The Chemists Corner: The Truths About "False Positives" in Drug Testing: What is a False Positive and Does it Really Mean Anything?

A false positive drug test by name is a bit scary; there is nothing more unsettling than to be falsely accused of having done something bad that you didn't do. Nevertheless, a great deal of hysteria has been generated by uninformed so-called drug test "experts" who travel the Internet dispensing half-baked advice on how to prepare for a drug test of some sort. Because the Internet is a bazaar of sorts, it is rife with bad and misleading information purporting to be guidance for avoiding and/or claiming a false positive drug test result. This discussion needs to be very clear and concise or we'll just end up adding to the body of confusion that already exists. In its current context, a false positive drug test is an occasion where some innocent or legal substance (ingested or endogenous) triggers a drug test to report the presence of an illicit drug that isn't in the sample being tested. In its most simple terms, a false positive is a case where a clean sample is falsely reported as containing a sought-for or banned substance. All sorts of scenarios can fit into a discussion of false positives. For those readers working the field of probation, drug court, and rehabilitative services, a claim of a false-positive drug test result is as common these days as a government bail out of a bank. Veteran donor-participants of drug testing programs are very fluent in the lingo of false positive (and of other alleged complications) drug tests. Experienced specimen donors know of all the latest claims that are zipping around the Internet and medical marijuana dispensaries. Most false-positive assertions and claims aren't by definition false-positive results at all.

It's crucial that there be clarity in understanding the processes involved in drug testing. The topic of false-positives relates to just one phase of the testing process; it is the stage of preliminary screening, the first pass if you will, where legitimate, false positive results do occur. For those readers using instant screening devices, you have probably seen first hand a case where a false-positive result was rendered. Nowadays, urinalysis screening is very precise and accurate, but there are well-documented situations where certain types of prescribed medications have reacted with proteins in a screening device to erroneously report that a drug of abuse is present in the sample. For instance, the antibiotic Bactrim (containing sulfamethoxazole and trimethoprim) has occasionally caused some people who've been prescribed that drug to falsely report as having benzodiazepines (Valium, Xanax, Ativan etc.) in their systems. Sustiva, an HIV drug-treatment has been associated with false-positive screening results for the presence of THC metabolites, the principal by-products...
of marijuana use.

A false-positive screening result, because it is purporting to be positive, automatically triggers a confirmatory process that utilizes a different set of extremely precise scientific instruments to check out the initial result. In this follow-up investigation, specially trained scientists confirm or rebut the original screening result. The final testing results are reviewed by certifying scientists before a final report is released. In the case of a Bactrim prompted false positive screening result for instance, a final laboratory report achieved through utilization of gas chromatography and mass spectrometry (GC/MS) confirmation would yield a final report of NEGATIVE. Confirmation testing procedures are quite different than those initial processes involved in a first-pass screen; different analytical methodologies distinguish screening systems from final extraction and identification in confirmations. Drug screening results are not confirmed with the application of another screen, if one were to do that, it's highly likely that the result will be duplicated. Redundant screening analysis achieves little towards determination of a final, reliable and confirmed result; but the practice is rather common and only serves as a seed for confusion and distrust in a given system. In deference to the bottom line, redundant screening is a waste of money, time and resources.

For those readers who don't use instant screening devices, you don't see the false positive screening results that occur on high tech instruments in laboratories. False-positive screening results occur in the lab at rates that are similar to those experienced with instant devices. But like all samples purported to be positive in their screening analysis, final confirmatory processing sorts the conflicting chemistry out and yields a final report that communicates a flawless, final 100% reliable result.

