A Three Month Study of the General Practitioner Sessions at the Cape Town Drug Counselling Centre – Dr T Berelowitz

Dr TC Berelowitz
5 Gousblom Street
Milnerton
7405

Curriculum vitae

Terry Berelowitz studied at UCT and qualified with a MBChB in 1981. After 5 years in general practice, he has had experience as company medical officer to a number of industries, as well as to the Cape Town Drug Councelling Centre. In 1988 he became the medical consultant and co-ordinator of Niklaas Louw Hospitium (the Hospice of the National Cancer Association). He is presently busy with part time studies at UCT for a DOM. Terry is married and has 2 children.

Summary

The aim of this study was to establish a trend pattern of the population which visited the Cape Town Drug Counselling Centre and how active GPs were in this field. Dagga and Mandrax were abused more heavily than elsewhere, and the numbers of White Capetonians who are abusing drugs, are increasing. The author gives an illness profile of the patients, their actual physical complaints as well as the findings and treatment of the doctors and the spectrum of substance abuse.

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KEYWORDS:
Drug abuse; General Practice; Counselling.

Aim of Study

The aim of the study was to see whether there were any trends in the population presenting to the Centre:

- The illness profile of the patients presenting.
- The spectrum of substance abuse.
- General Practitioners' involvement in the patients presenting.
- The physical complaints and results of an examination of the patients.
- Medication used for treatment.

It was hoped that a trend would be present to allow a rough picture to be painted of the presenting patient and to allow medical practitioners outside of the Centre to be more alert and aware of the presenting drug abuser.

Drug abuse during the adolescent period is not easy to detect. The main reason is that the signs of drug abuse can easily be mistaken for the changes seen in the adolescent's behaviour, relationships and adjustments.[1]

Introduction

The Cape Town Drug Counselling Centre is an out-patient Centre for the treatment of substance abuse. Its staff compliment includes a Clinical Administrator and Admin staff, a Clinical Psychologist, a Social Worker, Consultant Psychiatrist and a General Practitioner who has a twice weekly session, as well as an Educationalist. The results of a three month study of the General Practitioner sessions are produced below. They are meant to indicate the trends of the patients seen. Our patient population is reflected in the findings of Fiona Gibson that no socio-economic group is exempt and the average age of first use, appears to be decreasing from secondary to primary school level, as is the trend in other Western countries.[2] Cannabis is the primary drug of abuse in both these groups.

However, the proportion of polydrug abusers seems to be increasing particularly amongst White Capetonians.

Patients and Methods

The admission criteria to the Centre are generally any patient presenting (or referred) with a substance abuse problem other than alcohol. The only patients not seen are those with current theft cases and those that are psychotic at presentation – referred to Psychiatric Unit. The patients were not selected; that is, every patient seen by the General Practitioner (GP) over the three month period, August

. . . Drug Counselling Centre

– October '86, was included. The total number of patients seen and included in this study was 93. Each patient seen by the GP is examined. The mode of examination is a routine full medical check-up as well as an extensive history including social habits, medical, academic, family and occupational aspects.

No socio-economic group is exempt

Age Distribution

Age	No
15 - 19	25
20 - 24	44
25 - 29	14
30 - 34	9
35 - 40	1

Sex Ratio: M : F 9 : 1

Illness and Medication Used: See Table 1

18 reported previous illness. Significantly, 13 were respiratory related illness of which 5 were previous or ongoing tuberculosis and 4 reported episodes of bronchitis. The other illnesses were headaches, duodenal ulcer, pneumothorax, appendisectomy, hepatitis and congenital heart defect.

Table 1. Previous Illness and Medication

Total Number	93
Illness	18
Medication used	5

Only 5 had used previous medication including over the counter preparations.

Substance Abuse: See Table II

Only 7 were non-smokers (cigarettes) and most smoked 20-30 cigarettes daily; 40 reported the use of alcohol; a third of this group abused alcohol. Significantly, 53 reported no alcohol use but this was mostly on religious grounds. 92 smoked Cannabis and 80 used Mandrax as well, usually in a pipe. As I reported previously at the 1986 SANCA Summer School, 95% of the Dagga smoking population seen at the Drug Counselling Centre added Mandrax within three years of starting Dagga. The low figure for other is because patients dependent on Barbituarates and other "hard" drugs are mostly referred to the Groote Schuur Psychiatric Unit.

