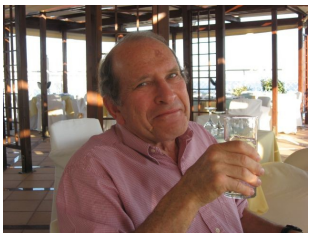
A PATIENT WHO SHOULD HAVE A HEROIN PRESCRIPTION DOESN'T GET ONE BECAUSE SENIOR ADDICTION SPECIALISTS DON'T KNOW THEIR PHARMACOLOGY.



Colin Brewer

The freedom of any British doctor to prescribe heroin for pain often amazes doctors from other countries. Unsurprisingly, most of it is prescribed for cancer but it is also used in other painful conditions. Although Britain has some heroin maintenance programmes for refractory methadone patients, this requires a special licence but any doctor can also prescribe heroin for addicts with documented pain that is inadequately controlled with other opiates or other techniques.

For several years, I treated one such patient (let's call him James) whose mysterious abdominal pain started in childhood after surgery and persisted despite numerous investigations and nerve-blocks. It was a powerful factor in his transition from adolescent experimentation with heroin to becoming a regular user. Previously, I had successfully detoxified him but as I feared and predicted, the pain was unmanageable without opiates. His private heroin prescription cost him very little because I prescribed it as pure but unsterile heroin powder, which he then sterilised for injection by boiling. 1g (nearly 3 day's supply) cost him about £6($9, €8). It wouldn't cost a lot more today. I got this economical idea from another patient who received his heroin in this form from one of our better NHS clinics. Both he and James were law-abiding, responsible, middle-class addicts. James never shared equipment or injected intravenously and heroin's high solubility was ideal for subcutaneous injection. Life wasn't perfect but he could work. To avoid misplaced accusations, I didn't charge him for his treatment but I did think that the NHS should provide it. His GP prescribed for a while but became too frightened to continue, so I referred James to a leading NHS clinic, which quickly agreed that he merited heroin maintenance. Unfortunately, James then became trapped in a bureaucratic game of pass-the-parcel. Two years later, he still had no prescription.

My clinic then became involved in a very high-profile clash with the medical authorities. Among other rulings, we were told not to treat addicts with pain problems but refer them instead to pain clinics (who usually treated them with neither success nor dignity). James still has no NHS heroin. For the past ten years, he has tried methadone and buprenorphine but mostly uses street heroin, paid for by his family. He has never managed to abstain for more than a few weeks. About three years ago, I tried to reactivate the NHS referral. The parcel-passing resumed. After I formally complained, he was seen by another addiction specialist who concluded that he did not merit heroin. Her report contained a common and serious error that is the main reason for this case history.

During one of James's admissions for withdrawal, an eminent NHS specialist, whose experience evidently included no heroin prescribing, had been very alarmed by James's heroin dose, about 400mg/day and pretty low-average for heroin programmes. When he converted this dose to the methadone equivalent, he forgot that whereas slowly-excreted methadone is a once-daily drug, heroin needs 4-6 doses/day. Consequently, he overestimated the methadone equivalent by a factor of >4. Worse, he had consulted his hospital pharmacist, who made the same error. His report claimed we had grossly over-prescribed for James. When the latest specialist wrote her report following my complaint, she included these miscalculations without comment and treated them as correct. It is difficult to believe that they did not influence her decision.

This depressing saga reveals that three experts failed to understand that the standard opiate conversion tables, which they presumably consulted, usually provide only the *dose-equivalents* of the different opiates and not the *24hr-equivalents*. Unfortunately, they are not untypical. From the late 1980s, I regularly suggested a trial of oral morphine to patients who found oral methadone unsatisfactory. No special licence is needed and the evidence-base validates it as a useful alternative. The clinic now maintains several patients on morphine. For 100mg/day of methadone, they typically need about 600mg/day of morphine but the current medical director has several times been reported to the General Medical Council by ignorant or frightened pharmacists for 'excessive prescribing'. These complaints have always been dismissed eventually but he was once suspended for several months by a GMC panel as ignorant as the pharmacists. It's been a while since the last complaint but I'm taking no chances. Two can play at this game and I'm making a formal complaint to the GMC about the latest specialist's report. I would complain about the earlier report as well but the two culprits are protected by the statute of limitations.