Discussions of false positive drug tests sooner or later get around to anecdotes of people who generate opiate-positive drug tests following consumption of a poppy-seed bagel or hamburger bun. Indeed, most poppy seed preparations contain fruit that is dotted with remnant traces of opium. These very small amounts of opium are insufficient of causing any sort of clinical symptoms; a consumer certainly feels no sensations that would be considered evidence of opiate consumption. Nevertheless, the urine of some poppy seed aficionados will screen and confirm as positive for morphine; this phenomenon is well-documented and courts routinely take judicial notice of its existence. This innocent consumption of a legal foodstuff and resultant positive opiate test report is roundly referred to as a false positive result. In reality and for the record, the test result is 100% correct and is accurately reporting the presence of opiate in the urine; this result is not a false positive. The fact that an opiate tainted non-prohibited food product triggered a positive drug test does not render the result to be false. But this scenario is common. Many prescription drugs and preparations contain drugs and narcotics that are the subject of pre-employment and public safety drug tests. A testing report generates a sterile analysis of any given sample, it by nature cannot describe the manner by which a given drug was consumed or ingested. It is vital that detailed pre-screening questions identify the use of prescription medicines and over-the-counter drugs that a donor may be taking. This sort of information allows for an orderly and informed assessment of final test results and a determination of whether or not a banned substance was legally present. In the workplace and school-based environments, a specially trained medical doctor called a medical review officer (MRO) is assigned the task of evaluating confirmation data and will reconcile the use of prescription medications with a donor before releasing a final test result. In public safety testing programs a different body of expert evaluators will guide probation, parole, drug court and other public safety officials with the interpretation of confirmation test results.

Understanding the distinct roles and phases of drug testing is vital, great confusion can ensue when testing officials don't understand what distinguishes a first-pass drug screen from a final confirmation testing result. Drug screening instant devices are highly accurate, very affordable instruments that facilitate timely drug testing without the entanglements that lab based protocols can sometimes cause. Negative screening results from an instant device represent the end of the road, negative screens are not sent to the laboratory for confirmation of that result. But positive screening results are properly sealed, identified and processed for confirmation testing in the laboratory. Official action based on a testing result can be initiated after the rendering of a final confirmed result by appropriately appointed and trained scientists.

In our next edition of the Newsletter, the Chemist's Corner will investigate a phenomenon related to false-positives, false-negative

http://campaign.constantcontact.com/render?v=001j56_HnETbxsRr...LFQj31BhNKvffNuy1OFQeIR52OIG3qhePmy5x1MWmAU_C2IrV_26BCchE%3D (2 of 10) [6/16/2009 11:02:37 AM]
Once in awhile our DAR staff discovers a good book that speaks to professionals working in the field of drug treatment in correctional settings; we've found one of those books. In "Substance Abuse Treatment with Correctional Clients: Practical Implications for Institutional and Community Settings", a book written by Barbara Sims, readers are provided a non-technocrat overview of the critical issues involved with treatment of substance abusers who are within the jurisdiction of state and local corrections agencies. Dr. Sims, who is a faculty member at Penn State University-Harrisburg, has penned a primer that deals with core concepts associated with identifying, rehabilitating and managing probation and parole clients who present with substance abuse disorders. This book is not a textbook of neurobiology and psychology, rather it is a primer that helps a reader understand the daunting challenges and complexities involved with efforts that must be made in order to effect change with substance abusing "clients." In an economic environment where public drug treatment programs are being cut, it's important that community corrections personnel keep an eye on the ball of drug addiction and insure that the community gets most bang for the buck from their public funded drug rehabilitation services.

Corrections agencies, institutional and community-based, have been an end of the road, a dumping ground of sorts for repeat offenders who are unable to correct their substance abuse disorders. If the truths about the backgrounds of most prison & county inmates in America were made known, the public would come to realize that no matter the precise nature of an inmate's offense (felony or misdemeanor) that earned a prison sentence, there is some sort of underlying substance abuse complication that fueled the bad behaviors. This situation is complicated and stoked by the incidence of mental illness (dual diagnosis cases) that exists in inmate populations. The public frequently assumes that addicted prisoners and probationers receive treatment for their conditions while serving their time or living out their terms of probation supervision. Sometimes that does happen, an addict can and does receive adequate rehabilitative services. But in most cases, a lack of resources means that a needy inmate or probationer may or may not get services that are spotty and/or uncoordinated. This book addresses the overwhelming impact of drugs and drug abuse on the American corrections scene. It is evident that community corrections personnel needs to have a more sophisticated understanding of what substance abuse disorders are all about; Dr. Sims has endeavored to do that.