Table II. Substance Abuse

Total Number	93
Cigarettes	86
Alcohol	40
Dagga	92
Mandrax	80
Other	2

General Practitioner Involvement: See Table III

34 had GPs and of this group only 4 were of the opinion that their general practitioners were aware of their addiction. There was a strong conviction not to correspond with the GP. The patient was concerned about a breach in confidentiality through the GP's rooms, and in some cases was embarrassed to be exposed to his Family Practitioner.

Table III. GP Involvement

Total Number	93
GP	34
GP Awareness	4

Ear, Nose and Throat Complaints: See Table IV

Sixty three (63) had symptoms relating to the ear, nose and throat; 8 to the eye, 22 to the nose and 33 to the mouth; 7 complained of tearing after smoking cannabis and mandrax; 12 had nasal congestion after smoking and 8 rhinorrhoea, usually the morning after; 7 reported salivation with smoking and 25 complained of a dry mouth; 3 had mouth ulcers.

Table IV. ENT Symptoms

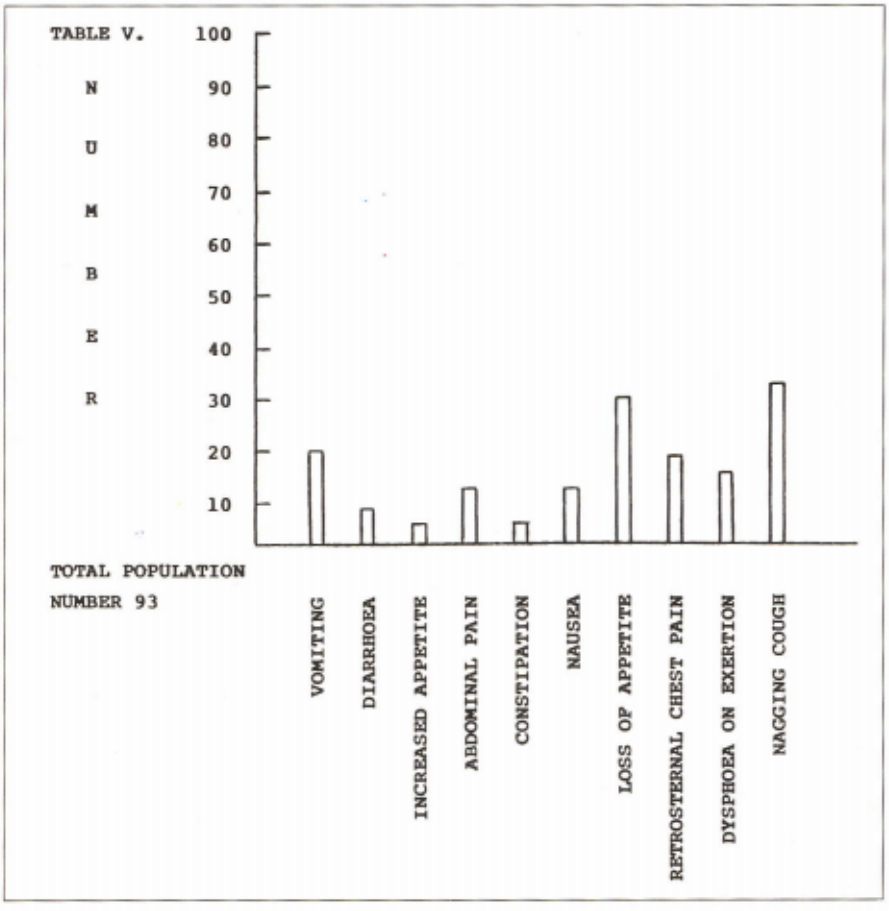
Total Number	93
Eye	8
Nose	22
Mouth	33

Gastro-intestinal, Cardiovascular and Respiratory Symptoms: See Table V

Because of the preponderance of GIT and CVS symptoms, they have been reproduced in Table V.

Sexual Problems

Nineteen (19) patients reported sexual problems. The commonest



problem encountered was decreased libido. Other problems were delayed orgasm, increased libido, secondary impotence and premature ejaculation.

There were no reported uro-genital problems.

