

Dihydrocodeine Treatment of Alcohol Addicts with Previous Opiate Addiction — Case Reports

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Summary

Objective: In papers already presented at conferences we were able to report that a successful maintenance therapy for alcohol addicts is possible with Dihydrocodeine (DHC). Here we report the case histories of 9 serious alcohol addicts; eight of these were former opiate addicts and the ninth a former non-addicted heroin user. **Methods:** We describe here all nine of our former heroin users who have more recently been treated with DHC because of a serious alcohol addiction. They had all distanced themselves for several years from their earlier phases of heroin addiction. All these patients had received professional counselling and, with one exception, had experienced professional addiction treatment. We prescribed DHC very cautiously and normally avoided exceeding the dosage of 320 mg daily, a much lower dosage than would have been needed for opiate substitution; higher dosages were prescribed to only two patients in this group. **Results:** All these patients substantially reduced their alcohol consumption; this led to a clear general improvement. Two patients stopped drinking altogether, the first over a period of 1.5 years at the time of writing, and the second over a period of nearly 3 years; both report an unrestricted feeling of well-being. One has, meanwhile, also completed his DHC-intake treatment. A third patient showing a similar improvement, who now drinks only very occasionally, does not seem to need absolute alcohol abstinence. In most of the patients the improvement was not sustained or absolutely irrefragable. One patient with a severe phasic depression committed suicide after years of clear improvement. Other patients showed an only transient improvement in their GGT, despite having reported nearly complete alcohol reduction and a drastic improvement in their anxiety and panic attacks, or they experienced a gradual relapse back to their original level of alcohol consumption. Two patients refused to undergo a regular DHC therapy as prescribed by us, and switched back to heroin or alcohol consumption. **Conclusions:** In 7 out of 9 patients a clear improvement in the situation was achieved by prescribing DHC. These seven patients substantially reduced their alcohol intake; in two cases drinking was completely eliminated. But one suicide, one heroin relapse and two apparently definitive alcohol relapses, in addition to other problems, show that we are unable to present DHC as offering all patients an easily won treatment success.

Key Words: Dihydrocodeine Treatment - Alcoholism - Heroin Addiction

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Introduction

Maintenance therapy has become by far the most important treatment for heroin addicts during the last few decades. But society, and even many addiction experts, think that the main reason for this is the illegal status of heroin, and most people tend to classify this therapy as harm reduction. They have not yet recognized that maintenance is a basic principle in the treatment of addiction diseases. What other reason could there be for the fact that dynamic, wide-ranging research into the development of maintenance therapies for alcohol dependants has not yet begun? The need is absolutely evident. Abstinence-based therapies play only a marginal role, as they have almost no statistical relevance, when considered alongside the total number of addicts.

A daunting number of patients have shown us how difficult it is for them to live with or without alcohol. Permanent relapses destroy substantial areas of their lives. In addition, patients who absolutely need alcohol abstinence for their health, but are not able to stay abstinent over long periods of time, bring with them an urgent and often life-challenging indication that they must have some kind of maintenance therapy. But no tests have been carried out, and up till now this approach has never been adopted.

A few German practitioners have experimented by transferring their experience of maintenance therapies for heroin addicts to alcohol-dependent patients. The results have been encouraging and clearly show that this approach should be applied much more widely. Based on the experience that methadone turns out to be accompanied by more problems with alcohol than those that occur when DHC is taken, and that some individual patients reported the disappearance of alcohol craving when using DHC, we started to substitute alcohol systematically with DHC. Since then we have become confident that this can constitute an adequate, in some cases, an optimum treatment, at least for heavily affected drinkers.

For instance, a few of our patients who previously drank continuously or were susceptible to relapses, with countless detoxifications, have now been living as alcohol abstainers for more than 5 years. Their health and quality of life display decisive improvements.

On the basis of our experience, the needed dosage of DHC is around one quarter or one third of what heroin addicts need. As a result, if we proceed in an orderly way, we can avoid any risk of inducing severe opiate addiction. In cases where success is unattainable, it is not normally too difficult to stop this kind of trial.

