Rapid Opioid Detoxification

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Introduction by

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Disclosures

- Speaker for Alkermes for Vivitrol

Historical aspects

- Substitution of prescribed opioids used for opioid dependency
  - Methadone – late 60's
  - Buprenorphine – 2002
- Utilization of alpha-2-agonist, clonidine
  - Since 1970's (off label)
- Gabapentin – reported in literature since 2009
- Rapid Detox – 1980 (Kleber) with clonidine/naltrexone
  - Reported by Bisaga, Kosten with buprenorphine/naltrexone/clonidine 2012
- Ultra-Rapid detoxification – 1990's

Rapid Opioid Detoxification is an Alternative to agonist therapy for motivated individuals

- Not intended for detox alone due to high relapse rate
- Concerns about compliance with oral naltrexone
  - Only provide oral agent if monitoring process in place
- Personal choice of some patients to avoid long term maintenance treatment usually in form of depot naltrexone (Vivitrol®)
- Difficulty in tapering patients off of maintenance medication
- Management of patients with chronic pain who opioid therapy no longer is thought appropriate and on low/moderate dose opioid analgesics

Experience at ABBHH

- Began using low dose naltrexone (6.25 mg) with clonidine around 2000
  - Failure to complete 50%
- Introduced very low dose naltrexone from specialty pharmacy – 3 mg
- Began using buprenorphine transition before adding naltrexone 2007
  - Failure rate < 20%
- Converted to liquid naltrexone via hospital pharmacy compounding process
- Approved protocol for Rapid Opioid Detox by local Medical Executive Committee in 2008
- Began outpatient detoxification program in 2012 – mostly opioid users
- Ascension Health, our parent organization adopted the protocol for use in behavioral health facilities to gather additional data

Technique

- Induce withdrawal from opioid (other than methadone)
- Introduce 2 – 4 mg buprenorphine to stabilize withdrawal over 24 hours
  - Due to affinity for opioid receptor
- Start comfort drug regime
  - Clonidine, gabapentin, quetiapine
- Day 2 - About 16 hours after buprenorphine dose administer 2-3 mg naltrexone
- Continue to introduce 2-3 mg naltrexone in briefer time intervals
- Day 4 - give 6 mg of naltrexone 4 hours apart
- Discharge from unit and immediately give depot naltrexone or continue monitored oral naltrexone

Technique (cont.)

- Immediately enter structured rehab program (Intensive Outpatient program, Partial Hospitalization Program, residential)
- Taper off the clonidine and gabapentin over three days
- Use non-controlled medication for sedation/insomnia PRN
- Monitor UDS
- Many patients will “test” the naltrexone effect
- Only highly motivated patients should use oral naltrexone while monitored.
- Continue in individual counseling or aftercare after rehab with community supports (NA, AA)

Follow up

- Monthly prescriber visits for uncomplicated pharmacotherapy
- UDS and PMP monthly
    - Check for synthetic opioids
- Minimum of six months but more typically 12 – 18 months preferred
- Continue in treatment with health care professional for 3 years or more with random UDS
- Need to make critical changes to life style, manage emotions, utilize community supports
- No long term outcome studies done following rapid detox

Warnings and side effects

- Opioid overdose risk – coming off naltrexone or trying to over-ride
  - Requires 20 “dime bags” of heroin to have modest effects
- Severe injection site reactions – often by injection into fatty tissue
  - Overweight or underweight individuals at more risk
- Sudden opioid withdrawal while starting or re-initiation of naltrexone therapy – check rapid UDS or introduce low dose naltrexone/naloxone
- Hepatotoxicity - > 300 mg oral naltrexone daily
  - Also in persons with significant hepatic impairment or disease

Managing acute pain

- Use of toradol IM or NSAID’s
- Over - ride naltrexone with fentanyl compound
  - Requires monitoring
- Nerve blocks
- Induce sedation

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Next steps

- Further ‘tweaking’ of protocol
- Gather outcome data perhaps with other sites
- Determine best candidates for rapid detox