Cocaine Addiction – Key Notes

Type of users	2.4% of 16-59 year olds have used cocaine in the last year 5.9% of 16-24 year olds have used cocaine in the last year M:F ratio of cocaine users around 2:1, majority with GCSE's or higher, in employment and prosperous
Forms of the drug	Coca leaves Powder Crystal ("rock") of freebase variety ("crack")
Street Names	Blow, white, rock (crack)
Purity	Powder 25-29%, crack 44-47%
Cutting agents	Phenacetin, benzocaine
Legal status	Class A controlled drug under the Misuse of Drugs Act 1971
Modes of taking	Chewed Smoking Sniffing Injecting
Patterns of use	Coca leaves are often chewed where the plant grows indigenously, in South American countries, giving a very small constant dose of cocaine with a small effect Infrequent use of chemical forms of cocaine - recreational Daily Binge use (continuous use followed by crash) Psychological, but not physical dependence Combination with heroin (speedball) Use of heroin / alcohol / benzodiazepines "to come down" Formation of cocaethylene when combined with alcohol

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Effects of the drug

Acute – wanted	Acute – unwanted
Euphoria	Paranoia
Energy	Anxiety
Loss of appetite	Acute psychotic episode (cocaine-induced psychosis)
	Insomnia
	Heart attack
	Post-use "crash"

Chronic – wanted	Chronic – unwanted
Sense of improved self-esteem and social standing (illusory)	A variety of physical, psychological and social problems (see Table)
	Nasal septum damage
	Chest problems

Clinical presentations

Occasional use
Intoxication (F14.0)
Harmful use (F14.1)
Dependent use (F14.2)

Natural history

Usually starts in teens and ceases on the adoption of adult roles, particularly marriage and having children (Kandel & Raveis 1989)

3 trajectories (Addiction Research 1994, p3):

1. Most common trajectory is a period of experimentation followed by reduced use and often cessation.

2. Period of moderate regular use, associated with occasional binges, tending towards reduced use and eventual abstinence.

3. Compulsive use leading to personal and social harm in 2% of lifetime users.

Those in treatment will have a 21% abstinence rate at 1 year, which will be around 26% at 5 years

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Modes of presentation

Self-referral to drug treatment unit
Presentation at A&E department / general hospital
Presentation to family doctor

- Consultation about cocaine use
- Diagnosis of another medical condition associated with cocaine use
- Concern expressed by another family member or friend

Referral by employer or from occupational health service
Referral from criminal justice system following arrest or further involvement in CJS (trial, sentencing, community treatment in Drug Intervention Programme or prison)

Assessment

Clinical diagnosis

- History
  longitudinal history of use and cross-sectional history (typical drug-using day, history of use over last week); amount used, type, cost of purchase and how funded (legal and illegal)
- Examination
  Examine skin for sites of injection, nose for evidence of trauma, pulse and blood pressure. Weigh patient, who should be very thin. Pupils for evidence of recent use (dilatation).
- Rating scales
  None
- Investigations
  Urine testing for presence of cocaine (and other drugs of abuse)
  Saliva testing for presence of cocaine (and other drugs of abuse)
  Hair testing for presence of cocaine (and other drugs of abuse)
  ECG, PEFR, CXR are not routinely performed
  Blood tests to rule out other causes of abnormalities (e.g. thyroid function tests to rule out alternate causes of cardiac arrhythmias)

Complications from drug use

- Physical
  Examination of the cardiovascular and respiratory systems
- Psychological
  Psychotic mental state, depressed mood, possibly with suicidal ideation in the crash
- Social
  debt, finances, benefits, housing, occupation

Motivational state

- motivated to continue using, ambivalent, motivated to cease use

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Treatment options

Self-help
Cocaine Anonymous

User support
Mainliners (Hep C)

Those continuing to use
Street agency support
Needle exchange
Motivational interviewing
Bloodborne virus testing
Contingency management

Those wishing to stop
Detoxification not formally needed, as no physical withdrawal syndrome. However, some appreciate support

Post-detoxification pharmacotherapy

- ?disulfiram
- ?bupropion
- Adjunctive antidepressants sometimes useful, but will not treat or prevent relapse to cocaine use

Relapse prevention therapy

Day programme
Residential rehabilitation
Outpatient treatment – 1:1 support, group therapy
Family support / family therapy

Assistance with process of finding accommodation
Assistance with addressing financial problems
Assistance with further education
Assistance with occupation / employment

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<table>
<tr>
<td>Cardiovascular
Chest pain
Myocardial infarction
Arrhythmias
Cardiomyopathy
Myocarditis
Infective endocarditis
Fungal disseminated infection and endocarditis</td>
<td>Genital
Sexual dysfunction
Sexually transmitted diseases, either because of libido enhanced by crack cocaine or because of prostitution to obtain funds
Fournier’s gangrene following intracavernosal injection</td>
<td rowspan="2">Head & neck
Erosion of dental enamel
Gingival ulceration
Keratitis
Corneal epithelial defects
Chronic rhinitis
Perforated nasal septum
Aspiration of nasal septum
Necrotizing infection of the face
Midline granuloma
Altered olfaction
Optic neuropathy
Osteolytic sinusitis</td>
<td rowspan="2">Skin
Crack hand
Cocaine-associated pseudovasculitis
Churg-Strauss vasculitis
Henoch-Schönlein purpura
Bullous skin disease
Stevens-Johnson syndrome
Necrotic livedo
Psychogenic skin excoriation
Cocaine-induced skin ulcer
Multi-focal skin necrosis secondary to impairment of soft-tissue perfusion and invasive bacterial infection (S.pyogenes & S aureus)
Cutaneous fibrosis (scars) healed from cocaine use</td>
</tr>
<tr>
<td>Pulmonary
Pneumothorax
Pneumomediastinum
Pneumopericardium
Pulmonary oedema
Exacerbation of asthma
Pulmonary haemorrhage
Bronchiolitis obliterans
“Crack lung”
Pulmonary eosinophilia</td>
<td>Obstetric
Spontaneous abortion
Poor pregnancy weight gain
Placental abruption
Lower infant weight
Prematurity
Premature rupture of membranes</td>
</tr>
<tr>
<td>GI
Intestinal ischaemia
Gastroduodenal perforations
Colitis
Hepatic amyloidosis</td>
<td rowspan="2">Pediatric
Microcephaly
Cardiac malformations
Subcutaneous fat necrosis in the newborn
Stillbirth
Respiratory distress
Congenital syphilis
Cocaine withdrawal
Seizures
Cognitive deficits, developmental but not motor delay
High risk of have child taken into care

nb. infant prenatal cocaine exposure not associated with mental, motor, or behavioural deficits after controlling for birth wt & environmental risks (Pediatrics 2004;113:1677)</td>
<td>Neurologic
Headache
Seizures
Cerebral haemorrhage
Cerebral infarctions
Cerebral atrophy
Cerebral vasculitis (with temporary blindness)</td>
<td>Endocrine
Hyperprolactinaemia</td>
</tr>
<tr>
<td>Renal
Rhabdomyolysis
Renal failure due to rhabdomyolysis
Renal failure not due to rhabdomyolysis
Nephrotic syndrome
Renal amyloidosis</td>
<td>Psychiatry
Anxiety
Depression
Paranoia
Delusional parasitosis (Formication)
Delirium
Psychosis
Suicide</td>
<td>Others
Sudden death
Hyperpyrexia
Cocaine platelet aggregation and thrombotic tendency
Immersion foot in homeless, aggravated by cocaine</td>
</tr>
<tr>
<td colspan="4">Table: Some Complications of Cocaine Use</td>
</tr>
</table>

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