Our very limited experience is not the outcome of any officially sponsored research, but is a systematic documentation of treatment development in daily practice. Official research is expensive, and often means following a long route from an idea to an official initiation, depending on the priorities of financial sponsors. There are also other handicaps, such as quasi-ideological barriers, especially in the field of addiction treatment.

In daily practice, therefore, a systematic documentation and collection of many individual cases is an essential alternative to, and supplementation of, established research, showing us many phenomena for which we have no established explanations or solutions currently exist. Of course, such learning-by-doing calls for a good degree of integration into professional discussions. That is why I am thankful for this opportunity to publish our first experiences with former opiate addicts here.

In 58 patients we prescribed a low dose of DHC for alcohol addicted patients. We limited the daily dosage to 320 mg (4x 80mg). It is not an easy matter to single out the cases in which this was successful. A DHC prescription was often one in a sequence of steps and only part of an extensive concept, which had to work together with the other parts. Roughly speaking, we can say that one quarter of these patients experienced crucial and sustained benefits from this treatment.

We must take into consideration that the conditions are still being developed. We have no knowledge of the optimal dosage, many fears continue to surround the experimental character of the treatment, and the whole logistical setting is missing. Some of our failures arose from our excessive caution: we explained extensively that this treatment was not an established one and was not accepted by several experts, that the window of DHC is much smaller than that of alcohol; we explained the danger of inducing a new kind of opiate addiction, and in some patients the low dosage reflected too much caution.

Former opiate addicts were not the first category of patients to receive DHC treatment from us because of a condition of alcohol addiction. We first started to treat ex-opiate addicts after years of encouraging experiences with other patients who had no history of opiate addiction. This history is connected with a short list of special questions and problems:

What happens if we lead these patients back to the opiates?

What about their former integration into illegal scenes? Heroin is illegal, alcohol is not. The rules for maintenance therapies pertinent to opiate addicts take the illegal status and the realities of the black market into account⁽¹⁻⁵⁾. This is a world set apart from the socially integrated world of alcohol addicts.

How about the best dosage?

Patients and methods

What follows is a description of all of our patients who were treated with DHC because of a serious alcohol addiction and who were former heroin users. They had all distanced themselves, over a period of several years, from their phases of heroin addiction. This history had ended many years previously (4 - 25 y) in 8 patients and, when under our care, none of them were opiate addicts. One patient with HIV and hepatitis C was in our maintenance therapy for opiate addiction from January 1989 to April 2004, with no further opiate problems for >10 years, but he had an increasing dependency on alcohol. He therefore underwent a special inpatient treatment in an addiction clinic but relapsed back into alcohol abuse a few weeks later. Another patient was a non-addicted heroin user years ago, but then became seriously alcohol-addicted. He suffered from a gambling addiction, too. All patients received professional counselling and, except one, had experienced in professional addiction treatment. Based on extensive information and a written informed consent, we prescribed DHC very cautiously and normally avoided exceeding a dosage of 320 mg daily (the usual limit was, in fact, 280 mg), a much lower dosage than would have been needed for opiate substitution (800-1000 mg). Higher dosages were only prescribed for two patients.

Case reports

Patient 1: A 34-year-old man with hepatitis C (virus type 1) reported that he had stopped using heroin and cocaine over 10 years previously. He then spent 5 years in prison. After leaving prison, he had never relapsed into opiate use. He said that alcohol had always been his leading drug, for over 15 years. This addiction was terrible; he was loud and turbulent, and could not wait. It was very difficult and nearly impossible to help him with any normal treatment. He had many contacts with our problematic patients in opiate maintenance therapy. Three former inpatient detoxifications and one therapy in an addiction clinic had no sustained success. Within 18 months he needed 8 further detoxifications, and he tried one further therapy in an addiction clinic. There was no sustained response.

