New Detox Medications Lessen Risk of Relapse

BY JANE SALODOF MACNEIL
Southwest Bureau

TUCSON, ARIZ. — Antiaddiction medications are becoming safer, more effective, and less prone to cause relapse, Dr. Michael E. Scott told clinicians at a psychopharmacology conference sponsored by the University of Arizona.

Not all patients remain abstinent on the new medications targeting neurotransmitters, but relapses tend to be shorter and less frequent, said Dr. Scott, medical director of the Sierra Tucson treatment center and a professor at the University of Arizona, Tucson.

"Success can be harm reduction, improvement in quality of life, and decrease in relapse severity," he said, urging greater use of pharmacotherapy.

Patient selection and education are important, according to Dr. Scott. Compliance can be a problem, and objections from addiction professionals committed to abstinence programs as well as from some family members must be addressed.

"A medication is not the same as a drug. … A medication is a therapeutic thing, and education is important. The patient needs to know the difference," he said, adding, "Those early in recovery are less likely to understand medication. Those later in recovery are at greater risk of relapse. You need to know where they are."

Alcohol Withdrawal

Dr. Scott favored benzodiazepines as the cheapest, safest, most effective therapies for alcohol withdrawal. Four drugs have been approved for treatment: disulfiram (Antabuse), naltrexone (ReVia), acamprosate (Campral), and naltrexone IM (Vivitrol).

Disulfiram works best in patients who are motivated, intelligent, and not impulsive, according to Dr. Scott. He said evidence does not support its use as a single agent to promote abstinence but suggests it can reduce drinking days and works well with cognitive-behavioral therapy. He gives it to people in recovery programs.

Studies have shown oral naltrexone (approved for alcohol and opiate dependence) can delay relapses and reduce heavy drinking. Compliance is a major problem, however. He called it abysmal and suggested the best candidates for naltrexone therapy are patients mandated to treatment—for example, airline pilots and physicians in recovery.

Intramuscular naltrexone received U.S. Food and Drug Administration approval for alcohol dependence in 2006. Dr. Scott said physicians are still learning how to use it, but the once-a-month injections make compliance less of an issue. Patient selection is complicated, he noted, in that naltrexone IV has an extensive list of serious side effects, including suicidality and depression.

Compliance also is an issue with acamprosate, he continued, calling its three-times-a-day dosing requirement a fantasy. "It is too difficult a challenge for patients who are compliance-poor to begin with," he said.

Acamprosate seems to promote abstinence, however, and has been shown to work well with naltrexone. "I think we are going to find the combination is better," Dr. Scott said. "I think it's the trend where polypharmacy of addiction is going to be the norm rather than the exception."

A medication is not the same as a drug, and the patient needs to know the difference.

DR. SCOTT

Opiate Detoxification

There's no clear choice of opiate detoxification regimen, according to Dr. Scott. Buprenorphine is a new option that only physicians can prescribe and only if they are licensed after taking a 1-day training program. "Even if you are not interested in addiction medicine, you do get addicts and opiate dependents in your practice," he said, encouraging physicians to become licensed.

He discouraged another new approach, however: rapid/ultrarapid detoxification in which naloxone and naltrexone are administered under general anesthesia. "This is not a life-threatening illness. You don't want to kill your patients," he said.

Treatment options include naltrexone, nalmefene (Revex), methadone, levo-alpha-acetylmethadol (LAAM), and buprenorphine. Dr. Scott said to make sure a patient is opiate-free before starting naltrexone or nalmefene, and he warned again that compliance is a major obstacle. Methadone is effective, he said, but LAAM has received a black box warning and is not recommended.

Buprenorphine is available by itself as Subutex or in combination with naloxone as Suboxone. Dr. Scott said both are effective but Suboxone can precipitate withdrawal and should not be used in pregnant women. Buprenorphine should not be used with benzodiazepine; the combination can be fatal.

Helping Smokers

Nicotine replacement, bupropion (Zyban), nortriptyline, and clonidine can help 1 more person out of 14 to quit smoking—an absolute benefit of 7%, according to Dr. Scott. Clonidine has serious side effects, however, and he suggested nicotine replacement products might be underdosed.

