapeutically. And we need to educate everyone that treatment for opiate dependence and addiction is available and effective."

The advisory describes OxyContin abuse as involving either crushing the tablet and swallowing or "snorting" it, or diluting the crushed tablet with water and injecting it. Crushing or diluting the tablet disarms the timed-release action of the medication and causes a quick, powerful "high." Abusers have compared this feeling to the euphoria they experience when taking heroin.

According to the advisory, abuse of OxyContin differs from that of other prescription analgesics because the drug contains a much larger dose of oxycodone than similar prescription pain relievers and because larger profits are to be made from its illegal sale (a 40 mg tablet currently sells for $20 to $40 on illicit markets).

The advisory cites information resources on diagnosis, detoxification and treatment of patients who are abusing OxyContin, either alone or in combination with other drugs. A fully referenced version of the advisory is available on CSAT's Web site at ***www.samhsa.gov/csat/csat.htm***.

Treatment Improves Outcomes for Addicted Pregnant Women

Pregnant and postpartum women (PPW) with addictive disorders are less likely to continue abusing drugs if they participate in a residential treatment project, according to research published in *Child Welfare*.

The study of 24 residential treatment projects funded by the Center for Substance Abuse Treatment (CSAT) further found that the PPW project helped reduce infant mortality and morbidity rates and improve women's parenting. The nationwide evaluation looked at 1,847 women and analyzed birth-related outcomes, treatment retention and completion rates, and behavioral outcomes following treatment.

The researchers concluded that, "Several steps should be taken to ensure that future work with pregnant and postpartum substance-abusing women includes a focus on substance abuse and child welfare in both research and practice: educating policymakers about the link between maternal substance abuse and child welfare; restructuring policies to foster collaboration; cultivating experts in the field who can provide appropriate care for the children of substance-abusing mothers; developing appropriate screening and assessment instruments to identify problems in children early; and conducting longitudinal studies to assess outcomes for children over time."

Source: Child Welfare, March-April 2001.

Study Examines Behavioral, Pharmacological Treatments

A new nationwide study will evaluate the effectiveness of behavioral treatments alone and in combination with medication, according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Eleven universities throughout the U.S. will be involved in NIAAA's Combining Medications and Behavioral Interventions (COMBINE) research, the first national study of its kind.

"More than 8 million American adults meet clinical criteria for alcoholism,"

"More than 8 million American adults meet clinical criteria for alcoholism," said NIAAA Director Enoch Gordis, M.D. "Of persons who receive treatment, as many as 50% relapse at least once and a minority achieve long-term remission of disease. Identifying and developing effective treatments is the first priority of alcoholism research."

The study, which will take place over 24 months, is to involve 1,375 participants who meet current diagnostic criteria for alcohol dependence. Participants will receive behavioral treatments (moderate-intensity and lower-intensity treatment, or a combination thereof) and medication (naltrexone, acamprosate, or both) or a placebo. In addition, patients will attend outpatient sessions for four months, then return for three follow-up visits over the subsequent 12 months.

Among other questions, COMBINE will explore whether treatment effectiveness is improved by pairing a medication that reduces the risk of any drinking with one that reduces the risk of heavy drinking. "During the past decade, research on medications to treat alcoholism has rapidly expanded as neuroscientists have advanced understanding of the biology of drinking behavior. From among the most promising pharmacologic and behavioral treatments, COMBINE is expected to define the optimal treatment combinations," said Ray Anton, M.D., of the Medical University of South Carolina, one of the participating sites.

The other research sites are Boston University, the University of Washington, the University of Texas, the University of Miami, the University of New Mexico, Yale University, the University of Pennsylvania, Brown University, Harvard University and the University of Wisconsin.

Source: National Institute on Alcohol Abuse and Alcoholism, March 8, 2001.