To best communicate the various concepts advanced in the successive chapters of the book, Sims has cobbled together an interesting group of contributing writers; 21 different contributors advance their observations and recommendations pertaining to topics and discussions where they're considered to be experts. The observations and theories put forth by the contributors are mostly evidence based and are up-to-date. Complicated and vexing topics such as mental illness and dual diagnosis disorders are dealt with in a clear and concise way. The book also addresses interesting ideas and suggestions that should be read by managers, policy makers and politicians who have responsibilities for the operation of county, state
What's the Depth of Your Knowledge? Name This Drug: The Fruit of WWII

This edition's drug of the month is a substance that plays an enormous role in the phenomenon of American drug abuse. This drug is a front row member of a large genre of well-studied narcotic-analgesics; it has chemical characteristics that make it a useful substance in the treatment of people who are addicted and physically dependent on opiates or other narcotic-analgesics. For many years, the drug's formula sat in the bottom of a dusty file belonging to a cadre of German scientists. This team of researchers had conjured up the original formula for this drug in 1938. Scientists had been searching for a non-addictive analgesic that could be used to treat moderate to severe pain. World War II had already broken out, Germany was on the move. War is a bloody, murderous business. Wounded soldiers need powerful analgesics; at that time opiates (morphine etc.) were the go-to drugs for field surgeons.

Because of geo-politics leading up to the war, the German war machine knew that it would have very limited commerce with the parts of the world where opium grew. In anticipation of a total cut-off from opium producing countries, these German scientists were rushed back to the lab to continue their work on a synthetic pain reliever, a drug that would work like morphine, but one that could be conjured up from non-opium precursors.

There is quite a legend associated with this and federal corrections programs.

This 257-page textbook and its 21 individual contributors are organized and portioned into four main sections. Part I, "Nature of the Problem" deals with the underlying concepts and theories that make up current substance abuse treatment programs. Indicators for program success and failure in institutional treatment are discussed here. Part II of the book deals with experiences and lessons of current and past prison substance abuse treatment programs. Historical analysis and discussions about the expectations of inmates is found in this section. Part III of the book deals with experiences of drug diversion programs and drug courts. Practical advice for starting a court-based treatment program is put forth. Suggestions for insuring accountability and treatment success are discussed by several writers in this section of the book. Part IV of the text deals with special treatment populations. Unique challenges posed by juvenile substance abuse problems are laid out in this part of the book; differences in treatment methods for boys and girls are discussed. The book wraps up with discussions of unique problems that may or may not have been experienced yet by a reader.

This book is a valuable read and a productive use of time for anyone who is working in the fields of probation, parole, institutions, drug court, social workers and drug treatment programs that accept patients from one of the foregoing sources.

Substance Abuse Treatment with Correctional Clients: Practical Implications for Institutional and Community Settings by Barbara Sims, PhD. Haworth Press, 2005. ISBN 0-7890-2127-7 (paperback), $24.95

Chantix (varenicline): Does it Really Help Efforts to Stop Smoking?

The importance of smoking cessation for recovering addicts is now front and center and is being discussed at drug and alcohol rehabilitation centers across America. Chantix (varenicline), a new drug developed to help smokers quit now adds a new twist to these dialogs. Proven to be more effective than Zyban (bupropion)-the only other prescription medication approved for use in smoking cessation-Chantix works at specific nicotinic receptors in the brain as a partial agonist/activator to reduce nicotine craving; Chantix achieves this by binding to corresponding receptors in the brain that regulate the neurotransmitter acetylcholine. Chantix is taken by mouth, twice daily. Clinical trials and early analysis of Chantix's effects suggest that the drug effectively reduces the intense craving that smokers experience while quitting smoking.

