Heroin and the New Prescribers

The opening of the new centres for treatment of drug addiction has been impatiently awaited. The Ministry of Health has been widely blamed for lacking a sense of urgency, but whatever the causes for delay it at last seems certain that the network of new centres will soon be opening their doors. Under the 1967 Dangerous Drugs Act the legal right to prescribe heroin and cocaine for addicts will be confined to doctors working in these clinics, and any registered addict will know where to turn to get his free supply of drugs. But many questions about these centres remain unanswered, indeed scarcely discussed so far. What exactly is to be their purpose? What are to be the quality and scope of the treatment they offer? What is their basis in medical ethics?

The number of patients to be expected at the centres defies any exact estimate at present. Facilities may be swamped. The official figure of 1,3494 for the number of heroin users in Britain in 1966 is an underestimate and may have to be multiplied two or three times. But the opposite possibility also deserves attention, for during the last few years some users of heroin who could have obtained supplies on prescription have preferred the expense of black-market dealings to the inclusion of their names on official records. If in the long run the drug-taking subculture the image of the centres is adverse their efficacy will be diminished.

The impetus for setting up the centres came largely from the conclusion of the Brain report5 that the drug habit was being spread by the over-prescribing of heroin by a handful of medical practitioners. A vital question, therefore, is whether doctors at the centres are going to be able to prescribe more accurately and more conservatively. How are they to avoid becoming simply new agencies for perpetuating the old process whereby the addict got more drugs than he needed, sold the surplus, and gained new recruits to addiction? For there is at present no satisfactory way of determining how much heroin a patient is taking. The dose of heroin which keeps an addict free of withdrawal symptoms is not necessarily the same as the dose which psychologically satisfies him, and which he sees as his need. The dilemma is that lax prescribing will feed the black market with N.H.S. heroin, while too strict prescribing may encourage illicit import of the drug. One particularly perplexing problem which will face the new prescribers is the identification of the heroin user who is not an addict but a so-called “chipper.” These are a subgroup of heroin users, sometimes adolescents still living with their parents, and generally stable and socially integrated, who are buying out of their wages enough heroin for occasional or weekend use. Free prescriptions of heroin to them might simply push them deeper into addiction.

When the regulations (expected to come into force soon) restrict to doctors in the clinics the prescribing of heroin or cocaine to addicts, these patients may provide general practitioners and casualty officers with a problem by asking for emergency treatment. Consequently the Chief Medical Officer of the Ministry of Health has circularized general practitioners and hospitals with suggestions on how to recognize addiction and
how to cope with the addicts. Methadone linctus 10-20 mg. is recommended if there are withdrawal symptoms. In the same circular he draws attention to the possibility that some addicts may switch from heroin to intravenous amphetamine (see also page 754).

If several thousand young people do attend the centres for a regular supply of heroin what happens to them? Whether any but a few addicts on several grains of intravenous heroin per day can function socially and hold down jobs is still a matter of conjecture, and it is possible that the longer a person is on maintenance drugs the longer he is being exposed to an experience which damages his social adjustment and personality. The serious risks to life and health inherent in heroin-taking are brought out by Dr. T. H. Bewley and his colleagues in three papers in the B.M.J. this week. They calculate a 20- to 35-fold excess mortality rate among British heroin addicts, and they point out that, despite free prescribing here, the death rate among heroin addicts in Britain is over twice that of addicts in New York.

For these various reasons the steady aim—rather than the pious hope—of the clinics must be to get their clients off heroin. To design a regimen which offers the disturbed adolescent drug-taker a recognizable alternative to being an addict is considerably more difficult than merely to go on handing out drugs to him. Nor do the problems end there, for the continuing care of the addict after his treatment at one of these centres needs to be unremitting. The Ministry of Health has issued an admirable memorandum advocating the setting up of hostels, but how the money or staff will be found to run even one is uncertain. To think of "aftercare" as such is unreal, for treatment cannot be conveniently divided into stages. The most hopeful strategy would be a policy which integrated treatment centres with clubs, community centres, and workplaces where workers reached out to addicts, coupled with the provision of hostels for some of them to live in temporarily. If ever community psychiatry is to have meaning it is in the treatment of drug addiction; psychiatry which sits back in the clinic will merely watch the tide come in.

Several factors are said to precipitate actual rupture of the lung. Strenuous physical effort is the one most often quoted in textbooks, but there is little evidence to support this theory. Respiratory infections have long been blamed, and indeed pneumothorax is rather more frequent in the winter than in the summer months. Other precipitating causes include pressure of the diaphragm, corticosteroid therapy, and menstruation. Right-sided spontaneous pneumothorax occurring at the onset of the menses (and sometimes but not invariably associated with pulmonary endometriosis) was described by E. R. Maurer and others in 1958, but it has lately been reported more frequently.

Excellent descriptions of the clinical features of pneumothorax are available in standard textbooks. However, successful diagnosis rests on an awareness of probability as well as a knowledge of signs. The increasing recognition of myocardial and pulmonary infection in previously healthy young men has distracted attention from pneumothorax as an alternative cause of sudden chest pain and dyspnoea. This tendency has been encouraged by the belief that spontaneous pneumothorax, like tuberculosis, is on the decline—a belief which has now been refuted in a study of nearly a thousand cases among R.A.F. personnel. In this relatively closed community it has been possible to calculate the annual incidence of pneumothorax in otherwise normal young men. It has increased from about 0.25 per 1,000 in the 1950s to over 0.4 per 1,000 in the 1960s, and tuberculosis was incriminated in none of these cases.

The prognosis of spontaneous pneumothorax depends on the cause. It is a dangerous and often mortal complication of obstructive airways disease in older patients. On the other hand, complete recovery is the rule in the larger group of young men with relatively healthy lungs, and in them there is little residual impairment of lung function. Considerable controversy pervades the management of pneumothorax, especially in this latter group. Some clinicians withhold treatment in the majority of cases and even permit some patients to continue at their work. Others recommend immediate re-expansion of the lung by intubation to ensure a more rapid and lasting return to normal function. The prevention of recurrence is also the subject of debate. The rate of recurrence reported in the literature varies from 10 to 60%, though in most large series the rate is around 20%. This uncertainty may account for the widely differing attitudes towards prevention. At one extreme are those who advocate bilateral pleurectomy after the first attack of pneumothorax and at the other those who believe that

Spontaneous Pneumothorax

Laennec knew that emphysematous blebs could cause pneumothorax, but the disease was usually attributed to tuberculosis until H. Kjærgaard and later K. M. A. Perry established a non-tuberculous aetiology in the majority of their cases. It is now accepted that spontaneous pneumothorax most commonly results from the rupture of a pleural bleb or bulla, and such lesions are usually found at thoracotomy even when they are not apparent in a radiograph. The bleb may result from a congenital fault or inflammatory scar associated with a check-valve mechanism due to partial obstruction of a peripheral airway; or it may be one part of a more generalized emphysema. Among the rarer causes of pneumothorax are silicosis, bronchial carcinoma, honeycomb lung, congenital and parasitic cysts, lung abscess, pulmonary infarction, and endometriosis.

20. Poole, G. H., Thorax, 1967, 22, 482.