Drug Abuse in Gay Men Linked to Other Issues

Depression, partner abuse, and childhood sexual abuse are often intertwined with drug abuse.

BY SHARON WORCESTER
Tallahassee Bureau

ATLANTA — Substance abuse is pervasive among gay men and is so intricately intertwined with epidemics of depression, partner abuse, and childhood sexual abuse that adequately addressing one issue requires attention to the others as well, said Ronald Stall, Ph.D., chief of prevention research for the division of HIV/AIDS prevention at the Centers for Disease Control and Prevention, Atlanta.

A population-based telephone-survey of nearly 3,000 gay men living in urban areas across the United States showed that in the prior 6 months, 90% of respondents had used alcohol, 50% had smoked marijuana, nearly 20% had used cocaine, 10% had used crack cocaine, and 10% had used methamphetamine. About 1% of respondents were current intravenous drug users.

Gay men on the East and West Coasts favored different drugs. Those on the West Coast preferred methamphetamine; those on the East Coast were more likely to smoke marijuana. "But by and large, they were using [the drugs] for the same purposes," Dr. Stall said at a conference jointly sponsored by the National Association of Addiction Treatment Providers and the Medical College of Georgia.

The survey findings debunk old, poorly constructed studies suggested that one in three was alcoholic, but that oft-quoted figure is inflated, Dr. Stall said.

'We have at least four epidemics going on among gay men that are associated with each other and making each other worse.'

Current alcoholism appears to be present in 10% of gay men, which is similar to the rate in a national sample of about 20,000 people from the general population.

About 1 in 10 gay men in the current study reported frequent heavy alcohol use (five or more drinks at one sitting at least once each week), and the same number reported three or more alcohol-related problems, which is diagnostic for problem drinking. Drug use was more prevalent. One in five reported drug use at least once each week or the use of three or more different drugs in the last 6 months, he said.

Compared with the general population sample, the gay male population sample had a 4-fold increase in marijuana use, a 7-fold increase in cocaine use, and a 10-fold increase in amphetamine use.

Data consistently show that drug use—particularly intravenous drug use—is associated with about a 40% increased risk of HIV infection. It appears that men who do not use intravenous drugs but who have high rates of other substance abuse have an equally high risk of HIV infection. Numerous studies have shown that substance use and high-risk sex are closely linked, he said.

In the current survey, substance use, childhood sex abuse, partner violence, and major depression emerged as interrelated issues that also are closely linked. Major depression and partner violence predicted multiple drug use and childhood sex abuse, and multiple drug use, childhood sex abuse, and partner violence were predictors of major depression.

"We have at least four epidemics going on among gay men that are associated with each other and making each other worse. Dealing with only one at a time may not be as effective as if we try to address them all," he said.

In treating a patient with a substance use disorder, for example, the ability to achieve sobriety might be impaired if a history of childhood sexual abuse or major depression is not addressed simultaneously. Effectively addressing these matters in the gay male population requires teamwork on the part of organizations attempting to resolve each of these problems in isolation from the others.

The four epidemics should also be considered in the context of HIV risk. Two solid trials have suggested that substance abuse treatment is effective for reducing HIV risk-taking behaviors, which raises the possibility that substance abuse treatment equals HIV prevention. ■

Naltrexone Depot Formulation Increases Adherence for Alcoholism

BY CARL SHERMAN
Contributing Writer

NEW YORK — An injectable depot formulation of naltrexone, now in phase III trials, may help overcome the adherence problems that have compromised the drug's efficacy in the treatment of alcohol dependence, Helen M. Pettinati, Ph.D., said at the annual conference of the Association for Research in Nervous and Mental Disease.

Naltrexone is one of three drugs that are Food and Drug Administration–approved to treat alcoholism. The compound, an opioid antagonist first used for opiate addiction, blocks reward pathways in the brain. It appears to reduce the excitement that some derive from alcohol ingestion, as well as alcohol craving.

Treatment with naltrexone appears less consistent with total abstinence than with reduction in excessive drinking. Of 24 double-blind controlled trials, 77% found significantly less harmful drinking with the drug compared with placebo, but many found no difference in drinking days or other measures of abstinence.