Chantix outperformed Zyban-a reduced dose version of the well-known antidepressant Wellbutrin-and placebos in double blind clinical trials. Over a 9-52 week interval of smoking cessation, 23% of smokers using Chantix, 15% of Zyban's smokers, and 10% of the people taking a placebo stayed nicotine free. However the side effects for Chantix, namely nausea and insomnia, occurred in 8% more people taking Chantix than Zyban. Following the entry of Chantix to the market, reports of untoward side effects began to trickle in. The trickle turned into a steady flow of complaints. A study recently published in the Journal of General Internal Medicine.
month's drug. Many stories have been told connecting this month's drug directly to Adolph Hitler. Among other claims, this month's drug is said to have been named after the Nazi leader, with the modern product name considered an alphabetical play on his name. This is not true. The drug's original name was nothing more than a connection of the French words for pain (dolor) and end (fin). It is also legend that the Nazi leader is said to have been a frequent abuser of this month's drug; although it is true that he was a poly-drug abuser of amphetamines and barbiturates, there is no credible evidence that he used this month's subject drug.

As a result of the frantic activity in the research laboratory, several chemical cousins to this month's drug were hatched. This particular chemical cousin is known by its product name of Darvon (Darvocet, Darvon 65, Darvon Compound and propoxyphene). Of all its sibling medications, this month's drug was found to be the most powerful analgesic of the bunch.

Like many other drugs that were synthesized in this era, this month's drug spurred little concern as a drug of abuse, certainly not a drug that could cause addiction and drug seeking behaviors. As decades have passed, this month's drug is known to be capable of creating a profound physical dependence; very unpleasant withdrawals can occur if administration is suddenly discontinued or if dosing is significantly reduced.

If you're thinking that this month's drug is Demerol right about now, you're close, but that's not it. Demerol (meperidine) is another chemical cousin that evolved out of the work the German chemists. You know how the story ends; Germany and all of its chemical cousin that evolved out of the work done by the German chemists. You know this is not true. Demerol (meperidine) is another drug that could cause addiction and drug seeking behaviors. As decades have passed, this month's drug is known to be capable of creating a profound physical dependence; very unpleasant withdrawals can occur if administration is suddenly discontinued or if dosing is significantly reduced.

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Smoking is a potent delivery system for any sort of drug; active ingredients of a drug are directly posited in blood that is destined for non-stop direct travel to the brain. Smoking is one of a couple different methods for delivery of nicotine to the brain. Cigarette smoking is especially dangerous because it deposits into the body a number of nasty carcinogens and poisonous gasses; cigarette smoking causes the majority of lung cancer cases in America. Several types of heart disease are also directly tied to the smoking of cigarettes. Not only is smoking a toxic exercise, but technically it also prevents people in drug rehabilitation programs from staying completely "clean."

Unfortunately, the rate of smoking among people in recovery is very high. If medications like Chantix are as effective as data suggests, then rehabilitation programs and recovery centers should strongly encourage their clients to quit smoking. Past editions of this newsletter have reported on studies that address the impact of smoking cessation programs on people in recovery. These studies found that efforts made to help addicts in drug rehabilitation to quit smoking early in their drug rehabilitation treatment did not lead to increased relapse and drug use. Discussions about how to best address smoking and nicotine dependency in rehabilitation programs are likely to grow.

the spoils of war. Following the cessation of hostilities, Allied powers searched the research laboratory where the drug had been cooked up. They found the apothecary formula and a treasure trove of other pharmaceutical innovations that were quickly shared with the rest of the free world.

This month's drug took very little time in coming to the attention of American and British scientists. Several iconic American drug companies (Eli Lilly et al) capitalized on the compounds and began to manufacture and sell the drug. This drug is used globally in an array of medical settings.