Lack of Research, Capacity Plague Adolescent Treatment

At least 140,000 adolescents are enrolled in publicly funded addiction treatment programs, but very little is known about what type of treatment is appropriate for young people, and very few programs are tailored to address their specific needs. "There really isn't much knowledge" about treatment matching, medication dosing, stages of change, or other facets of adolescent care, Marc Fishman, M.D., an assistant professor in the department of psychiatry and behavioral sciences at Johns Hopkins University School of Medicine, told a session at ASAM's annual Medical-Scientific conference. Dr. Fishman, a faculty member on a Center for Substance Abuse Treatment (CSAT) multi-site project to test adolescent treatment models, said that there are well over 1,000 studies of adult addiction treatment in the published literature, but fewer than 100 studies of adolescent treatment. Moreover, Dr. Fishman said, few controlled studies have been conducted, and many have problems with drop outs, viewing treatment experiences as discrete episodes ("which doesn't make a lot of sense with a chronic, relapsing condition," he noted), and viewing treatment as "one size fits all."

> *"There really isn't much knowledge about treatment matching, medication dosing, stages of change, or other facets of adolescent care."*
> Marc Fishman, M.D.

Randolph Muck, M.Ed., co-project officer for CSAT's Adolescent Treatment Models (ATM) project, said that even under the most optimistic projections, only one in five adolescents who needs treatment is getting it. CSAT has attempted to use its targeted capacity-expansion grants to boost treatment resources for adolescents, said Dr. Muck, but the effort has been undermined to some extent by the dearth of research and lack of dissemination. "Most applicants [organizations] don't even have a rudimentary knowledge of what we know works," Dr. Muck added. "It's rather astonishing."

Adult Models Inadequate

Even when adolescents are enrolled in treatment, they are likely to be placed in programs that are designed for adults. Progression of alcohol and other drug abuse among adolescents, however, often is quite different than among adults. Dr. Fishman described this progression as "counterintuitive"—for example, risk-taking and experimentation are normative for adolescents, while symptoms of dependence sometimes are seen even before symptoms of abuse. Nor can adolescent treatment be homogeneous: Dr. Fishman pointed out that the treatment needs of a 12-year-old are far different from those of a 14-year-old.

The research conducted to date shows that some treatment is better than no treatment for adolescents. An overview of the research literature conducted by Dr. Fishman shows that an average of 32% of adolescents remain abstinent one year after treatment, while 44% are either completely abstinent or suffer only minor relapses. But knowledge about the comparative effectiveness has been lacking, according to Dr. Fishman.

CSAT Assesses Effectiveness

CSAT's Cannabis Youth Treatment (CYT) program, launched in 1997, represents one of the most significant attempts to assess different theory-based treatment models in terms of their effectiveness. According to Dr. Muck, the CYT project found a number of models were effective in an outpatient setting, including motivational-enhancement therapy, cognitive-behavioral therapy, family support networks, adolescent community approaches, and multidimensional family therapy.

The ATM project is more ambitious, with 11 sites funded for three years to evaluate the relative cost-effectiveness and outcomes of a variety of adolescent treatment modalities. The programs funded under the project—each identified as promising by addiction researchers. Dr. Fishman added that research is also needed on treatment for subpopulations of adolescents, including youths with dual diagnosis, those who abuse specific types of drugs, and those who are cognitively impaired.

Given that 41% of all adolescents currently in the treatment system are referred from the juvenile justice system, research on this population also is seen as critical. Dr. Muck and other researchers are looking to the Reclaiming Futures project, funded by the Robert Wood Johnson Foundation, to greatly increase the field's knowledge of treatment of young people involved in the criminal justice system. The project, which encourages collaboration between the juvenile justice and addiction treatment systems, will spend at least $5 million on identifying and evaluating promising treatment programs for juvenile offenders.

Source: Join Together, May 14, 2001. ■

Addictions Conference Rescheduled

Dr. Jorge Gleser and his planning committee have announced the rescheduling of the Addictions 2000+1 conference, which had to be cancelled last fall because of violence in the Middle East. The conference now is set for September 7-11, 2001, in Jerusalem, Israel.

The conference is to be hosted by the Israel Anti-Drug Authority, the Israeli Society of Addiction Medicine, and the State of Israel Ministry of Health. ASAM is a cooperating organization, as are the International Society of Addiction Medicine, the World Health Organization, the U.S. National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism, the Pompidou Group, and other prestigious medical and scientific organizations.

