

## Opium dependency and in-hospital outcome of acute myocardial infarction

Hamid Reza Javadi<sup>1</sup>, Abbas Allami<sup>2</sup>, Navid Mohammadi<sup>3</sup>, Rezvan Alauddin<sup>4</sup>

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### Abstract

**Background:** Impact of substance abuse on outcome of hospitalized patients with acute myocardial infarction (MI) is a frequent question. Available studies show disagreements over its impact, thus we performed this study to find a clear answer.

**Methods:** In a cross sectional study, 304 patients (include 152 consecutive opium dependents and equal number of independents) with acute MI admitted to coronary care units (CCU) in Bou-Ali Sina Hospital of Qazvin University of Medical Science were enrolled. Data on demographics (e.g. age, sex and education), identified MI risk factor (smoking and diabetes), clinical findings (e.g. Killip class and in-hospital mortality), ECG findings (e.g. localization of infarction and arrhythmia), echocardiographic examinations (e.g. ejection fraction and regional wall motion abnormality) and laboratory findings (lipid profile, glycemic situation) were gathered.

**Results:** The mean age was  $63.01 \pm 12$  years for opium users and  $64.3 \pm 10$  for non-users. Educational level was higher in patients who used opium. No significant differences were found between opium users and non-users in rate of hypertension, diabetes mellitus, hyperlipidemia, and cigarette smoking. The mean duration of experienced chest pain in hospital stay was significantly higher in non-opium users compared to opium users ( $1.78 \pm 0.63$  vs.  $1.52 \pm 0.54$ ) ( $p < 0.001$ ). Higher Killip class and arrhythmia have been identified as the most important independent predictors of early in-hospital mortality (in both groups).

**Conclusion:** The higher Killip class and age identified as the most important independent predictors of early in-hospital mortality and addiction do not act as a major risk or protecting factor in this context. Nevertheless, we believe that a more comprehensive study with follow up of patients should be carried out for evaluation of opium addicted patients, their outcome after MI, and a better decision making for their treatment.

**Keywords:** Opium dependence, Myocardial infarction, Outcome.

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### Introduction

The 10th revision of the International Classification of Diseases and Health Problems (ICD-10) has defined the dependence syndrome as “being a cluster of physiological, behavioral, and cognitive phenomena in which use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviors that once had greater value” (1). The main components of opioid dependence include:

strong desire or sense of compulsion to take opioids; difficulties in controlling opioid-taking behavior; a withdrawal state when opioid use has ceased or been reduced; evidence of tolerance, such that increased doses are required to achieve effects originally produced by lower doses; progressive neglect of alternative pleasures or interests; and persistence with opioid use despite clear evidence of overtly harmful consequences (2). Opium abuse is a social prob-

1. Associate Professor, Department of Cardiology, Faculty of Medicine, Qazvin University of Medical Sciences, Qazvin, Iran. javadi.hr@gmail.com

2. (Corresponding author) Associate Professor, Department of Infectious Diseases, Faculty of Medicine, Qazvin University of Medical Sciences, Qazvin, Iran. allami9@yahoo.com

3. Associate Professor, Department of Community Medicine, Faculty of Medicine, Iran University of Medical Sciences, Tehran, Iran. nvmohammadi@iums.ac.ir

4. General Practitioner, Qazvin University of Medical Sciences, Qazvin, Iran.

lem and it is estimated that prevalence of opium addiction has grown up by three folds for the past 20 years and now has been estimated about 2-2.8% according to official reports in Iranian (3) A rapid situational analysis in 2007 showed a prevalence of 3.32 for men and 0.55 for women (more than 15 years old). Estimated number of drug dependent people is about 1.2 million in Iran (4).

