

1) Definitions¹

Substance Use Disorder (SUD): uncontrolled use of a substance leads to adverse consequences (e.g. health, or problems at work, school or home). More severe SUDs are may be called addictions.

Addiction's 4Cs: LOSS of **control** over substance use WITH **craving** &/or **compulsive** use which is **continued despite consequences**.

Dependence, physical: a state of adaptation resulting in drug class-specific **withdrawal symptoms** upon abrupt dose reduction, decreasing drug levels or antagonist administration.

Detoxification-managing acute withdrawal: treatment to remove the physiological effects of the addictive substances (protocols).

- **Social Detox:** managed & engaged in recovery; 3-10+ day stay.
- **Brief Detox:** ~24 hour observation; not medically managed.

Harm Reduction: measures to ↓adverse health, social, economic consequences of SUD, to individuals, families & communities without necessarily requiring abstinence or cessation of drug use

Tolerance: ↓effect of a drug over time, or ↑dose required for effect

⇒ **Tolerance & physical dependence should not be confused with addiction.** Addiction is characterized by compulsive use of a substance or preoccupation with obtaining it despite evidence that continued use causes harm (physical, emotional, social, economic).²

2) A Sampling of Statistics (CTADS 2017³; CADUMS 2011/12; PHAC 2021)

- Prevalence, past 1yr: any tobacco (18%), e-cigarette (3%); illegal drugs (3%), cocaine (2%), ecstasy (1%), hallucinogens (1%); problematic psychoactive use to get high or other (i.e. opioid, stimulant, tranquilizers & sedatives, 5%).
 - The rate of drug use cocaine or crack, speed, ecstasy, hallucinogens (including salvia) or heroin by youth 15-24 yrs is much higher (6.5%) than reported by adults ≥25 yrs (1.2%).
 - 72% of non-medical opioids used by students were obtained from home.⁴
 - The prevalence of harm 4x higher among youth aged 15 to 24 yrs (5.5%) than adults aged 25+ yrs (1.4%). (Age adjusted mortality ↑ 5x in urban SUD Boston⁵) {Harm related to social life, health, work, studies, employment, financial, legal, housing, learning.}
 - ~10% report drugs/alcohol as reason for 1st ever sexual intercourse.⁶
 - Opioid toxicity deaths: over 5yrs 2016-2020, there were 21,174. In 2020, half also involved stimulants. An ↑89% was seen during the COVID-19 pandemic.^{5,7}
- Factors : ↑ toxicity of drug supply, ↑ isolation/stress; ↓ access to services

3) Principles of SUD Treatment⁷

- 1) No single tx is appropriate for all; concomitant medications are useful for many; tx needs to be readily available
- 2) For success, attend to multiple needs, not just drug use
- 3) Assess for medical, family, vocational, social & legal services
- 4) Ensure adequate time in treatment (≥3 months)
- 5) Arrange for counselling & behavioural tx
- 6) Integrate tx for those with mental disorders
- 7) Acute detoxification is only the 1st stage of tx
- 8) Tx does not need to be voluntary to be effective
- 9) Drug & alcohol use monitoring should be ongoing
- 10) Assess for HIV/AIDS, HBV, HCV, etc., & counsel re. harm reduction
- 11) Expect a long-term, life-long recovery process with relapses
- 12) Individualize support programs, e.g. self-help & spiritual

Life worth living, without using!

4) SUD Screening: CAGE-AID, AUDIT, Other e.g. SASSI⁸

C – Have you ever felt a need to Cut down or Change your drinking/drug use?

A – Do you get Annoyed when others criticize your drinking/drug use?

G – Have you ever felt Guilty about your drinking/drug use for any reason?

E – Eye-opener: Have you ever felt the need for a drink/drug use early in the morning to steady nerves, decrease hangover or withdrawal?

When assessing a patient's answers to the above questions: one YES suggests caution; ≥ 2 YES suggests strong caution/need for vigilance.

AUDIT: questions to assess alcohol use ⁹	0	1	2	3	4
1) How often do you have 1 drink containing alcohol?	0	≥monthly	2-4x/mo	2-3x/wk	4+ x/wk
2) How many drinks do you have on a typical day?	1-2	3-4	5-6	7-9	10+
3) How often do you have 4+ drinks on one occasion?	0	< 1/mo	1/mo	1/wk	~ daily
4) How often last year were you not able to stop drinking?	0	< 1/mo	1/mo	1/wk	~ daily
5) How often last year did you fail to do what was expected?	0	< 1/mo	1/mo	1/wk	~ daily
6) How often last year have you needed a drink in the morning?	0	< 1/mo	1/mo	1/wk	~ daily
7) How often last year have you had a feeling of guilt after drinking?	0	< 1/mo	1/mo	1/wk	~ daily
8) How often last year have you not remembered the night before?	0	< 1/mo	1/mo	1/wk	~ daily
9) Have you/someone else been injured as a result of drinking?	No		Yes, not this yr.		Yes, this yr
10) Has a relative, friend or doctor been concerned about your drinking?	No				Yes, this yr
Total score: 0-7=low risk; 8-15=at risk; ≥16 likely problems					

Single Question Screen: ⇒ How many times in the past year have you used an illegal drug or prescription med for nonmedical reasons?

History – Use a non-judgmental, non-stigmatizing approach:

Ask first about socially acceptable drugs: caffeine, nicotine
Ask next about CBD & alcohol, specifically beer & wine; quantity used.
Then ask about high-potency cannabis, & illicit drugs. Don't rely on intuition!
⇒ Are illicit drugs available at school/work? What triggers craving?
⇒ Do you have any close friends who sometimes use drugs?
Obtain collateral information from family & friends as necessary; confirm patient history & assess for recent behaviour changes.
Ask re. weight loss, sleep disturbance, impotence, gambling, porn.

Physical findings (intoxication, withdrawal, other):

- Evidence of associated infections, hepatitis, HIV, oral thrush
- Needle marks, including hidden sites; STDs; pupil size, ↑HR, runny nose, watery eyes, sweating, slurred speech, yawning, unsteady gait
- Lab: LFTs, HBV/HCV/HIV & drug screens (e.g. UDT as at bottom of page)

5) RED Flags – Aberrant Rx Drug Use^{10,11}

Consider: Brief Intervention/Discontinuation/Referral if...

