



Canadian Society of Addiction Medicine

La Soci t  Medical  Canadienne sur l'Addiction

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President's Report

Greetings and Happy New Year! We are starting this year to get the Bulletin published according to the scheduled publication dates of February, May, August and November. The 1998 November issue was never published because of a lack of submissions. More material was submitted in the past month or so, hence it is presented for your interest and comment.

The two major accomplishments from last year included an agreement with the American Society of Addiction Medicine for Canadian Physicians to sit the 2000 ASAM certification examination based on the eligibility criteria set by the Canadian Society of Addiction Medicine; and successful negotiations with Revenue Canada to have our charitable status reactivated so that our Society can pursue activities in that direction, together with raising appropriate funds as

envisioned in our founding constitution. You will find more details about the Canadian Certification process under a separate heading in this Bulletin. The fundraising project will be further discussed at our Executive Committee meeting scheduled for 1999 March 27. Input is invited from our membership in terms of how it might be best to proceed plus volunteers are sought to assist in the fundraising and charitable work project. You may send your views by mail/fax/e-mail directly to me or through your Board member. The current Executive Committee includes Dr. Douglas Graham, Dr. Nady el-Guebaly, Dr. Laurie Hoeschen, Dr. Peter Mezciems, Dr. Claudia Peters, Dr. Suzanne Brissette, Dr. Gen Campbell and myself.

Our Annual Scientific Meeting in Victoria in 1998 October was reasonably attended and well received. Congratulations and thanks to all who assisted in organizing and attending that conference. It was nice to meet so many colleagues on the west coast. As always, it was great to see friends and colleagues that I only get to meet once a year. Hopefully, we will have a great turnout at our annual meeting in Montreal in 1999 October.

Looking ahead, I will be attending the founding meeting of the International Society of Addiction Medicine in 1999 April. Our own, Dr. Nady el-Guebaly, has been the Chair of the task force steering the formation of this international organization that is rapidly getting support from colleagues around the world. Our affiliation with the Canadian Medical Association is allowing myself and Dr. el-Guebaly to provide input to the CMA regarding addiction related matters. The ADD_MED list continues to be active under the leadership of Dr. Peter Mezciems. The web site is also being renewed and input in that regard to Dr. Peter Mezciems would be well appreciated.

I look forward to keeping in touch with all of you as much as possible. The membership is over 140 at present. With the help of all of you, let us aim for membership of over 200 with strong networking support for physicians working in this difficult field of addictions. Thanks to all who have renewed their membership already.

Raju Hajela, MD

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CMA Supports C*SAM Position on Opioid Dependence

The CMA Council on Health Care and Promotion supported the view that methadone maintenance and counseling programs should be expanded. The following recommendations were proposed by the Council on Health Care and Promotion and approved by the Board of Directors of Canadian Medical Association:

"That the CMA recommended to the federal Minister of Health that the investigation of prescription of heroin for opiate-dependent individuals follow the same approval protocol in practice for the use of any therapeutic drug in Canada"

"That the CMA recommend that methadone maintenance and counseling programs be more widely available across the country with appropriate education and remuneration of professionals delivering in such programs. This recommendation applies also to correctional institutions".

The C*SAM motions in this regard have already been communicated to the federal Minister of Health and the Health Protective Branch. The CMA support will further enhance our position.

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Methadone Program in Ontario

The College of Physicians and Surgeons of Ontario recently held a conference for methadone prescribing physicians on 1998 January 27. The College's support for the program was reiterated by Dr. Joseph Homer, President, College of Physicians and Surgeons of Ontario (CPSO), Dr. John Bonn, Registrar, CPSO, Dr. John R. Carlisle, Deputy Registrar, CPSO and Mr. Graeme Vardy of Ministry of Health. Matters related to administering the program together with an emphasis on the Physician-Pharmacist team approach were reviewed. There was considerable discussion around some contentious issues related to methadone maintenance guidelines and the interim methadone prescribing audit procedure put forth by the CPSO. The College was encouraging methadone prescribers to seek consultation from Addiction Medicine specialists, in difficult or complex cases.

Dr. David Marsh reviewed recent research highlights which emphasized that residential treatment and/or methadone maintenance therapy were a quarter to one tenth the cost of incarceration or an addict remaining on the street. Dr.

Peter Selby reviewed the treatment of methadone overdose, emphasizing the need for considering the presence of multiple drugs and recognizing the long acting nature of methadone which requires up to seventy two hours of treatment with ?Naloxone in various cases.

