Drug report: new cures for heroin

By Molly Kaalo

Although methadone has achieved widespread public acclaim, its use has many drawbacks. Perhaps the most obvious of these drawbacks is that, while the drug presents ethical problems, it is not, in practice, the panacea that it is supposed to be.

The procedure for eventual withdrawal is undetermined, its long-term effects are unknown, and it has already spawned a flourishing black market.

As a result, two true narcotic antagonists have been tested: cyclazocine and naloxone. Neither are addictive. Both show no tolerance and the continuous usage does not force escalation of doses to obtain the usual effect. If cycled, a high and only cyclohexane (slight) withdrawal symptoms in theory, the antagonists have a greater affinity for the central nervous system (membrane inactivation) where the narcotics would ordinarily attach themselves. Thus the antagonist blocks the opiate from reaching the central nervous system.

The two, cyclazocine has received far more testing. In a typical regimen, as described in the American Journal of Nursing, July 1971, a volunteer addict is admitted to the hospital and signs some form of consent. After two days of detoxification from heroin and given decreasing methadone dosages for 4-7 days for detoxification. He is then readmitted to a drug-free ward, and dosed with 4 mg/day in 4 days, during which he is used to build up to the daily dose. This induction period of side effects induced seen in many patients. These include some cases of respiratory depression, hallucinations, etc. Once a stable dose is established, he will enter some form of therapy. Some people have been on cyclazocine for over three years. Nearly all users will continue to receive the drug, and the withdrawal is not very high unless they skip one of their daily doses. It thus provides the political protection the user needs for 24 hours. The regimen with cyclazocine is difficult because there is no "build-up to the daily dose is needed."

There are a myriad of problems associated with these agents, however, and success rates have been variable. Dr. Max Fink reports that in five years of treatment in New York, only 5 of 302 patients stayed in the program. However, Dr. Martin Woldman in June 1970, a team reported an average "overall acceptance and continued treatment rate of 40% of 450 addicts."

Without therapy, the antagonists may do more harm than good for those whose addiction is a way of keeping from going to pieces. There is also the risk that the drug-dependent patient will just switch to barbiturates or speed. Many do like it because, unlike methadone, it gives them no high whatsoever. Their short period of action means they must be taken daily. And both are in short supply. Science writer Allen L. Hammond that the product they take is supplied by the same company that supplies the antagonists do to reluctantly, as a "public service" and reliable quality control. The potential market is not large.

The Federal Food and Drug Administration has its own problems. Continued use of cyclazocine causes a variety of side effects, including hallucinations, hypertension, hallucinations, etc. These effects will probably prevent widespread use of cyclazocine. Naloxone has no side effects to speak of, but it has one drawback. Anyone using 400 mg will hold off 50 mg of heroin in six hours, but longer periods require higher dosages. The antagonists should be 24 hours for 24 hours requires 2400 mg (compared cyclazocine 7 mg). Injection is not an option, and the effects are unpredictable. The feel of addicts must be broken from dependence. In essence, the antagonists can only work. The high dosage problem is exacerbated by (is extreme scarcity. Naloxone is derived from the very same substance opium, and the difficulties of obtaining, large, steady supply makes nationwide drastically limited production. This scarcity and cost has already cramped research.

Business success demanded some practical solutions. One is to use implants, which will release the drug continuously. This allows much lower doses, and a single implant may last for months. Another possibility is EN-539, which utilizes human tissue at Lexington, Ky., which similar to naloxone but lasts longer and can be implanted. These implants are currently used to wake up animals after surgeries, with opiate tapered down. But the idea is still in the embryonic stage. The idea is to select implants and implant in the head or subcutaneous space, with single oral dose is still in.

In addition to its use as an adjunct therapy, the antagonists can be used to treat heroin overdose. Since both antagonists have a short half life, they may be used in emergency situations. They have also been used to reverse withdrawal symptoms when given to addicts, and have been successfully used in Mannheim, Brooklyn, a plan which will stabilize in addicts on methadone for 3-4 months and switch them to cyclazocine is being tried. If a long lasting antagonist could be developed, mass immunization would be feasible, although this might pose legal problems. Finally, an occasional use might want temporary protection during a period of stress.

At present, these drugs are still classified as "experimental," and can only be used in government-approved research projects.

But don't count methadone out. Methadone has gone for it advice, very low cost, and has been used in Europe, but not currently used to wake up animals after surgeries, with opiate tapered down. Low toxicity, and properties make injection difficult. And research is gaslight "progressives" who don't want it approved, and make benzodiazepine (Valium) available, which is effective for three days.