June 2017

Chronic diseases are generally straightforward when viewed from high altitude. Take diabetes, for example. We understand the cause to be a genetic abnormality causing the body's immune system to attack the islet cells in the pancreas, leading to a failure to properly metabolize glucose. We understand that we can't cure diabetes, but we can provide treatment in the form of well-accepted medication which works to metabolize glucose. We know that treatment must be multi-factorial in that the patient must follow a special diet, keep stress to a minimum, and take responsibility for regularly checking their own status. We know rather precisely what the outcome will be for various treatment approaches.

With addictive disease, one would think from the media that we have a different picture. There appears to be uncertainty as to even the issue of disease itself. People still talk of an "addictive personality," as if there is also a "diabetic personality" or "hypertensive personality." There are arguments as to abstinence-based approaches versus harm reduction approaches, and even questions such as whether one treatment or another falls into the former or latter approach strategy! Is buprenorphine maintenance, for example, an abstinence-based approach or a harm reduction approach? There are non-medical approaches offered by many programs around the country. There is even a special lingo: "medication-assisted treatment" as opposed to, simply, medical treatment (which would, as always, include pharmacotherapy), "aftercare" as opposed to ongoing treatment for a chronic disease state, and a special advance planning process such as a 28 day rehabilitation. Why 28? Why not 26 or 15 or 90? There is no science or magic behind the number 28.

In fact, though, we have a scientific platform just as our endocrinologist friends do. If we ignore the media and focus on the science, we find that we have a clear definition of the illness, a straightforward diagnostic process, and an evidence-based set of guidelines developed to assist us in obtaining the best possible long term outcomes and lowest possible morbidity and mortality with our patient population. We simply use a medical approach – that is, a bio/psycho/social/spiritual approach just as we would for any other chronic disease state. We use the appropriate medication when indicated and implement the practice of medicine just as we would for other illnesses. So as my initial guidance to our medical staff, I ask that they review the National Practice Guideline for the use of medications in the treatment of addiction involving opioid use. This is available at https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

Remember that medications represent only one portion of the overall treatment of addictive illness, just as insulin represents only one portion of the overall treatment of diabetes. But also remember that our patients can't afford to simply follow the pack led by facilities which simply detox and discharge. Our job is to provide high quality long-term chronic disease treatment resulting in the highest possible functional improvement and greatest reduction of morbidity/mortality.

Please send questions or comments to info@TRRN.org

Dr. Stuart Gitlow
Chief Medical Officer
The Recovery Research Network