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ER naltrexone for opioid use disorder

We appreciate the important review by Gluck et al ("Managing patients with comorbid opioid and alcohol use disorders," Current Psychiatry, February 2023, p. 20-28, doi:10.12788/cp.0327) addressing the common co-occurrence of opioid use disorder (OUD) and alcohol use disorder (AUD) among hospitalized patients, and we offer a friendly amendment to the algorithm they presented. Early in their algorithm, the authors suggest asking patients whether they want pharmacologic treatment for OUD. We recommend that if the patient affirms interest in OUD medication, the next question should be whether the patient prefers to be opioid-free. If the patient says "yes," extended-release injectable naltrexone (XR-NTX) is offered. If the patient answers "no," they can be offered buprenorphine or methadone.

XR-NTX should be considered an equal OUD treatment alternative to buprenorphine-naloxone, especially for patients who prefer an opioid-free option.[1,2] It has the added advantage of being FDA-approved for both AUD and OUD.

One obstacle to the success of XR-NTX is the induction period. The National Institute on Drug Abuse Clinical Trials Network X:BOT trial found that once the induction hurdle was surmounted, XR-NTX and buprenorphine were equally effective in a population of approximately 80% heroin users and two-thirds injection drug users.[2] Patient variables that predict successful induction include young age, baseline preference for XR-NTX, fewer drug complications, and fewer family/social complications.[3] If the length of the induction (usually 7 to 10 days) is a deterrent, a study supported the feasibility of a 5-day outpatient XR-NTX induction.[4] Further research is needed to improve successful induction for XR-NTX.

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The authors respond

We appreciate Drs. Ogbuchi and Drexler for their thoughtful attention to our review. They proposed amending our original algorithm, recommending that XR-NTX be considered as another first-line option for patients with OUD. We agree with this suggestion, particularly for inpatients. However, we have some reservations about applying this suggestion to outpatient treatment. Though research evidence from Lee et al[1] indicates that once initiation is completed, both medications are equally safe and effective, the initial attrition rate in the XR-NTX group was much higher (28% vs 6%, $P < .0001$), which suggests lower acceptability/tolerability compared with buprenorphine. Notably, the initiation of both medications in Lee et al[1] was done in an inpatient setting. Moreover, although some medications are endorsed as "first-line," the actual utilization rate is often influenced by many factors, including the ease of treatment initiation. Wakeman et al[2] found the most common treatment modality received by patients with OUD was nonintensive behavioral health (59.5%), followed by inpatient withdrawal management and residential treatment (15.2%). Among all patients in the Wakeman study,[2] only 12.5% received buprenorphine or methadone, and 2.4% received naltrexone.

Data from our clinic corroborate this trend. Currently, in our clinic approximately 300 patients with OUD are receiving medications, including approximately 250 on

buprenorphine (including 5 to 10 on the long-acting injectable formulation), 50 on methadone, and only 1 or 2 on XR-NTX. Though this disparity may reflect bias in our clinicians' prescribing practices, in the past few years we have had many unsuccessful attempts at initiating XR-NTX. To our disappointment, a theoretically excellent medication has not translated clinically. The recent surge in fentanyl use further complicates XR-NTX initiation for OUD, because the length of induction may be longer.

In conclusion, we agree that XR-NTX is a potential treatment option for patients with OUD, but clinicians should be cognizant of the potential barriers; inform patients of the advantages, expectations, and challenges; and respect patients' informed decisions.

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Disclosures

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