Cannabis is the most popular drug

Weight Change: See Table VI

Weight loss was evident as a significant problem despite in some patients good or increased appetite; 40 reported weight loss, with 6 having marked weight loss, one patient having lost 40 kg.

Examination

The physical examination was of interest in that it produced a dearth of pathology, only 2 patients having a physical problem, Hypertension.

Pharmacology

Only 2 forms of medication were used by the GP, Thioridazine HCL, usually in doses of 10mg twice daily or 25mg 2 - 3 times daily or 10mg morning and 25mg evening. An evening dose (6pm) was usually recommended as this is the time when the urge to smoke is strongest. The only problem experienced with Thioridazine HCL was retrograde ejaculation and somnolence. This was not frequent enough to present a problem.

Dothiepin HCL was used where indicated, usually with good results, that is relief of depression. At present Amitryptiline is being used in doses of 25 - 100mg on average. Where depression is present and it responds to counselling and/or medication, abstinence is usually good and more rapidly achieved.

Results: Table VII

The success and failure of treatment is shown in Table VII. *Success* being eventual complete abstinence from the substance abused and compliance with treatment on follow up. The follow up is not a fixed time and is dependent on the counsellor's decision with reference to the particular patient. The Cape Town Drug Counselling Centre proposes

Table VI

Weight Loss %			No Change	Weight Gain	Total
49			37	7	93
< 5 kg	5-10 kg	> 10 kg			
22	21	6			

to do a much needed retrospective study of longterm (more than a year) abstinence. *Failure* is where the patient fails to abstain and/or drops out of treatment.

Table VII

Total Cases	93
Success	29
Failure	64

Discussion

There was relatively little morbidity in the patients seen but there was a preponderance of respiratory illness. The physical examination produced no pathology at all, besides two cases of Hypertension. It must be stressed that these examinations were a routine medical screening. No ECG tests and no lung functions were done. As could be predicted, the vast majority were heavy cigarette smokers and many reported increased cigarette consumption with abstinence. Alcohol was abused by the minority, some abstaining totally.

Poly-drug abusers seem to be increasing amongst White Capetonians

Alcohol does not seem to play a strong role in the culture of drug abuse. It is significant enough to re-emphasize that the often innocently labelled Dagga is followed by Mandrax in 95% of our findings. Surely, this tarnishes Dagga's innocent label. The figures shown for the GPs' involvement glaringly show the inactivity of the GP in fighting drug abuse. Ear, Nose and Throat, Gastro-intestinal and Cardiovascular symptoms were prevalent. Of interest was the often reported retrosternal chest pain, occurring after smoking. This reported symptom deserves further investigation. Because of the frequently reported symptoms of nausea, vomiting and loss of weight, it is important to consider drug abuse when a patient presents with these symptoms.

A strong pattern of symptomatic complaints was seen and albeit in strong contrast to the lack of pathology, this is very significant. These symptoms from backache to rhinorrhoea, cause decreased work performance, impaired efficiency and absence from work. An Occupational Health Study would surely show the loss of manpower hours to be immense.

The weight loss reported was worrying, not so much because of its prevalence, but because it occurs insidiously often with an associated good, or even increased, appetite. What is causing the weight loss?

Statistics show the inactivity of GPs in fighting drug abuse

The low success rate may seem dismal at first, but it must be borne in mind, that the patients referred to the General Practitioner are usually problem patients, with decreased motivation, many not being self referred, and includes those requiring detoxification.

Conclusion

Although the study was done in 1986, the patterns observed then have remained consistent with these findings.

The data collected did not produce a scientific model but it did allow a rough picture to be painted with relevance for the general and occupational physician.