Myocardial Infarction (MI) is one of the most common diseases with high mortality and morbidity. There are well-known risk factors for coronary artery disease (CAD) including old age, male gender, cigarette smoking, hypertension, diabetes mellitus and hyperlipidemia (5). Theoretically, substance abuse could be a risk factor for the appearance of complication in ischemic heart disease (IHD) due to coincidence of smoking. On the other hand, presence of risk factors such as diabetes and history of heart disease, probably make people prone to opium use. Behind the great occurrence of opium addiction in Iran, especially among older age people, is a general traditional belief of inhibitory effects of opium on the progression of diabetes mellitus (DM), hypertension, and cardiovascular disease (6). Though, few studies have investigated the effect of opium addiction on CAD. Some studies reported harmful effects of opium on the cardiovascular system (7-9). Although intravenous morphine sulfate was recommended for the relief of chest pain or anxiety in patients with acute MI for many years, recent studies have indicated that use of morphine either alone or in combination with nitroglycerin has been associated with higher mortality for patients with non-ST-segment elevation acute coronary syndromes (10). Some other studies did not find any association between opium and CAD (11-13). Hence, we performed this study to compare in-hospital outcome and characteristics of MI patients in two groups of opium users and non-users.

## Methods

In a cross sectional study, 304 patients (include 152 consecutive opium dependents and equal number of independents) with acute MI admitted from May 2010 to October 2011 to coronary care units (CCU) of Bou-Ali Sina Hospital of Qazvin University of Medical Science were enrolled. All the patients were chosen on a strict "first-come, first-chosen" basis and all eligible patients were included. Diagnosis of acute MI was established based on clinical presentation, serial electrocardiography (ECG) changes and cardiac enzyme analysis. For patients who fulfilled the criteria, essential data including demographics, clinical and paraclinical characteristics (i.e. information on cardiovascular risk factors such as hypertension, hyperlipidemia, diabetes mellitus, family history of CAD and smoking) were gathered. Hypertension was defined as the recent use of antihypertensive medication or a blood pressure more than 140/90 mmHg on two different occasions. Hyperlipidemia was defined by serum cholesterol level more than 200 mg/dl, serum triglyceride more than 200 mg/dl or use of antihyperlipidemia drugs. A diagnosis of diabetes mellitus history was made if the patient used insulin or oral hypoglycemic agents as well as evidence of previous fasting blood glucose  $\geq 126$  or postprandial blood sugar (BS)  $\geq 200$  mg/dl (14). Localization of infarction was defined according to criteria proposed by The New England Journal of Medicine (NEJM) (15). In all patients, Killip class (a system to risk stratification in patients with acute MI) was determined. All patients were examined at rest in supine and left lateral decubitus positions. Two-dimensional, M-mode and Doppler-echocardiographic examination were performed using a 2.5 MHz phased array transducer. Echocardiographic examination was performed using standard views and techniques for detection of mitral regurgitation and regional wall motion abnormality (WMA). During CCU stay, all patients were subjected to check by 12-lead ECG (and posterior or right precordial

leads if necessary) in a daily basis to assess ST segment shifts, arrhythmia, MI site, and atrioventricular or interventricular block. Follow-up was carried out on entire duration of hospital stay.

Opium dependency was diagnosed by patients' self-report of daily consumption of at least 200 mg opium in different ways from oral to inhalation, and according to DSM-IV definition and criteria of substance dependency (16), and confirmed by interview. Type and duration of substance abuse were recorded through interview. Data was compared between the opium users and non-users by using chi-square and Fisher's exact tests for nominal and student's t-test for continuous variables. The Mann-Whitney U test was used to compare differences between two groups when the dependent variable is either ordinal or continuous, but not normally distributed. To assess effect of opium dependency on in-hospital mortality, we used a binary logistic regression model. Relationships were examined by Pearson Chi-Square test. SPSS for Windows, Version 19 (SPSS Inc., Chicago, IL) was used for statistical analyses. Values are expressed as mean  $\pm$  SD, and  $p < 0.05$  was considered statistically significant. The study received approval by ethical board of Qazvin University of Medical Sciences and all patients completed the informed consent form.

