Dear Editor:

Schechter and Kendall accuse us of being opposed to heroin substitution treatment (HST) for ideological reasons. This is false; our criticisms have been based on a careful review of scientific evidence. NAOMI investigators chose to ignore these criticisms, and as a result the NAOMI trial is seriously flawed.

Schechter and Kendall continue to skirt around our criticisms. Their only stated criterion for increasing the methadone dose is the patient’s ‘wishes’. For decades, the standard of practice has been to increase the dose for patients who report persisting withdrawal symptoms, cravings and heroin use. Studies have shown that doses of 100-120 mg or more lead to higher rates of treatment retention than doses below 100 mg. Nor do the authors address our concern about the slow titration rate (only 60 mg by day 30). Thirty-four subjects dropped out of the MT arm between days 0-30, versus only 8 subjects in the HST arm; this trend was reversed from day 30 to month 12. Thus, the supposed benefits of HST can be attributed primarily to early drop-outs from suboptimal dose titration.

Our statement that HST is far more expensive per patient than MT is correct. The cost-effectiveness of HST versus MT is unknown. The analyses based on the Netherlands trials are of little value because the trials used very low mean methadone doses (67 and 71 mg). The most one can say is that HST is more cost-effective than substandard MT.

Schechter and Kendall misinterpret our comments on the need for both ITT (intention-to-treat) and OT (on-treatment) analysis when interpreting treatment retention results. More patients were on MT than HST by the end of the trial. It is misleading to record these subjects as retained in HST when they were in fact on MT for several months before the trial ended.

The rate of life-threatening events, 0.16 per patient per year, is unacceptably high for a long-term outpatient treatment. The authors attribute the large difference in overdose rates to under-reporting of off-site overdoses in the MT group. Our understanding is that the NAOMI trial recorded hospital and emergency admissions for all subjects, so off-site overdoses requiring medical treatment results have appeared in such journals as the Lancet, and the British Medical Journal.

As we have stated several times in various publications, we believe that methadone, provided according to best-practice guidelines, should remain the treatment of choice for the majority of patients. We also advocate for greater accessibility to such treatment, not only in Vancouver but also outside the lower mainland of BC.

Our significant difference from Kahan and colleagues is our recognition that even when optimally provided, methadone maintenance has a non-trivial failure rate, and second-line alternatives do exist that are cost-effective and provide clinically and socially significant improvements for individuals who have not benefited from methadone maintenance alone.

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REFERENCES