DETOXIFICATION

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PHILOSOPHY OF DETOXIFICATION

The whole philosophy of detoxification is to allow the brain to continue the formation of endorphins so that the patient would have better pain control. For example if the patient is on Lortab, an opioid agonist. Lortab, similar to Morphine, Methadone, Codeine, etc., has a tendency to occupy the cerebral opioid receptor sites. There are three main opioid receptor sites, i.e., mu, theta, and kappa receptors. The opioid agonists have a tendency to occupy all three opioid receptor sites. As a result, the formation of cerebral endorphins comes to a halt because there is no receptor to receive the endorphin. As a result, the patient becomes dependent upon any opioid agonists. Moreover, this dependency is complicated by fluctuation of the drug dosage. Every time the patient takes Lortab after 3 - 4 hours, the plasma level of Lortab drops, and as a result, the patient develops rebound (withdrawal) pain. Even after the original pathology has cleared up, the rebound phenomenon continues to fluctuate the dosage of opioid in the brain and continues to cause withdrawal pain in absence of the original pathology because of the fact that the brain depends on endorphines for its normal function.

On the other hand, the opposite group of opiates which are called opioid antagonists, in a therapeutic dose they do not occupy all the opioid receptors. Usually, the kappa receptor, which is the larger receptor, is left intact. The availability if the kappa receptor allows the endorphins to be formed and to occupy the kappa receptors. Hence, the patient received pain relief both from the opioid antagonists as well as the natural endorphins. Only in toxic dosages, the opioid antagonists occupy the kappa receptors and they act exactly similar to opioid agonists with similar side effects.

The main problem with detoxifying the patient in an accelerated fashion is that the patient becomes very jittery, nervous, shaky, tremulous, as well as nauseated.

During the detoxification, things may go smoother if the following precautions are taken:

1. To increase the dosage of the antidepressant, specifically Trazodone which is an excellent analgesic depressant in and of itself. Wellbutrin on the other hand, does not have the analgesic property and can contribute to the patient's agitation.

For example the dosage of Trazodone can be increased up to 2 ½ -3 tablets at night.

2. Increasing the dosage of Klonopin® is extremely helpful in prevention of agitation, tremor, jerky movements of the extremity (myoclonic jerks) due to withdrawal, and tremor.

If the patient is agitated and not drowsy, then the patient should be allowed to take two Klonopin even every 2-3 hours as needed. The moment the patient becomes drowsy, then the patient should hold off the Klonopin. Obviously, the generic Clonazepam is not as affective, and only causes more drowsiness and feeling of depression. Klonopin is probably the most affective tool against the complication of rebound (withdrawal) symptoms.

3. The withdrawal also has a tendency to be accompanied by nausea, even vomiting as well as excessive drooling from the mouth and runny nose. Vistaril is the treatment of choice for this complication with the dosage being 50 mg every four hours as needed.

As long as the patient is motivated, with the above schedule the dosage of Lortab can be dropped by one tablet every five days instead of every seven days.

Finally, another precaution may become necessary while the patient is going through detoxification. If the patient acts agitated, confused, and forgetful which are common complications of opioid agonist withdrawal, there should be a relative or a friend supervising the patient's intake of medications to make sure that the patient is taking the right dosage of medicine. Otherwise, the patient will forget and will take either too much or too little dosages of medication.

DETOXIFICATION PROTOCOL

We have a strict protocol of detoxifying the patients from the habituating drugs that they have been on before. In our experience, simple detoxification of the patients from addicting drugs such as Codeine, Vicodin, Morphine sulfate, etc., is enough to provide complete relief of pain in more than 20% of the patients.