1. Prescriptions from multiple physicians (check prescription profile)
2. Frequent visits to emergency room requesting drugs of abuse
3. Requests from patients outside local area! Check picture ID!
4. Stolen, modification or tampering of prescriptions
5. Polypharmacy with CNS depressants, habituating substances
6. Forgery, selling, stealing, or using other persons' medications
7. Injecting oral or chewing long-acting formulations

Reassess Regimen &/or Treatment Agreement if...

1. Rapid ↑ in doses e.g. opioid especially if ≥ 90mg morphine equivalent in CNCP
2. Frequent early refills, excuses for running out of, or losing Rx's
3. Aversion to concurrent recommended non-opioid tx or UDT
4. Request for brand-name vs generic & short vs long-acting meds
5. Missed follow-up visits, lack of adjunct analgesic refills

6) Adopting a Continuum of Care Approach for Substance Use Disorders¹²

CONTINUUM OF CARE	HARM REDUCTION	Screening	Identify those who may be at risk
		Assessment	Diagnose, assess severity, & intensity of tx needs
		Brief Interventions <i>Ask, Assist, Advise</i>	Provide harms info; explore motivation to change
		Special Access Clinics	Option of specialist involvement when needed
		Community Outreach	Education, harm reduction resources, referrals, outreach programs
		Withdrawal Management	Interim pharmacological & psychological supports
		Pharmacological Interventions	Sometimes an option to help achieve desired outcomes in SUD
		Psychosocial Interventions	CBT, contingency management, counselling
		Recovery, Sustaining Wellness & Ongoing Care	Ongoing supports, formal & informal, to help change lifestyle & behaviour

A SUD is a chronic disease. Patients with a SUD will require acute & ongoing intervention. A continuum of care approach supports patients in accessing various levels & intensities of care over time. An effective team approach is often the critical factor toward a successful outcome.

Best Practices (Adapted)¹³

- 1) The individual experiencing harm should determine ultimate goal of treatment (e.g. safer use, substitution therapy, abstinence, etc.) with input from provider
- 2) **Determine treatment plan together.** Offer stepped care with least intensive services first (collaborate; offer menu of options)
- 3) Assess, address, coordinate all wellbeing components
- 4) Ensure services are **culturally, trauma & gender informed**
- 5) **Reduce stigma** to overcome major recovery barriers
- 6) Peer-engaged and peer-led services help with trust
- 7) Enhance outcomes by being **recovery-oriented**

Harm Reduction Measures (See chart)

- 1) **Address risks for other diseases** (e.g. HIV, Hep C, syphilis)¹⁴
 - a) screening, b) needle distribution & exchange programs, c) vaccinations, d) counselling regarding risky behaviours, e) safer smoking options, f) referral, related services g) oral hygiene
 - 2) **Educate regarding responding to overdose** (including recommending take-home naloxone; [see chart](#))
 - 3) **Inform re supervised consumption services when available**
- A non-judgmental attitude is a key for success!**

Emerg Presentation & Possible Causes: •**Unresponsive:** hypoglycemics, opioids, EtOH, cyanide, CO, tranquilizers, hydrocarbons, barbs. •**Seizures:** hypoglycemics, amphetamines, cocaine, hallucinogens, anticonvulsants, TCAs, PCP, meclizine. •**Hyperthermia:** salicylates, Ecstasy, atropine, phenytoin. •**Hypothermia:** EtOH, opioids, sedative/hypnotics, TCAs, barbs, CO

Links: WHO: http://www.who.int/topics/substance_abuse/en/; Medline Plus: <http://www.nlm.nih.gov/medlineplus/substanceabuseproblems.html>; AAFP: <http://familydoctor.org/familydoctor/en/diseases-conditions/opioid-addiction/treatment.html>;

National Institute on Drug Abuse: <http://www.nida.nih.gov/>; Community Learning Network (CLN): http://www.cln.org/themes/substance_abuse.html; Opioid & Stimulant Identification pics: ¹⁶

Links-CDN: Canadian Centre on Substance Abuse (CCSA): <https://www.ccsa.ca/>; CAMH: <http://www.camh.net>; **SK link¹⁷ Pregnancy/Lactation:** <http://www.camh.net/pregnancy/>;

National Anti-drug Strategy: <http://www.nationaldrugstrategy.ca/index.html>; Éduc'Alcool: <http://www.educalcool.ca/en/>; RxFiles AUD link: http://www.rxfiles.ca/rxfiles/uploads/documents/members/CHT_Alcohol-Use-Disorder.pdf

Responding to aberrant behaviour: Do not debate the motive; rather get agreement that such behaviour is problematic. Then delve into the root cause of the problem.

Do's: Educate - Celebrate Success - Encourage - Implement Non-drug Approaches e.g. for insomnia - Prescribe Exercise & Healthy Eating - Find Support Groups

Urine Drug Screening (UDS): to monitor medication compliance & identify/manage SUD risks.

- **Immunoassay:** rapid, inexpensive & preferred for initial screening. **Chromatography:** ↑\$, delay but ↑ accuracy.
- Assess drug causes for false positives. • Ensure proper collection technique & integrity of specimen.
- Goal is to improve patient care & communication, NOT to police!!! Discuss unexpected results with patient.
- Is prescribed drug there? Are any non-prescribed drugs there? • [See UDS chart](#)
- If issues identified, advise of consequences, tighten boundaries, refer to addiction service/specialist when necessary

