A case report by Sakamoto and colleagues,4 a patient’s opioid needs were precipitously diminished after nerve block such that oxycodone dosage was reduced from 240 mg daily to 160 mg and then to 80 mg daily within 2 days.4 The abrupt taper resulted only in nausea as the sole withdrawal symptom.

Symptoms of opioid withdrawal, including nausea, diarrhea, anxiety, insomnia, myalgias, and hypertension can be readily mitigated with safe nonnarcotics in patients without malignancies with clonidine or tizanidine, which are efficacious by diminishing compensatory sympathomimetic cardiovascular withdrawal from opioids. Proactive presymptomatic treatment of nausea may facilitate safe rapid opioid withdrawal.5

Just as Guillod and colleagues1 noted that ventilatory tolerance is not ubiquitous, so too must clinicians appreciate that withdrawal is also not 100% pervasive. People who misuse or abuse their prescribed opioids through early consumption of illicit use of opioids or experiencing an opioid overdose following the loss in tolerance. Multiple studies demonstrate that patients who have been on long-term, high-dose opioid agonist therapy benefit from an immediate transition to long-term partial agonist therapy. For example, a seminal study2 of 40 individuals with opiate dependence compared treatment with buprenorphine maintenance to placebo and demonstrated 75% treatment retention in the buprenorphine group compared with 0% in the placebo group at 1 year. Similarly, a meta-analysis3 of patients dependent on pharmaceutical opioids concluded that when compared with detoxification and psychological therapy alone, buprenorphine maintenance led to less self-reported opioid use, fewer positive urine test results, and greater retention in treatment. As clinicians increasingly become aware of the safety of rapid full-agonist opioid discontinuation, long-term treatment strategies are essential for managing prolonged withdrawal symptoms and cravings.

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Conflict of Interest Disclosures: None reported.


CORRECTION

Error in Data Presentation in Figure and Text: In the Invited Commentary titled “The Last (Randomized) Word on Screening for Abdominal Aortic Aneurysms,” published in the December 2016 issue of JAMA Internal Medicine,2 incorrect numbers for total deaths were used for the Western Australian trial. In the Figure, 9739 should replace 9649 for the number of events in the Screening group and 9832 should replace 9734 for the number of events in the No Screening group. The summary results in the Figure should then read as follows: risk ratio 0.987; 95% CI, 0.975-0.998; P = .02. Although these changes did not affect the conclusions, they slightly altered the second and third sentences in the seventh paragraph of the text, which should now read: “The combined result remains statistically significant (risk ratio, 0.987; 95% CI, 0.975-0.998; P = .02) when all Western Australian participants are included. When only the Western Australian men 65 to 74 years old are included, the result is similar (risk ratio, 0.986; 95% CI, 0.973-0.999; P = .03).” This article was corrected online.


In Reply We would like to thank Dr Geller for his insightful letter concerning our Teachable Moment and the additional literature regarding the established safety of rapid-dose tapering or discontinuation of opioids. We agree that the best course for our patient was abrupt discontinuation in contrast to a lengthy taper. We would like to emphasize, however, that it was just as essential to offer our patient long-term treatment of opioid dependence immediately following discontinuation to minimize the risk of initiating illicit use of opioids or experiencing an opioid overdose following the loss in tolerance.

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Conflict of Interest Disclosures: None reported.

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