## Results

All 304 participants were selected from patients admitted to CCU, with a mean age of  $63.66 \pm 11.38$  years (range: 40–89). Nearly 3/4 of the participants (74.1%,  $N = 301$ ) were male (Table 1). The mean age was  $63.01 \pm 12$  years for opium users and  $64.3 \pm 10$  years for non-users ( $p = 0.319$ ). In our study, men had a higher rate of opium use [(53.81%; 95% CI: 47.26-60.23) versus (38.46%; 95% CI: 28.45-49.56),  $p = 0.02$ ], while women had a higher rate of in-hospital mortality than men [(5.74%; 95% CI: 3.31-9.77) versus (9.86%; 95% CI: 4.86-18.98)], although this difference was not significant ( $p = 0.271$ ).

Overall length of hospital and CCU stays were  $6.96 \pm 3.25$  and  $2.69 \pm 1.54$  days. No significant difference regarding length of stay was observed between the two groups ( $p = \text{NS}$ ). Educational attainment was higher in patients who used opium ( $p = 0.024$ ). Table 1 shows the demographic and clinical characteristics of the two groups.

No significant differences were found between opium users and non-users considering hypertension, diabetes mellitus, and hyperlipidemia (Table 2). The mean duration of experienced chest pain in hospital stay was higher in non-opium users compared to opium users ( $1.78 \pm 0.63$  vs.  $1.52 \pm 0.54$ ), and the difference was statistically significant ( $p < 0.001$ ).

Although total number of blocks were not different in two groups, opium non-users more frequently had left bundle branch block (LBBB). Localization of acute MI and Killip class at admission were not different between the two groups. Overall in-hospital mortality was 7.8% among opium users and 6.3% among other group ( $p = 0.6$ ). In our study, opium addiction did not show any impact on arrhythmias development, ejection fraction and worsening of wall motion. In binary logistic regression model (to assess effect of opium dependency on in-hospital mortality) included variables were opium dependency, age, sex, Killip class, hypertension, diabetes, MI Site, arrhythmia as covariate. After an enter method analysis, Killip class and age remained in the model (Table 3).

## Discussion

In our study, we did not find any difference in the prevalence of risk factors of CAD (e.g. diabetes mellitus, hypertension, and lipid profile) between the two groups of opium users and non-users. During recent years in Iran, most studies conducted on this context did not reveal beneficial effect of opium consumption on DM, hyperlipidemia and CAD (7, 11, 17-18). A study for evaluation of opium effect on lipid profile revealed that opium did not have any impact on triglyceride, low density lipopro-

Table 1. The frequency of demographic variables of patients according to opium usage

Variable		Group		Chi <sup>2</sup> P Value
		Opium Users (%)	Opium Non-users (%)	
Sex	Male	120 (80.0)	103 (68.2)	0.020*
	Female	30 (20.0)	48 (31.8)	
Education	Not educated	14 (10.7)	33 (23.6)	0.024*
	Primary school	53 (40.5)	55 (39.3)	
	High school	46 (35.1)	41 (29.3)	
Smoking status	Academic	18 (13.7)	11 (7.9)	0.225
	Active Smoker	14 (9.9)	23 (16.4)	
	quitter	31 (21.8)	32 (22.9)	
History of MI	Non Smoker	97 (68.3)	85 (60.7)	0.154
	No	136 (89.5)	141 (94.0)	
History of CABG	Yes	16 (10.5)	9 (6.0)	0.643
	No	140 (94.0)	138 (92.6)	
History of IHD	Yes	9 (6.0)	11 (7.4)	0.174
	No	114 (76.5)	105 (69.5)	
Hypertension	Yes	35 (23.5)	46 (30.5)	0.053
	No	78 (51.3)	80 (52.6)	
CRF	Yes	74 (48.7)	72 (47.4)	0.314
	No	149 (99.3)	147 (98.0)	
Diabetes mellitus	Yes	1 (0.7)	3 (2.0)	0.101
	No	97 (66.0)	112 (74.7)	
FBS	Yes	50 (34.0)	38 (25.3)	0.812
	Normal	107 (70.4)	114 (75.0)	
BS in admission time	Up	45 (29.6)	38 (25.0)	0.001
	Normal	108 (71.1)	107 (70.9)	
cholesterol	Up	44 (28.9)	44 (29.1)	0.252
	Normal	138 (91.4)	144 (94.7)	
triglyceride	Up	13 (8.6)	8 (5.3)	0.219
	Normal	103 (67.8)	112 (74.2)	
Mitral regurgitation	Up	49 (32.2)	39 (25.8)	0.409
	No	86 (57.7)	80 (53.0)	
WMA	Yes	63 (42.3)	71 (47.0)	0.137
	No	99 (65.6)	87 (57.2)	
Kind of Block	Yes	52 (34.4)	65 (42.8)	0.026*
	No Block	148 97.3	142 93.4	
Arrhythmia	LBBB	0 0	7 4.6	0.757
	RBBB	4 2.63	3 1.9	
	No Arrhythmia	134 88.1	136 89.4	
Killip class	VF	11 7.2	8 5.2	0.387
	VT	7 4.6	8 5.2	
	1	79 (53.4)	93 (61.2)	
MI Site	2	65 (43.9)	56 (36.8)	0.728
	3	4 (2.7)	3 (2.0)	
	Inferior Group	63 (41.4)	66 (43.4)	
Mortality	Anterior Group	89 (58.6)	86 (56.6)	0.644
	Live	141 (92.8)	143 (94.1)	
	Death	11 (7.2)	9 (5.9)	