Because of his hepatitis it was urgent to interrupt his alcohol consumption. Repeated examinations revealed no hint of any further use of illegal drugs. But his GGT figures was 940 U/l. Directly after his 11th detoxification and with his extensively informed consent, we prescribed 160 mg DHC daily. The success obtained was impressive. He immediately reported having no further alcohol craving; he lost his restlessness and distanced himself from the scene of methadone patients. After a few days he suggested reducing the dosage to 120 mg daily, and remained on that dosage for 20 months. Then he completed the maintenance therapy, reducing the dosage within 7 months. Four months after initiating the DHC-therapy, he started a successful therapy for his hepatitis. His liver parameters have now been normal for over 2 years, and he has been living without alcohol or craving for nearly 3 years; in the meantime, he has been living without DHC for 5 months.

Patient 2: A 51-years-old man with heroin addiction since 1978, and with HIV (identified in 1985) and hepatitis C (virus type 2b) was in our methadone maintenance therapy for opiate addiction from January 1989 to April 2004, with no further opiate problems for >10 years, but his dependency on alcohol continued to rise. His GGT went up to 1137 U/l. He therefore underwent a special inpatient treatment in an addiction clinic, but relapsed into alcohol abuse a few weeks later. We performed a new detoxification and treated him initially with 160 mg, then with 280, and, since November 2005, with 400 mg DHC daily (exceeding our dosage limit for alcohol addicts because of the short time that had elapsed since our long-term maintenance therapy for his previous opiate addiction ended). Since then he seems to have stayed free of relapses and craving. His liver parameters are normal, despite the still unresolved hepatitis. The HIV-infection remains very stable (his current CD4-count is 900/ μ l). His quality of life is good — the best he ever had. According to the rules for opiate maintenance therapies⁽²⁻⁵⁾ he has to come for a new prescription and consultation every week.

Patient 3: A 32-year-old lady came to us in 1993, because of her HIV infection, which was identified in 1989, (stage B3, OHL, CD4 190/ μ l) and her chronic hepatitis C (virus type 1). We treated her with antiretrovirals every year, and, unsuccessfully, with interferon in 1996. She had finished her four-year phase of drug-taking in 1987, undergoing an inpatient therapy in a specialized addiction clinic. Since then she has lived a more stable life, working as an office manager in the same factory as her husband. I did not have the impression she had a psychological disorder at any time, apart from a mild depression. But, on her own initiative, she told me she that she was drinking too much alcohol on a daily basis and that she feared

a bad prognosis because of the hepatitis and permanently elevated liver parameters (as high as 164 U/l). “There is always too much strain on me”. Besides this, she reported that her sexual life with her husband was not very satisfying because of the loss of her libido. We tried to stabilize her situation for years with a psychotherapeutic approach, two times with acamprosate, and once with naltrexone, but without success. After 9 years the gravity of her situation escalated, with her GGT rising to 248 U/l.

In March 2003 we initiated a very low dose DHC treatment (40 mg daily). Her immediate answer was: “I feel so much better!” She has not needed alcohol to cope with her daily life since then. It also seems that she doesn’t need to be absolutely abstinent; she allows herself a drink at rare intervals, taking a small amount, for instance, at birthday parties. We raised the dosage to 280 mg and then reduced it provisionally to 260 mg. Her GGT didn’t fall into a normal range, but went down to 70 U/l. Our impression is that in the current phase of her life DHC seems to be the ideal answer to her longstanding life problems, the most important of which was her high alcohol consumption. Now, with DHC, the dangerous prognosis for her liver disease has clearly improved.

Patient 4: A 26 year-old-lady came to us in 2001, because of her HIV infection, which had been identified in 1998, and her chronic hepatitis C (virus type 1). She was just finishing a follow-up therapy after her third inpatient treatment in an addiction treatment centre. She didn’t like to be questioned about 4 inpatient detoxifications, an unsuccessful Interferone-Ribavirin therapy or about an earlier six-month methadone-maintenance therapy. Her main goal had become that of building up a new, abstinence-based life. But whatever she tried, she didn’t succeed. Recurrent anxiety and panic attacks, and endless trouble with other people destroyed all her attempts to live a normal life. The impression made by her always reminds us of a lack of some addictive substance. She tried several antidepressants, but without without success. She reported more and more openly that she had been drinking too much alcohol, starting in 1992. We therefore started to prescribe a low, 80 mg dose of DHC in March 2004. But she felt extremely concerned about contracting a new dependency. This fear was the main reason why she never reported feeling well at any time. She also complained about her DHC-related constipation, and she finished the DHC intake after 10 weeks.