Codeine a Class II and Vicodin a Class III are opioid agonists, strong narcotics. The Class I being the street drugs such as Heroin, etc. The Class II is quite a restricted type of drug because the Class II group such as Morphine, Codeine, and Vicodin a (Class III) are opioid agonists meaning that they flood the brain with strong opioid narcotic, and as a result the brain stops forming endorphins (natural cerebral analgesics). As the endorphin formation is ceased, they every 4-5 hours after taking Vicodin or Codeine, the patient will have a severe rebound (withdrawal) pain because of the fact the level of the drug (Codeine or Vicodin) has dropped to a negligible amount and the brain realizes that there is no endorphin. This causes a severe pain and a marked generalized pain not limited to the area of pathology, but from head to toe. This is what is called iatrogenic

(medication or treatment originated) pain. Such complex chronic pain patients can never have a day of rest unless they are detoxified from Codeine, Vicodin, or Morphine. Instead, the patients should be treated with opioid antagonists. The opioid antagonists are limited in number, and their characteristic is the fact that the brain does not recognize the opioid antagonists as a Morphine type of drug. As a result, endorphins keep forming and will not become suppressed. Endorphin uses three opioid receptors in the brain to naturally relieve pain. These are called mu, theta, and kappa receptors. The opioid antagonists such as Nubain, Buprenex, and Butorphanol, in therapeutic doses, only occupy mu and theta receptors, but not the kappa receptors. As they leave the kappa receptors alone, endorphins will keep forming to fill the kappa receptor. Hence, the patient will have the benefit of the opioid antagonist pain relievers plus the patient's own endorphins.

It is essential to preserve the function of the endorphin because it is totally opposite to the synthetic pain medications. It increases the level of ACTH which is important for counteracting stress, it increases the level of sex hormones, and it has an antidepressant and strong analgesic effect. The other synthetic opioid agonist medications do the opposite. They suppress the sex hormone, cause depression, and also have only temporary pain relieving effect.

There are two choices. Either to go according to the financially-driven decisions by the insurance carrier - and have the cheaper medications in the form of opioid agonists, Vicodin, or Codeine, or on the other hand to use the opioid antagonists such as Nubain, Buprenex or Butorphanol, which are the treatments of choice medically.

We also have to realize that opioid antagonists in therapeutic doses provide excellent pain relief and do not cause depression. On the other hand, opioid agonists or antagonists, any one of these medications if given in higher than therapeutic range causes suppression of endorphin and will have the same type of adverse side effect. Fortunately, when the patients are on opioid antagonists, these medications act similar to Antabuse in regard to the fact that if they mix opioid antagonist and agonist, they become severely nauseated, vomit, and learn not to sneak in the wrong kind of medications.

For almost 30 years, the treatment of choice for chronic pain has been the use of antidepressants.

TYPES OF PAIN

There are three different types of pain:

1. Acute pain: such as a heart attack or bone fracture or appendicitis. It is acute and has a duration of less than one week. For the acute pain, the only treatment that will save the patient's life is strong Morphine derivative. If I have a heart

attack or a blood clot in my lung in acute stages, the only thing that will get rid of the pain and keep me alive for the first week or ten days is Morphine.

2. Chronic pain: with a duration of usually six months or longer, the use of Morphine derivatives will cause serious side effects as outlined above. The Morphine derivatives cannot be used on these patients as the sole agent for pain management.

In chronic pain, the most effective form of pain treatment is antidepressants-not because the patient is depressed, but because the antidepressants improve the exchange of biogenic amines in the nerve cells and improve the function of the nerve cells and as a result, the brain itself with the help of endorphin and with the help of inhibitory nerve cells in the brain completely controls the pain. The most ideal medications of the anticonvulsants family for pain is first of all Trazodone, and secondly Elavil.

3. Cancer pain: a combination of acute and chronic pain. In this condition, any palliative treatment is justified on humane basis. The cancer pain treatment should not be mistaken for benign chronic pain treatment.

CONCLUSION

In conclusion, we are not going to sit back and regress back to the 1950's or 1960's and treat patients with addicting pain medications (opioid agonists), and discontinuing the nonaddicting antidepressants which help prevent pain, provide normal natural sleep, and a better quality of life for the patient. The patient does not have to chase their pain away with addicting pain medications.