Clinically, compliance difficulties have limited the utility of naltrexone, said Dr. Pettinati, professor of psychiatry at the University of Pennsylvania, Philadelphia.

In one study, rates of relapse to heavy drinking were significantly lower among 60 naltrexone patients than among 44 placebo patients who attended 80% of clinic visits (10% vs. 38%). But there was no difference in relapse rate between 50 patients who were nonadherent to placebo and 42 who failed to follow the naltrexone regimen: 40% vs. 42%, respectively.

Attention to adherence should be a routine, proactive part of naltrexone treatment, Dr. Pettinati said. The actual use of the medication may be monitored with blister packs or diaries. "If there's a poor response to treatment, ask about adherence—it's one of the most common explanations," she said at the meeting, cosponsored by the New York Academy of Medicine.

Reasons for nonadherence should be explored and strategies devised to overcome problems. "The most common reason patients give for not taking the medication is "I forgot," but usually it's because they feel they are getting better and want to go out drinking," she said.

The depot formulation of naltrexone should provide an alternative to tablets that will reduce adherence difficulties. The intramuscular preparation lasts for 30 days. In a 24-week study involving 624 people, those receiving 380 mg of naltrexone monthly had significantly (25%) fewer days of heavy drinking per month than did those receiving placebo. Participants on a lower dosage (190 mg) of the drug had 17% fewer drinking days, which was not significant."You see the effect right away—you don't have to wait 6 months," Dr. Pettinati said.

Contrary to some concerns, patients appeared to have no difficulty adhering to the regimen: Seventy-four percent took at least four of the six injections.

In another study of 315 alcohol-dependent persons, those taking a somewhat lower dose (150 mg/mo) of depot naltrexone were significantly more likely to remain abstinent than was a placebo group during a 12-week study (18% vs. 10%). Adherence was high: Three-fourths in the naltrexone group received all scheduled injections.

Other recent research suggests that variations in a μ-opiate receptor gene may account for differences in response to naltrexone. In one study, those with one or two copies of the allele Asp40 had significantly lower relapse rates and a longer time to heavy drinking, when treated with naltrexone, than did those who were homozygous for the Asn40 allele, Dr. Pettinati said. ■

Antiseizure Drug Reduces Frequency of Binge Eating

Obese patients with binge-eating disorder treated with topiramate in an open-label study binged significantly less often and lost weight, according to a study by Susan L. McElroy, M.D., and her colleagues.

A previous, randomized, placebo-controlled trial of 61 patients conducted by Dr. McElroy and her coinvestigators reported that topiramate (Topamax) reduced both binge-eating behavior and body weight in obese patients suffering from binge-eating disorder (BED). That study lasted 14 weeks (Am. J. Psychiatry 2003;160:255-61).

It is estimated that 1.5%-2.0% of Americans binge eat, including 8%-30% of obese individuals.

To assess topiramate's effectiveness and tolerability over a longer period, the investigators extended the study for an additional 42 weeks in subjects who completed the first study and wanted to pursue treatment with the drug. The 42-week extension was open-label, nonrandomized, and uncontrolled (J. Clin. Psychiatry 2004;65:1463-9).

Fifteen patients who received topiramate during the controlled study and participated in the extension study showed an average drop of 4.0 binges per week, compared with their binge frequency before they started taking the drug ($P < .001$), and lost 14.1 kg in weight ($P = .023$), compared with their baseline weight. Sixteen patients who received placebo during the controlled study and participated in the extension study showed a drop of 2.5 binges per week ($P < .044$), compared with their baseline rate, and lost 14.5 kg ($P < .002$), the researchers reported.

Attrition rates, primarily due to protocol nonadherence and adverse events, were high in both the controlled and extension studies (43% and 68%, respectively).

While topiramate's mechanism of action in BED is unknown, the investigators speculated that the antiseizure medication curbs appetite and enhances satiety through glutamate receptor antagonism.

It is estimated that 1.5%-2.0% of Americans have BED, including 8%-30% of obese individuals, 70% of those in Overeaters Anonymous, and 50% of those seeking bariatric surgery.

Dr. McElroy, cautioned that because the extension trial was not a controlled randomized study, further studies are needed. He consults for Ortho-McNeil Pharmaceutical Inc., the maker of topiramate.

—Jay C. Cherniak