Ultra rapid opiate detoxification

Background

Ultra rapid opiate detoxification (UROD), also known as rapid anesthesia assisted detoxification (RAAD) or rapid opiate detoxification under general anesthesia, was pioneered by Norbert Loimer, MD, in Vienna during the late 1980s. UROD allows patients to achieve an “opiate-free” state by treating the addiction syndrome at the receptor level, according to the Center for the Investigation and Treatment of Addiction (CITA)-Americas.

Prior to UROD, patients undergo a psychiatric assessment and physical exam to determine whether they are suitable candidates for the procedure. Conditions that typically disqualify potential candidates include critical psychiatric disorders, alcohol dependency, hepatitis, liver cirrhosis, immune disorders, acute infections, respiratory or cardiac disease, or a lack of self-motivation for success, according to CITA.

During the procedure, patients are anesthetized for six to eight hours while large doses of opiate antagonists, such as naloxone, are administered to the system. These antagonists displace opiates from the receptors in the central nervous system and essentially “undo” the effects of opiate drugs.

The rapid administration of antagonists accelerates the detoxification process, allowing quicker repair of the body’s systems and regeneration of natural opiates, the CITA notes. Patients do not feel the painful symptoms of withdrawal while they are under anesthesia; consequently, the transition between detoxification and rehabilitative treatment is made easier.

Possible side effects of the procedure include flu-like symptoms such as nausea and vomiting, anxiety, fatigue, and restlessness. However, symptoms are much less severe than those experienced by patients who undergo awake detoxification.

After detoxification, Naltrexone, a nonaddictive anti-opiate medication, should be taken for several months to prevent physical cravings, which may lead to relapse. In addition, patients should be involved in individual and group counseling to deal with the psychological aspects of the addictive disorder.

The cost of UROD can range from $2,500 to $7,500, according a 1997 article in the Journal of the American Medical Association.

Involved specialists

Anesthesiologists, certified registered nurse anesthetists (CRNAs), addictionists, addiction psychiatrists, and pain management specialists.
The American Society of Anesthesiologists (ASA) does not have a position concerning the delineation of privileges for UROD. However, in its 1998 *Guidelines for Delineation of Clinical Privileges in Anesthesiology*, the ASA states that “clinical privileges in anesthesiology are granted to physicians who are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical, and certain medical procedures using general anesthesia, regional anesthesia, or sedation/analgesia to a level at which a patient’s protective reflexes are likely to be obtunded. Performance of preanesthetic, intra-anesthetic, and postanesthetic evaluation and management are essential components of the practice of anesthesiology.”

Furthermore, “privileges in anesthesiology should be awarded on a time-limited basis, not to exceed two years. The granting of reappraisal and revision of clinical privileges should be in accordance with medical staff bylaws and institutional/facility rules and regulations, as applicable.”

The ASA recommends the following criteria for the delineation of clinical privileges in anesthesiology education:

- Graduation from a medical school accredited by the Liaison Committee on Medical Education, from an osteopathic medical school or program accredited by the American Osteopathic Association (AOA), or from a foreign medical school that provides medical training acceptable to and verified by the Educational Commission on Foreign Medical Graduates.
- Completion of an anesthesiology residency training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or by the AOA.
- Permanent certification by the American Medical Association or completion of 100 hours of CME over two years, of which 40 hours are in category 1 of the ACGME.
- Compliance with relevant state or institutional requirements for CME.
- At least 50% of CME hours in the primary specialty of practice.
- Certificate indicating completion of a course in advanced life support within 24 months preceding application for clinical privileges.

In its 1998 *Position on Monitored Anesthesia Care*, the ASA defines monitored anesthesia care as “a specific service in which an anesthesiologist has been requested to participate in...
the care of a patient undergoing a diagnostic or therapeutic procedure. Monitored anesthesia care includes all aspects of anesthesia care—a preprocedure visit, intraprocedure care, and postprocedure anesthesia management.”

In addition, the ASA states that “during monitored anesthesia care, the anesthesiologist or a member of the anesthesia care team provides a number of specific services, including but not limited to:

- Monitoring of vital signs, maintenance of the patient’s airway, and continual evaluation of vital functions.
- Diagnosis and treatment of clinical problems that occur during the procedure.
- Administration of sedatives, analgesics, hypnotics, anesthetic agents, or other medication as necessary to ensure patient safety and comfort.
- Provision of other medical services as needed to accomplish the safe completion of the procedure.
- Anesthesia care often includes the administration of doses of medications for which the loss of normal protective reflexes or loss of consciousness is likely. Monitored anesthesia care refers to those clinical situations in which the patient remains able to protect the airway for the majority of the procedure. If, for an extended period of time, the patient is rendered unconscious and/or loses normal protective reflexes, then anesthesia care shall be considered a general anesthetic.”