Drugs/Substances of Abuse & slang terms		Signs/Symptoms: Overuse/Health Concerns		Management & Treatment Options; Comments ^{18,19} Acute intoxication; Withdrawal symptoms		
Cannabinoids ²⁰ (THC = delta-9-tetrahydrocannabinol) Hashish dried hemp flower resin - boom, hash, hemp <small>Synthetic: Spice, K2</small> Marijuana dried hemp - dope, grass, joints, pot, weed. cannabis : blunt/shatter/budder/crumble; concentrates (↑potency=↑risk) {may be "spiked" with cocaine, meth, methylphenidate; pesticides} ganja		⇒ euphoria, impairment learning & reaction time, ↑accidents MVA; panic, confusion, ↓balance, coordination; ↑HR, ↓BP _{orthostatic} , ↑appetite → pulmonary dx/cancer: physical smoke; ↑psychosis risk; renal synthetic → assoc. problems : physical, psych, financial, legal & social (failure to achieve), ↓testosterone gynecomastia; hyperemesis (rare)		Acute intoxication : 1-3 hour; similar to alcohol; changes in mood, perception & fx ↑accidents can persist Withdrawal syndrome : anger, anxiety, irritable, insomnia, etc. Peak ~2-6 days ⇒ CBT & supportive tx Legal cannabinoids for medical use : ⇒ consider if indicated: see RxFiles Cannabis Chart ²¹ {Urine drug testing (UDT) available; remains +ve: 1-3 days with single use, ~10 days casual use, 2-4 weeks in heavy use, months in chronic heavy use. NOTE: nabilone does not show up on UDS} (See chart pg 139-140)		
Hallucinogens, Misc (Δs: perceptual, cognitive, ECG) LSD lysergic acid diethylamide - acid, cubes, microdot, ... Other: Mescaline buttons, cactus, mesc, peyote; Psilocybin		⇒ altered state of perception & feeling; persisting flashbacks ⇒ ↑body temp, HR, BP; ↓appetite, ↑5HT, ↓sleep, weakness, tremors (LSD & mescaline); mental disorders long-term (esp LSD)		LSD : most potent; psychedelic effects: onset <1 hour; duration <8 hours; psychotic effects persist 2+ days Treatment: ⇒ provide calm, supportive environment [still used in college; squares on eyes to absorb] Psilocybin : magic mushroom, purple passion; chewed ⇒ nervousness, paranoia. Mescaline : usually turns out to be something else		
Opioid/Opiate	Codeine +/- acetaminophen - cody, doors & fours, lean, loads, ... FentaNYL DURAGESIC - China girl, TNT, Tango & Cash Heroin diacetylmorphine - brown sugar, H, junk, skag, smack HYDROMORPHONE - DILAUDID, dillies, dilly-2 or -4, beads HYDROcodone combo's- Vike, Watson-387. Meperidine DEMEROL - demmies. Loperamide :IMODIUM central opioid @ >70mg/day - poor man's methadone Morphine MS CONTIN - M, the down, Miss Emma, ... {reds=200mg; greys=100mg; peaches=60mg; purples=30mg} Opium - big O, black stuff, gum, hop Oxycodone OXY-CONTIN, OxyNEO - Oxy, O.C., killer. {Contaminants may be an issue; e.g. heroin-anthrax ²² , botulism. If prescribing opioids, counsel to store properly & avoid sharing!!! }		⇒ analgesia, euphoria, drowsiness, nausea, constipation, confusion, ↓libido/ED, sweating; sleep apnea. On overdose: resp. depression <12/min, coma; ↑death esp with benzos/gabapentin ²³ If heroin ⇒ staggering gait; possible cardiac manifestations (duo to ↑QT) ⇒ seizures (especially propoxyphene DARVON-N, meperidine DEMEROL, tramadol, combo pentazocine TALWIN + tripeleminamine T's & blues) → long-term tolerance, hyperalgesia; Desomorphine KROKODIL: homemade inj; corrosive; necrotize tissue; green scaly lesions) ◆ Be careful to distinguish between appropriate use versus an opioid use disorder; there is some overlap in presentation ◆ Always check med profile for hx of opioid, benzo, etc. use! ◆ Address withdrawal: with tapering or opioid agonist therapy ◆ ↑ Overdose risk if restart same dose after abstinence period!		Acute toxicity : ⇒ reversed by naloxone NARCAN, an opioid antagonist 0.4 - 2mg IM, may repeat after 2-3 minutes, Max 10mg; or intranasal Lasts 45 min-4 hours. May precipitate withdrawal (agitation severe, anxiety, NV/D, yawn, sneeze, rhinorrhea, cramps). (Deaths often associated with co-use of other CNS depressants. Contaminants: MPTP parkinsonism, quinine, strychnine). Withdrawal : lacrimation, rhinorrhea, yawn, dilated pupils, NV/D, diaphoresis, chills, ↑HR & BP, myalgia, cramps; anxiety, dysphoria, craving, restless, insomnia, fatigue. ◆onset <8 hrs from last use; peaking between 36-72 hrs; physical withdrawal resolves in 5-10 days; longer with methadone onset in 24-48 hrs; persists 2-3 wks. Symptomatic Tx of Withdrawal : see chart pg 133 (Consider local protocols) ²⁴ . Overall goals in opioid use disorder (OUD) are to achieve recovery through ↓withdrawal symptoms, manage/↓cravings, prevent relapse, ↓harm. Core components include: opioid agonist therapy (OAT) with buprenorphine or methadone. [See OUD/OAT chart, pg 136-138] Buprenorphine : partial μ-agonist: e.g. PO buprenorphine + naloxone SUBOXONE; SC buprenorphine/SUBLOCADE; Implant buprenorphine/PROBUPHINE Methadone : very LA μ-opioid agonist; daily admin; Many DIs: e.g. ↑QT. OAT: ↓cravings: prevent withdrawal without intoxication. Clonidine : α-2 adrenergic agonist; non-opioid withdrawal tx option. Harm reduction: e.g. Provide naloxone kit! Naltrexone : opioid μ antagonist block analgesia & euphoria; -50mg/d; hepatotoxic if high dose FDA. VIVITROL monthly FDA	
	Alcohol ^{25,26,27} - ETOH, booze, liquor ... {zero-order kinetics} ⇒ major fetal harm (FASD)		⇒ withdrawal esp if >4drinks/wk: tremor; Lab clues: ↑MCV, ↑GGT; ↑ca ⇒ ↓inhibitions (may result in ↑anger/violence, unplanned sex, inappropriate speech) ⇒ ↓HR, BP & RR ⇒ drowsy, ↓concentration; fatigue, confusion ⇒ impaired coordination, memory & judgement ⇒ slurred speech {Seizures on withdrawal, esp if previous hx; alprazolam particularly of concern.}		Respiratory Depression & Coma : ⇒ tx intubation & ventilation; Hypoglycemia (e.g. with excessive ETOH in kids); ⇒ tx IV glucose Alcohol : Social Norms Interventions (limit to "moderate drinking" & avoid binge drinking.) Consider cultural factors. Long-term Skills Interventions (e.g. drinking myths, drink refusal & assertiveness skills): ↓over-drinking risk Stimulus Control (avoid/limit friends & places visited); Coping Skills; 12 Step Facilitation Therapy http://www.aacapubs.com/12s.htm Drug Tx: Acute : benzos for tremor (diazepam; lorazepam if hepatic dysfx or elderly; gabapentin ²⁸ ; pregabalin ²⁹); tiamide- see pg 221. ↑clonidine Long-term: Naltrexone ReVia, DEPADE; Acamprosate CAMPRAL; ↑. Topiramate off label ³⁰ See Alcohol Use Disorder (AUD) Chart , pg 221-222 Disulfiram compounded from powder ANTABUSE; blocks ALDH enzyme inducing dizziness, flushing, N/V, ↓BP (aversion treatment); GBH : onset rapid ~10min; duration ≤2-4 hrs. Flunitrazepam: onset rapid 15min; duration ≤6 hrs. Gabapentin 900-1800mg/d ✓ Oral benzodiazepine : Acute intox. rarely lethal, except with alcohol or CNS depressants; ⇒ flumazenil ANEXATE inj (benzo antagonist): useful but may cause acute withdrawal/seizures; avoid routine use. Long-term withdrawal: diazepam or clonazepam tapering protocols	
	GHB Gammahydroxybutyrate - G, grievous bodily ham, liquid ecstasy GBH, soap, easy lay; "date rape"; clear liquid often mixed (ETOH)		⇒ HA, loss of reflexes, memory; seizures, coma, death Resp depr		⇒ ↓HR, BP & RR ⇒ drowsy, ↓concentration; fatigue, confusion ⇒ impaired coordination, memory & judgement ⇒ slurred speech {Seizures on withdrawal, esp if previous hx; alprazolam particularly of concern.}	
