Here was the secret of happiness, about which philosophers had disputed for so many ages, at once discovered; happiness might now be bought for a penny, and carried in the waistcoat-pocket; portable ecstasies might be had corked up in a pint-bottle; and peace of mind could be sent down by the mail.

--Thomas De Quincey, Confessions of an English Opium Eater

Opium has been used (and misused) for millennia. A brief Internet search will reveal that the opium poppy has been found in grave sites dating back some 6,000 years or so and that it has been cultivated since at least since 3400 BCE. Coca leaves, likewise, have been used for at least 5,000 years and likely much longer. But it has only been in the last 2 centuries that pure and potent drugs have become readily available—morphine was synthesized in approximately 1803, cocaine in 1859, amphetamine in 1887 (and methamphetamine in 1893), and heroin in 1898.

De Quincey’s 1821 ode to the wonders of opium (and his later description of its costs) predated the development of the hypodermic needle (in 1844 by Francis Rynd) and its combination with a glass syringe (by Alexander Wood) in 1853. Opium was already available and often misused. Is it a surprise to find that this medical advance was first used as a means of delivering morphine to the patient? One must wonder what Rynd and Wood might think today, with so many more psychoactive drugs to choose from, about how their inventions have been employed. Technology, in the form of the syringe, has been a tremendous boon to medicine, but it has not been without its costs.

But the problem of drug injection is not restricted to opiates—cocaine and amphetamine species are also frequently injected as are sedative-hypnotics, phencyclidine and related compounds, and hallucinogens. In fact, pretty much anything that can be swallowed, snorted, sniffed, or smoked can be (and has been) turned into a form suitable for parenteral use. The result is not attractive: there are now more than 16 million people worldwide who inject drugs and the number continues to increase. With that increase has come an incredible burden of medical cost and suffering—not only from HIV infection and its sequelae, but from the transmission of other blood-borne diseases and from the consequences of unsterile injecting practices.

There are also the tremendous psychological and social costs of addiction. It should be kept in mind that any history of drug injection, active or not, strongly suggests that the patient is or has been addicted not only to the injected drug but to many other substances as well. Why are people who inject drugs (PWIDs) so vulnerable? This is a group characterized by high rates of childhood adversity and behavioral problems, adult antisocial behaviors, depression, and by tremendous need for housing, education, vocational skills, and medical care. Whether such problems are causes or effects of addiction or something of both (leading to a vicious cycle of illness and dysfunction), any history of drug injecting is a signal to the clinician that the patient will likely have many needs but may not be motivated to address them because of active addiction, the impulsive and self-defeating behaviors associated with antisocial personality disorder, the effect of other psychopathology, or the consequences of overwhelming social disadvan-
tage. Such problems are unlikely to disappear even if the practice of drug injecting is halted. The clinician who cares for such challenging patients risks succumbing to a sense of “learned helplessness”—patients may not accept intervention and even those willing to change may not have sufficient resources readily available. But without treatment, all too often the outcome may be death by suicide, ongoing medical or psychiatric illness, or continued involvement in high-risk behaviors associated with severe drug addiction.

Much remains to be learned about PWIDs. What are the psychological, economic, and cultural forces that preceded and promote the decision to inject drugs? We have some general ideas, based on clinical experience, of behaviors that indicate high risk of progression to drug injecting, but how can we efficiently identify and intervene in that population? How can we more efficiently treat addiction in PWIDs? We know that harm-prevention techniques are effective, if they are made available, but can we do better in convincing our patients to use them?

As long as there are syringes and people willing to use them for nonmedical purposes, injection drug use (IDU) will remain a significant public health problem. It is hoped that greater familiarity with the epidemiology of IDU, the many associated psychiatric and medical comorbidities, and an understanding of risk-reduction strategies for this population will better equip the clinician to meet the many challenges of treating this population.

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Disclosure: The author has no relevant financial relationships to disclose. doi: 10.3928/00485713-20161207-01