



**HAL**  
open science

**Prevalence of psychoactive drug use in patients hospitalized for acute cardiac events: Rationale and design of the ADDICT-ICCU trial, from the Emergency and Acute Cardiovascular Care Working Group and the National College of Cardiologists in Training of the French Society of Cardiology**

Jean-Guillaume Dillinger, Théo Pezel, Charles Fauvel, Clément Delmas, Guillaume Schurtz, Antonin Trimaille, Edouard Gerbaud, Vincent Roule, Jean-Claude Dib, Albert Boccara, et al.

► **To cite this version:**

Jean-Guillaume Dillinger, Théo Pezel, Charles Fauvel, Clément Delmas, Guillaume Schurtz, et al.. Prevalence of psychoactive drug use in patients hospitalized for acute cardiac events: Rationale and design of the ADDICT-ICCU trial, from the Emergency and Acute Cardiovascular Care Working Group and the National College of Cardiologists in Training of the French Society of Cardiology. Archives of cardiovascular diseases, 2022, 10.1016/j.acvd.2022.05.012 . hal-03789560

**HAL Id: hal-03789560**

**<https://hal.science/hal-03789560>**

Submitted on 4 Nov 2022

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

# Prevalence of psychoactive drug use in patients hospitalized for acute cardiac events: Rationale and design of the ADDICT-ICCU trial, from the Emergency and Acute Cardiovascular Care Working Group and the National College of Cardiologists in Training of the French Society of Cardiology<sup>☆</sup>

Jean-Guillaume Dillinger<sup>a,1</sup>, Théo Pezel<sup>a,1</sup>, Charles Fauvel<sup>b</sup>, Clément Delmas<sup>c</sup>, Guillaume Schurtz<sup>d</sup>, Antonin Trimaille<sup>e</sup>, Edouard Gerbaud<sup>f,ac</sup>, Vincent Roule<sup>g</sup>, Jean-Claude Dib<sup>h</sup>, Albert Boccard<sup>i</sup>, Damien Millischer<sup>j</sup>, Christophe Thuaire<sup>k</sup>, Julien Fabre<sup>l</sup>, Thomas Levasseur<sup>m</sup>, Tanissia Boukertouta<sup>n</sup>, Arthur Darmon<sup>o</sup>, Ruben Azencot<sup>p</sup>, Benoit Merat<sup>q</sup>, Marie Haugel-Moreau<sup>r</sup>, Alain Grentzinger<sup>s</sup>, Clément Charbonnel<sup>t</sup>, Cyril Zakine<sup>u</sup>, Marc Bedossa<sup>v</sup>, Benoît Lattuca<sup>w</sup>, François Roubille<sup>x</sup>, Victor Aboyans<sup>y</sup>, Etienne Puymirat<sup>z</sup>, Ariel Cohen<sup>aa</sup>, Eric Vicaut<sup>ab</sup>, Patrick Henry<sup>a,\*</sup>, for the ADDICT-ICCU investigators

<sup>a</sup> Department of Cardiology, Hôpital Lariboisière, AP-HP, Université de Paris Cité, Inserm U-942, 75010 Paris, France

<sup>b</sup> Department of Cardiology, Rouen University Hospital, 76000 Rouen, France

<sup>c</sup> Intensive Cardiac Care Unit, Rangueil University Hospital, 31000 Toulouse, France

<sup>d</sup> Department of Cardiology, University Hospital of Lille, 59000 Lille, France

<sup>e</sup> Department of Cardiovascular Medicine, Nouvel Hôpital Civil, Strasbourg University Hospital, 67000 Strasbourg, France

<sup>f</sup> Cardiology Intensive Care Unit and Interventional Cardiology, Hôpital Cardiologique du Haut-Lévêque, 33604 Pessac Cedex, France

<sup>g</sup> Department of Cardiology, Caen University Hospital, 14000 Caen, France

<sup>h</sup> Département de Cardiologie, Clinique Ambroise Paré, 92200 Neuilly-sur-Seine, France

<sup>i</sup> Department of Cardiology, Andre Gregoire Hospital, 93100 Montreuil, France

<sup>j</sup> Service de Cardiologie, Hôpital Montfermeil, 93370 Montfermeil, France

<sup>k</sup> Service de Cardiologie, Centre Hospitalier de Chartres, 28630 Le Coudray, France

<sup>l</sup> Department of Cardiology, University Hospital of Martinique, 97261 Fort-de-France, France

<sup>m</sup> Service de Cardiologie, Centre Hospitalier de Fréjus/Saint-Raphaël, 83600 Fréjus, France

<sup>n</sup> Department of Cardiology, Hôpital Avicenne, AP-HP, 75011 Paris, France

<sup>o</sup> Department of Cardiology, Hôpital Bichat, AP-HP, Université de Paris Cité, 75018 Paris, France

<sup>p</sup> Service de Cardiologie, Hôpital Cochin, AP-HP, 75014 Paris, France

<sup>q</sup> Service de Cardiologie et Médecine Aéronautique, Hôpital d'Instruction des Armées Percy, 92140 Clamart, France

<sup>r</sup> Service de Cardiologie, Hôpital Ambroise Paré, AP-HP, 92012 Boulogne-Billancourt, France

<sup>s</sup> Service de Cardiologie, Centre Hospitalier de Saintonge, 17100 Saintes, France

<sup>t</sup> Service de Cardiologie, Hôpital Mignot, 78000 Versailles, France

<sup>u</sup> Clinique Saint Gatien Alliance (NCT+), 37540 Saint-Cyr-sur-Loire, France

<sup>v</sup> Service de Cardiologie et Maladies Vasculaires, CHU de Rennes, 35000 Rennes, France