	Flunitrazepam - R2, Roche, roofies/roofied, rope ROHYPNOL - "date rape"; forget me pill; roofinol Barbiturates - barbs, reds, phennies, yellows Benzodiazepines - candy, downers, sleeping pills Ativan, Halcion, Librium, Valium, Xanax Alprazolam; Etizolam, [benzos]		⇒ visual & GI disturbance; drowsy; urinary retention; memory loss ⇒ depression, irritable, dizzy		⇒ ↓HR, BP & RR ⇒ drowsy, ↓concentration; fatigue, confusion ⇒ impaired coordination, memory & judgement ⇒ slurred speech {Seizures on withdrawal, esp if previous hx; alprazolam particularly of concern.}	
	Methaqualone - ludes, mandrex, quad, quay		⇒ euphoria, depression; coma		⇒ ↓HR, BP & RR ⇒ drowsy, ↓concentration; fatigue, confusion ⇒ impaired coordination, memory & judgement ⇒ slurred speech {Seizures on withdrawal, esp if previous hx; alprazolam particularly of concern.}	
Stimulants	Amphetamine DEXEDRINE - bennies, speed, uppers, ... Methylphenidate RITALIN (CONCERTA has ↓ abuse risk!)		⇒ tremor, ↓coordination, irritable, restless, aggressive; IV trackmarks ⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.		Cocaine : onset ~5 min; peak/duration: snort <30-60 min, oral <90min, IV <5min; t½=1 hr; longer in body packers } most toxicity too brief to tx; anxiety/seizures/↑temp ⇒ benzodiazepine; ↑BP ⇒ nitroprusside/NTG; CV toxicity ⇒ BZ ↓sympathetic stimulation, ASA ↓thrombus, NTG (or CCBs: verapamil or diltiazem) ↓vasoconstriction, O2. (β-blockers: caution!) Sinus bradycardia long-term. Amphetamines other: similar toxicity (& tx) as cocaine but ↓ duration. Strokes: hemorrhagic & ischemic. Life-threatening hyperthermia >39! Psych sx's may persist. Meth: duration 6-8hr; tooth decay. Ritonavir: DI & ↑risk fatal overdose. ³¹ Ecstasy : onset: 20 min; peak: 2-3 hrs; duration: ~4 hrs. Amphetamine like CV effects, rhabdomyolysis, stroke, death ³² Seizures common cause of ER visits ⇒ usual tx; persisting cognitive impairment. Contaminants (amphetamines e.g., PMMA) ⇒ lethal overdose (hyperthermia: tx with rapid cooling, etc. +/dantrolene or cyproheptadine). Ritonavir: DI, ↑risk fatal overdose. ³³ Young-healthy: high risk → Long-term: memory/motor impairment; psychosis; MI chest pain, stroke ICH. (↑DA & ↑NE release.) Explosive/fire risk if making! ^{34,35} Stimulant Use Disorder Tx : behavioural tx e.g. CBT; insufficient evidence for pharmacotherapy [See chart pg 220]	
	MDMA 3,4-methylenedioxymethamphetamine. Ecstasy -E,X,XTC adulterants common: Adam, lover's speed, hug, clarity, Molly		⇒ hallucinogen mild; impairment; ↓Na ⁺ , ↑temp; toxicity (cardiac, renal & hepatic)		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
	Methamphetamine - crystal meth, speed, ice, pint, jib, gak, (made from pseudoephedrine) glass, white, lady, fire, tina, pink, chalk, crank		⇒ aggression, violence, psychotic behaviour; CV & neurological damage		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
	Amphet. analogues designer drugs: [MDA love drug, MDEA Eve; PMA Death (similar to MDMA); MDPV bath salts]		⇒ ↑temp, chest/GI pain, resp failure; HA, seizure, panic; MI, vasoconstriction; talc ⇒ pulm fibrosis, HTN; long-term ⇒ excited delirium, rhabdomyolysis; "coke nose" or deviated nasal septum common with long term use (irreversible; requires plastic surgery)		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
Various	Cocaine Erythroxyl coca leaf - blow, C, candy, coke, snow, adulterants common (e.g. levamisole, clenbuterol, benzocaine, sugar, talc) ^{36,37} ; crack freebase, solid (smokeable) 92% pure		⇒ impaired motor fx, memory loss, numbness; ketamine ↑HR, ↑BP ⇒ ketamine: delirium, depression, respiratory depression, ↓bladder capacity ⇒ PCP: ↓BP, ↓HR; panic, aggression, violence; ↓appetite		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
	Dissociative Anesthetics (floating, out of body) ◆ Ketamine Ketalar SV - K, Kat, cat Valiums, Special K ◆ PCP Phencyclidine - angel dust, love boat, peace pill		⇒ acne, hostility, aggression; long-term ↑BP, ↓clotting, ↑stroke, hepatic cysts/ca, renal ca; premature growth stagnation, depression		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
	Steroids, Anabolic - Andriol, testosterone, andro, etc; nandrolone, androsterone, stanozolol {common in unapproved products}		⇒ stimulation, ↓inhibition, HA, N/V, slurred speech, ataxia, ↓coordination, cramps, ↓wt, depression; resp depr, coma		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
	Volatile Inhalants - solvents, gases, nitrites whippits N2O {Toluene: paint, lacquer, glue}, poppers liquid gold, rush; puffers		⇒ stimulation, ↓inhibition, HA, N/V, slurred speech, ataxia, ↓coordination, cramps, ↓wt, depression; resp depr, coma		⇒ ↑SHT: ↑HR, BP, energy, wt loss; hyperkinesia, alertness; ↓appetite, insomnia, nervousness; violence?; ↑Parkinson's risk? ⇒ high followed by the crash! lethargy, anhedonia, ↑sleep, irritable → HF, MI, CVA; seizure, hyperthermia, abruptio.	
Other: Baclufen; BuPROPION deaths reported with inj & inhalation; Caffeine : e.g. energy drinks ³⁸ ; wt loss ³⁹ ; withdrawal esp if >100mg/day (HA ^{50%} , fatigue, drowsy, irritable), over ≤ 9 days. Dextromethorphan (DM) : euphoria at 5-10x usual dose - Robotripping (sweat, ↑HR, ↑BP, dyskinesias, speech disorders, N/V, mydriasis, photophobia, ↓resp), ↑5HT; blocks NMDA. Dimenhydrinate & Diphenhydramine: Gabapentin NEURONTIN: (gabie) snort/inject high dose for euphoria (400mg caps of choice); potentiate or ease withdrawal from alcohol, cocaine. 40%: Oxybutynin; Pregabalin LYRICA: ~euphoria 4%: Propofol health professionals. QUETiapine SEROQUEL ⁴¹ : (quell, baby heroin, Susie-Q, Q-ball = Q + cocaine); PO, intranasal, & IV cooked, then injected; use ↓BZ withdrawal, as sedative/anxiolytic or ↑heroin effect; dose reported ~200mg-2400mg/d; alternatives antipsychotics, SSRIs, buspirone, VPA, lithium.						
BP =blood pressure BZ =benzodiazepine ca =cancer CV =cardiovascular DM =diabetes ED =erectile dysfx FAS =fetal alcohol syndrome fx =function HA =headache HCV =hepatitis C Hep =hepatitis HR =heart rate LA =long-acting LFTs =liver fx tests NV/D =nausea/vomiting/diarrhea sx = symptoms tx =treatment wt =weight Other : Gambling, gaming, porn, sexual addictions/behaviours & intimate partner violence may also be present/require tx. Club Drugs raves: Ecstasy, Rohypnol, ketamine, crystal meth, GHB, poppers. Nicotine [See chart, ⁴²]: cigarettes, cigars, snuff, chew, hookah ⇒ ↑CV/ca Impurities/Adulterants : common! Risk of: bacterial (endocarditis, osteomyelitis, sepsis), fungal, viral (HIV/AIDS) infection in IV users (needle sharing) & crack cocaine smoking ⁴³ . Bleach in meth, Talc from tabs crushed for inj. causes pulmonary granulomas. Levamisole rash, neutropenia. Lead. Pregnancy : ⁴⁴ Club drugs (MDMA, Rohypnol, GHB, ketamine), Cocaine , EtOH : avoid (malformations/abortion). Amphetamines : weigh benefit/risk; not teratogenic. Cannabis : avoid (↓cognitive development/↑stillbirth risk). Opioids : Opioid Agonist Therapy (OAT) ↓risk (See pg 135-136)						

