Use of insulin as an anabolic agent

EDITORS—We are writing to alert you to a problem that we are seeing in our drugs in sport clinics—namely, the increasing use of insulin as an anabolic agent.

The potential for widespread use of insulin was brought to our attention in July/August of 1996 when discussions of its use were published in two bodybuilding magazines, leading us to ask our patients about this.

It is difficult to estimate the current usage but at the present time six of our 200 clients have admitted to its use. Worryingly, inquiries about insulin are increasing weekly and we believe this will be a major problem in the coming months.

We have noted two different regimens of administration—namely, 10 IU of short acting insulin twice daily and, more commonly, the use of 2–15 IU of short acting insulin 20 to 40 minutes after training. With each regimen the body builder increases the intake of carbohydrate and protein with the injection.

If the insulin has not been provided on prescription it can be purchased from a pharmacist, if the pharmacist feels that the patient is indeed diabetic. The price for an "Actrapid 3 ml pen" is £0.70 including tax. This can then retail for £0 to a body builder on the "black market". In view of this potential profit we advocate maintained vigilance on repeat prescriptions of insulin and pharmaceutical products purchased.

One of our patients was informed that he could recoup some of this outlay by selling on the unused portion of this pen. Although there will be little risk with the pen delivery system if clean needles are used, it does raise obvious concerns about the risk of hepatitis B, C, and HIV if multidose phials are used without access to a needle exchange.

Our clients have apparently little knowledge about the types of insulin and the variable rates of absorption from different injection sites. This leads to our major concern of the potential for unexpected hypoglycaemic episodes, particularly in those using anabolic steroids.

We would like to alert all practitioners to this possibility if faced with collapsed, confused, or aggressive patients who may in fact be hypoglycaemic and require glucose or glucagon. This may be of importance at the scene of road traffic accidents if the episode has taken the patient unawares.

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General practitioner knowledge of prohibited substances in sport

EDITORS—May I draw your attention to an error in the article on prohibited substances in sport by Drs Greenway published in this journal—namely, that non-steroidal anti-inflammatory drugs are cited as being banned via the intramuscular route. Firstly, non-steroidal anti-inflammatory drugs are not listed in the International Olympic Committee’s list of prohibited substances in the current document dated 31 January 1997 and to my knowledge never have been, therefore doctors can feel free to prescribe this group of drugs without fear of the recipient being in breach of the IOC’s regulations.

Secondly, in the most recent IOC list published on the 31 January 1997 diexopro- phine has been removed together with propoxyphene and ethylmorphine. It is therefore quite in order for an athlete to take co-proxamol.

This merely highlights the difficulty that general practitioners face when dealing with athletes liable to be dope tested and the need for doctors to check regularly each year the IOC’s current listing.

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General practitioner knowledge of prohibited substances in sport.

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