

## Synthetic legal intoxicating drugs

(APRIL 2012)

**TO THE EDITOR:** I greatly appreciate the well-presented article by Drs. Jerry, Collins, and Stroom in your April 2012 issue.<sup>1</sup>

As a specialist in integrative addiction medicine, I have had first-hand experience with many of the medical concerns described by the authors, and I expect to learn more about optimal management strategies as we learn more as a profession.

The lone case report cited in the article suggests a relatively short time to onset of seizure of 30 minutes following intentional ingestion of synthetic cannabinoids (JWH-018).<sup>2</sup>

In the residential treatment (“rehab”) setting where I work, I am seeing a latency to seizure onset of 24 to 72 hours with patients reporting use of synthetic cannabinoids.

Given this experience to date, I have two questions for the authors regarding new-onset seizures.

Are the authors aware of this trend in patients who present to non-emergency-department treatment settings such as residential treatment facilities? And in these cases, what if any recommendations would the authors make regarding seizure prophylaxis in patients with no history of seizure?

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### ■ REFERENCES

1. Jerry J, Collins G, Stroom D. Synthetic legal intoxicating drugs: the emerging ‘incense’ and ‘bath salt’ phenomenon. *Cleve Clin J Med* 2012; 79:258–264.
2. Lapoint J, James LP, Moran CL, Nelson LS, Hoffman RS, Moran JH. Severe toxicity following synthetic cannabinoid ingestion. *Clin Toxicol (Phila)* 2011; 49:760–764.

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**IN REPLY:** We thank Dr. Chandiramani for his thoughtful comments.

Only four cases of seizure-like activity associated with synthetic cannabinoids have been reported in the literature. In addition

to the case reported in our paper,<sup>1</sup> there was another in which a 19-year-old had two seizures soon after smoking a spice product, and the second seizure was witnessed by paramedics on the way to the hospital.<sup>2</sup> Though this patient’s urine was not analyzed for synthetic cannabinoids, the spice product that was reportedly smoked by the patient was later sent to a laboratory for analysis and was found to contain four synthetic cannabinoids: JWH-018, JWH-081, JWH-250, and AM-2201.

In another case,<sup>3</sup> seizure occurred after use of an incense product called “Spicy XXX,” but neither the incense sample nor the patient’s urine was tested for synthetic cannabinoids.

The final case reported in the literature involved a 25-year-old man who was brought to an emergency department by coworkers who had witnessed seizure-like activity.<sup>4</sup> He was reported to have smoked an incense product about “45 minutes prior to presentation,”<sup>4</sup> indicating that the seizure-like activity happened within that time frame. Two synthetic cannabinoids (JWH-018 and JWH-073) were detected in the patient’s urine.

In the case by Lapoint et al<sup>1</sup> that we referred to in our paper,<sup>1</sup> seizure activity recurred in the hospital and was successfully treated with lorazepam. The case reported by Schneir and Baumbacher<sup>2</sup> described treatment of the second seizure with intranasal midazolam, with no recurrence of seizure activity.

In summary, the literature on seizure activity related to synthetic cannabinoids is sparse. When the time course has been documented in these few cases, seizures seem to occur “soon” after using these products,<sup>2</sup> or from 45 minutes to 1 hour after use.<sup>1,4</sup> Although benzodiazepines have been used to treat seizure activity, there have been no published reports of using medications to prevent seizures in individuals who have been using spice products. Furthermore, the routine employment of seizure prophylaxis of any kind would probably be premature at this point given the uncertainty of the actual seizure risk among all synthetic cannabinoid users. We would consider giving a benzodiazepine to prevent possible seizures after drug ingestion in cases in which prior seizures have

occurred, in cases of extreme excitement or agitation, or in those with marked alterations of mental state.

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#### ■ REFERENCES

1. Lapoint J, James LP, Moran CL, Nelson LS, Hoffman RS, Moran JH. Severe toxicity following synthetic cannabinoid ingestion. *Clin Toxicol (Phila)* 2011; 49:760–764.
2. Schneir AB, Baumbacher T. Convulsions associated with the use of a synthetic cannabinoid product. *J Med Toxicol* 2012; 8:62–64.
3. Simmons JR, Skinner CG, Williams J, Kang CS, Schwartz MD, Wills BK. Intoxication from smoking “spice” (letter). *Ann Emerg Med* 2011; 57:187–188.
4. Simmons J, Cookman L, Kang C, Skinner C. Three cases of ‘spice’ exposure. *Clin Toxicol (Phila)* 2011; 49:431–433.

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## Geriatric patient-centered medical home

(MAY 2012)

**TO THE EDITOR:** The discussion by Gennari and colleagues<sup>1</sup> on how to obtain certification from the National Committee for Quality Assurance (NCQA) for a geriatric patient-centered medical home was very timely and instructive. The great effort that must be put into getting one’s practice certified was thoroughly documented.

Some community-based physicians will not require financial incentives to undertake this laborious process, finding sufficient reward in continuous quality improvement. However, economic reality dictates that time spent on certification must be taken away from other, productive (ie, income-generating) activities. Therefore, it is reasonable to ask what kind of financial incentives will be provided to physicians who obtain NCQA certification, and which organization or entity will pay for these incentives.

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#### ■ REFERENCE

1. Gennari A, Fedor K, Bakow E, Resnick NM. A geriatric patient-centered medical home: how to obtain NCQA certification. *Cleve Clin J Med* 2012; 79:359–366.

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**IN REPLY:** At this time, the financial incentives for acquiring NCQA medical home certification depend on your geographic location. According to a June 5th publication in *Health Care Payer News*,<sup>1</sup> 26 states have adopted policies to make payments to health-care providers that have met medical home standards. These payments and their specific requirements vary from state to state.

Your question underscores the importance of our recommendation to partner with your local health insurance provider. By reaching out to them, you can learn about what incentive programs are in place in your area or are under development. The model that many insurance companies have used is to give higher reimbursements for practices that are medical homes or that meet certain quality insurance markers. If you align your medical home quality insurance markers with your local insurance company’s incentive plan, then your medical home work can translate into real dollars for your practice. This concept of an incentive plan for quality care is becoming more and more prevalent. Furthermore, the public (ie, patients) are also becoming more savvy about the concepts of the medical home and quality. Becoming a medical home has great marketing potential that can turn into financial benefits for a practice, as well.

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#### ■ REFERENCE

1. Mosquera M. States make progress with medical homes. *Healthcare Payer News*. June 5, 2012. Available at [www.healthcarepayernews.com/content/states-make-progress-medical-homes](http://www.healthcarepayernews.com/content/states-make-progress-medical-homes). Accessed July 5, 2012.

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