Letters to Editor

REFERENCES

1. Kalaiselvan V, Prasad T, Bieht A, Singh S, Singh GN. Adverse drug reactions reporting culture in Pharmacovigilance Programme of India. Indian J Med Res 2014;140:563-4.

2. Patel KJ, Kedia MS, Bajpai D, Mehta SS, Khirsagar NA, Gogtay NJ. Evaluation of the prevalence and economic burden of adverse drug reactions presenting to the medical emergency department of a tertiary referral centre: A prospective study. BMC Clin Pharmacol 2007;7:8.

3. Ramesh M, Pandit J, Parthasarathi G. Adverse drug reactions in a south Indian hospital— their severity and cost involved. Pharmacoepidemiol Drug Saf 2003;12:687-92.

4. Raut A, Diwan A, Patel C, Patel P, Pawar A. Incidence, severity and financial burden associated with adverse drug reactions in medicine inpatients. Asian J Pharm Clin Res 2011;4:103-11.

5. Sarkar S, Varshney M, Petil V, Lal R. Maintenance treatment of opioid dependence with tramadol. J Neurosci Rural Pract 2017;8:998-101.

How to cite this article: Dhagudu NK, Erravalli A, Sarkar S, Chadda RK. Tramadol-related adverse drug reactions at an addiction psychiatry setting: A cross-sectional analysis. Indian J Psychol Med 2019;41:593-5.

© 2019 Indian Psychiatric Society - South Zonal Branch | Published by Wolters Kluwer - Medknow

Substance Use Related Emergencies in a Tertiary Care General Hospital Setting: Observations and Discussion

Sir,

Those with a substance use are less likely to seek routine medical care. Emergency services may serve as their primary, and often, the sole, contact with healthcare services. Some are still active users, whereas others contact after their substance use is interrupted or stopped.

Specific data pertaining to substance use related emergencies in the Indian context are sparse and dated. A few studies available on the general psychiatric emergencies have no/minimal representation of substance use patients. There are several gaps in the available knowledge about the pattern and profile of substance use related visits in the Indian context.

This letter aims to discuss a few observations gathered from a retrospective, descriptive analysis of consecutive drug-related emergency psychiatric referrals made from a general hospital emergency department and attended by psychiatry on-call/emergency team over a 13-month period. The records of all the mental and behavioral emergencies are maintained routinely, from which the relevant data pertaining to substance-related emergencies attended between Jan 2015 and Jan 2016 were extracted using a semi-structured proforma.

Substance use related emergency referrals constituted 12.6% (84/666) of the total mental and behavioral emergencies attended in the period. The visits were distributed equally throughout the year, with no significant difference observed over the year quarters. The socio-demographic and substance use profile of the sample is shown in Table 1. Compared to the non-drug related emergencies (n = 582) attended during the same study period, substance use group (n = 84) had a significantly older age (P < 0.01) and a higher likelihood to be male (P < 0.01).

The proportion of substance use referrals within the total psychiatric referrals (12.6%) is comparable to that seen in prior studies from India (12-14%), and is much less than the rates found by similar western studies (29-43%). The under-representation of substance-related referrals in general hospital Indian settings in comparison to most western studies might be because of under-utilization, under-detection, under-reporting, or low rates of referrals. Administration of brief screening tools or having a psychiatry resident stationed within psychiatry emergency has been reported to enhance referrals by several fold.
The prevalence of comorbid psychiatric illness and comorbid medical illness was much lower than that reported for the general population and emergency visits.[9,10] The low prevalence of comorbid illness may be because the evaluation is often more focused on the primary cause of the visit. In addition, many patients were brought by police or non-related attendants, leading to a lack of information regarding comorbidity. In addition, there might be a selection bias in the sample, as patients with more severe medical comorbidities are less likely to be referred for psychiatric evaluation.

A comparison with an earlier study from three decades ago from the same center[3] reveals certain useful insights that be summed up as (i) about three-quarters of the earlier study sample was brought by the police after disruptive behaviors (as opposed to only one-fourths in the current sample). It appears that a higher proportion of referrals are now driven by clinical rather than legal reasons; (ii) co-occurring psychiatric illness was detected in 16% of the previous sample, compared to 10.7% in present sample; and (iii) over 85% of the patients in the earlier study explicitly refused any advice or need for further follow-up, in contrast to none in present study. This change might be reflective of a higher acceptance of the medical model of substance use. Another Indian study[11] from the same decade did not have their presentation of a single case of substance-related emergency among psychiatric emergencies seen in a general hospital. There is an upward trend for substance-related referrals in general hospitals over the past three decades in India, even if such figures are less than those from the western settings.

Female under-representation in treatment-seeking samples of substance users is a well-known finding. It could be because of stigma and socio-cultural factors. Alcohol was the most common substance (73.4%) to precipitate emergency visit in the present study, in consonance to a previous study from India.[4] Alcohol withdrawal management often needs a multi-disciplinary setting of a general hospital, in view of the comorbidities and anticipated complications.

It appears that opioid users are not availing emergency services adequately, in contrast to the findings of some western studies.[1,12] This could be because of a fear of medico-legal repercussions, poor resources, or a preference for alternate community-level health services from other governmental and non-governmental organizations. Community-based secondary prevention is needed to prevent emergencies in such users, including management of opioid overdose, basic supportive care, and first aid for substance intoxication.

