Rapid Opioid Detoxification

By Steven A. King, MD, MS [2]

The use of general anesthesia to speed opioid detox without the discomforts of withdrawal has no scientific support.

The history of medicine is filled with treatments for which there was little scientific support. Although we like to believe that the therapies we provide today are based on solid research, there are still many that fail to meet this standard.

One of these is anesthesia-assisted rapid opioid detoxification (ROD) for those addicted to or abusing opioids. First developed in the 1980s, this treatment involved placing patients under general anesthesia for a 4- to 8-hour period during which they received high doses of an opioid antagonist (eg, naloxone or naltrexone) and a combination of medications to reduce withdrawal symptoms such as clonidine, antiemetics, and antidiarrheal agents.

The theory behind ROD is that it is easier—and more successful—to detoxify patients from opioids if they are unable to feel any discomfort during the process. However, it is a theory that has never been demonstrated to be valid. In fact, as far as I am aware, no one has demonstrated that ROD is any more effective than other detoxification methods, especially for patients abusing prescription opioids.

Other methods of detoxification include simply reducing the amount of medication or using a long-acting substitute, usually methadone, and gradually reducing that dose. Using these methods, patients could be safely detoxed within 7 to 10 days and completely off the drug.

We know that under the worst circumstances, opioid withdrawal is not life-threatening. Furthermore, in most patients, even those who go “cold turkey” from prescription opioids, the worst symptoms they feel are mild flu-like ones.

In contrast, as ROD requires general anesthesia, the treatment itself carries the risk of adverse events much more severe than those related to the withdrawal it is being used to prevent.

A recent CDC Morbidity and Mortality Weekly Report (MMWR) notes that risks associated with ROD are far from only being theoretical. Out of 75 patients treated with ROD at a facility in New York City in a 9-month period in 2012, 2 died after the procedure and 5 others experienced adverse events severe enough to require hospitalization. Four of the patients were being treated for prescription opioid abuse, 2 for both prescription and heroin use, and one for heroin use alone. An investigation of the facility found that its practices were consistent with those generally considered to be acceptable for ROD, although the MMWR report notes that there are still no standard protocols for this procedure to use for comparison.

The 2 fatalities were reported to be the result of pulmonary edema and cardiomegaly in one and hypokalemia and cardiac arrhythmia in the other. Patients who required hospitalization experienced cardiac arrest and suffered severe electrolyte imbalances, pulmonary edema, and changes in mental status.

Obviously, none of these problems with the possible exception of the mental status changes could be attributed to opioid withdrawal itself rather than to the procedure. Based on the problems associated with it, the CDC strongly recommends against using ROD.

In an even tougher statement in a recent health advisory on the procedure, the New York State and New York City departments of health declare, “The procedure is associated with substantial risks of serious adverse events, including death. In recent years, New York State has experienced a number
of fatalities and serious complications following the provision of ultra-rapid opioid detoxification (UROD). Moreover, UROD confers no advantages in reducing opioid dependence over traditional detoxification methods which do not involve sedation or general anesthesia."

This advisory also notes that multiple professional societies, including the American Society of Addiction Medicine and the National Institute for Health and Clinical Excellence in the United Kingdom, have already issued statements against the use of ROD.

Anyone who deals with opioid abusers, whether users of prescription opioids or illicit drugs, knows that detoxifying them from these drugs is the easy part of the whole process. The hard part is keeping the abusers from returning to use of the drugs. This involves addressing the often complex reasons why they began using the drugs in the first place.

There is a marked psychological component for most of these patients. For at least some of the prescription abusers, they began taking the opioids as a legitimate treatment for pain and subsequently began to abuse them. Detoxifying them from drugs that they originally took for pain and then failing to address the pain is a sure-fire path back to drug abuse and to beginning the dangerous cycle all over again.

It is obvious that ROD does not in any way address these issues and most facilities that provide this service do not even offer recommendations for dealing with the psychosocial elements.

Based on the lack of evidence to support its use and the risk of severe adverse events that are not associated with other methods of opioid detoxification, which, by the way, are usually far less expensive than ROD, I cannot see any reason for referring any patient for this treatment or for not advising against it for those patients who might be considering it.

References

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