ASAM, AAAP, APA, and AAPM

The American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Psychiatric Association, and the American Academy of Pain Management do not have positions concerning the delineation of privileges for UROD.

Positions of other interested parties

Massachusetts General Hospital
Boston, MA

According to David R. Gastfriend, MD, director of addiction medicine at Massachusetts General Hospital in Boston, MA, the claims that UROD is 100% effective are nothing more than “gross misrepresentations.”

While UROD does eliminate craving, it does not eliminate withdrawal symptoms, which may persist for up to four weeks even after all of the opioid has been knocked out of the receptors, Gastfriend says. “Since the withdrawal symptoms persist, there should be integration with a substance abuse treatment program. It is not appropriate or acceptable to have a solo rapid detox provider operating independently of a longitudinal substance abuse center.”
Gastfriend’s research findings argue against “unbounded” treatment systems in which UROD is administered and patients are sent on their way with only the phone numbers of a few addiction help lines in hand.

Instead, anesthesiologists or anesthesia supervised practitioners, such as CRNAs, who are performing UROD should be operating jointly with other practitioners who have training in addiction medicine, such as certified addictionists or certified addiction psychiatrists, he says.

In addition, only selected patients who have demonstrated stability in their work, their relationships, and with some other medication such as methadone are good candidates for UROD.

“It doesn’t make sense to administer a fairly invasive treatment if the patient does not have a stable treatment lifestyle to begin with,” Gastfriend concludes.

NEURAAD
Portland, OR

“RAAD should not be viewed as a stand-alone procedure. Anesthesiologists should integrate with other providers,” says Marshall Bedder, MD, medical director of NEURAAD in Portland, OR, one of seven private treatment centers throughout the nation that concentrate exclusively on the RAAD procedure.

Anesthesia should only be administered by anesthesiologists or anesthesiologist-supervised practitioners, he says. However, during pre- and post-anesthesia care, there should be practitioners involved who are board-certified in pain or addiction medicine.

Bedder notes that when hospital administrators create their own RAAD programs, they must decide whether the programs are being set up in a “comprehensive manner.” The following medical standards, adhered to by each of the NEURAAD facilities, address this issue:

1. Interdisciplinary team
   - physicians experienced with opioid addiction
   - anesthesiologist trained in the NEURAAD technique
   - psychologist/psychiatrist trained in addiction treatment
   - nurses trained in NEURAAD protocol
2. Board certification in specialty
3. Certified medical facility
4. Adherence to ASA standards for anesthesia practice
5. Commitment to complete quality care
Ultra rapid opiate detoxification

NEURAAD is effective on any natural or synthetic opioid such as heroin, methadone, opium, morphine, Demerol, and Dilaudid or prescription opioids such as Percocet, Percodan, and Vicodin. According to Bedder, the following steps are the basis of the NEURAAD treatment program:

1. Evaluation—a patient’s medical history is first reviewed and then appropriate candidates are admitted after an intensive psychological evaluation and testing
2. Procedure—a patient undergoes anesthesia administration and is required to stay at a NEURAAD facility for a minimum of 23 hours afterward
3. Treatment—initiation of a patient’s “aftercare” program, which usually addresses the psychological aspects of opiate dependence and may include maintenance treatment with naltrexone to prevent relapse

NIDA

According to its 1996 *NIDA Scientific Report of Ultra Rapid Detoxification with Anesthesia (UROD): Opinion of the Consultants and Criteria Relating to Evaluating the Safety and Efficacy of UROD*, the National Institute on Drug Abuse states, “Based upon the available information, it is the opinion of selected experts in the United States who are prominent in the opiate addiction field, that the UROD anesthesia method is currently without ethical, medical, scientific, or financial justification as a clinical detoxification treatment at the present time based upon the following six criteria:

1. Risk: Benefit ratio is unacceptable as a detoxification procedure
2. Detoxification is not a cure for opiate addiction
3. The expense and elaborate nature of UROD is not justified since there are several other less expensive and less elaborate detoxification methods
4. Medication without psychosocial support has little impact on opiate addiction
5. Only one double-blind study and few research reports systematically documenting the nature of the UROD treatment and its safety and efficacy for both immediate detoxification and longer term relapse prevention
6. No double-blind studies indicating that ultra short detoxification procedures are more successful in decreasing relapse to opiates than longer duration treatments”

JCAHO

The JCAHO has no formal position concerning the delineation of privileges for UROD. In its 1998–1999 *Comprehensive...
Accreditation Manual for Hospitals (CAMH) the JCAHO states (MS.1.1.1) that “each medical staff . . . includes fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospital (both physicians and these other individuals are referred to as ‘licensed independent practitioners’).”