Once again we had to face a very difficult situation. Abstinence was unsuccessful, in July 2006 she needed an alcohol detoxification, and during the last few weeks she has tried to separate from an alcoholic friend. She experienced a lot of trouble with authorities and other people, and it seems that her life will never succeed, or only after a very long period beset with plenty of difficulties. Should we try another approach with buprenorphine? Her desperate parents would support that. But she herself fears the prospect of dependency.

Patient 5: A 41-year-old man came to us in 1994 because of his freshly detected HIV infection. It was unclear if he has become infected through his former drug use, years earlier, or, as he believed, through heterosexual contacts. After a short time we had to face a series of severe alcohol intoxications and 12 inpatient detoxifications with him. When asked about the cause of these intoxications he answered: “Because of my desperation”. Several antidepressants didn’t help, and his antiretroviral therapy was seriously endangered. In 1998, we prescribed 150, and, a few months later, 180 mg DHC daily, and for over a year it seemed

perfect: there was no craving, no relapse and no further desperation. But he continued to report a severe relapse into desperation. He urged us to drastically increase the dosage. We raised to 1580 mg, but he needed three inpatient treatments, more because of his desperation than because of slight alcohol relapses. After this phase lasting over six months the rather stable phase returned without any new relapses for the next two years, and he continued to reported a crucial improvement in his life because of the DHC. The dosage was gradually lowered to 360 mg, without encountering any resistance from him. But his depression still failed to respond adequately to treatment. He suddenly committed suicide, by jumping in front of a train.

Patient 6: A man, born in 1961, had been addicted to heroin from 1982 to 1989. He came to us in 1992 because of HIV infection (recognized in 1990) and hepatitis C (virus type 1). A treatment with interferon in 1996 was not successful. We have been treating him with antiretrovirals since 1997. He reported increasingly severe alcohol problems. His GGT rose to 136 U/l. In October 1998 we started to prescribe a very low dose of DHC. He was fearful of taking this regularly and started to take it only as needed. This was against our advice, but his use of DHC was very low, and it looked successful for one year, with falling liver parameters. But after this first year, he reported needing more and more, and we switched to our substitution dosages. He took 200, and then 280mg daily for 7 months. His alcohol-craving was drastically reduced, and he was nearly completely alcohol-abstinent. Then he reported relapses into heroin; he preferred to stop the DHC medication and underwent a new inpatient detoxification. He interrupted his HIV-medication too, and didn't resume until, three years later, his CD4 count fell to 140/ μ l. Shortly after his detoxification he resorted to alcohol again repeatedly, but he also used more heroin, fearing the alcohol because of his hepatitis and preferring heroin anyway.

Meanwhile, after taking drugs for 26 years, he still fears a “real addiction”, as he calls it, and rejects all offers of substitution. One of the major reasons for this rejection, he says, are the rules for maintenance therapies in our country, which makes him feel under greater pressure than when he buys his drugs on the illegal private market. Last week he underwent a new inpatient detoxification, but “It's a permanent fight”, as he stated afterwards.

Patient 7: A 35-year-old lady came to us in 1996 because of her HIV infection (identified in 1985) and chronic hepatitis C (virus type 3a). In 1991, two inpatient therapies in addiction clinics had stopped her opiate consumption after 10 years. But now she was drinking a lot of alcohol, often smelled of alcohol and always had high liver parameters (with GGT as high as 224 U/l). The major problem was: constant severe anxiety and permanent panic attacks. She was a very difficult patient for us, due to her borderline personality, and was almost nearly untreatable, but really suffered from a very poor prognosis. The prescription of a mini-dosage of DHC (50 mg daily) led to an impressive change: her anxiety and panic attacks seemed to have been resolved. Within 20 months, she needed an increase in dosage up to 200 mg. Her general status remained much improved, and she reported that she was not drinking alcohol any more. Her GGT fell to 55 U/l. But during the next few years it oscillated between 22 and at least 338 U/l again. Because of the concomitant hepatitis and the treatment for her HIV infection it was almost impossible to decide whether alcohol or

these diseases were the reason, but she had never again smelled of alcohol. Repeated checks did not show any alcohol in the blood probe. In the meantime the daily DHC dosage has been lowered to 150 mg daily. But we are unsure if this dosage is the optimum one. We think it would be better to treat and stabilize her at a higher dosage. To discuss this in an open manner is difficult because of her borderline disorder and her strong wish to become independent of our treatment in due time.

