Stimulant use: patterns and clinical approach

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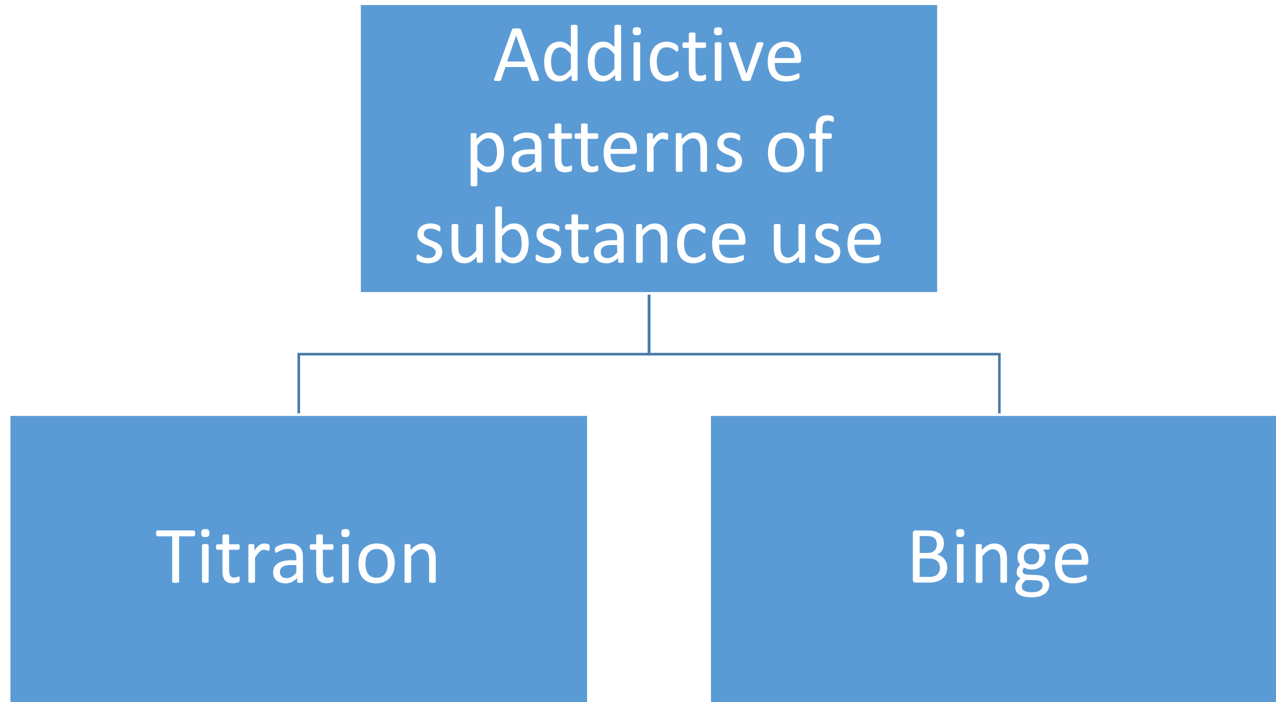
Case: pipefitter

- 52 year old man presents with dizziness
- Ventricular tachycardia 280 beats per minute
- Successful cardioversion
- Verbally abusive to the staff 24 hours after admission
- Drug screen positive for methamphetamines and amphetamines
- States he uses the drug to help him accomplish his job

- What do you ask next?