Dr. Scott said a newly approved medication called varenicline (Chantix) might be more effective. "Patients seem to like it. It is fairly easy to take." ■

Bupropion as Adjunct to Patch Yields Long-Term Results

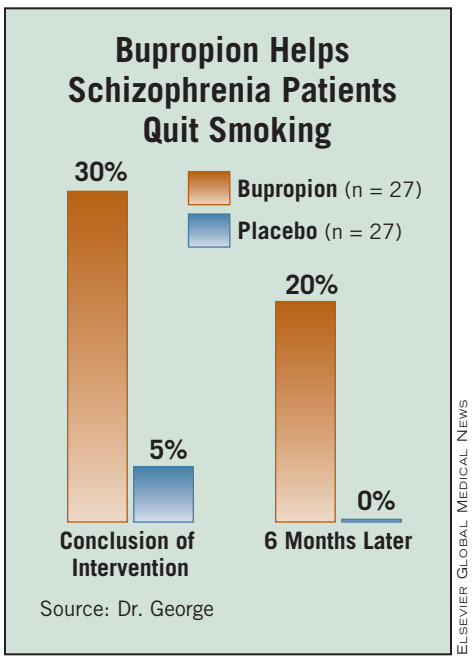
BY JANE SALODOF MACNEIL
Southwest Bureau

PARIS — Enhancing a smoking cessation program with a daily dose of bupropion enabled a small group of schizophrenia patients to stay off nicotine in a randomized, placebo-controlled trial reported by Dr. Tony P. George at the annual congress of the European College of Neuropsychopharmacology.

All patients received 10 weeks of behavioral therapy during which they wore a transdermal nicotine patch 24 hours a day. In addition, 27 patients took 300 mg of bupropion SR daily, while 27 patients received a placebo.

At the conclusion of the intervention, 30% of the bupropion group and 5% of the placebo group had quit smoking. Six months later, 20% of the patients given bupropion were still not smoking. Not one member of the placebo group was able to stay off cigarettes that long.

"It is possible to get these difficult-to-treat patients to quit—more so in the short term, but also in the long term," said Dr. George, recently appointed professor and chair of addiction psychiatry at the University of Toronto.



"This is very exciting to us," he added. "This conclusion seems to be superior to the patch alone for short- and long-term outcomes."

The research was done at Yale University, New Haven, Conn., where Dr. George had conducted previous studies of cognitive-behavioral therapy and the nicotine patch as smoking cessation strategies for patients with schizophrenia.

The National Institute on Drug Abuse funded the new trial. Dr. George presented preliminary results in Paris. However, he said that enrollment was nearly complete and that he did not expect any significant changes in the outcomes.

Patients in both arms of the study were about 40 years old on average and smoked about 24 cigarettes per day.

Schizophrenia patients have much higher rates of smoking and nicotine dependence than does the general population, according to Dr. George. They also have much more difficulty quitting smoking for reasons that may be related to the disorder. His earlier work suggests, for example, that cigarette smoking can enhance prefrontal cortical dopamine function and visual spatial memory in those with schizophrenia.

Nonetheless, Dr. George said in an interview at the meeting that many patients are highly motivated to quit because of the impact on their health—in particular, the risk of early death from cancer and cardiovascular diseases.

"It [nicotine] is helping them in the short term, but it is going to kill them in the end," he said.

Dr. George said he plans to look at other nicotinic acetylcholine receptor agents in future studies as well as atomoxetine and the role of genetic polymorphisms in moderating treatment response.

"Developing better treatments will depend on the pathophysiologic relationship between smoking and the disorder itself—and possibly other disorders," Dr. George said. ■

Smoking Cessation Alters Attention, Processing Abilities in Schizophrenia

AUSTIN, TEX. — Patients with schizophrenia who are trying to quit smoking may display altered results on various psychiatric tests, according to preliminary findings presented at the annual meeting of the Society for Research on Nicotine and Tobacco.

Kristi Sacco, Psy.D., of Yale University, New Haven, Conn., and her colleagues noted that patients with schizophrenia have well-documented cognitive deficits, including sensory-motor gating, as measured by prepulse inhibition (PPI) of the acoustic startle response. It also has been documented that such persons have high rates of smoking, Dr. Sacco said.

Her group examined the correlation between PPI and results on the Wisconsin Card Sorting Test (WCST) in 12 smokers with schizophrenia, 7 nonsmokers with schizophrenia, 13 nonpsychiatric control smokers, and 12 nonpsychiatric control nonsmokers.

At 3 years' follow-up, they found a significant association in smokers with schizophrenia between PPI and the "categories completed" WCST measure. However, no such correlation was found between these outcomes in the other three groups.

Thus, it should come as no surprise to see patients with schizophrenia who quit smoking display attentional and processing difficulties, Dr. Sacco said in an interview. That is especially the case if patients "go cold-turkey with their quitting," she said.

—John R. Bell