Patient 8: A 36-year-old man reported he had been drinking a lot of alcohol or too much alcohol for 13 years and, that he had finished his sporadic use of heroin, cocaine and fungi, 6 years before. Four inpatient therapies in addiction clinics and 13 detoxifications led to no sustained success. Besides this, he suffered from a gambling addiction. Within 10 months he needed 5 further alcohol detoxifications. Then we prescribed 120 mg DHC daily and raised the dosage to 240 mg within 6 weeks. His alcohol consumption was strictly reduced, but a few weeks later he reduced the DHC dosage by himself, adding the comment: "I don't like it". Two weeks later he needed a new treatment for alcohol detoxification. We finished the short DHC treatment together which had, perhaps, been too cautious. But we did not have enough experience to be able to promise him that an improvement would be probable with a higher dosage or a longer treatment. He remained alcohol-dependent, and, up to now, we have not been able to really help him. But since the DHC treatment phase, he has reported a crucial, sustained improvement of his gambling addiction that has been uninterrupted so far.

Patient 9: A 45-year-old man came to us, referred to us by an advisory centre, because of his alcohol dependency, together with a simultaneous severe form of Crohn's disease. He reported that he had been drinking too much alcohol for more than 10 years. 20 years ago, he had used heroin i.v. for two years. After a first outpatient detoxification, we treated him initially with acamprosate. Because of its gastrointestinal side-effects and because there was no immediate positive effect on his craving, he stopped the intake after only 4 weeks. But he obviously remained alcohol-abstinent for a whole year, coming to us every third week. GGT and MCV turned to their normal range. Then he relapsed and interrupted his visits to our practice for nearly two years. When he came back, his situation showed a drastic deterioration. It had become much more difficult to stabilize his addiction disease and his Crohn's disease. During the next two years, his GGT rose to 250 U/l, and his MCV up 107fl.

After a new outpatient detoxification we started him on 160 mg DHC daily. His alcohol craving disappeared at once, and his GGT fell to 74 U/l. After that, we had several discussions because he had some elevated GGT results, with values as high as 137 U/l and there was sometimes the impression of ongoing alcohol consumption, which, however, he denied. Suddenly, after 10 months, he stopped the DHC intake, complaining that we would not trust him, and interrupted the whole treatment. Then, last week, 11 months later, he came back and asked to resume the DHC treatment. But he remained ambivalent and couldn't bring himself to restart really this treatment.

Discussion

All these cases go to show that it is possible to treat former heroin addicts with DHC, if they have problems with alcohol addiction. This seemed to be an ideal solution for some of our patients. But the field has not been fully prepared yet. In some cases, the patients, and we ourselves, have been too cautious. Our experience was not broad enough, and the patients showed an extreme fear of the pathway leading back to opiates. They had heard one continually repeated message: that their highest goal should be to get away from opiates. All their counsellors said it, and so did all the experts. There was, in fact, no advisory system in place capable of supporting an alcohol-substituting treatment. We have no secure knowledge of the best dosage or the best substance. We are only able to present preliminary experiences that this principle of treatment method is possible, and that, in a few patients, it gives almost ideal results.

In many cases, however, these results do not come easily. This approach must be founded on systematic research. We need a surrounding system of logistical support, and this requires a complete change in the paradigms being used. Abstinence is not the best solution in all patients, as was true of patient 4. In many patients, too, it is clearly better to keep them on opiates than on alcohol. Thus it is wrong to promote opiate abstinence as the top priority. In this way, too, alcohol proves to be life-devastating and dangerous to our patients, and these constraints on treatment often leave us with a feeling of desperation. A change in attitude is an absolute necessity.