In the decades that followed the war, this month's drug made slow, but steady gains in terms of worldwide prescriptions written. The drug had many of the direct effects and characteristics of heroin, but didn't stir all that much interest as a drug of abuse. In both America and the United Kingdom however, there were hundreds of documented cases of addiction and physical dependency associated with the use of this drug, nevertheless, these overall numbers were small when compared to the addiction statistics generated by the relative legions of heroin abusers.

In medicine, this month's drug was mostly used in particular settings; obstetrics was one of those special areas of practice & surgery where the drug seemed to find regular work. The drug was recognized as having a slow onset of action, but when it finally hit a point of peak plasma concentration, it was equal if not superior to morphine in effects of overall analgesia. Of additional interest to researchers and physicians was the realization that this drug did not cause the sought after opiate high and euphoria that users that this drug did not cause the sought after analgesia. Of additional interest to not superior to morphine in effects of overall of peak plasma concentration, it was equal if onset of action, but when it finally hit a point where the drug seemed to find regular work.

The drug was recognized as having a slow of those special areas of practice & surgery that was passed by voters or judicially established protocol, rules and laws that exist to safeguard them from drugs that are brought to market. The proposal for marijuana as a medicine was an emotional high point for the audience that was reached when Judge Gray asserted that police officers were intruding into the private arenas of doctor-patient relationships by arresting medical marijuana using patients and recommending physicians. The judge's point was that marijuana's current hazy legal and political status is complicated by police officers that seek to arrest medical marijuana patients for cultivation and sales of the stuff. Although he ultimately retracted his claim, his shrill and emotional assertion caused an emotional shift in the crowd, a move towards his claims that drug laws perpetuated misery and suffering.

Marijuana as a medicine is complicated. A present, 13 states have chosen to take steps that decriminalize the drug and make it legal to possess if used at the direction or "recommendation" of a physician. California is the leader in terms of establishing a well-oiled system for collecting and dispensing marijuana to "patients" who meet the criteria of legislation that was passed by voters or judicially ordained. Marijuana is the only drug in existence where Americans called for an end-run around established protocol, rules and laws that exist to safeguard them from drugs that are brought to market. None of the 13 states associated with medicalized marijuana consulted the FDA with their initiatives. Marijuana's official federal classification into Schedule I establishes it as a drug that has no accepted medical application; the drug is also judged to be a substance that has a high potential for abuse. Marijuana's status as a Schedule I drug misleads many listeners into believing that cruel and ignorant federal officials stand in the way of curative powers associated with tetrahydrocannabinol (THC), the principal active ingredient in marijuana. This isn't the case. For many years now, synthetic versions of

If this utopian vision can be achieved, money saved by dismantling of drug enforcement agencies would go to organizations involved with the treatment of substance abuse disorders. Taxes gleaned from tariffs on newly legalized drugs would also go for the treatment of a minority population of people who unwittingly discovered that they could not responsibly or maturely use one or more of a bevy of legalized substances (PCP, LSD, methamphetamine, cocaine and heroin included) they chose to experiment with. In his utopian world, the federal government would regulate and in some cases sell drugs to the public according to strict commerce rules that would be overseen by a newly created bureaucracy. Federal government control and participation in drug use would be necessary in order that drugs be sold at low prices; if prices were to too high in this new legal market, black marketers would then assert themselves by providing cheaper (and more pure) products. The whole concept is founded upon a principle that once the profit motive is taken out of drug dealing, then drug addiction and attendant crime will roundly dissipate. Gangs, cartels and drug producers will pack up and go home once they realize that the federal government will undercut them. What a grand idea it is to have one's federal government providing addictive and anesthetizing drugs at bargain basement prices? Making this idea more attractive is the notion that the elimination of criminal penalties and prohibitions will empty prisons of good people whose only societal transgression was to be an addict to a drug or narcotic. Pie in the sky? Sure it is. But the rhetoric and stump speech doesn't stop here.