Management Of Substance Abuse In Emergency {To contact poison centre in your Canadian province: <http://capcc.ca/provcentres/centres.html> }

Aim: ↓ morbidity & mortality; ↓ risk of relapse; consider plan short & long term

Assessment & Management issues:

- **Infections:** soft tissue; other (endocarditis, HIV, hepatitis, etc.)
- **Overdose vs Intoxication vs Withdrawal vs Other** {Other e.g. subdural hematoma from fight, stroke, infectious component}
- **Consider detailed assessment if:**
 - o Acknowledgment of drug use
 - o Physical signs e.g. track marks, nasal septum atrophy
 - o Urine drug screen +ve {Note: emergency drug screen is unlikely to significantly affect impact upon management in the ER.⁴⁵}

- **Approach for engagement**
 - o Accept patient autonomy
 - o Non-judgemental approach/[Motivational Interviewing](#)
 - o Collaborative approach with patient
 - o Confidentiality
 - o Proactive discussion on meds and behaviours
- **Managing Potentially Violent Patient⁴⁶:**
 - o Have a staff & public safety plan!
 - o Maintain autonomy & dignity of users, intervene early, approach patients with caution, don't startle, avoid provocation, be aware of your own demeanour, use calm

language, don't make promises, provide options and choice, remove dangerous objects from your person, know exits, don't turn back on patient, role for distraction, be firm & compassionate, depersonalize issue; avoid confronting, but if necessary maintain distance, avoid corners/cornering, explain intension, ask for facts & encourage reasoning, ask for weapons to be put down not handed over, know how to call for help.

Antipsychotics are not 1st line for substance abuse withdrawal. If in a controlled setting, temporary use of a benzodiazepine may be preferred.

