Clinical Recognition of Stimulant Use Disorder (StUD), Including Methamphetamine

Key "Take-Aways":

1. **STIGMA**. Appreciate that stimulant use is stigmatized; therefore, folks do not usually self-disclose.
2. **SELF-MEDICATION**. Know the predictable primary conditions for which people who use stimulants are self-medicating.
3. **SECONDARY CONDITIONS**. Recognize the predictable secondary health conditions.
4. **YOU HAVE THE POWER**. Own the power of primary care! Your usual chart review plus nonjudgmental clinical interview allows for rapid clinical recognition of stimulant use. **Recognition leads to treatment**.

Presentation Transcript:

Hi, my name is Frances Southwick. I'm an osteopathic family physician practicing in California, and I am very pleased to be presenting to you today related to stimulant use disorders in primary care settings. This is part of the Clinical Provider Quick Tips. And thank you so much for joining us today.

This is all about stimulant use disorders, also known as StUD. It certainly includes methamphetamine, which is common here in California, but it also does include other stimulants such as cocaine or use of prescription stimulants for non-prescription, non-medical purposes. Again, I'm an osteopathic family physician. I'm also the lead MAT provider for community care health centers in Yolo County.

We have four main takeaway tips. And interestingly, I realized that it comes down to the four S's. In primary care, we love our mnemonics. This is the four S's of recognizing stimulant use disorders.

1. Stigma, appreciating that stimulant use is stigmatized and therefore patients often do not self-disclose.
2. Self-medication, recognizing that people are self-treating for predictable conditions. That's also key.
3. secondary conditions. stimulants in and of themselves cause medical conditions, and if you know what they are, you can pick it up and help patients recognize their own use.
4. Superhuman. I'm going to toot our own horn. In primary care, we're superhumans. We have the power to recognize and engage a patient and encourage treatment. And this lecture is all about recognition, so that's number one.

Case Study:

Before we launch into this let's just think about a case. Yesterday, I had a hospital follow-up patient who was about 67 year old female coming in. She had a first ever episode of atrial fibrillation. I'm getting into her history with her a little bit. She's there with her granddaughter who is her caregiver. And we're talking about how she's been exhausted; she has neuropathy; she's had a few other psychiatric conditions; she has some skin complaints. But the main thing is a hospital follow-up for atrial fibrillation. After the visit, I'm kicking myself because I'm literally talking to you about recognition. After the visit, I went through the problem list in more detail and recognized that she had CHF for years and that it was originally due to methamphetamine use. Don't make the same mistake I did. Be able to pick this up by the end of the talk.

Stigma:

(04:05) Stigma, our favorite word in substance use disorders in general. Stigma means being marked, and that means carrying a lot of shame. Patients or people, in general, internalize that shame and stigma and don't want to volunteer that they have a stimulant use disorder. They're worried about what you're going to think of them; they're worried they're not going to get appropriate medical treatment. Maybe they're worried that you're connected to law enforcement in some way. So, it's up to us to be able to recognize the signs of stimulant use disorder and not expect patients to volunteer it.

Now there is a one-question screening tool for substance use disorders in general, which is "*how many times in the past year have you used an illegal drug or a prescription medication for non-medical purposes*?" Consider incorporating that, which has some data behind it, into your clinical practice to give you another line of defense.

But if you don't incorporate that, use your clinical prowess to be able to pick up on stimulant use disorder.

Self-Medication:

(05:35) We are on the second S already. Self-medication, just like with any addiction, any substance use disorder, people are self-medicating for predictable conditions. For example, with methamphetamine use, with stimulants, patients are sometimes self-medicating for **ADHD**. We didn't used to be very good at picking up on ADHD, that's changing in healthcare. But if it's not recognized or not adequately treated sometimes people will self-medicate with stimulants.

Number two is **PTSD**, intrusive memories from trauma. Trauma is huge in addiction disorders in general. It's the basis of why people start using many substances, and it's often a vicious cycle. Trying to escape those intrusive memories is sometimes a reason to use stimulants.

Next is **depression or lack of motivation**. We prescribe stimulating medications in medicine for depression ourselves, don't we? Such as Wellbutrin, also known as bupropion. And patients will self-medicate as well. Think about poverty or multiple jobs for a minute. If you're somebody living in California trying to make rent, trying to work multiple minimum wage jobs, trying to take care of your kids, it can be a huge uphill battle and a big ask. And some people need something else to be able to just survive. Stimulants can ease that burden, at least temporarily, in helping people have more energy for just basic survival.