Behind his frontal assault on drug laws, was Judge Gray's attempt to soften up the crowd for a second wave of proposals, amongst them was the further relaxing and "medicalization" of marijuana laws. Marijuana is couched as a drug that is equal, but has fewer health consequences than alcohol. Marijuana was posited as an overly reasonable candidate for decriminalization; marijuana's recent popularity as a medicinal tonic evidenced a compelling reason for a downgrade in its current status as a controlled drug. The proposal for marijuana as a medicine was an emotional high point for the audience that was reached when Judge Gray asserted that police officers were intruding into the private arenas of doctor-patient relationships by arresting medical marijuana using patients and recommending physicians. The judge's point was that marijuana's current hazy legal and political status is complicated by police officers that seek to arrest medical marijuana patients for cultivation and sales of the stuff. Although he ultimately retracted his claim, his shrill and emotional assertion caused an emotional shift in the crowd, a move towards his claims that drug laws perpetuated misery and suffering.
This month's drug is known by its market or product name of "dolophine" (dolor + fin). In spite of its well-recognized roll as a drug that is used to treat or counter drug addiction and dependency, it has also proven to be a drug of abuse that has a strong following with trendy and tony populations; the club drug scene is a frequent redoubt for this drug. Unlike heroin, this month's drug has some unusual and untoward effects. It remains to be seen though if this month's drug is ultimately bumped from its primary role in narcotic replacement. Buprenorphine is a synthetic narcotic that possesses complex qualities and characteristics that makes it a tricky drug for doctors. Buprenorphine centered opiate treatment programs are growing fast; federal regulations now allow for office-based treatment of opiate addicts.

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pointed side effects that can lead to sudden death. Sudden death is always a possibility when opioids are used in large doses; it's especially risky for people who are non-tolerant or opiate naïve.

This month's drug has a well-documented association with a dangerous cardiac arrhythmia or tachycardia known in medical circles as Torsades de Pointes. Complicating this association is the fact that the long acting nature of this drug can lead to toxic accumulations of the drug and a list of problems that stem from the marked sedation that occurs with it.

Because of this drug's utility and associations with drug treatment and rehabilitation, it as acquired a reputation on the street as a safe drug, a mature and responsible alternative choice to smoking or injecting heroin, or nowadays, a better choice than Oxycontin. In some parts of the country, this drug is combined with other non-opiate drugs to create a "load." These cocktails are ad hoc combinations that strive to maximize the sedating and euphoric effects that each drug brings to the high. On the east coast, dolophine and Xanax are frequently mixed together by heroin addicts who are enrolled in narcotic maintenance programs. Users of "loads" claim that Xanax "sticks" elevate dolophine's high to an extent that is even more euphoric than heroin.

What drug am I?

This month's drug: methadone (aka: dolophine). When used in drug treatment and addiction medicine settings, the protocol is called methadone maintenance.

* Methadone maintenance program participants who combine the use of these drugs are known on the streets as "Methodonians."
A Public Service Announcement from the State of Alabama

What is the Narcotics Anonymous Program? For more information go to:

Alabama North West Florida Regional Service Committee of Narcotics Anonymous

and

Central Alabama Narcotics Anonymous Events

Counter drugs currently available to help with wakefulness, No-Doz and caffeine preparations have been around for decades. Modern energy drinks like Red Bull are capable of causing stimulation and hyperactivity in the consumer that goes beyond the limits of Provigil. Nevertheless, Provigil has more central nervous system potency than caffeine. Provigil is a medication where it can be sometimes difficult to draw the line between what is appropriate use of a performance-enhancing drug and what isn't? These sorts of questions do not begin or end with Provigil. There will probably be other drugs like Provigil that will come to market and be made available by prescription. Is there really any downside to enhancing the capacity and performance of a person's executive function? Not if it's your executive functioning right?

Further information about Provigil and its utilization in the treatment of stimulant addiction can be obtained by contacting the MEDTOX DARS Program at darsprogram@mac.com