Further information about the conference can be found on the ISAM Web site ***(www3.sympatico.ca/pmdoc/ISAM)***.

EU: New Approach to Tobacco Advertising Signalled

The European Union (EU) is close to unveiling a new plan to ban tobacco advertising, after the European Court of Justice overturned its first attempt last October. EU Health Commissioner David Byrne said he would be ready to present the new proposal to the full commission before the August summer break.

In its first effort, the EU attempted to ban advertising of tobacco products on billboards and in movie theaters. The ban also would have prohibited ads on umbrellas, ashtrays, and other items used in hotels and restaurants. However, the European Court of Justice overturned the ban in October on the grounds that the Health Commission had overstepped its authority because the underlying issue was one of trade rather than public health.

Details of the new proposal have not been disclosed, although it is said to take the court's objections into account.

Tobacco companies charged that the original proposal would restrict their right to communicate with adult consumers, but EU Health Commissioner David Byrne said the law is needed to end the connection between advertising and the social acceptability of smoking.

Source: Associated Press, May 9, 2001.

WHO: Tobacco Control Treaty Negotiations Continue

The World Health Organization continues negotiations to draft an unprecedented international treaty to reduce smoking. Talks began last October in Geneva, Switzerland, in an effort to develop a Framework Convention on Tobacco Control (FCTC). "The ultimate objective is to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke," according to an early draft of the framework.

The draft treaty would place tougher restrictions on tobacco advertising and gradually eliminate sponsorship of sporting events by cigarette companies. In addition, governments would commit to using price as a means of discouraging smoking.

The proposed treaty is strongly opposed by tobacco companies. British American Tobacco (BAT) said such an agreement undermines the decisionmaking authority of national governments. WHO wants a treaty ratified and in place by 2003.

Source: Reuters News Service, April 30, 2001.

China: Addiction Rates Increasing

China is faced with soaring drug addiction rates, according to statistics released at a recent national conference on drug abuse. The data show that China's overall addiction rate increased by more than 25% within the past 12 months. Drugs singled out as particularly of concern include Ecstasy, methamphetamines and heroin.

China's Public Security Minister Jia Chunwang called for stronger measures to crack down on the manufacturing, sales and use of illicit drugs. Jia added that a concerted interdiction effort must be made along China's border with the "Golden Triangle" drug-producing regions of Laos, Myanmar and Thailand. In addition, he called for stronger controls over precursor chemicals used in the production of drugs of abuse.

Source: Associated Press, February 12, 2001.

Japan: Tobacco Policy Weighed

With tobacco taxes comprising the largest source of public revenue in Japan, government officials have been slow to implement anti-smoking measures. With the country in debt, tougher anti-smoking measures proposed by Japan's health ministry have been repeatedly blocked by the ministry in charge of finances. Prime Minister Junichiro Koizumi is wrestling with the option of either strengthening Japan's weak anti-smoking programs and reducing a much-needed source of funds, or putting the interests of public finance before public health. Koizumi, who quit smoking 20 years ago, is an anti-smoking proponent.

Sales of cigarettes generate more than $18 billion in tax revenues annually for Japan. "The Japanese government gets far more benefits than the damage that is caused by smoking," said Takuro Morinaga, a senior analyst at Sanwa Research Institute. "That may sound drastic, but from a fiscal point of view, smoking is a good thing."

Source: New York Times, June 13, 2001.

FUNDING OPPORTUNITIES

Grants for Tobacco Control Initiatives

Up to $21 million in grants over three years are available from the American Legacy Foundation through its Expanding the Dialogue: Reducing Disparities in Tobacco Control program, part of the foundation's Priority Populations Initiative.

Fundable proposals will address tobacco-related health disparities and support tobacco cessation and prevention efforts, or reduce secondhand smoke exposure for the following priority populations: African American, Asian-American, Pacific Islander, Native American and Alaska Native; gay, lesbian, bisexual and transgender; Hispanic and Latino; and persons with low socioeconomic status.

