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
Next steps

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