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**Intravenous Use of Buprenorphine Tablets Associated With Rhabdomyolysis and Compressive Sciatic Neuropathy**

*To the Editor:*

Despite its action as a partial mu-agonist, buprenorphine has been abused.1,2 We describe 2 patients who developed sciatic neuropathy from severe myositis and rhabdomyositis consequent to the misuse of buprenorphine.

**PATIENT 1**

A 27-year-old male presented with pain and weakness involving both lower limbs of 2 days’ duration. An ex-heroin user, he had been prescribed sublingual tablets of buprenorphine for drug detoxification 2 months prior to presentation. He admitted to having crushed 4-mg tablets of buprenorphine and dissolving them in hot water before injecting into his peripheral veins at the wrist and cubital fossa. He denied any period of unconsciousness, trauma to his limbs, medical history or family history of neurologic disease. The clinical examination was significant for bilateral weakness of ankle plantar flexion, foot extension and eversion and toe extension. Motor power of the left lower limb was graded at 2/5 on the Medical Research Council scale. Tenderness was elicited over the right buttock and inner thigh. There were numerous venipuncture marks over both forearms, the neck, and right groin (Figure). The upper limb, cerebellar, cranial nerve and systemic examinations were unremarkable. Needle scars were present over the left wrist and cubital fossa. Laboratory investigations were significant for rhabdomyolysis [creatine kinase, >32 000 U/L (normal, 30-350); serum myoglobin, 16500 ng/mL (normal, 16-96)], leukocytosis [white cell counts, 16.58 × 10^9/L (normal, 3.20-8.90)] and raised C-reactive protein, 3.6 mg/dL (normal, 0.0-1.0).

On MRI, both patients showed abnormalities within the musculature: patient 1 developed symmetrical multifocal areas of irregular heterogeneous enhancement within the vastus lateralis, adductor magnus and gluteus maximus muscles; and patient 2 developed diffuse swelling of the muscles within the posterior-medial compartment of the right thigh (Figure). Both patients developed rhabdomyolysis and sciatic neuropathy (verified with nerve conduction studies) that reversed with conservative measures. Autoimmune, toxicological, HIV and repeated microbiological studies did not yield any explanation.

Even though severe myositis and rhabdomyolysis are known to occur in the injection of opiates such as heroin, piritramide...
and pentazocine, they are not known to occur with buprenorphine. An etiopathogenic association between buprenorphine and severe myositis is suggested by the close temporal relationship between buprenorphine injection and the development of severe myositis in our patients. Further studies are needed to address if the severe myositis and rhabdomyositis are a direct result of buprenorphine or an indirect effect of the impurities and additives present in the drug.

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REFERENCES

Emergency Intensivists . . . Why Not Now?

To the Editor:

I would like to congratulate Huang and colleagues for making a most compelling argument for critical care medicine certification for emergency physicians in their “white paper” on this subject. Compelling arguments notwithstanding, the political nature of American Board of Medical Specialties approval has frustrated many of us over the past 20 years. The intellectual honesty and enthusiasm of this new generation of emergency physicians interested in critical care medicine is refreshing and reinvigorating.

I strongly believe that our ability as emergency physicians to recognize and resuscitate critically ill and injured patients is truly our reason for being. Our ability to provide unscheduled ambulatory care utilizing the full diagnostic armamentarium of the hospital results from our need to be there 24/7 for the critical cases. Accordingly, our physicians must be absolutely capable in providing this high-end care. We have made great strides in our curricula for airway management, trauma, acute coronary care, toxicology, acute cerebrovascular episodes, etc. Yet, certain critical care concepts, such as assessing systemic perfusion and understanding the determinants of systemic oxygen delivery and how to manipulate them, remain underemphasized in residency curricula and post graduate courses. As