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nearly 1% of all medical emergencies, 15% of all toxic exposures, regard to cocaine use in Spain. First, that cocaine accounted for reports in Emergencias highlight two significant issues with USD/gram of a product that approaches 50% purity. Recent cocaine regularly. The estimated cost in Spain is about 80 over 800 metric tons of pure cocaine. Although all in South America, used for cocaine production. This yielded previous years with nearly 175,000 hectares of land, essentially Global production of cocaine in 2008 increased slightly from The major area of production varies by drug class – for example cocaine is predominantly produced in South America, heroin in Afghanistan and South-East Asia, synthetic amphetamines in Central and Eastern Europe and methamphetamine in South East Asia. These drugs have to be transported to the users and we will discuss the routes and methods of drug trafficking. In particular, we will focus on body packers (drug mules) and the potential health impact of this practice. Additionally, there is small scale local production of individual drugs for example methamphetamine in the west and south of the USA and we will briefly discuss the implications of this. The prevalence of drug use varies across the general population. There are higher prevalence rates of use amongst younger individuals, the men who have sex with men (MSM, gay) community and those attending nightclubs, bars, party venues and festivals. These sections of the community tend to have higher use of recreational / party drugs such as MDMA (ecstasy), cocaine, ketamine, gamma-hydroxybutyrate (GHB) and legal highs. A number of studies over recent years have assessed the impact of tourism and in particular low cost travel (package holidays, low cost airlines, and youth holidays) on recreational drug use. We will summarise these studies and in particular describe the effects of travel on individuals’ drug and alcohol use compared to when they are at home and the initiation of drug use whilst on holiday in previous non users. Finally, we will discuss the impact of drug and alcohol use on other issues relating to the individual (e.g. unprotected sex, sexually transmitted diseases and violence) and the local community in the tourist region (e.g. crime and healthcare service utilisation).

CONFERENCIA DE CLAUSURA

“Cocaina epidemia siglo XXI”.

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Global production of cocaine in 2008 increased slightly from previous years with nearly 175,000 hectares of land, essentially all in South America, used for cocaine production. This yielded over 800 metric tons of pure cocaine. Although there are large regional variations in the recreational used of cocaine, a 2009 United Nations report suggests that about 0.3% of people between the ages of 15 and 64 are current users of cocaine. The greatest rates of use can be found in the United States and Western Europe, particularly in Spain where 38 metric tons of cocaine were seized by law enforcement in 2007 alone. Although cocaine use is falling in North America, it appears to be stable in Spain, where approximately 3.0% of people between ages 18 and 54 use cocaine regularly. The estimated cost in Spain is about 80 USD/gram of a product that approaches 50% purity. Recent reports in Emergencias highlight two significant issues with regard to cocaine use in Spain. First, that cocaine accounted for nearly 1% of all medical emergencies, 15% of all toxic exposures, and 29% of all emergency consultations for substance abuse. Second, these numbers are clearly an underestimate because when patients with trauma or chest pain were studied, the overall prevalence of undisclosed cocaine use was nearly 20%.

Among the sympathomimetics cocaine is particularly toxic because not only does it produce hypertension and vasospasm which are mediated by alpha-adrenergic agonism; tachycardia largely mediated by beta-adrenergic agonism; and increased shear force (dp/dt) on vessels mediated by the combined effects of hypertension and tachycardia; but it also accelerates atherosclerosis.** These mechanisms produce ischemia to virtually any organ system, or, alternatively can result in hemorrhage from vessel rupture. Additionally because cocaine blocks cardiac fast sodium channels, repolarizing potassium channels and has effects on calcium channels a variety of arrhythmias can result.7 Additional predictable toxicities from these effects include psychomotor agitation, seizures and hyperthermia, with attendant rhabdomyolysis and the potential for multiorgan failure. Although hypertension and tachycardia are often the most visible manifestations of toxicity, animal models and human experience clearly demonstrate that the most immediate life-threatening event is hyperthermia.7 Critical elevations in temperature should be treated with rapid cooling, volume resuscitation and sedation. Hypertension and tachycardia usually responds to sedation. The use of beta-adrenergic antagonists and mixed alpha- and beta-adrenergic antagonists are absolutely contraindicated when alpha-adrenergic effects are present. Vasospasm can be treated with phenolamine or a direct acting vasodilator such as nitroglycerin or nitroprusside. Cardiovascular complications generally respond to most standard therapies. An exception can be made for the treatment of wide-complex dysrhythmia in the setting of cocaine toxicity. Here, as with other sodium channel blockers, the use of hypertonic sodium bicarbonate is preferred over antidysrhythmic agents.7

Referencias bibliográficas