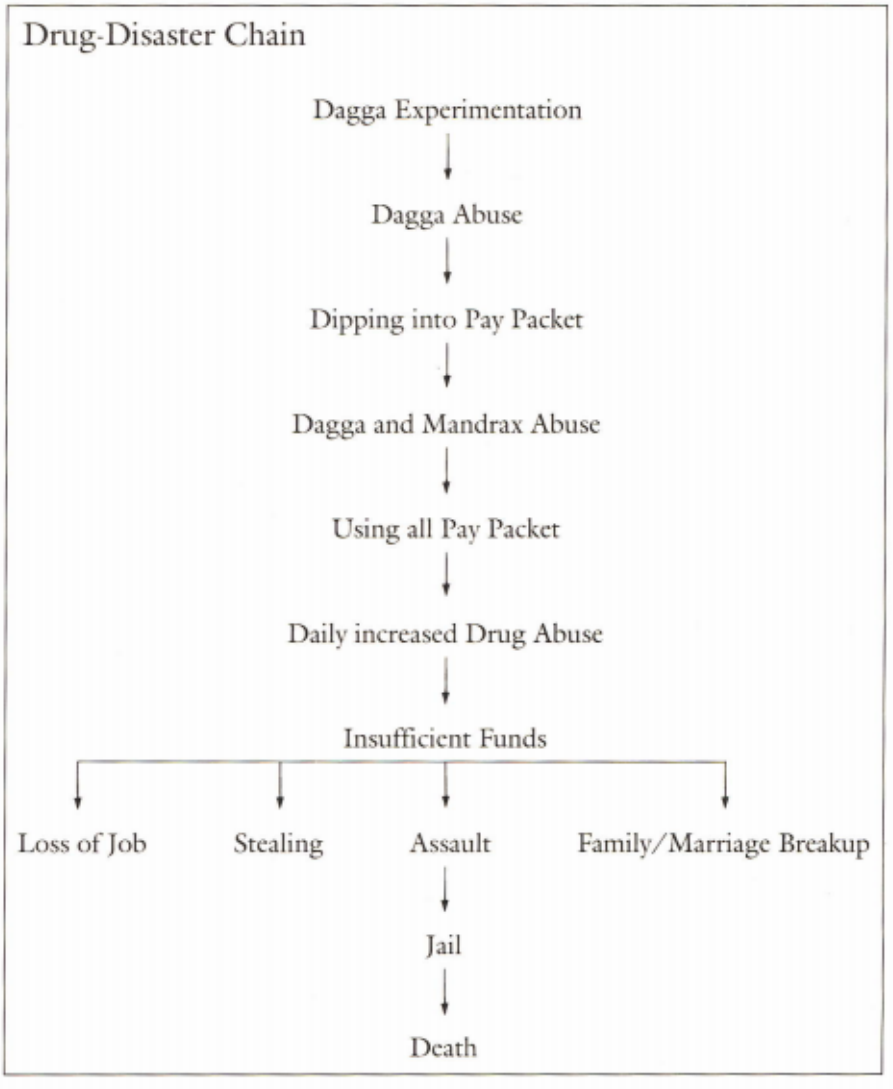
The lay public and many doctors feel that there is little danger from mandrax and especially dagga. Physically this was shown to be probable, but there was a strong trend of complaints of wheezing, impaired effort tolerance and dyspnoea on exertion, this anecdotally improved with continued abstinence.

The social dangers of these drugs cannot be over emphasised. They perpetuate a *drug-disaster chain*.

Another pattern strongly believed in, is the relationship between alcohol and dagga/mandrax. As reported, there was very little alcohol and drug abuse, mostly because of religious restrictions.

The gateway label of dagga was firmly pinned on, it being followed by mandrax in so many of the patients seen.

The often observed good response



and abstinence which occurs when depression is noted and treated, reinforces the popular belief that, besides other reasons, the depressed patient will often use drugs to "cure" his depression and will make a more approachable patient in a treatment program.

Depression and/or with anxiety was a common symptom and should often be looked for, if not assumed until proven not to be present.

I have made no comparisons to other Centres, as part of the aim of the study was to establish a trend pattern of the Cape Town Drug Counselling Centre population, which culturally and socially is rather unique. Dagga and mandrax are abused more heavily and exclusively in our population as compared with most other communities.

GPs should assume depression (and anxiety) until it is proven not to be present

The deceptiveness of drug abuse is very evident. It is therefore essential that family members and other significant people be involved in the identification and assessment procedure. This will ensure an accurate picture which will also facilitate effective, early management of the problem. It follows then that early management makes for a better prognosis.[3]

Finally with reference to the medical practitioner, it is hoped that this study will alert the practitioner to the possible drug abuser and encourage a more active involvement and referral to specialist centres. It is hoped that the many patients booked off work for vague respiratory, gastro-intestinal and musculo-skeletal problems will be looked at more closely.

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