Abbreviations: MI: Myocardial Infarction, CABG: Coronary artery bypass surgery, IHD: Ischemic heart disease, CRF: Chronic Renal Failure, WMA: wall motion abnormality, LBBB: Left bundle branch block, RBBB: Right bundle branch block, VF: ventricular fibrillation, VT: ventricular tachycardia. \*  $p < 0.05$ . Data are number (%).

tein (LDL), and high density lipoprotein (HDL), but total cholesterol levels were lower in opium addicted patients (introduce as a known side effect of opium). Nevertheless, researchers' findings were not sufficient to make an exact judgment about the direct effect of opium on serum lipids because of many confounding factors

on lipid profile such as dietary habits (19,20). Also, these data indicated that the belief of protective effect of opiates on cardiovascular disease is used to justify substance abuse.

In our study, opioids users and smokers had higher levels of education. As a matter of fact, the unprecedented growth in use of

Table 2. Baseline characteristics of two study groups

Variable	Mean (SD)		p
	Opium users	Opium non-users	
Age (years)	63.01 (12.20)	64.31 (10.49)	0.319
FBS (mg/dl)	121.34 (55.29)	118.71 (47.85)	0.658
BS in admission time (mg/dl)	175.20 (84.06)	176.42 (83.58)	0.899
Cholesterol (mg/dl)	166.07 (48.40)	157.70 (42.63)	0.111
LDL (mg/dl)	106.93 (27.93)	105.43 (25.02)	0.621
HDL (mg/dl)	37.26 (8.19)	37.15 (7.71)	0.904
TG (mg/dl)	151.28 (73.79)	151.41 (89.61)	0.989
Duration of experienced chest pain (day)	1.52 (0.54)	1.78 (0.63)	0.000 <sup>*,1</sup>
hospital stay(day)	7.12 (3.42)	6.80 (3.06)	0.397
CCU stay (day)	2.86 (1.64)	2.53 (1.42)	0.061

Abbreviations: FBS: Fasting blood sugar, BS: blood sugar, LDL: Low-density lipoprotein, HDL: High-density lipoprotein, TG: Triglyceride, CCU: coronary care unit. \* p < 0.05. Data are mean ± SD, 1: the Mann-Whitney U test was used to compare differences