<sup>w</sup> Department of Cardiology, Nîmes University Hospital, Montpellier University, 30029 Nîmes, France

<sup>x</sup> Department of Cardiology, CHU de Montpellier, 34000 Montpellier, France

<sup>y</sup> Department of Cardiology, Dupuytren University Hospital; and Inserm U1094 & IRD U270, Limoges University, 87000 Limoges, France

<sup>z</sup> Department of Cardiology, Hôpital Européen Georges Pompidou (HEGP), AP-HP, 75015 Paris, France

<sup>aa</sup> Service de Cardiologie, Hôpital Saint-Antoine, AP-HP, 75012 Paris, France

<sup>ab</sup> Unité de Recherche Clinique, Hôpital Fernand Widal, AP-HP, 75010 Paris, France

<sup>ac</sup> Bordeaux Cardio-Thoracic Research Centre, U1045, Bordeaux University, 33000 Bordeaux, France

Abbreviations: EMCDDA, European Monitoring Centre for Drugs and Drug Addiction; FACE, Fast Alcohol Consumption Evaluation; ICCU, intensive cardiac care unit; MACE, major adverse cardiovascular events; QFR, quantitative flow ratio.

<sup>☆</sup> Tweet: The ADDICT-ICCU trial, an original prospective study about the prevalence of psychoactive drug use in patients admitted to intensive cardiac care unit! Twitter address: @PezelT.

\* Corresponding author at: Lariboisiere Hospital, AP-HP, Université de Paris, 2, rue Ambroise Paré, 75010 Paris, France.

E-mail address: [patrick.henry@aphp.fr](mailto:patrick.henry@aphp.fr) (P. Henry).

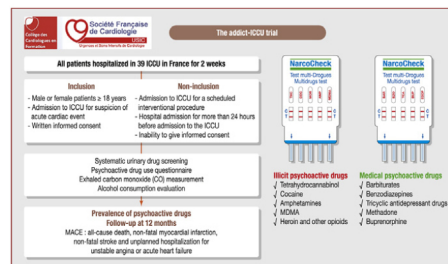
<sup>1</sup> Jean-Guillaume Dillinger and Théo Pezel contributed equally.

## HIGHLIGHTS

- Psychoactive drug use is a public health concern.
- Psychoactive drug use is prevalent and increases the risk of CV events.
- Psychoactive drug use can induce acute CV events.
- Prevalence of psychoactive drug use in patients hospitalized in an ICU is unknown.
- ADDICT-ICCU will assess this prevalence by systematic urinary drug screening.
- Consecutive patients hospitalized in ICU for an acute CV event will be screened.

## GRAPHICAL ABSTRACT

Study design of the ADDICT-ICCU study, a nationwide prospective multicentre study involving 39 centres throughout France, evaluating the prevalence of psychoactive drugs detected in consecutive patients hospitalized in an intensive cardiac care unit (ICCU) for an acute cardiovascular event. Detection of illicit (cannabinoids, cocaine, amphetamines, ecstasy, heroin and other opioids) and non-illicit (barbiturates, benzodiazepines, tricyclic antidepressants, methadone and buprenorphine) psychoactive drugs will be performed through urine analysis using NarcoCheck® (Kappa City Biotech SAS, Montluçon, France) within 2 hours of admission to the ICCU. MACE: major adverse cardiovascular events.



## ARTICLE INFO

### Keywords:

Psychoactive drug  
Illicit drug  
Addiction  
Intensive cardiac care unit  
Prevalence

## SUMMARY

**Background:** Psychoactive drugs, including illicit drugs, are associated with an increased rate of cardiovascular events. The prevalence and outcome of patients using these drugs at the time of admission to an intensive cardiac care unit is unknown.

**Aim:** To assess the prevalence of psychoactive drugs detected in consecutive patients hospitalized in an intensive cardiac care unit for an acute cardiovascular event.

**Methods:** This is a nationwide prospective multicentre study, involving 39 centres throughout France, including all consecutive patients hospitalized in an intensive cardiac care unit within 2 weeks. Psychoactive drug use will be assessed systematically by urine drug assay within 2 hours of intensive cardiac care unit admission, to detect illicit (cannabinoids, cocaine, amphetamines, ecstasy, heroin and other opioids) and non-illicit (barbiturates, benzodiazepines, tricyclic antidepressants, methadone and buprenorphine) psychoactive drugs. Smoking will be investigated systematically by exhaled carbon monoxide measurement, and alcohol consumption using a standardized questionnaire. In-hospital major adverse events, including death, resuscitated cardiac arrest and cardiogenic shock, will be recorded. After discharge, all-cause death and major adverse cardiovascular events will be recorded systematically and adjudicated at 12 months of follow-up.

**Results:** The primary outcome will be the prevalence of psychoactive drugs detected by systematic screening among all patients hospitalized in an intensive cardiac care unit. The in-hospital major adverse events will be analysed according to the presence or absence of detected psychoactive drugs. Subgroup analysis stratified by initial clinical presentation and type of psychoactive drug will be performed.

**Conclusions:** This is the first prospective multicentre study to assess the prevalence of psychoactive drugs detected by systematic screening in consecutive patients hospitalized for acute cardiovascular events.

## 1. Background

Recent studies have highlighted the increasing rates of psychoactive drug use around the world [1–4], causing an increased risk of mortality, in particular as a result of acute cardiovascular events: sudden cardiac death; acute coronary syndrome; acute heart failure; thromboembolic events; and arrhythmias [5–10].