Dr. Jim Cairns, Deputy Chief Coroner, Province of Ontario presented a detailed review of methadone related deaths, 1996-98. The increased availability of methadone has led to methadone being implicated in drug related deaths more often. The numbers were around nine in 1996 and pre 1996. In 1997 there were 47 deaths where methadone was detected and in 1998 there were 64 deaths where methadone was detected. It is noteworthy that at least in one third of the cases the presence of methadone was not directly related to the cause of death. Close to two-thirds of people dying from methadone related deaths were not on a methadone program themselves. The use of methadone with other drugs was more common, alcohol being the more significant other drug present. Interestingly, Dr. Cairns noted that the number of heroin deaths in Ontario have not shown a drop in the last two years.

R. Hajela, MD

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ASAM Board Approves Canadian Certification in 2000

The ASAM Board has passed the following motions approving the criteria proposed by the Canadian Society of Addiction Medicine:

1. A Canadian physician seeking to be certified in Addition Medicine by the Canadian Society of Addiction Medicine (C*SAM), may sit for the ASAM certification examination after a C*SAM Credentialing Committee has reviewed an application and determined that the Canadian applicant has met the criteria established by C*SAM for certification by C*SAM.
2. A Canadian physician seeking to be certified in Addiction Medicine by both ASAM and C*SAM, may sit for the ASAM certification examination after both the C*SAM Credentialing Committee has determined that the applicant has met the criteria for C*SAM certification, and ASAM Credentialing Committee has determined that the applicant has met the criteria for ASAM certification.

3. A Canadian physician seeking to be certified in Addiction Medicine by ASAM only may sit for the ASAM certification examination after the ASAM Credentialing Committee has determined that the applicant has met the ASAM criteria for ASAM certification.

4. For those seeking C*SAM certification only, the ASAM examination committee and the staff of National Board of Medical Examiners may eliminate from scoring those questions that relate to medical review officers (MROs), questions regarding methadone regulations, or questions pertaining to the U.S. Control Substances Act that may not be appropriate for Canadian examinees.

5. Implementation of the Canadian Certification Project using the ASAM certification examination being approved by the ASAM Board once the board has received and approved an administrative and implementation plan agreed upon by C*SAM and ASAM.

The details of the certification process in terms of administrative issues, costs etc. are being worked out presently between the C*SAM Standards Committee and ASAM Credentialing Committee.

Canadian physicians who are interested in writing the 2000 certification examination are requested to send a letter of interest to the C*SAM secretariat in Kingston so we can mail you the appropriate procedures and application forms once they are finalized.

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Substance Use and Pathological Gambling Disorders Final Needs Assessment Report Recommendations.

The following advocacy recommendations from the Substance Use and Pathological Gambling Disorders Project were approved by the CMA Board:

1/Advocacy

1.1 That the CMA advocate for the development of core curricula the substance use and pathological gambling disorders to be offered at undergraduate, post graduate levels and through CME programs. In addition, that the CMA explore partnerships with other health care professionals to develop interprofessional or

interdisciplinary curricula in substance use and pathological gambling disorders.

1.2 That Governments implement harm reduction approaches such as limiting the number of gambling establishments, particularly video lottery terminals (VLTs) and casinos. That age limits be placed on accessibility to VLTs such that children and adolescents are restricted from their use.

1.3 That CMA advocate for elementary school programs to help prevent substance use and pathological gambling disorders.

1.4 That CMA advocate for further research into substance use and pathological gambling disorders. This research should be communicated to all physicians working in this area. Topic areas could include: the biological basis for gambling and other addictions, effective prevention and treatment strategies and dispelling the myths surrounding addiction patients.

1.5 That the CMA, through its divisions, lobby provincials/territorial governments on behalf of physicians to ensure that they and other health care providers receive adequate remuneration for helping to prevent, assess and manage patients in substance use and pathological gambling disorders and for time spent working on behalf of their patients.

The Canadian Medical Association has committed to communicating these recommendations to various target groups through the assistance of CMA public affairs directorate. The target groups include CMA affiliates and divisions, deans of medicine, provincial/territorial government Ministers of Health, Health Canada and other relevant groups who were consulted in the needs assessment phase.

C*SAM members involved with the above project have been Dr. Nady el-Guebaly, Dr. Raju Hajela, Dr. Suji Lena and Dr. Katherine McCullam.