Furthermore, the 1998–1999 CAMH states (MS.5.4) that “professional criteria that are specified in the medical staff bylaws and uniformly applied to all applicants for medical staff membership, medical staff members, or applicants for delineated clinical privileges . . . constitute the basis for granting initial or continuing medical staff membership and for granting initial, renewed, or revised clinical privileges.” The JCAHO further requires (MS.5.4.3) that “the criteria at least pertain to evidence of current licensure, relevant training or experience, current competence, and ability to perform the privileges requested.”

While the JCAHO does not require hospitals to use any specific method in delineating clinical privileges, it does require such privileges to be hospital-specific and based on an individual’s demonstrated current competence (MS.5.15). It further requires (MS.5.15.1–MS.5.15.1.3) “privileges to be related to an individual’s documented experience in categories of treatment areas or procedures, the results of treatment, and the conclusions drawn from organization performance improvement activities when available.”

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding this procedure.

**Minimum threshold criteria for requesting privileges for UROD**

Basic education: MD, DO, or CRNA under the supervision of an MD or DO who is trained in anesthesiology.  
Minimum formal training: The applicant must be able to demonstrate successful completion of a postgraduate residency training program in anesthesiology of at least three years’ duration or completion of a program approved by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education programs.  
Required previous experience: The successful applicant must be able to demonstrate that he or she has performed general anesthesia for at least 50 patients during the past 18 months.
In addition, the applicant must have completed hands-on training in UROD under the supervision of a qualified physician preceptor.

**Note:** It is recommended that the pre- and post-anesthesia care of patients undergoing UROD also involve practitioners who are trained in addiction medicine. Nonacute Privilege White Paper, Addiction Medicine—SS01, part of CRC’s sister publication Credentialing Across the Continuum, discusses the requesting of privileges in this area in more detail.

**References:** References must come from a board-certified anesthesiologist, or if the applicant is a CRNA, at least one reference must come from a CRNA. Also, a letter of reference must come from the individual responsible for UROD training or a physician who is familiar with the practitioner’s experience with UROD.

**Note:** All health care organizations are advised to review applicable state licensing laws/regulations governing the administration of anesthesia. At present, the Health Care Financing Administration’s (HCFA) Conditions of Participation require that anesthesia care provided by CRNAs be subject to supervision by a physician.

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to the hospital’s existing quality assurance mechanisms. The applicant must demonstrate that he or she has maintained competence by demonstrating that he or she has met the hospital’s minimum requirement for UROD privileges.

In addition, continuing medical education relating to UROD should be required.

**For more information**

For more information regarding privileging UROD, contact:

American Academy of Addiction Psychiatry
7301 Mission Road
Suite 252
Prairie Village, KS 66208
Telephone: 913/262-6161
Fax: 913/262-4311
Web site: members.aol.com/addicpsych/private/homepage.htm
E-mail: addicpsych@aol.com
Privilege request form
Ultra rapid opiate detoxification

To be eligible to request privileges for ultra rapid opiate detoxification, a physician must meet the following minimum threshold criteria:

- **Education:** MD or DO, or CRNA under the supervision of an MD or DO who is trained in anesthesiology.

- **Minimum formal training:** The applicant must be able to demonstrate successful completion of a postgraduate residency training program in anesthesiology of at least three years’ duration or completion of a program approved by the American Association of Nurse Anesthetists Council on Accreditation of Nurse Anesthesia Education programs.

- **Required previous experience:** The successful applicant must be able to demonstrate that he or she has performed general anesthesia for at least 50 patients during the past 18 months. In addition, the applicant must have completed hands-on training in UROD under the supervision of a qualified physician preceptor.

*Note: It is recommended that the pre- and post-anesthesia care of patients undergoing UROD also involve practitioners who are trained in addiction medicine. Nonacute Privilege White Paper, Addiction Medicine—SS01, part of CRC’s sister publication Credentialing Across the Continuum, discusses the requesting of privileges in this area in more detail.*

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*Note: All health care organizations are advised to review applicable state licensing laws/regulations governing the administration of anesthesia. At present, HCFA’s Conditions of Participation require that anesthesia care provided by CRNAs be subject to supervision by a physician.*

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Privilege request form  continued from p. 9

I understand that in making this request I am bound by applicable bylaws or policies of the hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

Physician’s signature: ______________________________________________________

Typed or printed name: ____________________________________________________

Date: ____________________________________________________________________