

# Rapid opiate detox out for the count

**Following last year's inquest into the death of Brendan Woolhead while undergoing rapid opiate detoxification, a public debate and a number of recent cases have called into question the basis of such detox programmes.**

Mr Woolhead survived the IRA bus bomb blast in Aldwych in 1995, and used some of the compensation awarded after being wrongly accused of being a terrorist, to book himself into the detox programme.

Thirty hours after beginning the treatment – which involves the administration of a general anaesthetic for six to eight hours as well as that of the opiate antagonist naltrexone – Woolhead went into convulsions and died.

The inquest into his death was halted in February 1997 and the case referred to the Criminal Prosecution Service after allegations of negligent treatment were made. *Druglink* has learnt that police enquiries are ongoing and that the inquest will reconvene in the next few weeks. The possibility still remains that a criminal prosecution may be undertaken.

The concern surrounding the use of anaesthesia has even surfaced in the pages of the *British Medical Journal*. A team from Norfolk Mental Health Care NHS Trust recently wrote:

"The introduction of anaesthesia and polypharmacy . . . has, we believe, quite unnecessarily introduced major hazards . . . Clinical trials of rapid detoxification with anaesthesia cannot be justified."<sup>1</sup>

## Limited support

Even past supporters of ultra rapid opiate detox appear to have modified their position. The Maudsley Hospital had been lined up to conduct controlled studies into the technique, while another branch of its parent organisation, the Institute of Psychiatry, had won the psychological aftercare contract from one of the UK's major provider of this treatment. But in a *BMJ* editorial, Michael Gossop (one of the first to bring the technique to the attention of a British readership<sup>2</sup>) and John Strang of the Maudsley wrote of ultra rapid detox's:

"inherent dangers . . . the hazards of prolonged general anaesthesia and those that must result from the sudden pharmacological bombardment with an opiate antagonist . . . Until there is adequate evidence of effectiveness and safety for this technique it should be used only in clinical trials."<sup>3</sup>

Professor Strang does not, however, believe that his position has changed. "I think it's a pity that we needed to call a halt," he told *Druglink*. "We're still stuck where we were four years ago, unable to support it and unable to oppose it. This is a rather unsatisfactory state of scientific affairs."

Colin Brewer, who pioneered rapid opiate detox in Britain, dismisses the anti-anaesthesia arguments. "Anaesthetic is not dangerous now. The death rate's something like one in 200,000," he says. "So, you don't need a clinical trial to know that anaesthesia relieves pain. If we followed that advice, all surgery would have to stop while we performed controlled trials



Under the knife: Rapid detox's innovator, Dr Norbert Loimer (in white coat), supervising a detox

on surgery with and without chloroform!"

## Aftercare, afterburn?

But it is not just the anaesthesia which has caused alarm. One of a number of recent cases which *Druglink* is aware of centres around a Merseyside casualty department, where doctors have confirmed that they treated "someone who came in as a barbiturate OD – taking vast amounts of sedatives". He had taken at least 120 mgs of temazepam and four tuinal – and had arrived in Liverpool from London, where he had been treated privately via rapid detox under anaesthesia. "We left him alone for a day and he woke up," the doctor told *Druglink*, "but I thought we'd progressed beyond barbiturates, and such high dosages at that".

"This sounds rather atypical", Colin Brewer admits, "but persistent withdrawal symptoms are an aspect of the treatment which I have never attempted to hide. Generally speaking, if people are not fit to travel, we keep them in overnight. We don't send patients home with

We're still stuck where we were four years ago, unable to support it and unable to oppose it

barbiturates." However, he maintains that barbiturates are sometimes a necessary element of the treatment's aftercare package: "Sleep is a serious problem for a minority of patients after a detoxification, and quite often benzodiazepines don't work. If people don't sleep, they go up the wall. Ultimately, chemical sleep's better than no sleep. I believe that the avoidance of early relapse is so important that almost any measure is justified – including the risk of over-enthusiastic self-medication – if it helps to achieve that goal" ■

1. Rumball D. and Williams J. "Assessment is needed to exclude certain patients before detoxification." *BMJ*: 13.9.1997, 315, p.682.  
 2. Legarda J. and Gossop M. "A 24-hour inpatient detoxification treatment for heroin addicts: a preliminary investigation." *Drug and Alcohol Dependence*: 1994, 35, p.91-3.  
 3. Strang J. et al. "Opiate detoxification under anaesthesia." *BMJ*: 15.11.97, 315, p.1249-50.