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Treatment of Opioid-Use Disorders REPLY

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Treatment of Opioid-Use Disorders

TO THE EDITOR: In his review of the management of opioid-use disorders, Schuckit (July 28 issue)[1] focuses on withdrawal syndromes and the central role of opioid-agonist maintenance therapy in long-term rehabilitation. However, patients must first engage in treatment in order for the therapeutic approaches described to be implemented. Increasingly, patients with opioid-use disorders come into contact with the health care system because of hospitalization for other reasons such as infection, pregnancy, or trauma.[2] Such hospitalizations provide a brief but unique opportunity to offer treatment for opioid-use disorders.

The use of methadone and buprenorphine for adjunctive treatment of opioid-use disorders during such hospitalizations is recommended by international guidelines, and under the Code of Federal Regulations (21 CFR 1306.07), any hospital-based provider is explicitly allowed to provide this treatment.[3,4] However, hospital pharmacies and medical providers vary in their interpretations of this regulation, and many health systems prohibit or limit the use of these agents for hospitalized patients with opioid-use disorders. Policies are needed to clarify and standardize this practice in order to engage this most vulnerable patient population in treatment for addiction.

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No potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: Schuckit's review article attempts to provide "an overview of the current treatment of opioid-related conditions." However, the article does not meaningfully address what happens after an addicted patient has been helped through withdrawal with the use of pharmacologic agents and then enters a pharmacologic maintenance program. Although both of these approaches are extremely important, sadly, the inability of most of these patients to achieve lifetime sobriety means that pharmacologic successes ultimately fail.

A spiritual defect develops wherein addicted patients use chemicals to replace hope and faith that a normal life will work satisfactorily.[1] The chemicals in turn cause major biologic, social, and psychological problems. The spiritual defect can be addressed only with a spiritual solution, and the only widely available and effective long-lasting spiritual treatments of addiction are the 12-step Alcoholics Anonymous and Narcotics Anonymous programs. Millions of patients in Alcoholics Anonymous, Narcotics Anonymous, or both of these programs agree with the *Big Book* of Alcoholics Anonymous, which says that "rarely have we seen a person fail who had thoroughly followed our path."[2] Short-term pharmacologic success in persons with addiction must be followed by long-term spiritual healing.

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No potential conflict of interest relevant to this letter was reported.

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THE AUTHOR REPLIES: In this article as in many review articles, judgments had to be made regarding which of the many issues that relate to the topic would be included and the amount of space they would occupy.

Winetsky et al. note the challenges associated with engaging patients who have substance-use disorders in treatment; doing so is an essential first step before therapeutic interventions can be instituted. They also emphasize the available op-

portunities for intervention when persons seek care for other medical reasons, as well as the need to clarify and standardize ways to implement the relevant Code of Federal Regulations regarding treatments in clinical settings. Too many health care systems inappropriately prohibit these approaches. These points are worth emphasizing, and approaches for identification of substance-use disorders and interventions were major points in my 2009 review of the treatment of alcohol-use disorders.[1]

Benumof's points expand on my comments and associated references[1,2] in the second paragraph of the section "Approaches to Rehabilitation and Maintenance" of my article. He emphasizes the key roles played by self-help groups such as Alcoholics Anonymous and Narcotics Anonymous in recovery from substance-use disorders. These 12-step programs offer round-the-clock guidance from nonprofessionals who are themselves in recovery; assist with relapse prevention; provide models of how abstinence can develop and be maintained; and introduce members to peers who are not abusing alcohol or drugs. In addition to these elements of what might be considered to be cognitive behavioral approaches, most groups stress the importance of spiritual growth. Regardless of which of these many elements are most essential to specific members, I echo Benumof's enthusiasm for these programs.

Finally, another valued colleague (Skolnick P: personal communication) made an informal comment that I want to convey to readers. The Food and Drug Administration recently approved an intranasal formulation of naloxone for treating opioid overdoses.[3]

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Since publication of his article, the author reports no further potential conflict of interest.

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Long-Term Follow-up of TBI

TO THE EDITOR: An article by Okie (July 14 issue)[1] on traumatic brain injury (TBI) focused on the personal paths to recovery taken by combat veterans with TBI. The article, however, gave an erroneous impression that previous research on the long-term effects of TBI has been scarce. In fact, there is considerable published literature on this topic that could guide present and future research and clinical management of both closed (including blast-related[2]) and penetrating TBI. Even if it is difficult to predict with absolute certainty a precise outcome after TBI in any individual patient, there are key preinjury and postinjury indicators that can greatly help clinicians forecast potential issues (e.g., return to work[3]) for patients with TBI, including preinjury cognitive ability, genetic polymorphisms, and postinjury evaluation of physical, epilepsy, and neurobehavioral status.[4-6] In treating veterans with TBI, it is our responsibility to know this literature and do everything we can to improve care.

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No potential conflict of interest relevant to this letter was reported.

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