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Letter to the editor

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What is the right dosage for our patients?

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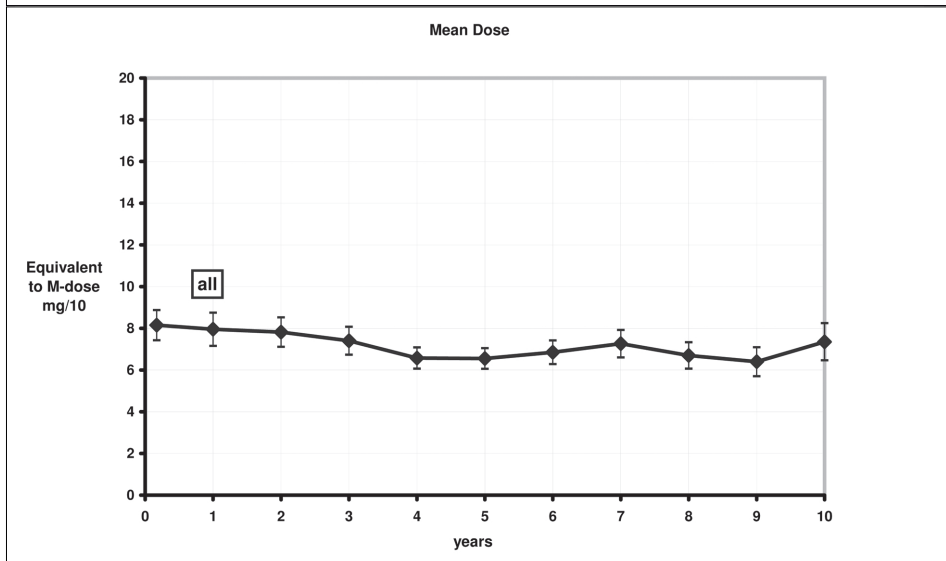
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TO THE EDITOR: To prepare a discussion about the right dosage, I took our own documentation, using the charts for all patients treated during the last 20 years, with entries for the dosage used ($n = 184$) and made an evaluation: What was our average dosage after 2 months, 1 year, 2 years, and so on, up to 10 years. I also evaluated the changes in average dosage in a particular treatment-phase as that progressed. Our hypothesis was that of an average reduction in dosage. We were permanently aiming for abstinence and, in most cases,

trying carefully to reduce the dosage after initial stabilization. For the evaluation, the Dihydrocodeine dosage was divided 1:10 (1000 mg DHC corresponding to 100 mg Methadone), whereas the Buprenorphine dosage was multiplied by 3.3.

The average dosage after 2 months corresponded to 81.5 ± 7.3 mg Methadone, that of the year 10 to 73.5 ± 8.9 mg. Hence the average dosage is nearly constant over the whole time considered (Figure 1). During the last 20 years, there has been a trend to higher dosages. Our mean dosage at

Figure 1. Average prescribed Methadone dosage for 10 years



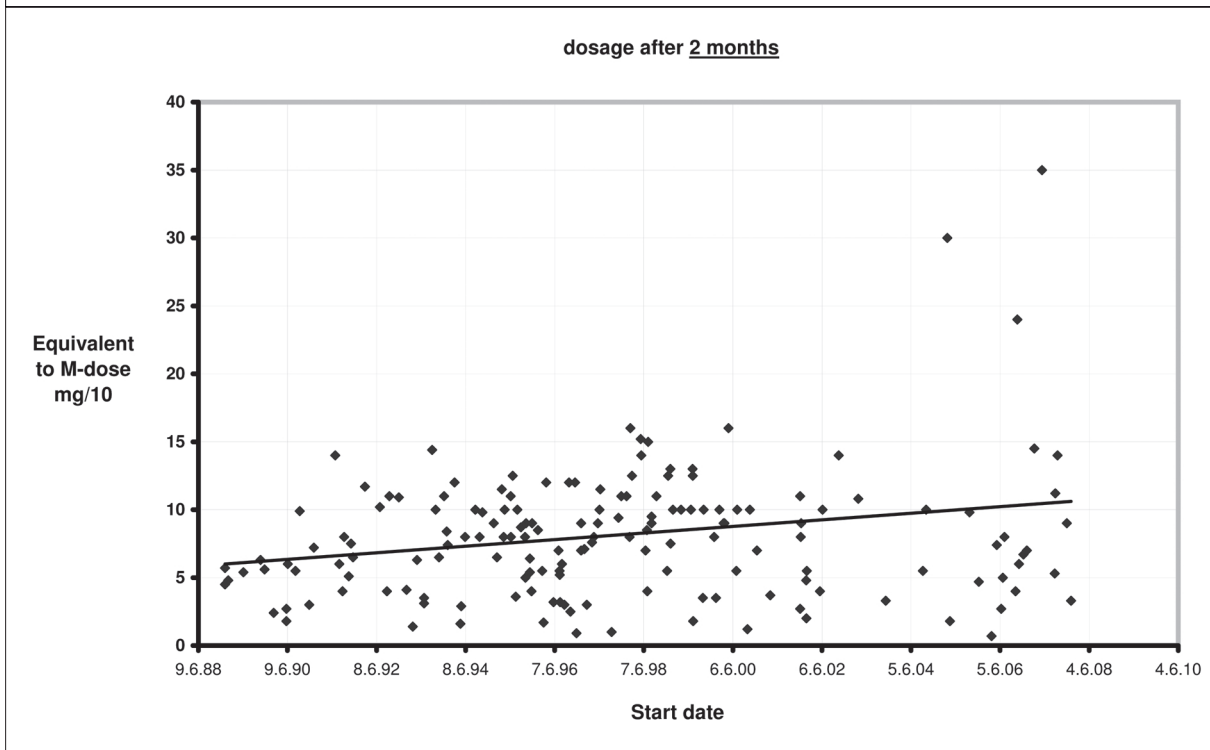
month 2 was 66 mg in 1989 and 108 mg in 2008 (Figure 2), with a similar development for all later dosages (year 1, 2, 3 etc.). For many years we excluded very high dosages (> 200mg). Only in the last few years did we prescribe much higher dosages (up to 450 mg) for a few patients – and we were able to record very good results and had a very good general impression in some of these patients. The 10-year-dosage information was only available from 26 patients. Of 12 patients, we know that they have died, and our latest information from 12 other patients was a successful completion of the maintenance treatment, reaching stable abstinence. The other patients are either lost to follow up or have not completed 10 years yet.

abstinence in some distant future. The consequence to be drawn from the de facto constant average dosage over such a long period must be that we should always prescribe the clinically optimal dosage.

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Figure 2. Methadone dosage



The almost constant average dosage over a period of 10 years was a surprise, because we had expected that our ongoing attempt to reduce dosages would lead to lower average dosages after a number of years. The constant average dosage is a consequence of the fact that some patients need a repeated increase in their dosage, and, with a few patients, we did not find out for several years that it is much better to treat them with much higher dosages (as found out especially by M. Shinderman, but also following other published data). The results make it clear that some of the patients are not on the way to abstinence. These patients are not being treated optimally if we continue to prescribe the lowest possible dosage, always aiming for

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Conflict of Interest

The author has no relevant conflict of interest to report in relation to the present letter.

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