Beyond alcohol and tobacco, these drugs include prescription psychoactive drugs (e.g. benzodiazepine or opioids) and illicit drugs. Cannabis, cocaine, ecstasy and amphetamines are the most common illicit drugs used by European adults, with a prevalence in recent years of 7.6%, 1.3%, 0.8% and 0.6%, respectively [2]. In France, the prevalence of use of any illicit drug is estimated at 11.4% of

the population, ahead of Italy (10.6%), the UK (8.7%) and Germany (7.8%) [2]. Further, in France, more than 100,000 deaths per year result from the use of drugs, including alcohol, tobacco and illicit drugs [11].

Whereas previous studies regarding psychoactive drug use were generally population based [1–3], we sought to determine the frequency of such use among patients hospitalized in an intensive cardiac care unit (ICCU), knowing its implication in acute cardiovascular events. Interestingly, the current guidelines recommend a declarative survey to investigate psychoactive drug abuse, but no systematic urine or plasma screening [12,13]. However, patients may under-report psychoactive drug use when presented with a questionnaire, and self-reporting may be limited by recall bias

**Table 1**  
ADDICT-ICCU study inclusion and non-inclusion criteria.

Inclusion criteria	Male or female patients aged $\geq 18$ years Admission to an ICU, whatever the medical reason Written informed consent obtained at enrolment into the study
Non-inclusion criteria	Admission to an ICU for a scheduled interventional procedure Admission for $> 24$ hours at any hospital facility before ICU admission Inability to give informed consent or high likelihood of being unavailable for follow-up

ICCU: intensive cardiac care unit.

[14,15]. These limitations may have attenuated the accuracy of prevalence data in previous studies, because of the lack of systematic drug screening [16].

To our knowledge, no study has ever assessed consecutively the prevalence of psychoactive drug use with systematic urine or plasma screening at the time of an acute cardiovascular event.

The ADDICT-ICCU study is designed to assess the prevalence of recent use of psychoactive drugs in all consecutive patients admitted to an ICU for acute cardiovascular events in several French centres.

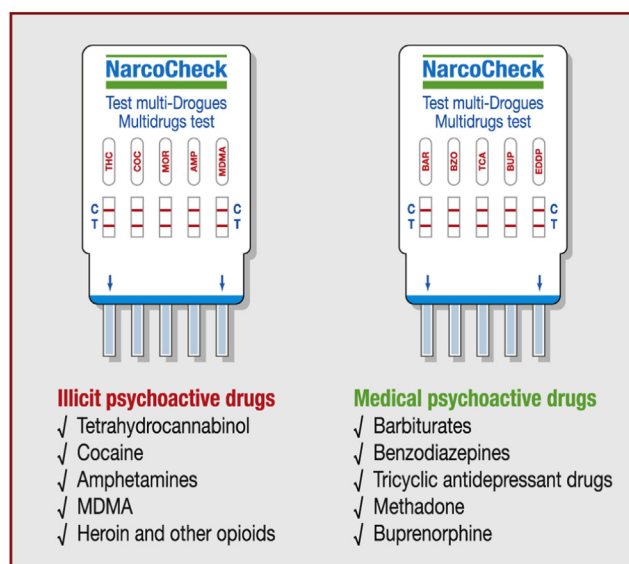
## 2. Methods

### 2.1. Study design and population

We will conduct a French multicentre cohort study (39 centres), with prospective enrolment of all consecutive patients admitted to an ICU, to assess the prevalence of psychoactive drug use by systematic urinary screening (Central illustration). The list of participating centres is provided in Table A.1. The inclusion and non-inclusion criteria are presented in Table 1. The numbers of excluded patients and of those who decline participation will be collected to build the study flowchart. The management of each patient will be at the discretion of the treating physicians, following the current European Society of Cardiology guidelines. The study has been approved by the ethics committee (Committee for the Protection of Human Subjects, Île de France-7, France). Written informed consent will be obtained from all participants. Anonymized data supporting the findings of this study will be collected using Cleanweb™ software (Telemedicine Technologies, Boulogne-Billancourt, France), and will be available from the corresponding author upon reasonable request. The study has been registered on the ClinicalTrials.gov website (<http://clinicaltrials.gov/>) under the identifier NCT05063097, and study data and results will be added on completion of the study. All authors and investigators of this study have read and approved the manuscript as written (the full list of ADDICT-ICCU investigators is available in Table A.2).

### 2.2. Detection of psychoactive drug use

The presence of psychoactive drugs will be determined through urine analysis using a dedicated drug assay (NarcoCheck®; Kappa City Biotech SAS, Montluçon, France) within 2 hours of admission to the ICU. The following illicit drugs will be screened for all consecutive patients: cannabinoids (tetrahydrocannabinol [THC]), including cannabis and hashish; cocaine and metabolites, including crack; amphetamines; 3,4-methylenedioxy-methylamphetamine (MDMA or ecstasy); and heroin and other opioids. In addition to the analysis of illicit drug use, the NarcoCheck® urine drug assay



**Fig. 1.** Presentation of the urine drug assay (NarcoCheck®; Kappa City Biotech SAS, Montluçon, France). The following illicit or medical psychoactive drugs will be evaluated by NarcoCheck®: cannabinoids (tetrahydrocannabinol [THC]), including cannabis and hashish; cocaine and metabolites, including crack; amphetamines; 3,4-methylenedioxy-methylamphetamine (MDMA); heroin and other opioids; barbiturates; benzodiazepines; tricyclic antidepressant drugs; methadone; and buprenorphine.

will detect the following medical psychoactive drugs: barbiturates; benzodiazepines; tricyclic antidepressant drugs; methadone; and buprenorphine (Fig. 1). Depending on the type of drug incriminated, the test remains positive for 3–5 days after its last consumption. A table giving the different information for each drug is available in Table A.3. The reliability of the NarcoCheck® device as evaluated in the laboratory is 97–99%, depending on the substance measured. Moreover, in a random subgroup of 60 patients, detection of illicit psychoactive drug will be assessed by high-performance liquid chromatography to evaluate the specificity and sensitivity of the NarcoCheck® urine drug assay. Of note, morphine and other opioids administered for pain sedation during the initial management of patients before admission to the ICU will be recorded, and their urine tests for opioids will be considered negative. To assess the rate of self-reported use of psychoactive drugs, a standardized questionnaire will be used.