Two other communities to consider: the **unhoused population**. A very common substance to use in the unhoused population in California is methamphetamine. Imagine that you're unhoused, imagine at night, it's scary out there. Feeling safe is major. Being on guard is important to avoid being approached by law enforcement or having your stuff messed with, or, you know, experiencing assault. Stimulants are big in unhoused community. It also helps people feel warmer, less hungry. If you're food insecure, methamphetamine can help you feel less hungry and miserable. And it also helps to connect folks in the unhoused community. For example, imagine again that you're unhoused, and someone comes to you and offers you some methamphetamine. It can sometimes be safer to build community and continue using rather than avoid use. And so again, that's part of a vicious cycle.

And lastly, **men who have sex with men or MSM**. Initially, stimulants such as methamphetamine enhanced sexual performance, but overall, it's been associated with more social inclusion.

(09:34) Addiction is the result of using a substance over prolonged time. So, eventually people are self-medicating the hole in the nervous system to avoid the withdrawal effects of psychosis, inability to get out of bed and hopelessness, and lethargy. The withdrawal from stimulants is so difficult to get through that it becomes a major reason that people continue using.

Secondary Conditions:

(10:07) S number three is secondary conditions. I'll give you a clinical example, two clinical examples. Back in Pittsburgh, PA, I was practicing in an urban setting at an FQHC. I was covering for a partner of mine. And the patient came in, I saw that she was a little tachycardic; she was kind of walking in and out of her room. She was a little confused; she was maybe 60 years old. I came in the room, and we started talking a bit and I noticed that she had a little bottle with her, a little plastic medication bottle that she had repurposed, and it had little pieces of facial tissue in it. And she said, you know, *I have this infestation and it's been going on for years*. And she showed me that she had been collecting scabs - she had been **picking and collecting skin**. I also saw, and her problem was that **scabies** was there and had been treated multiple times, and she just wasn't getting any better. That was a clue to me, maybe there's a stimulant use disorder. On her problem list also was **cocaine use** and a history of a **stroke**. Putting those all together, we were able to offer her treatment.

The other clinical example, similar except it was here in rural California. I was in a night clinic, and this was the same day, a patient who had been waiting hours to see us. I came in the room and again, little bottle, and he was in tears. He was just so distraught. He told me that he had seen five different dermatologists and they all just laughed at him, and he was just really struggling. He had **lots of excoriations** on his shins and around his knees and it was bleeding, and he had a lot of scarring on his arms and legs. And I agreed to send his sample out to the lab just for his own peace of mind. It was a great story because when he came back, he was finally willing to accept that he had a stimulant use disorder that **was perpetuating this delusion of infestation**.

Tachycardia is another one that's acute. Right after you use a stimulant, you're going to have a fast heart rate. With prolonged use, you're going to develop a **cardiomyopathy**. That means you're going to see that on the problem list. You're going to see hospital follow up like my first patient. You're going to see CHF, maybe there'll be Furosemide on the medicine list.

And then **psychosis**, this is big too. Look at the problem list and see if somebody may have written on there, “delusional disorder”, or they may have written “a mood disorder with psychosis” or “schizophrenia”, even. We can dance around the fact that someone has a stimulant use disorder by collecting these other diagnoses when really the stimulant is at the heart of the issue.

People can develop auditory, visual, or tactile **hallucinations**. But tactile hallucinations are common, feeling like there's bugs crawling. **Unexpected weight loss**, people who are **unhoused**. Again, these are predictable

signs that there's a stimulant use disorder. And **frequent ER trips, hospitalizations, interactions with law enforcemen**t keep those at the forefront.

You Have The Power:

(14:32) In primary care, **we are the ones with the power** here, we are the first and last lines of defense. We are there because someone is suffering; they're there asking us for help. So, when we do our clinical prep work, looking at old notes, problem list, medications, vitals, before we even walk in the room, we can have most of the information there that someone may have a stimulant use disorder. Then, the physical exam can sometimes be the clincher. And at that point, once you know that there's a highly stigmatized condition, that people are self-medicating for the causes, secondary conditions that are predictable - we can be the superheroes, put it all together and approach a patient in a non-judgmental manner to invite self-disclosure.

I hope this was somewhat helpful and thank you so much for having me.