



ASAM

American Society of Addiction Medicine

Public Policy Statement

On Rapid and Ultra Rapid Opioid Detoxification

(Formerly Public Policy Statement on Opioid Antagonist Agent Detoxification under Sedation or Anesthesia (OADUSA))

Background

Opioid addiction is a complex disease involving physiological, psychological, genetic, behavioral and environmental factors. It shares features of other drug dependencies but often requires unique treatment strategies. No single treatment approach is effective in all cases. In carefully chosen patient populations, both abstinence-based treatment and opioid agonist maintenance treatment are effective, safe and accepted modalities. (See ASAM Public Policy Statements on Methadone and Buprenorphine.)

The withdrawal syndrome from opioids--including those that have been therapeutically administered in an opioid maintenance treatment program--can be protracted and intensely symptomatic, albeit virtually without risk of mortality. There is no single "right way" to detoxify all opioid addicted patients. Traditional methods include tapering with methadone or buprenorphine or discontinuing opioids and administering oral clonidine to ameliorate symptoms of withdrawal. Even when pharmacologic agents are utilized in the management of opioid withdrawal, there is often a significant amount of patient discomfort. Patients who are unable to tolerate this discomfort often terminate the detoxification process and many return to illicit opioid use. Other opioid-dependent patients--both those engaged in active illicit drug use and those stabilized in an opioid agonist maintenance program--will not even attempt opioid withdrawal because of their fears of the discomforts of the process. Whereas mortality from opioid withdrawal is negligible, the mortality rate for persons who resume opioid use is significant. This is due not only to the mortality inherent in active opioid addiction but also to the increased risk of fatal overdose which results from the loss of opioid tolerance associated with even a short period of abstinence, as occurs in most detoxification attempts.

Clinicians have developed various accelerated methods of opioid detoxification that rapidly induce withdrawal through the monitored therapeutic administration of opioid antagonist agents, while concurrently diminishing the patient's discomfort by inducing various degrees of sedation through the use of sedative hypnotic agents or general anesthetics. More commonly used terminology refers to rapid opioid detoxification

(ROD), in which oral opioid antagonists (naltrexone) are administered along with moderate sedation orally or ‘conscious sedation’ intravenously; and ultra rapid opioid detoxification (UROD), in which intravenous opioid antagonists (naltrexone) are administered along with general anesthesia.

The topic of antagonist-assisted acute detoxification accompanied by heavy sedation or anesthesia has been the subject of two Cochrane Database Reviews, most recently updated in 2004. In these reviews, the available literature was surveyed and described in detail. The reviewers conclude that there is insufficient evidence to support the clinical use of antagonist-assisted detoxification with **heavy sedation or anesthesia** in the management of opioid addiction (UROD). In the case of the use of antagonist-assisted detoxification with **minimal sedation** (ROD), the reviewers conclude that adjunctive use of minimal sedation with an opioid antagonist and an alpha-2 adrenergic agonist may increase the likelihood of entry into longer-term naltrexone treatment, compared to withdrawal managed with an opioid antagonist and an adrenergic agonist without the assistance of minimal sedation. A high level of monitoring and support (for several hours following administration of opioid antagonists) is recommended because of the possibility of vomiting, diarrhea and delirium.

The goal of addiction treatment is to have patients functioning optimally in their families and communities; abstinence alone does not assure optimum functioning, and detoxification does not in itself address the chronic dysfunctions of addiction. Ongoing engagement in addiction treatment is an important variable in how effective treatment will be. It is unclear how any specific method of detoxification relates to retention in addiction treatment. Further research could give information on the safety and effectiveness of antagonist-induced acute detoxification regimes, as well as of the variables influencing the severity of withdrawal, the prevalence and severity of adverse effects, the most effective antagonist-based detoxification regimens, and approaches that might increase retention in subsequent treatment and/or opioid or naltrexone maintenance programs for persons receiving opioid detoxification services. As stated so succinctly by authors of a 1998 article in the Journal of the American Medical Association, “the existing literature on Rapid Opiate Detox is limited in terms of the number of subjects evaluated, the variation in protocols studied, lack of randomized design...and the short term nature of the outcomes reported. Further research is indicated and needed using more rigorous research methods, longer term outcomes, and comparison with other methods of treatment for opiate dependence.” Almost a decade since the appearance of this article, the same conclusions are justified.

Policy Recommendations

- 1. Opioid detoxification alone is not a treatment of opioid addiction. ASAM does not support the initiation of acute opioid detoxification interventions unless they are part of an integrated continuum of services that promote ongoing recovery from addiction.**

- 2. Ultra-Rapid Opioid Detoxification (UROD) is a procedure with uncertain risks and benefits, and its use in clinical settings is not supportable until a clearly positive risk-benefit relationship can be demonstrated. Further research on UROD should be conducted.**
- 3. Although there is medical literature describing various techniques of Rapid Opioid Detoxification (ROD), further research into the physiology and consequences of ROD should be supported so that patients may be directed to the most effective treatment methods and practices.**
- 4. Prior to participation in any particular modality of opioid detoxification, a patient should be provided with sufficient information by which to provide informed consent, including information about the risks of termination of a treatment plan of prescribed agonist medications such as methadone or buprenorphine, as well as the need to comply with medical monitoring of their clinical status for a defined period of time following the procedure to ensure a safe outcome. Patients should also be informed of the risks, benefits and costs of alternative methods of treatment available.**

Adopted by the American Society of Addiction Medicine Board of Directors April 2000 as Public Policy Statement on Opioid Antagonist Agent Detoxification under Sedation or Anesthesia (OADUSA); *rev.* April 2005.

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