management must be based on clinical criteria. If naloxone is not administered, progression to respiratory and cardiovascular collapse leading to death occurs. At autopsy, cerebral edema and sometimes frothy pulmonary edema are generally found. Opiates generally do not produce seizures except for unusual cases of polydrug use with the opiate meperidine, with high doses of tramadol, or in the newborn.

TREATMENT OPIOID OVERDOSE

Beyond the acute treatment of opiate overdose with naloxone, clinicians have two general treatment options: opioid maintenance or detoxification. Opioid agonist and partial agonist medications are commonly used for both maintenance and detoxification purposes. Alpha-2-adrenergic agonists are primarily used for detoxification. Antagonists are used to accelerate detoxification and then continued after detoxification to prevent relapse. Only the residential medication-free programs have had success that comes close to matching that of the medication-based programs. Success of the various treatment approaches is assessed as retention in treatment and reduced opioid and other drug use; secondary outcomes, such as reduced HIV risk behaviors, crime, psychiatric symptoms, and medical comorbidity, also indicate successful treatment.

Stopping opiates is much easier than preventing relapse. Long-term relapse prevention for opioid-dependent persons requires combined pharmacologic and psychosocial approaches. Chronic users tend to prefer pharmacologic approaches; those with shorter histories of drug abuse are more amenable to detoxification and psychosocial interventions.

OPIATE OVERDOSE

Managing overdose requires naloxone and support of vital functions, including intubation if needed **(Table 468e-2)**. If the overdose is due to buprenorphine, then naloxone might be required at total doses of 10 mg or greater, but primary buprenorphine overdose is nearly impossible because this agent is a partial opiate agonist, meaning that as the dose of buprenorphine is increased it has greater opiate antagonist than agonist activity. Thus, a 0.2-mg buprenorphine dose leads to analgesia and sedation, while a hundred times greater 20-mg dose produces profound opiate antagonism, precipitating opiate withdrawal in a person who was opiate dependent on morphine or methadone. It is important to recognize that the goal is to reverse the respiratory depression and not to administer so much naloxone that it precipitates opiate withdrawal. Because naloxone only lasts a few hours and most opiates last considerably longer, an IV naloxone drip with close monitoring is frequently employed to provide a continuous level of antagonism for 24–72 h depending on the opiate used in the overdose (e.g., morphine vs methadone). Whenever naloxone has only a limited effect, other sedative drugs that produce significant overdoses must be considered. The most common are benzodiazepines, which have produced overdoses and deaths in combination with buprenorphine. A specific antagonist for benzodiazepines—flumazenil at 0.2 mg/min—can be given to a maximum of 3 g/h, but it may precipitate seizures and increase intracranial pressure. Like naloxone, administration for a prolonged period is usually required because most benzodiazepines remain active for considerably longer than flumazenil. Support of vital functions may include oxygen and positive-pressure breathing, IV fluids, pressor agents for hypotension, and cardiac monitoring to detect QT prolongation, which might require specific treatment. Activated charcoal and gastric lavage may be helpful for oral ingestions, but intubation will be needed if the patient is stuporous.

TABLE 468e-2 MANAGEMENT OF OPIOID OVERDOSE

Establish airway. Intubation and mechanical ventilation may be necessary.
Naloxone 0.4–2.0 mg (IV, IM, or endotracheal tube). Onset of action with IV is approximately 1–2 min.
Repeat doses of naloxone if needed to restore adequate respiration or a continuous infusion of naloxone can be used.
One-half to two-thirds of the initial naloxone dose that reversed the respiratory depression is administered on an hourly basis (note: naloxone dosing is not necessary if the patient has been intubated).

OPIATE WITHDRAWAL

The principles of detoxification are the same for all drugs: to substitute a longer-acting, orally active, pharmacologically equivalent medication for the substance being used, stabilize the patient on that medication, and then gradually withdraw the substituted medication. Methadone or buprenorphine are the two medications used to treat opioid use disorder. Clonidine, a centrally acting sympatholytic agent, has also been used for detoxification in the United States. By reducing central sympathetic outflow, clonidine mitigates many of the signs of sympathetic overactivity but typically requires augmentation with other agents. Clonidine has no narcotic action and is not addictive. Lofexidine, a clonidine analogue with less hypotensive effect, is not yet approved in the United States.

Methadone for Detoxification Dose-tapering regimens for detoxification using methadone range from 2–3 weeks to as long as 180 days, but this approach is controversial given the relative effectiveness of methadone maintenance and the low success rates of detoxification. Unfortunately, the vast majority of patients tend to relapse to heroin or other opiates during or after the detoxification period, indicative of the chronic and relapsing nature of opioid use disorder.

Buprenorphine for Detoxification Buprenorphine does not appear to lead to better outcomes than methadone but is superior to clonidine in reducing symptoms of withdrawal, retaining patients in a withdrawal protocol, and in completing treatment.

Alpha-2-Adrenergic Agonists for Detoxification Several alpha-2-adrenergic agonists have relieved opioid withdrawal by suppressing brain noradrenergic hyperactivity. Clonidine relieves some signs and symptoms of opiate withdrawal such as lacrimation, rhinorrhea, muscle pain, joint pain, restlessness, and gastrointestinal symptoms. Related agents are lofexidine, guanfacine, and guanabenz acetate. Lofexidine can be dosed up to ~2 mg/d and appears to be associated with fewer adverse effects. Clonidine or lofexidine is typically administered orally, in three or four doses per day, with dizziness, sedation, lethargy, and dry mouth as the primary adverse side effects. Outpatient-managed withdrawal will require close follow-up often with naltrexone maintenance to prevent relapse.

Rapid and Ultrarapid Opiate Detoxification The opioid antagonist naltrexone typically combined with an alpha-2-adrenergic agonist has been purported to shorten the duration of withdrawal without significantly increasing patient discomfort. Completion rates using naltrexone and clonidine range from 75 to 81% compared to 40 to 65% for methadone or clonidine alone. Ultrarapid opiate detoxification is an extension of this approach using anesthetics but is highly controversial due to the medical risks and mortality associated with it.

Opioid Agonist Medications for Maintenance Methadone maintenance substitutes a once-daily oral opioid dose for three- to four-times daily heroin. Methadone saturates the opioid receptors and, by inducing a high level of opiate tolerance, blocks the euphoria from additional opiates. Buprenorphine, a partial opioid agonist, also can be given once daily at sublingual doses of 4–32 mg daily, and in contrast to methadone, it can be given in an office-based primary care setting.

METHADONE MAINTENANCE Methadone's slow onset of action when taken orally, long elimination half-life (24–36 h), and production of cross-tolerance at doses from 80 to 150 mg are the basis for its efficacy in treatment retention and reductions in IV drug use, criminal activity, and HIV risk behaviors and mortality. Methadone can prolong the QT interval at rates as high as 16% above the rates in non-methadone-maintained, drug-injecting patients, but it has been used safely in the treatment of opioid dependence for 40 years.

BUPRENORPHINE MAINTENANCE While France and Australia have had sublingual buprenorphine maintenance since 1996, it was first