Intoxication: Common Presentations – Possible Causes ^{47,48}

- **Unresponsive:** hypoglycemics, narcotics, alcohol, cyanide, carbon monoxide, tranquilizers, hydrocarbons, barbiturates
- **Seizures:** hypoglycemics, amphetamines, cocaine, hallucinogens, anticonvulsants, TCAs, PCP, mescaline; benzodiazepine withdrawal especially high dose ; alcohol withdrawal tremors/seizures
- **Hyperthermia:** salicylates, Ecstasy, atropine, amphotericin B, phenytoin
- **Hypothermia:** ethanol, narcotics, sedatives/hypnotics, TCAs, barbiturates, carbon monoxide.
- **If mixed presentation consider possibility of mixed ingestion!**

For table outlining Toxic Syndromes or “toxicidromes”, see Goldfrank’s Toxicologic Emergencies ⁵⁶

Intoxication Management - [Primary assessment ABCs: airway, breathing, circulation]

Opioids	Intoxication {coma, lethargy, stupor; constipation, N&V; flushing, pruritis; hypotension; miosis; resp depression} <ul style="list-style-type: none"> ♦ supportive tx; regular assessment of cardio/respiratory safety ♦ airway protection; ♦ correction of hypoxia ⇒ naloxone option: short term duration; balance reversal of resp depression with opioid withdrawal (naloxone can be considered if opioid toxicity suspected). ♦ consider type of opioid for duration of risk & naloxone effect ♦ consider N-acetyl-para-aminophenol level if overdose cause unknown (r/o acetaminophen as possible agent). CAUTION: depending on timing, a “non-toxic” level can become toxic; consult poison centre
Stimulant	Supportive tx {agitation, diaphoresis, hypertension, hyperthermia, mydriasis, psychosis, seizures, ↑HR} <ul style="list-style-type: none"> - oral diazepam or lorazepam for agitation & hypertension e.g cocaine induced - IV lorazepam, diazepam or midazolam short acting if severe agitation/anxiety - Optional (if predominant psychosis): sedating antipsychotic (e.g. olanzapine, risperidone, quetiapine) {Avoid mixing benzodiazepine & antipsychotic if possible due to risk of oversedation & respiratory AE - Monitor: hyperthermia, hypothermia, cardiac, electrolytes - HTN: benzodiazepines; alternatively nitroprusside, NTG - α-blockers. {generally avoid β-blockers as will result in unopposed α constriction} <p>See also Stimulant Use Disorder Chart</p>
Alcohol	Supportive tx {immediate life-threatening complications in kids are respiratory depression & hypoglycaemia} <ul style="list-style-type: none"> ♦ airway; ♦ IV access (fluid management); correct hypoglycaemia with dextrose soln & electrolytes; ♦ thiamine

* **Hemodialysis** may be an option in life threatening intoxication. Hemodialysis may be useful to remove barbiturates, sedatives, hypnotics, anticonvulsants, alcohols, analgesics, solvents, etc.

When to Discharge? ♦ Consider time from last ingestion. ♦ Can they walk unaided?

Extras (RxFiles - Substance Abuse)

- o if using cocaine/other stimulants then detox is the only option. Rapid detox is not recommended during pregnancy.
- o Patients should only be “nodding” (falling asleep on methadone) if the dose is too high, they are a new start, or if they using BZD’s at the same time – may consider a tox screen to assess if patient is also using any other drugs
- o In Saskatoon methadone doses goes up by 10mg increments and down by 5mg increments for dose adjustments with some physicians.
- o Using both oral LA morphine (Kadian) in addition to methadone when starting patients is sometime done to prevent acute withdrawal & allow for methadone titration (e.g. a few weeks of dual treatment); controversial.
- o IV drug abusers: considerations see reference ⁴⁹
- o Other substances of abuse: volatile inhalants, Listerine mouthwash
- o Be weary of illegitimate on-line pharmacies which supply controlled substances without a prescription.⁵⁰

Acute Alcohol Intoxication ^{51,52}

- **Blood Alcohol Levels (BAL):** <50mg/dl (< 10.9mmol/l): impairment in skills, ↑ talkativeness, relax; ≥100 mg/dl = impaired judgement, ↓ coordination & reactions, mood/personality change; > 200 mg/dl: amnesia, diplopia, N&V; >300-500 mg/dl = ↑ risk of respiratory depression, coma & death
- **DSM-IV:** A) recent EtOH, B) clinically significant behavioural/psychological change e.g. aggression, mood, impairment C) one or more of [1. slurred speech, 2. ↓coordination, 3. unsteady gait, 4. nystagmus, 5. ↓ attention/memory, 6. stupor/coma, other.]
- **Other effects & associations:** Respiratory, GI, alcoholic hepatitis. ↑ risk of injury, ↑ risk of life years lost, ↑ violent crimes.
- **Tx:** 1) Stabilize patient: [airway, resp fx, prevent aspiration, mechanical ventilation prn, IV access & correction of hypoglycaemia, electrolytes (dextrose, Mg, folate, thiamine, multivitamins); 2) Sedate patient (droperidol, haloperidol); 3) evaluate for chronic EtOH abuse; Ref: Ostacher MJ et al. Impact of substance use disorders on recovery from episodes of depression in bipolar disorder patients: Prospective data from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). *Am J Psychiatry* 2009 Dec 15; [e-pub ahead of print].
- **When to let them leave the emerg?** Consider holding till they can walk out unassisted.

Management of Cocaine Body Packers ⁵³:

Hx: # & type of packets; other agents; GI symptoms; **Investigations:** ECG, CBC/SCR, etc., chest & abdom x-rays; **Management if asymptomatic:** admit, oral gastric lavage till all packets passed; 4 hr observations of vitals after packets passed; light/normal diet, IV access, daily evaluation for intoxication/bowel obstruction.

Lifespan Spectrum of Complications: **Pregnancy** - obstetrical complications, fetal distress, stillbirth, low birth weight; **adolescent & young adult** – self inflicted injuries, homicides, premature morbidity; **Later life** - ↑ decline. {Associate health problems: non-fatal overdose, ↑ infections IV and NIDU (HCV; Hepatitis A, B); liver fibrosis cannabis, periodontitis cannabis; psychiatric (psychosis, anxiety, depression) various, cannabis; long-term ↓ cognitive performance.}⁵⁴

Substance Abuse in Older Adults ⁵⁵: 2005 USA data on treatment programs: Alcohol only (48%), alcohol + 2nd illicit substance (52%); 2nd substance cocaine 40%, marijuana 29%, opiates 16%, stimulants 5%, other 10%.