Tobacco smoking will be evaluated for each patient using a standardized questionnaire with three items: “no smoker”, “past smoker” (specifying the number of years since cessation) or “current smoker”. In addition, we will quantify the tobacco consumption in pack-years, and we will also assess e-cigarette use. Nicotine dependence will be assessed using the Fagerström test, marked on a scale of 0–10 (Appendix A) [17]. In all patients, a standardized exhaled carbon monoxide measurement will be performed systematically with a CO Check Pro device (Micro Direct Diagnostics Ltd, Chatham, Kent, UK) immediately on arrival in the ICU [18]. The threshold of  $> 10$  parts per million will be used to signify active smoking [19–21]. Then, we will assess the prognostic value of the level of exhaled carbon monoxide on clinical outcomes.

Alcohol dependence will be assessed using the Fast Alcohol Consumption Evaluation (FACE), marked on a scale of 0–24 (Appendix B). A FACE score  $\geq 9$  indicates high alcohol dependence, whereas scores between 5 and 8 and  $< 5$  indicate moderate alcohol dependence and low alcohol dependence, respectively [22]. The impact of alcohol consumption on prognosis will be also assessed in the study. Each patient will be informed of the urine drug assay and

exhaled carbon monoxide measurement, and trained investigators will conduct the tests.

### 2.3. Collection of baseline characteristics

Baseline data will include clinical characteristics (date of birth, sex, height, weight, temperature, systolic and diastolic blood pressure, heart rate, Glasgow score, Killip score, oxygen saturation and ventilation mode), reason for hospitalization, list of medications (especially cardiovascular drugs) at admission, history of cardiovascular disease, psychiatric illness or other significant clinical histories. In all centres, the first electrocardiogram performed upon ICCU admission, and all clinically significant electrocardiogram results will be collected prospectively using the same touchpad with a camera and dedicated scanner function of 12 megapixels (4032 × 3024 pixels; Samsung Galaxy Tab S7; Samsung, Seoul, South Korea). Electrocardiogram analysis will be performed at the end of the study by a core laboratory composed of independent blinded experts (a list of electrocardiogram variables to be evaluated is presented in [Table A.4](#)). Transthoracic echocardiography will be performed systematically within the first 24 hours of admission for all patients (all standardized echocardiographic variables to be assessed are presented in [Table A.5](#)). Biological data will be collected systematically upon admission, including haemoglobin, serum potassium, creatinine, the peak of high-sensitivity troponin I, N-terminal prohormone of B-type natriuretic peptide or B-type natriuretic peptide. All diagnostic cardiovascular imaging or invasive angiography reports, as well as all treatment introduced during hospitalization will be collected. For all patients with invasive coronary angiography, baseline and procedural coronary angiograms will be collected and sent anonymously to the angiographic core laboratory at Lariboisière Hospital (Fernand Widal Clinical Research Unit) for secondary analyses. The coronavirus disease 2019 (COVID-19) status of each patient will be assessed systematically at ICCU admission using real-time polymerase chain reaction, following current World Health Organization guidelines [23]. Final diagnosis at the end of hospitalization will be adjudicated by two independent experts, and divided into several large main categories ([Appendix C](#) and [Table A.6](#)). In the event of a discrepancy in the diagnosis, a third expert will be requested to jointly discuss the final diagnosis.

### 2.4. Angiographic core laboratory

As the ADDICT-ICCU registry is a prospective and recent multicentre database of patients admitted to ICCU, the angiographic data will be collected for additional analyses on the current management of patients with acute coronary syndrome. For all patients referred to ICCU for invasive coronary angiography, baseline and procedural coronary angiograms will be collected and sent anonymously to the angiographic core laboratory at Lariboisière Hospital (Fernand Widal Clinical Research Unit). The ADDICT-ICCU angiographic core laboratory will constitute independent experienced interventional cardiologists not involved in the trial, all blinded to clinical, biological and psychoactive drug detection results. For each patient, two independent experienced interventional cardiologists will perform a comprehensive angiographic and haemodynamic analysis, including description of coronary lesions, periprocedural complications and the measurement of the quantitative flow ratio (QFR) and the non-invasive index of microvascular resistance. The QFR and the non-invasive index of microvascular resistance will be computed using the Medis Suite XA/QAngio XA 3D/QFR software (Medis, Leiden, The Netherlands). Notably, in case of significant discrepancy between two experts, a third expert will perform the analysis.

### 2.5. Outcomes

The primary outcome will be the prevalence of the different psychoactive drugs (illicit or medical) among all consecutive patients hospitalized in an ICCU. The secondary outcomes assessed during hospitalization will be: in-hospital major adverse events, defined by all-cause mortality, cardiogenic shock (requiring medical or mechanical haemodynamic support) and resuscitated cardiac arrest (severe ventricular arrhythmia requiring defibrillation or antiarrhythmic agents); use of mechanical ventilation; use of intravenous diuretics; non-invasive ventilation; and use of catecholamines or inotropic agents. In addition, the duration of ICCU and in-hospital stays will be recorded.