Two types of grants are available: capacity-building grants ranging from $75,000 to $100,000 for up to one year, and innovative projects and applied research grants for up to three years, with awards ranging from $75,000 to $200,000 a year.

Proposals are due by December 19. Detailed information is available from the American Legacy Foundation, 1001 G Street, NW, Suite 800, Washington, DC 20001; phone 202/454-5555 or e-mail ***priorityrfp@americanlegacy.org***.

Resource: Women and HIV/AIDS

The HIV/AIDS epidemic, now in its 20th year, is widely perceived as primarily affecting men. However, women comprise a growing share of new AIDS cases. In 1986, women accounted for only 7% of new AIDS cases in the U.S., whereas by 1999, that share had risen to nearly 25%. Today, women represent an estimated 30% of new HIV infections. While researchers and clinicians have begun to focus on the impact of the epidemic among women, gender disparities in access to treatment persist.

A new report from the Kaiser Family Foundation on "Women and HIV/AIDS" examines how the epidemic affects women, highlights the characteristics of women living with HIV/AIDS, and presents information on the health care issues in preventing women from acquiring HIV and treating women who already have the disease.

The report and a related "Fact Sheet on Women and HIV/AIDS" are available through the Foundation's Web site at ***www.kff.org*** (click on the Capitol Hill Briefing on Women and HIV/AIDS).

Gender Differences Seen in Progression from HIV to AIDS

During the first years of HIV infection, women have significantly lower amounts of the virus in their blood than do men, according to one of the largest studies ever to examine gender-specific differences of HIV infection. Despite their lower initial viral levels, women suffer the loss of immune cells and develop AIDS just as swiftly as men. The findings lend further support to recent changes in the criteria used to help doctors tailor anti-HIV drug therapy to delay the onset of AIDS.

Through a collaboration funded by NIDA, investigators from the National Institute of Allergy and Infectious Diseases (NIAID) and the Johns Hopkins University monitored more than 200 participants in the AIDS Linked to the Intravenous Experience (ALIVE) cohort.

Source: New England Journal of Medicine, March 8, 2001.

Problem Drinking, Noncompliance with HIV Treatment Linked

Patients with HIV infection who have drinking problems appear to have more difficulty adhering to complex antiretroviral drug regimens than their non-drinking counterparts, study results show. Dr. Robert L. Cook and colleagues at the University of Pittsburgh surveyed 212 HIV-positive patients visiting two outpatient clinics. Nineteen percent of the patients reported problem drinking in the previous month, including binge drinking, drinking a large quantity every week, and having specific problems related to drinking. Patients who reported drinking problems were twice as likely to have taken their medications off schedule and somewhat more likely to have missed a medication dose than those who did not report alcohol problems.

"We encourage physicians to screen all [HIV] patients for drinking problems. If drinking is identified, we encourage physicians to discuss this with their patients and to point out that drinking could interfere with medication adherence," the researchers said.

Source: Journal of General Internal Medicine, April 2001.

Special Issue of MMWR Focuses on IDUs

The May 18 issue of *Morbidity and Mortality Weekly Reports* (Volume 50, Number 19) from the Centers for Disease Control and Prevention focuses on injection drug users (IDUs) and their risk for HIV disease. The editors point out that approximately one million persons in the U.S. are active IDUs and that, in the U.S., approximately one-third of acquired immunodeficiency syndrome cases and one-half of new hepatitis C cases are associated with injection drug use..

They add that "substance abuse and addiction are major underlying causes of preventable morbidity and mortality. The risks increase when illicit substances are injected, which contributes to multiple health and social problems for IDUs, including transmission of bloodborne infections (e.g., human immunodeficiency [HIV] and hepatitis B and C infections) through sharing unsterile drug injection equipment and practicing unsafe sex."

MMWR is available on-line at ***www.cdc.gov/mmwr***. A paper copy can be ordered by phoning the U.S. Government Printing Office at 202/512-1800. ■

Ruth Fox Memorial Endowment Fund

Dear Colleague:

The ASAM Board of Directors recently approved the use of up to 20% of the interest income from the Ruth Fox Memorial Endowment Fund to underwrite scholarships to ASAM's educational programs. The precise number of scholarships for each event will be determined by a subcommittee, which also will develop a mechanism for selecting recipients.

