November 21, 2017 (/blog/2017/11/21/lessons-learned-on-opiates-and-ldn-for-fibromyalgia)

Lessons Learned on Opiates and LDN for Fibromyalgia (/blog/2017/11/21/lessons-learned-on-opiates-and-ldn-for-fibromyalgia)

By Ginevra Liptan, MD

The typical recommendation has always been to only prescribe low dose naltrexone (an opiate blocker that acts in the brain to lower volume of pain, see **my previous blog post** (http://www.drliptan.com/blog/2016/2/28/the-three-letters-you-need-to-know-if-you-have-fibromyalgia-ldn) for more details) for people that are taking no opiate-based pain medication. The concern is that naltrexone as an opiate blocker will force opiates off their receptors in the brain and induce unpleasant withdrawal symptoms.

But since so many patients in chronic pain utilize opiates to manage symptoms, this really limited the folks with whom we could try LDN as a treatment. When I presented on using LDN for fibromyalgia at a recent conference, the audience asked the most questions about trying LDN on patients taking opiates. So here is a review of my experience thus far.

To be a candidate to try LDN in my practice while still taking opiates, patients had to meet these criteria:

- Not taking any long-acting opiates such as morphine Extended Release (MS Contin), Oxycodone Extended Release (Oxycontin), Butrans or fentanyl patch (since long-acting opiates hang around on the receptors for a long time, very likely to trigger withdrawal)
- Take only short-acting opiates and be willing to separate LDN dosage by six hours
- Be on a relatively low dosage of opiates; for example a total daily dosage of 40mg or less of morphine or hydrocodone, 30mg or less per day of oxycodone, or 300mg or less per day of tramadol
- If they were on the higher end of these opiates dosage ranges or very prone to medication side effects, we did ultra low dose naltrexone ULDN (typically 0.5 mg or under), otherwise we did the typical dosage of 3-4.5mg.

Here are a few success stories and a few cautionary tales:

SUCCESS: Patient #1 was taking tramadol 50mg four tabs daily for fibromyalgia pain and headaches. We added in LDN in typical dosage titration of 1.5mg x 14 days, 3mg x14 days and then went up to 4.5mg nightly. I instructed her to separate her LDN and tramadol dosages by at least six hours. Since she takes LDN at bedtime around 11pm, this meant no tramadol after 5pm. She followed this schedule, had no experience of withdrawal once starting LDN, and felt tramadol retained its effectiveness. Even better, her overall pain was reduced by LDN to the point that she was able to reduce from taking four tabs of tramadol daily to only one or two.

FAIL: Patient #2 is very sensitive to medications and prone to side effects. She was taking 3.5 tabs of hydrocodone 5mg/325mg acetaminophen, but due to concern about side effects we opted to try ULDN at dosage of 0.35mg nightly. Although she was separating her dosage of hydrocodone and ULDN by six hours, within an hour or so of taking the ULDN she experienced opiate withdrawal symptoms of intense sweating, anxiety, and restlessness, so she stopped it after a few nights.

PARTIAL SUCCESS: Patient #3 takes hydrocodone 10mg/325mg acetaminophen, four or five tabs daily to manage fibromyalgia and arthritis pain. We added in LDN in typical dosage titration of 1.5mg x 14 days, 3mg x 14 days, and then went up to 4.5mg nightly, separated by

six hours from last opiate dosage. At the 4.5mg dosage she noted worsening of headaches and hot flashes, but no overt withdrawal symptoms. The headaches and hot flashes returned to her usual levels within a few weeks. She continued taking LDN at 4.5mg for three months, but noticed no improvement in pain so stopped taking LDN.

FAIL: Patient #4 had been working on tapering down her morphine dosage for years with the goal of trying LDN. She had been on dosages as high as 240mg total of morphine daily, including both long-acting and short-acting forms. Over several years we worked together to get her off the long-acting morphine (MSContin) completely and down to only 15mg of short-acting morphine twice daily as needed for about two weeks, when we started 1.5mg of LDN at bedtime, again separated by six hours from last morphine dosage. The next day she woke up in full-blown opiate withdrawal, what they call the "opiate flu" with diarrhea, body aches, and nausea. In hindsight, because she was on high doses of opiates for many years, we should have chosen ultra low dose naltrexone.

Lessens Learned:

- Everyone is very different in their sensitivity to both opiates and propensity to experience withdrawal symptoms when adding in LDN or ULDN
- If someone has been on high dosages of opiates for years and only recently tapered down, choose ULDN
- LDN or ULDN may not work as well while also taking opiates
- Always separate dosages of short-acting opiates from ULDN or LDN by at least six hours, but even with that separation may still experience withdrawal symptoms

My next blog post will answer some frequently asked questions I get about using LDN and ULDN for fibromyalgia. Stay tuned!

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