The secondary outcomes assessed at 12 months of follow-up will be: a composite endpoint of major adverse cardiovascular events (MACE), including all-cause death, non-fatal myocardial infarction, non-fatal stroke and unplanned hospitalization for unstable angina or acute heart failure; each criterion of the combined MACE; and unplanned cardiovascular hospitalizations. Using the standardized definitions [24], the definition of each MACE is provided in [Table A.7](#).

### 2.6. Follow-up

A centralized follow-up of all patients included in the ADDICT-ICCU study will be organized during the first year of follow-up at the Unité de Recherche Clinique Fernand-Widal, Assistance Publique–Hôpitaux de Paris, and performed by dedicated research technicians or nurses. Hospital discharge reports will be sought for each reported event leading to hospitalization or death, and will be analysed by two independent adjudication experts blinded to drug use. All cases of cardiovascular events in which the final diagnosis appears debatable will be reviewed by a third expert.

### 2.7. Statistical analysis

#### 2.7.1. Sample size calculation

The sample size calculation was performed to determine the minimum sample size for an expected prevalence of illicit psychoactive drug use with a margin of error in the confidence interval. Based on recently available data published by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) [2], we consider that the expected prevalence of use of at least one illicit psychoactive drug will be 11% among the overall population for the primary outcome. The calculation was performed with a level of precision of 2% and with a confidence level of 95% of this result. A two-tailed  $P$  value  $< 0.05$  will be considered statistically significant. Under these assumptions, and with a 5% urine drug assay refusal or failure rate, we estimate a sample size of 990 patients to attain a specified confidence interval width of 4% and to assess this prevalence accurately [25]. During the 2-week period of inclusion in the 39 French centres, we plan to include approximately 1500 patients.

#### 2.7.2. Statistical methods

Demographic and clinical characteristics collected at baseline, as well as severity variables and procedures performed during ICCU hospitalization will be summarized and compared between patients in the “psychoactive (illicit or medical) drug use group” and the “no psychoactive drug use group.” Continuous data will be reported as means  $\pm$  standard deviations for normally distributed data or as medians (interquartile ranges) for non-normally distributed data, as assessed through graphical methods and the Shapiro-Wilk test for normality. Categorical data will be reported as counts and percentages. Between-group comparisons will be performed using Student’s  $t$  test or the Mann-Whitney test for

continuous variables, and the  $\chi^2$  test or Fisher's exact test for categorical variables, as appropriate.

Regarding the analysis of the clinical outcomes, four analyses will be performed: (1) the propensity score method, using a doubly robust estimator with augmented inverse propensity score weighting (R package "gbm", version 2.1.8) [26]; (2) a multivariable logistic regression analysis with the following co-variables, based on clinical input: co-morbidities as known predictors of in-hospital severity and the main admission diagnosis (model 1: age, sex, diabetes, current smoking status, history of cardiovascular disease before hospitalization, known chronic kidney disease with a glomerular filtration rate <90 mL/min, history of cancer and the main admission diagnosis), and the baseline clinical variables of in-hospital severity and the main admission diagnosis (model 2: age, sex, the main admission diagnosis, systolic blood pressure, Killip class and heart rate); (3) a multivariable logistic regression analysis with adjustment for the propensity score in the overall population; and (4) a separate multivariable logistic regression analysis using the propensity score with a propensity score-matched population (with versus without illicit drugs detected).

To create the propensity score, a logistic regression analysis will be used to balance baseline characteristics in patients with versus without illicit drugs detected [27]. To minimize any potential selection bias, the effects of the illicit drugs detected on outcomes will be assessed using a 2:1 propensity score-matched population (with versus without illicit drugs detected; R package "MatchIt", version 3.0.2). The probit model with 2-to-1 nearest neighbour matching and without replacement will be used to identify two patients without illicit drugs detected for each patient with illicit drugs detected. Variables used to calculate the propensity score include baseline characteristics and the main admission diagnosis. To assess the performance of the propensity score, we will use the area under the receiver operating characteristic (ROC) curve (or C-statistic) as a measure of the adequacy of a propensity score. In addition, imbalances between groups will be considered to be small when the absolute standardized difference for a given covariate is less than 10% [28].

For multivariable logistic regression analysis, two prespecified models will be used to verify that patients with psychoactive drugs use do not have more co-morbidities or a more serious condition on admission. Moreover, we will use two separate models to avoid a risk of overfitting by adding too many covariates in the final model because of the limited number of outcomes already described in this population. As a sensitivity analysis, a stepwise forward regression logistic strategy to select the strongest parsimonious set of clinical covariates for outcomes, considering all clinical covariates with a  $P$  value  $\leq 0.2$  on univariate screening, will be performed and added to the supplementary files.

The cumulative incidence rates of MACE after discharge will be estimated using the Kaplan-Meier method, and compared with the log-rank test. The data of patients lost to follow-up will be censored to the time of last contact. Cox proportional hazards methods will be used to identify the predictors of outcomes among patients with and without psychoactive drug use. The proportional hazards ratio assumption will be verified visually using Schoenfeld residuals. Martingale residuals will be used to detect non-linearity in continuous variables.

Prespecified subgroup analyses will be performed according to clinical characteristics, final cardiovascular diagnosis and psychoactive drug use (no drug, one drug, multiple drug use). As cannabis is the most prevalent drug, only this drug will be analysed separately in a subgroup analysis. A two-tailed  $P$  value <0.05 will be considered statistically significant. All data will be analysed using R software, version 3.6.3 (R Project for Statistical Computing, R Foundation, Vienna, Austria).

