letters

Rapid opiate detoxification and the striking off of Dr Gary Gerson

The disciplining of Dr Gary Gerson for fatally mismanaging the treatment of Brendan Woolhead following Rapid Opiate Detoxification (ROD) was expected and deserved. However, to state that 'the GMC ruling is yet another blow to the standing of the UROD procedure' ignores the increasing body of evidence to the contrary. It's also inappropriate to use the term UROD (Ultra-Rapid Opiate Detoxification).

ROD basically involves using opiate antagonists (naloxone or naltrexone) to push opiates off opiate receptors. This greatly accelerates and shortens the acute withdrawal period from the usual 3-7 days to about 6 hours. It needs anti-withdrawal drugs and/or sedation to make the process tolerable but most patients can return to family care the next day. After both classical withdrawal and ROD, the *post*-acute symptoms can still be unpleasant and sometimes continue for months.

When ROD first hit the news in 1994, it wasn't new. In the mid 1970s, US groups described how repeated doses of naloxone could enable patients on methadone to transfer to naltrexone within 24hrs. Even earlier, it was reported that when opiate addicts accidentally swallowed naltrexone, it was unpleasant and alarming but not lethal.

The discovery in 1978 that clonidine reduced opiate withdrawal symptoms led to combined clonidine-naltrexone-sedative detox programmes, which got people off methadone or heroin, in 3-4 days later reduced to 1 day. Then as now, ROD was seen as a technique not just for getting addicts *off opiates* but also for getting them *on to naltrexone*, because when taken regularly or implanted, naltrexone considerably reduces relapse, especially early relapse.

These techniques worked well for most patients but for a minority, symptom control even with generous sedation was inadequate. Even if patients had no recall of the procedure, a combination of restlessness and diarrhoea could make for difficult nursing. I was doing these procedures myself by that time and I remember thinking how much nicer it would be for everyone if we could simply anaesthetise patients during this period of restlessness.

I didn't have access to an intensive care ward but in the department of psychiatry at the University of Vienna, they just happened to have one. A team led by psychiatrist Norbert Loimer used anaesthesia in ROD for the first time in 1987 and it was published in medical journals within a few months. When I met them in 1988 it was a standard detox option and quite popular, especially with patients who wanted to graduate from methadone maintenance.

Loimer and his team went on to develop and refine the technique and they published several papers on the topic before the team disbanded as the members went their separate ways. Few people took it up because few were interested in naltrexone and because there was (and still is) a massive anti-pharmacological bias in addiction treatment circles, especially in the US.

Many opiate addicts have relatively mild withdrawal symptoms and can be withdrawn and started on naltrexone more economically as out-patients, or as in-patients in 24 hours using oral sedation. Over 70% of our in-patients choose this method, which has proved its safety in a Spanish study now involving over 3000 patients. So-called UROD (*ultra*-rapid opiate detoxification) is no more rapid than any other 24 hour procedure. But, for the minority with severe symptoms (or who are severely frightened of withdrawal), techniques using anaesthesia or i/v sedation are sometimes the only way detoxification can attract and succeed.

The 'internal report' by NIDA which said that 'UROD...is currently without ethical, medical, scientific or financial justification' was true in 1996, when it was written, in the sense that no randomised controlled trials had been done but absence of evidence is not evidence of absence and the evidence is accumulating steadily. Several comparative studies of ROD vs conventional detox have now been done or are in progress. For *all of them*, ROD gave much higher completion rates, higher uptake of naltrexone treatment and a much *lower* cost per successful detoxification. ROD is now available in the state hospitals of several countries.

Why is the term UROD inappropriate? Because it is simply the trade name given to ROD by the company CITA whose founder claimed to have invented the whole process and who then not only tried to patent it, but also threatened to sue doctors such as myself for conducting the very same treatment. The GMC decided that Dr Gerson was 'motivated by commercial gain' which condemns the company he was working for every bit as much as the fallen doctor.

Dr Colin Brewer, Medical Director, The Stapleford Centre. London.

References supplied.

connections

Independent living project

We are evaluating a local project for stabilised or drug-free individuals designed to promote self-esteem, confidence and independent living, and help to access education and employment.

We would be very grateful to hear about any similar projects which have been evaluated, for comparison.

Mark C. Connelly, Information and Research Officer, Lanarkshire Drug Action Team, email: mark.connelly@lanarkshirehb.scot.nhs.uk

DrugScope Millennium Awards

DrugScope recently made recommendations to the Millennium Commission for 12 Round 2 Award Winners. There is still £1m to distribute in grants and the scheme has so far supported 13 Award Winners.

The scheme is still only operating in 3 pilot areas but will be available across England from March next year. The next deadline for applications is 25 January 2002. DrugScope is happy to offer workshops for potential applicants so please let us know if you would like to find out more.

Contact the Millennium Awards team on 020 7928 1211 or e-mail: nicolac@drugscope.org.uk web: www.drugscope.org.uk/funding