We used DHC because of the experience of two colleagues and because of the report of one of our own first patients that a pain treatment with codeine dissolved his alcohol craving. This patient, who has now been taking DHC for 9 years, has been free of alcohol relapses since then. Before this, all experts and we ourselves were desperate and couldn't think of any way of helping him with his therapy-resistant craving and permanent relapses.

The history of maintenance therapies in Germany started with DHC. Methadone remained illegal up to 1992, and in the early years, up to 1998, it remained very difficult to prescribe it, because of the Narcotic Act. As we are based in Germany, we were able to gain a lot of experience with DHC, which, up to 1998, could be prescribed freely. But this freedom led to a lot of abuse and inappropriate prescriptions for heroin addicts, and some cases of death were related to these prescriptions. DHC was therefore classified under the Narcotic Act in 1998, and was almost forbidden. Physicians and patients were forced to change over to methadone. This change went almost unnoticed in scientific assessments. But we and other colleagues had the clear impression that many patients went on to develop a severe problem with alcohol dependency thereafter. We therefore came to believe that DHC is a better substitute for alcohol than methadone.

Many heroin addicts report that alcohol was their first gateway drug, but that they stopped drinking it when they became dependent on heroin. Under methadone, many of them started to drink too much alcohol again. This second viewpoint again leads us to conclude that methadone is not as good a substitute for alcohol as DHC, which is pharmacologically closer to heroin.

But we have no knowledge of other opioids. No research and no experience with bu-

prenorphine, for instance, are available. In one single patient, buprenorphine reduced craving, but did so much less effectively than DHC.

Why has there been no research up to now? It is not yet an accepted fact that abstinence is not possible for some patients or that it is not the best option for the patient. A considerable proportion of patients with addiction diseases need substitution therapies for very many years, some of them indefinitely.

Once this is realized, we should follow up by optimizing the structure for this kind of treatment. Subordinating it to many difficult rules has the outcome that very few doctors are able to offer this treatment, and patients have to come to treatment centres regularly. This looks like a dead end. People on maintenance therapies should receive as much support as possible in living a normal, integrated life. For most of them this is made impossible by there being so very few treatment centres. A regular involvement of most of the practitioners is needed, with a minimum of rules and a maximum availability of the best possible support for their efforts.

In any case, systematic research on substitution treatments for alcohol addicts must be the first step.

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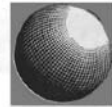
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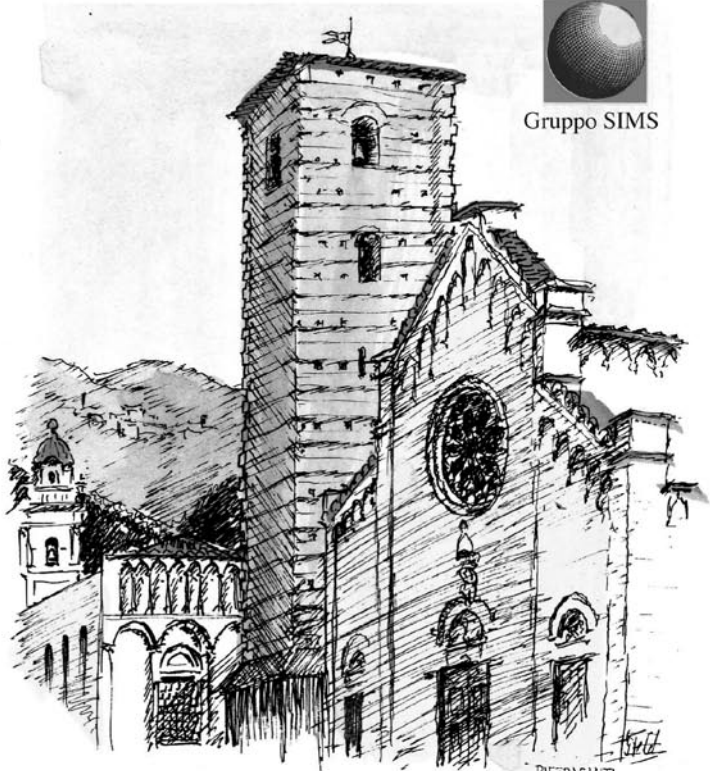
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