### 3. Discussion

This study will provide a broad overview of 10 classes of illicit or medical psychoactive drugs screened systematically in a prospective cohort of consecutive patients hospitalized in an ICCU for an acute cardiovascular event. The association of recent illicit or medical psychoactive drug use with major cardiovascular adverse events during hospitalization and 1-year follow-up will be assessed.

Previous studies have used both self-reporting and registry-based data to assess substance use among acutely hospitalized patients. A major strength of our study is the addition of urine sample analysis. The use of psychoactive substances is increasing in Europe, particularly in France, according to the latest data from the EMCDDA [2]. In the USA, the 2019 National Survey on Drug Use and Health reports similar results, with increasing prevalence over the years [4]. Among the drugs, two categories can be distinguished: (1) illicit psychoactive drugs, the most common of which are cannabis, cocaine, amphetamines, ecstasy and heroin; and (2) medical psychoactive drugs that are not in accordance with prescribing guidelines or procured illicitly (e.g. barbiturates, tricyclic antidepressants, opioids and benzodiazepines).

Regarding illicit drugs, all the substances have cardiovascular and haemodynamic effects, and can cause various acute cardiovascular events, including sudden cardiac death, acute coronary syndrome, acute heart failure, aortic dissection, thromboembolic events, myocarditis and cardiac arrhythmias [9,29,30]. The pathophysiological mechanisms are multiple, and include prothrombotic effects with increased platelet activity and aggregation, sympathomimetic effects with blood pressure variation and increased heart rate, myocardial oxygen demand and temperature [7,13,31].

Regarding medical psychoactive drugs, the use of barbiturates, meprobamates and phenothiazines has been associated with an increased risk of myocardial infarction [32]. Similarly, both overdose and opioid withdrawal can trigger major adverse cardiovascular events [33]. Other psychoactive substances, such as tricyclic antidepressants, have significant effects on heart rate, as well as having the propensity to cause a prolonged corrected QT interval [34]. Moreover, these drugs are used to decrease anxiety, which has been linked to adverse cardiovascular outcomes [35].

Whereas several studies have shown that these psychoactive substances cause acute cardiovascular disease [7–9,36], no study has assessed the prevalence of psychoactive drug use upon ICCU admission using systematic screening drug tests. This study will provide an overall prevalence of psychoactive drug use, detailed by type of drug. In line with the current guidelines [12,13], screening for the use of illegal substances is crucial to initiate the appropriate treatment for addiction, and to limit the risk of cardiovascular event recurrence as a result of the persistence of favouring factors. Although drug screening upon ICCU admission would be crucial for public health, current guidelines do not propose systematic screening because of a lack of evidence [12]. We believe that this study, including consecutive patients, regardless of the medical reason for admission and regardless of age, will identify a particular ICCU population with a higher psychoactive drug use risk. In the future, the results may help cardiologists to improve screening for drug use at ICCU admission, allowing for an earlier weaning programme to reduce the risk of recurrent cardiovascular events.

Current screening relies primarily on questioning, without systematic screening by urine or plasma testing, which has a significant risk of under-reporting, causing a recall bias. Although this risk of under-reporting is well known to practitioners in clinical practice [37], it has not yet been published in such large cohorts. In one study, in patients undergoing cardiac rehabilitation after an acute coronary event, 25% of those who declared stopping smoking were positive for urine cotinine detection [38]. The current study will provide an accurate prevalence of under-reporting of

psychoactive drug use, as both questioning and urinary screening will be performed.

Interestingly, the prevalence of any psychoactive drug is different in terms of sex, whatever the country (in France, 15.8% for males and 7.3% for females) [2]. Therefore, this study will also explore any sex difference concerning psychoactive drug use.

Finally, polyintoxication with multiple drugs, illicit or not, is frequent [37,39,40]. For example, benzodiazepines have been reported to be used to prolong the intensity and duration of the effect of opioids, or to alleviate adverse effects following the use of alcohol or cocaine [41].

Multiple drug use can potentiate side effects, and may increase the risk of adverse consequences, including engaging in self-harm or other risky behaviours, fatal and non-fatal overdose or acute cardiovascular events [10]. By performing systematic drug screening at admission, this study will also provide novel findings on the prevalence of drug combinations, and on the short- and mid-term cardiovascular prognostic impacts of multiple drug use from a large sample.

### 3.1. Study limitations

This study will have some limitations. First, urinary screening upon admission to the ICCU may give false negatives in cases of drug use several days before hospitalization. However, the urine drug test used continues to show positives 2–6 days after substance use. In addition, to reduce the risk of false negatives, we will exclude all patients hospitalized for more than 24 hours at any hospital facility. Second, the evaluation of drug use will only be performed upon admission to an ICCU, and this study will not aim to evaluate the evolution of drug use or possible cessation as a result of addiction treatment during or after hospitalization. Moreover, for medical psychoactive substances, it will be difficult to differentiate between misuse and use of the drug in the context of medical prescription. Third, the study will be conducted in France, where the general prevalence of illicit drug use is high. The results cannot be extrapolated to other developed countries, but may nevertheless provide interesting information about prevalence in ICCUs. Fourth, this study will not be carried out in all ICCUs of France. However, the recruitment of 39 centres from all regions of France (including large metropolises and medium-sized towns), including public university hospitals, non-university hospitals and private hospitals, should allow for an accurate representation of psychoactive drug use, despite probable geographical variations. Fifth, the study will include patients regardless of age and whatever the reason for admission, creating a certain heterogeneity. However, this choice seemed relevant to us to avoid creating a selection bias by studying a single pathology or a targeted population. Finally, residual confounding factors cannot be eliminated from this study, as with all epidemiological studies.

