Codeine Usage in Ireland - A Timely Discussion on an Imminent Epidemic

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Introduction

Codeine is a highly abused substance in Ireland yet remains relatively under-documented in research studies. From a dual perspective as both a current medical student and practising community pharmacist, I note that codeine is an addiction that is often hidden under the guise of pain management, going unaddressed by both doctor and patient. Pain is a very common complaint in primary care settings in Ireland and the UK. In the UK, an estimated 1 in 25 of primary care consultations are thought to be related to headache and 1 in 7 related to musculoskeletal pain. Opioids are commonly used in Ireland and the UK for pain reduction with codeine being the second most prescribed opiate in the UK and an estimated 640 codeine prescriptions were dispensed per 1,000 patients in 2012. A short-acting opiate-based analgesic, codeine binds weakly to opioid receptors primarily in the central nervous system, reducing nociception. It also binds to opioid receptors elsewhere in the body like the gastrointestinal tract however, accounting for its side effect profile including constipation and nausea. As well as analgesia, codeine elicits effects such as euphoria and sedation which give the user short-term experience of a ‘buzz’ or ‘calm’.

Ease of Access and Supply

In Irish law, codeine is classed as Schedule 5 under the Controlled Drug Regulations meaning that it is available to patients over the counter in pharmacies under supervision of a pharmacist who should make the patient aware of the side effects, especially the sedating nature of codeine and emphasise the addictive potential of the drug. Of course, professional judgement is required and if misuse is suspected, the supply should not be made. Yet despite all of these safeguards, codeine-containing analgesics are some of the biggest selling products over the counter in Irish pharmacies.

Perhaps it is the patient’s ability to navigate codeine restrictions so easily that weakens the legislation. Research on future pharmacy practice in 2016 showed that Ireland had 4 pharmacies per 10,000 population, a figure considerably higher than its comparative counterparts including the USA and the UK. Despite the large number of pharmacies per capita, Ireland has a lower number of pharmacists per pharmacy which could mean they have less time for patient consultations due to a high workload. It may be difficult to monitor a particular patient if they are ‘codeine shopping’ - travelling to different pharmacies to purchase codeine. Furthermore, it may be difficult for a pharmacist to discern unsuitable codeine sales if well-constructed and credible explanations regarding pain are given by the patient and
there are no obvious outward signs of misuse. Without medical supervision, a large proportion of the Irish population is self-medicating with codeine and many have unknowingly developed an addiction.

Do Irish prescribing practices need revisiting? Professor Denis Cusack at the Irish College of General Practitioners Annual Conference in 2018 reported that from 2006-2016, there were remarkable increases in prescribing of certain addictive medications for medical card holders. This decade saw a 208% increase in codeine. General practice is the ideal setting to recognise codeine misuse and intervene at an early stage as patients are better known to their GPs than hospital doctors where often opiate prescriptions are initiated.

**Long-term Effects**

Maybe it is the fact that painkillers (those on prescription and not) are legally supplied to patients by healthcare professionals initially with the aim of pain management that makes their subsequent addiction so insidious. Those who suffer from a codeine addiction often tell how their relationship with the drug started so innocently in the quest for pain relief in a medical consultation and they had little to no understanding of the truly addictive nature of the drug. Often when pain has been fully resolved, the shackles of an opiate drug have bound an unassuming victim and withdrawal symptoms have become unbearable. A psychological and physiological dependence to opiates such as codeine can develop after a matter of days and drug tolerance increases quickly correspondingly. Opiate withdrawal symptoms include chills, constipation, nausea, insomnia, sweating, anxiety, lacrimation and muscle aches. In short- a truly horrible experience that is relieved only by succumbing to the drug again. Rebound headaches are also very commonly encountered among patients misusing codeine. A 2011 audit of the Dublin Neurological Institute Headache Clinic in The Mater Hospital Dublin revealed 52% of the cohort of 200 patients suffered from medication overuse headache, with the majority overusing paracetamol and codeine based products. Identifying knowledge gaps in both patients and doctors could help both parties recognise warning signs of addiction early and enable more successful and sustainable treatment plans.

**Current Treatment of Codeine Addiction**

At present, no specific treatment guidelines exist for detoxification from codeine but it is encompassed in broader guidelines for opioid substitution treatment. The current recommended treatment for codeine and pharmaceutical opioid dependencies is Suboxone, a sub-lingual preparation of buprenorphine and naloxone. Buprenorphine is a partial opioid agonist which works to reduce cravings during withdrawal whereas naloxone prevents overdose by blocking receptors. The patient suitability criteria for Suboxone exclude a significant cohort of people with poly-drug use, alcohol dependence, benzodiazepine abuse and those planning pregnancy or already pregnant. Perhaps it is time that the variance of opiate addiction between individual patients is recognised and the management and treatment plans in codeine addiction are developed as opposed to continuing with a ‘one size fit all’
**Future of Addiction Management**

It is important to note that those suffering from codeine addiction may have a self-perception that they are distinct from those with illicit drug addictions and may need to be dealt with in a manner different to dealing with illicit use. Regarding treatment centres, mixing of patients with various addictions may not be preferable and staff’s expertise in codeine addiction may be lacking as codeine-specific treatment regimens have not yet been developed in Ireland. The problem of self-medicating with codeine could possibly be reduced to some extent if the drug’s legal status was changed to prescription only as has been done recently in Australia and Italy, removing the possibility of its availability over the counter in pharmacies and reducing its relative ease of procurement. Although this could put further pressure on doctors to prescribe codeine, having prescriber involvement may unveil otherwise covert addictions. The introduction of screening tools for codeine addiction may also be a useful intervention in combination with improved medical training on prescribing addictive medicines and managing addiction. The possibility of reducing the quantity of codeine prescribed nationally could be considered especially in patients with a previous history of taking medications with addictive potential or those uninformed and at risk. Perhaps, medication addiction could become a routine question when eliciting a medical history from a patient, listed the same way as a medication allergy is to remove the social taboo associated with addiction and improve communication of such information between patient and prescriber.

Further, the establishment of a centralised monitoring system could help to keep track of the number of people being prescribed and purchasing the drug. This could provide vital information on the true consumption of codeine in Ireland and better enable policy and public health decisions to be made to combat it. Also being aware of the ease with which one can buy codeine online is important too— a patient’s actual codeine intake could be significantly more than accounted for by doctors and pharmacists. The lack of sanctions currently in place to obstruct such online activity is extremely worrying.

**Conclusion**

The prevalence of codeine usage in Ireland is high and little progress can be made in the area until the issue is fully acknowledged and necessary research is conducted. At present, there is scarce literature available on the topic in Ireland. Codeine addiction is an epidemic verging on eruption and should be recognised now. Hopefully, this discussion will be viewed as a conversation starter among colleagues to bring a very prevalent and grave public health threat to the forefront of medical practice and encourage Irish healthcare professionals nationally to work together to improve the current recognition and management of codeine addiction.
Conflicts of Interest Statement
The author has no conflict of interest to declare.

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References