Table 3. Independent variables associated with in-hospital mortality (Method = Enter)

	p	Exp(B)	95% C.I. for EXP(B)	
			Lower	Upper
Step 1 <sup>a</sup>				
age	0.034*	1.077	1.006	1.154
sex	0.245	3.421	0.430	27.205
hypertension	0.978	1.022	0.217	4.815
Killip class	0.172			
Killip class (1)	0.063	0.094	0.008	1.135
Killip class (2)	0.106	0.149	0.015	1.494
smoking status	0.037	0.114	0.015	0.876
arrhythmia	0.000*			
arrhythmia (1)	0.002*	0.053	0.008	0.334
arrhythmia (2)	0.097	5.585	0.731	42.663
Myocardial Infarction site	0.810	1.194	0.280	5.086
diabetes	0.468	1.718	0.399	7.408
Constant	0.104	0.007		

a; Variable(s) entered on step 1: age, sex, hypertension, diabetes mellitus, Killip class, smoking status, arrhythmia, MI Site. b: \* p < 0.05

narcotics among educated people is one of the major concerns of many social pathologists in Iran (21-24). In prevention strategies, it is suggested to target messages and attitude changes on addiction and its adverse effects, especially to the older people with higher levels of education. The association of education and opium use should be studied with a representative sample. In our study, in-hospital mortality was similar among opium-users and non-users. Similarly, in a recent cohort of patients who were admitted with AMI, there was no significant difference in specifications, short term outcome and prognosis of AMI between opium-users and non-users except for duration of hospitalization (9). In our patients, the average time of experienced chest pain in hospital was higher in non-opium users while CCU stay was significantly shorter in opium users. This dif-

ference may partly be due to self-medication or more request of opium in user group. Results of our study indicate that opium addiction in hospitalized patients does not have an important impact on development of arrhythmia, ejection fraction and WMA after MI.

From the current study strengths are prospective design, availability of data to adjust for confounders, and multiple outcome measurement of acute myocardial infarction. These outcomes include clinical findings (e.g. Killip class, in-hospital mortality), ECG findings (e.g. localization of infarction, arrhythmia), echocardiographic examinations (e.g. ejection fraction, WMA) and laboratory findings (lipid profile, glycemic situation). Our study limitations included inaccurate amount of causes and route of abuse, the study observational design and therefore the potential for residual

confounding, a possibility of measurement bias in determining the actual amount and route of opium consumption because these data were collected solely based on self-reporting.

### Conclusion

In our study, higher Killip class and age identified as the most important independent predictors of early in-hospital mortality and addiction do not act as a major risk or protecting factor in this context. Nevertheless, we believe that a more comprehensive study with follow-up should be carried out for evaluation of opium addicted patients, their outcome after MI, and a better decision making for their treatment.

### Conflict of interest

The authors declared no competing interests.