## 4. Conclusions

This French multicentre prospective study will assess the prevalence of psychoactive drug use in consecutive patients admitted to ICCUs, and its association with cardiovascular outcomes. In addition, this study will highlight the value of psychoactive drug screening in patients hospitalized for an acute cardiovascular event, to improve the screening and management of these patients.

## Sources of funding

This research received an institutional grant from the “*Fondation Cœur et Recherche*” (Paris, France).

## Acknowledgments

The authors would like to thank all the investigators at the centres for agreeing to participate in this study, and the “Unité de Recherche Clinique Fernand-Widal” team, particularly Brahim Mohamed Elarbi, for their help in the design and implementation of this study.

## Disclosure of interest

J.-G. D. Consulting and lecture fees from the companies AstraZeneca, Bayer, Boehringer Ingelheim, BMS/Pfizer and Sanofi. Grants from the companies Bayer, Bristol Myers Squibb/Pfizer and Biosensors.

T. P. Consulting and lecture fees from the companies AstraZeneca, Bayer, BMS/Pfizer and General Electric. Grants from the companies Bayer and Servier.

E. P. Fees for lectures and/or consulting from the companies Amgen, AstraZeneca, Bayer, Biotronik, BMS, Boehringer Ingelheim, Daiichi Sankyo, Lilly, MSD, The Medicine Company, Sanofi, St. Jude Medical, Servier and Siemens.

P.H. Consulting and lecture fees from the companies AstraZeneca, Bayer, Boehringer Ingelheim, BMS/Pfizer, Sanofi and Daiichi Sankyo. Grants from the companies Bayer, BMS/Pfizer and Biosensors.

The other authors declare that they have no conflicts of interest concerning this article.

## References

- [1] Carrasco-Garrido P, Lopez de Andres A, Hernandez Barrera V, Jimenez-Trujillo I, Jimenez-Garcia R. National trends (2003–2009) and factors related to psychotropic medication use in community-dwelling elderly population. *Int Psychogeriatr* 2013;25:328–38.
- [2] European Monitoring Centre for Drugs and Drug Addiction. European drug report 2021: trends and developments. Publications Office, 2021. Available at: <https://data.europa.eu/doi/10.2810/18539> [accessed date: 7th October 2021].
- [3] Mojtabai R, Olfson M. National trends in psychotropic medication polypharmacy in office-based psychiatry. *Arch Gen Psychiatry* 2010;67:26–36.
- [4] Substance Abuse and Mental Health Services Administration (SAMHSA). 2020 National Survey of Drug Use and Health (NSDUH). Available at: <https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases>.
- [5] CEIP-A. Décès en Relation avec l'Abus de Médicaments Et de Substances: Principaux résultats enquête DRAMES 2014. Available at: <https://addictovigilance.fr/wp-content/uploads/spip/pdf/drames.2014.pdf>.
- [6] Compton WM, Volkow ND. Abuse of prescription drugs and the risk of addiction. *Drug Alcohol Depend* 2006;83(Suppl 1):S4–7.
- [7] Frishman WH, Del Vecchio A, Sanal S, Ismail A. Cardiovascular manifestations of substance abuse: part 2: alcohol, amphetamines, heroin, cannabis, and caffeine. *Heart Dis* 2003;5:253–71.
- [8] Jouanjus E, Lapeyre-Mestre M, Micallef J. French Association of the Regional Abuse and Dependence Monitoring Centres Working Group on Cannabis Complications. Cannabis use: signal of increasing risk of serious cardiovascular disorders. *J Am Heart Assoc* 2014;3 [e000638].
- [9] Lucena J, Blanco M, Jurado C, Rico A, Salguero M, Vazquez R, et al. Cocaine-related sudden death: a prospective investigation in south-west Spain. *Eur Heart J* 2010;31:318–29.
- [10] Xu KY, Hartz SM, Borodovsky JT, Bierut LJ, Grucza RA. Association Between Benzodiazepine Use With or Without Opioid Use and All-Cause Mortality in the United States, 1999–2015. *JAMA Netw Open* 2020;3:e2028557.
- [11] Ministère des affaires sociales de la santé et des droits des femmes. Rapport Addictions, 2014. Available at: <https://solidarites-sante.gouv.fr/fichiers/bo/2015/15-10/ste.20150010.0000.0049.pdf> [accessed date: 25th May 2021].
- [12] Knuuti J, Wijns W, Saraste A, Capodanno D, Barbato E, Funck-Brentano C, et al. 2019 ESC Guidelines for the diagnosis and management of chronic coronary syndromes. *Eur Heart J* 2020;41:407–77.
- [13] McCord J, Jneid H, Hollander JE, de Lemos JA, Cercek B, Hsue P, et al. Management of cocaine-associated chest pain and myocardial infarction: a scientific

