2 Letters (Blachly)

December 22, 1971

Dr. Paul H. Blachly
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Dear Paul:

Once again, I find your questions thought-provoking and most relevant to public issues. I accept your premise that "those who are physically dependent or have been so in the past" should be admitted to methadone programs - and our program is limited to those males with at least a 2-year history and one confirmed treatment failure. In answer to your questions:

(1) We do not use naloxone to screen routinely.

(2) I know of no program that does.

(3) We do not use naloxone to screen, for we admit all patients to the ward, observe for withdrawal symptoms, and then detoxify with methadone if symptoms are observed.

Were I to run a large methadone program, I would use naloxone tests. We give naloxone for test purposes about 4-7 days post-withdrawal (0.8 mg IV) 24 hours (or more) before we give heroin challenges. At various times, 3-6 days after the last does of methadone, our patients have had chills, piloerection, irritability, and insomnia - sufficient for the staff not to wish to do a naloxone challenge routinely.

(4) About prisoners, your suggestion is interesting. In normal subjects, naloxone has no effect on behavior, pupils, heart rate, or EEG. In the recent post-addict, symptoms are precipitated. I do not know what to expect in an addict, "clean" for some weeks or months, although I would anticipate he would be like our normals. Surely, a man claiming to be dependent - and using opiates within 3-6 days - would be identified easily by a naloxone test.

(5) The suggestion about naloxone's availability to police and ambulance drivers is brilliant. The only objection would be the rare sadist who would enjoy the discomfort of precipitated abstinence - but this is a miniscule risk compared to the possible saving in overdose deaths. I would anticipate a coma from non-opiate cause would have no adverse consequences from the naloxone.

On two occasions, in patients receiving 100 mg methadone daily, our heroin challenges (50, 75 mg) elicited euphoria, respiratory slowing, and miosis - evidence of insufficient blockade (cross-tolerance). We gave 1 mg naloxone IV, and in each case, precipitated a severe abstinence syndrome, unresponsive to additional heroin, methadone, and chlorpromazine, and being relieved only by time (3-6 hours).

Note also, that naloxone IV is usually effective for 2-3 hours only and in overdoses, must be repeated frequently.

I would support the suggestion that naloxone be freely available to ambulances, police, physicians', and pharmacies; would not object to an over-the-counter availability; and would encourage studies of naloxone in prison (or hospital) units as a test for eligibility for methadone maintenance.

Incidentally, our acetylmethadol study is completed and it confirms your initial optimism in 1969. It will appear in JAMA - a copy is enclosed for your interest. Also, our first trials with naloxone pamoate began December 16.

My thanks for the good wishes - and for the opportunity to think about these provocative questions.

Sincerely yours,

Max Fink, M.D.
Professor of Psychiatry

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