We greatly appreciate the support and commitment of all our donors, and ask you to please consider an additional gift/pledge or to upgrade your current pledge to help us reach our $3.5 million goal. If you are not already participating in the Endowment Fund, please join your colleagues now. Pledges can be paid over a five-year period. All contributions are completely tax-deductible.

The Fund is very close to reaching our next goal of $3.5 million by year-end 2001. To date, we have received $3,250,000 in pledges, contributions, bequests, insurance and trust funds. You can help us reach this goal and help ASAM continue its work in years to come by including a gift to the Ruth Fox Memorial Endowment Fund in your will, trust fund, retirement plan, or insurance policy. Whatever you choose to do will help secure ASAM's future. Please let us hear from you.

In this regard, we especially thank long-time member Joseph D. Beasley, M.D., M.P.H., for his very generous bequest to the Endowment Fund. It gives us great pleasure to add his name to the Founders' Circle.

For information about providing a life insurance policy or making a deferred gift, pledge, contribution, bequest or memorial tribute, or to discuss in confidence other types of gifts, please contact Claire Osman at 1-800/257-6776 or 718/275-7766. Of course, financial decisions should be discussed with your personal tax advisor.

Max A. Schneider, M.D., FASAM, Chair, Endowment Fund
Jasper G. Chen See, M.D., Chair Emeritus, Endowment Fund
Andrea G. Barthwell, M.D., FASAM, Chair, Resources & Development Committee
Claire Osman, Director of Development

As of July 15, 2001...Total Pledges: $3,250,000

NEW DONORS, ADDITIONAL PLEDGES AND CONTRIBUTIONS:

Founders' Circle ($25,000-$49,999)

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▶ **PARITY FORUM** *continued from page 1*

abuse "carve-out" contractor. To demonstrate the value of treatment, it would be essential to link the data in the data captured in these "silos."

At the Consensus Forum, consumer groups representing recovering individuals spoke eloquently, both of the need for protecting privacy and of the need to collect data that would validate treatment. Before this data linkage will happen, current culture will need to soften privacy barriers and allow evaluators to utilize technical tools to maintain confidentiality.

Multiple organizations have initiated their own measures, and these represent the unique interests of substance abuse, mental health, child and adolescent mental health, and prevention. The Washington Circle Group developed substance abuse outcome measures from the clinical perspective of a patient's experience. These process measures included the rate of primary care case-finding, speed of treatment referral, rate of completion in treatment engagement, and efforts at supporting maintenance of recovery gains. The National Association of State Alcohol and Drug Abuse Directors added outcome measures involving employment and criminal justice involvement. At the Consensus Forum, both groups made an important decision to work on merging their lists.

Work has progressed to the point that two pilot studies are in the analysis stage, one examining insurer databases, and another testing a new consumer satisfaction questionnaire. Both studies demonstrate that the nature of addictive disease mandates unique measures in any general health plan evaluation standard.

Resource: Physician's Guide Tells How to Advocate for Effective Policies

This booklet outlines steps physicians can take to advocate for more effective drug policies, including ways to work with the media and with legislators. It provides sample editorials, talking points, and other resources. The booklet is available as a PDF document, which can be downloaded from ***www.JoinTogether.org/sa/files/pdf/plndpguidefinal.pdf***, or a free print copy can be obtained by contacting Physician Leadership on National Drug Policy (PLNDP), Center for Alcohol and Addicition Studies, Brown University, Box G-BH, Providence, RI 02912; phone 401/444-1817; fax 401/444-1850; or e-mail ***info@jointogether.org.***

Dr. Salsitz Fights Stigma As He Treats Patients

ASAM News *is proud to showcase the many ways in which ASAM members contribute to the field of addiction medicine.*

Jeanne Erdmann

Imagine that you're an attorney planning a family vacation to Disneyland. You have airline and hotel reservations, you've arranged for your partner to cover your practice; the kids are packed and ready to go. Are you ready?