- statement from the American Heart Association Acute Cardiac Care Committee of the Council on Clinical Cardiology. *Circulation* 2008;117:1897–907.
- [14] Cherpitel CJ, Ye Y, Stockwell T, Vallance K, Chow C. Recall bias across 7 days in self-reported alcohol consumption prior to injury among emergency department patients. *Drug Alcohol Rev* 2018;37:382–8.
  - [15] Napper LE, Fisher DG, Johnson ME, Wood MM. The reliability and validity of drug users' self reports of amphetamine use among primarily heroin and cocaine users. *Addict Behav* 2010;35:350–4.
  - [16] Althubaiti A. Information bias in health research: definition, pitfalls, and adjustment methods. *J Multidiscip Healthc* 2016;9:211–7.
  - [17] Heatherton TF, Kozlowski LT, Frecker RC, Fagerstrom KO. The Fagerstrom Test for Nicotine Dependence: a revision of the Fagerstrom Tolerance Questionnaire. *Br J Addict* 1991;86:1119–27.
  - [18] Walker N, Parag V, Verbiest M, Laking G, Laugesen M, Bullen C. Nicotine patches used in combination with e-cigarettes (with and without nicotine) for smoking cessation: a pragmatic, randomised trial. *Lancet Respir Med* 2020;8:54–64.
  - [19] Low EC, Ong MC, Tan M. Breath carbon monoxide as an indication of smoking habit in the military setting. *Singapore Med J* 2004;45:578–82.
  - [20] Underner M, Peiffer G. [Interpretation of exhaled CO levels in studies on smoking]. *Rev Mal Respir* 2010;27:293–300.
  - [21] West R, Hajek P, Stead L, Stapleton J. Outcome criteria in smoking cessation trials: proposal for a common standard. *Addiction* 2005;100:299–303.
  - [22] Dewost AV, Michaud P, Arfaoui S, Gache P, Lancrenon S. Fast alcohol consumption evaluation: a screening instrument adapted for French general practitioners. *Alcohol Clin Exp Res* 2006;30:1889–95.
  - [23] World Health Organization. Diagnostic testing for SARS-CoV-2. Available at: <https://www.who.int/publications/i/item/diagnostic-testing-for-sars-cov-2>.
  - [24] Hicks KA, Tcheng JE, Bozkurt B, Chaitman BR, Cutlip DE, Farb A, et al. 2014 ACC/AHA Key Data Elements and Definitions for Cardiovascular Endpoint Events in Clinical Trials: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Cardiovascular Endpoints Data Standards). *J Am Coll Cardiol* 2015;66:403–69.
  - [25] Machin D, Campbell MJ, Tan SB, Tan SH. Sample size tables for clinical studies. Chichester. Wiley-Blackwell; 2009.
  - [26] Robins JM, Rotnitzky A, Zhao LP. Estimation of Regression Coefficients When Some Regressors are not Always Observed. *J Am Stat Assoc* 2012;89:846–66.
  - [27] Caliendo M, Kopeinig S. Some practical guidance for the implementation of propensity score matching. *J Econ Surv* 2008;22:31–72.
  - [28] Mamdani M, Sykora K, Li P, Normand SL, Streiner DL, Austin PC, et al. Reader's guide to critical appraisal of cohort studies: 2. Assessing potential for confounding. *BMJ* 2005;330:960–2.
  - [29] Havakuk O, Rezkalla SH, Kloner RA. The Cardiovascular Effects of Cocaine. *J Am Coll Cardiol* 2017;70:101–13.
  - [30] Page RL, 2nd, Allen LA, Kloner RA, Carriker CR, Martel C, Morris AA, et al. Medical Marijuana, Recreational Cannabis, and Cardiovascular Health: A Scientific Statement From the American Heart Association. *Circulation* 2020;142:e131–52.
  - [31] Liaudet L, Calderari B, Pacher P. Pathophysiological mechanisms of catecholamine and cocaine-mediated cardiotoxicity. *Heart Fail Rev* 2014;19:815–24.
  - [32] Pratt LA, Ford DE, Crum RM, Armenian HK, Gallo JJ, Eaton WW. Depression, psychotropic medication, and risk of myocardial infarction. Prospective data from the Baltimore ECA follow-up. *Circulation* 1996;94:3123–9.
  - [33] Krantz MJ, Palmer RB, Haigney MCP. Cardiovascular Complications of Opioid Use: JACC State-of-the-Art Review. *J Am Coll Cardiol* 2021;77:205–23.
  - [34] van Noord C, Straus SM, Sturkenboom MC, Hofman A, Aarnoudse AJ, Bagnardi V, et al. Psychotropic drugs associated with corrected QT interval prolongation. *J Clin Psychopharmacol* 2009;29:9–15.
  - [35] Celano CM, Daunis DJ, Lokko HN, Campbell KA, Huffman JC. Anxiety Disorders and Cardiovascular Disease. *Curr Psychiatry Rep* 2016;18:101.
  - [36] Virmani R, Robinowitz M, Smialek JE, Smyth DF. Cardiovascular effects of cocaine: an autopsy study of 40 patients. *Am Heart J* 1988;115:1068–76.
  - [37] Hasin DS, Hatzenbueler M, Smith S, Grant BF. Co-occurring DSM-IV drug abuse in DSM-IV drug dependence: results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Drug Alcohol Depend* 2005;80:117–23.
  - [38] Twardella D, Kupper-Nybelen J, Rothenbacher D, Hahmann H, Wusten B, Brenner H. Short-term benefit of smoking cessation in patients with coronary heart disease: estimates based on self-reported smoking data and serum cotinine measurements. *Eur Heart J* 2004;25:2101–8.
  - [39] Burdzovic AJ, Lauritzen G, Nordfjaern T. Co-occurrence between mental distress and poly-drug use: a ten year prospective study of patients from substance abuse treatment. *Addict Behav* 2015;48:71–8.
  - [40] Kraus L, Augustin R, Kunz-Ebrecht S, Orth B. Drug use patterns and drug-related disorders of cocaine users in a sample of the general population in Germany. *Eur Addict Res* 2007;13:116–25.
  - [41] Hockenhull J, Black JC, Haynes CM, Rockhill K, Dargan PI, Dart RC, et al. Non-medical use of benzodiazepines and Z-drugs in the UK. *Br J Clin Pharmacol* 2021;87:1676–83.