

BRIEF COMMUNICATION

A case of poppy tea dependence in an octogenarian lady

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Abstract

*While poppy seed and poppy tea dependence has been described, it is unusual to see such patients actively seek treatment in India. We report the case of an 82-year-old client with dependent use of poppy for 55 years. She was brought for treatment as access to poppy became difficult following legal restrictions. She was successfully maintained on buprenorphine maintenance. [Subodh BN, Murthy P, Chand PK, Arun K, Bala SN, Benegal V, Madhusudhan S. A case of poppy tea dependence in an octogenarian lady. *Drug Alcohol Rev* 2009]*

Key words: poppy tea, poppy seeds, dependence, geriatric, buprenorphine.

Introduction

Poppy tea drinking has been depicted in the past in Asian and Western literature. However, this practice has fallen out of favour, and there is dearth of information related to poppy tea usage in the more recent medical literature. While there are a few cases described from western countries, no case has been reported from the Asian region, particularly India. In a study in New Zealand, 11 of 24 (46%) patients with opioid dependence reported using poppy seed tea [1]. There is a subgroup within the illicit drug using community in rural England using poppy tea in a nondependent pattern [2]. Unnithan and Strang described a 37-year-old man dependent on poppy tea who underwent a methadone withdrawal regimen commencing on 30 mg methadone daily [3]. King *et al.* described a 26-year-old man who underwent withdrawal using MS Contin, commencing at a dose of 60 mg twice daily [4]. Lloyd-Jones and Bonomo reported two cases of poppy tea dependence, one treated with buprenorphine replace-

ment therapy commencing at 4 mg and increased to 16 mg day⁻¹ and another case treated with methadone commencing at 30 mg. Formal dosage conversion data are not available and it can be difficult for clinicians to estimate starting doses [5]. We present here an unusual case of opioid dependence on opioid seeds/pods in a geriatric patient who was subsequently successfully maintained on buprenorphine.

Case report

Mrs S, an 82-year-old widow living with her children, presented to our centre with an approximately 55 year history of the use of opioid preparations. She had a significant family history of alcohol dependence, nicotine dependence and opioid dependence in a first degree relative. Her first use of opioids occurred 55 years ago when she was given 'afeem' (opium) candies prepared from poppy seeds by her father after the birth of her fourth child, as a remedy for pain and weakness. After taking it she reported feeling effective

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relief from pain. Over a period of 1 year she started increasing the frequency and number of afeem candies and started taking it daily. When she did not consume the candies regularly, she reported that she would become dull, start yawning frequently and experiencing cramps all over the body. She became irritable towards others, expressed death wishes and even made a few attempts of self-harm. In order to avoid these complications, her family members used to give her poppy seeds regularly. They purchased them from different parts of the country as it was not easily available where they lived. For the past 10–15 years they were not able to get a regular supply of poppy seeds due to legal restrictions. Someone suggested that she could use the poppy pods for the same effect. She made a concoction by crushing the dry pods of the poppy obtained from local homeopathic shops and boiling it for 15–30 min in lemon juice and sugar for taste. Later she sieved the contents through a cloth and consumed the brown-coloured filtrate. The effects she obtained with the concoction were similar to the effects she had with the afeem candies. Gradually she increased the quantity used. She had to make at least 1–2 L of concoction in a day and drank it throughout the day. The family members recall that they would be able to manage her only if this decoction was readily available and they had to carry it in bottles wherever she went. She was admitted several times to various general hospitals for management of her withdrawal symptoms. Every time the exasperation of her family grew as no physician was able to provide a solution to her problem. Meanwhile legal restrictions became stricter and extended to poppy pods. Unable to procure these pods and as a last option the family brought her to our treatment centre.

Physical examination revealed no significant physical abnormality. Upon assessment she was found to be in the pre-contemplation phase of motivation. The decoction brought by her family on diagnostic testing was positive for opioid compounds. A complete blood work up, including haemogram, tests of liver and renal function, serum electrolytes, blood and urine culture sensitivity and CT scan of the brain were within normal limits. She was diagnosed as a case of opioid dependence syndrome as per ICD-10 and was rated on the Clinical Opioid Withdrawal Rating Scale (COWS). She had a score of 26 indicating moderately severe withdrawal symptoms. She was initially detoxified using conventional detoxification procedures (Clonidine 0.15 mg per day, Diazepam 10–15 mg per day and combination of Diclofenac 50 mg + Chlorzoxazone 500 mg + Paracetamol 500 mg for pain) given as oral tablets. However, after the second day of admission she developed a picture of delirium characterised by disorientation, visual hallucinations, agitation and restlessness. Clonidine and diazepam were withdrawn and

Haloperidol 1–2.5 mg per day was prescribed in divided doses to control her behavioural symptoms. After 3 days the delirium completely resolved. The option of further management was discussed with the patient and family members and they opted for treatment with buprenorphine, a partial opioid agonist. After informed consent, medication was started at a low dose of 0.4 mg and gradually titrated upwards to 1.2 mg per day. Relapse prevention counselling and psychoeducation of the patient and family members were also done. After 3 months the buprenorphine dose was reduced and the patient is currently on two tablets of 0.4 mg daily. She is regularly followed up and urine opioid tests have been negative for 1 year.

Conclusion

Traditional use of afeem (opium) balls ingested orally or smoked and the practice of opioid decoction in North West India in the older age group has been largely replaced by illicit opioids (heroin) and non-prescription use of opioids in the younger generation. This elderly lady presented with a long history of dependence on poppy seeds and poppy pod decoction. Her family was supportive of her habit for several decades and brought her for treatment only when opioid seeds/pods became scarce because of legal restrictions.

The delirium on the second day after admission may have been due to withdrawal as all tests to rule out other causes for delirium were negative. This case also highlights the fact that care must be taken in treating withdrawal symptoms in geriatric patients using traditional methods of treatment. Substitution therapy may be a better alternative in this group.

The case also illustrates that dependence on poppy seed/pod can be severe and warrants maintenance treatment. To our knowledge this is the first case of an elderly person successfully maintained on buprenorphine. The dose of buprenorphine required for maintenance was low, compared with those described in the western literature. This may be due to lower body weight among Indians [6]. This case not only reminds us of the practices of a bygone era, but also highlights the challenges in treating elderly people with opioid dependence.

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