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Collateral History Regarding Alcohol Use Predictive of Dementia-

Preliminary Review of Canadian Study of Health and Aging Data

Although there is controversy in the medical literature about the existence of a pure alcohol related dementia syndrome, clinicians recognize an increased

prevalence of dementia in seniors who have a history of alcohol abuse. A minority of these have Wernicke-Korsakoff syndrome. Some have had head injuries, some suffer the effects of cirrhosis of the liver. Drinkers are more likely to be smokers, and cerebrovascular disease may be more prevalent. Alcohol may accelerate the aging process, so Alzheimer's and other degenerative processes may present earlier. The direct toxic effect of alcohol may be the cause or a major factor in the etiology of this dementia. The Canadian Study of Health and Aging, part one (1991), seems to support both an increased prevalence of dementia in heavy drinkers, and an alcohol related etiology for cognitive loss. Collateral history suggestive of alcohol abuse may be a very efficient way of identifying those at most risk.

The closest available relative or caregiver was asked if the senior ever was a heavy drinker, and if he or she ever had problems related to alcohol use, such as losing jobs, or driving while impaired. A positive response to these questions was associated with half the chance of normal cognition, and almost double the chance of dementia compared with control groups matched for age, sex and illness. This group had a greater smoking history than controls. A second group with only one positive alcohol history response had a similar high smoking rate and little difference in the prevalence of dementias and abnormal cognition to their "non-smoking" controls. The cigarettes are unlikely to be the cause of the observed higher rate of dementia.

There was no increased prevalence of Alzheimer's or Vascular Dementia. The etiology identified for this increased prevalence of dementia was "Other", likely because the study had no specific coding for alcohol related dementia. Support for this explanation comes from another part of the study. There was an option for clinicians to identify alcohol as the etiology for cognitive loss. Chronic alcohol use was identified as the cause of cognitive impairment (not meeting the criteria for dementia) in 46% of the subjects with positive response to the alcohol history questions, when this was the case for just 5% of the control group. Perhaps they would have been just as likely to identify alcohol as the specific cause for dementia.

Most of those with collateral history suggestive of alcohol abuse were men in the "young old" category: ages 65 to 70 years. They were no more likely to be unmarried, living alone, or to be in nursing homes than controls. The clinical course of alcoholism can be marked by relationship problems and declining health and function. Further evaluation of their status from CSHA-2 data (five years later) is planned. Caregiving burden for these youngish dementing males with heavy alcohol use histories may be quite different than the burden described for caregivers of Alzheimer's patients and deserves further study. The

stability of caring may be at risk, and behaviour problems may well be different than expected for other demented individuals. Continued alcohol use may be a complicating factor, abstinence may not only make management easier, but may also reverse cognitive impairment to some degree.

This preliminary look at some findings from CSHA-1 may have two messages. Firstly, clinicians are reminded of the value of collateral history about their patients, especially if cognitive impairment or substance abuse is suspected. Secondly, service planners are warned of a care-giving challenge in the community. Families and friends caring for this population are facing unique challenges requiring specific support efforts. Long-term care facilities should be aware that not all of their demented residents will be very elderly women with Alzheimer's. Younger demented males are aging in the community. They are likely to have unique behaviour challenges and care needs that facilities will be expected to meet.

D. Evans, MD

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1999 Annual Scientific Meeting-Montreal-October 15, 16, 17

Plans are underway for the organization of our [annual meeting](#) this fall at the Chateau Champlain Hotel in Montreal. Call for abstracts and more information will be available on our website soon. Further information will be mailed. Those wishing to assist in the organization of the conference are invited to contact the C*SAM secretariat or Dr. Suzanne Brissette at phone 514-281-2121 X6553 or email - brissette-suzanne@sympatico.ca

C*SAM Membership Pins

As mentioned in the minutes of the 1998 Annual General Meeting, membership lapel pins are available for the cost price of \$25.00. They are a great way to let colleagues and friends at various meetings you may attend know about your involvement with C*SAM!

Addiction Medicine Practice Opportunity

Is anyone interested in moving to Kingston, Ontario? My practice is bursting at the seams. There are also teaching opportunities at Queen's University, Faculty

of Medicine. If interested, please contact me (Raju Hajela) at 613-541-3951 (voice), 613-541-0175 (fax) or email - hajela @ kingston.net

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Contributions from members are welcomed. This Newsletter and its editor depend on it!



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