

Naltrexone blocks pain medication

The contraindications to intramuscular (IM) naltrexone listed by Dr. Richard Rosenthal (Out of the Pipeline, CURRENT PSYCHIATRY, March 2006, p. 106-11) are inadequate because they refer to patients who are addicted to opiates or being maintained on opioid therapy.

What about patients who need a prescription opioid after an accident or to manage other pain? Naltrexone powerfully antagonizes all opiates/opioids. The patient taking naltrexone would need an extremely high—and unsafe—opioid dosage to alleviate pain. Managing pain after an accident or emergency surgery would be difficult until naltrexone leaves the system.

Also, in addressing how endogenous opioids help reinforce alcohol use, Dr. Rosenthal writes, “Persons vulnerable to alcohol dependence generally have lower basal levels of opioid secretion and are stimulated at higher levels.” This statement is strange and misleading because:

- The author refers to endorphins, not opioids.
- Higher levels of receptor stimulation probably indicate tolerance because the CNS decreases the effectiveness of continuous stimuli.
- If endorphin levels were important, completely blocking them with naltrexone would impair quality of life and increased cravings for a mood-enhancing drug. Even weak opioids are perceived as pain-relieving and calming, indicating that the endorphin system—which theoretically is an emergency calming and pain-management system—does not “kick in” when we need it. Why would we need opiates to manage pain if endorphins protect us



from injuries, menstrual cramps, kidney stones, and other pain?

The endorphin antagonist naltrexone is appropriate for some patients with addiction disorders, although it negates the slight increases of endorphin activity achieved with meditation and exercise. The medication has almost no negative effect on quality of life and is not perceived as psychoactive. Other effects include decreased binge eating and diminished dissociative symptoms, with or without self-abuse.

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Dr. Rosenthal responds

Dr. Aeschbach suggests that the contraindications of IM naltrexone outlined in my article are inadequate because they apply to opioid-maintained or opioid-addicted patients.

My article covered his point about avoiding opioids for pain while using long-acting naltrexone under “Contraindications:” “IM naltrexone...will likely be contraindicated in patients who are taking opioid analgesics...” This point could have been rephrased to include “those who will need opioid analgesia.”

Concerning my reference to endorphins, not opioids, I clearly established the context by stating: “Alcohol stimulates the release of **endogenous** opioids...” Opioid secretion is by definition release of endorphins or enkephalins.

To clarify, nonalcohol-dependent persons who are vulnerable to developing alcohol dependence—such as a first-degree relative of an alcoholic—have fewer baseline endorphins but have a higher endorphin response to alcohol than do nonvulnerable persons.^{1,2} This differs from Dr.

Aeschbach's claim that increased receptor stimulation probably indicates tolerance. Tolerance means that the CNS has adapted to stimuli (alcohol) and produces less response to receptor stimulation, not more.³

Dr. Aeschbach reasons that blocking opioid receptors with naltrexone contraindicates use of opioids for acute pain management. IM naltrexone's package insert describes the need for intensive medical monitoring and support when attempting to surmount naltrexone and provide acute pain relief with opioids.⁴ In emergency cases, use regional analgesia, conscious sedation with a benzodiazepine and nonopioid analgesics, or general anesthesia in patients taking IM naltrexone.⁴

When opioid analgesia is necessary, a higher-than-usual opioid dose may be required, and the resulting respiratory depression may be deeper and more prolonged. In such cases, a fast-acting opioid analgesic can reduce respiratory depression duration.⁴

Dr. Aeschbach also argues that opioid receptor blockade "would impair quality of life and trigger drug cravings," but little evidence suggests that this is true. In fact, researchers have found that alcohol cravings may be reduced in persons taking naltrexone.^{5,6} Interestingly, blocking opioid receptors might decrease pain sensitivity by upregulating opioid systems.⁷

Further, many patients in the initial 6-month IM naltrexone trial⁸ have continued with injections for more than 4 years, suggesting that the drug's impact on quality of life and physiologic responsiveness is not severe.

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