Poppy Tea Dependence

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A patient presenting with dependence on opium poppy tea infusion is reported. Poppy tea drinking, although previously described in certain parts of the UK, rarely presents in the form of a dependence syndrome. Issues relating to the management of poppy tea dependence are discussed, including the results of existing laboratory urinalysis for drugs of abuse, the calculation of opiate dose equivalence, and the likelihood of transition (or not) from use of poppy tea to use of other opiates.
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Poppy tea drinking was a widespread social activity in rural areas of the UK in the 19th century (see Berridge & Edwards, 1981). Its use declined from that time, however, coinciding with the increased development of commercial supplies. Poppy tea was generally used in the role of a herbal remedy for minor ailments rather than specifically for a psychoactive effect. More recently the use of poppy tea to supplement black-market/prescribed opiates was described (London *et al*, 1990), with 17 of 43 opiate addicts using poppy tea for this effect. Most consumption was nevertheless of a non-dependent form and a generally insignificant source of opiates.

We report the case of a patient dependent on poppy tea and reliant on this as the sole source of opiates, with no history of use of other illicit drugs and living in an urban setting. Additionally, this report illustrates two further issues: firstly, the use of dihydrocodeine preparations (in this instance proprietary DF118) as a substitute for preferred opiates; and secondly at present, the absence of a formal dosage conversion formula for individuals using non-commercially produced opiates.

Case report

The patient was a 37-year-old man referred to a Drug Dependence Unit with a 17-year history of drinking poppy tea. He had no serious medical history, no personal or family history of psychiatric illness, and had never previously presented for treatment of drug dependence. The patient was from a stable family background with no family history of drug or alcohol misuse. His personal and marital history were unremarkable. The patient had no forensic history and was currently self-employed. He took no medication regularly but admitted to occasional self-medication with his wife's benzodiazepines (prescribed for her mild insomnia) to treat his own occasional insomnia.

His first use of poppy-head infusion was 20 years ago, after working in a pharmacy where he learnt how to manufacture opiate cough mixtures on the premises. The patient's initial use of the poppy-head tea was to treat mild insomnia. He had no history of injecting the infusion, or of experimentation with other drugs, although he drank approximately 25–28 units of alcohol per week.

The early use of the poppy tea infusion was intermittent but, over the next 18 years, a gradual increase had occurred in frequency and quantity of ingestion. For the two years before presentation there had been a marked increase in use, by which time he was boiling 14 poppy heads per day. All the poppy heads were obtained from ordinary florists. The patient associated this increase in use with a period of sudden unemployment, consequent anxiety, and worsening insomnia.

At the time of presentation he denied having a low mood or feelings of anxiety, and expressed a desire to stop using the poppies as he was now in steady employment. He had had one previous attempt at self-detoxification (by sudden cessation of use), resulting in typical opiate withdrawal symptoms including rhinorrhoea, diarrhoea, vomiting, sweating, and acute anxiety. These symptoms lasted 24 hours, following which he resumed use of the poppies. On a separate occasion when he required dental treatment he ceased using poppy heads. He then attempted to prevent withdrawal by taking 15 tablets of dihydrocodeine (DF118) orally which had originally been prescribed for the dental pain. However, he described himself as feeling 'stoned' after taking this quantity of tablets.

At presentation, the patient showed no abnormalities in mental state. Physical examination was normal with no evidence of injection marks. Urinalysis using thin-layer and gas–liquid chromatography (for overview, see *Lancet*, 1987) revealed the presence of morphine and benzodiazepines, consistent with the patient's own account.

It was then decided to commence the patient on an opioid substitute (methadone) for detoxification. However, in order to assess the starting dose, the patient underwent a day of test dosing. Having attended during withdrawal, the methadone requirement was titrated against objective measurements of pulse rate, blood pressure, and skin temperature, and the patient's subjective description. The total starting dose requirement was found to be 30 mg of methadone daily. The patient was therefore commenced on a methadone withdrawal programme as an out-patient with close nursing follow-up.

Discussion

The 150th anniversary of the death of Friedrich Serturner, discoverer of morphine, was in 1992. As

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the founder of alkaloid chemistry, Serturner was the first to report on the isolation of a "sleeping agent" from the poppy plant (Goerig & Schulte-am-Esch, 1991). The cultivation of poppy plants for illicit use is now rare in the UK, but concern was expressed in the mid-1980s about the increasing use of this method in other countries, such as Poland (Tobolska-Rydz, 1986). A particularly disturbing recent trend has been the diffusion of a new pattern of abuse with the injecting of home-made 'poppy straw' (prepared from harvested poppies) in many parts of the former Soviet Union and in Poland (Chopin, 1992), and careful scrutiny will be required to examine the extent to which this development spreads internationally.

Our patient illustrated the more common use of poppies when used illicitly, that is the boiling of poppy heads to produce an infusion. What is unusual is the fact that the poppies were obtained from suppliers found in an urban setting. Although a urine result positive for morphine would typically indicate use of illicit heroin, reports have shown this result may also be consistent with ingestion of poppy seeds (el Sohly *et al*, 1990).

The use of non-commercial opiates (such as poppies) in a dependent form is rare. This case highlights the absence, however, of formal dosage conversion procedures, normally available for other preparations (Department of Health, 1991). In this instance, test dosing of the patient resulted in a conversion formula of 14 poppy heads being equivalent to 30 mg of methadone. There may therefore be an argument for collation of reports of those presenting in a similar fashion to allow comparison of treatment regimes.

Finally, consideration may be given to the use of dihydrocodeine tablets by our patient. Swadi *et al* (1990) have previously reported on the extent of use of dihydrocodeine (DF118) tablets by opiate addicts attending a London drug dependence unit: their report describes the codeine intake as an abuse – likened to the World Health Organization definition of 'unsanctioned use' as "use of a drug that is not approved by a society, or a group within a society" (Edwards *et al*, 1981). However, the use of dihydrocodeine by our patient might reasonably be construed as an example of adaptive use of dihydrocodeine, similar to the descriptions by Robertson *et al* (1990) and Strang *et al* (1990) in their reply to Swadi – an adaptive use of an alternative opiate preparation, at times of shortage of the preferred opiate. Indeed, dihydrocodeine is listed as a possible drug to be prescribed in the management of opiate withdrawal (in the 'Orange Guidelines' from the Department of Health, 1991). It may perhaps be appropriate for such use of the drug to be afforded a degree of sanctioning if it assists, for example, in self-detoxification off opiates as has recently been described (Gossop *et al*, 1991).

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