Table 1: Socio demographic and clinical profile of substance use related psychiatric emergency referrals (n=84)

| Variable                                  | n (%)          |
|-------------------------------------------|----------------|
| Age (in years)                            | 36.3±14.8      |
| Gender                                    |                |
| Male                                      | 77 (91.7%)     |
| Female                                    | 7 (8.3%)       |
| Religion†                                 |                |
| Hindu                                     | 75 (89.3%)     |
| Muslim                                    | 4 (4.8%)       |
| Sikh                                      | 2 (2.4%)       |
| Christian                                 | 2 (2.4%)       |
| Medico Legal Case†                        |                |
| MLC                                       | 21 (25.0%)     |
| Non-MLC                                   | 61 (72.6%)     |
| Known substance use disorder+             | 24 (28.6%)     |
| Known medical illness+                    | 9 (10.7%)      |
| Primary drug of use                       |                |
| Alcohol                                   | 62 (73.8%)     |
| Opioids                                   | 10 (11.9%)     |
| Cannabis                                  | 7 (8.3%)       |
| Sedatives/hypnotics                       | 2 (2.4%)       |
| Multiple substance use                    | 3 (3.6%)       |
| Pattern of substance use                  |                |
| Dependent use                             | 71 (84.5%)     |
| Harmful use                               | 13 (15.5%)     |
| Comorbid psychiatric disorder (ICD 10)    | 9 (10.7%)      |
| Common reasons for presentation†          |                |
| Alcohol withdrawals                       | 49 (58.3%)     |
| Complicated alcohol withdrawals (seizures)| 12 (14.3%)     |
| Complicated alcohol withdrawals (delirium tremens) | 19 (22.6) |
| Sedative-hypnotic withdrawal              | 1 (1.1%)       |
| Any substance intoxication                | 20 (23.8%)     |
| Opioid overdose                           | 8 (9.5%)       |

MLC – Medico-legal case. †data on religion not available for 1 patient and MLC data not available for 2 patients; ≤ previously, diagnosed illness as reported by patient/attendants/treatment records ‡categories provided are overlapping and not mutually exclusive

Interpretations are limited by a reliance on records for data extraction and an exclusive focus on referred population. Further, a proportion of cases, such as those shifted to intensive care or medical wards, may not have been referred immediately.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Tamonud Modak, Swarneep Singh, Saurabh Kumar, Raman Deep

Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India
REFERENCES

1. McGeary KA, French MT. Illicit drug use and emergency room utilization. Health Serv Res 2000;35:153-69.
2. Brubacher JR, Mahie A, Ngo M, Abu-Laban RB, Buchanan J, Shenton T, et al. Substance-related problems in patients visiting an urban Canadian emergency department. CJEM 2008;10:198-204.
3. Adityanjee, Mohan D, Wig NN. Alcohol-related problems in the emergency room of an Indian general hospital. Aust New Zeal J Psychiatry 1989;23:274-8.
4. Chakrabarti A, Bhalla A, Dutta S. A profile of substance abusers using the emergency services in a tertiary care hospital in Sikkim. Indian J Psychiatry 2006;48:243.
5. Keertish N, Sathyanarayana MT, Hemanth Kumar BG, Udagave K. Pattern of psychiatric referrals in a tertiary care teaching hospital in southern India. J Clin Diagn Res 2013;7:1689-91.
6. Owens PL, Barrett ML, Weiss AJ, Washington RE, Kronick R. Hospital inpatient utilization related to opioid overuse among adults, 1993-2012. HCUP Statistical Brief #177. August 2014. Agency for Healthcare Research and Quality, Rockville, MD. Available from: https://www.hcup-us.ahrq.gov/reports/statbriefs/sb177-Hospitalizations-for-Opioid-Overuse.jsp. [Last accessed on 2016 Dec 01].
7. Curran GM, Sullivan G, Williams K, Han X, Allee E, Kotira KJ. The association of psychiatric comorbidity and use of the emergency department among persons with substance use disorders: An observational cohort study. BMC Emerg Med 2008;8:17.
8. Adityanjee, Wig NN, Mohan D. Patterns of coverage of psychiatric emergencies. Acta Psychiatr Scand 1987;76:101-2.
9. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. The DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville, MD, December 28, 2010.
10. Kessler RC. The national comorbidity survey of the united states. Int Rev Psychiatry 1994;6:365-76.
11. Trivedi JK, Gupta AK. A study of patients attending emergency out-patient services of a large teaching institution. Indian J Psychiatry 1982;24:360-5.
12. Schiller MJ, Shumway M, Batki SL. Patterns of substance use among patients in an urban psychiatric emergency service. Psychiatr Serv 2000;51:113-5.

Access this article online
Website: www.ijpm.info
DOI: 10.4103/IJPSYM.IJPSYM_410_18

How to cite this article: Modak T, Singh S, Kumar S, Deep R. Substance use related emergencies in a tertiary care general hospital setting: Observations and discussion. Indian J Psychiatr Med 2019;41:595-7.