♦ **Signs:** headache, ↓ cognitive/memory ability; **Unique features** in elderly: tendency to drink smaller quantities more often, DI with ↑ metabolism of other drugs, Δ in sleep patterns. **Clues:** recent losses, psych hx, family hx of abuse.

ALDH=alcohol dehydrogenase **5HT**=serotonin **fx**=function **HCV**= hepatitis C virus **HX**=history **NIDU**= non-injecting drug users **Qt**=qt interval **RR**=respiratory rate

Extras Continued: Quotes

- ♦ "it takes more than 2½ minutes to assess a patient for a possible opioid prescription" ; a challenge, especially for busy walk-in and minor emergency types of practice
- ♦ "it takes only 30 minutes to argue, but only 30 seconds to write a Rx"; reflecting the realities and frustrations of everyday practice.

www.RxFiles.ca – Substance Abuse

- ♦ "Its OK to say 'No'"
- ♦ "I didn't realize how big a problem Rx opioids were on the street"

UK Study Ranking - most harmful drugs: overall, to individual and to society.

- o Nutt DJ, King LA, Phillips LD: on behalf of the Independent Scientific Committee on Drugs. Lancet. 2010 Oct 29. Drug harms in the UK: a multicriteria decision analysis.
- o BACKGROUND: Proper assessment of the harms caused by the misuse of drugs can inform policy makers in health, policing, and social care. We aimed to apply multicriteria decision analysis (MCDA) modelling to a range of drug harms in the UK. METHODS: Members of the Independent Scientific Committee on Drugs, including two invited specialists, met in a 1-day interactive workshop to score 20 drugs on 16 criteria: nine related to the harms that a drug produces in the individual and seven to the harms to others. Drugs were scored out of 100 points, and the criteria were weighted to indicate their relative importance. FINDINGS: MCDA modelling showed that heroin, crack cocaine, and metamfetamine were the most harmful drugs to individuals (part scores 34, 37, and 32, respectively), whereas alcohol, heroin, and crack cocaine were the most harmful to others (46, 21, and 17, respectively). Overall, alcohol was the most harmful drug (overall harm score 72), with heroin (55) and crack cocaine (54) in second and third places. INTERPRETATION: These findings lend support to previous work assessing drug harms, and show how the improved scoring and weighting approach of MCDA increases the differentiation between the most and least harmful drugs. However, the findings correlate poorly with present UK drug classification, which is not based simply on considerations of harm. FUNDING: Centre for Crime and Justice Studies (UK).

Salvia leaves (magic mint, diviner's sage, sally D, purple sticky)

- o Member of mint family, smoked or chewed. Contains salvinorin A, a selective kappa opioid receptor antagonist; does not bind to 5HT_{2A} receptors like other hallucinogens. Hallucinogen effects rapid & last <30min. SE: dysphoria, diuresis, chills, headache, insomnia, exhaustion, loss of control, impaired coordination & judgement (= DANGEROUS!). Sensationalized in SK by Saskatoon media DJ who smoked herb on live broadcast in Dec 2010.

Angel's Trumpet: (Angel's tears, Apple of Peru, Green Dragon, Devil's trumpet)

- o Alkaloid (atropine, scopolamine) containing flowers & stem. Each flower contains 0.2mg atropine & 0.65mg scopolamine; 3-6 flowers causes hallucinations; 9+ flowers can be life-threatening. Commonly ingested by making a tea. Effects in 1-4hrs; duration 24+hrs. SE: mydriasis, dry mouth, tachycardia, fever, erythema, constipation, ↑↑ thirst, retrograde amnesia & anxiety; arrhythmias & CV collapse / respiratory failure in high doses. (= DANGEROUS!)

"Bath Salts" PABS for abuse: are actually designer stimulants (e.g. methylenedioxypropylvalerone-MDPV, NRG-1; mephedrone-M-Cat, Meow, 4-MMC, Bubbles; methylone-methylenedioxyamphetaminone, bk-MDMA, M1, Explosion) being sold in shops & online. Cloud 9, Ivory Wave, Vanilla Sky, Purple Wave, Blizzard, Blue Silk, etc. Common in UK, now USA via New Orleans, India, China.

Similar effects (↑HR, paranoia, psychosis) & tx as stimulants. May/11 CDC: MMWR- Emergency Department Visits After Use of a Drug Sold as "Bath Salts" --- Michigan, November 13, 2010–March 31, 2011 <http://www.cdc.gov/mmwr/pdf/wk/mm60e0518.pdf>

Two common ingredients: MDPV (a dopamine & norepinephrine (NE) reuptake inhibitor → stimulant); mephedrone: MAOI effects that ↑ 5HT, NE, & DA at neuronal synapses (AEs: agitation, aggression, anxiety, bruxism, chest pain, confusion, diaphoresis, headache, hyperreflexia, ↑BP, N&V, palpitations, peripheral vasoconstriction, paresthesia, psychosis, seizure, ↑HR.)

Sep/11: DEA invoked its emergency authority necessary to protect the public & will make Schedule 1 substances in 30 days from now.

Ross EA, Watson M, Goldberger B. Bath Salts Intoxication. NEJM. 2011 Sep 8;365(10):967-8.

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National Institute on Drug Abuse (NIDA) <http://www.drugabuse.gov/publications/drugfacts/synthetic-cathinones-bath-salts>

Spice – ("legal highs"): a range of synthetic drugs; combustible vegetable material sprayed with a variety of chemicals, each slightly different; often mixed with tobacco & smoked; effect (heightened awareness acoustics; imagination; potential for panic & violence; blackouts).

- The most extreme of effects often subside in 15min. Signs: acrid breath smell; higher voice pitch. Withdrawal: cramping, sweating, twitching. Other cautions: Low moods & self harm common. "Not for human consumption!"

Dimethoxybenzeneethanamine (2-CB) – (note 2-CB is a misnomer) a synthetic hallucinogen & club drug; sometimes sold as ecstasy; showed up in Prince Albert, SK, Feb 2017.

Poppers – volatile alkyl nitrite compounds inhaled for enhanced sexual experience. AE: foveal maculopathy (vision disturbance).

Kratom – herbal product, opioid agonist properties; mostly obtained as a powder and consumed as a beverage; doses >15g may produce opioid like toxicity; severe adverse events, including death, have been reported; naloxone may be given (if drowsy/respiratory depression).