Not if you're on methadone maintenance and your medication comes from clinic visits. Before going anywhere, you would need to obtain a week's worth of medication and, depending on local regulations, you may or may not be able to leave town for a week. If the whole idea of methadone fitting into a family setting and a professional life doesn't seem plausible, Ed Salsitz, M.D., director of methadone medical maintenance at the Beth Israel Medical Center in New York City, is ready to change your mind.

Dr. Salsitz has an internal medicine practice that includes addiction medicine and medical methadone maintenance. His opiate-addicted patients are treated in a medical office setting rather than in a methadone clinic. Because his patients come to the office to pick up a month's worth of methadone tablets, they can travel when they need do so and avoid at least the outward stigma of a methadone clinic visit. "To have one bottle with all your pills in it for a month is an amazing thing for most patients," remarks Dr. Salsitz.

In reality, most opiate-addicted patients still need to visit methadone clinics, which can be a hardship. For example, patients in rural areas may need to travel hundreds of miles to reach a clinic. In the mid-1960s, methadone pioneers Drs. Vincent Dole and Marie Nyswander were able to provide a month's worth of methadone in an office setting, under an Investigational New Drug (IND) application approved by the federal Food and Drug Administration. In 1985, they transferred their IND to Dr. Salsitz and his colleagues at Beth Israel.

Dr. Salsitz began his career as a board-certified internist in pulmonary medicine, and gradually began working with patients on methadone, eventually branching out into a wider practice of addiction medicine. Today, he works with a group of six physicians in an internal medicine practice, offering primary medical care along with medical methadone maintenance. To qualify for this type of maintenance, patients are selected from traditional methadone clinics. They need to have been in the clinic for four years, have urine free of illicit substances for three years, and they must be working productively.

"We have the oldest, largest, and most advanced private-practice model of methadone maintenance. Patients on methadone are fully integrated into our regular practice. They come in just like a regular doctor visit; they sit in waiting room with other patients of other physicians; no one ever knows why they are there," says Dr. Salsitz.

Over the past 15 years, about 300 patients have enrolled in Beth Israel's program. Of those 300, roughly 10% were referred back to a traditional methadone clinic. At present, 225 patients are enrolled. Although few patients have voluntarily withdrawn, a few have died, most commonly from tobacco-related problems or hepatitis C. No patient deaths were related to methadone.

"We've had seven patients receive eight liver transplants. Of those, five are alive and well and back to work," adds Dr. Salsitz. He maintains that ignorance and misinformation among opiate-addicted patients, the lay public, health care workers, even those in the addiction field stigmatize those on methadone. "It's every place they look. Many addiction treatment centers will not admit patients on methadone because they don't consider these patients be in real recovery from their addiction because they are not abstinent," continues Dr. Salsitz. "Methadone maintenance is a bigger stigma in our patient population than being HIV positive, gay, having been heroin-addicted or having been in prison."

This stigma, says Dr. Salsitz, has kept six of his patients from telling their spouses or significant others that they use methadone. One or two patients are on the brink of divorce because spouses want them off methadone. Patients won't tell co-workers, and often keep it from extended family. The stigma keeps successful patients hidden so the only methadone patients visible are the ones not doing well. "Those patients are outside the clinics, in the parks, and they have no problem going on TV," remarks Dr. Salsitz.

His admiration for his patients keeps Dr. Salsitz motivated to help them put and keep their lives together. He educates families by bringing in spouses or significant others—even parents—to explain the physiology and rationale behind the drug. His methadone patients are engaged in a broad spectrum of occupations: they are physicians, nurses, lawyers, psychologists, plumbers, teachers, and construction workers. About 40% are college graduates, and their average family income is $80,000. Some are multi-millionaire entrepreneurs.

The best way to view methadone, says Dr. Salsitz, is to think of it as a necessary part of some people's physiology, like insulin or blood pressure medication. "The goal of being on methadone is to live as functional as happy a life, to stabilize brain function and to put the disease of opiate addiction into a long-lasting remission," remarks Dr. Salsitz. "Methadone doesn't cure addiction. Nothing does. There is no cure for any addiction—food, gambling, anything. If we lived in a different world, methadone would be considered one of true wonder drugs of our time and used a lot more than is today."