### References

1. WHO. Dependence syndrome definition. Available from: [http://www.who.int/substance\\_abuse/terminology/definition1/en/](http://www.who.int/substance_abuse/terminology/definition1/en/) [cited 2013 Aug 2].
2. Office on drug and crime. WHO/ UNODC/ UNAIDS position paper Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention [http://whqlibdoc.who.int/unaid/2004/9241591153\\_eng.pdf](http://whqlibdoc.who.int/unaid/2004/9241591153_eng.pdf) [cited 2013 Aug 2].
3. Safaei N. Outcomes of Coronary Artery Bypass Grafting in Patients with a History of Opiate Use. *Pak. J. BioI. Sci.* 2008; 11 (22): 2594-2598.
4. ATLAS of Substance Use Disorders Resources for the Prevention and Treatment of Substance Use Disorders, Country Profile: IRAN. Available from: [http://www.who.int/substance\\_abuse/publications/atlas\\_report/profiles/iran.pdf](http://www.who.int/substance_abuse/publications/atlas_report/profiles/iran.pdf). World Health Organization; Published 2010 Accessed April 2, 2013.
5. Ebrahimi M, Kazemi-Bajestani SMR, Ghayour-Mobarhan M, Ferns GAA. Coronary Artery Disease and Its Risk Factors Status in Iran: A Review. *Iran Red Crescent Med J* 2011; 13(9):610-623.
6. Abdollahi MH, Forouzan SKH, Zahreh S. Demographic characteristics of opioid addiction in patients undergoing coronary artery bypass graft. *Tehran Med. J.* 2007; 64: 54-59
7. Asgary S, Sarrafzadegan N, Naderi GA, Rozbehani R. Effect of opium addiction on new and traditional cardiovascular risk factors: do duration of addiction and route of administration matter? *LipidsHealth Dis* 2008; 7: 42.
8. Sadr BSM, Rafiei M, Bahadorzadeh L, et al. Is opium addiction a risk factor for acute myocardial infarction? *Acta Med Iran* 2005; 43: 218-222.
9. Sadeghian S, Darvish S, Davoodi G, Salarifar M, Mahmoodian M, Fallah N. The association of opium with coronary artery disease. *Eur J Cardiovasc Prev Rehabil* 2007; 14: 715-7.
10. Van de Werf F, et al. Management of acute myocardial infarction in patients presenting with persistent ST-segment elevation *European Heart Journal* 2008; 29: 2909–2945.
11. Joukar S, Najafipour H, Malekpour-Afshar R, Mirzaeipour F and Nasri HR. The Effect of Passive Opium Smoking on Cardiovascular Indices of Rabbits with Normal and Ischemic Hearts. *The Open Cardiovascular Medicine Journal* 2010; 4: 1-6.
12. Davoodi G, Sadeghian S, Akhondzadeh S, Darvish S, Alidoosti M, Amirzadegan A. Comparison of specifications, short term outcome and prognosis of acute myocardial infarction in opium dependent patients and nondependents. *J Tehran Heart Center* 2006; 1: 43-7.
13. Azimzade-Sarwar B, Gholamreza YG, Narooy S. A case-control study of effect of opium addiction on myocardial infarction. *Am J Appl Sci* 2005; 2:1134-1135.
14. Standards of Medical Care in Diabetes 2011. *Diabetes Care* 2011; 34:S11.
15. Zimetbaum PJ, Josephson ME. Use of the electrocardiogram in acute myocardial infarction. *N Engl J Med* 2003; 348:933.
16. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV). American Psychiatric Association, Washington D.C., 1994,
17. Karam GA, Reisi M, Kaseb AA, Khaksari M, Mohammadi A, Mahmoodi M. Effects of opium addiction on some serum factors in addicts with non-insulin-dependent diabetes mellitus. *Addict Biol* 2004; 9: 53-58.
18. Saadat H, Ziai SA, Ghanemnia M, Namazi MH, Safi M, et al. Opium Addiction Increases Interleukin 1 Receptor Antagonist (IL-1Ra) in the Coronary Artery Disease Patients. *PLoS ONE* 2012; 7(9): e44939.
19. Mohammadi A, Darabi M, Nasry M, Saabet-Jahromi JS, Afshar RM, Sheibani H. Effect of opium addiction on lipid profile and atherosclerosis formation in hypercholesterolemic rabbits. *Experim Toxic Pathol* 2009; 61: 145-149.
20. Fatemi S, Hasanzadeh M, Arghami A, Sargolzaee M. Lipid profile comparison between opium addicts and non-addicts. *J The Univ Heart Ctr* 2008; 3: 169.172.
21. AhmadiNejad M, Jadidi F, Dehghani MR, Divsalar K. Studying Prevalence and Pattern of Taking Narcotic and Ecstasy Drugs by Patients

Admitted to Special Care Centers of Shahid Bahonar Hospital, Kerman, Iran. *Addict & Health* 2012; 4 (1-2): 57-64.

22. Narenjiha H, Rafiey H, Jahani MR, Assari S, Moharamzad Y, Roshanpazoo M. Substance-dependent professional drivers in Iran: a descriptive study. *Traffic Inj Prev* 2009; 10(3): 227-230.

23. Rahimi Movaghar A, Sahimi Izadian E. Drug use condition among school students in Iran. *Social Welfare* 2006; 5(19): 9-29.

24. Ahmadi J, Fallahzadeh H, Salimi A, et al. Analysis of opium use by students of medical sciences. *Journal of Clinical Nursing* 2006; 15: 379-386.