Para-fluorofentanyl and metronitazene – two new drugs that are being increasingly associated with overdose deaths in the USA (Jan 2022). https://www.cdc.gov/mmwr/volumes/71/wr/mm7104a3.htm?_cid=mm7104a3_w

Miscellaneous Other Drug Considerations / Cautions

- Salbutamol: sometimes used to enhance effect of crack cocaine
- Benzodiazepines: calming effect
- Bupropion: sometimes messed with & snorted for high
- Quetiapine: may enhance heroin effects & risk
- Vitamin C sometimes used as an acidifier to help dissolve substances (i.e. crack cocaine, heroin) for injection

Harm reduction recommendations for substance abusers at risk of HIV, HCV & other harms (CATIE). Link: <http://www.catie.ca/en/programming/best-practices-harm-reduction>

Oxymorphone OPANA ER Abuse

- Thrombotic thrombocytopenic purpura (TTP) strongly associated with injection drug abuse of OPANA ER.

Buprenorphine/naloxone (ZUBSOLVE), 1.4mg/0.36mg – new SL tab formulation (available in USA); ↑bioavailability & may taste better than Suboxone. (Achieves plasma concentrations = 2/0.5mg and 8/2mg strengths of other Brand tabs.)

Synthetic Cannabinoids – common in herbal incense products

- Full agonists of CB1 & therefore ↑potential for overdose & toxicity
- ↑ association with seeking medical attention. AEs: agitation, altered time perception, anxiety, dysphoria, ↑BP, listlessness, hallucinations/psychosis, nausea, paranoia, seizures, tachycardia.
- Marijuana extraction/concentration ⇒ production of very highly concentrated levels (80-90%) called "Shatter"; easily over consumed resulting in overdose / emergency visits

Videos – informational related to teen drug recreational drug use (for teens, by teens) - Canada

- ♦Unwasted - 4 videos by teens regarding gambling, alcohol, marijuana, opioids/oxycontin: <http://unwasted.ca/>; or <http://unwasted.ca/the-pressures> (★★★★★)
- ♦Mixing prescription drugs and alcohol. <http://itdoesntmix.ca/>
- ♦Your when moment (videos from Nova Scotians): <http://changingtheculture.ns.ca/>

Videos – other

- ♦Addressing the risk of diversion of Rx drugs; secure storage of medications. Powerful. <http://www.youtube.com/watch?v=-sunbJDZe1wh><http://www.youtube.com/watch?v=-sunbJDZe1w>

Guidelines of interest:

Buprenorphine/Naloxone for Opioid Dependence: Clinical Practice Guideline CAMH: http://www.cpso.on.ca/uploadedFiles/policies/guidelines/office/buprenorphine_naloxone_gdlns2011.pdf

Other Links of Interest:

See RxFiles Alcohol Use Disorder Chart: <http://www.rxfiles.ca/rxfiles/uploads/documents/members/CHT-Alcohol-Use-Disorder.pdf> v

Pregnancy Screening: Alcohol, smoking, and other substance use in the perinatal period (BMJ)

Motivational Interviewing – Modules/videos exploring ambivalence in behaviour change: modules/videos of interest: <https://www.youthadtoolbox.org.au/motivational-interviewing>

Get Help for Problematic Substance Use (Patient Links from Health Canada): <https://www.canada.ca/en/health-canada/services/substance-use/get-help/get-help-problematic-substance-use.html>

Low Risk Cannabis Use Guidelines (for youth, by youth): <http://www.camh.ca/en/health-info/guides-and-publications/lrcug-for-youth>

SK Health Links:

www.saskatchewan.ca/addictions; the target audience is the public.

Direct links re Crystal Meth:

- Infographic: <http://publications.gov.sk.ca/documents/13/106826-Crystal-Meth-Infographic-2018.pdf>
- FaQ : <http://publications.gov.sk.ca/documents/13/106827-CM-FAQ-2018.pdf>
- Fact Sheet : <http://publications.gov.sk.ca/documents/13/99220-CrystalMeth%20Factsheet%20Sept%202016.pdf>

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Health Canada Mar/11 **Salvia divinorum** (*S. divinorum*) is a species of sage belonging to the mint family. Some street names for *S. divinorum* include: Sally D, Lady Sally, Maria pastora, ska Maria pastora, ska pastora, diviner's sage, magic mint, puff, incense special, and salvia. Canadians are cautioned against the use of products containing *S. divinorum* and/or salvinorin A because these products are known to cause hallucinations and little is known about the long-term effects of these substances on the brain and body.

Health Canada May/13 has been made aware of three products ("Rochefort", "Rush" and "Amsterdam Special"), commonly known as "poppers", labelled to contain alkyl nitrites. These products, labelled as leather cleaners and/or liquid incense, are known to be used by consumers to get "high" and may pose serious risks to health if they are inhaled or swallowed.

Health Canada Jun/13 Eight products labelled as leather cleaners or liquid incense contain, or allege to contain, **alkyl nitrites** were being sold by Saints N Sinners Ltd, 1715 Centre Street N.W., Calgary, Alberta. These products, commonly known as "poppers" are used by consumers to get "high" and may pose serious risks to health if they are inhaled or swallowed

Health Canada Dec/14 is following up with Rapha Biotech Inc. **Rapha Diet** (630 mg, 270 Capsules) -- undeclared ingredients: amphetamine, methamphetamine.

Health Canada Jun/17 is advising health care professionals and Canadians that the **Canadian authorized version of NARCAN** will transition onto the market by July 5, 2017. NARCAN is a nasal spray form of naloxone, the life-saving drug that temporarily reverses the effects of an opioid overdose.

Health Canada June/18: Health Canada reminds Canadians of the **limitations of fentanyl test strips being used to check street drugs** before consumption.

Health Canada Sep/19 is advising Canadians about the increased risk of **opioid overdose and serious side effects when taking gabapentin (e.g., Neurontin) or pregabalin (e.g., Lyrica)** with an opioid.

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small amount of very low quality evidence that medication was well tolerated. There was no evidence that alcohol use was responsive to medication. Large, rigorously conducted RCTs would help supplement the small evidence-base for the efficacy and tolerability of pharmacotherapy for anxiety and comorbid alcohol use

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