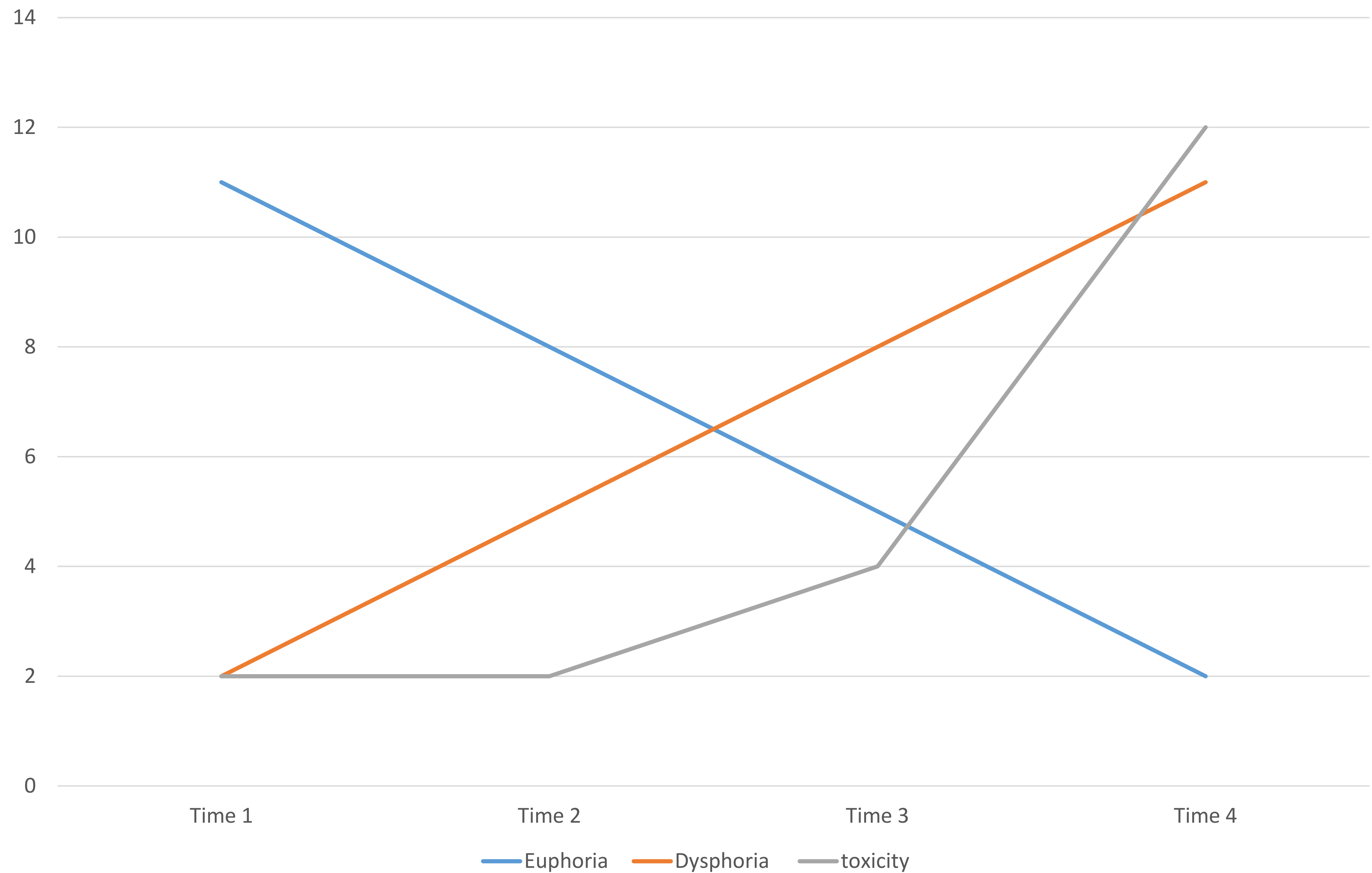
Case: lost phone

- Todays presenter is at a trendy distillery dressed in all green last Saturday night
- On my way out a woman ran up to me from behind and grabbed my arm
- She was wearing a low-cut dress; touching my arm flirtatiously; large pupils; rapid speech
- The woman suggested that I had possibly stolen her friends iphone and suggested that it would be nice for me to just give the phone back



Titration: maintaining continuous blood levels and effects of a drug within a certain range over time

Binge: consuming the drug rapidly in limited time to achieve escalating blood levels and effects



Stimulant Binge Architecture
14
12
10
8
6
4
2
0
Time 1
Time 2
Time 3
Time 4
Euphoria
Dysphoria
toxicity

Early binge

- Alert
- Sexy/flirtatious
- Energetic
- Confident
- Chatty
- Awake
- Euphoric

Mid-binge

- Vigilant
- Adventurous
- Jittery
- Bold
- Verbose
- Up late
- “Need a bump”

Toxicity

- Paranoid
- Hypersexual
- Agitated
- Aggressive
- Pressured
- Insomnia
- Dysphoric

Physical signs of toxicity

- Tachycardia, Hypertensive, Hyperthermia
- Psychomotor agitation, restlessness
- Dilated pupils
- Shortness of breath, Chest pain, arrhythmia
- Stoke, Seizure

Psychiatric signs of toxicity

- Pressured speech, raised voice
- Paranoia
- Visual tactile hallucinations (2 types)
- Exhausted, yet psychomotorically activated
- Suicidal
- Homicidal
- Aggressive

Mental status exams consistent with stimulant use

https://www.youtube.com/watch?v=7PH35C7Fhq0

https://www.youtube.com/watch?v=WoRc0UHjHkA

Managing stimulant toxicity

- Olanzapine
- Lorazepam

- Safety for staff
- Avoid arguments, deescalate
- Reassure the patient you are there to help
- Promptly removing the patient from your lobby
- Allow to leave

Frequency of readministration dictates duration of stimulant binges

Crack	Cocaine	Meth
30 min	2 hours	8 hours
12 hours	36 hours	5 days

How do binges end?

- Criminal justice
  - Violence, disruptive behavior
- Emergency room
  - Medical or psychiatric complications
- Taking a CNS depressant
  - To break the upward spiral of stimulant use

“What do you use to come down?”

- Alcohol
- Benzos
- Opioids
- Quetiapine
- Et c

Stimulant “wash out”

- How would you feel if you if you had been up partying for days straight?
- True withdrawal “wash out” a vestigial term
- Post toxicity fatigue, irritability, sleepiness, shame, depression
- Intense appetite for sweets (juice)
- Denial/minimizing the extent of the binge
- Promise to self not to do it ever again

High risk sexual behavior

- 50% of patients with stimulant use disorder directly associate their drug use with sex
- Alcohol disinhibits existing sexual desires
- Stimulant expand sexual repertory
- High risk sex; sexual exploitation; shame when sober
  - Screen for STI (HIV!), safety
- Ultimately stimulants may poison the physical ability to perform sex acts
- Loss of healthy “courtship” skills
- A goal of sobriety should be healthy romance and sex

Shame

Managing triggers

- Money
- People
- Sex

Treatment

No good medication options for stimulant use disorder
Inpatient/outpatient treatment

Complete the sentence:
“The best treatment of methamphetamine use disorder is…”

- Contingency management
- Rigorous avoidance of using friends
- Payee
- Sexual counseling

Thank you!
Questions?