While buprenorphine (which is not yet approved by the FDA) also offers patients the convenience of receiving treatment from a physician's office or pharmacy, Dr. Salsitz believes methadone still will be superior for some patients. He points out that methadone is a complete opiate agonist, while buprenorphine is a partial agonist. Thus, while buprenorphine may be less likely to cause respiratory depression, it may not be as effective in treating opioid addiction.

Jeanne Erdmann is a St. Louis-based medical writer who also writes for Science and CBS HealthWatch.

ASAM CONFERENCE CALENDAR

ASAM

September 13-16, 2001
ASAM Conference on Tobacco Dependence
Atlanta, GA
15.5 Category 1 CME credits (plus 6 CME credits for preconference workshops)

October 6, 2001
Buprenorphine Training Course
St. Louis, MO
8 Category 1 CME Credits

November 1-3, 2001
Conference on the State of the Art in Addiction Medicine
Washington, DC
19 Category 1 CME credits

November 4, 2001
Buprenorphine Training Course
Washington, DC
8 Category 1 CME Credits

November 29, 2001
Forensic Issues in Addiction Medicine
Washington, DC
7 Category 1 CME credits

November 30-December 2, 2001
Medical Review Officer (MRO) Training Course
Washington, DC
20 Category 1 CME credits

April 25, 2002
Pain & Addiction: Common Threads III
Atlanta, GA
7.5 Category 1 CME credits

April 25, 2002
Ruth Fox Course for Physicians
Atlanta, GA
8 Category 1 CME credits

April 26-28, 2002
33rd Annual Medical-Scientific Conference
Atlanta, GA
Up to 19 Category 1 CME credits

OTHER EVENTS OF NOTE

August 9-10, 2001
2nd National Conference on Drug Abuse Prevention Research
Washington, DC
(Sponsored by the National Institute on Drug Abuse)
[For information, contact Mildred Prioleau at 301/46?-6008 x431]

August 8-11, 2001
IDAA 2001: A Spiritual Odyssey
Oklahoma City, OK
Sponsored by International Doctors in Alcoholics Anonymous
[Contact David Blackshaw, M.D., at 405/728-3668]

September 7-11, 2001
Addictions 2000+1:
Challenges and Opportunities for a New Millennium
Jerusalem, Israel
[For information, e-mail *jorge.gleser@moh.health.gov.il*]

September 12-14, 2001
ISAM Annual Conference:
Addictions — Sharing International Responsibilities in a Changing World
Trieste, Italy
[For information, e-mail ***isam@theoffice.it***]

September 26-29, 2001
Carolina Conference on Addiction and Recovery
Charlotte, NC
22.5 Category 1 CME Credits
[For information, phone 877-392-9973 or e-mail *info@carolinaconference.com*]

October 18-21, 2001
Canadian Society of Addiction Medicine
13th Annual Scientific Meeting
Rimrock Resort Hotel, Banff, Alberta
[For information, e-mail *sweeney@ucalgary.ca*]

October 21-24, 2001
Advancing the Conversation:
Alcoholism and Substance Abuse Prevention and Treatment in the Empire State
Saratoga Springs, NY
[For information, e-mail asap@asapnys.org or phone 518/426-3122]

February 20-23, 2002
Society for Research on Nicotine and Tobacco
8th Annual Meeting
Savannah, GA
[For information, e-mail smt@tmahq.com or phone 608/838-3787 x144]

February 20-24, 2002
American College of Preventive Medicine
Prevention Medicine 2001
San Antonio, TX
[For information, visit www.PreventiveMedicine2002.org, or phone 202/466-2044]

*For additional information, visit the ASAM Web site at **www.asam.org**, or contact the ASAM Department of Meetings and Conferences at 4601 North Park Ave., Suite 101 Upper Arcade, Chevy Chase, MD 20815-4520, or phone 301/656-3920, or fax 301/656-3815, or e-mail **email@asam.org**. Information on ASAM's Web site will be updated as meetings are scheduled.*

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